A message from the president:

Envisioning The Future of ABPP

Nadine J. Kaslow, PhD, ABPP, President ABPP

As a board certified psychologist in both clinical psychology and couple and family psychology, I am firmly committed to competency-based education and credentialing. Thus, the opportunity to serve at the helm of the American Board of Professional Psychology (ABPP), which is the only organization in the United States devoted to competency-based credentialing in 13 specialty areas in professional psychology, is truly an honor and a privilege. I am particularly pleased that during my presidency, we will hold the ABPP Continuing Education Conference, which will take place in Portland, Oregon, July 6-10, 2010. The event will be held at the Hilton Portland and Executive Tower. We have a wonderful line-up of speakers and I encourage everyone to join us.

Reviewing Our Recent Accomplishments

I want to thank Christine Maguth Nezu, PhD, ABPP for her courageous and dedicated leadership of ABPP over the past two years. It truly is remarkable what we accomplished during her presidency. What is particularly noteworthy is that everything the ABPP Board of Trustees (BOT) set out to do during her tenure, we accomplished. Below is a list of some recent key highlights that deserve particular acknowledgment.

Not only did we move our office to Chapel Hill, North Carolina, but we have a wonderful new website. I encourage you to check it out if you have not already done so (www.abpp.org).

We developed an ABPP Statement of Value that reads as follows: “The mission of the American Board of Professional Psychology is to increase consumer protection through the examination and certification of psychologists who demonstrate competence in approved specialty areas in professional psychology.”

We have begun the process of disseminating the early application program and there are a growing number of training programs supporting this program for their students. We held our first Meet and Greet reception at the annual convention of the American Psychological Association (APA) for training directors and plan to make that an annual event. In a related vein, key leaders within our organization were inter-viewed for the American Psychological Association Graduate Student (APAGS) Newsletter.

Diversity is one of the core foundational competencies that each specialty board evaluates in the examination process of Candidates for board certification. In addition, diversity and inclusiveness are core values of our organization and there are a number of ways in which we have advanced this agenda. The Diversity Committee is now a standing committee of the BOT. This group is crafting a survey that will be sent to our members in 2010. A number of members of the ABPP Executive Committee attended and presented at the National Multicultural Conference and Summit in January 2009. Our new website spotlights the diversity of our board certified psychologists.

We developed and approved a policy for the examination of individuals who currently are in the military, particularly those who are employed. And the ABPP BOT worked closely with the ABPP Ethics Committee and with two consultants with expertise in ethics to develop a new ethics policy, which was approved at the December 2009 BOT meeting. We continue to work on developing a subspecialty application draft, which hopefully will be completed in 2010.

Significant strides have been made toward creating enhanced sources of revenue for our organization. Drs. Maguth Nezu, Finch, and Simon, our three past presidents, published the book Becoming Board Certified by the American Board of Professional Psychology, with Oxford University Press in 2009. Dr. Finch has made significant progress toward the formation of a 5013C tax exempt fund (The ABPP Foundation, Inc). Individuals or organizational groups will be able to contribute to this foundation for either general or specific activities. More details will follow on this as they become available.

We also made some important infrastructure changes to our BOT and the relationship between the Specialty Boards and Academies. For example, each specialty has the opportunity to develop a customized model in terms of their relationship between the specialty board and the academy, which can range from the two organizations fully merging on the one hand to the two organizations remaining as separate but closely and productively collaborating on the other hand, with many groups falling somewhere in the middle on this continuum.

Envisioning Our Future:

ABPP in 2020

We will continue to build on these accomplishments as we move forward. In order to move forward, I led the BOT through a strategic planning exercise at our December 2009 meeting. Rather than the standard SWOT (strengths, weaknesses, opportunities, threats) analysis, we engaged in an activity called Envisioning Our Future.

A vision is a shared understanding and accepted sense of where we will be and what we will be doing in the future. It influences direction, focuses efforts and energies, guides us through conflict and challenge, and clarifies what is relevant and significant. A vision should be achievable, yet lofty. In other words, it will take time and dedication to reach and the process leading toward the attainment of the vision will be associated with progress. A vision that is worth achieving will motivate us to invest our resources, energy, and effort to bringing it to life. Envisioning Our Future helps us to identify and develop high-impact ideas and approaches that can help transform ABPP, generate and share publically our insights and strategies so that our colleagues within ABPP and within profes-
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2009 was a busy, but fruitful, year! I would like to praise our ABPP Central Office staff! ABPP has successfully completed its first full calendar year since relocation to Chapel Hill, North Carolina. We continue to have the fantastic support of Nancy McDonald, Assistant Executive Officer. Although continuing to live in the Savannah, Georgia area, Nancy has maintained her steady level of support for ABPP by telecommuting and intermittent travel to the Chapel Hill facility. After an initial period of uncertainty due to the novelty of the arrangement, it is clear to Nancy and ABPP that this is working quite well. We are very thankful that this has worked out, as Nancy is a very valued employee. Our relocation has provided us with the opportunity to hire new staff from a pool of talent in the area that suits our needs quite well. An initial attempt to have a more technical person (IT type) in the office did not work out, and Nancy and I took that opportunity to re-think our strategy. We decided to outsource some technical items and bring on staff who were willing and able to learn new technical skills. We are very pleased that Lanette Melville and Diane Butcher joined us and help keep the Central Office running smoothly on a day to day basis. They each have brought backgrounds that facilitated an easy transition into our organization, and we feel certain that any interactions you have with them will provide you the same pleasant experience that they contribute to the office.

ABPP’s efforts to complete a web site rebuild has taken longer than we had hoped, not unlike many of our related organizations. Long story short, we liked what we learned from ASPPB about association management software and we decided to build our site using the same organization as did ASPPB. We have now completed Phase I, and “went live” in October. Your Annual Attestation can be processed by logging in to the Member Login, and you can independently update your contact information. You will be responsible for updating your contact information as needed. (Let this serve as a reminder regarding attestations - if you have not completed this yet – late fees go into effect April 1 – no joke!) The site will evolve into a more complex one with increased usability for the public, applicants and ABPP board certified psychologists as it grows. This development process has been a trying time during which I, and others I feel sure, learned a lot. I have to admit to being very concerned by the fact that we had two starts that did not work out well, yet the third time appears to have been the charm! The process did permit CO to reassess how we wanted to tackle this problem, and we are pleased with the decision we have made to use a system that permits all of CO staff to learn how to use the site and related database, with updates being able to be made almost instantly. On launch day, we were notified of two or three errors; within 15 minutes they were rectified. In the past, that would have taken several days as we would have had to communicate with outside sources to get the tasks done. This is overdue, but a tremendous step forward. We are working on setting up attestations, conference registrations and other automated aspects to the site that will facilitate specialists being able to go to it and update their own information, file their attestation and fees, register for the July 2010 conference, obtain CE, etc… Again, many thanks are due to the CO staff in getting this project up and running! I personally thank you all for your patience while we struggled through the past year of fits and starts!

As you know, Oxford University Press has now published two ABPP-specific books; more are forthcoming. Board Certification in Clinical Neuropsychology: A Guide to Becoming ABPP/ABCN Certified Without Sacrificing Your Sanity was published in July 2008 and is, as the title implies, specific to the ABCN process. Becoming Board Certified by the American Board of Professional Psychology was published in July 2009 and is written for those who want a good overview of the ABPP process, yet who may or may not yet have determined a specialty area. ABPP, ASPPB and other groups have had their own independent as well as joint initial discussions and informal exploration of maintenance of certification (MOC) issues. In psychology as a whole, as well as in other professions, there is discussion of if, and how, some sort of periodic review of competency might be established. Please note that ABPP is exploring this area and there are no immediate plans as to if, and how, such a system might be implemented. Work on this is ongoing and will require careful consideration and time to discern the appropriate mechanism for implementation. As this area evolves, we will keep you posted; but do not assume that this means there will be re-examination on the horizon. The Standards Committee produced an online survey of ABPP specialists recently. It is clear that ABPP specialists are engaged in a variety of activities that help maintain and sharpen competency on a regular basis. That survey had a terrific response – over 1,000 of you responded. See page 6 for the responses. Thanks!

We are working diligently on the ABPP Summer Workshop Series, scheduled for July 6-10, 2010 in Portland, Oregon. There will be multiple tracks to address a wide variety of special interests, opportunities for networking with friends and colleagues. You will find, on our website and elsewhere in this edition of The Specialist, more information about this event. It is shaping up to be a terrific several days of continuing education and collegial interaction with topics that should have an interest across specialties.

The Central Office has been handling an increasing number of applications for specialty certification, many of whom are beginning the process through our Early Entry Option. As you know, that program permits students, interns and residents to begin the application process and learn about what is necessary to “stay on track” if a specialty area is identified early on. A number of institutions have agreed to sponsor their students, interns and/or residents (Alliant-CSPP is sponsoring its entire 4th year class of 205). We have received 129 EE applications, not including those.

The ongoing saga of the issue of recognition of board certification in Florida has continued this year. At the time of this writing, the Florida Board of Psychology has apparently deemed it appropriate to reconsider the situation; it seems that what began as a reasonable effort to help clarify board certification in psychology for the public turned out to have resulted in perhaps even more confusion. Concerns arose about whether organizations were actually doing what they reported, whether some boards may be credentialing non-psychologists and other concerns have also been expressed. Despite being given authority to recognize board certifying organizations, it appears (per the BOP’s counsel) that the Florida BOP may not have the authority to either 1) establish a mechanism to monitor an organization’s compliance or 2) “un-recognize” an organization once it has been approved. Thus, there are now discussions about revisiting this issue in the legislature. Stay tuned.

Participation by ABPP psychologists in APA governance continues at a relatively high rate. APA’s CAPP has added new members this past year that include several ABPP psychologists. Nadine Kaslow, who will serve as ABPP President starting in January 2010, was recently elected.
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sional psychology more broadly can share their wisdom and inform our decision-making, and build connections and strengthen relationships by fostering the creation of new networks focused on common goals and a shared agenda.

Our activity was as follows. Individual BOT members crafted a statement about how they would like ABPP to be in 2020 and then in small groups they helped one another clarify these vision statements and work as a group to develop a comprehensive vision statement that incorporated everyone’s ideas. The following steps of the exercise took place in these small groups. Group members were asked to imagine being catapulted into 2020 and to address how they would know if their group’s vision had been achieved, with attention paid to both the positive and negative results of their vision. Then they were asked to imagine themselves living in the desired future, being as detailed and concrete as possible. Subsequent to this, they were invited to consider how they and their ABPP colleagues reached this point, including crafting a backwards timeline.

In the next phase of the activity, the entire group was included. Each subgroup shared their goal statements, indicators, consequences, and futures histories. The entire group commented on the similarities and differences across subgroups. The next step was what is referred to as a present system analysis, in which we focused on ABPP as it is today, with our strengths and weaknesses. We talked about what to keep, what drop, and what to create. Then, from the perspective of desirable futures, we shared our ideas about the aspects of the present that can serve as resources for moving ABPP toward the desirable futures, as well as our thoughts about what would inhibit such progress. Attention was paid to ways in which our resources can be utilized effectively and how the constraints could be bypassed. The final step in the process was for us to develop, through the process of group consensus, our top initiatives, so that we could move ABPP forward toward a commonly shared, desirable future. Of course, at the end, we became concrete and developed specific task groups that would enable us to achieve our overarching goals via making progress on our initiatives.

The following is a brief summary statement of some of the highlights of this exercise. For more details about our strategic planning process, please visit the ABPP website and see the power point presentation entitled 2010-2020 Strategic Plan.

VISION FOR THE DECADE - The group agreed that our goals for the next decade are that there be a culture shift within the profession, such that board certification in psychology has the same status and level of expectation as board certification in medicine, that board certification by ABPP is the expected standard for specialty practice in professional psychology at the entry level, and that the public recognizes ABPP as the premier body for specialty board certification and evaluation of the maintenance of competence. It also is hoped that Board certification by ABPP is expected by all organizations that hire and employ psychologists and by all groups that credential psychologists, that there is differential pay and reimbursement for ABPP board certified psychologists, and that students learn the value from their educators and trainers that board certification is the endpoint and they come to view board certification as accessible to them. Moreover, during the next ten years, ABPP will have strong senior partnerships with all relevant professional organizations, including education, training, credentialing, employment, and psychology groups. And finally, the ABPP Central Office will have the human, financial, technological and communication resources needed to provide comprehensive service and support to all relevant constituencies.

INDICATORS OF SUCCESS - Although the groups differed with regard to the numbers of psychologists that would ideally be board certified in 2020, it was hoped that at least 40-50% of eligible psychologists would be board certified by ABPP; at least 50% of employers and credentialing bodies would require ABPP board certification; at least 40% of the faculty in training programs are board certified, with all training directors board certified and at least 50% of accreditation site visitors having the credential. Consumers will routinely ask if their psychologist is board certified and graduate students, interns, and postdoctoral residents will recognize the value of the credential and demand attention to preparing for board certification as an endpoint of their training program. Further, ABPP will be in a leadership role nationally within organized professional psychology education, training, and credentialing groups; will convene major conferences; and will be recognized as a point of contact for the public and the media. ABPP will be financially strong with multiple funding streams to support its activities, and will have a well-resourced Central Office, a state-of-the-art website, and a strong and cohesive governance.

GOING BACKWARDS – Below is a bird’s eye view of how we can achieve our long-term vision, moving backwards from 2020. Just some illustrative examples are provided, rather than an extensive listing of creative suggestions. In 2018-2020, ABPP will be the only specialty board credentialing body. Some members of the BOT believe we should have 20 vibrant boards, and the addition of new boards as the opportunity arises and new specialties develop and mature. Others think that in 2018-2020, there may be few specialty boards, but they will be more inclusive and capture a greater proportion of individuals in the specialty. Time will tell which approach or some combination of the two is the best for the organization and the field. Further, ABPP will be the predominant organization that offers continuing education workshops and each specialty board will have its own peer-reviewed journal. Each specialty board will have: an official journal, with associated on-line continuing education credits that includes consensus statements and position papers; an on-line based continuing education book series written by key ABPP experts (workshop books, traditional books); a close affiliation with an APA division or some other focused professional society; and a role in the creation of specialty specific residency training programs.

From 2014-2017, each specialty board will publish consensus statements and related position papers; host an annual meeting that includes a specialty board meeting, examinations, and continuing education workshops for the community and board certified specialists; and hold a training model conference that creates a blueprint document for the specialty. Also during that time frame, there will be large testing centers for board examinations created throughout the country, and multiple specialty boards will be able to administer examinations simultaneously. ABPP will take the lead in major conference initiatives, which will shift the landscape in professional psychology; will assist in the changing of training models to ensure ABPP eligibility of all students completing training; and will ensure that individuals who complete residency programs are expected/required to apply for board certification. Further, there will be widespread buy-in of the early entry program across training programs.

Over the next three years, from 2010-2013, we will partner with quality improvement organizations, influence employers and payers to recognize board certification by ABPP as essential to employment and credentialing, and work to ensure that payers and employers provide bonuses to those holding the credential. We will initiate a public relations effort and undertake a public education campaign. ABPP will support an active mentoring system for each specialty board that includes workshops at meetings, web-based materials, workshop-related small books, and lists of local mentors and study/support groups. We will conduct outcome studies of both board certified psychologists and the specialty boards, develop and institute a reasonable and user-friendly recertification plan, and ensure that our new website remains current and meets the needs of the public. We also will provide enhanced support to our low performing boards, so that all specialties grow and thrive.

ABPP’S STRENGTHS - ABPP has many strengths that will help us to achieve our goals. We offer the only evaluation within the profession that evaluates hands-on competency and our assessment protocol has a high degree of fidelity. Not only does our organization have longevity, but we have a long history in competency-based assessments. Our BOT members are dedicated, hardworking and imaginative; our Executive Director is well-respected; and our Central Office staff is superb. Moreover, we have an impressive cadre of board certified psychologists and we trust that we can call on you to serve as ambassadors for ABPP.

INITIATIVES: 2010-2011 – As an outcome of this strategic planning process, the ABPP

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BOT agreed upon six key strategic initiatives for 2010-2011. (1) As a BOT and with the input of our specialty boards and academies, we will agree upon a soft target for number of new board certified psychologists and work toward that goal. (2) We will increase our efforts to partner with the most likely education, credentialing, and student groups to increase number of board certified psychologists and the value of board certification (e.g., APA Education Directorate, CCTC, ASPPB, APAGS). (3) We will continue to strive to communicate the ABPP message through multiple venues, including success stories. (4) We will craft an internal document and blueprint to help specialty boards be more successful and to communicate most effectively with the public. (5) We will develop a cadre of ambassadors engaged in moving forward the ABPP agenda (academies, board certified psychologists in leading positions) and create talking points for them. (6) We will devise strategies to help ABPP gain greater public recognition and improve its public relations.

To this end, we created six task groups comprised of members of the ABPP BOT: (1) Education and credentialing community plan, (2) Communication plan, (3) Specialty board plan, (4) Ambassador plan, and (5) Public recognition and relations plan. We welcome participation of other members of the ABPP community in these efforts.

In Closing

I am enthusiastic about the opportunity to collaborate with the members of the ABPP BOT, the specialty boards, the academies, all ABPP board certified specialists, the ABPP Central Office staff, and other relevant constituency groups over the next two years. I look forward to receiving your feedback and input and dialoguing with you about issues of mutual interest and concern. I hope to engage each of you as partners in ABPP’s forward trajectory. Please feel free to contact me at nkaslow@emory.edu with your feedback and suggestions.

EO REPORT, from pg 3

ed to the APA Board of Directors. We are quite pleased that of the five candidates for APA President-elect in the most recent election, four were ABPP board certified psychologists. Thanks to all of them for offering to take on the role, and Congratulations to APA President-elect Melba Vasquez!

Our ABPP application rate continues to grow, despite the downturn in membership of some related organizations and the economy. As we are all keenly aware, many other organizations are experiencing declining participation. We are somewhat ahead of last year’s pace; in 2009 we had 398 new applications. This is a small increase over 2008 (about 3%) during which we had a record increase in applications. Being able to match (and slightly improve upon) the growth we saw in 2008, particularly given the economy, is considered terrific news! The applications are 32% Early Entry, 68% “standard” application. Clinical Neuropsychology, Clinical Psychology and Forensic Psychology lead the areas of specialty application among these folks. It is also interesting that 71% of the Early Entry applicants have identified a specialty of interest; 29% have not. Of those designating an area of interest, 57% have identified Clinical Neuropsychology. The others are spread across a number of boards. I think this speaks, at least in part, to the clear expectations, “track” of education, training and experience that has become a part of the field of neuropsychology. ABCN has clearly played a key role in this over the years. Although many factors play into how many people apply in each specialty area, and we should be careful not to draw unwarranted conclusions about other boards based on these numbers, there are perhaps lessons to be learned by continuing to have inter-board communication about the board certification process across specialties.

Speaking of that, the Periodic Comprehensive Review (PCR) process of reviewing each specialty board also continues. 2009 saw the American Board of Cognitive and Behavioral Psychology (ABCBP) undergo its review. The process was helpful to the board, as it has been to each that has been through the PCR process. ABCBP is to be commended on its work! In 2010 we have already scheduled PCR dates for Rehabilitation Psychology and Clinical Health Psychology; Psychoanalysis in Psychology will also be starting the PCR process in 2010. Thanks to everyone on each board who has been working diligently to update materials and improve the communication and examination process!

Don’t forget to review the information about the ABPP Summer Workshop Series – and plan to be there! See you then!
### ABPP Specialist Survey: 2009

<table>
<thead>
<tr>
<th>Activity</th>
<th>Very Frequent</th>
<th>Frequently</th>
<th>Occasionally</th>
<th>Rarely</th>
<th>Never</th>
<th>Rating Average</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participate in programs and/or classes that help continue your education?</td>
<td>46.3% (482)</td>
<td>39.3% (410)</td>
<td>12.1% (126)</td>
<td>1.6% (17)</td>
<td>9.7% (7)</td>
<td>1.71</td>
<td>1,042</td>
</tr>
<tr>
<td>Participate in programs that provide on-the-job experience?</td>
<td>28.5% (297)</td>
<td>23.0% (249)</td>
<td>20.3% (212)</td>
<td>16.2% (169)</td>
<td>11.3% (116)</td>
<td>2.58</td>
<td>1,042</td>
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<tr>
<td>Supervise others?</td>
<td>50.2% (523)</td>
<td>18.7% (196)</td>
<td>16.5% (172)</td>
<td>6.4% (68)</td>
<td>5.2% (54)</td>
<td>2.01</td>
<td>1,042</td>
</tr>
<tr>
<td>Provide teaching and instruction to others?</td>
<td>49.8% (511)</td>
<td>23.0% (246)</td>
<td>17.2% (179)</td>
<td>6.8% (71)</td>
<td>2.9% (27)</td>
<td>1.89</td>
<td>1,042</td>
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<tr>
<td>Conduct research?</td>
<td>23.4% (244)</td>
<td>12.5% (130)</td>
<td>21.4% (223)</td>
<td>25.1% (262)</td>
<td>17.5% (183)</td>
<td>3.01</td>
<td>1,042</td>
</tr>
<tr>
<td>Publish?</td>
<td>19.0% (199)</td>
<td>13.2% (139)</td>
<td>20.4% (213)</td>
<td>23.7% (250)</td>
<td>14.7% (155)</td>
<td>3.02</td>
<td>1,042</td>
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<tr>
<td>Participate in leadership activities (e.g., Chief of Director of Psychological Services or)</td>
<td>37.6% (392)</td>
<td>18.0% (188)</td>
<td>14.2% (148)</td>
<td>12.2% (127)</td>
<td>12.9% (137)</td>
<td>2.55</td>
<td>1,042</td>
</tr>
<tr>
<td>Hold office or participate in professional associations?</td>
<td>39.9% (422)</td>
<td>21.4% (223)</td>
<td>20.2% (211)</td>
<td>14.9% (153)</td>
<td>12.9% (134)</td>
<td>2.57</td>
<td>1,042</td>
</tr>
<tr>
<td>Participate in program development and consultation?</td>
<td>28.1% (293)</td>
<td>25.2% (263)</td>
<td>22.1% (230)</td>
<td>15.3% (160)</td>
<td>0.3% (3)</td>
<td>2.52</td>
<td>1,042</td>
</tr>
<tr>
<td>Serve on journal editorial boards?</td>
<td>17.2% (179)</td>
<td>10.0% (104)</td>
<td>12.8% (131)</td>
<td>13.2% (138)</td>
<td>47.0% (490)</td>
<td>3.63</td>
<td>1,042</td>
</tr>
<tr>
<td>Serve on ABPP exam committees?</td>
<td>5.2% (54)</td>
<td>6.3% (68)</td>
<td>16.5% (172)</td>
<td>18.1% (189)</td>
<td>53.8% (561)</td>
<td>4.09</td>
<td>1,042</td>
</tr>
<tr>
<td>Participate with Board and Academy activities?</td>
<td>8.3% (87)</td>
<td>7.3% (78)</td>
<td>16.9% (173)</td>
<td>24.4% (245)</td>
<td>43.4% (452)</td>
<td>3.87</td>
<td>1,042</td>
</tr>
<tr>
<td>Conduct seminars?</td>
<td>24.6% (259)</td>
<td>20.4% (213)</td>
<td>28.9% (300)</td>
<td>14.4% (150)</td>
<td>11.8% (123)</td>
<td>2.88</td>
<td>1,042</td>
</tr>
<tr>
<td>Serve on dissertation committees?</td>
<td>12.2% (127)</td>
<td>6.5% (68)</td>
<td>10.0% (107)</td>
<td>18.9% (198)</td>
<td>45.5% (474)</td>
<td>3.80</td>
<td>1,042</td>
</tr>
<tr>
<td>Serve as an APA Accreditation Site Visitor?</td>
<td>1.1% (11)</td>
<td>1.5% (16)</td>
<td>5.0% (52)</td>
<td>6.4% (67)</td>
<td>86.0% (896)</td>
<td>4.75</td>
<td>1,042</td>
</tr>
<tr>
<td>Participate on medical center standard boards?</td>
<td>4.0% (42)</td>
<td>4.2% (44)</td>
<td>0.0% (0)</td>
<td>10.4% (108)</td>
<td>74.9% (770)</td>
<td>4.40</td>
<td>1,042</td>
</tr>
<tr>
<td>Participate in structured Peer Review?</td>
<td>13.7% (143)</td>
<td>15.8% (165)</td>
<td>18.8% (195)</td>
<td>16.1% (168)</td>
<td>37.5% (391)</td>
<td>3.68</td>
<td>1,042</td>
</tr>
<tr>
<td>Serve on licensing boards?</td>
<td>2.9% (30)</td>
<td>1.5% (16)</td>
<td>3.4% (35)</td>
<td>4.8% (50)</td>
<td>87.4% (911)</td>
<td>4.72</td>
<td>1,042</td>
</tr>
<tr>
<td>Serve on Institutional Review Boards</td>
<td>6.8% (71)</td>
<td>4.1% (43)</td>
<td>7.6% (79)</td>
<td>12.1% (126)</td>
<td>69.4% (723)</td>
<td>4.33</td>
<td>1,042</td>
</tr>
<tr>
<td>Mentor others?</td>
<td>44.7% (463)</td>
<td>25.2% (263)</td>
<td>17.7% (184)</td>
<td>8.6% (90)</td>
<td>3.7% (36)</td>
<td>2.01</td>
<td>1,042</td>
</tr>
</tbody>
</table>
CPPSA in 2010: Challenges and Opportunities

by Steve K. D. Eichel, Ph.D., ABPP
Chair, CPPSA

I have been involved with ABPP Academy issues for ten years now—which by some standards still qualifies me as a newbie—and all I can say is: wow! I am writing this column after returning from my first ABPP Board of Trustees (BOT) meeting as Chair of the Council of Presidents of Psychology Specialty Academies (CPPSA). I have been involved with a range of (non-ABPP) boards and professional associations over the years and I am thrilled to report that the level of energy, intelligence and competence I experienced at the December, 2009 BOT meeting was truly impressive. I have been cautiously hopeful about ABPP and the Academies for several years, but now I am bluntly and loudly optimistic. ABPP is going places. We are strong which, given the decreased memberships and finances of many other professional associations during this major economic downturn, is no small achievement. The policies that have been adopted (and that many Academies pushed for and supported) are clearly having a positive impact. The streamlining of the application process, Academy-sponsored scholarships, the early-entry program, the presentations made to other APA-related professional organizations (e.g., APPIC, CCPTP, etc.) are beginning to bear fruit.

The general sense of the BOT (and many Academy members and officers I’ve spoken with) is that the current ABPP central office staff are the best we could ever hope for. I wholeheartedly agree. Whenever I have had a question or a concern, I have had those addressed promptly, courteously and most importantly, accurately.

As a whole, the academies are fairly healthy. Our years-long efforts to recruit new candidates for board certification have begun to yield results. A number of specialties seem to be experiencing a moderate-to-strong increase in the number of ABPP applicants. Active academies continue to produce excellent continuing education programs and many now have active mentoring programs. Several are also sponsoring scholarship programs to help with the financial burden of becoming board certified. A few of the smaller academies are seeing some new life. The early entry program, which was strongly supported by CPPSA, is showing early signs of being a run-away hit. If even half the early entry applicants eventually advance to ABPP candidacy, the future overall health of board certification will be robust indeed.

CPPSA has some hurdles to clear in the coming year before we can move fully ahead once again. Through an apparent attorney’s error when we were incorporated in Wisconsin years ago, CPPSA was not properly registered as a non-profit, educational/professional association. As a result, we have a tax liability that needs to be cleared up (i.e., removed). I believe we have gathered together the documentation we need to correct this mistake, and are in the process of obtaining legal assistance in Wisconsin. There is a possibility that CPPSA may reincorporate, perhaps as a subsidiary of ABPP or perhaps as a separate corporation in another state (one with better lawyers!).

BOT reorganization is now fully implemented, with every Specialty Board and Academy up to speed. From now on, each specialty will choose its representative to the BOT; the BOT will no longer be limited to Board members only. Academy members will now be eligible to serve on the BOT, depending on each individual specialty’s rules. CPPSA believes this revision of the BOT bylaws will allow for equal representation on the BOT within each specialty.

On a completely unrelated note, I want to relay an ABPP Standards Committee determination related to the proper use of the “ABPP” initials after one’s name. Some specialists tend to identify themselves with Academy-related initials after “ABPP” to signify their fellow status in their specialty academy (e.g., “Steve K. D. Eichel, Ph.D., ABPP, FAACoP,” meaning “Fellow, American Academy of Counseling Psychology”). Please note that the ABPP Board of Trustees has now recommended us to ONLY use the initials “ABPP” after our name; specialties should be listed in a by-line (e.g., “Steve K. D. Eichel, Ph.D., ABPP - Board certified in Counseling Psychology”). It is confusing and potentially misleading to use the moniker “Fellow” in a manner that implies an additional credential. Unlike medicine, Fellow status in an ABPP Academy is not an earned credential. In medicine, board certification does not automatically make one a Fellow of his/her specialty academy. Becoming a Fellow of a medical academy involves an additional application and review process; Fellow status is typically granted only to those board certified physicians who have made some other significant contribution (often involving publishing research) to their specialty. Thus, in medicine board certification is necessary for Fellow status but does not guarantee it. In psychology, Fellow status in an Academy is granted to anyone who is board-certified and pays Academy dues. Therefore, it is not an earned credential and should not be employed as such. Similarly, psychologist specialists should not personalize the “ABPP” after their name (e.g., “ABPP-Co” or “ABPP-Cl” to indicate board certification in Counseling or Clinical Psychology, respectively). Not only does this practice obscure ABPP “brand recognition,” but since a significant portion of ABPP psychologists are board certified in multiple specialties, it could become exceedingly cumbersome and confusing to the public.

On to 2010!
Major News – ABPP APPROVES CONSIDERATION OF SUBSPECIALTIES

by Florence W. Kaslow, Ph.D., ABPP, BOT Representative

Long ago and far away... before the existence of Division 43 of APA, AB-CFP and AACFP there was the Academy of Psychologists in Marital, Family and Sex Therapy. Out of this pioneer group came the initial leadership who formed the Division and later the American Board of Family Psychology. But, the sex therapy aspect seems to have vanished. Both our Board and Academy believe it is now time to bring this back to the forefront in an updated and expanded form, as an important part of what many couple and family psychologists do. For the time being, we are calling the potential subspecialty Clinical Sexology.

For subspecialties to come into being in a form ABPP will recognize, ultimately they must come from and through an existing Specialty Board. Thus, as the ABCFP representative to the Board of Trustees, and someone very interested in promoting this development now, I have proposed we form a Special Interest Group (SIG) under Academy auspices in Clinical Sexology/Human Sexuality of those Diplomates with expertise and great interest in this domain. This proposal has been accepted and we are ready to move ahead. Some of you have published key texts and professional books on sex therapy. Others direct major training programs. We need your involvement and you need to know you definitely have a home as a well respected Board Certified Couple and Family Psychologist.

It is intended that out of this SIG will come the draft of the document to be revised and submitted by the Board and Academy to ABPP for this subspecialty to be recognized. It will define educational background and practice experience necessary within the foundational and functional competency model now being utilized by ABPP and APA.

Much remains to be fleshed out and determined. If you are interested in being part of this SIG, please let me know. Initially we will communicate by email and hopefully, we can have our first SIG meeting at APA in San Diego in August 2010. If this newsletter reaches you before the January due date, please respond anyway so that you can be included.

Direct responses to: drfkaslow@bellsouth.net
Mark your calendars and make your reservations! From July 6-10, 2010 the American Board of Professional Psychology (ABPP) will host a summer continuing education workshop series in Portland, Oregon at the Hilton Portland & Executive Tower. All of the workshop speakers are board-certified in their specialty areas by ABPP and enjoy national or international reputations for outstanding research and practice.

The Format and Experience
Psychologists can customize their schedules and pick and choose from 18 one-day and half-day workshops on a wide variety of topics. All psychologists are welcome to attend this stimulating program and ABPP-certified specialists will receive a discount on workshop fees. This should provide a great opportunity to gain cutting edge knowledge, re-kindle old relationships with colleagues, and establish new ones in a beautiful setting in the Pacific Northwest.

The Setting and Locale
Situated at the confluence of the Willamette and Columbia rivers, Portland is a city of discreet charms. That it claims a rose garden as one of its biggest attractions should give you an idea of just how laid-back this city is. Sure, Portlanders are just as attached to their cell phones and laptops as residents of other urban areas, but this is the City of Roses, and people still take time to stop and smell the flowers. Spend much time here during the long summer days and you, too, will likely feel the leisurely pace seeping into your bones.

The city is also the nation’s microbrew capital. Espresso may be the beverage that gets this town going in the morning, but it is microbrewed beer that helps the city maintain its mellow character. There are so many brewpubs in Portland that the city has been nicknamed Munich on the Willamette. Wine bars are also popular hangouts, which shouldn’t come as a surprise, considering how close the city is to the Willamette Valley wine country. Portland itself may be short on things for visitors to do, but the city's surroundings certainly are not. Within a 1 1/2- to 2-hour drive from Portland, you can be strolling (or surfing) a Pacific Ocean beach, walking beside a waterfall in the Columbia Gorge, hiking on Mount Hood (a dormant volcano as picture perfect as Mt. Fuji), driving through the Mount St. Helens blast zone, or sampling world-class pinot noirs in the Oregon wine country. It is this proximity to the outdoors that makes Portland a great city to use as a base for exploring some of the best of the Northwest.

Visitors seeking the arts and culture will also be satisfied as this city has a selection of offerings one would expect to find in a city twice its size including an established regional theater, a resident symphony, an opera company, and a collection of more specialized cultural organizations. And nowhere is Portland’s trademark eclecticism more apparent than in its live music scene — from jazz at Jimmy Mak's to indie rock at the Doug Fir — which is embraced both by local fans and the many noted musicians who call Portland home.

The Hotel and Venue
The Hilton Portland & Executive Tower is a premier hotel and conference center located in the heart of downtown Portland only a block away from the MAX Light Rail System that allows easy access to all the sights and activities of this fascinating city. The Hilton Portland & Executive Tower is proud to be the largest Green Seal Certified hotel on the West Coast. ABPP workshop attendees who register early will pay a special convention rate of $135/night.

The Speakers and Topics
Melba Vasquez, Ph.D., ABPP is board-certified in Counseling Psychology and is in independent practice in Austin, Texas. She is the co-author (with Dr. Kenneth Pope) of three editions of Ethics in Psychotherapy & Counseling: A Practical Guide and Multicultural Theories (published by APA). She will present two, half-day workshops, one on cultural diversity, “Ethical Considerations in a Multicultural World” and one on professional burnout, “The Ethics of Self Care: Burn out Prevention for Psychologists”.

Alan Goldstein, Ph.D., ABPP is board-certified in Forensic Psychology and will present a one day workshop entitled “An Introduction to Forensic Psychology Practice.” Dr. Goldstein has written seminal books on forensic psychological practice. He is Professor of Psychology on the graduate faculty of John Jay College of Criminal Justice, and on the doctoral faculty of the Clinical Psychology Ph.D. Program of the Graduate Center – CUNY.

A recipient of APA’s Gold Medal Award for Life Achievement in the Practice of Psychology, Florence Kaslow, Ph.D., ABPP is triple-boarded in Clinical Psychology, Couple and Family Psychology, and Forensic Psychology. She will present two half-day workshops on “Ethical Issues and Challenges in Couples & Family Psychology: From What is Confidential to Dealing with Affairs & Other Intimate Matters” and “Key Trends in Couple and Family Psychology: Theory Update, Contemporaneous Issues And Clinical Populations.”

Don Bersoff, JD, PhD, ABPP is a board-certified school psychologist who is currently a Professor of Law and Psychology and Director of the JD/PhD Program in Law and Psychology sponsored by Drexel University, and has served as General Counsel for APA in the past. Dr. Bersoff is the author of Ethical Conflicts in Psychology (published by APA and now in its 4th edition). He will present a one day workshop on current ethical controversies in professional psychology entitled “Current Ethical Conflicts in Psychology”.

Linda Sobell, Ph.D., ABPP is board-certified in Cognitive and Behavioral Psychology and is Professor and Associate Director of Clinical Training at the Center for Psychological Studies at Nova Southeastern University in Florida, and also Co-Director of the Guided Self-Change clinic. She is renowned for her research on controlled drinking that eventually inspired both the harm reduction movement and motivational interviewing, now fully accepted and empirically documented.
supported treatment approaches. Dr. Sobell will present a one day workshop teaching attendees motivational interviewing (MI) skills to work more effectively with their patients entitled “Using Motivational Interviewing to Help People Change Risky Problem Behaviors”.

David Patterson, Ph.D., ABPP is board-certified in Rehabilitation Psychology and is a Professor in the Departments of Rehabilitation Medicine, Surgery, and Psychology at the University of Washington School of Medicine. Currently, he is Head of the Division of Psychology of Rehabilitation and Chair of the Ethics Committee at Harborview Medical Center. He will present a one day workshop focusing on hypnosis for treating acute and chronic pain entitled “Hypnosis for Pain Control”.

Ida Sue Baron, Ph.D., ABPP is a board-certified clinical neuropsychologist, Professor of Pediatrics at the University of Virginia School of Medicine and the author of Neuropsychological Evaluation of the Child and Pediatric Neuropsychology in the Medical Setting, both published by Oxford University Press. She will present a one day workshop on assessment and treatment of neuropsychological disorders in children entitled “The Neurodevelopmental Effects of Premature Birth Are Lifespan Issues: What Every Clinician Should Know”.

Robert Mapou, Ph.D., ABPP is a board-certified clinical neuropsychologist in independent practice in Silver Spring, Maryland, where he specializes in the evaluation of adolescents and adults with learning disabilities and attention-deficit/hyperactivity disorder. He is the author of Clinical Neuropsychological Assessment: A Cognitive Approach and Adult Learning Disabilities and ADHD: Research-Informed Assessment. He will present a one day workshop on research-based strategies for assessment of learning disabilities and ADHD entitled “Neuropsychological Assessment of Learning Disabilities and ADHD in Adults.”

Associate Dean for Research at the University of Florida, Michael Perri, Ph.D., ABPP is board-certified in Clinical Psychology and has served on scientific review panels for the Institute of Medicine, the National Institute of Diabetes, and the U.S. Surgeon General’s Office. Dr. Perri will offer a one day workshop entitled “Innovations in the Clinical Management of Obesity”.

John Lucas, Ph.D., ABPP is a board-certified clinical neuropsychologist—iss an Associate Professor of Psychology and Vice Chair of the Department of Psychiatry & Psychology at the Mayo Clinic in Florida. In addition to his clinical, teaching, and administrative responsibilities, Dr. Lucas is an investigator in Mayo’s NIA-funded Alzheimer’s Disease Research Center. Dr. Lucas will present a one day workshop entitled “Neurobehavioral Syndromes in Older Adults: What Psychologists Should Know”.

Christopher Martell, Ph.D., ABPP is board-certified in both Clinical Psychology and Cognitive and Behavioral Psychology. He is in private practice in Seattle and is a Clinical Associate Professor in the departments of Psychology and of Psychiatry and Behavioral Sciences at the University of Washington. The co-author of four books, he has published widely on behavioral treatments for depression, couples therapy, and issues affecting gay, lesbian and bisexual individuals. Dr. Martell will present a one day workshop entitled “Behavioral Activation for Depression: Principles and Competencies” and a half day workshop “Lesbian, Gay and Bisexual Affirmative Cognitive-Behavior Therapy”.

Arthur Nezu, Ph.D., ABPP is triple-boarded in Cognitive and Behavioral Psychology, Clinical Psychology, and Clinical Health Psychology and is Professor of Psychology, Medicine, and Community Health and Prevention at Drexel University, as well as Special Professor of Forensic Mental Health in Psychiatry at the University of Nottingham in England. He is previous editor of the Behavior Therapist, incoming editor of the Journal of Consulting and Clinical Psychology, and co-editor of the Oxford University Press book series on Competencies in Professional Psychology Practice. Dr. Nezu will present a one day workshop entitled “Problem-Solving Therapy to Enhance Health & Mental Health Outcomes”.

Jay C. Thomas, Ph.D., ABPP is board-certified in Organizational and Business Consulting Psychology and is Professor and Assistant Dean at the School of Professional Psychology, Pacific University. He has written or co-edited 13 books including the forthcoming Competency & Best Practice: Organizational & Business Consulting Psychology, Volume X of the Competencies in Psychology Specialties. The half day workshop entitled “Organizational Factors in the Successful Adoption of Evidence-Based Practices” will present the organizational factors that must be taken into account for successful adoption of EBPs.

Jon Frew, Ph.D., ABPP is a Professor in the School of Professional Psychology, Pacific University, and directs the organizational consulting track. Trained in both counseling psychologist and in organizational development, he has over 30 years experience practicing both. Jon has made continual contributions to Gestalt theory in both the therapeutic and consulting arenas. He is the co-author of the widely used textbook Contemporary psychotherapies for a diverse world: Theory and practice.

Morgan T. Sammons, Ph.D., ABPP is currently Systemwide Dean of the California School of Professional Psychology at Alliant International University. He is a retired Captain in the US Navy. He is a prescribing psychologist and one of the first graduates of the Department of Defense’s Psychopharmacology Demonstration Project.

Jeffrey W. Pollard, Ph.D., ABPP is Professor of Psychology and Director of Counseling and Psychological Services, George Mason University. He has spent 32 years working in college counseling centers. He co-edited Campus Violence, Kind Causes and Cures, and is on the Editorial Board of the Journal of College Student Psychotherapy. He served on the Ohio Department of Human Services, Domestic Violence Advisory Committee and recently worked with the U.S. Department of Justice as a Content Area Specialist at the Campus Threat Assessment Summit. He has testified before the U.S. Congress on the status of mental health resources on campus and currently serves on the Board of the International Association of Counseling Services. He is Past President of the American Academy of Counseling Psychology, current President of the American Board of Counseling Psychology, and a Trustee of the American Board of Professional Psychology.

Registration Information

Registration is now open and a workshop schedule is available on the newly-revamped ABPP website (www.abpp.org) and, by request, via hardcopy. ABPP certified specialists and others seeking more information or to add their names to the email/mailing list should notify ABPP Central Office at ws2010@abpp.org. Lodging reservations can be made with the Hilton Portland and Executive Towers (1-503-226-1111).
MISSION STATEMENT
The mission of The ABPP Specialist is to inform and communicate issues, developments, and news relevant to specialization, specialties, specialists, and board certification to the cohort of ABPP-certified specialists and the wider professional community, and stimulate continuing interest and involvement in ABPP and its activities.

POLICIES & PROCEDURES
• The newsletter is published twice yearly as Winter and Summer issues, in mid-February and mid-July. Deadline for submissions to the Winter issue is December 24. Deadline for submission to the Summer issue is May 15. The issue is posted on the ABPP website at abpp.org and printed copies mailed to selected professional organizations.
• Issue content includes the following: (1) a message from the BOT President; (2) a column by the Executive Officer; (3) a column from the CPPSA President; (4) news columns from the Specialty Boards and Specialty Academies; (5) a column by the Editor; (6) news items regarding individual Specialists; (7) announcement of new Specialists; (8) a necrology; (9) letters to the Editor; (10) other organizational and governance news and information; (11) specific articles on ABPP-related topics, pertinent to board certification in psychology, and professional competencies, or submissions solicited with regard to specific issues or topics deemed appropriate by the President, BOT, Editor, or Communications Committee.
• Submissions:
  • The theme and content of submitted articles should be consistent with ABPP interests and issues: specialization; credentialing; board certification; professional competencies; and/or to the specific interests of ABPP-certified specialists. Articles with content of more general interest, or unrelated to the above topics, should be submitted elsewhere.
  • The ABPP President, BOT, Editor, or Communications Committee may initiate requests for submissions on particular themes and topics, for inclusion in Special Sections of grouped articles.
  • The ABPP President, BOT, Editor, or Communications Committee may solicit or invite contributions from individuals and organizations.
  • Submissions may be of any length, but typically do not exceed 15 pages of word processed text.
  • Submissions should conform to the APA Publications Manual, where appropriate.
  • Submissions should be made by e-mail attachment in Word to the Editor's attention at thespecialist@abpp.org. The submission attachment itself should clearly identify the author(s).
  • Article submissions will be subject to review and acceptance or rejection by the Editor, with the Advisement of the Editorial Board. Authors may be asked for revisions based on the review.
  • Submissions or letters to the Editor with particularly controversial content may be referred through the Communications Committee to the ABPP President for possible further recommendation or action.

Revised by Communications Committee 12/09, based on EC revisions of 6/09

ABPP Technical Reports
Made Available to Scholars

Upon request of the PsycEXTRA Department at the American Psychological Association, ABPP has agreed to make some of our technical reports and material available to the wider intellectual community. APA has been working with the Archives of the History of American Psychology to digitize important works in the field through this “gray literature” project. The material will also be available through PsycINFO.
ABPP was particularly active at last August’s APA Convention, held in Toronto, Ontario. The Annual Convocation and Awards Ceremony featured the presentation of the 2009 Distinguished Contributions to the Profession of Psychology Award to Walter B. Pryzwansky, Ph.D., ABPP and the Russell J. Bent Award for Distinguished Service to ABPP to Norma P. Simon, Ed.L., ABPP. Drs. Pryzwansky and Simon are both past ABPP BOT Presidents. The program was highlighted by Dr. Alan E. Kazdin’s 2008 Distinguished Contributions Awardee address, a version of which appears in this issue.

In the morning preceding the Convocation, ABPP held its Governance Day, at which officers of the Boards and Academies meet with the BOT for planning purposes. The BOT also held an informational luncheon session with directors of training programs, to acquaint them with our current activities, as well as our procedures for credentialing specialists. Below are some views of these activities.
The delivery of psychological services to the public is regulated and enhanced in several ways. Many of the activities are directed toward increasing and ensuring competence of clinical psychologists in practice. A variety of activities, including accreditation of graduate programs, state licensing, and continuing education, serve to address the competency issues. The American Psychological Association (APA) plays a major leadership role in setting standards for accredited programs in clinical and counseling psychology (APA, 2008), deciding the criteria to recommend for States for being a licensed psychologist (e.g., Model Licensing Act), and developing reports that elaborate criteria for and assessment of competencies (e.g., Assessment of Competency Benchmarks Workgroup, 2007). Among the many activities within the profession, Diplomate Status of the American Board of Professional Psychology (ABPP) is widely recognized as the highest level of achievement. As readers of this publication well know, the ABPP mission “is to increase consumer protection through the examination and certification of psychologists who demonstrate competence in approved specialty areas in professional psychology” (www.abpp.org). This is a modest statement given the criteria and high standards invoked to render Diplomate status and other efforts of ABPP to serve the profession and public.

The various activities I have sampled and others like them have as their overriding goal of protecting both the profession and the public. The profession and public are protected by ensuring that anyone in clinical practice who says they are a psychologist in fact has had appropriate training, with a suitable curriculum and complementary experiences. The training is not only in substantive areas of psychology but also in the many ethical and legal responsibilities that ought to guide professional behavior. There can be little disagreement about the importance of these goals and the need for ongoing professional efforts to monitor and achieve them. My topic is not to challenge these goals but rather to consider them in the context of other goals of clinical care.

Two topics I wish to discuss that relate to clinical work are: 1) providing high quality clinical care and 2) reducing the burden of mental illness. Presumably these are central goals to which our work is directed. By quality of clinical care, I refer to the precise services we provide, which our work is directed. By quality of clinical care, I refer to the precise services we provide, which our work is directed.

Context: Overview of Psychotherapy for Children and Adolescents

My own work is in the area of therapy for children and adolescents. Permit me to use child therapy research and clinical practice to convey my points, although the points themselves are not restricted to work with children.

Current Psychotherapy Research. There has been enormous progress in research on psychotherapies for children and adolescents (see Kazdin, 2000; Weisz, 2004). First, the quantity of controlled outcome studies is impressive. Well over 2000 controlled studies have been completed. The number increases monthly as many journals continue to publish issues sprinkled with more such investigations. Second, the quality of studies has improved in the past 20 years. Randomized controlled trials (RCTs) are standard; treatment manuals are used to codify the procedures to facilitate therapist training and replication of the study; assessment routinely uses multiple outcome measures with multiple assessment methods; and studies frequently evaluate whether the changes are clinically as well as statistically significant.

Third, conclusions from reviews consistently suggest that several therapies “work” and that the effects are strong, as attested to in meta-analyses (see Weisz et al., 2005). The magnitude of effect (effect size) is relatively large (.70). Effect size does not necessarily translate to clinical benefits, but measures of “clinical significance” are used to show how much change has been made or that symptom levels fall within the normative range after treatment.

Fourth, there are now many evidence-based treatments (EBTs) for clinical problems (e.g., Christophersen & Mortweet, 2001; Weisz & Kazdin, in press). “Evidence based” has many definitions among professions, organizations, and countries. Commonly used requirements are that an intervention has at least two studies with:

1. Random assignment of clients to conditions;
2. Careful specification of the client population;
3. Use of treatment manuals;
4. Multiple outcome measures (raters, if used, are naive to conditions);
5. Statistically significant differences between treatment and a comparison group; and
6. Replication of outcome effects, especially by an independent investigator or team.

Very often, the criteria are far surpassed. For example, I work with the children referred for aggressive and antisocial behavior (Conduct Disorder in contemporary psychiatric diagnosis). This is the most frequently referred problem for child treatment (approximately 33%–50% of referrals) and, because of its course, one of the most expensive mental health problems in the United States. There are now at least seven evidence-based treatments for this problem alone, an extraordinary accomplishment of clinical research. Many of these treatments have several studies in their behalf, often with diverse clinic samples, often with follow-up assessment, and with evaluations of clinical as well as statistical significance, as noted previously.

The progress in child therapy research is truly remarkable. Perhaps this is even more remarkable, given that the vast majority of research and training in therapy focuses on adults rather than children. Even so, there are now techniques for many domains of child dysfunction (e.g., anxiety, depression, trauma, oppositional and aggressive behavior). The research has focused on clinical populations and youth with multiple...
(comorbid disorders). In many instances, the cases included in research are more severe and complex than those seen in the vast majority of clinical practice settings.

**Current Treatment in Clinical Practice.** I have selectively highlighted characteristics of research and let me do so similarly with clinical practice. First, conservatively, over 550 types and variations of therapy are in use for children (Kazdin, 2000 for a list). The large majority has never been investigated empirically. Second, many treatments known to be effective are not in very widespread use. I mentioned EBTs for Conduct Disorder, but there are now several EBTs for other problem domains. These treatments are not used very much, are not included in graduate training, are not part of licensing requirements, and are not covered in most required internships.

Third, some treatments in widespread use are known not to be effective. The traditional view that one cannot support the null hypothesis is arguable (especially if you saw the findings of my dissertation). Replicated, well-designed studies that show little or no effect are a strong basis for moving on. Traditional talk and play therapy for disruptive behavior disorders is an example of the need to move on. If EBTs have been unsuccessfully applied to a given problem, alternative procedures are reasonable, but talk therapies continue to be a first line of attack in many settings.

Fourth, some treatments that are often harmful are still in use. Group therapies for aggressive and antisocial behavior among children, common in hospitals and day-treatment settings, are questionable at the very least in light of randomized trials showing that treatment can make children worse when compared to no treatment (Dishion et al., 1999; Dodge et al., 2006). Not all group treatments harm, some help, and others can be altered so they do help. Even so, the findings lobby for great caution.

Fourth, many well-intentioned efforts to help children (e.g., fresh air, military regimentation, take care of a [horse, cow, yourself]) still emerge and inspire the public. Apart from lacking evidence, their use as a first or second line of attack can detract from providing an effective intervention.

Finally, psychosocial treatments with unclear conceptual or empirical bases continue to proliferate. Horticulture therapy (taking care of plants), smudge art therapy (to examine and explore feelings as an outlet for fear), and music therapy combined with movement exercises (for the treatment of autism) are merely the tip of the iceberg (e.g., Simson & Straus, 1998; Weber & Remschmidt, 2001).

As with research, there is much more to be said about clinical practice. Also, the comments I make are not exclusively about psychology, but fully encompass our partners in mental health services (e.g., child psychiatry, social work, nursing). In making these comments I have focused on the interventions that are used—more of the what of treatment. Certainly, how treatment is administered is no less important, and to which I return.

**Improving the Quality of Care**

The brevity of my comments in relation to research and clinical practice do not well serve the richness of these areas. Even so, I believe the claims are readily supported and do not distort that fuller report. I mention both clinical research and practice to provide a context for comments on the quality of clinical care.

I and my age cohort of training in clinical psychology were exposed to and often trained in nondirective (client-centered) psychotherapy. As the readers in this cohort may fondly recall, a key component of the therapy is unconditional positive regard of the client. My own exposure to this form of treatment has made me very much in favor of its key tenets. In particular, I try to practice unconditional positive regard all of time (no matter what my children and the attorneys say). That said, where are we as a profession in accepting clinical services of our field (and other mental health professions)? There appears to be an ambience of unconditional positive regard in our clinical services and training. It seems off limits to question what we or our colleagues do in relation to the specific services we are delivering, as illustrated for example by the 550+ treatments and their status mentioned previously. Is there no emperor’s new clothes problem here in what we are delivering?

At the outset, I noted the many efforts, standards, and credentials that psychologists have knowledge and training, with the goal of protecting the public and developing competent therapists. What of our training and what of our practice has any relation to the quality of actual services we provide to the public? Quality of care itself requires careful analyses to elaborate its components, and I have no special insights to make me the arbiter of what those analyses might yield. In advance of a consensus, I would hope to use an “unconditional positive regard” and “anything psychosocial (and ethical) is OK” are not part of the consensus. Presumably it is worth elaborating what is done in clinical practice and what ought to be done in light of what we know. For starters and in my opinion, I would opt for providing the best treatment based on evidence and consensus guidelines, setting goals (or being explicit about saying there are not goals in a particular case but just a process), and evaluating ongoing treatment for the benefit of the individual patient. All of these are arguable and incomplete but it places some meat on the otherwise calorie-restricted skeleton.

With that in mind are the courses, licensing requirements, and accreditation standards designed to protect the public helpful in providing quality of clinical care? These are empirical questions in part. Perhaps current requirements are designed to minimize the prospect of poor or completely unacceptable clinical care. That is reasonable and perhaps needs an additional dose of positive psychology, i.e., what on the positive side makes therapy high quality? Quality of care is aimed at the public’s interest and ought to drive what we do, what we study, and the claims we make. Claims that we use (e.g., “I tailor my treatment to the individual,” “I use what works,” and “every one is an individual”) actually ignore findings and arguably reduce the quality of care (Kazdin, 2008). Guidelines for evidence-based practice are to integrate evidence, clinical expertise, and the individual needs, values, and preferences of the patient (APA, 2005). These are lofty goals, palatable to many including me, but, as far as I can discern, lack evidence at this point in time. It is not clear that we know how to do this integration, that we can do so consistently (reliability), and that doing it makes a difference (validity) in patient care. We need standards as to what quality care would be and then research that evaluates whether these standards help in executing treatment and in what ways.

**Reducing the Burden of Mental Illness**

The second issue for consideration is our reach, that is, the scale of our delivery of services and the impact. As I mentioned at the outset, “mental illness” is useful to consider broadly and as those psychosocial domains of functioning that lead to impairment. Impairment is critical dimension as a criterion and refers to interfering with performing various roles. For adults, impairment means that one’s dysfunction leads to problems at work, lost days on the job, problems in one’s relationships, and so on. Impairment due to mental illness exerts an enormous personal burden to individuals and financial burden to society (e.g., Merikangas et al., 2007).

Our dominant model of delivering treatment is to provide services on an individual or small group basis (e.g., couple, family, other group of 8-10 people). In the case of child therapy, the child is usually seen in treatment and in the majorities of instances the parents are directly involved as well. In principle or practice, the dominant model of delivery would have enormous difficulty in reducing the burden of mental illness.

Consider for a moment the number of children who might be candidates for and in need of psychological services. Several studies spanning different geographical locales (e.g., the United States, Puerto Rico, Canada, and New Zealand) have yielded rather consistent results on the prevalence of psychiatric disorders among children and adolescents (e.g., ages 4 to 18 years old). Between 17 and 22 percent suffer significant developmental, emotional, or behavioral problems (e.g., US Congress, 1991; World Health Organization, 2001). Approximately 1 in 5 or 20% in community samples meet criteria for a psychiatric disorder. Of the approximately 70 million children (youth <18) in the United States, 1 in 5 means 14 million might be in need of services. This high prevalence rate of psychiatric disorder is likely to underestimate the range of mental disorders and impairment. Children who fail to meet the cutoff for a diagnosis because of the severity, number, or duration of symptoms can nonetheless suffer significant impairment and untoward long-term prognoses (e.g., Boyle et al., 1996; Lewinsohn, Solomon, Seeley, & Zeiss, 2000). Also, not all psychological
cally caused impairment is due to a psychiatric disorder. There are social, developmental, and learning based sources as well that are not captured by psychiatric diagnosis. Clearly, prevalence rates, when based on meeting criteria for diagnoses, provide a conservative estimate of child impairment and the need for services.

For purposes of discussion let us begin with 14 million in the US in need of psychological services. Approximately 70% of children in need of treatment services do not receive them, although estimates often go higher (e.g., up to 80%; Masi & Cooper, 2006). Let us use the more conservative estimate. I have represented those who need services and the proportion that does receive them in Figure 1 (upper panel). Figure 1 (upper panel) conveys that 70% of the children in need do not and 30% do receive treatment. We have also learned from studies of treatment that 40-60% of children (but also adults) drop out of treatment early (Kazdin, 1996). In the too breezy analyses here, let us take the 50% drop out rate. The upper panel (Figure 1) presents the approximately 30% who receive treatment, and the lower panel conveys this drops to 15% if we count those who drop out of treatment before its completion.

Again, given the brevity of the article, weighty topics such who does and does not receive treatment and why cannot be elaborated. And a “yes but” could be placed with each of the numbers I have noted. For example, all disorders are not the same in the burden they produce for individuals or society; some vary in duration, in physical health consequences, and in the likelihood of their association with crime and violence. All these and more are critical points for another day. For present purposes, these more refined points distract from the overall conclusion, namely, the majority of people in need are not receiving treatment. Also, the current model of one therapist seeing a child or family individually is not likely to have impact on reducing the burden of mental illness in society. Of course it is wonderful when we help the life of one individual and it is worthwhile, important, and something from which we should never turn. Yet, if our dominant model of delivery can be shown to exclude the vast majority in need, I think we ought to question our model and training in that model.

A putative solution is to raise the person power issue, i.e., we need more people trained to handle the load. Approximately 700,000 mental health professionals provide services including but well beyond psychologists (Hoge et al., 2007). These are not focused on children but mostly adults. Leaving that aside even doubling the work force and directing all of them to treat children exclusively are not likely to redress the problem. This is not a person power issue or only a person power issue. We cannot reach many in need for all sorts of reasons (e.g., access, perceived and genuine barriers, insurance, rural areas), but one of them is “in-house,” i.e., our view of how treatment should be delivered.

There are moves to augment our models of delivery. In the context of adult therapy, computer and internet-based treatments (e.g., email, online, live, face to face over the computer) reflect an accruing literature with randomized trials and clinical samples (e.g., anxiety, depression, smoking cessation, substance use and abuse) (e.g., Barak et al., 2008; Ritterband et al., 2003; Rochlin et al., 2004). Some of these can be scaled up to deliver treatment across thousands of people across several countries (e.g., Muñoz et al., 2006). I am not implying that we substitute one model of delivery of treatment for another. Actually, if we wish to reduce the burden of mental illness, multiple models are needed to ensure we can reach people in ways that accommodate the many different contexts, settings, and circumstances that may limit receiving services.

**Clinical Competence, Quality Care, and the Burden of Mental Illness**

As psychologists, what we do in clinical work is unique among the mental health professions. Three facets of our training can be readily identified.

1. **Conceptual Models:** We are trained in conceptual models of human functioning. These models encompass learning, motivation, affect, cognition, and behavior, social interaction, and so much more. These models can serve to guide our treatment;

2. **Assessment:** We know about assessments and the formalities of their development (e.g., scale development, reliabilities, validities, test interpretation, and limitations). We can use measures to describe and understand client functioning, to help guide decisions in treatment, and to evaluate both processes and outcomes of treatment;

3. **Application of Research:** Our training fosters the opportunity to apply empirical findings to inform patient care and help patients. These findings may derive from broader models or from studies on topics whether or not they reflect such models. Findings on beliefs, expectations, persuasion, problem solving, decision making, choice, commitment, and most obviously research on the effects of psychotherapy can be applied.

Each of these is indeed very special. The features can be utilized by other mental health professionals (e.g., child psychiatrists, social workers, nurses) and many are, but they are our canon and it is our colleagues (mentors, professors, researchers) who continue to do the updating in each area. In the battle to improve the quality of clinical care and reduce the burden of mental illness, I find such characteristics as the three noted above as inspiring. When in the trenches and one sees how the battles are actually carried out much seems to have been lost in translation.

For example, psychological assessment is indeed our forte. Within the past decade or so, advances have been made in developing, reliable, valid, very brief, and user friendly measures to improve the quality of clinical care both with children and adults. For example, among the most prominent is the Outcome Questionnaire 45 (OQ-45), which is a self-report measure designed to evaluate client progress (e.g., weekly) over the course of treatment (see Lambert et al., 2003, 2004). The measure requires approximately five minutes to complete and provides information on four domains of functioning, including symptoms of psychological disturbance (primarily depression and anxiety), interpersonal problems, social role functioning, (e.g., problems at work), and quality of life (e.g., facets of life satisfaction). Total scores across the 45 items present a global assessment of functioning. The measure has been evaluated extensively and has been applied to thousands of patients and shown to be useful in evaluating and predicting therapeutic changes. This measure and others like this are not routinely used in treatment or as a basis for decision making about how to proceed. Not using systematic measures actually undermines the other two characteristics of clinically psychology (e.g., applying conceptual models and research findings). Cognitive processes (e.g., heuristics, neurobiology of decision making) suggest rather strongly that we ought to be wary of our own experienced but unaided judgments. Systematic assessment ought to complement our own judgment, if not the other way around, in the context of therapy. I mention these larger issues now in the context of quality of care.

We are all concerned about the role of clinical psychologists now and in the future. The APA is actively involved in ways to protect and expand clinical practice. I have mentioned licensing and accreditation at the outset of the article as
examples of professional efforts to ensure competence. And of course, ABPP standards and criteria extend these further. With priority of protecting and expanding our practice and ensuring competence, is there a role for these other priorities, i.e., improving the quality of clinical care and reducing the burden of mental illness? It is not empirically established that much of what we do in training and what we emphasize improves patient care. The course assignments for accreditation, licensing, state statutes, continuing education courses and workshops, and competencies that we evaluate are intended to provide the knowledge base and are a starting place. For example, licensure as a psychologist in the United States requires completion of the Examination for Professional Practice in Psychology, a multiple-choice test covering diverse content domains and designed to protect the public by ensuring that a candidate has basic knowledge and competencies as a psychologist (Sharpless & Barber, 2009). There is no pretense that licensing leads to quality care in relation to what is provided, whether that care is evaluated, and whether it has impact.

Among the key questions that might guide us are:

1. What is it that we do that ensures the quality of the services we provide?
2. Basic competence (knowledge of our field) in what we do is obviously important, but what are the "best practices" we can draw from the evidence and experience to maximize the quality of care?
3. What can we do to extend treatment to reach those in need to have impact on the personal but also the enormous societal burden of mental illness?

Adult and child psychiatry professional organizations update clinical practice guidelines based on research and clinical experience (e.g., American Academy of Child and Adolescent Psychiatry, 2009; American Psychiatric Association, 2006). Over the years, one can see that research advances increasingly are incorporated into the guidelines. This does not necessarily mean clinical practice has been changed but it is useful to see efforts to specify what the practices ought to be in light of what we know. This is an active effort to improve the quality of care and with ongoing review in the diverse specialty areas of medical practice. Clinical psychologists often abhor references to medicine or related fields. The fact is that clinical dysfunction and the burden of mental health is a public-health problem given the scope and impact; moreover, mental health is a physical-health problem and vice versa because they are arm in arm so often (e.g., depression and heart attack, obsessive compulsive disorder and brain injury). If we do not see the problem as a public-health concern, we may continue to draw on models that do not serve the need. The quality of care issue raises questions about our interventions and their mode of delivery, but assuming the intervention is effective, how are we getting it out to those in need?

I share these thoughts with ABPP colleagues because of the very special status of this organization for clinical practice and the leadership role ABPP has played in setting standards for professional competence. Clinical practice and the public can be better served if we can show that what we do makes a genuine difference, draws on our research findings, and can reach the many in need. This is not instead of protecting our practice and advocating for the profession, but there is a higher moral ground and set of opportunities here about the quality of patient care, bases of and standards for clinical practice, and leadership among the mental health professions.

We serve ourselves well and perhaps best when our advocacy but also our daily work is directed toward improving the quality of care and reducing the burden of mental illness. As part of that, our adoption of practices and requirements ought to at least have an eye to these other goals. Other agenda can fall into place in relation to these, but if quality of care and reducing the burden of mental illness are not top among our priorities in providing clinical care, what are? Adherence to a model of training (e.g., science-practitioner), to a set of requirements (e.g., for state license), and to a model of delivering treatment (individual and small group therapy in an office) are not ends in themselves. The goals of our practice are not to help the very small proportion who have access to care and or restrict to whom we deliver care in ways to foster that exclusivity even further.

Improving the quality of care and reducing the burden of mental illness are not simple concepts or goals. Each warrants careful specification with multiple definitions and means of moving from definitions to operations and implementation. I readily concede that the brevity of my comments cannot adequately articulate the issues, yet suggest a course to generate solutions. There are many facets of our profession devoted to developing knowledge and competence and policing violations (e.g., misrepresenting oneself, other ethical violations). These are all essential. Now for something different. What in our field emphasizes and guides the quality of clinical care and efforts to palpably reduce the burden of mental illness? The goals fall to us and we should not let them fall. If not our field, what other discipline? If not our students, who? There is no group I would entrust more to consider these issues than ABPP and perhaps as well to begin to sketch out how our field might proceed. Competence and proficiency are in relation to goals. Our goals are not only to protect the public but also to serve them well and in the process reduce the burden for individuals and society.

References


Stop maligning the Scientist-Practitioner Model and start aligning with its objective criteria
by James C. Overholser, Ph.D., ABPP

Despite its widespread use, the term “scientist-practitioner” has never been defined in a clear or objective manner. Surprisingly, the original report from the Boulder conference on graduate education in clinical psychology (Raimy, 1950) never used the term scientist-practitioner. Instead, Raimy (1950) described the need for coursework that is integrated with supervised clinical experience, and the need for supervisors who are competent to train others because they are themselves experienced clinicians. However, the report from the earlier Detroit meeting (American Psychological Association, 1947) was a bit more explicit, stating the belief that “no clinical psychologist can be considered adequately trained unless he has had sound training in psychotherapy” (p. 548). Although not stating that ongoing clinical activity should be required, the Detroit report expressed the view that ongoing therapeutic contact with clients provided unique and important experiences that are essential for all clinical psychologists because these relationship qualities “cannot be duplicated by any other type of relationship” (p. 548).

It should not be a surprise to confront many disagreements over the term “scientist-practitioner”. It often seems as though “scientist-practitioner” has become a label used by many psychologists even if it does not accurately describe their current work activities. For many people, “scientist-practitioner” is more of a philosophical ideal than a descriptive label. Ideally, clinical psychologists strive to integrate science and practice into one coherent activity (Jones & Mehr, 2007). A clear and objective definition of scientist-practitioner may help psychologists to align their work with the ideals of the Boulder model.

Many psychologists struggle to integrate the science and practice of psychology, partly because different jobs pull for different activities. Time is perhaps the greatest obstacle to the actualization of the scientist-practitioner model (Vespia, 2006). University faculty typically spend most of their time involved in teaching, research, and the supervision of students. There is often little time left for the direct provision of clinical services. In contrast, most full-time clinicians devote the majority of their time conducting psychological evaluations or psychotherapy sessions. Any remaining time is likely to be devoted to clinical supervision or completing clinical paperwork. The clinician would need to push hard to make time for scholarly activities (Overholser, 2007). Sadly, the scientist-practitioner model is not a good fit for all clinical psychologists. It makes sense to avoid using the scientist-practitioner label unless it sincerely captures both the professional values and the typical work displayed by the psychologist.

Recently, ten criteria have been proposed to establish clear and objective standards for the scientist-practitioner in clinical psychology (Overholser, 2010). The scientist-practitioner criteria are distributed across three domains: Scholarship, clinical service, and the integration of science and practice. According to this “immodest proposal”, clinical psychologists who aspire to the ideals of the Boulder model should remain actively involved in ten professional activities that are normally performed during the typical work week. However, it is also realized that

Awardee Address, from pg 16

Professional Credentialing Services.


Author Note
This article is based on the award presentation for the 2008 ABPP Distinguished Service Award to the Profession of Psychology presented at the 2009 convention of the American Psychological Association in Toronto, Ontario. The presentation expressed how deeply honored I am for this recognition and what a privilege it is to be a member of the ABPP family. I am very grateful for the comments of Pat DeLeon, Ph.D., MPH, J.D. and ABPP on an earlier draft of this manuscript.

Footnotes
1 The treatments include parent management training, multisystemic therapy, multidimensional treatment foster care model, cognitive problem-solving skills training, anger control training, brief strategic family therapy, and functional family therapy (for a review, write for Kazdin, 2007)

2 For a review and update of research on OQ-45, an excellent overview is provided at www.nrepp.samhsa.gov/programfudetails.asp?PROGRAM_ID=191. Also, the 45-item measure has been reduced to 30 items and also has been validated (Lambert et al., 2004).
many great clinical psychologists may remain active in many, but not all of these activities.

The scholarship criteria focus on work that culminates in scholarly products that advance the theory or research of the field (Overholser, 2008). The scientist-practitioner remains active in scholarly works, publishing or presenting at a national level. This is perhaps the most contentious of the ten criteria, because the emphasis on national impact thereby eliminates college lectures, as well as presentations at local workshops. However, it seems important to focus on scholarly works that have the potential for advancing the field through theoretical review papers, clinical research studies, or comprehensive review papers that help to integrate the field.

The clinical practice criteria emphasize the importance of remaining active in the direct provision of clinical services. The clinical work can include the provision of psychological assessment, psychiatric diagnosis, and psychotherapy sessions. Furthermore, the clinical work is not simply research-bound protocols that are overly regulated by treatment manuals, because these structured activities often lack the sensitivity, flexibility, and spontaneity seen in most clinical work. Finally, the clinical work is not simply the supervision of others, but includes direct contact with clients who are struggling with psychiatric disorders or medical patients who have psychological factors affecting their medical condition. As noted in the early reports (APA, 1947), clinical experience provides a unique experience that is essential to the field of clinical psychology.

The integration criteria represent the pinnacle of clinical psychology. Aspiring scientist-practitioners are encouraged to follow the recommendations from Evidence-Based Practice. At a more basic level, psychologists should focus their work on areas within the domain of psychology, which is hereby defined as the mind and mental processes. Unfortunately, some great psychologists have stretched the limits of the field, and now focus their work on biological factors, functional neuroanatomy, or cross-cultural factors. However, psychology seems most clearly centered around the mind and mental processes (Overholser, 2003). Clinical psychologists are expected to work with medical or psychiatric patients. Too often, research studies are collected with college students, high school students, or other nonclinical samples. However, different populations may be appropriate when the scientist-practitioner model is applied to specialists in counseling psychology, I/O psychology, school psychology, and health psychology. The scientist-practitioner incorporates psychological measures that strike the balance between research and practice. The assessment tools have displayed adequate psychometric properties, and they are brief enough to be administered in most applied settings.

It seems inaccurate to label oneself a “scientist-practitioner” when the psychologist is no longer active in one of the primary domains (i.e., scholarship or clinical service). However, instead of creating a schism in the field, whereby scholars are pitted against clinicians, it makes more sense to integrate, unify, and encourage clinical psychologists to extend the range of their activities. It is hereby proposed that the field moves away from a categorical typology (e.g., “I am a scientist-practitioner”) and adopt a dimensional rating (e.g., “I satisfy the majority of the criteria for a scientist-practitioner”). Thus, the average academic psychologist may place heavy emphasis on research and publishing, and may even supervise graduate students who provide clinical services, but the faculty member does not directly provide any clinical services. In contrast, a full-time clinician who appreciates scholarship and research but lacks the time or resources to conduct research studies may satisfy some of the scientist-practitioner criteria. It is hoped that the scientist-practitioner model can survive, as seen in the actual weekly activities of most clinical psychologists, and move away from an idealistic but unrealized phantom in the field.

Table 1. Self-assessment for rating the scientist-practitioner criteria

1. In the past year, have you remained active in scholarly activities, such as collecting research data, writing journal articles or book chapters, or submitting a presentation to a conference meetings?
2. During the past year, have your scholarly works been presented or published at a national level (i.e., more than local workshops or newsletters)?
3. Does your scholarship extend beyond teaching college courses or continuing education workshops?
4. Do you provide clinical service on a regular basis (e.g., psychological assessment, psychiatric diagnosis, psychotherapy sessions conducted each week)?
5. Do you provide clinical services that are similar to standard clinical practice (i.e., not overly regimented through a structured treatment manual)?
6. Does your clinical activity extend beyond the supervision of others (e.g., graduate students or master’s level employees)?
7. Does your work follow the recommendations for Evidence-Based Practice?
8. Does your work focus on issues that are central to clinical psychology (e.g., psychological factors that are related to psychopathology)
9. Do you regularly work with clinical samples (i.e., medical or psychiatric patients)?
10. Do you use psychological measures that have demonstrated adequate psychometric properties and can be easily collected in a time-efficient manner?

References
Doug Hodgson, my undergraduate political theory professor in 1974, was fond of ridiculing my young, naive belief that a world that devoid of pain, suffering and conflict was both desirable and achievable. “Humans need conflict,” he warned the class, “Conflict produces growth and growth is a central aspect of human nature. The opposite of conflict is death.” Ten years later, I remember talking in Boston with a research psychiatrist who was working on a “wonder drug” that he claimed would not only cure depression, but be the first of an entire class of new medications designed to target specific neurotransmitters. They would eventually end mental illness. I remember wondering, as did Peter Kramer (1993, 1997), if these drugs might be capable of altering not only personality but the “soul.” That drug—fluoxetine (Prozac)—and its offspring (the other SSRIs, SNRIs, atypical antipsychotics, etc.) would not live up to the psychiatrist’s medically-informed but naïve expectations. The search continues for quick and preferably pharmacological ways to end not only psychopathology but problems of living.

I recently rewatched the 1998 film “Pleasantville,” with its all-star cast that includes Reese Witherspoon, Tobey Maguire, Jeff Daniels, William Macy and Joan Allen. It also boasts a screenplay and direction by Gary Ross (who also wrote “Seabiscuit” and cowrote the wonderful parable “Big” that arguably launched Tom Hanks’ career as a serious actor) and original music by Randy Newman (best known for his sardonic song about prejudice, “Short People”). If you have not seen this movie since its release 11 years ago, it is worth a serious re-examination. If you have never seen it, please give yourself a treat and view it. Either way, keep in mind what many perceive as the goals of psychiatry and medical psychology: the alleviation of pain, suffering and conflict.

Briefly, Pleasantville (the film) tells the story of teenager David (Maguire) whose wish for a kinder, gentler, conflict-free life is epitomized in “Pleasantville,” a fictitious 1950s series that is a cross between “Father Knows Best,” “The Andy Griffiths Show” (Don Knotts even has a role in this film) and almost any other Eisenhower-era black and white family TV series. In real life, David and his sister Jennifer (Witherspoon) are contrasting characters. David is the quintessential nerd; well-read but unassertive and anxious, he escapes each day into the TV-land utopia of the Pleasantville series. Jennifer is vacuous, narcissistic, pleasure-centered and motivated only by her need to be popular and attractive. She is proudly promiscuous. Both are unaware that their identities are only partially-developed.

This is a movie with multiple levels of interpretation. On one level, it is an allegory about being cast out from paradise. At one point, Maguire is even offered an apple by a girl who is attracted to him, a very literal allusion to Eden and the Fall. (In fact, religious imagery abounds in this film, with Knotts as a wy, cunning God while Bud and Mary-Sue are arguably cast in the role of Lucifer, the “bringer of light.”) But clearly this movie views the Fall from the perspective of Erich Fromm (1941) rather than the Hebrew patriarchs. Eating the apple from the Tree of Knowledge brings awareness and freedom—of both good and evil. On the “good” side, the people of Pleasantville learn about jazz and rock music, art books depict nudes and abstract expressionism, and formerly blank books begin fill with the works of Twain, Lawrence and Salinger. Bill Johnson, an amateur painter who operates the local soda fountain, is initially portrayed as a mindless dreamer until Bud brings him a book that surveys great art. His usual Christmas window mural becomes transformed into a Picasso-like abstract. Color abounds. On the “bad” side, not everyone is appreciative of this new-found diversity. Soon, stores sport “No colors allowed” signs. Bill Johnson scraps off his abstract Christmas mural and instead paints a lusty but exquisite reclining nude of Betty and the town is scandalized. In a wonderful scene, Bud defends his TV-mother’s honor when local boys begin mocking Betty and hinting at rape. He belts one of them, and the boy bleeds red. Bud, who has until now been puzzled over the fact that he has remained black and white, now becomes colorized. Aggression—the feelings and behaviors that terrified him in the real world and were part of his shadow self—is what brings him his color.

Specialists influenced by psychoanalytic theory will also be impressed with this film’s depiction of sexuality. Sexuality is what initially introduced to sex by Jennifer/Mary-Sue, and when he tells his teammates about what he has discovered, their basketball skills are destroyed and they lose their first game. As in real life, sex has the power to both bring out and disrupt the best of our humanity. Later, Mary-Sue explains sex to her mother, Betty (played by Joan Allen), including the joys of masturbation. When Betty experiments alone in her bathtub, the results are literally inflammatory: as she climaxes, the tree in the Parker’s front yard bursts into flame, which completely baffles the town fire department since there has never before been a fire.

Each perceives the source of their discontent to be rooted in the “outside” world. In a sense, each believes in an external solution; if only a pill could give them what they believe they want. David’s “pill” arrives, in the form of a TV repairman (Knotts) who magically transports the siblings into the TV series “Pleasantville” in which everyone is attractive, the basketball team is undefeated (players never miss a hoop), and a hot date between teen couples involves holding hands in Lover’s Lane. Everything is “perfect” and gloriously routine. There is no rain and no color, no fire, no anger and no pain (physical or emotional). There is also no “outside” world beyond the two or three streets of this small, perfect American town. The streets all circle back. Married couples sleep in separate beds. Breakfasts are gigantic and include every manner of carb, fat and sugar imaginable. There is no history, no world affairs. The school library has books, but they are blank on the inside.

In Pleasantville, Maguire and Witherspoon are transformed into TV-land counterparts Bud and Mary-Sue Parker. Bud is initially thrilled. He has every episode of “Pleasantville” memorized and knows all the townspeople. He fits right in. Mary-Sue is shocked and revolted. With no sex to her mother, Betty (played by Joan Allen), including the joys of masturbation. When Betty experiments alone in her bathtub, the results are literally inflammatory: as she climaxes, the tree in the Parker’s front yard bursts into flame, which completely baffles the town fire department since there has never before been a fire.

Dr. Steve K. D. Eichel

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Specialists influenced by psychoanalytic theory will also be impressed with this film’s depiction of sexuality. Sexuality is what initially liberates the townspeople, beginning with basketball star and school heartthrob Skip. He is introduced to sex by Jennifer/Mary-Sue, and when he tells his teammates about what he has discovered, their basketball skills are destroyed and they lose their first game. As in real life, sex has the power to both bring out and disrupt the best of our humanity. Later, Mary-Sue explains sex to her mother, Betty (played by Joan Allen), including the joys of masturbation. When Betty experiments alone in her bathtub, the results are literally inflammatory: as she climaxes, the tree in the Parker’s front yard bursts into flame, which completely baffles the town fire department since there has never before been a fire.
RESEARCH REPORT

Combat Related Post Traumatic Stress Disorder: A Multiple Case Report Using Virtual Reality Graded Exposure Therapy with Physiological Monitoring

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(1) The opinions expressed are the private ones of the authors and should not be considered approved or representative of the Navy Medical Department, the Office of Naval Research or the Department of Defense. This study was sponsored by the Office of Naval Research (ONR) Contract #N00014-05-C-0136 to Virtual Reality Medical Center San Diego, CA. Originally presented as a Poster Presentation, Association of Medical Service Corps Officers of the Navy Poster Session, Association of Military Surgeons of the United States (AMSUS) Annual Meeting, November 2008, San Antonio, Texas.

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Key Words: Post Traumatic Stress Disorder (PTSD); Virtual Reality Graded Exposure Therapy (VRGET); Office of Naval Research (ONR); combat exposure; War on Terrorism; Bio-feedback; physiological measurements; Operation Iraqi Freedom (OIF); Operation Enduring Freedom (OEF); Driving Phobia

Summary:
The Office of Naval Research (ONR) has funded a multi-year treatment research project to investigate the utilization of Virtual Reality (VR) and biofeedback therapy with warriors diagnosed with combat-related Post traumatic Stress Disorder (PTSD). The Virtual Reality Medical Center (VRMC), in San Diego, was awarded an ONR funded VR research grant and VRMC is currently treating warriors, diagnosed with combat-related PTSD, at both Naval Medical Center San Diego and Navy Hospital Camp Pendleton. The following report provides a summary describing the warriors treated with VR and their response to VR treatment.

Introduction
Both the recent Report of the President's Commission on Care for America's Returning Wounded Warriors and the June 2007 Report of the Department of Defense Task force on Mental Health concluded that 11-25% of OIF and/or OEF veterans have been diagnosed with PTSD (1, 2). It was also expected and documented that the rate of PTSD will be higher among troops who have been to Iraq more than once (3 -6). Mental health diagnoses, including PTSD, secondary to combat tours in Iraq, have been rated as the second leading cause of combat injury (7). Concerns have also been most recently centered on traumatic brain injury (TBI), with both PTSD and TBI being referred to as the signature wounds of the Afghanistan and Iraq conflicts (6).

Furthermore, both the Report of the President's Commission on Care for America's Returning Wounded Warriors and the Report of the Department of Defense Task force on Mental Health have recommended that VA and DOD should aggressively prevent, develop early intervention strategies and treat PTSD (1, 2). Early treatment intervention for PTSD has been endorsed in other reports, as well (4, 5).

Virtual Reality Graded Exposure Therapy (VRGET) treatment has been documented as an exceptional treatment for anxiety disorders and specifically for PTSD (8 - 13). The Virtual Reality Medical Center (VRMC) was awarded an Office of Naval Research (ONR) grant to complete an evaluation of Virtual Reality Graded Exposure Therapy (VRGET) with active-duty personnel diagnosed with combat-related PTSD. This evaluation is being conducted at the Naval Medical Center San Diego (NMCSD) and Naval Hospital Camp Pendleton (NHCP). Recently, VRMC completed the Pilot Phase of the VRGET study with eleven male participants who were all OIF or OEF veterans. All of VRGET Pilot Phase participants had been diagnosed with PTSD and four of these participants had also been diagnosed with mild Traumatic Brain Injury (mTBI). Following is the report of the VRGET with the Pilot Phase participants.

Method:
Eleven male participants, all volunteers, diagnosed with combat-related PTSD, met the study requirements for participation and they initiated the pilot phase of Virtual Reality Graded Exposure Therapy (VRGET). These participants were all members of the United States Navy and 8 of these participants experienced one or more combat deployment to Iraq and/or Afghanistan.
between January 2003 and September 2006. One of our participants experienced multiple combat deployments to other areas of the world in support of the War on Terrorism. Four of our participants had been diagnosed with mTBI. All of our participants initiated VRGET since March 2006. As part of the treatment protocol, treatment was typically delivered in 10, 90 – 100 minute separate sessions conducted one time each week by one of the authors (DPW). The VRGET system relies on two computers and specially designed software to present a combined visual and auditory combat environment. The participants “walked” in the virtual combat environment or “drove” a Humvee by pushing buttons on the hand-held joy-stick. The participants “fired” an M-16 rifle by depressing another button on the joy-stick. Full assessments, with clinician-rated and self-report measures, were conducted at pre-treatment, mid-treatment (following 5 sessions of treatment), and post-treatment (following 10 sessions of treatment). Follow-up assessments were also conducted 3 months after the participants completed VRGET. During the VRGET sessions, the participants utilized a head-mounted display and headphones. Additionally, the participants’ physiological measurements (i.e., heart rate, breaths per minute, skin conductance and peripheral temperature) were monitored during each treatment session and also during pre-treatment, mid-treatment and post-treatment assessments; the arousal levels of our participants were utilized to “guide” the architecture of each participants’ VRGET in order to maximize “immersion” and “habitation” (i.e., to maximize the positive benefits of VRGET). The participants were trained in meditation techniques to assist them with better controlling their physiological arousal not only while engaged in VRGET but also when they were not in a VRGET environment (i.e., at home, at work, etc.).

Results:
The participants’ clinical levels of PTSD and Depression reduced significantly, from their pre-treatment to post-treatment assessments (see Figures 1 & 2). Additionally, the participants’ level of Depression significantly reduced between their pre-treatment to their follow-up assessments (see Figure 2). The participants’ level of Anxiety measurable reduced between their pre-treatment to post-treatment assessments and remained measurably reduced at their follow-up assessment (see Figure 3). At follow-up assessment, the participants’ PCL-M scores suggested the continued presence of a reduction in PTSD (i.e., PCL-M score equal to/less than 50).

Discussion:
Virtual Reality Graded Exposure Therapy (VRGET) let to significant reductions, pre- to post-treatment, in reported difficulties with PTSD and Depression and also led to measurable reductions, pre- to post-treatment, in reported difficulties with Anxiety in our participants. These reductions in PTSD, Depression and Anxiety continued at the follow-up assessment 3 months following the completion of VRGET. Consistent with other virtual reality literature for the treatment of anxiety disorders, our participants reported having become emotionally engaged in the graded exposures of the VR simulations (8 – 13). They also reported that the VRGET combat simulations, which spanned safe simulations to intense combat simulations, assisted their skills with “attentional refocusing” and also assisted them with the development of their meditation skills.

Based upon previous research, which documents that combat veterans diagnosed with PTSD continued to reduce their difficulties with PTSD following the termination of successful treatment (12), we expect that our participants would continue to improve their ability to more effectively manage their PTSD symptoms following the termination of their VRGET.

We must caution that there are obvious limitations to the generalizability of the clinical outcomes of our Pilot study trial to other PTSD treatment populations at other medical centers, military or civilian. However, we believe that the ONR treatment development grant was successful in fostering the creation of a new virtual reality exposure therapy for veterans of the War of Terror who have been diagnosed with combat-treated PTSD (i.e., VRGET). Our results suggested that our participants were success-

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Table 1. Ranks, ages, combat deployment, medical diagnoses, medical status, and current status of warriors treated with VRGET (N = 11).
fully treated with VRGET, leading to clinically measurable habituation of their physiological responses and reductions in PTSD symptoms.

Selected Bibliography


“Pleasantville” Revisited, from pg 19

However, Pleasantville does not descend into silly fascination with superficial lust. Sexuality is an aspect of libido, which according to Freud (1920, 1975) is in turn a manifestation of eros, the creative and connecting life-force. Libido/eros is what becomes sparked by the Parker siblings; the energy they conduct winds up inspiring art, poetry, music, curiosity and learning as well as the usual physical connecting among the town folk. And it is the reaction against this process of liberation, this bringing of pain and suffering and joy and wonder, that leads the “good” people of Pleasantville to rampone one evening. In a scene that clearly ties religious fanaticism to fascism, the town engages in a book burning. The mayor decrees this display of street anarchy, invoking the need for law and order. So he issues an edict on “civilized behavior” that could have been written by the Moral Majority.

“Pleasantville” clearly argues on behalf of integrating opposing aspects of the psyche. Mary-Sue becomes colorized when she begins reading and studying. She decides to stay in TV-land and we last see her sitting on the library steps of a university engaged in a conversation about her studies. She is no longer vacuous. Bud finally gains color when he stands up for his mother, who is being taunted by a group of boys. He punches one of the offenders, there-by “owning” the aggressive and risk-taking aspects of his personality. Specialists who incorporate an understanding of social/cultural contexts into their work will also be provoked by the film’s broader, more societal discussion. At what point do cultural agitators violate the rights of others? At what point does cultural upheaval become cultural violence? Where do the rights of expression end? These questions, raised by critics of medical psychopathology from Szasz to Laing, remain relevant.

For those of us who specialize in “non-medical” psychologies (e.g., counseling, family, group, psychoanalysis)—this film clearly reminds us of the value of pain, struggle and conflict and how these forces shape social/cultural as well as individual identity. The protagonists are not cast as having pathologies; theirs are existential issues, problems of the soul. Their “treatment” does not fit into evidence-based practice or a manual.

However, Pleasantville is a blatant product of the late 1990s, a time when the “culture wars” were raging, and it takes a very clear position in this conflict. The conclusion is, sadly, overly optimistic. Still, it is a truly inspired movie with excellent writing and acting by an ensemble cast that later went on to even greater fame. As a parable, it gently prods at our fantasies of the predictable and “perfect” world. The last bit of dialogue sums it up nicely. Betty Parker sits at a bus stop with her husband George. It is unclear if she is about to leave Pleasantville. “So what’s going to happen now?” asks George. “I don’t know. You know what’s going to happen now?” she replies. George laughs. “No, I don’t.” Bill Johnson appears in the scene, staring ahead, and adds: “I guess I don’t either.” Uncertainty is the only thing that is certain now. If you believe, as I do, that human psychology dictates there can be no light without the dark, nor love and connection without its counterpart, disconnection and destruction, then you and your students will feel inspired by the message of this film.

References


Steve K. D. Eichel, Ph.D., ABPP is a Past-President of the American Academy of Counseling Psychology and the current Chair of the Council of Presidents of Psychology Specialty Academies.
Editor’s Corner: “You’re Special”

Robt. W. Goldberg, Ph.D., ABPP

The children’s television icon, the late Fred Rogers, used to talk directly at the camera using my title quotation, making each little boy or girl feel as if s/he were the sole focus of this kindly man’s nonthreatening interest. He would sing songs to them, tell morality tales, and encourage them in order to convey this to his diminutive viewers. The psychodynamically-oriented among us might consider this a desirable infusion of narcissistic libido into the psyches of children whose very immaturity or circumstances might well produce feelings of insignificance or neglect. While this approach was well-suited to those times and that audience, it is not necessarily applicable to other groups and eras. It seems unlikely to be applicable to adult practitioners of a helping profession such as ours. Yet this is the approach which the American Psychological Association had historically taken for many years.

As a membership organization, with some charitable exceptions for extraordinary statuses (e.g. early career psychologists), APA pretty much treats members as equals, with respect to voting, access to services, availability of insurance programs, rental car discounts, etc. In this instance, following Mr. Rogers, we might say that everyone is special. When everyone is special, then, truly, no-one is special; everyone is the same. In the past, this implicit approach mitigated against the differentiation and development of the field and the emergence of clearly demarcated specialties and special proficiencies. On the individual level, licensure for professional psychologists – the ‘journeyman’ level – is deemed sufficient for practice, mitigating against the legitimate acknowledgment of specialty practitioners, which is considered elitism.

It will be recalled that the Board of Educational Affairs Subcommittee on Specialization, chaired by Dr. Bruce Sales, authored the S.O.S. report with a mechanism for recognizing new specialties, including those at the doctoral level. That report lay fallow for nearly a decade until the formation of the Interorganizational Council for Accreditation of Postdoctoral Programs in Professional Psychology prompted APA into action, resulting in the establishment of the Council for the Recognition of Specialties and Proficiencies in Professional Psychology and for the improved situation we have today.

Yet there remains reluctance for APA to acknowledge the obvious fact that there are differences in the skill sets, competencies, and levels of expertise among professional psychologists. This is not a problem for physicians, dentists, nurses, attorneys, and others; why is it a problem for psychology? Some practitioners know things different and distinct from what the journeyman knows and – as politically unacceptable as this may sound! – know more and do it better than other practitioners.

Times have changed. With the advent of what I will call the ‘Competency Movement’ emerging around 2002, psychology – including APA – has had an opportunity to craft an integrated system of competencies which can be specified and potentially gauged in psychologists and psychologists-to-be at all levels of training and experience. At this time, although the APA ‘Benchmarks’ have recently been adopted, there remains a proliferation of competencies promulgated by membership/interest practitioner groups in many areas – geropsychology, health psychology, traumatology, neuropsychology, etc. – rather than acceptance of an integrated or uniform taxonomy. The concept is here; the system is not. Occupying the chasm left by APA, it remains for the American Board of Professional Psychology to continue its sixty-three year role in certifying the competencies of individual specialists in clearly demarcated and well-defined areas (the different and distinct dimension above), and at a level of advanced competence (the more and better). To do so is not elitism; it is a responsibility. It is a role I am sure ABPP will continue to develop, taking the lead in shaping the field – including APA – into further clarifying and delineating practice areas, competencies and practitioner levels of attainment.

In the interests of unifying the field, merging the perspectives of APA and ABPP, I would offer the following quotation, by the late Executive Office and BOT President Russell Bent: “It is not the exceptional specialist who should be board certified, but the specialist who is not board certified who should be the exception” – at least in some area!

Reference
In Memoriam: 
Albert Angrilli
by O. Bernard Leibman, Ph.D., ABPP

About 30 years ago Albert Angrilli, a School Psychology ABPP Diplomate, and I attended a Queens College Professor’s funeral. During the eulogies we couldn’t figure out who they were talking about. We made a pledge that whoever survived would tell the unvarnished truth about the other and make it real. Al was very real and very present. He was not to be ignored. He was strong, definitive, opinionated, and always ready to share his thoughts and ideas. We have worked together and have known each other for almost 60 years. You always knew where Al stood - open, clear, and often outrageous.

In this last period of time, memories have flooded through me as I recall the thousands of meaningful interactions we have shared. We started out to write 2 books together – both unfinished: one on the History of the School Psychology Graduate Program and the other a collection of our humorous stories and jokes illustrating psychological issues. Al loved jokes – many good ones and many terrible ones. During the past few years a small group of colleagues met at the Jolly Fisherman for lunch, wine and conversation. Al would bring out his list of current jokes while eating his banana cream pie smothered in hot fudge and ice cream (but don’t tell Alma – his beloved). You always knew where Al stood. He stood for excellence above all. One time while interviewing candidates for our Graduate Program he asked the individual to name the Secretary of State. The prospective student complained that the question had nothing to do with Psychology and was unfair. Al disagreed, taking the position that a psychologist should not hold a narrow perspective of their world. He demanded evidence in his courses and the students loved him, although sometimes were scared witless of him. His classes were always powerful and exciting, imparting superior knowledge – also imparting food and wine.

Al and I were on the program at a weekend Queens College meeting. The two of us held a humorous debate, in the style of the comedian “Professor” Irwin Corey, on therapeutic issues. As we argued about the ‘interpretation of the constellation and suppressive pluralism of the deep configuration of the id over the ego’ we heard the audience convulsed in laughter. We were proud of what we had put over. Afterward the husband of a faculty member came to console us, saying that they should have been more respectful of our presentation. We had been so intense and heated that he was sure it was a legitimate discussion.

Al loved to spoof people with outrageous plays. When the Clinic was new to the Ed Department, we were on line in the Faculty Cafeteria. Behind us was a naïve faculty person. Al started a routine with me about how we would train his son, Bobby with the correct answers on the admission test for a special advanced class for which Bob was applying. This person was appalled that we would do thus and so. Of course we kept it going even more until we cracked up. We never knew what she believed was true. The Lewin-Lippet-White demonstrations of Autocratic, Democratic, Laissez-faire leadership was another example of Al’s passion for gamesmanship. He loved playing the Autocratic leader – so much so that many students believed that this was the true Al.

That is the picture of Al that will always remain. Full of life, fully present, always inquiring, always seeking involvement, opinionated, caring, sharing and most of all, clearly a Participant.

Thank you, Al, for a great run: The memories of the hundreds of wild behaviors as we worked together to build the Education Clinic and the Graduate Center in School Psychology will remain with me forever. Even more important –your imprint of excellence and integrity is a part of hundreds of well trained graduate psychologists.

You will be missed personally, but professionally you will live forever.

Board and Academy News

American Academy of Clinical Psychology

Christopher Ebbe, Ph.D., ABPP

The Academy Board met jointly with the clinical Examining Board Oct. 3 near Boston, to explore possibilities of joining or at least working together better. Such an exploration has been a long time coming, and I believe that all present were pleased with the positive and collegial discussions and outcome. Dr. Nadine Kaslow, Examining Board chair, is to be especially congratulated for all we accomplished. We agreed to meet together once a year and to jointly put on every other year a continuing education presentation highlighting the value of Board Certification and the contributions of those who are Board Certified. We will continue to examine the possibility of merger, which will depend partly on the BOT’s response to questions such as whether, with a merger, the new entity would continue to have “members,” whether members would still pay dues, what would become of those dues, and whether members would continue to be “Fellows.”

Bob Yufit was re-elected to a second term on the Board in our fall election. Lisa Grossman attended the ABPP Governance Day activities at the APA Convention for AACP. Member renewals seemed to be down somewhat, but assertive reminders have helped considerably. We added an option to pay on Google Checkout, which many used. The Academy is pursuing an active advertising campaign regarding Board Certification in various professional journals.
American Board of Couple and Family Psychology

A. Rodney Nurse, Ph.D., ABPP
We are very proud…

Florence Kaslow has been voted by the ABPP Board of Trustees as the recipient of the Year 2010 ABPP Distinguished Service and Contribution to the American Board of Professional Psychology Award (now the Russell J. Bent Award). It will be formally presented to Dr. Kaslow at the ABPP Convocation at the APA Convention in San Diego in August. I speak for our Couple and Family Board and, I’m sure, reflect the sense of our entire Academy membership, in congratulating her. She is presently our SB’s BOT Representative, and former Couple and Family Board President. We are all aware how central her work has been to the continued development of the specialty of Couple and Family Psychology, and her contributions to ABPP are legion. She stands out among leaders in the broad field of couple and family psychology. Florrie, we are deeply pleased that you have been selected for this justly deserved honor!

For the first time…

The ABCFP Board, our Academy officers, and the Board of the Society for Family Psychology (APA Div. 43) will be meeting together at a Midwinter meeting (to be held in Las Vegas February 11-14). Melton Strozier, Couple and Family Academy President, John Thoburn, 2010 President of Division 43, and I have worked together on the complicated Midwinter planning. We have been joined in planning by Terry Patterson, Chair of the group working on the petition to APA Council on Accreditation seeking provision for doctoral programs and internships in family psychology to be eligible to apply for APA accreditation. Terry, who served on the ABCFP Board a few years ago was elected anew for the ABCFP Board effective January, 2010.

A suggestion…

Although the Specialty of Couple and Family Psychology is not among the largest of ABPP specialties, the personal importance of couple and family relationships for the lives of psychologists who are psychotherapists is attested to by one of two related articles in the March 2009 issue of Psychotherapy. Drs. Denise H. Bike, John C. Norcross, and Danielle M. Schatz report on a replication and extension in 2007 of a 1987 national survey of American psychotherapists.

American Academy of Couple and Family Psychology

Melton Strozier, Ph.D., ABPP

This has been an exciting and productive year for the Academy. We are proud of our new website at http://www.familypsych.org/ and encourage you to go to it and browse. All is not done yet, but websites never are fully completed. This site will help disseminate information and sustain contact and communication among Academy members. Additionally the Academy has been busy working with fellow organizations to continue to define and develop the discipline of family psychology. We have been and will continue to be actively engaged with the Board, the Society, and the other organizations devoted to family systems assessment and treatment to define and encourage the training and practice of family psychology. At APA in Toronto the Academy co-sponsored the hospitality suite reception of the Society of Family Psychology and celebrated the Society’s 25th birthday, enjoying a delicious Division 43 birthday cake (below) and spending time with most of the past presidents of the Society.

Among their findings was the following: the top reason in both years’ surveys for psychotherapists seeking therapy was marital/couple distress (20%). Four of five of these professionals sought individual therapy as a remedy for their distress. The systemic theory of couple and family psychology would, however, be a basis for recommending an individual psychologist engage in couple therapy with the partner so that a disturbed relationship could be worked with directly. A range of viewpoints on this cross-cutting topic hopefully might be fruitfully included within some of the presentations at the July 2010 conference in Portland, Oregon.

Best wishes…

And thanks to outgoing ABCFP Board Members Keren Suberri and Jerry Morris for their service on the ABCFP Board,(Oxford University Press).

Different members of the Academy distinguished themselves this year – to many to really name. However, we are especially proud of one of our early and present leaders, Dr. Florence Kaslow, for her many awards and recognitions and her most recent honor of being voted to be recipient of the Distinguished Contribution to ABPP Award at the Convocation next year. Thanks to all the officers of the Academy for a year of sustained and unselfish activity to continue good work for our members. I am grateful to have the chance to serve with the likes of Florrie Kaslow, John Thoburn, Lenore Walker, Charles Guyer, Charles Huber, Andy Benjamin and especially our able Board president, Rod Nurse. Here’s to good things continuing to happen in 2010!
American Board of Organizational and Business Consulting Psychology

Jay C. Thomas, Ph.D., ABPP

Trends for the specialty have not been positive for the past few years, but things may be on the cusp of positive change in the foreseeable future. The Specialty is a hybrid, composed of traditional industrial and organizational psychologists and consulting psychologists. The former are primarily members of APA Division 14, the Society for Industrial and Organizational Psychology (SIOP), the latter are typically members of APA Division 13, Society for Consulting Psychology (SCP). Over the past few years almost all new specialist applications came from SCP members. SIOP leadership became more and more academically oriented, to the point that practice was an after thought. Historically, SIOP opposed accreditation of programs, licensure, and credentialing. In 2008 the Professional Practice Committee surveyed practitioner members and reported in October, 2008, that the activities engaged in by practitioners are different from those engaged in by researchers, that professional development needs are different, and that graduate programs do not teach the skills used by practitioners on a daily basis (Silzer, Erickson, Robinson, & Cober, 2008). A more recent report (Cober, Silzer, & Erickson, 2009) among other things, called for a move toward licensure and certification, supervised practice requirements for all Ph.D.s, and guidelines for internships that emphasize research and practice. If these recommendations were to come to fruition, then we could see new emphasis on developing licensing laws that allow non-health care psychologists to obtain licenses and practice psychology. Once this occurs and the need for certification is taken seriously, OBCP will be in a position experience tremendous growth. Even the recognition that certification is desirable will help the specialty and our Board. The Board will try to develop new strategies for dealing with these developments at its February meeting.

Our board owes a huge debt to Bill Amberg, former President and BOT representative. Bill was the force that recreated the specialty after the former I/O specialty became defunct. After serving those offices, Bill remained on the board as Exam Chair. He recently announced that he will be stepping down from the board after the February meeting. We will miss his enthusiasm and wisdom and our board members have been honored by his presence. Any future success of the specialty board will be a legacy of Bill’s.

References

American Board of Rehabilitation Psychology

Ellen Snoxell, Ph.D., ABPP

The Rehabilitation Psychology Board members have been busy the past nine months. Starting with our mid-winter conference in February 2009, we began the planning and preparation process for the PCR. Under Dr. Mary Hibbard’s guidance, individual and small groups of board members drafted portions of the manual and coordinated work via phone or e-mail. In addition, 2 half-days were devoted to intensive work during meetings when most of the Board was present for the Seattle examination and again in Toronto at APA. The work continues on pace in preparation for the 2010 review.

We also held exams over two days in Seattle, WA and would like to welcome and congratulate the following new diplomates:

Board members present at the Seattle examination (left to right): Lester Butt, Dan Rohe (president), Michelle Rusin (treasurer), Fernando Gonzalez, Mary Hibbard, Barry Nierenberg, Jan Niemeir (secretary) and Stephen Wegener. Not pictured: Bruce Caplan and Ellen Snoxell.

American Board of Clinical Health Psychology

American Board of Clinical Health Psychology

Exam Revision Committee Members:
Anne Dobmeyer, Stephen Bowles, Mary Ellen Olbrisch and John Linton.
American Academy of School Psychology

Michael Tansy, Ph.D., ABPP

For the School Specialty, 2009 has been a year of harmony, productivity, and visibility. AASP and ABSP share a close relationship in our shared effort to represent the Specialty within the field. This relationship is a very positive indication of the health of our fellowship.

The 2010 AASP Executive Committee consisting of David McIntosh (President), Judith Kaufman (President-Elect), Michael Tansy (Past-President), Shawn Powell (Treasurer), and Linda Caterino (Secretary), anticipates continued fellowship with the 2010 ABSP, comprised of Clifford Hatt (President), Thomas McKnight (Vice President, Treasurer), Barbara Fischetti (Vice President, Secretary), Shelley Pelletier (Director), Jeff Miller (Director), and Giselle Esquivel (Director). We offer sincere appreciation to several Fellows who have served the Board and Executive Committee tirelessly and are now retiring. Since its inception in 2005 AASP has awarded 22 $1000 Irwin Hyman and Nadine Lambert Memorial Scholarships, including six this year. These scholarships are funded through the generous donations of individual School Fellows, as well as Pearson Assessments ($2500), ProEd, Psychological Assessment Resources, and Western Psychological Services ($500 each). As we have done for several years AASP provided a special session on the ABPP examination at NASP and hosted our annual Fellowship Breakfast at APA. We continued to demonstrate strong leadership and visibility for the School Specialty by serving on several school psychology-related specialty groups, including the Specialty Council (formerly Synarchy), the School Psychology Leadership Roundtable, Trainers of School Psychology, and NASP (Standards Workgroup & Graduate Education Workgroup). Through these activities the Academy contributes to the development and maintenance of school psychology practice at its highest level.

In addition to maintaining existing initiatives, the Academy revisited our status as a non-profit corporation, assisted the ABSP in the development of a mentor training video, and established a relationship with the Journal of Applied School Psychology, now the official journal of the American Academy of School Psychology.

Perhaps our proudest 2009 moment occurred at the ABPP Convocation when AASP Fellows, Walt Pryzwansky, received the 2009 ABPP Distinguished Service and Contributions to the Profession of Psychology Award and Jeff Miller received an exemplary service award from AASP and ABSP.

News from the Specialists

W. Michael Nelson, Professor of Psychology at Xavier University, was one of the winners of a Bronze Telly Award in the 30th Annual Telly Awards, out of 11,000 worldwide entries. The video series Captain Judgment is a multimedia, interactive series of video vignettes focusing on children’s management of aggression. It is designed to enhance the Coping Power Program, sessions informing parents on the material imparted to their children. The Coping Power Program itself is a joint effort of Dr. Nelson and Dr. John A. Lochman, both ABPP-certified specialists.

John C. Linton was presented with the A. M. Wellner Lifetime Achievement Award of the National Register for Health Service Providers in Psychology.

Daniel Holland is the recent recipient of two honors. He has been awarded an APA Presidential Citation by Dr. Alan Kazdin, as well as having attained Fellow status in the Association of Psychological Science (APS).

Robert W. Goldberg has been elected as Chair-Elect of the Veterans Affairs Psychology Training Council, the organization of all internship and residency training directors in the VA health care system.

Judith Coche has published the second edition of her work Couples Group Psychotherapy, incorporating research review, theory, clinical applications, and vignettes on couples work and her own model, couples group work. The book is published by Taylor & Francis. An associated work intended for the general public, The Husbands and Wives Club: A Year in the Life of a Couples Therapy Group, by Laurie Abraham, illustrates the principles in Dr. Coche’s book.
New Editor For The ABPP Specialist Sought

Nominations are being sought for the position of Editor of The ABPP Specialist. The Editor will be appointed for a four-year term, commencing in January 2011, which is once-renewable. The Specialist is published twice each year, with Winter and Summer issues. The Editor has overall responsibility for compiling the newsletter including (1) solicitation of submissions, including articles, regular columns, and contributions to Special Sections; (2) assigning manuscripts for review by the Editorial Board (an Associate Editor and two others); (3) interacting and communicating with authors, including acceptance/rejection decisions; (4) writing an Editor’s column; (5) consulting with the ABPP President regarding controversial submissions; and (6) overseeing the actual production of the newsletter, including: proofreading of article “raw” copy (hard or electronic) and of the entire issue prior to dissemination; preparing the table of contents; deciding on article emphasis and placement; coordinating with the Executive Officer on production logistics (ABPP Central Office, in coordination with a vendor, integrates files and concretely prepares the issue for publication). The Editor also serves as Chair of the Communications Committee, a standing committee of the BOT, with responsibility for The Specialist, and for recommending actions to facilitate ABPP communication with Specialists, member Boards and Academies, other organizations, and the public at large (listservs, the website, etc.).

The Editor must be an ABPP Board Certified Specialist in good standing. Previous editorial experience is desirable. The position carries no remuneration, although expenses are covered to attend the Annual Meeting of the Board of Trustees. Potential candidates should submit a brief statement of interest, together with a current Curriculum Vitae, to Dr. David Cox, ABPP, Executive Officer, at drcox@abpp.org or the ABPP Central Office address. Preliminary inquiries or further information about the position and its responsibilities can be provided by Dr. Cox, the current Editor Dr. Robert W. Goldberg, ABPP (at Emu34@aol.com), or ABPP President Dr. Nadine Kaslow, ABPP (at nkaslow@emory.edu).

Letter to the Editor:

Dear Editor:

The Specialist Winter 2009 issue carried an interesting article by Dr. Amberg. Because our great admiration, gratitude and affectionate respect for Russell Bent whose life we were honoring in that issue, some of us may not have paid sufficient attention to “The importance of board certification.” The article focused primarily on Organizational and Business Consulting Psychology but the importance of ABPP certification applies equally to all specialties and, with the necessary changes, what the author states about OBCP is relevant to all other specialties.

This is to emphasize that the states ignoring the relevance of ABPP Diplomates are weakening the profession and creating confusion about psychology as a whole. The 29 US jurisdictions that still do not recognize “the importance of board certification” may reconsider their decision and how it affects the profession nationally. They may move towards professional unity by joining the states that already accept the ABPP Diploma as evidence of training and professionalism over and above that required for the state license. They may reflect on the disadvantages of divisiveness in any organization. They will do us a great service.

The states that are actively contributing to the unification of the profession and deserve our thanks are California, Colorado, Delaware, Florida, Hawaii, Iowa, Louisiana, Massachusetts, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Dakota, Texas, Utah, Vermont and Virginia.

Until all states are in agreement with “the importance of board certification” psychology is not united and is wasting energy. The sad point is that we already have ABPP as the effective mechanism to make us stronger as one profession . . . and some states refuse to use this system.

Sincerely,
Daniel L. Araoz, Ed.D., ABPP
Newly-Certified Specialists
June 2009 – December 2009

Clinical
Catherine R. Ayers, Ph.D.
Dene S. Berman, Ph.D.
Michael J. Cuttler, Ph.D.
James Earnest, Ph.D.
Kimberly S. Finney, Psy.D.
Mitchell W. Hicks, Ph.D.
Cathy L. McDaniels Wilson, Ph.D.
Mikel M. Merritt, Ph.D.
Laura L. Meyers, Ph.D.
Michael T. Mosko, Psy.D.
Randy K. Otto, Ph.D.
Donald R. Pake, Jr., Psy.D.
Robin S. Rosenberg, Ph.D.
Katherine L. Sellwood, Psy.D.
Patrick O. Smith, Ph.D.
Matthew W. Turner, Ph.D.
John M. Wryobeck, Ph.D.

Clinical Child
& Adolescent Psychology
Marni E. Axelrad, Ph.D.
Daniel M. Bagner, Ph.D.
Ann M. Davis, Ph.D.
Deborah A. Engerran, Psy.D.
David J. Kolko, Ph.D.
Michael W. Mellon, Ph.D.
Diane E. Rosen, Ph.D.

Clinical Health
Andrew R. Block, Ph.D.
Arthur M. Nezu, Ph.D.
Sara E. Rosenquist, Ph.D.
Jared L. Skillings, Ph.D.

Clinical Neuropsychology
Garrett W. Andrews, Psy.D.
Barry R. Ardolf, Psy.D.
Sharon B. Ashman, Ph.D.
Bryan A. Bernhard, Ph.D.
Kyle R. Bonesteel, Ph.D.
Erica M. Brandling-Bennett, Ph.D.
Michelle M. Braun, Ph.D.
James E. Bryan, Ph.D.
Kendra A. Bryant, Ph.D.
Robyn M. Busch, Ph.D.
Jennifer E. Cass, Ph.D.
Christine A. Clancy, Ph.D.
Jill M. Dorflinger, Ph.D.
Bryan M. Freilich, Psy.D.
Jennifer L. Gess, Ph.D.
Melanie C. Greenaway, Ph.D.
Monica L. Jacobs, Psy.D.
George R. Jewell, Ph.D.
Jose M. Lafortune, Ph.D.
Dongwook Lee, Ph.D.
Caitlin E. Macaulay, Ph.D.
Karin J. McCoy, Ph.D.
Vaishali S. Phatak, Ph.D.
Jonathan E. Romain, Ph.D.
Michael J. Sharland, Ph.D.
Ann B. Sollinger, Ph.D.
Peter L. Stavinoha, Ph.D.
Rachel Burmeister Tangen, Ph.D.
Janine A. Tiago, Ph.D.
Robert J. Weniger, Ph.D.
Bryan P. Yochim, Ph.D.

Cognitive & Behavioral
Deirdre A. Conroy, Ph.D.
Jonathan H. Hoffman, Ph.D.
Daniel C. Marston, Ph.D.
Katherine L. Muller, Psy.D.
Sheila A. M. Rauch, Ph.D.
Simon A. Rego, Psy.D.
Bradford C. Richards, Ph.D.
Emerson Wickwire, Ph.D.

Couple and Family
Jack A. Apsche, Ed.D.
Steve M. Kadin, Ph.D.
Nadine J. Kaslow, Ph.D.

Forensic
Stacey N. Fiore, Psy.D.
Daniel M. Krauss, Ph.D.
Rose M. Manguso, Ph.D.
Kara E. A. Marciani, Psy.D.
Rebecca V. Stredny, Psy.D.

Group
Jeanmarie Keim, Ph.D.

Organizational & Business
Consulting
Joseph G. Cutchliffe, Ph.D.

Psychoanalysis
Michael Libertazzoo, Ed.D.
Joanne T. Marengo, Ph.D.

Rehabilitation
Charles H. Bombardier, Ph.D.
Jeanne M. Hoffman, Ph.D.
Elizabeth A. Latsch, Ph.D.
Kristen Brewet Sherman, Ph.D.
Meredith J. Tackett, Ph.D.
Aaron P. Turner, Ph.D.
Philip M. Ullrich, Ph.D.
Shelley A. Wieseman Askay, Ph.D.
Rhonda M. Williams, Ph.D.

School
Robyn S. Hess, Ph.D.
Tony C. Wu, Ph.D.

Deceased Specialists
June 2009 – December 2009

George W. Briggs, Ph.D.
Maureen Maher Christian, Ph.D.
Edith Freund Kaplan, Ph.D.
Leah Blumberg Lapidus, Ph.D.

Revocations
Kerry deS. Hamsher, Ph.D.
Franklin P. Knill, Jr., Ph.D.
Roy A. Nisenson, Ph.D.
For the past 60 years, the American Board of Professional Psychology (ABPP) has been the premier credentialing agency for psychologists. ABPP is increasingly recognized as a highly valuable standard of specialty competency through the board certification process. For specialty recognition, some jurisdictions require ABPP certification, with more states getting involved each year. Additionally, there is increasing recognition of the importance of the ABPP credential by employers such as hospitals and health service systems, and organizations such as the US Public Health Service, the US Department of Defense, and the Department of Veteran Affairs.

This edited book provides a comprehensive description and hands-on, practical guide for individuals seeking certification from any one of the 13 specialty boards of the American Board of Professional Psychology. The book contains answers to frequent areas of inquiry and questions posed by potential candidates. In addition to providing a brief description of the history and mission of ABPP, the book offers step-by-step information concerning the “where, what, and how” of the board certification process. Finally, never-before offered information is provided, such as what pitfalls to avoid, and how to get further involved in the profession as a board certified psychologist.

Christine Maguth Nezu, Ph.D., ABPP, is Professor of Psychology and Medicine at Drexel University. She is President of the American Board of Professional Psychology (ABPP), a member of the Board of Directors for the American Board of Cognitive and Behavioral Psychology, a Fellow of the American Academy of Cognitive and Behavioral Psychology, and a Fellow of the Academy of Cognitive Therapy.

A. J. Finch, Jr., Ph.D., ABPP, is Professor of Psychology and former Dean of Humanities and Social Sciences at The Citadel. He is the current Past-President of the American Board of Professional Psychology (ABPP) and a member of the Board of Directors for the American Board of Clinical Child and Adolescent Psychology. He is former President of the American Board of Clinical Psychology.

Norma P. Simon, Ed.D., ABPP, is Former President Association of State and Provincial Psychology Boards, Emeritus Director of Training Programs for the New Hope Guild Centers, New York. She also maintained a private practice in New York City for many years.