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As we are quickly approaching the end of 2021, it is time once more to take inventory of our work and contributions over the past twelve months. And what a year it has been! It seems that psychologists have been busier than ever- and our specialists have often found themselves at the forefront. Please join me in reading updates across our specialty boards and other affiliated organizations—where colleagues are fervently working to inform and produce quality research, which in turn is knowledge translated into training, service delivery and policy making opportunities and vice versa.

Moreover, last October a call went out to our readers, with the intend to collect submissions from specialists and their collaborators across areas of expertise. Some suggestions were made requesting topics on leadership in times of change, mental health in the workplace, self-care in times of a pandemic, as well as global perspectives. Once again, it gives me sincere pleasure to announce that you have responded to the call; volume 49 of our newsletter has collected a solid compilation of articles on: a) the mental health needs of healthcare workers and of “healers”; b) global initiatives on appreciating cultural differences and similarities in the delivery of evidence based and culturally competent interventions; c) the essential elements on how to help individuals attempting to restore normalcy in their workplace— in a post-pandemic world. Additionally, we are fortunate to briefly feature some interesting publication attempts in the world of psychology.

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

On this note, I would like to express my sincerest gratitude for appointing me as Editor of the Specialist for the past four years. It has been an honor and a humble experience to meet and communicate with such an array of brilliant minds. Wishing you a wonderful holiday season and a healthy, happy, and prosperous 2022!

Respectfully,

Kristine T. Kingsley, PsyD, ABPP
Editor, the Specialist
President's Column

Christina Pietz, PhD, ABPP
President, American Board of Professional Psychology
Board Certified in Forensic Psychology

The impact of COVID-19 has been overwhelming for many organizations, but the American Board of Professional Psychology (ABPP) adapted our operations and business so that Specialty Boards and the ABPP could continue to conduct business successfully. As I complete my Presidency, the American Board of Professional Psychology continues to be in good standing.

As a consequence of the pandemic, the ABPP and Specialty Boards were tasked with pivoting from face-to-face examinations and in-person meetings to some form of remote interaction. During the June 2021 Board of Trustees’ Meeting, Trustees described remote oral examinations as successful and noted the desire to maintain the option of offering remote examinations post pandemic. Specialty Boards Presidents echoed this point of view. The pandemic has taught us that change can be positive, pushing us to do things in innovative ways. Thus, the ABPP Board of Trustees approved Specialty Boards continuing to offer remote evaluation post pandemic, as they see fit. In 2022, some Specialty Boards will continue to conduct business remotely; some will return to the traditional method of face-to-face oral examinations and meetings, while others will use a hybrid approach. Over the past two years, I met via Zoom with Specialty Board Presidents, and I was always impressed and grateful for the camaraderie exhibited by Specialty Board Presidents, who unselfishly, assisted other Boards with establishing a remote style of oral examinations that fit their needs. In 2022, I anticipate that Specialty Board Presidents will continue to assist other Boards with ongoing adaptations that fit that Board’s specific needs.

Currently, we have fifteen specialty boards, and one subspecialty. During our June 2021 meeting, the Board of Trustees heard the formal proposal from the Serious Mental Illness (SMI) group and authorized this group to begin the implementation phase of affiliating with ABPP. Likewise, in early 2020, the Addictions group, was authorized to begin the implementation phase of affiliating with ABPP; this group is progressing toward completing this phase. During the June 2021 meeting, the Board of Trustees heard from two other groups, Forensic Neuropsychology (subspecialty) and Psychopharmacology; Forensic Neuropsychology submitted a brief proposal to be recognized as a subspeciality, and Psychopharmacology submitted a brief proposal to be considered as a Specialty. The Board of Trustees deliberated both requests, and after much discussion, decided not to support either group moving forward to the full proposal phase.

In the March Specialist, I noted that the ABPP made a few changes to improve our organization, and since March 2021, this organization has continued to adapt and change. For example, a webinar task force was developed to explore opportunities for the ABPP to offer webinars for continuing education credits. In September 2021, the ABPP and the CONCEPT entered into a contract allowing the CONCEPT to assist the ABPP with developing webinars. This provides the ABPP an invaluable opportunity to reach out to our Specialists, other psychologists, and psychologists pursuing Board Certification with professional continuing education opportunities. The Board of Trustees considers this an incredible marketing tool for our organization, while providing Psychologists an

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opportunity to pursue ongoing professional education. Although ABPP’s webinars are currently in the development phase, we will soon offer a variety of webinars for attendance.

The pandemic provided us an opportunity to explore the structure for our Board of Trustees’ meetings, and we plan to hold our December 2021 Board of Trustees’ meeting in a different format. Some trustees will be attending live, while others will attend virtually. Hybrid meetings are going to be in our future, and the Executive Committee and Central Office are prepared to make this change. The Board of Trustees will likely need to invest in updating our technology to accommodate both those attending live and those attending virtually to receive the full experience of the meeting and, financially; we are able to assume these costs. Although in-person meetings have a significant advantage over Zoom meetings in terms of productivity and creativity, we recognize that, for some, traveling, may be a hardship. Consequently, we want to offer alternatives for our Trustees to attend meetings as they deem fit. Hence, our 2021 Board of Trustees’ meeting will be held in a hybrid / hyflex format, and we anticipate future Board of Trustee Meetings being held in this same format.

We recognize that IT is our future. For this reason, the Executive Committee has continued to explore ways to monitor and update our IT Platform. Toward this goal, the Executive Committee entered into contract with an IT Developer, who has developed a platform- both user friendly and adaptable to the nuances of each Specialty Board. Despite it still being in the developing phase, we are close to meeting our goal.

Reflecting on my two years as President of the Board of Trustees, I continue to be awed by the commitment, creativity, and devotion of Trustees, as well as their dedication to their respective specialty boards. During the pandemic, the Executive Committee, Trustees, and Central Office Staff never wavered on their commitment to this organization. The American Board of Psychology continues to positively impact the culture of professional psychology and fulfill the organization’s mission. As Past President, I will continue to challenge the Board of Trustees and all Specialists to actively participate in planning for the future of our profession by encouraging eligible licensed psychologists to pursue board certification. With Dr. Spiegler at the helm, ABPP’s future continues to be bright. It has been an honor to serve this organization for the past two years as its President.

Christina Pietz, PhD, ABPP

President, American Board of Professional Psychology
Board Certified in Forensic Psychology
And so, we continue during what I am sure we all wish are the final months of the pandemic. Hopefully, a return to relative normalcy is awaiting us in 2022. I yearn that we can look forward to not having to take COVID issues into account in 2022 and get back to “business as usual”. At ABPP, “business as usual” includes our terrific Central Office (CO) staff: Nancy McDonald, Lanette Melville, Diane Butcher, and Kathy Holland. Without them, we would undoubtedly be a ship adrift in the middle of the sea. There is a tremendous amount of work that goes on behind the scenes, and I want to be certain that our staff gets the recognition they deserve. The individuals at CO work very much as a team; each staff member plays a key role individually, yet also as a partner of the team. The outcome of the work of ABPP really does depend on each CO member’s efforts and dedication. I am writing this column, as we head into Thanksgiving week, and I will be the first to point out that I am incredibly grateful for having the opportunity to work with such a talented, committed, and fun group of people.

Post-pandemic, “business as usual” may never be the same again. We have experienced such dramatic changes in the way we conduct meetings, exams and other activities. Indeed, an “up-side” of the pandemic has been undertaking the process of beginning, and becoming adept at, the use of synchronous video as a means of communication that I anticipate will be used for years to come. Our Specialty Boards did a wonderful job of transitioning to A/V examinations; I suspect the technology going forward, will be used for exams in many instances. If for no reason other than scheduling and accessibility issues, this may forever change the way we think about exams.

ABPP typically reports the number of newly-board-certified specialists on a July through June calendar (this has historically been the case in order to prepare that roster for the Convocation in August). Using that benchmark, in 2020-2021 ABPP experienced the second largest number of newly-board-certified specialists in our history! The only period that exceeded that was a time when we had two new specialty boards affiliating and they generated a large cohort of folks. I suspect that the switch to A/V exams played a significant role in this. I am hopeful that continued use of A/V exams will allow for increased access for candidates, as well as positive changes in the way we schedule and process examinations. Kudos to all involved in making this unanticipated transition an enormous success!

Current status & updates of proposed ABPP Specialties & Subspecialties.
In the ABPP June Board of Trustees (BOT) meeting, Clinical Psychopharmacology presented a brief proposal for affiliation, which was declined. The vote was quite close, yet the motion to have the group present the lengthier full proposal did not pass. ABPP recognizes that this Specialty is recognized by the Commission for the Recognition of Specialties and Subspecialties in Professional Psychology (CRSSPP) and the vote was based upon the perceived viability of the proposed specialty examining board. Additionally, a Forensic Neuropsychology Subspecialty proposal, did not get a vote of support from the BOT to proceed. It should be noted that not getting the green light...
to move forward now, does not preclude a group from proposing an affiliation once more, at some point in the future.

At our December 2021 meeting, two groups will be presenting their plan for implementation of examinations for board certification. These are the: **Serious Mental Illness Psychology (SMI) and Addiction Psychology (AP)**. SMI is recognized by CRSSPP as a Specialty, while Addiction Psychology, currently recognized by CRSSPP as a proficiency, is seeking affiliation as a Specialty with ABPP. We will encourage the latter to seek Specialty recognition by CRSSPP, as is our custom.

The viability and sustainability of Specialty Boards has been addressed at BOT meetings on more than one occasion. This past year included the designation of an ad hoc workgroup to review the issue. The workgroup produced some suggestions and issues to consider that were briefly discussed at the June 2021 meeting. There had been a plan to have a more in-depth discussion of these matters at the December 2021 meeting; however, the schedule is quite full, and the decision has been made to reschedule that discussion to the June 2022 meeting. In the interim, I am asking that BOT representatives to refresh their memory on the issues (see June 2021 BOT Agenda Book) and hold discussions with your Specialty Board in preparation for our June discussion. A reminder that what was provided by the workgroup is to be seen as a one suggestion about how these matters might be managed; no final decision has yet been made, awaiting the BOT discussion.

**Interorganizational Work -**

That segues us into some issues related to the interorganizational nature of ABPP’s work. There are a couple of issues that our BOT will need to address explicitly and through some detailed discussion that have to do with our interface with CRSSPP, the Council of Specialties in Professional Psychology (CoS), and others.

One issue is that of recognition of subspecialties. With respect to affiliation with ABPP, ABPP has already decided that for specialties that are recognized by CRSSPP, ABPP will accept the specialty and focus on issues related to the fiscal and other factors regarding viability of a proposed new specialty board. ABPP has not yet had a similar discussion with respect to subspecialties. For the moment, this is a moot point in that CRSSPP has not yet recognized any subspecialties. However, at some point in the future we may be presented with the need to address how to handle an application for affiliation from a newly-CRSSPP-recognized subspecialty. It is best that we have the discussion regarding this prior to that time.

Another issue has to do with the **Taxonomy for Professional Psychology Health Service Specialties and Subspecialties** (hereinafter referred to as the Taxonomy). The Taxonomy has been a focus of work for many of us for well over a decade. I was a member of the original Taxonomy workgroup back in roughly 2008 and it has continued to be a part of my interorganizational work, as it has for many others. I have previously written some about this and provided a link or two; here is a valuable one for APA: [https://www.apa.org/ed/graduate/specialize/understanding-taxonomy](https://www.apa.org/ed/graduate/specialize/understanding-taxonomy) and here is one for the completed Taxonomy grids for various specialties as provided through COS: [https://www.cospp.org/education-and-training-taxonomies](https://www.cospp.org/education-and-training-taxonomies). The Taxonomy is an important aspect of how we as professionals and organizations define education and training as it relates to specialty. Please familiarize yourself with this area; we will be working with specialty boards to integrate the Taxonomy for their specialty into manuals and other materials.

Toward that end, there has been continuing work from the **Interorganizational Summit on Specialty, Specialization, and Board Certification 4.0** that has been done by the Outreach and Communication Committee from that meeting. We have worked on infographics regarding the Taxonomy as it may be perceived by various sectors (e.g., public,
students, psychologists). Many thanks to the group, comprised of Drs. Scott Sperling, Toni Minniti, Lesley Lutes, John Piacentini, and others at APA with whom I worked on this effort. We have completed much of the work and this can be viewed on the APA website at https://www.apa.org/ed/graduate/specialize/understanding-taxonomy and also at the CoS 2021 Taxonomy https://www.cospp.org/2021-cos-taxonomy-initiative.

Of course, meetings have been held exclusively in virtual format for the better part of the past two years. I have continued working with numerous groups including, but not necessarily limited to, the APA Board of Professional Affairs (BPA), APA Board of Educational Affairs (BEA), Association of State and Provincial Psychology Boards (ASPPB), Association of Psychology Postdoctoral and Internship Centers (APPIC), and others. I also hold regular meetings with the CEOs of ASPPB, the National Register of Health Service Psychologists (NR), and the Trust. I served on an invited group, the APA Summit on the Future of Education and Practice, which has held two meetings thus far. I will be continuing to serve as an ABPP liaison on an outgrowth of that group, in conjunction with BPA, on Licensing and Scope of Practice issues related to those with a master's degree in psychology. I am very pleased that ABPP is seen as an important component of these interorganizational activities.

Technology Update

ABPP has been diligently working with Cerebral Consulting on an updated platform for processing materials involved in the application, practice sample submission, and other aspects of the board certification process. We have been extremely pleased with the work done, responsiveness and professionalism, and prototype provided by Cerebral Consulting. The EC has had the opportunity to view this prototype, modeled after the American Board of Clinical Psychology (ABCP) process, as has the ABCP, and everyone is quite happy with what we see. The BOT will experience highlights of this during the upcoming BOT meeting; we welcome input and feedback and are hopeful to have a vote to move forward with a build-out for the rest of the ABPP specialty boards.

Respectfully submitted,

David R. Cox, PhD, ABPP

Executive Officer

June 2021 Board of Trustees – Virtual Meeting (Highlights)
John F. Kelly, PhD, ABPP
Elizabeth R. Spallin Professor of Psychiatry in Addiction Medicine at Harvard Medical School

Raymond Hanbury, PhD, ABPP
Chief Psychologist, Department of Psychiatry
Director of Psychology Education
Jersey Shore University Medical Center
Derek C. Phillips, PsyD, MSCP, ABMP
President, Society for Prescribing Psychology

Marlin Hoover, PhD, MS, ABPP, ABMP
Licensed Clinical Psychologist — Illinois
Prescribing Psychologist — New Mexico
Forensic Clinical Neuropsychology: Subspecialty Proposal presented to the ABPP BOT

American Board of Clinical Neuropsychology (ABPP-CN)

Joel Morgan (FN SIG Co-Chair)
Michael Westerveld (FN SIG Co-Chair)

June 19, 2021

Regarding a Proposed ABCN Subspecialty Certification in Forensic Psychology

Marc Martinez, PhD, ABFP President
Randy Otto, PhD, ABFP Executive Director

Presented at the June 2021 Meeting of the ABPP Board of Trustees

Randy Otto, ABFP Executive Director
During the late 1970s while I was completing my graduate studies, one of my late mentors and good friend, Jack Lit, PhD, ABPP, invited me to his home office for a group supervision session. While I was admiring his framed diplomas, I happened to notice one that was unfamiliar to me. It read, “American Board of Examiners of Professional Psychology.” This certificate was awarded to him in the early 1960s and appeared - for the most part - to be hand calligraphed except for the banner. I inquired with Jack as to what this certificate represented, and he went on to explain to me that it was the highest credential that a psychologist could obtain. It was also his belief that someday it would likely be the required credential of all practicing psychologists. Since it was so far off from my radar screen at the time, I forgot about it initially, but Dr. Lit’s words always resonated with me. Later on in the late 1980s, after I obtained my license and all of my post-doctoral training, I saw that a few of my colleagues had also obtained board certification by the American Board of Professional Psychology (ABPP) and decided that it was a credential that I should pursue. I became board certified in the early 1990s and I am so glad that I did, since it has proven to be a significant resource to my career many times over.

In the spirit of promoting board certification, about 20 years ago I published an article in Professional Psychology Research and Practice, titled “Board certification, is it really necessary?” (Dattilio, 2002). At that time, just shy of two percent of psychologists were board certified by ABPP. The gist of my article focused on the notion of whether board certification was really necessary for a psychologist to obtain. One of the most common responses that I received from colleagues when promoting board certification was, “Why is it necessary?” Hence, I penned this article in order to address the benefits of obtaining ABPP and why it was worth the time and effort to pursue. Since that time, there have been other articles published on the topic including one edited book (Maguth, Nezu, Finch & Simon, 2009).

Present Status
As of this writing, the recent statistics indicate that four percent of all psychologists in the country have now become board certified with ABPP.

Many of the reasons why psychologists avoid becoming board certified in the past have included the cost of application and fees along with time for preparation and study. Some may outright fear failing the test and become discouraged from even trying. In addition, many may view board certification as “elitist” and that it is more of an intellectual exercise than one that has practical utility. As with many psychologists, if they cannot see a direct benefit to the effort that is involved, they may likely be disinclined to obtain it.

As the field of psychology becomes more specialized, however Specialty Board Certification has proven to serve as a demarcation of distinction. More hospitals and institutions now respect and anticipate board certification among psychologists with some federal organizations actually remunerating employees accordingly. There is also a discount on the fee for malpractice insurance if one is also board certified. Expert witnesses are now routinely questioned about whether they maintain board certification in their specific area of practice. Also, many states and provinces have recognized the ABPP certification as a partial waiver for licensing in their respective jurisdiction.

According to the most recent edition of “The Specialist” (2021), there are now fifteen Specialty Boards and one...
Subspecialty Board. Additional areas of specialization are also being considered in the areas of Addiction, Forensic Neuropsychology and Psychopharmacology. The expansion of additional boards may also be an increasing attraction to psychologists who wish to display specialization in their particular area of expertise.

The Future of Board Certification
As stated in my article, Dattilio (2002), Bent, Packer and Goldberg wrote in 1999 that “It is not the exceptional specialist who should be board certified, but [it is] the specialist who is not board certified [who] should be the exception.” (p. 14). I believe that the future for board certification with ABPP is bright and will undoubtedly continue to grow. The looming question remains whether we, as psychologists feel that we have obtained the credentials that best reflect our true knowledge and expertise in our field. Board certification in the psychological specialty seems to be the most obvious means of confirming our stated expertise, and as such, board certification is likely to become the norm in the future credentialing of all psychologists, particularly as areas of specialization become more defined and the demand for accountability and credentialing increases.

The question that I posed in my 2002 article was whether board certification was really necessary. In the past 20 years since the article appeared in the professional literature, the need for professionals to detail their areas of expertise over and above generic licensing as psychologists has become increasingly essential. It is also my belief that in time board certification will become imperative as a way to define our qualifications and standards of excellence as the field of psychology continues to grow. As my late colleague, Dr. Lit, told me so many years ago, at some point in time, it will be the required credential of all practicing psychologists.

Promoting Board Certification
One of the best ways that we, as board certified psychologists, can promote future certification among students, mentors and colleagues is through education and supervision. The earlier that graduate students are educated to the benefits of this credential, the more they become persuaded to pursue it, which is why I disseminated my 2002 article to numerous doctoral training programs throughout the USA and Canada.

I also believe that promoting the credential during the course of supervision as my friend, Dr. Lit did so many decades ago can also be very influential to young professionals.

References


FRANK M. DATTILIO, PhD, ABPP, is one of the leading figures in the world in the areas of cognitive-behavior therapy, and clinical and forensic psychology. He received his doctoral training in Clinical Psychology at Temple University in Philadelphia, PA and trained in Behavior Therapy with Edna B. Foa, PhD and the late Joseph Wolpe, MD at Temple University School of Medicine in the late 1970s. He also completed a post-doctoral fellowship in Cognitive Therapy with Aaron T. Beck, MD through the department of Psychiatry at the University of Pennsylvania School of Medicine in the early 1980s. He is currently a part-time teaching associate with the Department of Psychiatry at Harvard Medical School where he formerly served as an instructor in psychiatry for 14 years. Dr. Dattilio is also a clinical associate professor in psychiatry (psychology) with the University of Pennsylvania Perelman School of Medicine where he has
taught since 1988. He is a licensed psychologist in the states of PA, NJ, NY, and DE, and is listed in the National Register of Health Service Providers in Psychology. He also holds a Certificate of Professional Qualifications (CPQ) in Psychology with the Association of State and Provincial Psychology Boards.

Dr. Dattilio is board certified in both clinical psychology and cognitive-behavioral psychology through the American Board of Professional Psychology (ABPP) and received a Fellowship Certificate of Training in Forensic Psychiatry (Psychology) through the Department of Psychiatry at the University of Pennsylvania School of Medicine, Philadelphia, Pennsylvania. He is also a founding Fellow of the Academy of Cognitive Therapy (ACT) and is a Fellow in the division of clinical psychology with the American Psychological Association. Dr. Dattilio has been a visiting faculty member at many major universities and medical schools throughout the world.

He is the recipient of numerous accolades, including the award for Distinguished Psychologist by the American Psychological Association’s Division 29 (2002) and the award for Distinguished Contributions to the Science and Profession of Psychology by the Pennsylvania Psychological Association (2002). Dr. Dattilio has also been inducted into the prestigious College of Physicians of Philadelphia for his many contributions to medicine and science (2004) and is the recipient of the 2005 Association for Behavioral and Cognitive Therapies (ABCT) award for “Outstanding Contribution by an Individual for Clinical Activities.” Dr. Dattilio also received the 2007 Award for Distinguished Contributions to Psychology and Humankind by the Philadelphia Society of Clinical Psychology, as well as the Marriage and Family Therapist of the Year Award for 2010 by the Pennsylvania Association of Marriage and Family Therapy (PAMFT). He is the recipient of the “Outstanding Contribution to Marriage and Family Therapy Award” for 2013 by the American Association for Marriage and Family Therapy (AAMFT).

Dr. Dattilio’s active areas of research involve selected topics in cognitive-behavior therapy, clinical and forensic psychology, and case-based investigations. He has been featured in “Harvard Science” and continues to provide Grand Round presentations to the faculty and staff.

Dr. Dattilio has over 300 professional publications (peer reviewed) and 21 books in the areas of anxiety disorders, forensic and clinical psychology, and marital and family discord. He is a world class educator who has presented lectures and keynote addresses extensively throughout the United States, Canada, Africa, the Middle East, Europe, South America, Asia, Australia, New Zealand, Mexico, Cuba and the West Indies on both cognitive-behavior therapy and forensic psychology. To date, his works have been translated into 30 languages and are used in 80 countries throughout the world.

Among his many publications, Dr. Dattilio is the co-author of the books, The Therapeutic Relationship in Cognitive-Behavior Therapy: A Clinician’s Guide (2017), as well as Case Studies Within Psychotherapy Trials: Integrating Qualitative and Quantitative Methods (2017). He is also the author of the book, Cognitive-Behavior Therapy with Couples and Families: A Comprehensive Guide for Clinicians (2010). This book has been translated into 17 languages. Additional co-authored, edited, and co-edited books include:

∞ Crime and Mental Illness (2008)
∞ Practical Approaches to Forensic Mental Health Testimony (2007)
∞ Mental Health Experts: Roles and Qualifications for Court (1rst ed, 2002; 2nd ed, 2007)
∞ Cognitive Therapy with Couples (1990)
∞ Handbook of Forensic Assessment: Psychological and Psychiatric Perspectives (2011)
∞ Comprehensive Casebook of Cognitive Therapy (1992)
Oddly, how to respond to the unethical behavior of others is rarely thoroughly discussed in the professional literature. (Koocher & Keith-Spiegel, 2016, p. 587)

It is no exaggeration to say that most, if not all, psychologists will face several situations during their careers that involve suspected or verified ethics violations committed by another psychologist. When these situations occur, psychologists are ethically obligated to respond. The American Psychological Association's (APA) Ethical Principles of Psychologists and Code of Conduct (EPPCC) identifies two, and sometimes overlapping, methods for responding to ethics violations. These are Standards 1.04 (Informal Resolution of Ethical Violations) and 1.05 (Reporting Ethical Violations) (APA, 2017). The former is a preferred method for resolution and to be sought whenever appropriate and possible (Barnett & Johnson, 2010). The latter, which is sometimes referred to as a formal method of resolution, is reserved for ethics violations in which an informal resolution is unsuccessful or when substantial harm has occurred or is likely to occur. The descriptions that accompany the EPPCC standards have sometimes led to confusion about what response is best for a particular situation. While the lack of clear direction may leave psychologists concerned about the appropriateness of their response and the potential for negative consequences (e.g., retaliation), the language used in the standards is likely purposeful because appropriate resolutions of ethics violations are often complex and difficult to distill into mechanistic, rudimentary steps. To provide additional guidance in determining whether informal, formal, or both types of resolutions is appropriate, a list of ethical dilemma assessment questions are provided below in Table 1. These questions were influenced by the work of several authors (Barnett & Johnson, 2010; Brodsky & McKinsey, 2002; Koocher & Keith-Spiegel, 2016; Pope & Vasquez, 2016) and organized into three general categories: self-reflective, potential or known ethics violator, and contextual. The categories and questions are not intended to provide an exhaustive list of considerations.

Table 1. Ethical Dilemma Assessment Questions

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<td>- How certain do I feel that unethical conduct occurred or will occur?</td>
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<td>- How confident are others with whom I have consulted that unethical conduct occurred or will occur, given a comprehensive presentation of the information available?</td>
</tr>
<tr>
<td>- How did I feel about the psychologist in question before I learned about the unethical conduct?</td>
</tr>
<tr>
<td>- How might my feelings about the situation or toward the psychologist negatively affect my ability to make objective decisions?</td>
</tr>
</tbody>
</table>
• If my ability to respond in a reasonable, professional manner is compromised, can someone else who has a better relationship with the possible or known ethical violator intercede or assist?
• What style of informal resolution would I respond to best?
• Have I considered having colleagues review my correspondence to the psychologist in question or role play the interaction that may occur during an informal resolution?
• If I am thinking about taking no action, have I considered whether this is due to “bystander apathy” (i.e., rationalizing that someone else will deal with the issue) (Koocher & Keith-Spiegel, 2016; Pope & Vasquez, 2016)?
• Do I have any support available—institutional or otherwise—that can assist me with navigating this process?
• Can I offer oversight that would provide the opportunity to see whether the informal resolution is effective?
• What steps can I take to protect my welfare?
• Have I adequately documented this situation?
• Should I seek legal consultation on this issue?
• What are my concerns about seeking informal versus formal resolution?
• Barnett and Johnson (2010) note that the term “reasonable” as used in the EPPCC means “the prevailing professional judgment of psychologists engaged in similar activities in similar circumstances, given the knowledge the psychologist had or should have had at the time” (p. 5). Could I defend the course of action I am considering to be consistent with this?
• Have I considered or do I need to consult others to understand the possible influence of cultural factors on the situation as they relate to my own and the potential or known ethics violator?
• How do I feel about the possibility of the potential or known ethics violation continuing to occur?

Potential or Known Ethics Violator

• What is the best organization to inform about the complaint based on what is known about the psychologist?
• Does the potential or known ethics violator have any personal characteristics that may compromise an informal resolution or increase the chances of retaliation/vigorous defense?
• Is the violation a pattern that has been long standing?
• Was the possible or known ethics violation unintentional or purposeful?
• Was the possible or known ethics violation due to incompetence?
• How did the psychologist respond to the informal resolution?

Contextual

• Has harm occurred or is there a risk it will occur? If yes, to what degree?
• What type of harm applies to this situation (e.g., emotional, physical, financial, reputation of psychology in eyes of public or other professionals)?
• Does a client’s privacy and confidentiality limit my ability to speak directly with the colleague or report the situation? If so, is it possible to obtain written consent of the affected individual(s)?
• Even if confidentiality issues apply, is someone in immediate danger that mandates breaking confidentiality?
• Have I considered whether there is any relevant state or federal case law that would dictate my response (e.g., privilege, mandated reporting of professional misconduct)?
• How reliable and persuasive is the evidence available (e.g., direct observation, secondhand information, casual gossip)?
• Are there any issues related to timing that should be considered (e.g., active involvement in ongoing forensic case)?
• What would be the possible effects of action and inaction?
As a case example, Dr. A receives information from a colleague about Dr. B who is allegedly billing Medicaid for the services of an unlicensed professional in a state where this is not permitted. Dr. A has had no personal interaction with Dr. B but has heard from the same colleague about Dr. B's questionable practices in the past. In the state where Drs. A and B are licensed, there is a mandate to report misconduct by another professional to the Board of Psychology. The mandate does not note any civil immunity for those making a report. After considering the ethical dilemma assessment questions, Dr. A decides there is limited information available and to contact Dr. B by phone in the hopes of clarifying and resolving the issue. Dr. B responds to the call by dismissing the accusations and lashing out at Dr. A with legal threats if Dr. A jeopardizes his license. Dr. A tells Dr. B that the intention of the call is solely to inquire about the possibility of unethical conduct and, per her ethical obligations, work toward a resolution if necessary. Dr. B apologizes to Dr. A, for his initial reaction and acknowledges billing for the services of unlicensed professionals, but not Medicaid and only with the formal agreement by applicable insurance companies. During their discussion, Dr. B was able to demonstrate a keen awareness of ethical billing practices and provided a colleague in his practice to confirm the information he provided. Dr. B thanks Dr. A, for contacting him directly rather than reporting the situation to the Board of Psychology without knowing all the details. Dr. A later learns that the colleague who provided her with the information did not have direct knowledge of the alleged billing behavior and had a long-standing feud with Dr. B due to their adversarial involvement in a legal case several years ago. In retrospect, Dr. A was grateful that she pursued clarification of the issue through informal resolution rather than reporting Dr. B to the Board of Psychology, especially since this could have had legal ramifications for Dr. A.

In the case presented, Dr. A was able to navigate the possible ethical violation appropriately. She correctly sought informal resolution due to the questionable nature of the information available and remained calm and non-defensive in response to Dr. B's initial anger and threats. Dr. A was able to obtain additional information that would have made a formal resolution inappropriate and potentially led to negative action against her license.

Ultimately the decision whether to pursue informal, formal, or both types of resolutions in response to a possible or known ethics violation will be made on a case-by-case basis after a careful analysis of the relevant factors. As a recommended practice, it is prudent for psychologists to document how they addressed potential or known ethics violations by detailing what they did and why as well as what they did not do and why. This analysis should then be maintained in an analogous manner as clinical records, which are directed by state and federal requirements.

REFERENCES


The American Board of Professional Psychology Foundation recognizes that early career psychologists represent tomorrow’s educators and leaders of psychology, and the Foundation has been sensitive to the fact that there can be real barriers for Early Career Psychologists (ECPs) should they wish to seek board certification. For many psychologists in the early phases of their careers, the journey to completion of doctoral studies and subsequent licensure required financial sacrifices and was often accompanied by external financial support in the form of educational loans. Early career psychologists report an average graduate education debt of $80,000 with monthly payments averaging over $400 (Doran et al., 2016). Discharging acquired financial obligations related to the academic, training, and experience requirements to become a psychologist quickly rise in priority as psychologists begin their careers. ECPs often take a decade or more to pay off their student loans (Doran et al., 2016). At this early stage of their professional lives, the costs associated with becoming board certified may be a deterrent for some highly qualified early career psychologists seeking board certification as substantiation of their competencies in an ABPP specialty.

The Foundation is committed to the growth of the future educators and leaders of professional psychology by promoting and supporting ECP’s path toward board certification in an ABPP recognized specialty as they begin and advance their careers as psychologists.

The Foundation has a number of different scholarship programs available to ECPs—a few of which are exclusively for psychologists at this early stage in their professional careers. These include: a) the ECP Scholarship; b) the Dr. Eileen Gupton Memorial Scholarship; and c) the National Latinx Psychological Association, ABPP Foundation, and National Register of Integrated Behavioral Health Scholarship (see more information below). Other Foundation scholarships that are available to ECPs (but not exclusively for them) are: the APPIC/ABPP/ABPP Foundation Scholarship for Training Directors; the Walter Katkovsky Scholarship; and the Kaslow Family Fund Scholarship. For information on the ABPP Foundation’s various scholarships and to apply for a scholarship, please go to: https://www.abpp.org/Foundation2/ABPP-Foundation-Funds.aspx.

a) Early Career Psychologist (ECP) Scholarship: The goal of the ECP Scholarship Program, the Foundation’s newest scholarship, is to provide financial support for early career psychologists seeking ABPP board certification in their chosen ABPP specialty. Scholarships are limited to ECPs who are not already board certified by ABPP.

b) National Latinx Psychological Association, ABPP Foundation, and National Register of Integrated Behavioral Health Scholarship: These scholarships are for ECPs who are pursuing ABPP certification in any of ABPPs recognized specialties. To be eligible, applicants must be a graduate student or ECP, a member of the National Latinx Psychological Association (NLPA), English/Spanish bilingual, and intend to work with Hispanic populations in an integrated health delivery setting.

c) Dr. Eileen M. Gupton Memorial Scholarship Fund: The Gupton memorial scholarship fund was established in honor of the late Dr. Eileen Gupton. It supports specialty certification in Police & Public Safety Psychology, particularly for early career psychologists.

The American Board of Professional Psychology Foundation has not always collected ECP information/status from scholarship applicants. However, increased emphasis on the needs of ECPs and the development of ECP focused scholarships has moved the Foundation to collect this essential information. To date (2021), the Foundation has
awarded a total 121 scholarships across all scholarships. Of these, the Foundation has collected ECP information from 118 scholarship recipients. Of the 118, 80 (68%) were ECPs and 38 (32%) were not ECPs. This reflects the Foundation’s commitment toward supporting ECPs in the ABPP board certification process.

References

The impact of the pandemic on youth has made the mission of ABCCAP, to promote the provision of quality psychological services through the certification of clinical child, adolescent, and pediatric psychologists, even more relevant. Despite having to curtail in-person activities, ABCCAP found ways to leverage virtual platforms to remain on mission and pursue a number of exciting initiatives in 2021.

ABCCAP collaborated with the Society of Pediatric Psychology (APA Division 53), the Society of Clinical Child and Adolescent Psychology (APA Division 45), and the Clinical Child Adolescent and Pediatric Training Council (CCAPPTC) on several endeavors consistent with our mission of promoting the field of clinical child and adolescent psychology. ABCCAP representatives participated on task forces that coauthored revisions to the Taxonomy for Education and Training in Clinical Child and Psychology and recommendations for training guideline development for clinical child and adolescent psychology. The renewal of the Clinical Child and Adolescent Psychology (inclusive of Pediatric Psychology) Specialty recognition application, which ABCCAP coauthored, was approved by the APA Commission for the Recognition of Specialties and Proficiencies in Professional Psychology (CRSPPP). Further, ABCCAP participated as a sponsor of the Society of Pediatric Psychology and the Association of Psychologists in Academic Health Centers 2021 conferences. ABCCAP also presented on Board Certification and ran a virtual information booth for attendees.

Over the past year, ABCCAP completed numerous examiner training and administration initiatives. ABCCAP President-elect Omar Gudiño developed and conducted three examiner training CE webinars, training thirty-eight new examiners in 2021. ABCCAP now provides access to this recorded Webinar as an additional resource for examining committees. Due to the overwhelming positive response to the webinars, ABCCAP plans to hold two examiner trainings annually. Under the direction of David Langer and Omar Gudiño, ABCCAP refi ed the Stage 2 and Stage 3 evaluation rubric with clearer, more descriptive behavioral anchors and Likert scale ratings. ABCCAP also revised our Examiners’ Supplemental Manual with more explicit directions for conducting Stage 2 Reviews and Stage 3 Examinations, and guidelines for mentoring new examiners. The ABCCAP Examiner Database was expanded to include information on examiner identification with minority groups and practice areas to promote DEI when constructing examination committees.

ABCCAP refi ed our diversity, equity, and inclusion goals based on the 2020 online DEI survey of ABCCAP specialists conducted by ABCCAP board members Omar Gudiño and Jarrod Leffler. Goals include:

1) Encourage gathering data on ABPP members identification and ABCCAP DEI efforts with diverse groups.

2) Increase representation of diverse groups in ABCCAP applicants.
3) Increase representation of diverse groups on ABCCAP Executive Board (25% of Executive Board identified with a minority group in 2020 increased to 33% in 2021).

4) Encourage diverse applicants to apply through board certification by explicit messaging in board certification presentations, marketing materials, and the ABCCAP website.

5) Actively identify and recruit Clinical Child, Adolescent, and Pediatric Psychologists from diverse backgrounds to apply for board certification.

6) Promote DEI by engaging with leadership of and marketing CE presentations on board certification to diverse organizations (APA MFP alumni, Association of Black Psychologists, National Latinx Psychological Association, Division 53 –diversity Sig, Division 54 – Diversity Committee, APAHC -Diversity and Health Disparities committee).

ABCCAP continues to utilize Box, a HIPPA-compliant content management platform, for submitting and reviewing applications including video practice samples. This content sharing platform enables us to efficiently and securely manage our application examination processes. Through Box, examiners have easy access to training materials, forms, letter templates, and manuals as well as application materials. ABCCAP also utilizes Box for communication, storage, and collaboration related to Executive Board activities.

The level of interest in board certification among Pediatric and Clinical Child Psychologists remains high with a steady flow of applicants that continues to grow. Over the past year, ABCCAP increased the visibility of board certification with SPP and SCCAP members through regular posts on listservs, conference CE presentations, and contributions to their newsletters. In 2021, ABCCAP reached over 250 psychologists through a series of highly successful and well-attended CE webinars on board certification.

In closing, we would like to recognize Jarrod Leffler, PhD, ABPP and Greta Francis, PhD, ABPP as recipients of ABCCAP’s distinguished contribution award: https://abpp.org/News-Events/Awards/Specialty-Boards-Academies/2021.aspx. Stay tuned for future developments related to developing video content to promote board certification, implementing engagement strategies with ABCCAP membership to increase the value of board certification, and executing initiatives to support DEI in our specialty.
American Board of Clinical Neuropsychology (ABCN) and American Academy of Clinical Neuropsychology (AACN)

By: Kathleen Fuchs, PhD, ABPP, President of American Board of Clinical Neuropsychology

Updates

This time last year, many of us expected that the pandemic would be over, and our lives and practices would return to "normal." It seems the virus is still very much with us, and we have had to embrace a new normal. Although our processes have been adapted in order to reduce the risk of transmission, ABCN has been able to hold exams and AACN has offered a conference with content relevant to the challenges of practicing during a pandemic. We appreciate all those who have worked to make this possible.

Oral Exams

Following the imposition of travel restrictions due to the pandemic, ABCN was able to pilot and implement a virtual format whereby we examined 101 candidates in 2020 and 36 in the spring of 2021. While pass rates have been comparable to in-person exams, our accumulated experience with this format has revealed potential problems, some of which are technical in nature. We felt it prudent to continue the virtual format for our fall 2021 exam but will seat fewer candidates simultaneously to mitigate against the aforementioned issues and allow more flexibility to better respond to technical problems when they arise. However, the nontechnical issues remain including “Zoom fatigue” and the challenges of building exam team cohesion and rapport with a dispersed cadre. So, while the virtual format allowed us to prevent candidates from being delayed in getting boarded during the pandemic, it is not a sustainable method for us in the long run. ABCN plans to return to an in-person format in spring 2022, which will allow us to seat more candidates per exam as well as train new examiners. We appreciate that in certain situations, the virtual format may be essential for some to complete the boarding process and, to that end, ABCN has convened a committee to explore criteria and guidelines for the board to consider.

Pediatric Subspecialty

After many years of service which included obtaining ABPP approval for the Subspecialty and seeing 123 individuals designated as sub-specialists, Ida Sue Baron, PhD will be stepping down as Chair. We are fortunate that Jennifer Koop, PhD has agreed to serve as the new Chair and will start her term in February of 2022.

We are proud that Velisa Johnson, PhD received the ABPP Early Career Diversity Award for 2020. Dr. Johnson is now also one of our three newly elected board members (and congratulations to Sakina Butt, PsyD and Anita Sim, PhD who are the other two). Additionally, Rob Davis, PhD was the recipient of this year’s Clinical Neuropsychology Specialty Board & Academy Award from ABPP. As noted in this update, he has been instrumental in facilitating the virtual oral exams and the virtual AACN conference.
AACN Conference
Following the cancellation of our 2020 conference slated for Washington DC, we had hoped to meet in person in Portland in June of 2021. While that in-person meeting did not take place, we were able to have a virtual meeting with a full schedule of workshops and presentations, as well as live online Q and A sessions that followed pre-recorded presentations. Additionally, many members appreciated that the CE courses were available for viewing for a period of time following the conference dates.

Diversity and Inclusion
Representatives from AACN and ABCN are currently part of a commission that is planning the “Minnesota 2022 Conference to Update Education and Training Guidelines in Clinical Neuropsychology.” This is an important, multi-organizational initiative to update the Houston Conference Guidelines which were developed in 1997 and included in the policy statement that a two-year postdoctoral fellowship in Clinical Neuropsychology is a required component for entry-level practice. ABCN includes this as a requirement for board certification for candidates who have completed training on or after January 1, 2005. The key factors that have been identified as needing to be addressed in the update include the incorporation of a well-articulated competency-based approach to training, the integration of multiracial/multiethnic/multicultural issues within every training experience and competency, and incorporation of innovative technologies and advances in neuroscience data analytics, and computer technology. This conference is intended to include delegates from all training, practice, and scientific organizations in neuropsychology and especially delegates who are members of groups that have been underserved clinically and professionally. It is expected that the resulting updated standards for education and training in Neuropsychology be a major step in addressing diversity concerns within the profession and in preparing specialists to better serve an increasingly culturally diverse population.

We are proud of AACN’s Relevance 2050 Committee for starting the update effort by reaching out to the professional and scientific organizations in the field and asking for partnership in this process, and we appreciate the enthusiasm of those who have agreed to join. We look forward to the policy statements that will emerge from this conference and are ready to update our exam content and boarding procedures to align with the revised guidelines.

Thanks to Drs. John Lucas, Rick Naugle, Brad Roper and the Houston Conference Guidelines Revision Planning Commission for their contributions to this update.
Candidate and Examiner Support for Continuing Virtual Oral Exams

On May 29, 2020, I had what turned out to be the pleasure of serving on the exam committee for the first virtual synchronous audiovisual oral exam conducted by the American Board of Clinical Psychology (ABCP). This followed a three month “layoff” from oral exams due to the COVID-19 pandemic’s onset. “Turned out to be the pleasure” is intentional; we three examiners were worried that it might be anything but a “pleasure.” We feared there would be some technical glitch with Zoom that would derail the exam, despite our Chair being an experienced Zoom user. We’d set aside four hours for our typical three-hour exam, just in case technology went sideways. We feared we would lose the non-verbal signals between examiners by which we transition questioning between each other during the give and take of the oral exam conversation. We feared the exam would be more awkward than collegial. Most important, we feared the virtual format would somehow undermine the high quality of the ABCP oral exam process that we, three highly experienced examiners, were determined to preserve as best we could.

None of that happened. The exam went really well in all regards. Technology worked, we “clicked” as a collegial committee, the candidate was pleased and thought the process had gone really well, and all three of us on the committee believed that there had been no loss of quality in the oral exam process. I passed along my surprised enthusiasm to my colleagues on the ABCP Board of Directors. Self-reflection, and feedback from the clinical psychology interns I supervise, confirm that I am an “electronic dinosaur”. The thinking I shared with our Board was “if I can make this work, it’ll work for all of us.”

As of the date of this writing, ABCP has conducted 84 more virtual oral exams. Utilizing those 85 exams, the ABCP Board has looked carefully at the virtual exam process, including feedback we have gotten from other examiners, our own assessment as examiners and frequently exam chairs, and feedback from our candidates after their oral exams. We’ve discussed this ongoing assessment at our Board meetings in October 2020, April 2021, and October 2021. We have determined that virtual oral exams have sustained the quality of the ABCP oral exam process, that technical issues have been quite infrequent and not a significant problem in any exam, and that the virtual oral exams are highly rated and appreciated by the candidates. We have unanimously agreed to continue offering candidates the option of virtual oral exams, even after the pandemic no longer presents an issue for in person exams. The rest of this article presents our findings supporting that decision.

To summarize verbal feedback from ABCP examiners at the conclusion of these oral exams, and occasional emailed feedback afterwards, none of our examiners have reported any significant concerns with the virtual exam process. The same is true of our Board members’ experience as very frequent examiners and chairs as well as our Board meeting discussions. None of us have had significant problems with virtual exams, either technological issues or a loss of the rigor, quality, or collegiality of oral exams. We have been able to successfully train and mentor new examiners and new chairs using exclusively virtual exams, and we have not seen any notable issues with that
training and mentoring process. We have learned a few things technologically along the way and have grown in our confidence conducting and chairing virtual exams. Our Board members and our experienced examiners agree that we miss seeing and interacting with each other in person for oral exams, but that there is no degradation of the oral exam process.

Even more affirming of our decision to continue with the option of virtual exams is the feedback from our candidates, which is quite positive overall. Several candidates informally commented either before or after their oral exams about appreciating decreased time away from home and work, and the significant financial savings associated with not having to travel for oral exams. This was particularly true for overseas military candidates. Additionally, after all oral exams, candidates are provided with a link to a formal feedback form on the ABPP website. They are invited to electronically submit their feedback on the oral exam process. The form asks candidates to rate their exam experience on five prompts (each with a five-point Likert scale, 1 = Strongly Disagree to 5 = Strongly Agree), plus offers an opportunity for comments. The five prompts, plus the open-ended request for comments, are as follows:

- Followed ABCP Manual guidelines.
- All relevant competencies covered.
- Exam team was well prepared.
- Thoughtful questions and feedback.
- Collegial, respectful atmosphere.
- Open Ended: Comment on any aspect of the content, format, or conduct of the exam.

48 of 85 virtual oral exam candidates have provided that feedback since May 2020. Likert scale means are as follows, indicating strong agreement regarding exam quality for all five ratings by the responding candidates.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Mean</th>
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<tbody>
<tr>
<td>Followed ABPP Manual guidelines</td>
<td>4.98</td>
</tr>
<tr>
<td>All relevant competencies covered</td>
<td>4.92</td>
</tr>
<tr>
<td>Exam team was well prepared</td>
<td>4.96</td>
</tr>
<tr>
<td>Thoughtful questions and feedback</td>
<td>4.88</td>
</tr>
<tr>
<td>Collegial, respectful atmosphere</td>
<td>4.92</td>
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Eight candidates specifically commented on the virtual format for their exams. Those comments are as follows.

“Apart from a very minor technical issue at the beginning, I found the Zoom format to be easy to use and mirrored the format of what I would have expected from an in-person examination.”

“The only slight glitch was the vignette was not available in the chat when I was in the break-out/waiting room. It did not impact the vignette presentation and I was given more time if needed.” (Note – an early learning opportunity for our process; we no longer use breakout rooms for candidates during the ethics vignette section of oral exams.)

“Also, the virtual format was as smooth as possible.”

“Although it would have been wonderful to meet them in-person, the zoom format worked surprisingly well.”

“Thank you for offering a virtual option during this time. The technology and flow were smooth.”

“I am happy ABPP considered doing online oral exams given COVID issues impacting so many people.”
“Really appreciate the willingness of the examination committee to complete the exam virtually in the context of COVID.”

“I appreciate the flexibility of the committee to meet over Zoom due to the pandemic. Thankfully, the technology was effective, and we only had a few hiccups with one connection.”

In conclusion, ABCP now has extensive data and multiple exploratory discussions, with both candidates and examiners, clearly indicating that virtual oral exams are completely effective in sustaining the quality of the ABCP examination process. Additionally, we believe the convenience and financial savings for candidates will prove to be an effective long-term tool to increase applications. Thus, ABCP intends to sustain virtual oral exams as a permanent option for candidates.
The American Board of Geropsychology (ABGERO) continues to be very active in certifying qualified individuals who identify as specialists in working with older adults. Since its founding in 2014, ABGERO’s membership has grown to include 86 practitioners; new applicants are regularly submitting their materials, and we aim to reach 100 specialists within our ranks within the next 18 months. Recruitment efforts within ABGERO remain robust; ABGERO members have conducted multiple webinars to increase awareness, most particularly in the areas of early career professionals and VA psychologists. Response to these outreach efforts has been consistently encouraging.

ABGERO recently underwent its first Periodic Comprehensive Review by ABPP’s Board of Trustees, and we currently await the results. Preliminary feedback suggests that the organization is functioning well in all major areas of functioning. Particular focus has been on the execution of virtual examinations—first undertaken during the pandemic by necessity but which are now being well-integrated into the ABGERO operations as a particularly effective option.

In terms of specialty-based advocacy, ABGERO also recently has taken a lead role in corresponding with a major cognitive test publisher to clarify and update what it considers required qualification for using the instrument. ABGERO seeks to obtain an exemption from requiring publisher-mandated proprietary training based on the nature and amount of training and experience that ABGERO members will have already accrued. Although currently this is an ABGERO-specific endeavor, ABGERO intends to collaborate with other specialties who are similarly invested in similar outcomes.

ABGERO is also taking a lead role alongside other Aging Leadership organizations (e.g., APA’s Committee on Aging, Society for Clinical Geropsychology, APA’s Division 20, Psychologists in Long Care, Council of Professional Geropsychology Training Programs) to develop guidelines for creating Age-Friendly Organizations, with the intention of expanding accessibility for, representation by, and general influence of older adults working in the field of aging services in general. Ideally these efforts would be able to be applied to specialties outside of geriatrics as well.

Overall, ABGERO continues to steadily expand its influence into the larger field of geriatric mental healthcare and beyond; ABGERO is viable, vibrant, and effective, and looks forward to many more opportunities to work alongside the other Specialty Boards to cross-promote all of our important missions!

Andrew L. Heck, PsyD, ABPP
Licensed Clinical Psychologist
Board Certified in Geropsychology and Clinical Psychology
President, American Board of Geropsychology (ABGERO)
The American Board of Group Psychology has been quite busy over the past several months. We are a relatively small Board, yet have spent time on our recent PCR, successful recruitment efforts, issues related to training exam committee members, discussing our examination's video stimulus, Board succession issues, preparing for CRSPP review and finally, expanding the diversity of our Board.

As a Board we recognized that our PCR was likely to be conducted either during or after the pandemic. Having already prepared our materials we decided to complete our PCR in a timely way in case it would require modifications or corrections. With many of us already working virtually, we were comfortable engaging in a virtual PCR even though it placed us in the role of trail blazers in holding our Board meeting, conducting an exam and answering the queries of our reviewers. I am pleased that our Board pulled together and worked with the Central Office to develop reasonable procedures for our Site Visit.

As a small Board that was just holding its own, we recognized that we needed to engage in a concerted recruiting campaign. Under the guidance of our Examination Coordinator, Dr. Lorraine Wodiska, everyone rose to the occasion. Within a couple of years, we developed a substantial pipeline of examinees drawn from College Counseling Centers, the Department of Corrections, and the Veteran’s Administration. This, in addition to our prior pool of applicants drawn from private practice has expanded both our numbers and the diversity of our membership. Most importantly, we have been able to attract more early career group psychologists.

Another area of focus has been the diversity of our Board. As our Board was originally formed of private practitioners, we were a fairly homogeneous and aging group of ABPPs. While our recruitment is bringing in younger members, earlier in their careers, we also have increased the diversity represented by different practice settings. Group Psychology is practiced in many settings and is especially important in the world of College Counseling Centers. Given that Group Psychology is now a recognized specialty of practice we also started an initiative to connect with the Group Coordinators in those settings hoping to engage them in certification and membership. Our expectation is that this will encourage the staff psychologists and trainees in College Counseling to pursue specialty certification.

We have also been very active in reaching out to psychologists in the Department of Corrections and the Veteran’s Administration; two places that are focusing almost exclusively on group treatments. We have recently added to our Board of Directors members from College Counseling, the DOC, and the VA. This has brought us diversity in theoretical perspectives, breadth of populations served, age diversification, and the start of racial diversification, though this remains a special focus of growth for us.

In the area of Diversity, we have paid attention to socio-economic status, gender, sexual orientation, age, and race. We are now focusing attention on reducing barriers to becoming board certified and member of the Board of Directors. Recognizing that Group Psychology is now one of the most practiced modalities of treatment by psychologists who are often in the public sector, we are currently attempting to reduce the expenses for members applying for certification. We have also developed scholarships to reduce the costs of gaining the experience to meet the standards of the Board, in addition to gaining the required supervised experience.
Our most recent endeavors are developing a better video stimulus that is used in the examination. The stimulus, in addition to the candidate's work sample and professional statement, allows the exam team to determine how the candidate responds to a standard sample of group work. Regardless of the theoretical approach of a candidate, we use this stimulus to see how they approach a standard situation using their own knowledge base. Unfortunately, it is very difficult to find good quality videos of group work and we have determined we will develop our own for the exam.

Finally, we are struggling with issue of succession. Many Certificants do not involve themselves in examinations, recruiting, and even less join the Board of Directors. The current Board, having many of whom have been on the Board for approximately 10 years in various capacities, is now experiencing a 'changing of the guard'. Several prominent members are ending their tenure and we are working hard to replace them with the next generation. This is quite a challenge for a small Board. I am heartened that at our recent Board of Directors meeting we were able to meet in person (masked) which facilitated very creative thinking. I believe that we are going to have a bit of an adjustment as we go through the changeover, but the cohesion of our group and the tenacity of its members will see us through this transition.

Darryl L. Pure, Ph.D., ABPP, FAGPA, CGP  
Clinical Associate Professor of Leadership, University of Chicago, Booth School of Business  
Chair, Group Foundation for Advancing Mental Health  
President, American Board of Group Psychology
Many candidates for Organizational and Business Consulting (OBCP) certification have questions about the required professional training and experience. Our board members often tell them that the short answer is “It depends.” Most consultants follow vastly different career paths than health services psychologists (HSPs) such as school, clinical, and counseling professionals. The purpose of this article is to provide an overview of the OBCP field and describe a typical professional journey to consulting.

Organizational and Business Consulting Defined
OBCP practice has a different focus from mainstream health services delivery. Its primary goal is to increase work performance rather than personal functioning or relationship success. The OBCP domain is individual employee, work team and total organizational effectiveness. Good consulting practice involves building the employee, team, and organizational competencies required for organizational success. At most, a secondary focus might be on personal health and well-being in isolated cases.

Another distinction in the OBCP world is defining the client. In organizational consultation, it is the entire organization rather than any individual employee. That means that our work must benefit the performance and effectiveness of the entire system, e.g., a team, cross functional project, the organization or even the enterprise interactions with its marketplace. It also means that any consulting that fails to serve the organization is misguided. Such work might even be considered unethical if it runs counter to the consulting agreement reached with the client. For example, encouraging an employee to file a lawsuit, violate company policy or leave the organization are all instances of putting individual interests before the entire client organization’s needs.

A final distinction for OBCP work is that it is framed by the strategic priorities of organizational leaders. For example, individual-level consultation could be to identify those job candidates with the strongest potential to be high performers in key mid- or high-level leadership roles. Or consultants might be charged with enhancing the capabilities of a critical but floundering work team. At the organizational level, OBCP specialists may work with senior leaders to evaluate and improve the overall structure, processes, and talent “bench strength” of a business unit or an entire enterprise.

The Applied Psychology Path to Consulting
Professionals in such general and applied psychology (GAP) specialties as industrial-organizational, social or consumer psychology often receive graduate training in relevant consulting topics. For example, they may complete coursework in organizational psychology, leadership research and theory, work motivation, employee training and development, or other topics. Faculty may involve them in consultation projects and provide professional supervision. Unlike HSPs, though, supervision is less formalized and often documented after the fact. Or GAPs may gain experience in businesses or non-profit organizations which need their expertise. Their masters’ theses or dissertations are likely to delve into a practical organizational issue such as employee engagement or selection methods.
After graduate school, GAPs might work inside of organizations in human resources or related positions. They could find a position with a consulting firm. Alternately, they may stay in academia and maintain a side consultation practice. The common thread is their attention to clients’ strategic, employee talent, and organizational issues.

**The Health Services Psychology Path to Consulting**

Most HSP candidates for OBCP certification discover that their careers gradually move away from traditional clinical practice. They spend an increasing amount of time working on organizational issues such as employee turnover or training deficits. Or these psychologists could be asked to help boost team or leadership performance or other issues. They soon realize that they need additional knowledge and skills to effectively address these issues. Assessment and intervention techniques that may suit therapeutic situations often will not help them determine how to investigate the reasons that employees leave, design a training program, facilitate team skill development sessions, or coach leaders about strategic issues.

HSPs who engage in consulting often seek out additional resources. They consult with or even work as an apprentice to an experienced consultant. They attend specialized professional development programs, join professional organizations like APA Div. 13 (Consulting Psychology) or the Society of Psychologists in Leadership (SPL), or even complete additional graduate coursework. They use independent study to find answers. Regardless of the exact learning strategy, these psychologists who are inexperienced as consultants must invest considerable energy to develop new perspectives on the challenges they face and groom the necessary talents.

A central problem with making a transition to full-time organizational consulting, though, is that professional development resources are often narrow and hard to find. Books, continuing education programs and webinars frequently address only a single type of consultation. For example, various professional publications in industrial-organizational psychology address current knowledge about employee turnover and training. Similar resources exist for team building, business strategy creation, and executive coaching. Few, however, help develop a well-rounded consulting perspective. What universe of knowledge and skills will help a psychologist understand and enhance individual, team, and organizational performance?

The answer lies in experience, expert coaching and continuing professional education. Just as no single graduate course fully prepares a HSP for effective clinical practice, a single consulting experience or partnering with a veteran will not develop a full-fledged OBCP professional. GAPs who consult devote years to building their competencies to tackle the many and varied issues and situations they face. That involves preparation, practice, learning from experience, and expert help. It also entails continuing education to stay informed about emerging developments in the consulting field.

Organizations such as the Society of Consulting Psychology, (APA division 13), the Society for Industrial and Organizational Psychology (division 14) and the Society of Psychologists in Leadership are the most prominent sources of up-to-date, research-based ideas, tools, and techniques. Similarly, work with an existing consultancy can provide a wider and deeper perspective on the diverse challenges of organizational work. Business publications such as the Harvard Business Review and the Wall Street Journal provide other useful insights into the organizational arena. A transition to consulting frequently means resetting one’s professional sights from the individual employee’s world view to understanding the larger organizational system and its strategy, processes, and priorities.

**In Summary**

GAPs and HSPs follow different paths to enter OBCP practice. The essential criteria for successful certification are adequate professional preparation, developing an organizational rather than an individual mindset, and well-grounded, up-to-date practice.

We encourage interested professionals to visit [https://abpp.org/Applicant-Information/Specialty-Boards/Organizational-Business-Consulting-Psychology.aspx](https://abpp.org/Applicant-Information/Specialty-Boards/Organizational-Business-Consulting-Psychology.aspx) and contact any board member for further information at [https://abpp.org/Applicant-Information/Specialty-Boards/Organizational-Business-Consulting-Psychology/Officers.aspx](https://abpp.org/Applicant-Information/Specialty-Boards/Organizational-Business-Consulting-Psychology/Officers.aspx).
One of the unique challenges facing the American Board of School Psychology (ABSP) is recruiting new applicants from a small pool of individuals who meet American Board of Professional Psychology (ABPP) qualifications. School psychology is defined by the Council of Specialties in Professional Psychology (found at https://www.cospp.org/school-psychology) as “a general practice and health service provider specialty of professional psychology that is concerned with the science and practice of psychology with children, youth, families, learners of all ages, and the schooling process.” You can find doctoral school psychologists in several different settings including school systems, universities, clinics, pediatric hospitals, and private practice to name a few.

While the practice of school psychology is not limited to school-settings, most school psychologists trained at the sub-doctoral and doctoral levels are employed by school districts and are certified by state boards of education to provide psychological services in the schools. In most states, school psychologists are not required to obtain a license for independent practice from state boards of psychology to practice in the schools. This makes school psychologists unique from a professional practice perspective by having a separate credentialing process through state boards of education. Other health service providers in psychology such as clinical and counseling require board of psychology doctoral level licensure to provide psychological services. Since independent licensure through boards of psychology is not required for practice in school settings and most school psychologists are in school settings, there is little incentive to obtain a license for independent practice. This automatically reduces the pool of doctoral level school psychologists who may meet ABPP’s general requirement for an independent license to practice psychology. Therefore, finding and recruiting potential applicants who hold doctoral school psychology degrees and licensure to practice at the independent level presents a unique challenge.

Two of the relevant changes to the requirements for board certification recently implemented by ABPP will reduce the pool of potential eligible applicants in school psychology even further: the requirement for (1) American Psychological Association (APA) accredited doctoral programs and (2) APA accredited internships. While this may not affect any applicants who obtained their degrees prior to 2018, any applicants who graduated after 2018 must be from APA-accredited programs. I conducted a search for doctoral programs on the APA Accreditation website. Based on that search, I found only 73 school psychology programs that are APA-accredited in the country. By comparison, there are 254 accredited clinical programs. Moreover, when searching for APA accredited internships in school systems and school districts, there were only nine. Albeit there are consortia (59) that may include experiences in school settings. As can be seen, the number of APA accredited school psychology programs and internships available are very limited in comparison to clinical and counseling psychology.

Now, for a bright spot to help address this shortage in internships. ABSP became a supporter of APA Division 16’s initiative “Grant Program in School Psychology Internships” to help develop more APA accredited internship sites within individual school systems, consortia, and other agencies and/or universities that work closely with schools. Grants are provided to support and supplement funds to develop internships through several phases of...
initial development, including Association of Psychology Postdoctoral and Internship Centers (APPIC) member status, APA self-study submission, and APA-accreditation. Now that APA-accredited internships are a requirement for ABPP Specialty Board applicants, it is essential that more internships in school psychology be developed. As of this year, approximately 20 internships are in some phase of development or accreditation, and over 315 interns have been trained in these grant-supported programs over the past five years. ABSP has provided funds to the grant program and will look at other ways of participating in this important endeavor.

It is important that new internship sites be developed and supported in school systems or through consortium relationships with schools. It can be helpful to enlist school administrators by highlighting some of the benefits an APA-approved internship training program can offer to a school district. Potential benefits include high quality doctoral interns who can bring current ideas and new ways to provide services to students and staff; connections to university faculty who can provide consultation and professional development; and a pathway for an employee pool after internship to fill school psychology positions with professionals that you know and trained. Since independently licensed psychologists are necessary to provide internship supervision, they can also provide any post-doctoral supervision for psychology board licensure. This can provide an advantage in legal situations and due process hearings. There are certainly other advantages as well.

It is also important that school psychology program faculty emphasize the importance of independent licensure and model that behavior to their students by being licensed themselves. And of course, seek specialty board certification through ABSP! With better understanding of the importance of independent licensure for doctoral school psychologists and an increase in APA accredited programs and internships, the future of our board will be brighter.
The American Board of Forensic Psychology (ABFP) and the American Academy of Forensic Psychology (AAFP) believe that Forensic Specialists can have the most impact on the field when they represent a wide variety of races, genders, ages, languages, ethnicities, cultural backgrounds, physical abilities, sexual orientations, and religious beliefs. For this reason, ABFP launched a diversity initiative and appointed Drs. Julie Gallagher and Trayci Dahl to spearhead the mission. To begin this initiative, Drs. Gallagher and Dahl surveyed the membership of AAFP with regard to diverse backgrounds and abilities, to ascertain how closely the AAFP membership matches the communities we serve. This survey relied on a self-selected sample of convenience in that AAFP members were solicited to voluntarily complete the survey via the AAFP listserv. As of September 24, 2021, 86 forensic specialists had responded to the survey. One respondent identified as having every diversity listed. This likely represents a misunderstanding of the survey (i.e., answered in terms of what populations are served rather than personal diversity). These responses were omitted. Presented below are some highlights from the survey, followed by comments on how the survey respondents compare to the U.S. population.
**Diverse Backgrounds:** Of the 85 included respondents, approximately 82% identified as White, approximately 9% identified as “other than White” (2.3% Latinx, 2.3% Black, 2.3% Asian, 1.1% Indigenous, 1.1% Ashkenazi Jew), and approximately 8% identified as multiethnic/multiracial (4.7% Latinx & White, 1.1% Indigenous & White, 1.1% Cajun & White, and 1.1% Latinx, Indigenous, & White). There was 1 individual (1.1%) who identified as a female veteran.

**Diverse Abilities:** Of the 85 included respondents, approximately 12% identified as having diverse abilities (5.9% diverse hearing abilities, 2.3% different physical abilities, 1.1% neurodiversity, 1.1% Type 1 Diabetes that is limiting, and 1.1% ADHD).

**Sexual and Gender Diversity:** Approximately 15% of included respondents did not provide a response to this question. Of the included respondents, approximately 93% identified as Cisgender and approximately 7% identified sexual and gender diversity (2.7% heterosexual, 1.3% two spirit, 1.3% “male,” and 1.3% “female with single gender”).

**Sexual Orientation:** Of 85 included respondents, approximately 5% did not answer this question. Of the included respondents who answered, approximately 91% identified as heterosexual, approximately 7.4% identified as having diverse sexual orientation (5% bisexual, 2.4% gay or lesbian), and approximately 1.2% (n=1) believed this was an inappropriate question for a professional organization to ask.

**Language Fluency:** Of 85 included respondents, approximately 9% indicated fluency in a language other than English (3.5% Spanish, 2.3% German, 1.1% Chinese, 1.1% French, and 1.1% Hebrew).

**Comparison to U.S. Population:** These results, while based on a small number from a convenience sample, highlight the need to increase diversity amongst board certified forensic specialists. For instance, while only 9% of forensic specialists identified as “other than White,” 2020 United States census data indicates that 29% of the U.S. population is “other than White” (see: https://www.census.gov/library/visualizations/interactive/race-and-ethnicity-in-the-united-state-2010-and-2020-census.html). While only 2.3% of the survey respondents identified as having different physical abilities, one in four Americans have some type of disability and 13.7% of people with any disability in the United States have a mobility disability with serious difficulty walking or climbing stairs (see https://www.cdc.gov/ncbddd/disabilityandhealth/infographic-disability-impacts-all.html). While approximately 22% of the U.S. population speaks a language other than English (see https://data.census.gov/cedsci/table?q=Language%20Spoken%20at%20Home&tid=ACSST1Y2019.S1601), only 9% of the survey respondents do. Of the 22% of individuals in the U.S. population who speak a language other than English, 13.5% of them speak Spanish (see https://data.census.gov/cedsci/table?q=Language%20Spoken%20at%20Home&tid=ACSST1Y2019.S1601); only 3.5% of the included survey respondents speak Spanish. On the other hand, of the included survey respondents, 7.4% identified as gay, lesbian, or bisexual. This is higher than some estimates of the percentage of adults in the United States who are gay, lesbian, or bisexual (see, for example, https://williamsinstitute.law.ucla.edu/publications/how-many-people-lgbt/).

**Summary:** Taken together, these results validate the importance of the ABFP diversity initiative. While the survey suggested adequate to higher-than-expected representation of gay, lesbian, and bisexual forensic specialists, forensic specialists are under-represented compared to the U.S. population when it comes to other important diversity variables, including race and ethnicity, physical abilities, and language fluency. ABFP and AAFP are committed to increasing the diversity of forensic specialists. The data summarized here will serve as a launch pad for action steps to follow.
Necessity is the mother of invention, or, how to make the pandemic work for Police and Public Safety psychologists.

Jocelyn E Roland, PhD, ABPP
President, American Board of Police and Public Safety Psychology

While the pandemic has made many of our professional lives challenging, it has also forced us to be flexible and look for ways to overcome difficulties employing novel and innovative solutions. For many psychologists, a good portion of practices have turned to “virtual reality,” with teletherapy, virtual assessments and evaluations, and synchronous meetings being the primary manner to stay in business and serve their consumers. Never before have so many of us relied on technology to provide service delivery, and due to the multiple platforms available, being a remote psychologist has been incredibly easy and fruitful.

The American Board of Police and Public Safety Psychology (ABPPSP) has in many ways truly benefitted from pivoting and embracing this technological world. For over a year now, all our oral exams (OE’s) have been conducted synchronously with great success. Due to the Board being comparatively small, with Specialists scattered across the country, our OE’s have usually coincided with conferences that draw the majority of our examination population. This has in the past proven to be a bit challenging in terms of securing locations, conducting exams in a timely manner relative to the completion of the Practice Sample, as well as the managing costs associated with exams.

Through the application of widespread and easy-to-use technology we have been able to complete nine (9) OE’s in the last year, which is the most since the initial inception of the ABPPSP 10 years ago. The feedback from candidates has all been positive, and with ABPP’s approval, it will likely be how we conduct the majority, if not all, exams in the future.

Another way in which the ABPPSP has been able to harness remote meeting technology has been “meet and greets” with prospective candidates, and those early on in the process of Board Certification. Historically we have conducted telephonic meetings with great success. However, in hindsight, those meetings now seem a bit clumsy and impersonal. Given that nearly everyone is comfortable with the available applications such as Zoom, Microsoft Teams, or Google Meet, these meetings have become more personalized, responsive, and inviting.

So far this year we have had two meetings, with another planned for November 10th. Lasting roughly an hour, the ABPPSP President, National Chair of Examinations and Oral Exam Coordinator have hosted these sessions to answer questions about applying for board certification, application requirements, and ways to best approach what can be a daunting process. It seems as though putting a face to the names of Board Officers and extending encouragement in person has been a productive way to increase applications and calm nerves. Other virtual meetings have been held with individuals expressing interest in application, as well as stakeholder groups such as psychologists from the California Department of Corrections & Rehabilitation, the Bureau of Prisons, and in December we will meet with staff from the Behavioral Services Section of the Los Angeles Police Department. It seems that our reach is unstoppable now that we can employ the benefits of technology!

One last benefit of being able to easily reach out and connect with those interested in becoming a Specialist has been the recognition that there are numerous practicing psychologists that the ABPPSP is interested in welcoming to our Board with whom we were not previously connecting. In particular, welcoming those from the military, the Veterans Affairs, and professionals working with corrections, public safety dispatchers, and the fire service are of
great interest to the ABPPSP. To that end, at our Annual Board of Directors Meeting just a few weeks ago it was decided to enhance, broaden, and improve our mission statement by specifically including these psychologists (additions in bold): “Police and Public Safety Psychology is concerned with assisting law enforcement and other public safety personnel and agencies, including the fire service, corrections, emergency communications, and all branches of military service, in carrying out their missions and societal functions with optimal effectiveness, safety, health, and conformity to laws and ethics.”

At this point we are all pandemic weary, and ready to return to a world without so much distance from the people we serve professionally, and care about personally. However, if there is a way to make lemonade from these lemons, the above are some examples of finding that silver lining. Creativity and flexibility are two of the keys to success, and the ABPPSP has been able to effectively apply these constructs to improving our reach and inclusivity to those who wish to become Specialists.

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**Virtual Mentorship and Sponsorship for Early Career Police Psychologists of Color**

*Philip S. Trompetter, PhD, ABPP and David M. Corey, PhD, ABPP*

APA CEO Dr. Arthur Evans (Evans, 2021) reminds us that “each of us must aid the effort to create a more diverse profession and discipline” (p. 10), and places mentorship of members of diverse communities as his first recommendation. This led us to recall the poignant article by Katherine Sharpe Jones, PhD, ABPP (Sharpe Jones, 2020) last year in *The Specialist* that reminded all board certified specialists that competence in the foundational competency of Reflective Practice/Self-Assessment/Self-Care assessed during our ABPP examination is not static. She implored each of us to reexamine our professional practices and maintain Self-Assessment in our response to the effort to dismantle racism.

Following the murder of George Floyd by a police officer, and the resounding calls to action expressed by millions throughout the world decrying racial injustice, the specialty of police and public safety psychology paused to reflect on how it may be contributing to the problem. As a result, each of the major police and public safety psychology (PPSP) professional organizations issued public statements committing their members to antiracism and the promotion of inclusion and diversity. Moreover, these organizations recommitted their members to doing more, particularly for communities and persons disproportionately impacted by violence, racism and other forms of discrimination. One element of this commitment was to examine our individual attitudes, actions and professional practices to mitigate the harmful effects of bias both in our work and in the law enforcement agencies we serve.

This re-examination highlighted the limited racial and ethnic diversity in professional psychology which is also reflected in police and public safety psychologists currently in practice or in preparation for practice. An APA survey in 2019 revealed 83% of the psychology workforce self-identified as White, 7% as Hispanic, 4% as Asian, and 3% as Black (APA, 2021). Beyond crafting an antiracism statement, it became clear to our specialty that more effort is required to identify and attract psychologists of color to the specialty. Within the past two decades, scholarly attention has turned to mentoring students of color as a corrective measure, particularly women students of color. In their analysis of data from Golde and Dore’s (2001) *Survey on Doctoral Education and Career Preparation*, which explored student perceptions of their advisors across 11 disciplines, Noy and Ray (2012)
concluded that “women of color are the most disadvantaged in advisor support”

*Mentorship*—a process of providing guidance/advice in a professional role—has gained increasing attention as a powerful tool to enable the careers of those advancing through the ranks in organizations and professions. Being ignored by school faculty is just one of the many ways that psychologists and psychology students from historically disenfranchised backgrounds are denied equitable mentorship. Minority students often are ignored and yet criticized for a perceived lack of active participation. Other common experiences include unequal access to research and training opportunities, fewer chances to connect with professors, and a lack of mentors who understand their diverse life experiences. In addition, *sponsorship*—an active process by which a person with an established presence in professional organizations endorses, advocates for, and supports a mentee for a leadership opportunity—is recognized as an important component of a deliberate effort to develop diversity in specialties in professional psychology. Sponsorship also involves assisting early career psychologists of color (ECPPoCs) in navigating PPSP policies, practices, and experiences that systemically and structurally create barriers for them.

In August 2020, 11 experienced police and public safety psychologists, six of whom are board certified in the specialty, formed a virtual mentorship and sponsorship program aimed at ECPPoCs (and master’s level clinicians who intend to practice police psychology at the doctoral level) interested in a career in police psychology to remedy the lack of inclusion and diversity in the specialty, and to navigate hurdles to leadership and visibility within the specialty. Effective mentorship and sponsorship involve the provision of both *career support*—career guidance, skill development, networking and opening doors, and *psychosocial support*—professional support, confidence boosting, and role modeling. Because a single mentor might not have the entire suite of knowledge, skills, abilities, or connections needed by a mentee, we adopted a group mentorship and sponsorship process. Our mentors are comprised of specialists from each of the four domains of the specialty, and the group is mixed-race and mixed-gender to enhance trust and interpersonal comfort because research shows that same-race and same-gender mentoring relationships provide better psychosocial support (Blake-Beard, et al., 2011). At the time of this writing, 20 ECPPoCs are participating in the program as mentees.

Online mentorship, also called virtual, electronic or e-mentorship, has grown in popularity with advances in social media and online communication (Ensher & Murphy, 2007). This form of remote mentorship appears to be particularly appealing to individuals who find themselves with a shortage of mentors in particular careers or disciplines. We are using Zoom, a videoconferencing platform, for 6 meetings each year. Each meeting may contain case presentations (with identifying information redacted), issue-centered discussions, standards of practice, practice/business issues, timely topical discussions, free-ranging questions and answers, etc. In addition, we invite an important thought leader in policing and/or psychology to join us each meeting for a 30-minute casual conversation to expose mentees to these leaders and open doors for further conversations with the guest if they desire.

Mentorship is an invaluable component of graduate training. Providing a continuing mentorship opportunity following completion of doctoral training and education offers guidance and access in the early stages of an ECPPoC’s professional development. Mentorship and sponsorship may take on additional importance for gender and racial minority students and early career police psychologists, who often face stressors related to stigmatized identities. It is our hope that the mentees enrolled in our initial program will benefit from receiving mentorship that encourages, teaches, and provides necessary resources to assist with the challenges they may experience as emerging professionals, and sponsorship to access the leadership space in police and public safety psychology and create impact once in that space.
References


Beginning in the year 2002, physicians from several sub-disciplines (e.g., psychiatry, surgery, pulmonology, family practice) and psychologists from the United States and Japan have met together at the Minnesota Research Station in Itasca state park (below) where the Mississippi river originates. We call ourselves the “Itasca Brain and Behavior Association (IBBA).”

Our main purpose has been to evaluate research progress from a previous year and formulate studies for ensuing time periods. We also reward ourselves with conviviality and recreational activities that include flyfishing in various lakes of the region. One major goal of our gathering is to explore collaborative research between the US and Japan (and occasionally other nations). This collaboration is usually well-organized and formal but occasionally emanates from relaxed, casual interactions.

On one occasion, psychiatrist Yasuhiro Kishi from Tokyo, and two clinicians from Minnesota (psychiatrist William Sheehan, and myself, a board-certified psychologist) were engaged verbally in a variety of superficial topics; in some mysterious way the interchanges eventuated in a more serious discussion of dissociative disorders. We Americans were intrigued by Dr. Kishi’s narrative about fox possession in the Japanese culture in which persons in certain religious ceremonies develop a trance-like demeanor, and begin to growl, walk on all fours, and become excited and agitated. This interchange led to a paper on the neurological underpinnings of mystical and ecstatic conditions that included a history and elaboration of fox possession in Japan (Sheehan, Kishi, & Thurber, 2008).

**Interculture Research**

**Patient Comparisons**

One of the first studies completed at Itasca was a comparison between the types of patients seen by mental health consultants in a Japanese hospital versus a hospital in the United States. Patients in the United States evinced more acute as well as more chronic conditions. Moreover, individuals in the Japanese hospital were essentially devoid of chemical usage problems suggesting either a low base rate for such disorders or alternatively a reluctance among Japanese clinicians to assign diagnostic classifications that might suggest a pervasive societal problem related to chemical usage (i.e., unlike conditions in the United States, the Japanese value system is protective of the collective rather than the individual) (Kishi, Meller, Kato, Thurber, Swigart, Okuyama, Mikami, Kathol, Hosaka, & Aoki, 2007).

Later, we investigated errors in the diagnosis of delirium in a United States hospital setting (Swigart, Kishi, Thurber, Kathol, & Meller, 2008) with 63% of 541 delirious patients referred for psychiatric consultation being misdiagnosed. We found a greater likelihood of an inaccurate diagnosis associated with younger patient age, patients oriented as to person, place, and time and those with a history of bipolar affective disorder or psychosis. The implications of this diagnostic error and concomitant failure to initiate treatment included increased healthcare costs and mortality. Our collaboration with Yasuhiro Kishi and his colleagues at Tokai University Hospital in Japan resulted in similar study and a delirium diagnosis error rate of 46%, with medical colleagues being unduly influenced by prior psychiatric diagnostic classifications and patient reports of pain levels (Kishi, Kato, Okuyama, Hosaka, Mikami, Meller, Thurber, & Kathol, 2007).
Incidentally, on the topic of delirium, Yasuhiro coordinated the gathering of data on the Delirium Rating Scale Revised-98 (DRS-R98) involving 859 participants in seven countries (Japan, United States, Brazil, Colombia, Ireland, Taiwan, and Korea). The result was a confirmatory factor analysis of the DRS-R98, published in the *Journal of Neuropsychiatry and Clinical Neurosciences* (Thurber, Kishi, Trzepac, Ishizuka, et al., 2015).

**Patient Complexity Assessment**

A strong joint interest among Itasca members in the US and Japan has been the biopsychosocial complexity of patients and the most efficient modes of treatment for patients with combined and interacting medical, chemical, psychiatric and interpersonal dysfunctions. Accordingly, several studies have been formulated over the years in the United States and Japan that have focused on the cross-cultural assessment of complexity. The major instrument used internationally for the assessment of patient complexity involves a semi-structured interview followed by clinician ratings of complexity on items covering the domains mentioned above, as well as patient access to various treatment and support services. It is termed “INTERMED,” developed in the late 1990’s in the Netherlands. Our published IBBA studies include validity data on the English version of INTERMED in the United States (Meller, Specker, Schultz, Kishi, Thurber, & Kathol, 2015; Thurber, Wilson, Realmuto, & Specker, 2018) together with psychometric characteristics of the Japanese INTERMED version (Kishi, Matsuki, Mizushima, Matsuki, Ohmura & Horikawa, 2010; Kishi, Hazama, Komagata, Ishizuka, Karube, Takahashi, Motoyama, Nagasaki, Thurber, & Kathol, R. (2016).).

**Interculture Statistical Issue**

In the process of our IBBA interculture research activities, we discovered several studies in which researchers uncritically assumed that the psychometrically sound attributes of instrument developed in a particular culture automatically transfer to cultures with differing language and value systems. Another apparent interculture assessment error involves the pervasive and sometimes inappropriate application of Cronbach's Alpha coefficient for internal consistency reliability estimates. As discussed in our article in the journal Assessment, the alpha coefficient is appropriate for so-called Tau equivalent or unifactor scales, not for tests that are factorially complex (Thurber and Kishi, 2014). To emphasize the point, Dr. Kishi translated into Japanese an 11-item Likert inventory on the attitudes of nurses toward patients who had attempted suicide. The scale was developed in the country of Sweden in the English language, presumed to be unidimensional with a reported alpha coefficient of .74. In contrast, our confirmatory factor analysis of the Japanese translation indicated a three-factor structure, suggesting an absence of tau equivalence. We then juxtaposed computation of the alpha coefficient with a reliability estimate appropriate for multidimensional scales, termed “composite reliability.” Whereas the alpha computation was an adequate .70, the composite value was .52. Researchers using as assumed homogeneous Japanese version of the instrument could overestimate scale reliability and hence the power of the inventory to detect an effect when it does in fact exist.

**Suicide**

Because of my expressed interest in the understanding and prevention of suicide, I was welcomed into ongoing Japanese research and clinical work on the topic. In concert with American and Japanese members of IBBA, we analyzed economic trends in Japan that were associated with increased suicidal behaviors and observed possible parallel trends in the United States. The resulting paper was presented at the meeting of the American Psychiatric Association (Yates, M. Matsuki, H. Matsuki, Thurber & Meller, 2011).

Yasuhiro invited me to be involved in a Japanese study involving the attitudes nurses toward patients with suicide attempts. Nursing personnel with experience in psychiatric units evinced more favorable attitudes in comparison to nurses who worked solely in emergency and intensive care units. The latter were less likely to express a reasonable...
understanding of suicidal patients, and were less inclined to be sympathetic (Kishi, Kurosawa, Morimura, Hatta, & Thurber, 2011). The results of this study engendered a training workshop designed for emergency room nurses who were more likely to have less experience with suicidal patients and hold attitudes that might impede beneficial interactions with such patients. A total of 52 nurses completed a seven-hour program. Questionnaires completed before the workshop and one month thereafter suggested improved understanding and a greater willingness to care for suicidal individuals on the part of attendees (Kishi, Otsuka, Akiyama, Yamada, Sakamoto, Yanagisawa, Morimura------& Thurber, 2014).

Finally, it may be of interest to note that the Japanese version of “Understanding the Suicidal Patient Scale” was accepted into the PsycTest database of the American Psychological Association (Thurber & Kishi, 2014).

Conclusions

Personally, and professionally, my collaboration with colleagues in Japan has been and continues to be, fruitful and stimulating. I have a better understanding regarding the possibility that societal values may affect diagnostic classification rates and the importance of avoiding the assumption that elevated psychometric characteristic of an American scale will automatically transfer to other countries. In addition, I think our collaborative research has contributed to the literature on patient complexity, delirium, the understanding and treatment of suicidal individuals, and psychological measurement.

We continue our annual convivial meetings at Itasca together with emails and zoom conferences throughout the year among Itasca attendees. Because most scientific journals require articles to be written in English, Yasuhiro, a prolific researcher, will often asked me to review his articles for word usage and grammar, prior to submission. I know he would do the same for me if conditions were reversed and journal editors (gasp) required manuscripts to be written in Japanese.

References


Steven Thurber, PhD, ABPP received his doctoral degree from the University of Texas at Austin, in 1970. He was a postdoctoral fellow in Pediatric and Clinical Child Psychology at the University of Oklahoma Health Sciences Center, 1980. He became board-certified in Clinical Child and Adolescent Psychology in 2005.

Short Bio:
Dr. Thurber served as the Interim Clinical Director, Child, and Adolescent Behavioral Health Services, from 2011 to 2019. His teaching appointments include Boise State University, University of California, San Francisco and the University of Minnesota Department of Psychiatry and Behavioral Sciences. He currently resides in New Orleans but maintains a research position at the University of Minnesota, Twin Cities.
Some members of the Itasca Brain and Behavior Association. From left, first row Yoko Kishi, Dr. William Meller, Jane Meller. Second row, Dr. Yasuhiro Kishi, Dr. Mary Kathol. Last row, Dr. Roger Kathol, Dr. Steven Thurber, Steven Smith.
Optimizing Biopsychosocial Wellbeing among Health Care Practitioners during COVID-19: The Unique role of the Clinical Health Psychologist

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Abstract
Recent literature has increasingly characterized the impacts of the COVID-19 pandemic as pervading biological, psychological, and social domains across socioecological levels in enduring and previously unobserved ways. A growing body of evidence suggests that healthcare workers are disproportionately impacted by the biopsychosocial effects of COVID-19, necessitating action among clinical health psychologists (CHPs) to determine optimal practices for maximizing the health and wellbeing of this vulnerable population during and following pandemic conditions. The purpose of the present article is to explore how CHPs can uniquely equip these practitioners to provide comprehensive services to healthcare workers affected by COVID-19 across assessment, intervention, and cultural competencies. A case study is utilized to illustrate practical application of each domain of competencies in serving healthcare workers during COVID-19 conditions. The authors conclude with recommendations for best practices among CHPs for providing competent care to healthcare workers within the context of the pandemic.

Introduction
Emergent literature exploring its early impacts has characterized COVID-19 as a social, economic, and medical disturbance unprecedented in the twenty-first century. Describing the biopsychosocial consequences of COVID-19, Gruber and colleagues (2021) have identified these pandemic conditions as uniquely detrimental to mental health in their: 1) uncertain length of systemic disruption and resulting diminished resources, isolation, ambiguity, and loss among individuals; 2) multidimensional character affecting both individuals and their overarching familial, educational, occupational, medical, and sociopolitical contexts; and 3) antagonisms between pandemic demands in reducing risk of disease and their interference with engagement in activities that are protective against adverse psychosocial outcomes. Despite its ubiquity of adverse consequences, investigators increasingly demonstrate how healthcare workers are disproportionately impacted by negative outcomes related to COVID-19. While pandemic conditions have elevated risk for depression, anxiety, suicide, traumatic responses, and substance abuse among the general population, healthcare workers exhibit even greater susceptibility to such concerns in their heightened vulnerability to exposure and/or witness to the devastating impacts of the disease, related medical decision-making and associated distress, reduced social support, and resulting clinically significant psychiatric and behavioral health disturbances (Gruber et al., 2021).

Investigators have identified healthcare workers as one of the most critical vulnerable populations on which psychological scientist-practitioners must focus their response to COVID-19, especially among segments of this occupational population whose experiences as older, minority, and/or health-compromised further heighten such risk (Castelnuovo et al., 2020; Gruber et al., 2021). As of the 2019 American Community Survey (ACS) of the U.S. Census Bureau, approximately 9.8 million healthcare workers were employed as technicians and practitioners, with women and racial and/or ethnic minority workers comprising nearly three-fourths and one-third of this occupational population overall, respectively, and Black Americans, one-fourth of healthcare support occupational roles (Laughlin, Anderson, Martinez, & Gayfield, 2021). In addition to its gender, racial, and ethnic diversity, the healthcare workforce encompasses an extensive range of socioeconomic status (SES) levels, with its lowest paying
professions eliciting annual median incomes lower than $30,000 among certified nursing assistants (CNAs), and highest paying, greater than $250,000 among emergency medicine physicians (Laughlin et al., 2021). As reflected in these findings, the current healthcare workforce impacted by COVID-19 is characterized by vast diversity across demographic, socioeconomic, and occupational characteristics.

Recent literature has examined the potential unique roles of clinical psychologists (Gruber et al., 2021) and health psychologists (Freedland et al., 2021) in addressing the biopsychosocial impacts of COVID-19 across the general population, relevant health-disparities that inform COVID-19 experiences across its diverse constituents, and, preliminarily, the differential effects of such experiences upon healthcare workers in their unique interfacing with COVID-19. To date, however, there has been little exploration as to how clinical health psychologists (CHPs) can apply their distinctive areas of competencies to fulfill current gaps in the public health response to COVID-19 specific to optimizing health and wellbeing among healthcare workers. The present manuscript seeks to accentuate unique functional clinical competencies demonstrated by CHPs as specialists committed to a bio-psycho-social-cultural perspective on health, and how such capabilities can be applied to improve health and wellbeing among healthcare workers across domains in the context of COVID-19 and its multifaceted, adverse impacts on health.

**Assessment**

In the multifactorial impacts of COVID-19 specific to healthcare workers, the centering of biopsychosocial knowledge in CHP assessment (Larkin & Klonoff, 2014) offers a comprehensive approach to optimizing wellbeing among healthcare workers. From a biological perspective, CHPs can familiarize themselves with the extent to which COVID-19 exposure affects healthcare workers across diverse professions; their relative risk of contraction, symptomatic presentation, and poor prognostic outcomes within their unique occupational environments (Castelnuovo et al., 2020); and the necessity for and efficacy of individual- and community-level measures to prevent and treat COVID-19 within their respective roles. CHPs can apply their psychological knowledge to evaluate risk for anxiety, depression, suicidality, trauma, and substance abuse across the clinical spectrum (Gruber et al., 2021) to which healthcare workers are at elevated risk during COVID-19; communicate psychiatric risk, symptoms, and quality of life impacts of COVID-19 unique to healthcare workers’ circumstances; and develop interventions accordingly. Understanding the intersectional, socioecological context within which these biobehavioral impacts occur (Larkin & Klonoff, 2014), CHPs are further equipped to contextualize such risk of diminished health within familial, cultural, financial, and overall societal factors that color these healthcare workers’ experiences.

CHPs offer evaluative expertise to address healthcare worker needs during COVID-19 not only in their knowledge base, but also in their skills applied within its biopsychosocial framework (Larkin & Klonoff, 2014). With such skills, CHPs can conduct comprehensive clinical interviews that afford analysis of the interplay among biological, psychological, and social factors that contextualize healthcare worker experiences as both providers and recipients of care throughout the COVID-19 crisis. In evaluating all predisposing, precipitating, perpetuating, and protective factors (Borell-Carrió, Suchman, & Epstein, 2004) that inform healthcare workers’ heterogeneous clinical presentations embedded within the common sociohistorical period of the present pandemic, CHPs demonstrate distinctive utility in describing the interactive influences that affect healthcare worker wellbeing during COVID-19 and appropriate redress via intervention planning.

Such applied skills extend beyond diagnostic mental health assessment and elucidate influences upon healthcare workers’ COVID-19 beliefs as providers and patients; environmental factors impacting adherence to care recommendations both specific to COVID-19 and to overall biopsychosocial health; engagement in health-promoting and risk behaviors as affected by COVID-19; and the familial, communal, and underlying societal environments wherein they occur. CHPs can evaluate the degree to which healthcare workers successfully navigate adherence to COVID-19 safety precautions (e.g., physical distancing), while also maintaining essential psychosocial support during this sociohistorical period of the pandemic. Further, CHPs can assess differential impacts of COVID-19 on healthcare worker engagement in risk behaviors, such as increased propensity towards sedentary lifestyles or substance abuse across professions. These bio-psycho-social-cultural assessment skills
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accentuate the vital role of CHPs in contextualizing such behavioral phenomena among healthcare workers within their respective preexisting demographic, socioeconomic, and health-related conditions, and their intersection with their respective occupational roles in interfacing with COVID-19.

CHP assessment can also explore differences within the healthcare worker population regarding occupational requirements for adherence, patient-provider beliefs surrounding such standards, and the impacts of occupational obligations during COVID-19 on psychosocial functioning. Holistically obtaining collateral information and communicating findings to various audiences, CHPs are integral to evaluating the bio-psycho-social-cultural effects of COVID-19 on the relational contexts within which healthcare workers operate (e.g., families, patient-provider relationships, non-healthcare and healthcare worker peers) and disseminating results to ensure optimal health promotion, prevention, and treatment for healthcare workers during COVID-19 within their socioecological contexts. Embedding assessment within the various demographic, socioeconomic, and health-related influences on COVID-19 experiences among healthcare workers, CHPs offer a bio-psycho-social-cultural approach to evaluation that seeks to comprehensively understand the effects of COVID-19 unique to this population.

Case study application. The following case presentation illustrates the utility of CHPs in optimizing healthcare worker wellbeing during COVID-19 conditions, with identifying details adjusted to maintain patient confidentiality. “Tamara” is a 49-year-old, non-Hispanic, African American woman referred to a board-certified, CHP by her primary care provider for evaluation due to occupational distress surrounding return to work following treatment for Stage III breast cancer. Tamara is a master’s-level nurse employed on an inpatient COVID-19 care unit within a large academic health science center. With her cancer diagnosis in March 2020, Tamara assumed medical leave to undergo surgery, radiation, and chemotherapy at the same institution by which she is employed. After completing her cancer treatments, Tamara was soon expected to return to nursing at her prior COVID-19 unit. Due to her elevated risk of exposure to COVID-19, Tamara was highly anxious to return to work on this unit, as evidenced in her significant panic symptoms when discussing her prospective schedule with her charge nurse.

Comprehensive assessment conducted by the CHP revealed history of significant childhood trauma, providing a foundation on which Tamara’s responses to both her role in COVID-19 inpatient care and her breast cancer diagnosis interactively elevated her risk for posttraumatic stress disorder (PTSD) and associated anxious panic symptoms. Her anxiety was exacerbated by concerns regarding her immunocompromised status following her cancer treatments accompanied by the elevated COVID-19 exposure risk inherent to her occupational role.

Embedding these concerns within Tamara’s socioecological circumstances, Tamara’s anxieties were heightened in context of her homelife with extended family, living with both older adults and unvaccinated grandchildren, whose elevated risks for contracting COVID-19 are further elevated in their intersections with their racial minority status (CDC, 2020). In thorough data collection across biopsychosocial domains, Tamara’s assessment demonstrates the distinctive utility of the CHP in obtaining a comprehensive illustration of healthcare worker, COVID-19 experiences and associated risks to health and wellbeing among this population.

Intervention.

CHPs exhibit several interventional competencies uniquely beneficial to healthcare workers affected by COVID-19 across functional domains, notably in our capacity to adapt technological advances to improving mental health care prevention and treatment (Larkin & Klonoff, 2014). In our COVID-19 response, CHPs have demonstrated remarkable efficiency in transitioning mental health services to telehealth throughout the U.S. (Holland & Carr, 2020; Leite, Hodkinson, & Gruber, 2020), affording healthcare workers opportunities to process their COVID-19 experiences through safe, efficient, and accessible media. Through these innovative responses via telehealth, CHPs embody an integral role in optimizing healthcare infrastructure that continues to comprehensively address biopsychosocial functioning in COVID-19 conditions, despite its imposition of unprecedented safety risks. Both live and via telehealth, the broader interventional competencies of CHPs are uniquely beneficial to addressing the biopsychosocial impacts of COVID-19 among healthcare workers. As in their socioecological
approach to assessment, CHPs implement interventions targeting both the microcosm of the individual and their interactions within systems (Larkin & Klonoff, 2014). Applying such competencies to healthcare workers during pandemic conditions, CHPs provide patient-centered, culturally sensitive therapeutic services that address their intersecting experiences across occupations; subjective experiences; demographic, socioeconomic, and health-related conditions; and the transactional effects of COVID-19 between their own biopsychosocial health and their surrounding contexts.

As previously detailed, healthcare workers are vulnerable to elevated risk of numerous psychiatric concerns (Gruber et al., 2021). The bio-psycho-social-cultural, CHP approach to treatment is critical to managing these concerns within the framework of our mental health expertise. In addition to heightened risk for diagnosable presentations, healthcare workers experience exceptional consequences related to quality of life and psychological distress overall. CHPs are vital to optimally managing such adverse outcomes, including elevated risk for burnout, interpersonal or familial strain, and isolation due to the uniqueness of their roles in the pandemic. Beyond treating these negative consequences, CHPs can implement preventive self-care measures tailored to healthcare workers, addressing balance between healthcare worker adherence to COVID-19 safety guidelines with heightened exposure risk and healthy psychosocial engagement that continues to ensure safety.

Beyond the individual and their immediate context, Larkin and Klonoff (2014) emphasize utility of CHPs in occupational environments for broader redress of health concerns. Their proposed broader interventional scale indicates a significant role for CHPs in implementing community-based interventions at the institutional level (e.g., hospital, clinic) to optimize bio-psycho-social-cultural wellbeing among healthcare workers. Prior such interventions have targeted basic self-care among healthcare workers, with an emphasis on cultivating resilience while avoiding detrimental effects of overtreatment. These institutional programs have typically focused on promoting work-life balance, stress management techniques, physical activity, and sleep hygiene, though are more recently accompanied by advocacy for more supportive clinical environments for healthcare workers overall through COVID-19 conditions (Gruber et al., 2021). In their familiarity with such environments in their own workplaces, CHPs provide unique insights as to how such programs can be optimally designed to enhance biopsychosocial functioning among healthcare workers. Where other mental health providers may have limited interfacing with such contexts, the occupational wherewithal of CHPs working in medical settings themselves offers unique contributions to improving work environments for healthcare workers through application of these personal insights during COVID-19.

The interventional competencies of CHPs encompass a broad range of clinical presentations, ranging from acute to chronic concerns necessitating varying levels of intervention from prevention to intensive treatment (Larkin & Klonoff, 2014). Such breadth of competency renders CHP expertise relevant across healthcare worker experiences throughout COVID-19, whether applied to optimize self-care among health practitioners or to manage severe traumatic responses to COVID-19 illness and death through frontline or personal exposure. CHP interventional expertise affords skill in addressing healthcare worker presentations within the context of their full life histories beyond the milieu of the pandemic, comprehensively treating healthcare workers with preexisting mental health or psychosocial concerns exacerbated by COVID-19 where relevant and their counterparts without psychiatric histories prior to pandemic conditions. Overall, CHPs can flexibly apply their interventional skills to the needs of these heterogeneous presentations among healthcare workers and their differential experiences in impact by COVID-19.

CHPs are uniquely equipped to utilize the bidirectional relationship between assessment and intervention competencies to evaluate outcomes throughout treatment (Larkin & Klonoff, 2014), and apply findings to targets specific to healthcare workers and their COVID-19 experiences. Applying and modifying preexisting outcome measures, CHPs can assess and adaptively refine interventions to the effects of COVID-19 on this population. CHPs can serve a pioneering role in developing outcomes that monitor measures specific to the unique psychosocial concerns for which healthcare workers are at elevated risk, as well as the impacts of CHP interventions in minimizing
adverse outcomes, during COVID-19. Through the ongoing balance between assessment and intervention that characterizes CHP services (Larkin & Klonoff, 2014), CHPs can cultivate critical insights into the interactive relationships between the multilevel, socioecological impacts of COVID-19, biopsychosocial factors embodied within the individual healthcare worker, and the efficacy of intervention in optimizing wellbeing among healthcare workers despite the distinctive demands of the pandemic imposed upon this population.

Case study application. Following recommendations for psychotherapeutic treatment, the CHP to which Tamara was referred applied numerous cognitive-behavioral techniques to address her anxious and posttraumatic symptoms. Specifically, the CHP guided Tamara in systematic desensitization to her occupational environment through graduated hierarchal exposures to mitigate her anxiety surrounding her return to work, while promoting engagement in optimal safety practices (i.e., consistent N95 usage) through similarly graded exposures. Further, Tamara was instructed in both 1) relaxation techniques for anxiety reduction and 2) interpersonal effectiveness skills to optimize communication with her charge nurse to ensure adequate self-care through practice of these techniques. The CHP, with specialized expertise in psycho-oncology, was equipped to apply such techniques within effective supportive care that addressed cancer-related impacts on Tamara's stressors, symptoms, and overall quality of life. These interventional approaches conducted via CHP expertise, accompanied by the familiarity of the CHP with the stressors unique to Tamara's occupational environment in the context of her cancer diagnosis during COVID-19, reveal the distinctive prowess of the CHP in advancing biopsychosocial health among healthcare workers during pandemic conditions.

Individual and Cultural Diversity.

The bio-psycho-social-cultural approach employed by CHPs prepares providers with holistic expertise to address how individual and cultural diversity inform the varied COVID-19 experiences of healthcare workers, understanding its constituents as cultural beings, examining health disparities and their determinants, and applying such knowledge to advancing patient services (Larkin & Klonoff, 2014). These competencies are particularly relevant to addressing COVID-19 challenges among healthcare workers, given the oft overlooked diversity of the healthcare workforce and the marginalizing influences that differentially exacerbate the effects of COVID-19 among underserved segments of this population. While healthcare workers are no exception to existence as cultural individuals, CHPs account for the essential impacts that demographic, socioeconomic, and health characteristics exert upon their COVID-19 experiences in both occupational and personal environments. Such competencies are critical to understanding COVID-19 incident and prognostic inequities to which healthcare workers are not only collectively more vulnerable, but also are at still further risk if living as racial and/or ethnic minorities, older adults, individuals with disabilities or immunocompromising conditions, in crowded environmental conditions, or in areas with greater socioeconomic inequity (Centers for Disease Control and Prevention [CDC], 2020). Given common neglect towards the demographic, socioeconomic, and health diversity characterizing healthcare workers, CHPs are vital to developing assessment and intervention that appropriately account for these differences among healthcare workers and their effects on COVID-19 experiences.

CHPs are also equipped to contextualize their services to healthcare workers within differential vulnerabilities to psychosocial and behavioral concerns underpinned by economic and sociocultural factors, which may be further exacerbated by COVID-19. For instance, CHPs can apply their expertise in patient-centered, culturally sensitive health care to address discriminatory experiences of Asian American and Pacific Islander (AAPI) healthcare workers, due to increased racial prejudice since the onset of COVID-19 and its publicization (CDC, 2020). The cultural competence of CHPs is similarly critical to understanding adverse biopsychosocial outcomes among older healthcare workers, especially among those with comorbid medical conditions or disability that both increase vulnerability to the disease and incentivize isolation. As illustrated in these examples, the CHP COVID-19 response necessitates centering of healthcare workers most vulnerable to adverse outcomes and scientific inquiry focused on how such experiences elevate risk for onset and maintenance of significant psychosocial concerns among marginalized healthcare workers. CHPs can utilize such knowledge of demographic, socioeconomic, and health influences on healthcare workers during COVID-19 such that they can tailor services to each practitioner,
considering their intersecting experiences as simultaneous patients, providers, and cultural beings within pandemic conditions.

Case study application. Considerations related to diversity and resulting health inequities were critical to the CHP’s approach to addressing Tamara’s concerns. Tamara’s presentation can be contextualized within Relational-Cultural Theory (RCT), a multicultural, feminist perspective that emphasizes health and wellbeing as products of mutually empathic relationships conducive to personal growth (Comstock et al., 2008). Embedded within the RCT framework, Tamara’s concerns were uniquely contextualized within 1) her marginalizing experiences related to her race/ethnicity, culture, and sex/gender and 2) possible co-occurring tendencies towards interdependent, collectivist, and spiritually interconnected values that may have informed her attitudes, perceptions, beliefs, behavior, and clinical presentation as an African American woman (Enns, 2004). Further complexified by “Superwoman Schema” (Woods-Giscombé, 2010), the phenomenon of pressure to simultaneously succeed in multiple essential life roles (i.e., parent, caregiver, employee, friend) for both survival and counteraction of negative societal perceptions especially among African American women, it is critical to conceptualize Tamara’s presenting concerns within this relational-cultural context as further detailed below.

At this intersection of identities, Tamara’s risk of disease and/or poor prognosis regarding COVID-19 was already elevated in the proxy variables embodied within racial minority status (CDC, 2020). As a master’s-level nurse, however, such elevated risk may have been mitigated for Tamara in her comparatively high income and associated physical living conditions relative to her counterparts in lower-paying professions, wherein African American women are overrepresented (e.g., licensed practical/vocational nurses [LPN/VNs]; Smiley et al., 2021; Bates, Amah, & Coffman, 2018). Despite the protective effects of her SES, cultural influences regarding her living environment (e.g., communal living among extended family) countered these protections in heightened risk of contracting and transmitting the virus among older and unvaccinated family members, and thus, her anxiety. Tamara’s cancer status following immunocompromising therapy further necessitated focused attention, in the intersection between her direct exposure to COVID-19 in her nursing role, her elevated predisposition to disease, and increased distress. In her CHP’s careful navigation of her intersecting demographic, socioeconomic, and health characteristics, Tamara’s reception of CHP care reflects the critical role that cultural competence among CHPs serves in optimizing biopsychosocial functioning among healthcare workers during pandemic conditions.

Conclusions: Overall, the functional clinical competencies embodied among CHPs entail important contributions to the COVID-19 response in optimizing biopsychosocial health among healthcare workers. Such contributions are critical in both 1) maximizing wellbeing among a diverse, occupationally vulnerable population during an unprecedented contemporary health crisis and 2) ensuring self-care among the practitioners that comprise it both for their own health and the health of their recipients of care. Given these considerations, we propose five objectives for CHPs to guide the enhancement of our response to COVID-19, delineated in Table 1. Through these recommendations, CHPs exhibit unique competencies that can significantly improve health outcomes across domains among healthcare workers within the sociohistorical context of COVID-19 and its consequences. In doing so, CHPs can optimize public health in addressing the needs of a vulnerable occupational population throughout the pandemic and in, thereby, ensuring care of the utmost quality among those whom its practitioners serve.
Conclusions: Overall, the functional clinical competencies embodied among CHPs entail important contributions to the COVID-19 response in optimizing biopsychosocial health among healthcare workers. Such contributions are critical in both 1) maximizing wellbeing among a diverse, occupationally vulnerable population during an unprecedented contemporary health crisis and 2) ensuring self-care among the practitioners that comprise it both for their own health and the health of their recipients of care. Given these considerations, we propose five objectives for CHPs to guide the enhancement of our response to COVID-19, delineated in Table 1.

Table 1. Recommendations for Clinical Health Psychologists in COVID-19 Response

<table>
<thead>
<tr>
<th>DISCOVER</th>
<th>Address the etiology and assessment of, interventions for, and sociocultural factors affecting psychosocial and/or behavioral health outcomes among healthcare workers as scientist-practitioners operating within pandemic conditions.</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONTEXTUALIZE</td>
<td>Develop and implement interventions tailored to the needs of healthcare workers at both individual and institutional scales through preventive and therapeutic approaches.</td>
</tr>
<tr>
<td>IMPLEMENT</td>
<td>Investigate biopsychosocial concerns specific to healthcare workers within the individual, relational, communal, and societal contexts within which they are embedded, with an emphasis on the intersection between demographic, socioeconomic, and health-related factors that underpin COVID-19 health disparities within this population.</td>
</tr>
<tr>
<td>REFINE</td>
<td>Optimize behavioral health promotion at all socioecological levels to both minimize risk of COVID-19 illness and death and maximize psychosocial engagement through adherent, safe approaches among healthcare workers.</td>
</tr>
<tr>
<td>EXEMPLIFY</td>
<td>Model biopsychosocial health promotion as healthcare workers ourselves through self-care within the current pandemic conditions, disseminating information on best practices for optimizing health during COVID-19 to healthcare workers and the relational contexts within which they live and work.</td>
</tr>
</tbody>
</table>

References


Freedland, KE, Dew, MA, Sarwer, DB, Burg, MM, Hart, TA, Ewing, SWF, & Kaufmann, PG (2020). Health...


**Dr. Deidre Pereira** is an Associate Professor in the Department of Clinical and Health Psychology in the College of Public Health and Health Professions. She received her PhD from the University of Miami in 1999 (Clinical Health Psychology). She completed her postdoctoral training on a NIMH-funded training grant on Biopsychosocial Research in Immunology and AIDS from the University of Miami in 2000. Dr. Pereira’s long-range research program is to improve health outcomes and promote the wellbeing of individuals with chronic and/or life-limiting illnesses, with an emphasis on malignancies that occur commonly or exclusively among women.

**Grace Hanvey** is a doctoral student in the Department of Clinical and Health Psychology. Grace received her bachelor’s degree in Psychology from the University of Florida in 2018, emphasizing in behavioral and cognitive neuroscience and minoring in health disparities. Grace is studying in the Clinical Health Psychology track and conducts research under the mentorship of Dr. Nicole Ennis in the Intervention Research Advancing Care Equity (i-RACE) lab Research Focus. Her present research investigates how socioeconomic status and associated factors inform inequalities in access to certain forms of health treatment.
“Who heals the healer?” is an old yet timely adage that alludes to the necessity for people in helping professions to take time to care for themselves. Self-care involves giving sufficient attention to our own physical and psychological wellness (Beauchamp & Childress, 2001). For psychologists, self-care is a core competency, along with reflective practice; we know that self-care is vital for psychologists as a mechanism to reduce or buffer stress (Brucato & Neimeyer, 2009; Rupert & Dorociak, 2019) and linked to well-being outcomes (Rupert & Dorociak, 2019). Importantly, research indicates that a continuum of self-care is most effective when practiced on an ongoing basis and not simply when one is in a challenging situation (Rupert & Dorociak, 2019). We ask specialists reading this article to reflect on their use of self-care. Does it happen when stress is up or is it a normal, ongoing part of our routine? For psychologists involved in teaching and training, how can we encourage self-care as a regular practice for our trainees?

Psychologists and other Clinicians in the Pandemic

In the early days and weeks of the COVID-19 pandemic, psychologists made a rapid shift to telehealth provision of services and had numerous concerns related to their practice (APA, 2020; Sammons et al., 2020). Along with another colleague, we studied 207 licensed mental health clinicians in private practice after the start of the COVID-19 pandemic in spring 2020 (Phillips et al., 2021). Although this research did not look at clinicians in a wider variety of settings, it did echo past research on the importance of self-care. Self-care (measured by the Self-Care Assessment for Psychologists) was associated with less stress, including all facets of self-care - having professional support, engaging in professional development, having life balance, utilizing cognitive strategies, and aiming for daily balance. While this finding does not make causal attributions about self-care, it supports prior findings that self-care likely buffers stress if engaging regularly versus engaging only when we feel an increase in stress (Brucato & Neimeyer, 2009; Rupert & Dorociak, 2019). We can all self-reflect on these findings. Were we giving ourselves enough care prior to the pandemic? Or did we learn the lesson of the importance of regularity at the start of the pandemic and as it continues? Consistent use of strategies is likely important for clinical practice beyond COVID-19, as is the importance of emphasizing these strategies in teaching and training of future psychologists. This study emphasized the importance of ongoing self-care as a buffer for stress in challenging times (i.e., the pandemic) and the pandemic may have taught us more about the unpredictability of stressors and making ongoing self-care even more important.

As the pandemic continues, how are we doing? Have we steadily decreased self-care as we’ve adjusted to life with COVID-19? These are likely questions each of us can explore. We can use this experience as an opportunity to re-invigorate our continuum of self-care. We could use existing literature to explore our regular use of strategies (e.g., Norcross and VandenBos, 2018 provide a thorough review of literature along with recommendations and APA provides resources for psychologist self-care here: https://www.apa.org/monitor/2014/04/self-care).

Moving the Lesson Beyond Us and to Future Psychologists

Psychologists also serve a vital role in educating the public and working with our clients/patients. We should be assessing how clients/patients are responding to the ongoing pandemic and assisting them with their self-care regimens. As leaders in our own places of employment, are we promoting policies that encourage and allow for sufficient self-care? For psychologists involved in teaching and training, are we emphasizing self-care as a competency, and if not, what are ways we can promote this? The remainder of this article will focus on this last question: how can we support students and trainees in their development of regular self-care? We chose this
focus because this author group includes an educator in a clinical psychology program (Phillips) and two doctoral students (Thompson and Ruiz).

Doran (2014) noted, “The unspoken reality is that self-care in graduate school is a struggle. As trainees, we receive mixed messages - perform at a high level and meet all rigorous training demands, while making time for outside activities, relaxation and fun” (para. 2). There are small preliminary studies and narratives about disruptions to graduate education during the COVID-19 pandemic (e.g., Kee, 2021) and studies illuminating concerns about student mental health during this time (e.g., Bratman et al., 2021). We do not fully understand the full impact of COVID-19 on graduate student mental health, but this pandemic could be a wake-up call for psychologists in training and supervising roles to increase emphasis on self-care.

Bamonti et al. (2014) sampled clinical psychology doctoral programs and utilized seven trained coders to review online program content (e.g., websites, handbooks) for evidence of information on self-care. While many programs mentioned access to services, only 11% had a general psychology department handbook that referenced self-care and only 32.4% had a clinical psychology handbook that referenced self-care. Bamonti et al. (2014) advocated for programs to clearly state the importance of self-care and adopt self-care practices as an institution. Educators and supervisors can integrate education and discussion about self-care into their coursework (Bamonti et al., 2014; Kolar et al., 2017). In fact, Dorociak et al. (2017) suggested that self-care be cultivated as early as possible in education and training. This emphasis should extend beyond our courses into the policies and handbooks we have for students and trainees. Norcross and VandenBos (2018) noted that not having time for self-care is a barrier for clinicians in practice; we need to emphasize how to make time for self-care in graduate training and beyond.

For those of us supervising post-doctoral trainees and/or mentoring early career psychologists, Dorociak et al. (2017) provided some insights from two surveys of Illinois psychologists at various points in their careers. Psychologists earlier in their careers reported more “emotional exhaustion,” greater “perceived stress,” and more days of “poor mental health in the past month” compared to those later in their career (p. 433). In the first survey, early-career psychologists reported engaging in fewer self-care activities than later-career psychologists. Although further research is needed, a concerning possibility is that early-career psychologists might face more difficulties while simultaneously engaging in less self-care.

Emphasis on self-care is vital in early training and early career. It was vital prior to the pandemic, and the pandemic has perhaps further emphasized its role in buffering stress. Recognize that the more we practice self-care, the more routine and frequent it becomes. Educators of trainees can be on the lookout for signs of fatigue and exhaustion among trainees in order to talk to them about and model for them self-care. This may be beneficial in helping them grow this crucial competency to aid in their career longevity as well as carry out in their personal lives. Psychologists can be aware that the best clinicians are emotionally aware and cognizant of when they need to take time for self-care. Finally, to answer our initial question at the opening of this article, we would post that one-way healer heal themselves is by implementing self-care as a regular practice, benefiting ourselves, our trainees, and our patients/clients.
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References


Opening Up: How Psychotherapy Can Address the Return to the Post-Pandemic Workplace

Jeffrey L. Kleinberg, PhD, MPH, ABPP

The Great Resignation has begun. As offices, stores, restaurants, and resorts open up, and workers are invited back, more and more choose not to return. In August, The U.S. Bureau of Labor Statistics reported: The number of quits increased in August to 4.3 million (+242,000). The quits rate increased to a series high of 2.9 percent. Quits increased in accommodation and food services (+157,000; wholesale trade (+26,000); and state and local government education (+25,000). The number of quits increased in the South and Midwest regions.

The prospect of returning to the same old job turns off many workers. Seeking more pay, better work conditions, a more equitable work-life balance, greater satisfaction and strengthened long-term fulfillment, resignation seems to be on a lot of minds. The safety net of additional unemployment benefits for some enabled millions to stay home and consider changing career direction.

My work as a psychotherapist with a focus on work-related issues has brought me into contact with people who seem ready to leave their current field and explore other options. Is this a “mid-life crisis,” a healthy response to the new normal, or a post-pandemic response to trauma? Transitioning back to work is likely to come up during ongoing treatment or cause potential clients to contact us. How might we help them understand the underlying issues they are facing and make sound decisions about how to move forward?

Let’s consider the impact on workers of the pandemic and public health restrictions. For many, remote stations led to months of social isolation that blurred the lines between work and family, brought on Zoom fatigue, fears of getting sick or sicker, and a stronger than ever sense time was running out. Thousands also had to cope with loss and mourning.

Clients will need to reflect on what they have been through and try to make some sense of the past year-and-a-half. Some will be tempted to make hasty decisions about their career path and be unclear about their motivation for seeking a change. The risks of a radical change in direction are huge. Holding off such decisions may be prudent until greater clarity emerges of the underlying psychological issues.

Consider a person in her mid-forties who would describe herself as ambitious. She states that she has pursued a set of goals for years that she hoped would fulfill her dreams. But during the pandemic, and working from home, she began to evaluate whether she was happy with the current trajectory of her life. Working exceptionally long hours, not being able to spend quality time with family and friends, often feeling on the verge of burn-out led her to reevaluate her career goals. Networking with colleagues and potential mentors helped her reality-check interesting opportunities and eventually prepare for a career shift. Through therapy, she used the pandemic detour to reset.

In contrast, another person in mid-life, couldn’t face going back to the office. Having to commute, feeling under-appreciated and under-paid, and already feeling burned-out, he decided enough was enough. He was prepared to tell his boss that he was resigning, effective immediately. While he was sure that quitting was the right thing to do, he became anxious that he didn’t know the next steps to take. He knew that impulsive decisions in the past often did not work out. He decided to postpone giving notice, until he understood better what the pandemic had done to him. Of major concern in treatment, was the relationship between the trauma and his ongoing and newly emergent psychological issues.
Since many psychotherapists do not frequently deal with work issues in ongoing treatment, I thought it would be useful to outline a process through which the post-pandemic client may address trauma and career goals.

Psychological reasons for wanting to change (or not change) career direction now are particularly prominent issues to be considered in psychotherapy. Much insight can be developed about the importance of work to the individual, potential pitfalls in making major life decisions, and the contributions of acute stress in shaping our ambitions. During therapy, the client might consider the extent to which a desire to change is a function of pandemic fatigue, job burnout, or an escape fantasy. A question that would be logical to ask: Were there any signs of wanting to change direction before COVID-19? It could turn out that the better path forward might be to seek improved job conditions, or obtain a similar job in a better company, or go back to school to advance, or re-balance the ratio between time spent with work and family. Informational interviews with people in the fields or companies under consideration would likely point to available opportunities for securing a job and maintaining a healthy work-life balance.

Within the treatment, the clients can consider how the current or new career path might increase feelings of self-worth and confidence. Thinking about securing a mentor as a sounding-board and a role-model would include trying to understand and manage anxiety that might be stirred up by such a search. Problems with authority, competition, and interpersonal conflict could be worked through in psychotherapy. Discussing career decisions with significant others would be expected, and this, too might be worthy topics for psychotherapy.

A post-pandemic self-reflective process could result in post-traumatic growth. We have all been through a lot but understanding the meaning of this traumatic experience and its impact on us can raise options we might not have otherwise considered. A well-thought-out plan for strengthening one's quality of work is far safer than hastily deciding on major changes and leaping before looking.

Determining how COVID-19 affects our feelings about work promotes empathy in treatment, creates a shared experience in managing the post-pandemic world, and yields insights about what drives the client and ourselves. Working with community trauma in individual psychotherapy, and opening-up about our hopes and fears, can help both therapist and client reset.

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Integrative Behavioral Health Services for Healthcare Workers in a Primary Care Setting: Early Clinical Insights and Other Considerations.

By Angela N. Hill, PsyD, ABPP

The research is scarce about addressing behavioral health needs for healthcare workers in a primary care setting – the primary care setting is often the gateway for behavioral health care (Huggard, 2020). The global coronavirus pandemic has contributed to levels of unpleasant psychological and behavioral changes that can negatively affect job performance and stress adaptability in the workplace. The coronavirus pandemic has also appeared to trigger the intensity of residual and underlying mental health issues that perhaps were unknown, dormant, avoided, or dismissed prior to such dramatic and unexpected global changes. Depression, anxiety, grief and loss, guilty feelings, and fear of uncertainty are some of the more common symptoms presentations. About two-thirds (67%) of adults with a behavioral health condition are not receiving appropriate behavioral health treatment – depression often goes unnoticed in primary care settings, particularly in more than half (50%) of patients, and primary care providers report difficulties in connecting patients with community outpatient behavioral health providers due to behavioral health staff shortage and health insurance barriers (Green, LA & Cifuentes, M, 2015). The need for behavioral health programs to address cognitive and emotional wellness for healthcare workers cannot be overstated. It is essential to improve their overall quality of life as well as to assist healthcare workers to feel effective with their interpersonal and work relationships; and to feel accomplished with their job responsibilities and demands especially during these uncertain times.

Program Overview:

Over the past year I have been tasked to develop an outcomes-based integrated behavioral health program for healthcare workers in a primary care setting. The program is aligned with an integrated behavioral health model that promotes collaboration between medical providers and other team disciplines for holistic care. The objective of primary care integrated behavioral care programs is to improve communication between behavioral health and primary care providers and thereby improve care coordination. Mild-to-moderate psychiatric symptoms are treated and focused on mental, emotional, and physical sources. There is a partnership with medical providers in the integrated behavioral health program to consult, coordinate, and collaborate with each other as we work together to deliver integrated care. The program also involves staff education on various clinical disorders and
other processes that may assist in diagnostic considerations and treatment, understanding and sensitivity, and seamless transition to integrated behavioral health services.

The program is housed on a safety-net hospital system that employs around 15,000 healthcare workers. Most healthcare workers are collaboratively referred to integrated behavioral health services by primarily their primary care medical providers. There has been more than 70+ patient encounters since the onset of the program last December. Racial disparity groups include the following: African American (43%), Caucasian (20%), Hispanic/Latina/Latino (35%), and Asian/Pacific Islander (2%). Each employee is required to complete a Patient Health Questionnaire at each medical visit (except for brief nursing visits for immunizations or blood pressure check). Other subjective symptom measures are also available to provide to patients at their visits. The referrals are reviewed by the clinician and approved or denied based on appropriateness for services, including acuity, symptom severity and chronicity. A Behavioral Health Coordinator performs a confidential behavioral health pre-screening before scheduling behavioral health services. The screening process involves the reason for referral, the patient’s understanding about the referral, the insurance coverage, and any co-payment. The screening also involves a review of treatment expectations and no-show stipulations, brief mental health concerns, current psychotropic and substance and tobacco use, memory concerns, pending legal issues, history of suicide attempts and psychiatric hospitalizations in the past 30 days, and treatment preference (individual or group therapy, medication, or combination). Patients can also be triaged for additional services that may focus on additional medical or psychosocial concerns. If patients require alternative behavioral health services, they are provided in-network or other low-cost community behavioral health resources.

Preliminary quantitative and qualitative data show symptom improvements across the course of participation in group and/or individual psychotherapy. Healthcare workers awaiting individual psychotherapy services often take advantage of attending weekly and bi-weekly group therapy sessions focused on depression, post-traumatic stress, and anxiety/stress management. Early treatment outcomes suggest that healthcare workers appear to be positively influenced by initial group attendance as a catalyst for improved insight and to explore more intensive behavioral health concerns (group therapy promotes development of trust, rapport, and safety). Individual psychotherapy sessions are contingent on patient needs and are conducted every 2 to 4 weeks. Treatment approaches are evidence-based and include Cognitive-Behavioral Therapy, Interpersonal Psychotherapy for Depression, Cognitive Processing Therapy for Post-Traumatic Stress Disorder, Brief Psychodynamic Therapy, Emotion-Focused Therapy (couple/marital therapy), and Mindfulness. The length of treatment varies and is a modified approach from standard therapy sessions often seen in primary care behavioral health, typically between 3 to 8 months or up to a year. The modified treatment duration approach was instituted to meet the specific needs of healthcare workers, who often present with chronic symptoms and concerns that require more treatment sessions to enhance their outcomes. Healthcare workers can further attend group or individual therapy maintenance sessions following therapy completion – these sessions can be held every 3 to 6 months. Healthcare workers have the option to attend sessions either virtually or in-person. Early findings show no clinically significant difference between these two platforms related to treatment outcomes.

Further data shows non-clinical populations supersede clinical populations (68% vs. 32%, respectively), with some rise in clinical populations as of recent. Clinical populations include direct patient care and non-clinical populations support patient care, but their jobs do not provide direct diagnosis, treatment, or care for patients. Twelve percent of healthcare workers were previously on short-term disability leave and all healthcare workers returned to work following behavioral health treatment. Anonymous patient testimonials continue to opine high satisfaction with the behavioral health program and staff. Testimonial themes include improvements in relatedness, universality and cohesion; the ability to apply therapeutic concepts into work and personal life; enhanced emotional expression; increased problem-solving skills; and cited preferences for communication – an open platform that affords opportunities to empower, to facilitate self-confidence and nurture personal strengths, and to feel a sense of collaboration and inclusion in the direction of their treatment. Trauma-focused therapy with critical care nursing staff have also shown steady reductions in post-traumatic stress symptoms since onset of treatment.
Summary and Clinical Considerations:

In this article, we briefly outlined an integrated behavioral health program in a primary care setting for healthcare workers. Early treatment findings highlight effective treatment approaches which psychologists can utilize in addressing the cognitive and emotional wellness needs of healthcare workers in a primary care setting. It is imperative to have support from supervisory and other leadership staff to have time allotted for healthcare workers to address their issues. Psychologists can continue to utilize their extensive knowledge and make viable contributions to program development, research, and prevention and treatment of clinical conditions of healthcare workers and in other work settings (Brown, et al, 2002). There is also a strong need for support from additional therapeutic resources for healthcare workers considering preliminary research findings from the integrated behavioral health program. This is based on the need to serve a range of healthcare populations with various psychosocial needs. Further analysis suggests the need for incorporation of social work services, psychiatry, and additional psychologists that can further address the chronicity, symptom severity, psychosocial needs, and volume of healthcare workers referred to the program. The incorporation of integrated behavioral health services for healthcare workers was instituted based on the needs of healthcare workers across the organization. Qualitative and quantitative data consistently demonstrate holistic benefits from behavioral health program participation. Research will need to further address specific findings, tools used to assess symptom outcomes, research limitations, potential biases, and other factors that can influence findings as well as recommendations and suggestions for future research.

Authors Note:

Angela N. Hill, PsyD, ABPP is board certified in Clinical Psychology by the American Board of Professional Psychology and is a practicing licensed psychologist at a large county hospital organization in Texas. She received the 2010 Early Career Psychologist Credentialing Scholarship, Certificate of Recognition for poster submission about interdisciplinary team training for helping patients with diabetes management (2019), Employee of the Month (2019), and Merit Scholarship Awards during her graduate school tenure. She provides outpatient primary care integrative behavioral health services to healthcare workers, their dependents, and retirees, who are identified in need of psychological and/or behavioral interventions by their primary care providers. She conducts individual psychotherapy; crisis interventions; comprehensive chart reviews; clinical documentation; novel support services; suicide risk assessments; group psychotherapy; staff education; family and marital psychotherapy; psycho-educational classes; and psychological and diagnostic evaluations for mental and emotional disorders of patients through observation, clinical interview, and brief cognitive screenings. She further conducts educational webinars and media appearances and other conference presentations to multi-disciplinary staff members across the organization as well as provides clinical consultation to medical staff and to other team members.

References:


Attention to mental health needs of healthcare workers during times of high stress is essential to ensure optimal functioning and reduce negative impacts. During an event such as a natural disaster or pandemic, providers often experience an increased patient load as well as a decrease of supplies or necessary equipment, leading to strain on staff. Providers in rural settings may experience additional stressors, as infrastructure may be lacking, and they may be practicing in situations in which the availability of healthcare providers is particularly limited. Occupational stressors can test personal coping strategies that are sufficient for typical daily needs.

Research on healthcare provider psychological response to emergencies has been limited. One review indicates that stress and anxiety are common while healthcare workers are dealing with current stressors, with lingering trauma symptoms, burnout, and insomnia for a minority for years after (Magill, Siegel, & Pike, 2020). Following an earthquake in L’Aquila, Italy, healthcare workers demonstrated higher levels of emotional exhaustion (Mattei et al., 2017). This increased risk has the potential to lead to more lasting negative consequences and enduring stress. Previous research on the impact of stress on healthcare workers after the 2003 outbreak of Severe Acute Respiratory Syndrome (SARS) found that clinically significant distress was often associated with quarantine, fear of contagion, fear for family health, and interpersonal isolation (Maunder et al., 2008). Though family support is often considered a protective factor, in cases of infectious diseases, healthcare workers with children had more distress about their family’s health (Maunder et al, 2008). These concerns seem congruent with stressors emerging for health care providers during the current COVID-19 pandemic.

The COVID-19 pandemic shares similarities with the studies reviewed above in that it is a substantial stressor with the potential to directly impact healthcare workers. However, it marks a departure in the worldwide scope, severity, and duration of the pandemic, with nearly five million deaths worldwide as of the end of October 2021 (WHO, 2021). An emerging literature documents the toll this is taking on healthcare providers. Studies suggest that rates of anxiety, depression, and PTSD are increasing rapidly among healthcare workers (Johnson, Ebrahimi, & Hoffart, 2020; Young et al., 2021). Providers may feel pressure to engage in behaviors which challenge personal moral values, such as making difficult triage decisions, which exacerbate distress (Wilson et al., 2021).

Integrated primary care is becoming an essential method to provide quality healthcare and is a key interface between psychology and other healthcare disciplines. Psychologists are uniquely equipped to provide brief,
focused interventions beneficial to decreasing burnout and mitigating stress. Psychologists in integrated primary care settings traditionally provide services to patients, and flexibly expanding this role for colleagues in times of community or global crisis could be warranted. Support is shown for interventions occurring after disasters to encourage resilience and decrease chronic emotive issues (Norris, Friedman, & Watson, 2002). We argue that psychologists in primary care settings are ideally situated to provide services that benefit other health care providers during this time of exceptional stress.

Precedent exists for psychologists on integrated teams to assist the team with coping with difficult events, such as the death of a patient. Psychologists seeking to provide support to an integrated health team must thoughtfully examine their roles and identify and minimize factors that could potentially impact professional relationships if they elect to provide services of any kind. The types of services provided should be considered carefully to ensure that the services can be competently and ethically delivered. Some such programs are already in place. Kroll et al. (2021) discuss a program developed by the Medical College of Wisconsin to provide support to healthcare workers during the COVID-19 pandemic, with support groups being a key component. Similarly, Houtsma et al. (2021) detail efforts to increase employee support in a VA healthcare system through mental health first aid, increased employee assistance program referrals, and expansion of employee well-being programming. Based on the increased risk of stress and burnout in healthcare workers as well as psychologists’ knowledge and skills-based approach, it appears that the current COVID-19 pandemic is a unique situation in which it could be beneficial for psychologists to intervene to support other healthcare providers.

We propose a model utilizing stress management and mindfulness strategies to provide coping tools for employees. This model was developed and implemented in an integrated primary care facility in West Virginia at the behest of the chair of the department and organized further by the vice-chair. The team psychologist provides basic, evidence based coping skills often taught for stress management, generalized anxiety, and emotion regulation. These skills include diaphragmatic breathing, progressive muscle relaxation, grounding, mindfulness, and guided imagery. These skills are taught in brief (20-30 minute) group sessions at various times throughout the day, two to three times per week to maximize flexibility for scheduling conflicts. Skills sessions are open to all employees working at the outpatient clinic, including physicians, nurses, allied health care providers, administrative staff, and others. The goal is to provide optional skill-based tools for staff during a high stress time in order to increase coping skills available. Sessions are all prefaced with relevant informed consent information, including a statement that the service does not replace psychotherapeutic services. Additional resource lists with local outpatient and inpatient services are provided to each person in attendance. In order to decrease the risk of impairing the psychologist’s judgement or objectivity, no personal information is gathered or discussed, focusing instead of practice of stress management skills. Informal feedback from attendees suggests this model provides beneficial coping tools during this stressful period of time. With time, during this ever-changing global pandemic, it is our hope that this model will provide necessary skills to healthcare workers in order to reduce the likelihood of burnout and fatigue.

References


Short Bios:

*Destiny Hoffman, MA, is a doctoral student in the Marshall University PsyD Program. She is currently completing her doctoral internship at Geisinger Medical Center in Danville, PA, in the Adult Clinical/Health Psychology track.*

*Brittany Canady, PhD, ABPP-CHP is an Associate Professor of Psychology at Marshall University and an adjunct professor in the Department of Internal Medicine at Joan C. Edwards School of Medicine. Dr. Canady completed her PhD at the University of Houston and her doctoral internship at Geisinger Medical Center.*
As I write this, I am aware that this is the 49th year I have been licensed and practicing as a clinical psychologist and psychotherapist. Wow, 49 years, I guess it's too late to seriously consider a career change! But maybe this is an appropriate time to try and understand how I came to choose this particular profession. Theodor Reik, in his largely autobiographical book, “Listening with The Third Ear”, recalls a time he asked his mentor, Sigmond Freud, about how to make an important decision. Freud, he said, told him that when it came to vital matters, like choosing a mate or a career, the choice should be entrusted to the unconscious. With all due respect to Freud, and I do respect him and his theories immensely, I believe there are certainly experiences and conscious thoughts that to some degree also influence our decisions. In my case, I am aware of both specific and pervasive experiences which shaped my decision. Two of these included:

The numerous hours my siblings and I spent patiently listening to our mother's constant lament about being separated from her family and home in Southern Italy. She'd always say to us, "you never forget your country, your parents, or your first love." Nearly 50 years after coming to America, and after my father had died, she finally returned for the 1st time to Italy and was broken hearted to learn that her "first love" had died only 6 months before she arrived. But that's another story.

The second ongoing experience that I believe shaped my decision was the unrelenting proselytizing to enter the religious life most of my Catholic peers and I were subjected to in both elementary and high school. According to the nuns, brothers, and priests we were all told that they knew we had a calling to enter a life of service. I think that for me, choosing to become a psychotherapist was, in part, a substitute way to "answer the call." I wondered if they received some kind of bonus for each recruit, yet later it occurred to me that they must have needed to get other young people to "sign up" to maintain their belief that they had not made a serious mistake in choosing the religious life for themselves.

In addition, three discrete experiences also seemed to play a key role in my career choice. The first occurred one morning while I was walking to school at about age 12. For whatever reason that morning, I was filled with patriotic zeal and marveling at how lucky I was to be living in the USA, the greatest country in the world! And then I stopped in my tracks as it dawned on me that at that very instant there was probably a kid walking across Red Square in Russia thinking the same thoughts about the USSR. Unbeknownst to me I had inadvertently stumbled across the psychological principle of "individual differences". All I knew was that I was intrigued by my conviction that my assumption was correct that people could be so individually different. Knowing this, I began to see the differences in others as compelling and interesting and found myself drawn to the behavior and thinking of those who were unlike me.

The next clear experience that contributed to the choice for my life's work occurred three years later. Our assistant parish priest would frequently find ways to provide enriching experiences for the adolescents in our church. To that end, he would frequently take one or another of us to amusement parks, ball games or on vacation trips. He had invited me to accompany him and his older, unmarried sister on a trip from Ohio to Washington DC to visit his younger sister and husband, who had recently married and moved to that area. We had driven a long day getting there and were all tired that night. So, after a late dinner we all retired early. Sometime in the middle of the night we were all suddenly awakened by bloodcurdling screams coming from the room of the older sister. When we rushed in, she was still shaking in terror and told us of the frightening nightmare she had had. It seems that she had dreamed that her new brother-in-law had come into her bedroom and was savagely and repeatedly stabbing her with his huge knife. It would be years before I had read enough Freud and his dream theory to appreciate...
how symbolization and displacement had come together to allow the older sister to mask the expression of her sexual desire, jealousy, and sibling rivalry. However, I knew even then that I was observing something remarkably significant about the mind, and that the content of her dream was not an accident but somehow meaningful. Again, I was fascinated and wanted to know more about what I in years later came to learn was called the unconscious.

The last early experience that impacted my career choice happened when I was a sophomore or junior in college. Early one evening, for whatever reason, I had a moment of intense existential anxiety in which I became aware of my mortality and the certitude that I would someday die (I never stop being amazed at how we all use various distractions to avoid this awareness). I was in a panic and unable to soothe myself, and frantic to find someone to help relieve my distress. I decided to try and find my metaphysics professor, since I thought he was the most knowledgeable person I knew. I hoped that maybe he might know something about how to tolerate this awful awareness.

On my way to find his office, I took a shortcut through the university library where I worked part-time during the week. As I passed through the library I ran into the assistant librarian, and he immediately insisted we talk. He was a kind gentleman, in his 40's I believe, devote Catholic with a house full of children and a healthy sexual appetite. He was complaining bitterly about "coitus interruptus," the only method of birth control permitted by the Catholic Church. He found this practice unsatisfactory and was struggling with his sexual frustration and difficulty complying with the church's teaching. Well, I listened to him for about 45 minutes, and really did not have much that I had to say. At the end of the conversation, he had experienced what appeared to be a relieving catharsis, and I was surprised to find that my own existential anxiety had dissipated. I realized that the process of listening to, and empathizing with, others allows me to partially escape my own misery while hopefully being of help to them. It made the choice of becoming a psychotherapist all the more irresistible.

So much for the more obvious conscious reasons I ended up spending my adult life as a teacher of clinical psychology and a psychotherapist. I really can't imagine having pursued another vocation or have had the pleasure of fostering psychological insights in the minds of students or missing the wonder of exploring the psyche of a patient or experiencing the satisfaction that I have known in getting to know and admire the struggles of the courageous people I have worked with. In the end, Freud was probably most correct in his discernment of the motivation of our choices. Had I continued my Analysis for another four or five years, I am sure I would have discovered that my decision was driven by components of masochism, narcissism, voyeurism and perhaps a need for redemption. Nevertheless, it has been interesting to speculate on the more apparent aspects of my career choice.

Dr. Trimboli, is semi-retired, a Clinical Professor of Psychiatry at the University of Texas Southwestern Medical Center (Dallas), and maintains a modest private practice in Dallas, Texas, where he specializes in the treatment of misery.
Please Explain Alzheimer’s Disease to Me.

&

Please Explain Vaccines to Me because I HATE SHOTS!

Announcing the publication of two new children’s books.

By:

Laurie Zelinger, PhD, ABPP, RPT-S

The effectiveness of bibliotherapy is well recognized. According to the National Research Center on the Gifted and Talented (1997), “Through reading, or being read to, a story similar to their own lives, children are able to experience and deal with an issue objectively which can then be applied to their own problems/issues. The stories should show the child there is a way out, others have the same issues, you are not alone. Bibliotherapy sends the message to the child that it is acceptable to talk about this and together we can work out a solution”. It is recommended for use by anyone who has contact with a child who is experiencing emotional turmoil or confronting a new issue that may be confusing.

I write books to help children understand difficult concepts and to support parents who want to have follow-up discussions. As a retired school psychologist and private practice child psychologist for many years, I have become quite adept at explaining difficult and uncomfortable concepts to children. In that vein, I developed a line of children books with Loving Healing Press, each of which contains a colorful children’s story about a particular issue, followed by a parent guide. The (6) books in the Please Explain series offer an engaging story which presents the issue to a child in text and illustrations that are developmentally engaging, while providing the caregiver with empirically based information that has been synthesized, condensed, and presented into a digestible format for the average reader. Some books provide scripts to use to begin a dialogue and all provide support for adults navigating difficult conversations with children.
Most recently, I completed two books which I feel have particular relevance at this time. “Please Explain Alzheimer’s Disease to Me: a children’s story and parent handbook about dementia” was released in July 2021 and is geared toward 6-9-year-olds. In October 2021, four months later, my most recent book was released which helps children who are afraid of injections. It is called, “Please Explain Vaccines to Me because I HATE SHOTS!” Both were written because they had personal relevance to me and societal pertinence.

I had always wanted to write a book that would help young people understand Alzheimer’s disease. When I was growing up my grandmother lived with us for a while and as a result, we too, lived with dementia. I saw firsthand the level of care she needed and the toll it took upon my parents. I was often afraid of my grandmother’s unpredictable behaviors and her confusion. In the mind of a young child, I wondered if this meant she was going crazy and what else might happen. My parents explained it to me as best as they could, but they were fi ring it all out for themselves. My mother was a scientist and tried unsuccessfully to stem the tide of the disease. She threw away all the aluminum pans in the house, stocked the apartment with vitamins whose names I could not pronounce, and in an attempt to protect herself she kept her mind active; even getting paid to proofread crossword puzzles after she retired.

And then, some 35 years later, we saw that ominous change in my mother. She started forgetting, becoming overwhelmed with tasks she managed easily in the past and her personality changed. As time went on, she was barely recognizable. I helped my father care for her, but I had a young family of my own. I was clearly the definition of what it meant to be in the sandwich generation. I became the decision maker in my mother’s care and did my best to support my father as he provided 24/7 care. When my mother’s needs grew beyond our ability to manage, we did our research and painfully, reluctantly, resignedly placed her in the best nursing home we could find. We visited her several times a week for 10 years, as we watched her live and die with dementia. As smart as my mother was, she couldn’t prevent the trajectory of heritability.

I have since learned a lot about Alzheimer’s disease because it hit so close to home…twice. Now that I am among the aging baby boomers, I am very much aware that in 2020, 5.8 million Americans (or one in 10) over age 65 had the disease (Park, 2018), affecting 3% of people in the 65-74 range, 17% of people ages 75-84 and 32% of people over age 85. The Alzheimer’s Association estimates that by 2025 that number will reach 7.1 million. While only one person may be diagnosed, it is truly a family disease. Young people need to understand what it is. I am sharing what I know.

“Please Explain Vaccines to Me because I HATE SHOTS!” is more lighthearted and grew out of my work using CBT in play therapy to desensitize children in my practice to impending blood tests and injections. It also tapped into my own paralyzing fear of injections as a child. Research indicates that 68% of children in the 6- to 8-year-old range, 65% of those in the 9-12 range and 51% of 13-17-year-olds in a study had a strong fear of needles (Taddio et al., 2012), while 3.5-10 percent of the general population has needle phobia (Nir et al., 2003). There is a high heritability rate where 80 % of adults report a fear of needles in fi st degree relatives (Accuroso et al., 2001). Blending my four decades of psychological experience with my interest in child development, it seemed that I could make a therapeutic contribution, especially now that young children may soon be lining up en masse for the COVID-19 vaccine.

The intended audience for this book is 5–8-year-olds who are afraid of shots, and their parents who need to help them manage that fear. The format is rhyme, the illustrations are colorful, the characters represent diversity, and it has a happy ending. The parent/caregiver section is based on empirical data as well as techniques I have found effective as a credentialed play therapist. I have also included actual drawings from children (ages 5-10) who were in the pilot group that heard the story as it was being developed. They said the book made them feel less scared. I am hoping to share this information, so that other children might benefit.
References:


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Dr. Laurie Zelinger is a board-certified psychologist with a specialty in School Psychology, and a Registered Play Therapist/supervisor with over 45 years’ experience. She is a licensed New York State psychologist who, after retiring from a Long Island public school system, is now devoting her time exclusively to her busy private practice for children and writing books that will help their emotional development. Her books include: Please Explain Alzheimer's Disease to Me; Please Explain Anxiety to Me; Please Explain Tonsillectomy & Adenoidectomy to Me; Please Explain Terrorism to Me; Please Explain Time out to Me!; Please Explain Vaccines to Me and A Smart Girl's Guide to Liking Herself Even On The Bad Days for American Girl.

Dr Zelinger has also written chapters on selective mutism and fears and phobias for compendiums on play therapy, as well as an article for Play Therapy magazine about expanding the use of social stories with widening populations. She is credited with being a consultant for the Bitty Baby book series by American Girl where she assisted in the development of the 'For Parents' sections as well as editorial development of another American Girl book. Her interest in writing began in 4th grade, when a play she wrote about the drought experienced in New York City at the time, was performed by the students in her public school.

Dr. Zelinger has held elected positions in the national American Academy of School Psychology, the New York State Psychological Association, and the New York Association of Play Therapy. As a highly respected child psychologist, she has contributed to nearly 200 venues regarding child development. She and her psychologist husband, Dr. Fred Zelinger, are both certified Red Cross Disaster Mental Health volunteers. They have been happily married for over 40 years, have raised four children, and relish their roles as grandparents.
Capacity Assessment: Clinicolegal, psychosocial, and ethical caveats.

Vivian Begali, PsyD, LCP, FACPN-ABN, ABPP

Dr. Vivian Begali, PsyD, LCP, FACPN-ABN, ABPP is one of 200 invited experts in the field of brain injury whose chapter is featured in the Third Edition of Brain Injury Medicine. This textbook of over 1350 pages and 90 chapters is considered one of the most comprehensive and contemporary reviews of multidisciplinary practice standards in the field of brain injury. Dr. Begali’s chapter entitled Capacity assessment: Clinicolegal, psychosocial, and ethical caveats outline the essential components of forensic neuropsychological capacity assessments based upon existing standards and personal practice. The chapter references clinical methods and legal exemplars of capacity evaluations; typical clinical, administrative, and legal referral scenarios; and specific recommendations for addressing ethical issues related to methods and means.

Capacity assessments are focused forensic neuropsychological examinations used in clinical, administrative, and legal arenas to inform decisions regarding residual ability following acquired brain injury and objectify the degree to which an injury survivor is ready and able to function independently. Standardized methods, tests, and normative comparisons described in the chapter elucidate a systematic approach to determining an individual’s ability to express a choice, plan, reason, make financial decisions, execute a will, return to work, and drive. Specific components that typically need quantification and qualification such as guardianship, need for supervision, disability determination, eligibility for insurance payout benefits, vulnerability to undue influence, and symptom validity are addressed.

The chapter integrates the methods and means used in forensic neuropsychological capacity assessment within a straightforward overview of potential interest to evolving forensic neuropsychologists, allied clinical professionals, administrators, and legal advocates.
Dr. Vivian L. Begali is a double-boarded specialist, board-certified clinical neuropsychologist, and licensed clinical psychologist with over 25 years of experience providing evaluation and treatment to adults and children with medical, psychological, and emotional problems. She has Diplomate status in clinical psychology awarded by the American Board of Professional Psychology (ABPP) and Diplomate status in clinical neuropsychology by the American Board of Professional Neuropsychology (ABN). She is a Fellow of the National Academy of Neuropsychology, American Academy of Professional Psychology, and the American College of Clinical Psychology. Dr. Begali has specialized training and experience in medical psychology, neuropsychology, and the psychological treatment of medical and neurological disorders. She provides psychological treatment to individuals across the life span to include the geriatric/older adult population and young children. When providing individual psychotherapy, Dr. Begali uses an integrated approach that draws from a combination of cognitive-behavioral, interpersonal process, and solution-focused frameworks to meet the individual’s specific needs.

She has advanced training in hypnotherapy. She completed the American Society for Clinical Hypnosis (ASCH) training requirements required for advanced certification-consultant and uses hypnotherapy in the treatment of chronic pain conditions (e.g., fibromyalgia, spinal disorders, back pain, surgical injury), depression, anxiety, and habit control (e.g., hair pulling, smoking cessation, weight control), and adjustment to neurological disorders. She provides forensic expert services to determine damages in personal injury cases (for plaintiff or defense), IMEs, and when conducting capacity evaluations.

She was born in Pittsburgh, PA. Since establishing residence in Virginia in 1979, she has been on staff at the University of Virginia Medical Center, Woodrow Wilson Rehabilitation Center, Charlottesville Public Schools, Cumberland Hospital, and Sheltering Arms Physical Rehabilitation Hospital. Presently, she is the owner and sole proprietor of Neuropsychology and Psychological Healthcare, North Chesterfield, VA.

Pitching in to Improve Employee Mental Health in a Hospital Setting

By: Laura L. Fuller, PhD, ABPP-Clinical Child & Adolescent Psychology

Even in the best of times, stress is part of the workplace. However, when one is working in a hospital during a pandemic, the stress is immense. And as the pandemic drags on, the toll on mental health is hard to calculate, but is understood to be quite significant. Psychologists can and do play key roles in a variety of mental health initiatives in the workplace.

I am a faculty psychologist at a large Midwestern teaching hospital. Similar to many other places, the impact of the pandemic on people in my healthcare system can be seen in staffing shortages, such as nurses who are leaving the field, and can also be seen in long waiting lists for mental health services, requests for employees and family members to be seen for therapy and medication appointments, and increased rates of anxiety, depression, and other issues. I have been honored to take part in a number of activities to help promote mental health among employees and their families and have been impressed at the ingenuity of my psychologist colleagues who have worked on additional pandemic-related projects.

We know from many studies that stress and mental health issues in the workplace have increased across the board. For example, the Portland, Oregon based insurance company the Standard conducted two surveys about behavioral health in the workplace, each with more than 1,425 U.S. workers. The first study was completed in late 2019 and a follow-up was completed in late 2020 in the midst of the COVID-19 pandemic. Nearly half of the workers surveyed at the end of 2020 reported that they were struggling with mental health issues, compared to 39% a year earlier, and 55% of workers said a mental health issue has affected them more since the pandemic began. Based on more recent studies, the numbers continue to increase.

Hospital workers are uniquely affected by workplace stress during the COVID19 era. In a May 2021 article in The Journal of Psychiatric Research by Wright, Griffin et al, data were collected from hospital workers from April 1 through early May 2020. The authors evaluated risks for mental health problems including traumatic stress, depression, anxiety, alcohol use, and insomnia in association with pandemic-related stressors in a sample of over 500 emergency and hospital personnel. Results showed that roughly fifteen to thirty percent of respondents screened positive for each disorder. Direct care providers had higher rates of screening positive for risky alcohol use, while being in a management role over direct care providers was associated with higher odds of screening positive for anxiety, risky alcohol use, and insufficient sleep. Interestingly, there was an inverse relationship between number of positive COVID-19 cases and anxiety, such that as positive cases went up, anxiety decreased.

Psychologists are well equipped to provide leadership and assistance in a setting such as a hospital. This edition of The Specialist focuses on member contributions to leadership, mental health in the workplace, and self-care during these times. I would like to share some of my experiences.

Early in the pandemic, from March through June 2020, I was asked by departmental and hospital leadership to help put together some employee wellness forums via webinar. This was done as a collaboration between my home department (Psychiatry), the University’s Employee Assistance Program, and the hospital’s Office of the Patient Experience, who provided input and assistance in planning and executing the webinars. In short order, I was provided with a team of people to help with production, publicity, and communication. We figured out how to
record the webinars and make them available to hospital workers and the broader community.

Planning the webinars was an enjoyable challenge, and it felt terrific to have a specific task that would contribute to the wellbeing of my colleagues during a time when so much was uncertain. Drawing on my knowledge of psychology helped me and my team to come up with topics for the webinars. Then, I relied on my network of connections and those of my team to prevail upon professionals from inside and outside of our institution to present material for 20-30 minutes, with opportunities for questions at the end.

Our group produced 20 wellness forum webinars over a 3-month period, focusing on basics such as sleep, eating, substance use, parenting, and maintaining physical health during the COVID19 pandemic, as well as specialty topics such as Radical Acceptance, ACT principles, Mindfulness, helping struggling co-workers, and moral injury. Contributors included psychologists and other clinicians, hospital leadership, and people from the employee wellness department. So far, these webinars have had over 7000 views. Sadly, we could not identify a way to measure the impact of these webinars in a scientific manner.

In addition to the wellness webinars, I took part in other support activities during 2020 such as helping to staff a 24-hour hotline for employees and assisting in de-escalation teams placed at hospital entrances when visitor restrictions went into effect. Over the past year and a half, I have also been interviewed more than a dozen times by local and regional news outlets about topics related to the pandemic, ranging from helping children manage school-related fears to coping with ambiguity. This is in addition to my daily work providing treatment to employees’ family members and leading a group of psychologists as we have repeatedly pivoted and adjusted to the ever-changing requirements and needs, throughout “surges” and times of relatively less COVID19 stress.

As the director of the Psychology Division within my department, I have also enjoyed seeing contributions of other hospital psychologists (including Specialists) to the wellbeing of staff and patients in our healthcare system. These have ranged from a group of child psychologists who put together Sing Play Love virtual “parties” for parents and caregivers of children ages 2-5, to a post-COVID clinic developed by psychologists in our department, together with medical colleagues.

The contributions of psychologists in the workplace are numerous, and the COVID19 pandemic has offered us another chance to share our unique skillsets… and shine. As we begin to emerge from the worst of this crisis, there will be increasing data to demonstrate that psychologists with specialized training and expertise are among those who have served to promote mental health within the workplace in a variety of ways.

Citations:


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