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President’s Column
Gregory Lee, PhD, ABPP

Over the past six months, the ABPP boards, academies, committees, workgroups, and central office staff have continued their hard work and productivity. For the first time in years, ABPP has held a second board of trustee’s (BOT) meeting in July of this year. The crowded agenda for this mid-year BOT meeting reflected the enormous amount of work that has been accomplished in recent months and the following are some of the highlights:

Maintenance of Certification (MOC). The MOC workgroup has met monthly since the annual December meeting, including a face-to-face meeting in April in Philadelphia. The workgroup has further developed the MOC grid and narrative forms; constructed reviewer rating forms; created a specialty board implementation tool kit; written the proposed MOC procedures into the Standards Committee manual; and, developed a “waiver” policy recommendation for current specialists. The current ABPP BOT goal is for all specialty boards to begin implementing MOC in January 2015. The workgroup has put forth several recommended motions for a BOT vote in July including the following summary statement:

“All specialists certified after January 1, 2015 must successfully complete renewal of certification every ten years to maintain their current ‘ABPP certified’ status. Specialists certified before January 1, 2015 may waive the requirement that they renew their certificate.”

After the BOT votes on the current status of the various MOC documents, it will be time for each specialty board to begin to decide upon specific MOC criteria and procedures for their specialty area. We all owe a large debt of gratitude to the members of the MOC Task Force chaired by Michael Tansy (with Chris Nezu, Charme Davidson, John Northman, Brenda Douglas, Deborah Attix, Randy Otto, Kathryn Korslund, and David Cox).

Central Office has been evaluating SharePoint software as an information technology platform for streamlining and consolidating various Specialty Board activities. Specialty Boards will have their own password protected “site” within the ABPP website where applications will be posted securely for access by reviewers who can hold a discussion regarding any issues needing to be addressed and provide a final review and recommendation. There will also be “team sites” for each of the various ABPP BOT committees and workgroups to facilitate their work. It is hoped that SharePoint will come to be used by Specialty Boards to access and review practice samples. Concerns were raised that some hospital and governmental systems may not allow access to, or be compatible with, SharePoint, particularly the VA system. We will need to find out if there are any limitations in accessing this software.

The new ABPP competencies will start being integrated into our Specialty Board examination criteria, procedures, and manuals over the next year or two, but definitely by the time of a Specialty Boards Periodic Comprehensive Review (PCR). Clinical Psychology and School Psychology have already accomplished this for their manuals and are using them in their current exams. Both the Clinical and School Specialty Boards offered their manuals as models to be used by other Specialty Boards as needed.

The Board/Academy Workgroup has developed a brief summary document containing bullet points to assist Specialty Boards and Academies in deciding the best model for academy affiliation with ABPP; that is, whether an academy should be merged, internally, or externally into the ABPP infrastructure.
The selection process for the next Public Member BOT representative is now complete. We are delighted to introduce Jeanne M. Galvin, J.D., the Assistant Attorney General with the Arizona Attorney General’s Office. Jeanne’s biography and photo are included in the New Leadership Appointments section of this issue of the ABPP Specialist Newsletter. Jeanne was selected from a pool of five excellent candidates all of whom were nominated by distinguished sources and all were highly qualified for the role. Jeanne will begin her term in January 2014. She will be urged to attend the December 2013 BOT meeting so that our current public member, Brenda Douglas, can provide her with a comprehensive orientation to ABPP.

Discussions among the Specialty Board Presidents, executive committee, and the BOT have been held as to whether ABPP should offer time-limited financial support to the ABPP Foundation. It has been the general feeling among these constituencies that ABPP should support the foundation in this manner.

Some of the important highlights of the past six months include:

- The BOT voted in June to accept Geropsychology’s implementation plan to become affiliated with ABPP as its 15th specialty board, and American Board of Geropsychology (ABGero) now moves on to the final monitoring phase before a final BOT vote for affiliation.

- ABPP’s Summer Workshops was a success in Boston, July 10-13, and planning for the next ABPP workshop series to be held in Chicago (May 14-17, 2014) has begun. Contact Randy Otto for suggestions regarding content for the Chicago meeting.

- Police & Public Safety has been recognized by the Commission for the Recognition of Specialties and Proficiencies in Professional Psychology (CRSPPP) as a specialty in psychology!

- ABPP submitted its application in February to become recognized by CRSPPP as an organization that provides specialty certification in professional psychology, and CRSPPP voted to accept ABPP as their first recognized specialty certification organization. The APA Council of Representatives will now need to vote on CRSPPP’s recommendation.

Upcoming Event Reminders:

- ABPP Annual meeting – Thursday, December 5-Saturday, December 7, Chapel Hill, NC

I’d like to thank all of our hardworking Central Office staff, Board of Trustees, Committee and Workgroups, Specialty Boards, and Academies for continuing to work diligently on increasing the visibility of the ABPP board certification process. ABPP’s application rate continues to increase, and our collaboration with other important educational, training, and credentialing organizations in psychology continues to grow. I look forward to working with all of you in the coming year to maintain the positive trajectory that ABPP is following. As in prior years, please feel free to contact me with your feedback and suggestions at any time at, glee@gru.edu.
CEO Update

By David R. Cox, PhD, ABPP

Executive Officer

Work on a New Technology Platform

We are working with a consultant on a project to facilitate the review of credentials, and perhaps practice samples, through the use of a technology platform called SharePoint. Many of you may have used this before, as it is used within APA by many committees for the dissemination of materials to the committee members. The platform is now an integrated part of Office 365, which is also being used by Central Office. The SharePoint platform will allow for uploading of credentials for review to one central repository for the specialty board reviewer(s) to access. Each specialty board will have its own “site” onto which applications will be posted securely for access by reviewers who can hold a discussion regarding any issues needing to be addressed, and provide a final review and recommendation. The platform is being prototyped for ABPP use and the ABPP Board of Trustees had a chance to see a prototypical use at the meeting recently held in Boston in conjunction with the Summer Workshop Series. Pending BOT approval to proceed, Central Office will start administering the site for specialty board credential reviewers and will also facilitate establishing a “team site” for each of the various ABPP BOT committees and workgroups. It is our hope that SharePoint will eventually supplant emailing materials back and forth, and also allow for a more collaborative online communication process for review of materials, editing of documents for committees and eventually for access to and review of practice samples.

ABPP continues to grow – ABGero; PPSP recognition; ABCN subspecialty in peds

Recently, the BOT voted to advance the American Board of Geropsychology (ABGero) to the implementation phase of affiliation with ABPP. This means that the geropsychology SB is in the process of completing the examination of the initial founding board members and the subsequent examination of at least 30 other psychologists that is necessary for final, formal affiliation with ABPP. We are pleased that this group has established the examination process and is proceeding in examination of specialists in the field of geropsychology. Geropsychology has already been recognized by the APA Committee of Recognition of Specialties and Proficiencies in Professional Psychology (CRSPPP) and is a member of the Council of Specialties (CoS). ABPP affiliation will complete the “trifecta” of recognition by these groups.

Also completing that trifecta recently was Police & Public Safety Psychology (PPSP). That specialty was recognized a couple of years ago by ABPP and was at that time encouraged to seek recognition by CRSPPP and seek a seat on CoS. This spring, CRSPPP indicated support of Police & Public Safety Psychology as a specialty, the CRSPPP recommendation was supported by the APA Council of Representatives in a vote this summer, and CoS extended the invitation to PPSP to sit on CoS (which was, of course, accepted).

Finally, the American Board of Clinical Neuropsychology (ABCN) has put forth a request to proceed with establishment of the first subspecialty within ABPP – that of Pediatric Neuropsychology. This request is under review by the ABPP Board of Trustees as of this writing. We are all encouraged by the diligent work of many in the efforts to establish a subspecialty.

Further details about all of the above groups’ efforts can be found either elsewhere in this newsletter and/or in forthcoming issues of the Specialist. Kudos to each for their work and success!
ABPP Recognized by APA Committee on Recognition of Specialties and Proficiencies in Professional Psychology (CRSPPP)

In early June, ABPP received notification from the Education Directorate of APA that our application to be recognized by APA as an organization that provides certifications in specialties and proficiencies in professional psychology has been approved for a period of seven years. ABPP becomes the first such organization so recognized, and is a significant stride in the profession. CRSPPP has long recognized areas of psychology, but this is the first time that an organization credentialing specialists has been recognized by APA.

APA members who hold a credential from ABPP will be allowed to list that credential in the membership directory. It should be noted that some ABPP specialty areas are not CRSPPP recognized (and CRSPPP recognizes the specialty of Geropsychology, which is just now in the process of ABPP affiliation). This underscores the importance of getting the whole of the profession “on one page” and reiterates the need for ABPP specialties that have not applied to or proceeded through the CRSPPP process to begin that effort.

Maintenance of Certification (MOC)

ABPP specialists have been reading and hearing about the work of the Maintenance of Certification (MOC) workgroup for some time now. This process has been in development for several years and is described elsewhere in this issue of the Specialist. Rather than go into detail about the history and/or current status of this, I refer you to that article. I do want to recognize and thank the members of the MOC Workgroup for their hard work on a topic that allows for a broad array of thoughts, opinions and concerns. Having watched the emails fly back and forth between their meetings, I know that this group of people has spent countless hours, put in tremendous thought and consideration and responded to many, many comments from ABPP specialists and others as they brought the proposal forward. Wanting to be sure that the workgroup was not doing a “thankless job”, I want to say “Thank You” to Michael Tansy (Chair), Deborah Attix, Charme Davidson, Brenda Douglas, Kathryn Korslund, Christine Maguth Nezu, and John Northman. Thank you!

Summer Workshops

ABPP once again hosted a series of workshops for continuing professional development of psychologists. This year, we held the workshops in Boston and had many exciting presentations. Among them: Alina Suris, PhD, ABPP presented on the DSM-V; David Barlow, PhD, ABPP and James Boswell, PhD presented on the Unified Protocol for the Transdiagnostic Treatment of Emotional Disorders; Victor Molinari, PhD, ABPP and colleagues presented on Geropsychology. Also included were a variety of workshops on legal and ethical issues (presented by Gerald Koocher, PhD, ABPP; Kirk Heilbrun, PhD, ABPP; Jeffrey Younggren, PhD, ABPP), and many other topics.

See https://www.abpp.org/files/Workshop/Full%20Brochure.pdf to see what you missed if you were not there, and expect to see more prominent specialists and topical presentations next year when ABPP holds its workshop series in Chicago May 14-17, 2014.
**BOT Meeting in July – long time since ABPP did 2 in one year**

The recently held ABPP Workshop Series overlapped with the first mid-year Board of Trustees meeting that ABPP has had in quite some time. Recognizing that our continued growth and efforts requires more than one board meeting annually, the BOT voted to initiate meeting in conjunction with the workshops in order to facilitate business, engage ABPP governance in the workshop series, and further encourage participation of specialty boards at all levels – presentation, representation in governance and, for several boards, examination of candidates for board certification. We are continuing to request that specialty boards attempt to schedule examinations and/or board meetings in this fashion as it does permit for interaction and cross-fertilization of specialty boards in a unique way.

**APA/ABPP CE Collaboration**

Speaking of the ABPP Workshop Series, we explored a new and exciting avenue for continuing education this year by teaming up with the APA Office of Continuing Education to collaborate on video recording of some of the workshops. These will be made available online in the near future for viewing and as a means of obtaining CE. We are very pleased to have been able to do this as a joint venture with APA. Recognizing the high quality of the ABPP presenters, APA sought this collaboration with ABPP as a “win-win” in the efforts of each organization to get quality education and professional development materials distributed more widely and with more flexibility to the consumer than “date-certain” continuing education workshops can provide. We will review the joint efforts, with hopes that this will prove to be a venture worth continuing into the future. Watch for emails and ABPP website posting of information about accessing the online educational series.
The main focus of CPPSA for the past several months has been the similarities and differences between external, internal, and merged (unified with examining board) academies. (The current status of academies is six external (Clinical, Clinical Neuropsychology, Counseling, Couple & Family, Forensic, Rehabilitation), 2 internal (Clinical Health, School), and 5 merged (Cognitive & Behavioral, Clinical Child & Adolescent, Group, Psychoanalysis, Police & Public Safety).) I worked with Greg Lee to define some of the differentiating details (such as whether merged/unified academies could have members), and our work clarified the questions that still needed to be answered. Some of these answers were forthcoming at the May Board/Academy Relations Group 2 (BARG2) meeting, and these were announced to all academies.

In the course of these discussions, I proposed some principles that might be used to define an ABPP academy, and these were discussed by CPPSA members. Since merger means that a separate academy no longer exists for that specialty, the most far-reaching issue for CPPSA is what or who is being represented if that specialty participates in CPPSA. One possible implication is that CPPSA may focus more on how academies and academy interests in merged groups can “get the academy job done” in addition to the traditional focus of representing and protecting the interests of academies. In the spirit of this sharing of ideas, I compiled a list of many of the various activities that the different academies engage in and sent it out to all academies, as a stimulant for brainstorming.

My goals for CPPSA are to encourage more communication and sharing of ideas among academies, to help academies that have no informational page on abpp.org to create one, and to assist any academy that wants to have an independent website to create one. (Clinical, Clinical Neuropsychology, Forensic, Cognitive & Behavioral, Clinical Child & Adolescent, and Couple & Family currently have their own websites.)

ABPP Central Office Update

We appreciate all you do in supporting ABPP board certification.

This time of year is a particularly busy time in Central Office, as we have just wrapped up the 4th annual ABPP Summer Workshop Series that was held in Boston, MA. If you attended, we welcome your feedback to assist the Central Office in planning for the 5th in the series scheduled May 14th – 17th in Chicago, IL.

For the third year in a row, abpp.org hosted the online registration and online continuing education evaluations for the 15th Annual Rehabilitation Psychology Conference, held Feb 21st -24th at the Omni Jacksonville Hotel. It was a great success!
Ongoing Central Office Projects:

Good news, if you are Board Certified with us, our staff is just a CLICK away to serve you on the web. Please review The ABPP SPECIALIST section of www.abpp.org carefully as there are changes, updates, and new features and information. Here are just a few:

1. ABPP Specialist members are now able to login online to obtain a verification of their board certification. Under ABPP Specialist you will find “VERIFICATION FOR ABPP SPECIALIST” on the left hand side of the screen. Using this directory search will provide a listing of a psychologist that is a current board certified psychologist through the American Board of Professional Psychology (ABPP). The results provided indicate in which specialty(ies) an individual is board certified. The information in our database is continuously updated and results may be considered to be primary source verified.

2. ABPP Specialists can now login online to order an additional ABPP Certificate. Under ABPP Specialist you will find “ABPP CERTIFICATE ORDER” on the left hand side of the screen. Be sure to review your information and submit the $35 fee. Your certificate may be expected to arrive in approximately 6-8 weeks.

3. If you are ABPP, and you’d like to apply to another specialty board, ABPP Specialists have their own “ABPP SPECIALISTS APPLICATION”. There is no additional application fee, however the ABPP Specialist application and Online Specialty Specific Form (Part 1) must be completed by the specialty board.

4. ABPP Specialist members can now go online to make updates to a member’s specific “member” profile 24 hours a day. Once a user logs in under ABPP SPECIALIST, he or she can follow the systematic prompts that enable the member’s editing profile web feature. Note: Be sure that state licensure information is current, as well as, the doctoral degree, educational institution, and the date of award of the degree.

5. If you are an ABPP Specialist and you cannot log in, it may be due to the fact that your 2013 attestation has not been submitted. If this is the case, please contact our office at office@abpp.org to verify payment of dues.

6. Need a RECEIPT? You can view/print/email yourself receipts now! To do so, login to your account under ABPP Specialists. Click on “Receipts” (on the burgundy bar). There you will be able to view/print/email the receipt you are requesting.

7. The Specialist newsletter, current and prior years are posted on our website for your convenience.

Be sure to check out the ABPP Specialists webpage to see what’s new and improved!

Special Note: If you are an APPLICANT OR CANDIDATE, please do not attempt to login under MEMBER LOGIN or ABPP Specialists. Many questions come from applicants and candidates saying they cannot login and that is because they need to go to the ‘APPLICANT’ portal and login under CANDIDATE INFORMATION.

If you would like more information or details regarding any of the above information, or if you have suggestions to share, please contact the Central Office at office@abpp.org. We value your feedback. Thank you.
This issue of the Specialist includes in the “Letters-to-The Editor,” the published work of several of our esteemed colleagues who are building the credibility of ABPP through recent distinguished book publications. As is our ongoing ABPP policy, CEU credits for reading and studying the full length articles are a free continuing education benefit that ABPP provides to Specialist Newsletter subscribers.

Consider logging on to our Facebook page where we are frequently posting material about ABPP and its activities. Our Facebook page is located at: http://www.facebook.com/pages/American-Board-of-Professional-Psychology/126100780742857?ref=ts&v=wall%20

If you desire to submit an article for the Specialist, don’t hesitate to send me an email at robert.hill@und.edu. I would be delighted to dialogue further with you about your ideas.

Below are the standing Specialist submission guidelines.

1. The theme and content of submitted articles should be consistent with ABPP interests and issues: specialization, credentialing, board certification, identification and development of specialty areas, etc., or to the specific interests of ABPP-certified specialists. Articles with content of more general interest, or unrelated to the above topics, should be submitted elsewhere. Questions regarding suitability for the Specialist and other questions may be directed to the Editor, Dr. Hill, at robert.hill@und.edu.

2. The BOT, Editor, or Communications Committee may initiate requests for submissions on particular themes and topics, for inclusion in Special Sections of grouped articles.

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

4. Submissions may be of any length, but are typically between 5 – 15 pages of word processed text.

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

6. Submissions should be made by e-mail attachment in Word to the Editor’s attention at thespecialist@abpp.org. The submission attachment document itself should clearly identify the author(s).

7. Article submissions will be subject to review and acceptance or rejection by the Editorial Board. Authors may be asked for revisions based on the review.

8. Submissions or letters to the Editor with particularly controversial content may be referred through the Communications Committee to the Executive Officer and the BOT for possible further recommendation or action.
The Maintenance of Certification (MOC) Work Group originated several years ago from the American Board of Professional Psychology (ABPP) Board of Trustee’s (BOT) Standards Committee. Currently, the Maintenance of Certification Work Group currently is comprised of Michael Tansy (Chair), Deborah Attix, David Cox, Charme Davidson, Brenda Douglas, Kathryn Korslund, Christine Nezu, and John Northman.

The BOT charged the Work Group with the responsibility to develop a model and timeline for implementation for a means by which ABPP renews the certification of specialists. In December 2012 the BOT accepted a proposal to “institute the MOC protocol” for renewal that included “the use of a grid and a narrative,” as well as a “face-to-face review…limited to outlier cases, as defined by each Specialty Board, with review and consultation by the ABPP Standards Committee.” Further, the BOT determined that “each board should develop standards for renewal, remediation, or nonrenewal, with multi-level appeal mechanisms defined for the Specialty Board and ABPP.” Further, in December 2012 the BOT charged the MOC Work Group with the responsibility for “further development of the process and its fiscal implications.”

Since the December 2012 BOT meeting Mary Hibbard resigned from the MOC Work Group and two members from the Standards Committee (Deborah Attix and Kathryn Korslund) were added. The MOC Work Group Chair oriented Drs. Attix and Korslund to the MOC Work Group history and current topics through telephonic outreach and review of supporting MOC Work Group documentation.

On 1/19/2013, 2/16/2013, 3/27/2013 and 6/1/2013 the MOC Work Group met telephonically to discuss the feedback from the BOT and to continue to develop the MOC model and timeline. Additionally, the MOC Chair met telephonically with the ABBP Specialty Board Presidents, Academy Board Presidents, and the ABPP EC updating them on MOC Work Group activities when asked. Also, the MOC Work Group submitted and published an article, Update from the ABPP Maintenance of Certification Work Group, in the winter 2013 issue of the Specialist.

During January the MOC Work Group developed a six-item survey regarding demands the MOC renewals may place on specialty boards, specialty boards thoughts about the number of reviewers necessary for their MOC review, thoughts about what would constitute a “pass” or “needs further review,” what Central Office and MOC Work Group support Specialty Boards would need for successful MOC implementation, whether they anticipated or received any “push back” regarding implementation, how they may have handled any “push back,” and what thoughts they had on how they might handle future “push back” regarding MOC implementation. This survey was distributed to all specialty board presidents and all specialty board presidents replied. This Specialty Board Presidents’ information was distributed to all members of the MOC Work Group as it was received from specialty board presidents. Also, for the twelve specialties who replied by late March, their responses were summarized and distributed to the MOC Work Group by Charme Davidson before the MOC Work Group met April 4-6, 2013.
Additionally, on March 28, 2013 the MOC Work Group sent an email to all ABPP specialists describing the activities of the MOC Work Group. In this outreach to specialists, they were asked to read the winter 2013 Specialist article, offer comments to their respective Specialty Board and Academy President, and to submit email feedback to MOC Work Group. Since seeking input, the MOC Work Group has received dozens of specialists' comments that were summarized in a single document by Michael Tansy, distributed to the MOC Work Group, and discussed via email, in person, and telephonically. Also, these specialists' comments were distributed to the ABPP leadership so that they may have a first-hand familiarity with Specialists' concerns regarding maintenance of certification.

The MOC Work Group met in Philadelphia April 4-6, 2013 to advance the mission of implementation of MOC, while maintaining appropriate attention to feasibility, integrity, acceptability, and reasonableness with an eye toward success. In attendance at this 2 ½ day meeting were Michael Tansy, Deborah Attix, Charme Davidson, Kathryn Korslund, John Northman, and Randy Otto, who attended in place of David Cox. Because of his considerable contributions, the MOC Work Group encouraged Randy Otto's continued membership on the MOC Work Group.

In a snapshot, since December 2012 the MOC Work Group:

- Sought, summarized, reviewed and considered feedback from the ABPP EC, specialty boards, academies, and specialists
- Met telephonically on 1/19/2013, 2/16/2013, 3/27/2013and 6/1/2013, and in person April 4-6, 2013
- Discussed and proposed that all specialists certified after January 1, 2015 will be required to renew their specialty board certification every ten years
- Discussed and proposed that all specialists certified before January 1, 2015 may waive the requirement for renewal of certification
- Discussed and proposed that Specialty Boards must allow specialists certified before January 1, 2015 to renew their certification, allowing all current specialists the option to renew their certification beginning January 1, 2015
- Discussed the certification procedure for multiple-boarded specialists, recommending a one-time submission that satisfies multiple-boards simultaneously
- Discussed and agreed on updated versions of the maintenance of certification grid, narrative, and rating instruments for specialty board use
- Discussed and agreed that Specialty Boards must adopt the grid and narrative as a model for maintenance of certification, but Specialty Boards may adopt maintenance of certification requirements beyond the generic model proposed
- Discussed and recommended that maintenance of certification is to be managed to the maximum extent possible electronically through central office personnel
- Developed a Specialty Board Maintenance of Certification Implementation Tool Kit with suggested procedures and recommended Specialty Board manual changes
- Crafted recommended language for the ABPP BOT Standards Manual pertaining to maintenance of certification
- Considered financial and staffing implications for this proposed plan
- Discussed and recognized the authority of the Board of Trustees over Maintenance of Certification, through advisement of the Standards Committee
- Discussed the importance of “hands on” collaboration between the MOC Work Group and Specialty Boards during the implementation phase
- Discussed recommended next steps for Maintenance of Certification implementation
As a result of these activities, the Maintenance of Certification Work Group offered several recommendations that were adopted by the ABPP Board of Trustees on July 13, 2013 in their governance meeting in Boston:

“All specialists certified after January 1, 2015 must successfully complete renewal of certification every ten years to maintain their current 'ABPP certified' status.” "Specialists certified before January 1, 2015 may waive the certificate renewal requirement."

"Before January 1, 2015 Specialty Boards must allow renewal of certification for specialists certified before January 1, 2015."

"The Maintenance of Certification Grid and Narrative and their respective rating instruments be adopted for use by all specialty boards as a generic template for renewal of certification."

"Specialty boards may modify the Maintenance of Certification Grid and/or Narrative for the purpose of specialty-specific requirements with the approval of the ABPP BOT."

"The MOC Work Group serves in a consultative role to specialty boards for the purpose of implementation, including modifying Specialty Board bylaws and manuals, as needed."

**Fall 2013 MOC Work Group activities**

Having completed its development and obtained approval of the ABPP Maintenance of Certification model, the focus of the MOC Work Group anticipates shifting our focus and purpose toward assisting specialty boards with implementation of maintenance of certification by January 1, 2015. In order to accomplish this task, the work group will focus on several topics they plan to forward to the Board of Trustees for consideration at the December 2013 Governance Meeting, including:

- A Maintenance of Certification Specialty Board Implementation Toolkit
- Recommended Maintenance of Certification-related changes to the Standards Committee Manual
- A recommended budget line item for Specialty Board Maintenance of Certification implementation activities
- Recommended funds for the development and maintenance of the electronic management of certain MOC activities

When Specialty Board Maintenance of Certification implementation is complete, the BOT must consider whether it is necessary to change its structure to add an additional entity charged with the responsibility to manage ABPP Maintenance of Certification or whether ongoing Maintenance of Certification activities are subsumed under an existing ABPP committee, sun-setting the current MOC Work Group. As we have done in the past, the MOC Work Group anticipates continuing the inclusive iterative process of reaching out to all levels of the ABPP organization, seeking input, and adjusting the certification renewal model. As always, we eagerly seek your input, guidance, and support.
Imagine a future in which ABPP is uncompromisingly recognized as an essential standard by our colleagues in psychology and across all disciplines, hospitals, insurance companies, courtrooms, state jurisdictions, and consumers of psychological services.

Such an aspiration requires an uncompromising mission to educate peers and the public, and support new ABPP Board-Certified specialists. It requires dedication and advocacy. Most of all, it requires financial commitment and investment in the future of board certification in psychology.

The ABPP Foundation Board of Directors, Drs. Florence Kaslow (Vice Chair/Chair Elect), Ted Packard (Secretary), Charme Davidson (Treasurer), G. Andrew Benjamin, Thomas J. Boll, Kirk S. Heilbrun, Norma P. Simon, and I invite you to join us in our journey toward our future.

Our Beginning

The American Board of Professional Psychology (ABPP) Foundation was formally recognized in 2010 by the Internal Revenue Service (IRS) as a charitable 501c3 organization established to provide a specific venue of support for ABPP. Our major purpose is to provide individuals or groups with the opportunity to make tax deductible contributions for charitable and educational activities directed toward continuing professional education and development for specialty practice in psychology, with the ultimate intent of improving the health and well being of the general public.

Development of Our Mission

In July 2012, following recommendations from the ABPP Board of Trustees, an ABPP Foundation Board that was separate from the administrative leadership of ABPP was established. Joined by an expanded full ABPP Foundation Board of Directors in October 2012, we worked to develop the infrastructure necessary to create an affiliated and viable charitable organization with the following mission:

The mission of the ABPP Foundation is the promotion of competent specialty practice and specialty board certification, the protection of the public through providing educational opportunities in the form of scholarships and assistance to training programs, and provision of continuing professional development. The Foundation supports educational programs to promote the importance of psychology board certification to the general public and related professions. To achieve this goal, the mission of the Foundation includes raising funds. No earmarked funds can be used for any purposes other than those by which they have been designated.

Our First Active Year

Our ABPP Foundation Board has had an active initial six months as a full board. Prior to January 2013, a small initial board received nominations for additional board members. After a review process and vote, we received approval from the by ABPP membership, represented by the ABPP Board of Trustees, and invitations were extended to bring our ABPP Foundation Board membership to its current number of 8.
Highlights of our initial efforts to build a strong board infrastructure included the following activities:

- A founding donors campaign resulted in raising over $20,000. A permanent sign designating donors for this campaign as Founding Fellows of the ABPP Foundation was compiled and printed as a display for future convention and conference exhibitions, promotional campaigns, and other outreach.
- Invitations were extended to an initial core of prominent specialists designated as “Ambassadors,” many who agreed to participate in future fundraising activities. We currently have a roster of 28 ABPP Foundation Ambassadors. Our goal for the coming year is to have an Ambassador in every state. The role of ABPP Foundation Ambassadors, is to assist the Board of Directors of the ABPP Foundation in fundraising and development, by providing consultation, organization of projects for fundraising, and to conduct outreach to all ABPP specialists to give generously. For example, several Ambassadors may work collaboratively with the board to organize a specific activity or event, such as hosting a tea, cocktail reception, or specialty conferences, and/or inviting other specialists for coffee or lunch; these initiatives provide our colleagues with the opportunity to learn about us and all of the important reasons for becoming donors. Ambassadors will also be involved in future advocacy efforts and asked to send out letters and news alerts that we will develop in the future to advocate and promote ABPP specialty board certification. Please let us know by contacting Dr. Chris Maguth Nezu (cmnezu@verizon.net) if you are interested in being considered for appointment as an Ambassador.
- Our ABPP Foundation By-laws were carefully reviewed, revised, edited, and unanimously passed.
- A fiscal policy committee, chaired by Dr. Kirk Heilbrun, drafted our policy statement concerning administration, management and associated fees for earmarked funds. This policy was recently approved, and will be disseminated to the ABPP Specialty Board and Academy Leadership this summer.
- A Conflict of Interest Attestation was constructed and approved, and subsequently signed by all members of the Board of Directors.
- Donation outreach forms and new contribution levels were developed, approved, and uploaded to the [ABPP Foundation page](http://www.abpp.org/i4a/pages/index.cfm?pageid=3577) on the ABPP website.
- A new memorial fund was developed consistent with the new levels of giving policy (The Eileen Gupton Fund, established by the Police and Public Safety Specialty Board and Academy).
- The Foundation Board Chair and Treasurer each met with representatives from several ABPP Specialty Academies to gain information and negotiate plans to move forward with these funds in the future.
- The President and Treasurer met with the ABPP Executive Officer to discuss ways in which the ABPP Foundation and ABPP Central office may be coordinated with future personnel that serve as administrative staff. An initial list of duties regarding office tasks, accounting, conference preparation and communications was developed, and a job description for future foundation administrative staff was written. Dependent upon incoming donations and support, the board would like to fill this position by October 2013.
- The ABPP Foundation Board has held six telephonic meetings over the past year (four in 2012) and 2 in 2013, with additional meetings planned for the remainder of 2013.

Our Philanthropic Activities to Date

Despite very limited funds, with the generous voluntary contributions of time from the members of the Foundation Board of Directors and the significant administrative contributions of Lanette Melville and Nancy McDonald from the ABPP central office, we have continued our efforts toward development and philanthropy in meaningful ways during the past year:

- A reception was sponsored for workshop presenters, founding donors and staff at the July 2012 CE Conference in Philadelphia. Much was learned from this event regarding the planning of future events and outreach efforts.
- A founding donors campaign was implemented and 88 individuals responded to this initial outreach, however, it fell far short of its $50,000 goal.
- A permanent Founding Fellows sign was constructed and will be on display at all events, as well as on the website.
• The Foundation will support the summer CE conference in Boston, July 2013, by providing a display table with brochures and personal outreach to all participants.
• The Foundation donated funds to support adjacent booths with ABPP at the APA convention July/August, 2013 in Hawaii. This fund raising activity is made possible by the volunteer efforts of Foundation Board members and Ambassadors who are donating their time to staff the exhibit.
• A promotional brochure was developed that describes the mission and future vision of the Foundation.
• Additional materials to provide incentives for our generous donors, such as convention badge ribbons, certificates, and plaques have been designed and are “in press.”
• A “Wall of Recognition” was developed and uploaded to the website that listed the 2013 donors to date under the relevant donor categories. The “Wall” will be updated quarterly.
• The Board has planned to provide a competitive ABPP Diversity Scholarship in the form of a full reimbursement of application and examination expenses in the coming year to an applicant from an underrepresented multicultural group, who has successfully passed their oral exam. Nominations will be solicited from across ABPP Specialty Boards.
• The Chair of the Foundation Board extended the Board’s gratitude to our 2013 donors. Additionally, all donors were invited to participate in focused interviews to learn of their hopes and visions for the future of the ABPP Foundation. We have learned from these interviews that in addition to expenditure of funds for board certification scholarships and continuing education sponsorship, our donors have collectively provided us with a mandate to build the advocacy focus of our mission. As such, we have already begun to discuss ways to promote the importance of specialty board certification through ABPP, and actualize our donors’ goals for greater advocacy.

Our Appeal to Help Reach Our Shared Dream:

We recognize the need to maintain a conservative approach to our philanthropic efforts until we have a significant increase in cash flow and the administrative/clerical assistance to move our initiatives forward. As such, our initial steps will be a bit smaller than our dreams. We anticipate that the fundraising activities we are currently developing and the rewards we are putting in place for our donors will ultimately result in raising the sufficient funds to significantly impact the importance of board specialization for both peers and the general public in the future. In order to do this we have developed the following strategies:
• Continued growth through outreach at conferences, conventions, and personal contact;
• The identification of an ambassador in every state, with encouragement and support for them to host events that recognize the importance of competent specialty practice and increasing the number of ABPP’s accessible to the general public;
• Support of the next ABPP CE conference for a lunch, speaker, or other event;
• Sponsorship of a fundraising event and speaker at future APA conventions;
• Working with the Specialty Academies who have invested in the ABPP Foundation to distribute scholarships from their earmarked funds.
• An initial scholarship competition for an ABPP candidate from an underrepresented multicultural group. Specifically, funds to support a full scholarship will be awarded from the present “Diversity Fund.” The scholarship will be competitive and open to any specialty board that wishes to nominate a candidate. The specific details will be provided at a future date.
• Development of aggressive advocacy efforts through our Ambassadors and Foundation Board Leadership, to promote the importance and value of ABPP Board Certification.

Please make a generous donation today by going to the link for the ABPP Foundation at www.ABPP.org. The promotion and support of ABPP Board Certification resulting in the type of culture change that is our vision does not come without a price. So many of your colleagues have so generously contributed their valuable resources of time and money. Individuals in the ABPP organization and central office staff have provided hours of volunteer time because they believe in our future vision. If every ABPP made a contribution that represented in dollars just one hour of their time per year, we would be well on our way. Make a donation today and give to the future of specialty practice.
CE Article - A Positive Aging Framework for Guiding Geropsychology Interventions

Robert D. Hill, PhD, ABPP, Counseling Psychology

To obtain CE, go to www.abpp.org and log on to the ABPP Specialists section (if you do not know login information click on the “Click Here” button that follows “Forgot Your Login Information?” and it will be sent to the email address that ABPP has on file for you). Once logged in click on The Specialist Online CE Exam.

This article characterizes the human aging process from the perspectives of normal, pathological, usual, successful, and positive aging. Positive aging is described based on four characteristics: the mobilizing of latent resources, psychological flexibility, an affirmative decision-making style, and the propensity to generate an optimistic response to stressors inherent in age-related decline. A positive aging strategy framework is proposed, inclusive of recent developments in intervention research employing gratitude, forgiveness, and altruism to preserve subjective well-being. The role of positive aging strategies in conjunction with behavioral intervention approaches to promote well-being in one's later years is recommended for addressing the complex needs of our graying population.
A Positive Aging Framework for Guiding Geropsychology Interventions

Robert D. Hill, University of Utah

This article characterizes the human aging process from the perspectives of normal, pathological, usual, successful, and positive aging. Positive aging is described based on four characteristics: the mobilizing of latent resources, psychological flexibility, an affirmative decision-making style, and the propensity to generate an optimistic response to stressors inherent in age-related decline. A positive aging strategy framework is proposed, inclusive of recent developments in intervention research employing gratitude, forgiveness, and altruism to preserve subjective well-being. The role of positive aging strategies in conjunction with behavioral intervention approaches to promote well-being in one's later years is recommended for addressing the complex needs of our graying population.

The number of older consumers of psychological services has increased precipitously in the past decade. Factors that have influenced this demand have included increased average life expectancy, the expanding demographic of older persons who report age-associated physical and cognitive impairment, and increased incidence of diseases of aging, including Alzheimer's disease and other forms of dementia. Extended average life expectancy means that a greater percentage of persons in the United States will be living into advanced age. The very old are substantial consumers of health-care services because almost every person in this age group is dealing with some form of chronic illness and/or age-related disability. In fact, recent demographic and epidemiological surveys have indicated that over 85% of persons 80 years and older have at least one chronic health condition and many (62%) have more than one (Anderson & Horvath, 2004).

In the psychological sciences, geropsychology has received increased attention as a specialty practice domain. Guidelines are now available that describe not only the role and function of the geropsychologist, but also issues of focus and the level of training needed for professional competency (Knight, Karel, Hinrichsen, Duffy, & Qualls, 2009). Within the past decade, evidence-based treatment (EBT) interventions have been developed for an older (or geriatric) clientele (Scogin & Yon, 2006). These approaches, not unlike those EBTs for other client groups—children, adolescents, early and middle-aged adults—focus primarily on the amelioration of pathology or symptoms associated with chronic physical and psychiatric conditions. Scogin (2007), editing a special issue of the Journal of Psychology and Aging, dedicated space to a comprehensive meta-analytic review of EBTs for some of the more pressing problems facing a geriatric clientele, including depression, anxiety, sleep disorders, caregiving, and behavioral problems in dementia.

The approach to treating the older patient’s chronic disease conditions parallels much of what is published in the medical literature where attention has focused on the treatment of the symptoms of pathology and the role of intervention to address maladaptive conditions as a consequence of aging and disease. Although this approach has important public health implications, it is also driven by socio-contextual forces that shape how most people characterize the human aging process and the role of the health-care professional as the point person in treatment delivery. These forces, like the process of aging itself, are dynamic and have evolved over the past several decades. The promulgation of terms (or labels) that have their genesis in the scientific and clinical literature and have migrated to the popular media impact not only
how the average person thinks about the process of growing old, but also the emphasis and the subsequent validation of interventions designed to mediate age-related decline.

Normal aging, pathological aging, usual and successful aging, and, more recently, positive aging are prominent in the lexicon of the science and practice of geriatrics. Such terms attempt to capture the phenomenon of age-related change from various perspectives, and this expanding taxonomy has aided in our understanding of how aging affects objective longevity, health, and quality of life. It has also influenced the kinds of interventions and outcome variables that are employed to deal with the issues of old age.

The purpose of this article is to: (a) briefly trace the evolution of prominent terms in the scientific literature descriptive of the human aging process, (b) examine the role of behavioral and related psychological interventions that have proliferated from these terms, (c) introduce a relatively new concept in the scientific literature, “positive aging” (Hill, 2005), that has been promoted from within the recent positive psychology movement (Seligman, 2000), and (d) describe an emergent positive-aging strategy framework for guiding future interventions with an older clientele.

**Normal and Pathological Aging: A Threshold Model**

Early definitions of human aging characterized it as a biological process akin to chronic disease; that is, aging (like disease) was viewed in the 1960s and 1970s as time related, irreversible, and deleterious (Dovenmuehle, Busse, & Newman, 1970). A limiting aspect of this formative definition was the difficulty of disentangling aging from disease. For example, arteriosclerotic disease could also be considered a form of aging because, like aging, arteriosclerosis is deleterious to health, becomes progressively more severe with the passage of time, and the impact of arteriosclerosis, particularly in its more advanced stage, is irreversible.

In the late 1960s, the term normal aging was proposed by Palmore (1970), who stated, “When we can distinguish normal and inevitable processes of aging from those which may accompany aging simply because of accident, stress, maladjustment, or disuse, we can better focus our attention and efforts on those factors which can be changed and corrected” (p. vii). The term normal aging has evolved as a result of large population-based studies, such as the Baltimore Longitudinal Study, that follows multiple cohorts of adults throughout their lifespan. A critical aspect of this definition is the presence or absence of disease. Shock (1984) defined normal aging as senescence in the absence of disease. Later definitions refined this view through a threshold model; namely, normal aging is the phenomenon of growing old when disease is not discernible or is at a subthreshold stage. In other words, until a disease reaches the threshold of symptom emergence, normal aging is the descriptive term of age-related decline. For example, in the normal aging lung, alveolar surface area decreases by up to 20%, which reduces maximal oxygen uptake by as much as 55% by age 85 (Wahba, 1983). Diminishment of organ capacity of this type may not be noticeable in everyday functioning, but such changes can exert a measurable impact on maximal output capacities. On the other hand, in Chronic Obstructive Pulmonary Disease (COPD) the walls of the alveoli break down appreciably, reducing the gas exchange area of the lungs. Depending on the stage of COPD, this can have a substantial impact on day-to-day function, and the effects of disease are magnified by the aging process. Figure 1 depicts a threshold model used to distinguish normal from pathological aging processes (adapted from van Boxtel, 1997).

In this model, there is the presumption of the existence of both protective and vulnerability factors that interact with the aging process. In the case example of lung function, protective behavioral factors would include regular aerobic exercise.
and optimal diet. These would be contrasted to cigarette smoking or residing in a region with poor air quality that would represent vulnerability factors. Protective or vulnerability factors have their origin in biological processes, genetics, and one’s environmental context and, as noted in this example, lifestyle behaviors. It is when normal physiological function is impacted by disease that the threshold from normal to pathological aging is crossed. In their seminal text, Fries and Crapo (1974) argued that the pathological aging process is similar to normal aging in that both produce functional loss—but pathological aging accelerates the progression of loss. The threshold model has given rise to interventions such as pharmacologically or behaviorally driven blood pressure control strategies to delay disease symptoms from exceeding the threshold of clinical detection.

Usual and Successful Aging: A Mediator Model

In later years, Rowe and Kahn (1987) proposed that the process of aging could be captured in terms more representative of its greater dimensionality, with emphasis on those individuals who experienced preservation of health and functionality even though they were aging. It was their view that the term normal aging was descriptive of two subcomponent processes that they labeled “usual” and “successful” aging. Usual aging emphasized extrinsic factors of deterioration, including diminished bone density, deficits in carbohydrate metabolism, diminished episodic memory efficiency, or other manifestations of deterioration that could be anticipated to occur for all persons as they increase in chronological age, especially through the latter half of the life span. Conceptualization of usual aging was similar to the term normal aging, although the usual aging terminology emphasized the substantial heterogeneity in the trajectory of functional decline in any given individual in the absence of detectible symptoms of disease. Successful aging, on the other hand, referred to the role of health behaviors as mediators of the aging process. They noted: “It is at least a reasonable hypothesis... that factors of diet, exercise, nutrition, and the like have been underestimated or ignored as potential moderators of the aging process” (Rowe & Kahn, p. 144).

Through this definition, Rowe and Kahn (1987) introduced and later popularized (see Rowe & Kahn, 1998) the idea that behavior and behavior change strategies could affect the course of aging for any given person, and in aggregate, could also alter general trends in longevity. This view, along with findings that emerged from the McArthur Longitudinal Studies of Successful Aging (Berkman et al., 1993), culminated in a general definition of successful aging based on three components: (a) active engagement with life, (b) absence or avoidance of disease or risk factors for disease, and (c) maintenance of high levels of physical and cognitive functioning (Depp & Jeste, 2006; Rowe & Kahn, 1999). In many respects, the successful aging terminology opened the door to designing and deploying behavioral change strategies such as regular exercise, proper nutrition through dieting, weight control interventions, as well as interventions that altered maladaptive lifestyle pattern such as smoking cessation and alcohol abuse interventions to mitigate the impact of age-related decline. The number and extensiveness of these interventions that have targeted an older clientele with the goal of not only helping them to maintain health and optimal function but to increase longevity has proliferated (Gage & Goreczny, 1998; Gallagher-Thompson, Steffen, & Thompson, 2008).

The concept of successful aging has stimulated a large body of research that has examined the impact of strategic behavioral interventions to alter behavior (e.g., smoking cessation) that can impact trajectories of physical decline associated with disease and with aging, including blood pressure control, the preservation of maximal oxygen uptake, and the maintenance of muscle strength and bone density. Recent studies have emphasized training regimens for mediating specific indices of cognitive health that are particularly susceptible to the aging process. Within the successful aging label, engagement in activities such as reading, crossword puzzles, or word or numeric exercises has been shown to mediate age-related cognitive decline (Shinya & Kawashima, 2008). In many respects, the “use it or lose it” mantra within the successful aging framework has been extended from sustaining physical fitness in old age through exercise to maintaining cognitive functioning through strategic forms of mental exertion exercises. These studies and others provide evidence that behavioral interventions that promote intellectual engagement are important in preserving cognitive functioning in healthy older adults into very advanced age (Ball et al., 2002).

Much of the research conducted under the umbrella of successful aging has focused on healthy individuals who are essentially disease free and are presumably highly resistant to age-related deterioration in physiological or cognitive processes. Whether such an approach to the preservation of physical health and cognitive function is possible within disease conditions such as Alzheimer’s disease remains relatively unknown. This may be partly due to the narrow confidence interval of
health within which the successful aging label is defined (Strawbridge, Wallhagen, & Cohen, 2002). For those older persons who are not endowed with such inherent resistance, or who are more vulnerable to age-related decline due to a history of poor lifestyle habits, poor living contexts, or who have simply lived to such an advanced age that their physiological constitution can no longer withstand the deteriorative effects of aging, a prominent need of these older persons is not simply to mediate age-related decline, but to find well-being, purpose in living, and happiness, even when physical deterioration is present.

More recent articulations of the concept of age-related frailty has focused on characterizing the condition of advanced aging as a kind of functional disability due primarily to unavoidable physiological and cognitive degradation. Hogan, MacKnight, and Bergman (2003) described frailty as a biological syndrome that leads to decreased resistance to stressors resulting from cumulative declines across multiple physiological systems, resulting in general vulnerability to adverse outcomes. Frailty, as defined in this way, not only increases with age but is further exacerbated by disease, which is expected to co-occur by virtue of the highly vulnerable and compromised state of the aged physiological system. Frailty is manifested by mobility restriction, acquired functional dependency, and deficits in cognition that constrain everyday living routines. Studies have documented that the concept of successful aging is viewed differently when those who are disease free define it versus when those who with chronic health conditions define it. A prominent theme in this relativistic approach to successful aging is that, among those persons who are less healthy, the emphasis on coping, adjustment, acceptance of one’s limitations, and the acknowledgment of suffering in the presence of decline is what constitutes the lay definition of “successful aging” (Phelan, Anderson, Lacroix, & Larson, 2004).

Thus, although the concept of successful aging has awakened society to the relationship between behavior, genetics, and the maintenance of functionality in the presence of advancing years, it has not been without its critics, who have argued that the successful aging terminology and the subsequent zeitgeist that has spurred people to believe that age-related decline can be thwarted through interventions in biology, genetics, pharmacology, or engaging in pro-health behaviors may have inadvertently created a barrier to life satisfaction for those individuals who cannot meet the successful aging criteria (Masoro, 2001). One example of the inevitability of age-related decline in even the most healthy (or fit) individuals is depicted in Figure 2, which plots 1997 Boston Marathon times by competitor age (Williams, 1998). In this graph, it is clear that, even among professional marathon runners, those who are older record longer completion times. This does not mean that a 60-year-old practices or prepares any less diligently than a 28-year-old runner; this function simply means that age-related decline exerts an absolute physiological effect on functionality, irrespective of one’s baseline physical condition or any effort that a person might engage in to ameliorate the impact of aging on performance times.

**SUCCESSFUL AGING: A PROPOSITIONAL MODEL**

In a revisionist approach to the concept of successful aging, Baltes and Baltes (1990) present a propositional model that focuses on the role of coping strategies to sustain optimal function in the presence of age-related decline. In this paradigm, deterioration in function is explicitly acknowledged and its consequences are construed as a dynamic between the biological processes inherent in human aging and the adaptation potential of the human organism through sociocultural mechanisms. A central tenet of this view that has become an important guiding principle in contemporary behavioral therapy interventions with older adults is a three-component model of adaptation that Baltes and Baltes describe as “Selective and Compensatory Optimization.” The elements of this approach consist of three processes: selection, optimization, and compensation (SOC).

Selection refers to the conscious reduction of choices to preserve resources; with fewer options available to the individual, coping becomes more amenable by a simplifying of the number of decisions that must be made within any given domain of functioning. An example of selectivity in social engagement is provided by Carstensen, Isaacowitz, and Charles (1999), who proposed socioemotional selectivity theory to describe how
older persons may choose to engage in fewer but more strategic social interactions to preserve functional resources in the presence of advancing age. Selection through the reduction or “pruning” of one’s social support network frees up an older person’s resources to make it possible to maintain more meaningful relationships as one’s overall capabilities for social interchange decline with age. Optimization infers practice and rehearsal of abilities that are intact and which one chooses to preserve. If a person desires to retain the ability to walk, then the practice of walking on a regular basis, even if this means incrementally decreasing the distance one walks as muscle weakness gradually increases, is engaging the process of optimization. The traditional notion that “practice makes perfect” is modified in optimization to “practice preserves function.”

Compensation is employed when a behavior is no longer executable in its typical form. When walking is no longer possible due to lost leg function, ambulation may still be possible through the means of a walker or a wheelchair. The concept of compensation has received substantial attention in the empirical research as it relates to nearly every form of rehabilitation training (Dixon & Bäckman, 1993). As a formal concept, compensation means the preservation of functioning through an alternative mechanism or method. Thus, one way to address a lost ability (walking) is to find an alternative means to engage in the function (ambulation via a wheelchair) even though walking using one’s own leg power is no longer possible.

Another criticism of the successful aging terminology is its narrow focus on the preservation of subjective well-being through the maintenance of physical functioning (Bowling, 2005). Even though most people know that subjective well-being is still possible in the presence of declining physical health and diminished functional abilities, the implications that are embedded in the strict definition of “successful” aging do not easily lend themselves to concepts of preserved well-being when physiological functioning is compromised through disease and/or aging. Can well-being and life satisfaction be found when an older person is experiencing limited mobility due to progressive osteoarthritis, or impaired cognitive function as a consequence of dementia? Is it possible to construe that an older person who is struggling with speech difficulties due to stroke would qualify as a successful ager? These are challenging questions about the extent to which the successful aging definition is sufficient to capture the wide range of change that is associated with age-related deterioration and the capacity of the individual to find well-being and life satisfaction across the full range of circumstances and health outcomes that are a consequence of age-related decline.

Positive aging (Hill, 2005; see also Hill & Mansour, 2008) is an extension of the positive psychology movement, which focuses on issues specific to old age. To paraphrase from Seligman (2000), through processes embedded in valued subjective experience that one acquires across the lifespan, people who are the most proficient in engendering well-being in later life learn how to construe age-related transitions in such a way that optimizes well-being. In aging, many of these transitions are a consequence of age-related decline—and to preserve well-being and happiness in the presence of this diminished functional capacity, particularly in advanced age, means dealing with unavoidable loss. A terminology that captures the processes to remain affirmative even in the presence of physical and cognitive decline, loss, pain, disappointment, grief, and suffering that is associated with aging will become increasingly important as greater numbers of older adults live into their 8th decade and beyond.

As was noted for successful aging, specific behaviors were postulated to mediate the deteriorative effects of aging. In an earlier work (see Hill, 2005), I described this approach in terms of positive aging characteristics; namely: (a) the ability to mobilize latent or dormant coping potentialities, (b) flexibility in thinking and behaving, (c) a decision-making style that affirms personal well-being even when choices represent departures from familiar activities that may no longer be possible when functionality for these activities is irrevocably compromised, and (d) an optimistic viewpoint about issues embedded in decline.

Recruiting Latent Potentiality
When confronted with a demand, whether it involves the expenditure of physical or psychological effort, personal resources are needed. Not unlike the concept of successful aging articulated by Baltes and Baltes (1990), there is explicit acknowledgment in the label of positive aging that functionality deteriorates irreversibly as a consequence of aging. Resources can, however, be recruited that are latent (or in reserve) when the need arises. In normal aging, the threshold model postulates that reserves are automatically recruited to offset loss. The presumption is that biology/genetics in the form of organ redundancy, for example, interact to offset age-related deficiencies. In Baltes and Baltes’s propositional model of successful aging, the concept of reserve capacity recruitment is described as a more active process involving the
learning and application of strategies to offset age-related deficits. Kliegl, Smith, and Baltes (1989) use terms such as developmental reserve capacity to describe this phenomenon for cognitive deficits where mnemonic strategies are employed to recruit latent resources to offset age-related memory deficits. In two related studies, Kliegl, Smith, and Baltes (1989, 1990) trained older adults to use the method of loci, a commonly known imagery-based mnemonic, to diminish age-related word-recall performance deficits.

From a psychological adaptation framework within which positive aging is embedded, if available coping resources are deficit as a consequence of age-related decline and are presumably irretrievable, latent resources may be recruited to sustain subjective well-being. This is accomplished by altering one’s personal focus. Specifically, by engaging strategies that can enable acceptance of irreversible age-related loss, it becomes possible to modify life routines while at the same time preserve self-consistency (or internal continuity) in the process. This capacity is captured by Robert Atchley (1999) in a continuity model of aging:

Despite significant changes in health, functioning, and social circumstances, a large proportion of older adults show considerable consistency over time in their patterns of thinking, activity profiles, living arrangements, and social relationships. . . . Continuity is conceived of . . . as strong probabilistic relationships among past, present, and anticipated patterns of thought, behavior, and social arrangements. (p. 1)

Psychological well-being is maintained by shifting one’s expectations when diminished functionality compromises activities. When capabilities are lost, consistency can still be maintained by recruiting features of one’s context to offset such a loss. For example, when personal tasks that generally involve the independent operation of a car (e.g., grocery shopping) are not possible, one could still accomplish such tasks by recruiting social resources to negotiate the task. In the previous example, an older person might still believe that he or she is independent although the construal of the personal meanings of independence in the presence of ongoing help from others would require, from a positive aging framework, reserve capacity recruitment (soliciting the help) as well as flexibility in reinterpreting a view of personal indendence with regard to this issue.

In their study, Strawbridge et al. (2002) found that many older adults who were experiencing chronic disease and declining functionality that would disqualify them for meeting the formal definition of successful aging continued to perceive themselves as successful agers and to enjoy well-being as a consequence. They accomplished this by altering how they construed the term successful aging (e.g., “the best old age one could expect”). In doing so, the study participants were able to maintain a view of themselves as successful agers even when chronic disease diminished or eliminated many aspects of independent function.

Flexibility
Flexibility refers to a person’s capacity to invoke novel strategies of behaving or thinking to promote better adaptation. Schaie (2005) defined flexibility as an approach to cognitive problem solving that involves the dynamic manipulation of multiple solution sets to yield the best outcome in the shortest amount of time. From a successful aging paradigm, flexibility has been characterized as a kind of plasticity or malleability that facilitates an individual’s search for the conditions that encompass the upper boundary of performance (Baltes, Staudinger, & Lindenberger, 1999). Both of these definitions emphasize performance outcomes through skill acquisition. Alternatively, as a psychological mechanism for dealing with stress, Lazarus and Folkman (1984) described flexibility as involving the balancing of one’s existing skills and personal resources to facilitate adaptation in stressful or demanding contexts. Flexibility in their definition is also skills based and is associated with specific behavioral outcomes. The focus of flexibility in dealing with stress, however, moves in the direction of adaptation to challenge versus maximizing performance gains. Rozanski and Kubzansky (2005) linked the active adjustment of one’s goals or priorities to address changing circumstances, setting limits on one’s abilities, invoking social support, and seeking advice or counseling as indices of coping flexibility. From a behavioral therapy perspective, the principle of flexibility is also demonstrated in the capacity to reframe automatic thoughts as a way to reduce their emotional impact and as a consequence yield an adaptive coping response.

The case of Edna, described by Robert Atchley (1999), is an example of flexibility in her behavioral routines responsive to irreversible loss that allowed her to maintain a sense of internal continuity (and personal satisfaction) even though she was replacing behaviors with more limited lifestyle routines as a direct response to progressive age-related deficits.

By 1991 Edna’s physical mobility problems had worsened considerably, but at age 88 she still maintained her very positive outlook on life. . . . She adapted her lifestyle to her more homebound state by doing less gardening and cutting back on her participation in politics. . . .
However, she . . . spent more time with her collection of family photographs . . . and watched more television . . . Adapting to her changing mobility was a major goal. . . . In 1995, Edna still had very high morale, a realistic appraisal of her personal agency and a very . . . satisfying life. (pp. 19-20)

Edna’s willingness to let go of established patterns and alter behavioral routines to accommodate functional decline as well as her effort to psychologically reframe her changing situation with the goal of preserving her positive attitude and maintaining life satisfaction is characteristic of the positive aging principle of flexibility.

Decisional Ability
Decision making involves evaluating the variables that will be influenced by a given decision and valuing the limited set of consequences that follow. Older persons who are better at evaluating choices and making decisions generate more satisfying life routines and, when the balance of decisions made across the lifespan weigh in favor of those where the consequences are sustained well-being, internal continuity is preserved. This is the case in very late life when decisions may involve the acceptance of unalterably diminished functionality. The focus of decision making as a positive aging skill in this regard is on establishing a plan to address a goal that acknowledges deficits. For example, most persons in our Western society are familiar with a Will (or a Trust) that represents a future financial plan for distribution of personal assets after one dies, and it has been estimated that over 80% of Americans have recorded a Will or a Trust for posthumous distribution of financial assets. The growing movement toward extending the concept of a Will to one’s care in advanced age—sometimes known as a Living Will—is a late-20th and early-21st-century positive aging manifestation of decision-making processes to address issues that are integral to loss. The most effective Living Wills influence the logistics of health care and preserve well-being and dignity near the end of life—and such a strategy is often designed to buffer the escalating medical and personal/family decision-making challenges just preceding the point of ultimate personal loss of one’s own life by relieving the individual (and the system) of the need to engage in what might otherwise be futile life-sustaining efforts.

Optimistic Viewpoint
An optimistic worldview describes an affirmative approach to life that is characterized by a striving for happiness versus a focus on alleviating symptoms of distress. This approach fits well with a contemporary conceptualization, proposed by Keyes (2005), of mental health, mental illness, and its treatment. In this scheme, a person’s pursuit of better health would be considered “flourishing” (a positive valence) if she or he possessed high levels of positive emotion, including active social engagement, the cultivation of meaningful personal relationships, and a positive future outlook. The absence of mental health, in contrast, Keyes labeled as “languishing,” or the experiencing of emptiness, loss, or stagnation associated with the inability to engage one’s environment to establish and sustain well-being. A critical element of this two-component model is that those who are moving in a positive direction toward health will more likely be engaged in coping or acting on their environment to enhance well-being than a person who is trying to escape or alleviate symptoms.

In their review of positive psychology and its role in clinical practice, Duckworth, Steen, and Seligman (2005) stated:

Positive psychology aims to broaden the focus of clinical psychology beyond suffering and its direct alleviation . . . positive psychology is the scientific study of strengths. . . . Viewing even the most distressed persons as more than the sum of damaged habits . . . positive psychology asks for more serious consideration of those persons’ intact faculties . . . positive life experience, and strengths of character, and how those buffer against disorder. (p. 630)

This viewpoint extends the concept of optimism as a strategy that mediates the impact of age-related decline on the threat to loss of subjective well-being as one encounters the inevitable challenges of functional and social loss in later life.

A Positive Aging Strategy Framework
A positive aging approach to coping is captured in the ability to recruit latent potentiality (or psychological reserve capacity) and to respond flexibly in age-related transitions, to engage affirmative decision-making processes, and to cultivate an optimistic view by reframing the deteriorative processes of aging in such a way that preserves life satisfaction. Within a behaviorally based strategy framework, two factors are important to consider: (a) the dependent variables and (b) the intervention approach.

Dependent Variables
Whereas the normal aging model focuses on control of symptoms or the delay of biological manifestations of disease and successful aging focuses on the ideal of aging or maximizing functional ability, positive aging emphasizes subjective constructs of well-being. At its root, positive aging is descriptive
of psychological adaptation to the inevitable consequences of late-life decline. A basic assumption in positive aging is that because decline is unavoidable, it is more adaptive to accept diminished functioning as part of one’s lifestyle routine rather than denying, controlling, or mediating it. This does not mean that one should ignore opportunities for controlling disease symptoms, or preserving functionality as one ages, but knowing when to make a shift that incorporates age-related decline into one’s lifestyle routine is a central feature for preserving well-being, even though the qualitative nature of one’s everyday functioning is unalterably diminished. The dependent variables that fit best within this description are those that emphasize psychological state.

In a study that involved 248 older adults with chronic osteoarthritis, Cignac, Cott, and Bradley (2002) evaluated whether coping behaviors within SOC could facilitate well-being. They defined selection as strategic personal restriction from activities that might exacerbate disease symptoms (withdrawing from any trips that involved extended walking). Optimization was defined as engaging in limited exercise routines that minimized pain (exercising while sitting in a chair), and compensation was defined as the early adoption of assistive devices to facilitate movement (using a walker). The findings from study participant interviews indicated that those who strategically altered their everyday behaviors using SOC strategies, although less engaged in care center activities, reported higher well-being than those who persisted in activities without modification. From a strict behavioral perspective, the reduction in the frequency of planned care center activities engaged in could be construed as a negative outcome; however, in this case, reduced activities were associated with better well-being. This study underscores the value of dependent variables that integrate psychological state with the maintenance of functional independence and/or social engagement. In positive aging, the impetus is to mediate the subjective experience of loss and personal disappointment associated with age-related decline. Preserving subjective well-being could involve choices to become more functionally limited with the goal of preserving resources by limiting the need to employ those resources in the additional care-center activities.

**Intervention Strategies**

Interventions that have proliferated within the normal aging and successful aging labels address categories of dependent variables consistent with these terms. To be sure, the pharmacological and/or behavioral treatment of subclinical disease states such as hypertension, or the promotion of healthy lifestyle behaviors such as regular physical exercise and diet, have as outcome measures biological or behavioral benefits such as diastolic and systolic blood pressure reduction, weight control, or fitness. The unique addition that positive aging adds to these medically or behaviorally generated dependent variables is the inclusion of outcomes of subjective emotional state. But are there intervention approaches that would uniquely characterize a positive aging outcome? That is, like normal and successful aging, how would the efficacy of a positive aging intervention be evaluated?

To address this question requires elucidating recent trends in the positive psychology movement that have pointed to specific interventions to harness features of the human condition that have been a source of meaning and well-being and that could be recruited when meaning or subjective well-being is challenged as a result of age-related decline. Specific examples of these interventions have been articulated in a strengths-based model of coping (Lopez et al., 2006) and there are three prominent meaning-centered life-span strategies grounded within this framework: gratitude, forgiveness, and altruism. These strategies are primarily designed to impact psychological state.

**Gratitude Interventions**

Gratitude interventions have proliferated in the empirical literature for a range of psychological and health issues. Bono, Emmons, and McCullough (2004) summarized several behaviorally based interventions within an empirical model of gratitude. From a positive aging framework, gratitude is a powerful flexibility strategy that, at its basis, can assist individuals in focusing on positive attributes of events or circumstances even when those events have been associated with objective loss. The underlying dynamic of a gratitude intervention is similar to the reconstrual principle in cognitive-behavioral therapy: that is, reframing automatic maladaptive thoughts to disconnect them from negative affect and therefore generate latent emotional resources to preserve well-being. In one empirical study, Emmons and McCullough (2003) demonstrated in a college-aged sample that gratitude journaling yielded not only improved mood but also resulted in a perception of enhanced personal resources to engage in health-promoting lifestyle behaviors such as physical exercise.

Although gratitude interventions have not been evaluated for older adult issues, per se, such interventions hold promise for addressing issues related to caregiver burden, chronic depression and/or anxiety, and issues associated with death and dying and the bereavement process. As an example,
a positive aging intervention employing gratitude journaling could involve the adoption of a behavioral strategy described by Emmons and McCullough (2003). In brief, this intervention included the following instructions:

There are many things in our lives, both large and small, that we might be grateful about. Think back over the past week and write down on the lines below up to five things in your life that you are grateful. . . . Examples . . . “waking up this morning,” “generosity of friends” . . . (p. 379)

In this example, the recipient of this intervention could be a spousal caregiver or an adult child who is the caregiver of an older parent. Caregivers could be taught the skill of gratitude journaling through a modified curriculum. Outcome measures to assess the efficacy of this intervention would be those that reflect enhanced positive meaning and purpose associated with the caregiving role, for example, the Positive Aspects of Caregiving Scale (Tarlow et al., 2004). A gratitude journaling intervention might be integrated with additional component techniques that have been enumerated in Gallagher-Thompson and Coon (2007) to relieve caregiver burden and stress.

**FORGIVENESS INTERVENTIONS**

Forgiveness interventions have been reported in the scientific literature to assist persons across the life span in dealing with loss and hurt. The literature that has examined forgiveness in later life has focused on interventions in which forgiveness has been employed to address difficult life transitions: loss of independent function, physical pain due to chronic disease, relieving the psychological burdens associated with caregiving, and repairing damaged relationships (Worthington, 2006). Forgiveness strategies have been used to manage a range of late-life issues, including chronic depression (Hebl & Enright, 1993). As a positive aging intervention, forgiveness training may be especially relevant for acute issues that challenge well-being, such as the management of grief. Among adults ages 18 and older, Toussaint, Williams, Musick, and Everson (2001) reported that forgiveness was most strongly associated with life satisfaction and self-rated health among those respondents who were 65 years and older. Bono and McCullough (2004) recommended a forgiveness curriculum for enhancing self-reported health in older clients with chronic illness. One aspect of this model involved construing forgiveness as multidimensional; that is, forgiveness could be engaged to help negotiate lifespan transition issues (e.g., moving from one’s own home to a residential care facility) where there may be a need to forgive one’s self (for an accident that may have precipitated the move), others (for initiating a residential care placement), or natural circumstances (the unavoidable consequences of age-related frailty). Forgiveness in any of these instances could be a resource for recruiting psychological reserves to cope with age-related deficits and preserve well-being and could benefit decision-making processes in the negotiation of such issues.

The goal of a positive aging forgiveness intervention would be one of learning to accept deficits as a result of age-related deterioration. Assessments that focus on sustaining meaning and purpose in life in the presence of these changing circumstances would be important outcome variables for assessing the impact of a forgiveness intervention. The Life Orientation Test–Revised (LOT-R) could be used to gauge the influence of forgiveness on the maintenance of optimism in the presence of personal loss (Robinson-Whelan et al., 1997). Forgiveness interventions could be used to challenge negative relationship interactions that frequently arise in the pressurized context of long-term caregiving, especially when the care recipient is unalterably deteriorating due to a dementing disease. In a related literature, forgiveness intervention strategies have been described for caregivers of persons suffering from AIDS. Aspects of these interventions might be adaptable to caregiver issues in an older adult clientele (Bono & McCullough, 2006).

**ALTRUISM INTERVENTIONS**

Altruism is commonly associated with the motivation behind acts of volunteerism. Among older adults, volunteerism is connected to a wide-range of positive outcomes, including increased longevity, resistance to negative affective states, better health, and enhanced well-being (Morrow-Howell, Rozario, & Tang, 2003; Post, 2007). Interventions that have engendered volunteerism in older adults have yielded positive outcomes even when the participants have been, themselves, in poor health and from lower socioeconomic strata (Dulin, Hill, Anderson, & Rasmussen, 2001). An extensive literature has examined the benefits that have followed when older persons have engaged in naturally occurring volunteer activities (Shmotkin, Blumstein, & Modan, 2003; Tan, Xue, Li, Carlson, & Fried, 2006). These studies provide preliminary evidence that volunteering is a potent source for generating meaning and purpose in life and that engagement in volunteer activities, even as one’s own health is declining, can be a source of well-being. To date, most of the research that has
examined volunteerism and enhanced well-being has focused on cognitively intact adults who are, for the most part, ambulatory. Whether engineered volunteer experiences could preserve well-being, for example, in older persons suffering from dementia is unknown.

An element of altruism that is not commonly considered in this clinical realm, but that may be relevant to a very old and/or impaired clientele, is learning how to “receive” help from others. In this way, older help recipients could, themselves, be instruments of altruistic acts from others (e.g., helpers need someone to help). However, among the barriers associated with this kind of approach to altruism is the social stigma that can be associated with receiving help. In other words, many persons, especially among those born in the 1930s and earlier, may hold expectations that it is socially unacceptable to receive help (e.g., the adage “There is no happiness in having or in getting, but only in giving”). For these persons, potential negative costs associated with imbalanced relationships when help-receiving cannot be reciprocated could create substantial subjective discomfort (Gergen, 1974). Some researchers have suggested, however, that the ability to receive help is a skill that, if learned, has the potential to promote subjective well-being even when the recipient cannot reciprocate the helper (Jett, 2002). It may be that the construal of help-receiving as a form of altruism is adaptable for older persons who are substantially physically or cognitively impaired.

**Implications for Clinical Practice**

This introduction to positive aging as a term descriptive of strategies for preserving the subjective experience of well-being into one’s later years has highlighted the importance of meaning-centered interventions to facilitate this process. The positive aging label should not be construed as a replacement term for normal or successful aging. That is, most persons are already very familiar with accessing sources of meaning and purpose in life (e.g., there are few people who would not acknowledge the role of forgiveness in healing relationship wounds). Positive aging may, however, represent a framework for an expanded repertoire of strategies. The clinical implications of incorporating behavioral strategies that can recruit latent psychological resources through gratitude, forgiveness, and altruism requires an expanded view of what it means to adapt by learning to accept (versus ameliorate) the irreversible deficits in age-related decline. To employ a positive aging strategy within a behavior therapy framework presupposes the identification of dependent measures to not only assess the impact of such interventions on indices of health but the role of self-perceptions in adapting to old age. This article has provided examples of outcome variables that fit within a positive aging framework, but, for the most part, tailored instruments of subjective psychological state in later life have yet to be fully elucidated in the extant literature. Further, instrumentation to assess the impact of specific meaning-centered interventions (a gratitude measure tailored to age-related decline) is currently unavailable.

There are multiple challenges in implementing positive aging strategies for enhancing well-being in one’s later years. Intervention designs that are specific to the range of old and very old clientele have yet to fully emerge. For example, it is relatively unknown whether a gratitude intervention could enhance life satisfaction in a person with dementia. Such an approach would require generating not only age-specific materials but a curriculum that is manageable by an older person with cognitive deficits. Quality-of-life instruments for older persons with dementia currently exist (Brod, Stewart, Sands, & Walton, 1999), but whether these could be adapted as dependent measures to gauge the effectiveness of behaviorally based interventions is unknown. As these kinds of issues are tackled, discoveries that highlight the dimensionality of meaning-centered interventions and their potential for preserving well-being in later life emerge.

Issues of quality of life in advanced age have become a part of the larger public health agenda. The Positive Aging Act of 2009 (H.R. 3191) describes the importance of not only providing mental health services to older Americans, but acknowledges that there will be more older persons with mental health needs, many of whom have been otherwise healthy and free of mental health concerns during earlier phases of the adult life cycle. The Positive Aging Act of 2009 (H.R. 3191) has been the first proposed U.S. governmental legislation to acknowledge the challenges of adapting to the inevitable consequences of old age and the role of the professional mental health service provider in this process.

In sum, the need for behaviorally oriented strategies for teaching individuals techniques for meaning finding in the presence of loss and to move, with dignity, through the transitions of old age are an essential complement to strategies for preventing chronic disease and maximizing function. However, when the biology of aging ultimately impacts the individual in irreversible ways, strategies for coping with progressive and irretrievable loss will become increasingly important as more persons in our society struggle with
the challenges of negotiating the vicissitudes of advanced and very advanced aging.

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Evidence-Based Practice in Couple and Family Psychology (an overview)

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Introduction

This article will present a brief overview and rationale for evidence-based practice (EBP) in couple and family psychology. Evidence-based practice utilizes treatment protocols originating out of empirical data that are grounded in a history of effectiveness through outcome-based research (Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000; Sexton, Alexander, & Mease, 2004).

The field of couple and family psychology is moored in an ecosystemic epistemology. Within this framework, individual behavior is understood to derive from nested reciprocal interactions between intrapersonal, interpersonal and environmental systems; each partner's behavior is influenced and shaped by emotionally laden, relationally recursive patterns of negative or positive reinforcement loops maintained through homeostasis (Auerswald, 1990; Bateson, 1972; Bronfenbrenner, 1979; Stanton, 2009).

Couples therapy differs from individual therapy due to its framework being rooted in an ecosystemic epistemology. A few key differences include the therapeutic focus, the perspective on interpersonal interactions, transference and countertransference, and communication patterns. In individual therapy, the therapeutic focus for change tends to be on the person present with the therapist. In contrast, it is not uncommon during couples therapy for partners to focus on the other person's need to change, which has therapeutic implications as the therapist seeks to shift the focus from other to self. Additionally, the therapist often only has the client's individual perspective on interpersonal interactions during individual therapy whereas couples therapy allows for direct observation of functional and dysfunctional interpersonal exchanges. Therefore, any assessment of interpersonal dynamics during couples therapy is more in the moment. Transference and countertransference are another key difference between the two therapies. During individual therapy, transference and countertransference occur between therapist and client while in couples therapy it tends to primarily take place between partners. Lastly, communication patterns are a key difference between individual and couples therapy. Communication in individual therapy occurs in two directions, client to therapist and therapist to client, where couples therapy communication has nine different pathways. Therefore, the therapist typically deals with a more emotionally charged atmosphere during couples therapy due to the greater number of people and communication lines in the room (Patterson, Williams, Grauf-Grounds, & Chamow, 1998).

Healthy and distressed couples

Every form of couples therapy seeks to move couples from unhealthy, distressed, and unpleasant ways of relating to more healthful and pleasurable relationships. Couples can be identified as distressed based on a variety of different characteristics. Distressed couples evidence lower rates of positivity in their relationships. These couples do not spend time in pleasurable activities together or in building pleasant memories (Weiss, Hops & Patterson, 1993). Ineffective communication and conflict management skills are hallmarks of the distressed couple relationship.
(Halford & Sanders, 1990; Jacobson & Follette, 1985; Weiss & Heyman, 1990). Additionally, distressed couples think about their partner in negative ways and focus on negative behavior as personality traits rather than expressions of temporal situations. Therefore, they develop negative relationship schemata and these schemata often result in negative generalizations about their partner or relationship (Buehlman, Gottman, & Katz, 1992; Halford, Osgarby, & Kelley, 1996). A distressed couple's behavior is often more hostile, forming escalating negativity loops, accumulating criticism, hostility, excuses, denial of responsibility, withdrawal and complaints about the other's personality (Weiss & Heyman, 1990).

A variety of characteristics are also present in healthy couples. Healthy couples possess a belief in relative rather than absolute truth, which means they understand that there is more than one point of view on any given issue. Healthy couples also operate under the assumptions that the partner has good motives underlying his or her actions or communication, their differences will be resolved, and there is a belief in something larger than the individual self (Beavers, 1985; Sperry & Carlson, 1991). The practice of healthy behaviors and patterns includes taking responsibility in the relationship, having goals that are in alignment, mutually encouraging one another, having open communication, sharing in joint conflict resolution and adhering to a commitment to relationship equality. Gottman suggests that friendship is the main factor in happy marriages, “a mutual respect and enjoyment of each other’s company” (Gottman, 2000, p. 19).

**Evidence-Based Couple and Family Therapy Interventions**

A decade ago, Division 43 of APA, The Society for Family Psychology, created a Task Force on evidence-based couple and family therapy (Sexton et al., 2011). The task force identified a number of promising empirically supported, cost effective family therapy approaches for working with a range of populations, including conduct disordered youth, drug abuse, marital distress, parenting problems, and other mental health issues (Atkins, Dimidjian, & Christensen, 2003; Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998; Cedar & Levant, 1990; Sexton & Alexander, 2002). Among these approaches are evidence-based couples treatment approaches which are mainly manualized, specific, and include defined goals and protocols for change (Sexton & Alexander, 2002; Sexton, Alexander, & Mease, 2004). Evidence-based couple treatments have strong empirical support including randomized control trials, process based research studies and outcome research (Sexton, Datachi-Phillips, Evans, LaFollette, & Wright, 2012).

The Division 43 Task Force determined the best approach to evidence-based practice for couples treatment to be a level-of-evidence model which matches the clinical questions to the appropriate level of research evidence (Sexton, Kinser, & Hanes, 2008). The model includes a pre-treatment level and three additional levels that reflect a graded rigor of testing and research evidence attesting to the validity of a given modality (Sexton & Coop Gordon, 2009). Pre-treatment and Level I models are evidence-informed treatments that have little pre-existing empirical validation or have research that partially supports the model. Many of the traditional family therapy models would fall into these categories, including Bowen Family Systems Therapy (Charles, 2001; Miller, Anderson, & Keala, 2004), Structural Family Therapy (Keim & Lappin, 2002), Brief Integrative Marital Therapy (Gurman, 2002), and Affective Reconstructive Marital Therapy (Snyder, 1999; Snyder & Schneider, 2002).

Level II treatments have met some criteria for evidence-based treatments but require further study with specific populations or with specific settings (Sexton & Coop Gordon, 2009). Examples of these programs include Insight-Oriented Marital Therapy (Snyder & Wills, 1989; Snyder, Wills, & Grady-Fletcher, 1991) and Attachment Based Family Therapy (Diamond, Reis, Diamond, Siqueland, & Isaacs, 2002).
Level III evidence-based treatments have a strong history of research backing a high degree of evidence validating their efficacy (Sexton & Coop Gordon, 2009). Currently, two models of couples therapy are empirically supported for treatment at this level. In a meta-analysis of the couple and family literature, Traditional Behavioral Couples Therapy (TBCT) had an effect size of .78 and Emotionally Focused Therapy (EFT) had an effect size of .87 (Sexton et al., 2012, p. 622). A variant of TBCT, Integrative Behavioral Couples Therapy (IBCT; Jacobson & Christensen, 1996), integrates emotion with behavior. IBCT has been found to be more effective than BCT in maintaining therapeutic change over time (Baucom, Sevier, Eldridge, Doss, & Christensen, 2011; Sexton et al., 2012). Therefore, the theoretical modalities this paper will compare and contrast include Traditional Behavioral Couples Therapy, Integrative Behavioral Couples Therapy and Emotionally Focused Therapy.

TBCT focuses primarily on behavioral exchange contracts and communication skills enhancement (Baucom et al., 1998; Dimidjian, Martell, & Christiansen, 2002). IBCT “relies on ‘contingency-shaped’ change in promoting better communication and in fostering emotional acceptance” (Baucom et al., 2011, p. 566). EFT seeks to influence “constricted emotional responses… fostering the development of a secure attachment bond between partners” (Johnson & Lebow, 2000, p. 26).

**Behavioral Couples Therapy**

Traditional BCT recognizes that non-distressed partners exchange more pleasing and less displeasing behaviors than distressed couples (Thibaut & Kelly, 1959; Gottman, 1993). The couple is interviewed in order to gain an understanding of individual functioning, relationship strengths and weaknesses, how the couple expresses affection and sexuality, how they view the future and how the relationship is affected by the greater social environment. Assessment is utilized for the purpose of ascertaining the ways in which rewards and punishments are exchanged between the couple (Nichols & Schwartz, 2001). Therapy begins with the therapist identifying the presenting problem or problems. The therapist wants to understand the couple’s complaints, the reinforcers for perceived problematic behaviors, the antecedents and consequences for problematic behaviors, and when behaviors occur or fail to occur.

The therapist often employs various objective assessments in the functional analysis of the relationship. These various areas of assessment reflect an ecosystemic approach to understanding the couple's relationship, including individual assessment, couple assessment, family assessment and perhaps even an assessment of how personal resources are enhanced or eroded by community commitments through the use of an ecomap. Using individual assessments, the therapist may want to rule out individual mood and anxiety disorders or evaluate overall personality with a personality assessment, such as the Millon Clinical Multiaxial Inventory-III (MCMI III; Millon, Millon, Davis, & Grossman, 2009). Couple assessments might evaluate overall marital satisfaction using the Dyadic Adjustment Scale (Spanier, 1976) and more specific relational factors with the Marital Satisfaction Inventory-Revised (MSI-R; Snyder & Aikman, 1999). The MSI-R has eleven scales that assess couple interactions on a range of relationship factors including problem solving communication, affective communication, sexual dissatisfaction, conflict over parenting, family history of distress, aggression and global distress. The therapist would be especially interested in a couple's problem solving acumen as well as their scores on overall global distress.

**Therapy Goals and Interventions**

The therapy goals of TBCT are to aid couples in modifying behavioral exchanges in the relationship by having couples exhibit more desired behaviors, help couples use conflict as a problem solving tool, correct faulty attributions in interactions, educate couples in the use of self-instructional procedures to decrease destructive interactions, and help couples improve overall communication. Interventions are specific and behavioral, along with communication training to increase a couple's ability to express their thoughts and emotions clearly, clarification and listening
techniques, problem solving training and contingency contracts. Contingency contracts aid in identifying specific problems in the couple's relationship that require a solution through the use of contingency contracts in dyadic negotiations (Nichols & Schwartz, 2001). The therapist teaches couples to share clearly in terms of behaviors that are occurring or not occurring and generate potential solutions that are positive and feasible to both parties. This will require free form creative brainstorming, followed by a careful evaluation of each proposed strategy which culminates in the couple implementing concrete solutions. The therapist helps the couple agree on a trial period for implementation, crafts behavior change agreements with the couple and implements various interventions where cognitive restructuring is often blended with behavioral interventions.

IBCT developed in response to the emphasis in TBCT on behavioral exchange, which produces sharp immediate reduction in relational distress, but poor durability in long lasting change (Dimidjian et al., 2002). TBCT seems most useful for couples that are less distressed, younger and not experiencing co-occurring individual pathology (Jacobson & Addis, 1993). It has also been found that some couples experience the rote nature of behavior exchange as artificial and off putting.

IBCT suggests that relationship problems are a result of how couples respond to their dyadic difficulties, not the fact that couples have disagreements, difficulties or conflicts. Jacobson and Christensen (1996) discuss the erosion over time of partners’ willingness to accept and tolerate the idiosyncratic behavior of the other with three types of problematic responses: mutual coercion (criticizing, withdrawing, stonewalling, contempt; Gottman, 2000), vilification (making of each other opponents rather than allies) and polarization (unsuccessful attempts to reform the other leading to greater relational distance).

Six questions are used to guide the assessment phase: 1) How distressed is the couple? 2) How committed to the relationship is the couple? 3) What are the dividing issues between partners? 4) Why are these issues such a problem? 5) What are the couple's strengths? 6) How can treatment help them? (Dimidjian et al., 2002, p. 257). The fundamental treatment goal for IBCT is for couples to be more understanding and accepting of one another as well as develop a collaborative set to improve the quality of the relationship. Techniques of IBCT treatment include promoting greater acceptance, encouraging greater tolerance and facilitating relationship change.

Acceptance is promoted through the use of a rational approach to relationship problems, empathic joining (couples hearing each other without accusation) and soft disclosures (emphasizing hurt and vulnerability over anger and resentment). Couples are encouraged to become more tolerant of each other's ways of relating, rather than constantly trying to change the other. The therapist helps the couple find the positive places in the relationship to emphasize and reinforce. Tolerance accrues as a byproduct of self-care. Each partner seeks to satisfy his or her own needs rather than relying on a partner over whom one has little control. This notion of self-care through self-control underlies the technique of behavior exchange where couples are encouraged to focus on changing their own behaviors in order to provide greater pleasure for their partners. Behavior exchange is a method employed in TBCT as communication training and problem solving training. Couples are encouraged to share their feelings, to employ listening skills in the service of process sharing and to take a collaborative approach with each other in the service of generating solutions to problems as allies rather than opponents (Dimidjian et al., 2002).

Emotionally Focused Therapy

The other level three evidence-based treatment approach for couples therapy could not be more different from cognitive-based therapeutic approaches, yet is just as effective. Emotionally Focused Therapy (EFT) interventions focus on the emotional experience of the client and how that experience is impacting interactions and relationships. EFT integrates an experiential/gestalt approach with an interactional/family systems approach. The roots of EFT lie in systems theory, humanistic psychology, and attachment theory. A key principle of EFT is that attachment needs are normal, healthy and adaptive. While attachment needs have their roots in the child/caregiver relationship, adult emotional bonds also address adaptive needs for security, protection and connectedness. The task for adults is to develop a secure interdependence that nurtures both partners. Marital distress is “the failure of an attachment relationship to provide a secure base for one or both partners” (Johnson, 1996, p. 124).
The responses that couples take to each other become habituated positions. Two of the most common positions are around affiliation-closeness or control-dependence. These positions become self-determining relationship events that feed into the inner experience of each partner. Inner and outer experiences become negative reinforcing feedback loops and through homeostasis tend to repeat, reinforce and maintain themselves. Problems are maintained by the ways in which interactions are organized and by the dominant emotional experience of each partner.

EFT targets the experience and expression of emotion and uses these avenues to shift couple interactions towards accessibility and responsiveness. Emotion is the primary agent in organizing attachment behaviors and determining how self and other are experienced in intimate relationships. Emotional communication allows for a degree of predictability for individual behavior on the part of a couple and is therefore a key regulator of marital interaction (Johnson, 1996, p. 125). Emotion links the intrapsychic and the social. Therapists should reflect and validate the emotional experience of the client in a way that expands the client’s understanding of his or her experiences. Reflection is a key intervention especially when it is empathic, tracks the interaction, positively reframes the topic, and restructures the interaction in a way that creates new emotional responses. This interaction demonstrates a new way of engaging with others and can offer a new perspective that the couple did not originally understand. When a therapist assists the couple in creating a new and enlightened dialogue (i.e. seeing each other in a new light and communicating on that basis), clients often report more satisfying interactions.

**Therapy Goals and Interventions**

The therapist-couple relationship is a collaborative alliance which offers partners a secure base from which to explore their relationship. The clinician's initial task is to identify if a partner's emotion is secondary or primary. Secondary emotion, such as anger, represents a defensive posture, while primary emotion, such as hurt, represents greater vulnerability. Once the therapist has established secondary and primary emotions in the relationship, he or she can utilize these emotions to address the inner experiences of each partner which are contributing to their defensive posture in the relationship. Additionally, the therapist will aim to identify the specific relationship events that have shaped the couple's attachment and individual views of self that have coalesced into hardened relationship patterns (Johnson, 1996, p. 122). After de-escalating the couple's negative relational patterns, the therapist aims to create new interaction patterns that aid in developing secure attachment. The emotional climate of early childhood, (primitive developmental feelings, i.e. fear-mistrust, shame-inadequacy, guilt-insecurity) are re-experienced in the adult couple relationship. By helping partners identify, express and restructure their emotional responses at different points in the interactional cycle, the EFT therapist helps the couple develop new responses to each other and a different frame on the nature of their problems (Johnson, 1996, p. 223).

As established by EFT, change occurs not through insight or negotiation, but through new emotional experiences in the present attachment relationship (i.e. new secure bonding). Therefore, the therapy process needs to facilitate the expression of underlying emotions of partners as well as de-escalate negative interaction patterns and reactive emotions. Shaping new, positive interaction cycles for the couple will be signs of evidence of the couple making strides forward in the change process.

**Appropriate Couples for EFT**

EFT is designed to be brief therapy lasting 8-15 sessions. A meta-analysis of research found 70% of couples found distress relief after 8-12 EFT sessions (Johnson, 1996). EFT is not recommended for all couples; therefore, the clinician should be aware of the boundaries for utilization. When a couple presenting in therapy is planning to divorce or is experiencing domestic violence or sexual dysfunction, EFT is not the appropriate therapy technique. It is also contraindicated as a modality when alcoholism, psychosis or attempted suicide is present. EFT is appropriate for couples hoping to increase intimacy, e.g., couples who report problems with communication or where one partner desires more intimacy than the other.
Future Directions

Numerous future professional practice and research directions should be explored to enhance the evidence-based practice and research literature for couple and family therapy. The field needs clearer definitions and descriptions for problems, treatments and monitoring of treatment adherence in order to establish a unifying language. Additionally, the majority of outcome studies have been short-term, so a focus on longer treatments is needed to expand the knowledge of long-term effectiveness. For example, three long-term follow-up studies of IBCT, which is lauded for its long-term efficacy, still found substantial relapse and deterioration of behavioral change (Jacobson & Addis, 1993).

In addition to changes in research procedure, future research should focus on the process of change in couples therapy. This focus would explore the therapist and client behaviors leading to substantial change in therapy as well as the critical types of change and moments of change during the life cycle of the therapeutic relationship. Johnson and Lebow (1999) have warned, “if we do not adopt some unifying frameworks to describe, predict, and explain relationship problems and guide intervention, the field may be in danger of fragmentation and marginalization” (p. 33). Finally, the power of evidence-based treatments is in the synergistic approach that combines scientifically based treatments with the unique aspects of the couple relationship to produce a treatment that is tailored to the specific needs of a particular couple. Recognizing the interaction of objective and subjective elements of treatment will lead to treatment protocols that truly unify theory, research and practice.

References


New ABPP Leadership Appointments

Jeanne is currently the Assistant Attorney General with the Arizona Attorney General’s Office in the Licensing and Enforcement Section. She received her Bachelor of Science degree in Political Science from Arizona State University in 1989 and her Juris Doctor in 1993. She joined the Arizona Attorney General's Office in April of 1994. As an Assistant Attorney General with the Administrative Law Section and the Licensing and Enforcement Section, Ms. Galvin has represented numerous state agencies including the State Board of Education/State Department of Education, Department of Health Services (the Division of Healthcare Licensure), Peace Officer Standards and Training Board, Arizona Board of Dental Examiners and the Administrative Offices of the Supreme Court. Her current client agencies include the Arizona State Board of Appraisal, Arizona Board for Private Post Secondary Education, Arizona Board of Certified Reporters and the Arizona Board of Psychologist Examiners. Ms. Galvin is also Rules Attorney for the Arizona Attorney General’s Office.
**Historian’s Column**

**Historian, Robert W. Goldberg, PhD, ABPP**

**A FISTFUL OF DOLLARS**

I consider the 1946-1949 period in American professional psychology as analogous to the nineteenth century ‘Wild West,’ with rapid expansion of professional territory and a corresponding need to devise systems to regulate behavior within that territory. That period encompassed reorganization of APA into divisions, the creation of an accreditation system for doctoral programs and internships, and the beginning of states’ licensing of psychologist generalists. The need to identify specialty practitioners fell to the American Board of [Examiners in] Professional Psychology. The fledgling organization was funded with a mere ‘fistful of dollars.’

The ABPP was founded in 1947, having evolved from an APA committee which determined that credentialing of specialists should not be carried out by a membership organization (APA). APA granted $7,500 to the original Board to begin operations. The ABPP then solicited applications for specialist credentialing, receiving 1,557 applications. It took 26 physical meetings to determine that 1,086 of these merited conferring of a specialty Diploma. (It is interesting to note that the ‘pass’ rate for this ‘grandfathering/grandmothering’ [48% of new Diplomates were women!] process approximated the 65-year ‘Pass’ rate for actual examinations in any format.) Candidacy fees garnered an additional $16,250 to cover expenses.

In 2004, the late former BOT President and Executive Officer Dr. Russ Bent unearthed the 1947 (first) AB(E)PP budget. Expenditures for the year were $18,971, most of which were paid for by the candidacy fees. The largest line item was Traveling Expenses to the physical BOT meetings, $1,220. Some of the amusingly low line-item expenditures were:

- Office equipment depreciation $ 7.70
- Office salaries 766.47
- Social Security taxes 1.29
- Insurance 12.36
- Telephone & telegraph 29.46

For last year, ABPP expenses were $921,922, an increase of 48 times over the 1947 expenses. However, in comparison, the Dow Jones Average this morning was 15,409, an increase of 95 times over its 1947 figure of 163.12. And the cumulative rate of inflation for the dollar since 1947 is 943%!

As Bent (2006) pointed out, ABPP is no longer a small, unitary ‘cottage industry’ organization. Our greatly expanded activities now encompass expenses for: governance and examinations for 14 specialty boards; a physical Central Office with full-time personnel; BOT governance expenses; the Convocation, Governance Day, and ABPP booth at the APA Convention; accounting and legal expenses; maintenance and redesign of website and electronic data systems; liaison activities with other psychology organizations; printing of certificates and awards, and – of course! – this newsletter. And, despite these necessarily greater expenditures, ABPP remains well ‘in the black’ financially.

**Reference**

LETTERS TO THE EDITOR*

ABPP Members in the News

Dr. Louise Evans, PhD, ABPP, Clinical Psychology, was selected as one of the International Biographical Centres Top 100 Health Professionals of 2013 and awarded a commemorative medal for her outstanding contributions to the field of psychology. For nearly half a century IBCs Research institute, Cambridge England, has amassed biographical details of nearly two million people worldwide in 163 countries who have made significant contributions to their diverse fields of expertise.

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ABPP Specialist 2013 Book Highlights

Russell Barkley, PhD, ABCN, ABPP

Russell Barkley, a diplomate in clinical psychology (ABPP), clinical child and adolescent psychology, and clinical neuropsychology (ABCN, ABPP) and a professor in the department of psychiatry at the Medical University of South Carolina (MUSC) has been very active in publishing in 2013. He has just completed a recent 3rd Edition update of his highly acclaimed book, Taking Charge of ADHD: The Complete, Authoritative Guide for Parents. Congratulations Dr. Barkley, a stellar example of a best-practices ABPP scientist practitioner. If you desire more information on this updated text consult the link below:

This set of notes and practice tools on brief and very brief psychodynamic psychotherapy incorporates very recent empirical research by esteemed professionals including the author’s observations from over thirty-five years of practice. Topics include a review of the therapeutic alliance, establishing the focus, client/patient selection considerations, and here and now work in the relationship. In addition, there is the presentation of micro-technique tools such as the affect bridge, metaphors of the problem, therapeutic stories and tales, the problem solving daydream and active imagination, contrasting videos and others with easy to use scripts to guide the therapist in the process of brief therapy. Excerpts from the Foreword by distinguished psychotherapy researcher, Jeffrey Binder co-author with Hans H. Strupp of “Psychotherapy In A New Key”, appear on the back cover.

Joe is a diplomat in both counseling psychology and clinical psychology (ABPP), Professor of Medical Psychology, Department of Psychiatry and Behavioral Sciences, Duke University Medical Center. He is president emeritus of the American Academy of Counseling Psychology and chair and chief executive officer emeritus of the Council of Presidents of Psychology Specialty Academies. Joe's professional interests include the use of imagery and hypnosis in therapy provision. He specializes in techniques brief and very brief psychotherapy techniques and in the interface of spirituality and psychology as part of the process of psychotherapy. He has been the primary author/editor of seven books, most of which are in the field of university student counseling services and psychotherapy.


This is a practical guide authored by experienced ABPP psychologists for successfully achieving Board Certification in Clinical Psychology. The text offers experience-based methods for increasing applicant success rates. Written by a team of accomplished clinical psychologists who are experienced mentors for professionals seeking American Board of Professional Psychology certification.

http://www.springerpub.com/product/9780826199812#.UiFgIT8uctd

*Letters to the Editor will highlight scholarly book publications by ABPP Specialists. If you would like your recently published book information to be acknowledged in the Specialist Newsletter please send your name, address, a short bio, your picture and a picture of your book cover (in jpeg format) to the Specialist Editor at robert.hill@und.edu.*

*Due to space limitations we may not be able to provide detailed highlighting including the book cover and your picture for every book or textbook submitted, but, we will ensure that an acknowledgement of your book by citation is printed.*
The American Board of Clinical Child and Adolescent Psychology (ABCCAP) has undertaken a series of projects to support the goal of advancing specialty board certification in the field. Specifically, ABCCAP has been an active participant at three national conferences that specifically focus on the specialty. These include the National Conference in Clinical Child and Adolescent Psychology, the National Conference in Pediatric Psychology and the Niagara in Miami Conference on Evidence-based Treatments for Childhood and Adolescent Mental Health Problems. ABCCAP is highly visible at these meetings by providing financial support, and exhibit materials at an ABCCAP table (with the ABPP drape). Additionally, ABCCAP officers provide a welcome to the conferences and have program time for a presentation regarding the nature of ABPP, ABCCAP, and the value of specialty board certification. These activities have been instrumental in increasing the number of inquiries about and applicants to ABCCAP. In addition to these informational opportunities, we have offered oral exams at these conferences as a convenience to applicants who are at the last stage of the certification process.

As psychologists, ABCCAP officers have been ever mindful of the potential for examiner “drift” in applying the standards for the review and examinations. Thus, we are establishing an initial training process that will help preclude drift by standardizing expectations from the outset. We are working on improving the examination process through enhanced examiner training, such as improving clear understanding of the expectations and requirements for evaluating applicant materials, and conducting and evaluating oral examinations. We are seeking support to develop training videos for evaluating application materials and an abbreviated mock exam capable for participant role plays. As part of this process, the board has established both informal and more formal mentoring of potential and actual applicants with a set of recommendations for best mentoring practices.

Just in the last year, ABCCAP has become aware that more hospitals and mental health agencies are starting to require board certification for employment and/or promotion, and we might anticipate that this will be an increasing trend because of the need for quality assurance. ABCCAP answered questions on a couple of listservs by providing distinctions about terminology, specifically, highlighting the differences between licensure, board certification, and credentialing. We noted that being licensed is distinct from being board certified whether in medicine or psychology. However, board certification is not the same as being credentialed. That is, credentialing for many practice groups, agencies, hospitals, and medical centers, for example, usually means that the practicing professional completes a form with the institution every one or two years, in which he or she documents certain characteristics (e.g., license renewal, verification that continuing education is current, which may also be required for ongoing licensure in the state, proof of malpractice insurance, attestation that the professional has not had a malpractice action/suit, and verification of board certification. We emphasize that board certification, such as through the American Board of Professional Psychology and its specialty boards, is a distinctive process from what the hospital may do.

We provide informational updates to related divisions such as Society of Pediatric Psychology (Division 54), Society of Clinical Child and Adolescent Psychology (Division 53), Society for Child and Family Policy and Practice (Division 37) via listservs and newsletters. In particular, we have described to these professionals how specialty recognition in Clinical Child and Adolescent Psychology correlates to their practice. Because of its inclusion in the coverage and mission of ABCCAP, the board makes a concerted effort to accommodate pediatric psychologists in particular. Pediatric psychologists comprise about 50% of those who are board certified in Clinical Child and Adolescent Psychology and many members of the governing board have an orientation to pediatric psychology and child health psychology.

Over the next year, ABCCAP will hold exams at the Niagara in Miami Conference (in early Winter, 2014), the National Conference on Pediatric Psychology in Philadelphia (March, 2014), and at the National Conference in Clinical Child and Adolescent Psychology, (October, 2014 in Lawrence, KS). ABCCAP board members hold “Learn about ABCCAP and ABPP” workshops at these and other conferences.
The American Board of Group Psychology (ABGP) continues to be a small specialty board relative to the other thirteen boards. We are working to increase our numbers by continuing to administer examinations, and to mentor candidates. We know that this is a challenging process, especially for busy, practicing group psychologist professionals. We encourage each of you to discuss board certification with your colleagues. Encourage them to apply, and mentor them during the process to ensure a successful outcome. We have found that the most successful recruitment has been via one’s colleagues. If the thought of recruitment appears to be overwhelming, just remember why you chose board certification, and what proved helpful to you during the process.

I thought that it would be helpful for you to hear from some of the latest ABGP members. They were asked to provide their responses regarding why they applied, what kept them going, if they are pleased with the outcome, and what they have done with their ABPP. Their answers put into context what we might say to a potential ABGP candidate, when they ask us “Why do this?”.

Lorraine Wodiska, PhD, ABPP, practicing in Arlington, VA responded:

**What influenced you towards getting an ABPP?**

As I recall the process, I was reading the newsletter from APA’s Group Psychologist and saw a short article by Josh Cohen. Ruthellen Josselson had also mentioned something to me about the ABPP years before. So, that day when I read about the ABPP, my thoughts clicked into plans for action. The ABPP offered a way for me to publicly acknowledge my full commitment as a group therapist—from understanding self to theoretical knowledge to (hopefully) excellence in group practice. As Joe Kobos noted in my exam, it was a “capstone” to a career. My “career” in groups began in my 20’s during the exciting encounter and sensitivity training movement of the 1960’s. I went to graduate school again in my 30’s and I created experiences to learn, do and teach group process. I wrote my dissertation on group. I have always run at least one group in my practice. My primary professional home has been AGPA. It was all there in the ABPP.

**Are you glad that you pursued your ABPP?**

Absolutely. I am proud of it every day.

**What will you do with your ABPP that makes it worth having done it?**

There is likely nothing I will “do” with it. Interestingly, at the same time I pursued the ABPP, I also thought it was time for me to study for my Bat Mitzvah, learn Hebrew and prepare to read from the Torah. (I was 63 and therefore it was exactly fifty years after it is typically celebrated). It was a different but equally meaningful endeavor to me. These are both statements about publicly acknowledging my enduring values.

Additionally, Lorraine is so excited with her ABPP, that she wanted to know how she could become active within ABGP. She is now our newest member of the ABGP Board of Directors. I am sure that you will hear more from her, and about her.

Lyn Sommer, PhD, ABPP, practicing in Westport CT wrote:

**What influenced you towards getting an ABPP?**

My good friend Dr. Caren Glickson was getting her ABPP, and asked me to keep her company in the process. Since I sometimes consult in different places throughout the US, I hoped that ABPP would be a distinguishing and recognizable credential to have.

**Are you glad that you pursued your ABPP?**

Yes, I remember the whole process with pride. I learned a great deal, and really enjoyed meeting the members of my committee.
What will you do with your ABPP that makes it worth having done it?

Honestly, I enjoy using my ABPP notation every chance I get, from signatures on my emails to those on important professional communications. When I lead a group workshop, I believe that the ABPP credential helps my colleagues to trust that I have some expertise in my field. When I initiate new work projects, and when I hold leadership or volunteer posts in my community, I take pride in having this senior credential. Also, I really enjoy the fact that my psychologist peers respect the accomplishment.

Again, I encourage you to think of who among your colleagues might be a good candidate. Talk with them, and be sure to let us know so that we can also follow through. We appreciate the efforts that you make on our behalf.

Sally H. Barlow, PhD, ABPP, and Joel C. Frost, EdD, ABPP, conducted a workshop entitled: “How Group Treatments Promote Interpersonal Growth and Change: From The Basics to Specific Competencies” as part of the 4th Annual Summer Workshop Series. Handouts from the workshop are available for sale on the ABPP website.


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**American Board of Rehabilitation Psychology (ABRP)**

**Lester Butt, PhD ABPP and Jan Niemeier, PhD, ABPP**

Greetings from the American Board of Rehabilitation Psychology (ABRP). We trust this submission finds all Board Certified professionals healthy and productive.

In collaboration with APA Division 22, Rehabilitation Psychology, the ABRP Board of Directors is fully engaged in the planning of our next conference. This event, Rehabilitation Psychology 2014 16th Annual Conference: Translating Research Into Practice, will occur in San Antonio, Texas, February 27-March 2, 2014. The following areas will be emphasized: ethics; military and veteran issues; research methodology; and, clinical practice issues. Regarding practice issues, particular attention will be given to skill development, and the utilization of evidence based practices, including Prolonged Exposure Therapy; Mindfulness-Based Cognitive Therapy; Dialectical Behavior Therapy; and, Acceptance and Commitment Therapy. Other topics include, the business of practice; sexuality; and, special interests of students and early career psychologists. Introductory and advanced tracks for those contemplating or actively involved in our Board Certification process are staples of this conference.

Shamelessly cannibalizing an idea from our colleagues within the Health Psychology Board, the Rehabilitation Psychology Board held its first conference call-in on June 24th for all those interested in or participating in the ABRP process. The call was intended to maintain visibility of the ABRP process and to provide an opportunity for prospective candidates and candidates to have their questions answered by a Board member. The call-in provided a low cost opportunity for connection between Board representatives and students and professionals. This initial call included Board members, Michele Rusin (Independent practice, Atlanta, GA) and Stephen Wegener (Associate Professor, Johns Hopkins School of Medicine, Baltimore, MD). The call was scheduled at a time when persons in all time zones would be at work, and hopefully before children needed to be picked up at day care. Announcements of the call were made via twitter, Facebook, and the listservs of pertinent APA Divisions (22 – Rehabilitation Psychology, 38 – Health Psychology, and 40 – Clinical Neuropsychology). We appreciate the support of the Presidents of these Divisions, approving the posting to their members. Participants were invited to e-mail questions in advance, or to
bring their questions to the call. During this process, we recognized that we were reaching a group of individuals
not commonly encountered in ABRP Preparation workshops. Graduate students inquired about how to shape
their training to assure that they will have the credentials to obtain Board certification. Thus, the conference call-in
will potentially extend the reach of ABPP earlier in the training process. Based on our positive experience with
this call, we look forward to hosting more calls in the future.

Our Board is attempting to enhance recruitment via focus upon three primary populations - senior professionals
involved in the rehabilitation field for many years; DOD/VA psychologists; and, early career professionals. We feel
confident that our future is bright with the Saldívar legacy firmly entrenched on our Board of Directors for years
to come.

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American Academy of School Psychology/American Board of
School Psychology

Michael Tansy, PhD, NCSP, ABPP, President, ABSP, & Shelley Pelletier, PhD, ABPP, President, AASP

The ABPP School Specialty continues to partner effectively in the mission to promote competency-based
certification of professional school psychologists through ongoing collaboration between the American Board
of School Psychology (ABSP) and the American Academy of School Psychology (AASP) Executive Committee.
The Board is led by Michael Tansy (President), Barbara Fischetti (Vice President-Secretary), Cynthia Riccio (Vice
President-Treasurer), Judith Kaufman (Director of Examinations and Director of Mentoring/AASP Liaison), Tony
Wu (Practice Samples Reviewer) and Roger Kaufman (Credential Reviewer). The Academy is governed by its
Executive Committee, which is led by Shelley Pelletier (President), Shawn Powell (Past President), Robyn Hess
(President Elect), Thomas Huberty (Treasurer), and Walter Pryzwansky (Secretary). Michael Tansy represents
the Specialty as its ABPP Board of Trustees Representative.

For many years the School Specialty has focused on increasing the number of applicants for school psychology
specialty board certification. A unique challenge facing School Psychology certification is the fact that the American
Psychological Association’s Model Licensure Act allows non-licensed school psychologists to practice within
school settings (APA, 2010). As a result of the exception allowing non-licensed school psychologists to practice
in schools, only 3% of the 35,000 practicing school psychologists are licensed at the doctoral level (Charvat, 2008).
While this fact limits the pool of board eligible school psychologists to approximately 1050 individuals, recruitment
is further challenged by the lack of professional incentives (e.g., institutional recognition, financial incentives,
tenure and promotion) for becoming ABPP board certified in school psychology. Recognizing these hurdles, the
School Specialty has been unceasing in its efforts to promote ABPP School Psychology certification.

Toward this end, the AASP hosted a reception and special session on ABPP board certification at the 2013 annual
convention of the National Association of School Psychologists in Seattle. The Academy has also scheduled its annual
Fellowship meeting at the 2013 convention of the American Psychological Association in Honolulu. At each of
these events, students, early entry psychologists, regular option psychologists and senior option psychologists
are informed of the process, pathway, and support available for becoming ABPP board certified in school psychology.
Additionally, Shelley Pelletier, AASP EC president, sought and received several thousand dollars in donations
from publishers/organizations including Multi-Health Systems (MHS), PAR, the Woodcock-Munoz Foundation,
and the Council of Directors of School Psychology Programs (CDSPP), to fund the Irwin Hyman and Nadine
Lambert Memorial Scholarships. For the past decade, these scholarships have attracted numerous well-qualified applicants among doctoral level school psychology students, and provided invaluable support for the recipients. This year the Academy anticipates awarding four $1000 scholarships at the APA convention. To further the specialty's efforts, Shawn Powell, the AASP EC's past president, continues to spearhead a BOT sponsored initiative to identify, reach out to, and encourage licensed school psychologists to become board certified in school psychology. The AASP continues to promote ABPP certification through the *Journal of Applied School Psychology*, the official journal of the AASP. To further promote board certification, Michael Tansy has published articles on obtaining board certification in school psychology in two key school psychology journals - the National Association of School Psychology’s *Communique* (Tansy, 2013) and the APA Division 16’s *The School Psychologist* (Tansy, 2013).

As a result of these ongoing and persistent efforts, the school specialty has achieved an unparalleled level of success with regards to the number of applicants and candidates. Currently, there are twelve applicants and twelve candidates. Though this number may seem small relative to other ABPP specialties, when contrasted with the number of ABSP examinations held in the past decade, it is, indeed, very encouraging. To safeguard each of the candidate's passage from candidacy through examination, ensuring the greatest likelihood of success, the ABSP assigns each candidate a mentor; sends letters clarifying the steps they must take to be successful in their efforts to become board certified; and, sends emails encouraging candidates to follow through with the examination process.

The ABSP recognizes that with the success of having a significant increase in candidates, it must successfully manage these candidates through the process of examination. Toward this end, the ABSP developed and distributed a mentoring manual; and, has developed a spread sheet that tracks each candidate through each stage of the examination process. Thus, every ABSP member is made aware of candidates’ progress, as well as, actions required of the ABSP.

An important next step for the school specialty is implementation of renewal of certification. The ABSP has discussed the steps required of the Board, and anticipates coordination with ABPP Central Office and the Board of Trustees toward successfully implementing this initiative.

**References**


American Board of Clinical Neuropsychology (ABCN) and American Academy of Clinical Neuropsychology (AACN)

Aaron Nelson, PhD, ABPP – President, AACN
Brenda Spiegler, PhD, ABPP – President, ABCN

ELECTIONS

At its February 2013 board meeting, ABCN welcomed new board members Drs. Heather Belanger, Christopher Grote, Joseph Kulas, and Nathaniel Nelson. ABCN expresses sincere thanks to outgoing board member Dr. Mark Bondi and outgoing officers Drs. Brenda Spiegler (President), Jennifer Haut (Secretary), and Fred Unverzagt (Treasurer). The contributions of these individuals have proven invaluable in advancing the mission of the board!

Current ABCN officers, effective February 2013 include:

President: John Lucas
Vice President: Anthony Stringer
Secretary: Laura Flashman
Treasurer: Corwin Boake
Representative to ABPP: Deborah Attix
Examinations Chair: Bernice Marcopulos
Executive Director: Linas Bieliauskas

In 2013, Drs. Kira Armstrong and Paul Kaufman completed their terms on the AACN Board of Directors, and Ms. Amanda Gooding completed her term as AACN Student Representative. The board welcomes new members Drs. Michelle Braun and Daniel Drane, and new student representative, Ms. Michelle Reinlieb.

ABCN News

ABCN continues to grow, certifying its 932nd specialist in Clinical Neuropsychology at the 2013 Spring oral examinations in Chicago. Due to growing space needs, Spring 2013 also saw a change in venue, with the ABCN oral exams being held at the University of Illinois, Chicago Neuropsychiatric Institute for the first time. The ABCN Board is grateful to Dr. Neil Pliskin for assisting with local arrangements for this and future examinations. We are also indebted to Dr. Christopher Grote and Rush University Medical Center, who have been most gracious and accommodating hosts to the ABCN oral exams for many years.

The ABCN written examination is now administered electronically at Prometric centers across the US and Canada. Individuals who are advanced to candidacy may take the written exam in any of four, two-week windows offered each year. The examination was revised and updated in 2012/2013, with inaugural administration of the new exams during the June 2013 and September 2013 exam windows.

Our transition to an electronic platform for the submission and review of practice samples has been extremely successful. This process utilizes the Scholar One manuscript submission and review portal and saves time, money, and trees. The transition to electronic submission has been seamless and well received, with nearly 95% of candidates choosing electronic submission over surface mail options between Jan-April 2013. In light of this rapid acceptance of the transition, ABCN officially moved to electronic-only practice sample submission as of May 1, 2013.

In February 2013, the ABCN Board of Directors approved an application for the creation of a subspecialty in pediatric neuropsychology developed by the ABCN Subspecialty Committee under the continued leadership of Dr. Ida Sue Baron. ABCN has submitted the application to the ABPP Affiliations Committee which, in turn, has forwarded it to the ABPP Board of Trustees for review in July 2013.
AACN NEWS

Our 11th annual AACN Conference and Workshops convened at the Renaissance Hotel in Chicago this past June. A record breaking, 832 registrants attended the conference and enjoyed a wide offering of excellent CE workshops. In her first year as program chair, Dr. Julie Bobholz did a splendid job putting together a stellar line-up of presenters in adult, pediatric, and forensic neuropsychology. The conference kicked off in festive fashion with the annual AACN Foundation fund-raising event in which approximately $20,000 was pledged for the support of outcomes-related research grants. Karaoke offerings spanned the musical landscape from Dr. Jacobus Donders channeling Janis Joplin, to Drs. Margaret O'Connor and Mary-Ellen Meadows delivering a stirring rendition of Nancy Sinatra's heartfelt classic, These Boots Are Made for Walkin'.

Under the strong leadership of Drs. Pamela McMurray and Gina Rehkemper, we also had a record-breaking number of abstract submissions (> 225) for the Scientific Session. Perhaps the highlight of the conference was the Point/Counterpoint program in which Drs. Robert Stern and Christopher Randolph faced off on the topic of Chronic Traumatic Encephalopathy (CTE). Over five hundred people crowded into the Grand Ballroom for this event that was covered by Chicago media. Links to coverage by Chicago Tribune and the Chicago Sun-Times are:


We had the privilege of presenting Dr. Thomas Hammek with our 2013 AACN Distinguished Neuropsychologist Award. Dr. Hammek was introduced by former AACN President Mike McCre, who provided the academy with a touching, humorous, and insightful introduction of a truly remarkable man. Dr. Hammek's talk was poignant and, despite his characteristic humility, provided a glimpse of his tremendous record of accomplishment within our field and the vast influence he continues to exert through his students and fellows, past and present.

Several major initiatives underway within AACN include a complete review and updating of our Bylaws; the ongoing transformation of our website and associated internet-based communications; and, a reanimation of our committee structure. Dr. Chris Morrison assumed the chair for the Public and Professional Information Committee and will be working closely with our web developer to optimize our ability to connect with the public and other interested constituencies around relevant neuropsychological issues. Dr. Karen Postal's work with the Interorganizational Practice Committee (IOPC) has already been instrumental in unifying previously disparate voices within Neuropsychology around a number of key issues.

American Board and Academy of Psychoanalysis

Thomas W. Ross, EdD, ABPP, President, and Practice Sample Coordinator

The primary mission of the American Board and Academy of Psychoanalysis is to identify national standards for the education, training and competencies needed for Board Certification in the specialty practice of Psychoanalysis by licensed psychologists who practice in North America. Our Board and Academy promote an inclusive position that actively affirms the importance of theoretical and practical diversity within the specialty of contemporary Psychoanalysis practiced by Licensed Psychologists.

The Directors of our Board, along with the support of Board Certified Fellows of the Academy of Psychoanalysis, review each candidate's post-doctoral credentials and practice sample, and provide the examinations for becoming a Board Certified specialist in the practice of Psychoanalysis. Our Board and Academy, as a member board of the American Board of Professional Psychology, offers the only national, independent, and competency-based board certification for psychologists practicing Psychoanalysis.
During this last year, our Board completed the merger of our Examining Board and Academy, approved new By-laws, refined our applicant eligibility criterion, revised our Examination Manual and Oral Examination procedures, and participated in an ABPP Periodic Committee Review. We are presently in the process of preparing a new Oral Examination and Mentor Training Program for implementation in the Spring of 2014.

**Our Board's Priorities for 2013 and 2014 include the following initiatives:**

- Refinement of Applicant/Candidate Eligibility Requirements
- Completion of the ABPP Periodic Committee Review Process
- Implementation of a new Applicant Recruitment Program
- Provide Support for the Psychoanalysis CRSPPP renewal application
- Development of a Website for the Board and Academy Fellows
- Sponsorship of Advanced Practice CE Programs for Fellows
- Implementation of a new Examiner and Mentor Training Program
- Awarding of new, updated Academy Fellows Certificates
- Outreach to Division 39 members and Local Chapters members
- Coordination of the Psychoanalysis Specialty Renewal Application
- Coordination and Liaison with Post-Doctoral Training Programs
- Coordination and Liaison with Training Program Accreditation

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**The American Academy of Clinical Health Psychologists (ACHP)**

**Executive Committee:** **President:** Jared Skillings, **Curriculum:** Andrew Block, **Listserve:** Jeff Matranga,  
**Continuing Education:** Kaki York-Ward, **Member At-Large:** Jennifer Kelly

The American Academy of Clinical Health Psychologists (ACHP) has made significant strides in organizational structure and service provision for academy members during the past year. ACHP had been dormant in the past, but we have undertaken the important task of developing its vision and operational goals. In the biggest sense, it has become clear that we need to change our psychology culture. All psychology trainees (especially in CHP) ought to view ABPP board certification as a natural and expected requirement, just as physicians do. Towards this vision, ACHP has adopted the following 6 organizational goals:

ACHP will improve the organizational structure of the mentoring program, and increase its utilization by new candidates.

ACHP will enroll our CHP specialists in a professional listserve. This will provide opportunity to interact with other specialists regarding clinical or academic issues, ethical challenges, or professional advice.

ACHP will increase advertising and sponsorship at important conferences, such as the APA Division 38 (Health Psychology), Association of Psychologists in Academic Health Centers (APA Division 12, Section 8), and the Society of Behavioral Medicine, among others.

ACHP will develop a website, which will (a) identify Academy members and their contact information, (b) educate potential candidates about ABPP board certification in CHP, (c) describe the mentoring program, and (d) provide website links and information about the CHP specialty.

ACHP will annually mail letters to each CHP specialist who has provided service to ABPP (mentoring, reviewing work samples, committee service, etc), officially documenting their service and our gratitude for their efforts.
Longer term, ACHP would like to partner with key organizations or independently provide top-notch continuing education about CHP and/or board certification.

ACHP has been able to make notable progress towards these goals in only six months. In February 2013 ACHP co-sponsored the biennial conference for the Association of Psychologists in Academic Health Centers (APA Division 12, Section 8) in Nashville, TN. This group has a number of ABPP specialists who encourage their students and new members to join ABPP; this will be an important partnership into the future. The ACHP mentoring program has been restructured, and utilization has increased by 150% in the past six months. The ACHP listserve, has also just been reinvigorated, which we will continue to use for professional networking and consultation for years to come. We have begun working on website design, with hope for rollout in fall/winter 2013. Lastly, we are planning for the development of a “CHP curriculum” so that a resource guide of recommended educational materials will be available to psychologists or students interested in learning more about the CHP specialty.

We are very pleased to announce that one of our ACHP members and biggest advocates, Dr. John Linton, will be receiving the 2013 Distinguished Service and Contributions to ABPP Award (Russell J. Bent Award). This prestigious award is based upon his many years of tireless service in advancing the goals and vision of ABPP. Congratulations, Dr. Linton.

American Board of Forensic Psychology
Ronna Dillinger, Daniel Davis, Lisa Kalich, Kevin Richards, Lois Condie

The goals of the American Board of Forensic Psychology and the American Academy of Forensic Psychology remain constant. The members of the American Board of Forensic Psychology aim to certify the most highly qualified group of forensic psychologists in the nation and the American Academy of Forensic Psychology supports that process through a variety of high-quality continuing education and advancement activities. Workshops cover basic to advanced topics, emerging domains of practice, and a broad range of subspecialty topics. The reach of both of these organization is becoming increasingly international as specialists engage in international practice and consultation, cross cultural and cross-national research, international paper presentations, and publications in international journals. Both boards have enjoyed a longstanding and positive association with the American Board of Professional Psychology.

Below, you will find the contributions of some of our newest specialists. Ronna Dillinger, Daniel Davis, Lisa Kalich, and Kevin Richards describe emerging issues in telepsychology as it relates to forensic practice, and then return to a more routine but equally vital presentation of advising new applicants, thinking through the challenges to forensic psychologists, and ways of engaging new specialists. The melding of the traditional (certification) with the new (emerging international practice / telepsychology) reflects how the field remains steadfast in its devotion to the goal of producing highly-trained professionals, while embracing emerging and advancing domains of forensic practice. Join us in welcoming these four relatively new specialists, along with our most recent 2012-2013 Class: Ann Ancevic, Michael Biscaro, Trayci Dahl, Ronna Dillinger, Nancy Elliott, Julie Gallagher, Michelle Guyton, Jeffrey Haun, Tye Hunter, Lynn Luna Jones, Phil Kinsler, Tracy Luchetta, Paul Montalbano, Tricia Peterson, Kevin Richards, Angela Torres, Delton Young, and Emily Wisniewski.

The role of technology and social media in psychology and within the specialty of forensic psychology continues to expand as the advancement of technological options increases and improves. Technology reaches into our professional lives in a multitude of areas, including education, practice, research, and teaching, through social media, webinars, blogs, and use of telepsychology or telehealth, just to name a few.
For personal education, the use of technology and social media has made it easier for the forensic psychologist to stay abreast on relevant journal articles, court decisions, and obtaining continuing education credits. For example, there are numerous ways to set up a customized and automatic notification system to send an alert regarding new court decisions, articles, or a new posting to a legal or psycholegal blog. This method of delivering information is quick and convenient. Professional organizations (e.g., American Psychological Association, APA) maintain Facebook pages and at FindLaw.com, one could choose to follow the website via Facebook, Twitter, Google+, Pinterest, and YouTube.

Technology and social media influence the practice of forensic psychology. It is becoming routine that social media entries posted by examinees during the course of an evaluation might be introduced by an attorney as evidence in court (Parker & Swearingen, 2012). It is unknown the frequency of this occurrence but there are plenty of anecdotal accounts related to use of social media in the course of a forensic evaluation (e.g., Griffin, 2009). Ethicists are debating the appropriateness of viewing social media entries as part of any psychological evaluation or treatment.

One burgeoning area within technology is the use of telehealth to provide mental health services. A number of states, as well as APA and other professional organizations, are developing or have implemented guidelines for the use of telepsychology to address the potential morass of legal, ethical, and general practice issues. APA recently released a draft of guidelines for public comment entitled “Guidelines for the Practice of Telepsychology.” At APA, a symposium will be held entitled “Psychology of the Future – APA/ASPPB/APAIT Telepsychology Task Force Guidelines and Relevant Policies.”

Telehealth has extended into forensic and correctional practice and is used routinely in certain courts (Bastatini, McDonald, & Morgan, 2012). Performing forensic evaluations via telehealth mediums is already in use in some states and this approach to forensic evaluations appears to be expanding. The benefits to the state policy makers appear numerous; namely, expediting the processing in states with large geographic expanse while utilizing long-term cost-saving measures. To the forensic psychologist, a host of challenges arise, including issues of reliability and validity, seeking temporary licensure for practice across state lines, potential loss of valuable face-to-face information, acceptance by the courts, security and privacy concerns, and limited information concerning the standard of care for such evaluations. To date, research has not kept pace with technological advancement of delivery of services in this manner, although specific research exists examining satisfaction ratings for telehealth competency to stand trial evaluation (Manguno-Mire, Thompson, Shore, Croy, Artecona, & Pickering, 2007) and reliability of an in-person and telehealth uses of the MacArthur Competence Assessment Tool – Criminal Adjudication (Lexcen, Hawk, Herrick, & Blank, 2006).

In conclusion, use of technology in the field of forensic psychology will likely continue its fast-paced growth, and it is incumbent upon the forensic psychologist to stay informed regarding guidelines and assess risk management factors. Hopefully, the research will be undertaken to inform the critical legal and ethical decisions we are being asked to make in light of the technology.

**Advice to Applicants**

One of the intrinsic rewards of being a forensic clinician is that one becomes, I believe, a better clinician overall. Given the intensity and demands of our work, we must stay close to the literature and practice in a sound, ethical and evidenced-based way. This approach to practice cannot help but improve our forensic work, but I believe also assists us in other aspects of our clinical work. Although quality forensic work, including assessment, must rely upon sound clinical principals, it does not, of course, stop there. Rather, Forensic Psychology demands much more and has evolved now to a distinct specialization area.
I’m almost afraid to admit my “age in the profession.” I began during the time that Forensic Psychology was emerging. My first job as a licensed psychologist was Supervising Psychologist of the newly opened maximum-security hospital for the state of Ohio. In the past 30 years, the profession has grown in so many ways. We, and those we serve, are so much the better for that.

A few years ago, as a very proud father, I visited my son at his doctoral program in psychology at the University of Oklahoma. On one of the floors, there was a museum of psychology. To my chagrin, encased in the display was essentially my first testing kit: a WAIS-R, Rorschach, TAT and Bender.

So why, then, why at 60 years of age and 30 years of successful practice in adult and juvenile forensic psychology, did I decide to pursue an ABPP? Basically, I choose to do it because of that display. I prefer not to become a museum piece, so to speak. I think that the greatest challenge in forensic psychology today is staying abreast of the ever-growing literature. The base of literature relevant to forensic practice routinely contains new information. The specialty is developing quickly and there are continually new offerings of novel research and unique career opportunities. The ABPP community helps specialists stay current.

In my preparation for the ABPP, I learned far more than I thought I might and I sharpened my skills. I improved the quality of my work. Along the way, I met some very good people in our Academy. Sadly, forensics can be a bit isolating and most certainly stressful. Without exception, the people I have met along the way of my ABPP journey have broken down that isolation and stress. They have been kind, gracious and supportive, including those of my examining committee. I have enjoyed the learning and civil discourse of important issues. My only regret is that I didn't do it sooner.

What are the challenges facing your specialty today?

Maintaining current clinical knowledge and being able to apply new psychological concepts in a legal context sometimes is a formidable task for forensic evaluators. A forensic psychologist must first possess competence as a generalist. The psychologist must be able to rely upon a wide range of clinical knowledge and skills in order to address the wide variety of issues posed in forensic cases. For example, in conducting parenting capacity or child custody evaluations, an evaluator must not only possess knowledge regarding the applicable legal standards, but must also be competent (and familiar with up-to-date research) regarding issues such as child development, child abuse and neglect, parenting skills, as well as with adult and child psychopathology. The scope of knowledge required to competently address most psycholegal questions is broad and complex, demanding that forensic psychologists devote considerable time and effort to professional development.

A related challenge concerns ethical issues relevant to the psycholegal domain of practice. Over the course of a routine week, a forensic psychologist might be asked questions that tread into the domain of legal adjudication or that simply are unanswerable: Will this inmate kill again? Has this child been sexually abused by this perpetrator? Is this defendant telling the truth? Both psychologists and legal professionals are ever hopeful that the behavioral sciences can make a contribution to answering these difficult legal questions. There is an immense body of research regarding parenting; however, there is limited research which speaks to the minimally acceptable threshold of parenting required for a parent to prevail in a case involving a petition for termination of parental rights. Similarly, there are no forensic assessment instruments or decision matrices that predict violence with high certainty or accuracy. Forensic psychologists face ongoing challenge to assist triers of fact without providing opinions which are beyond the scope of the knowledge in the field.

Other more exciting challenges to the profession include moving beyond traditional clinical roles to consult on better ways to determine Miranda rights comprehension, better ways of determining the overall comprehension and appreciation of other constitutional rights, ways to streamline assessments and consultations in an increasingly demanding work force, looking ahead to international forms of practice and research data exchange, welcoming diversity into the profession, and better understanding issues of culture and diversity in our clientele. Forensic psychologists are continually branching out into preventive domains of practice by facilitating efforts to stabilize communities, provide youths with opportunities to engage positively with the community, reintegrating newly released adults back into the community, providing parents with approachable and anonymous groups aimed at helping and acceptance, and consulting internationally to improve safety and security.
Engaging Newly Certified Specialists

Is a newly certified specialist really "new?" The welcoming nature of the forensic certification membership, and the involvement of professors, supervisors, and mentors leading up to certification suggests otherwise. The achievement of Board Certification is both a discrete event and a point along a continuum. Engaging newly certified specialists in forensic psychology is less of an event and more of a process. It begins well before any written or oral exams have taken place and continues on after certification has been achieved.

The American Academy of Forensic Psychology, whose mission is “to contribute to the development and maintenance of forensic psychology as a specialized field of study, research, and practice by (1) operating a continuing education program in forensic psychology, (2) providing a forum for the exchange of scientific information among its members, and (3) conferring awards upon outstanding students and practitioners of forensic psychology,” facilitates the first steps in the process of identifying and welcoming potential candidates by offering a full day seminar on preparation for seeking Board Certification. This full day continuing education program is aimed at those practicing forensic psychologists who are considering seeking certification. Presenters answer questions, demystify some aspects of the process, assist in developing a strategy to prepare and to give the workshop facilitator the opportunity to encourage those in attendance to move forward with the process. This pre-certification enthusiasm and encouragement was universal among those Certified Specialists I already knew and those directly involved in the process that I met along the way. The proctor for my written exam, the work sample chair and those who conducted my oral exam were appropriately formal and professional, but never dismissive or off-putting in any way. As such, by the time I was informed that I had passed, I felt like I was already well into the process of being welcomed and engaged with the group.

Following certification, the American Academy of Forensic Psychology immediately encourages new specialists to join and become active members. Right off the bat, new specialists are invited to (a) join the academy, (b) send an autobiography, which is then distributed to the existing specialists, (c) provide information for listing on the Academy website and (d) join the AAFP listserv. This leads to an introduction of the new specialists to the members of the list, which then results in an avalanche of posts welcoming the new specialists into the group. In this way, the Academy harnesses the speed and efficiency of electronic communication to keep up the momentum that had been building during the certification process. Finally, new specialists are invited to a convocation at the APA convention (which just happened to be in Hawaii this year) in order to be honored in a ceremony marking the achievement of newly certified specialists in all of the specialty areas recognized by ABPP.

Once the initial excitement and welcoming emails and posts to the list, the process of engaging the new specialists continues with new specialists being encouraged to immerse themselves as fully as possible in the field. Just in the months since I achieved certification, I have received announcements about opportunities to serve on standing and ad-hoc committees that deal with issues important to the specialty. Each time I have sent a query about one of these activities, I have received a quick and enthusiastic reply. In one case where I was not a particularly good fit for the opportunity about which I had inquired, I was actually given this news in an email that suggested several other opportunities to be of service and to become more involved. These opportunities also include the chance to consult and seek consultation with other specialists and to engage in discussions of issues that are unique to our field of practice.

I recently had the experience of finding myself on the other side of the new specialist engagement process when I was asked if I would proctor the written exam of a psychologist in my area who has decided to pursue certification. As I communicate with her about the logistics of this first step, I am reminded again about how the engagement of new specialists is not an event but a process; I can hear myself saying the same sorts of things others said to me during my own travels toward certification.
Summary

No matter which side of training you are on (student, young professional, seasoned professional, approaching retirement) and no matter which type of practice you embrace (clinical, consultative, preventive, research), the community of ABPP certified forensic psychologists welcomes you and encourages those who engage in forensic practice to consider specialization as one point along a continuum of professional growth and development. We look forward to seeing you at our AAFP workshops. We look forward to watching our youngest professionals continue to bring us their unique and vibrant perspectives, and facilitate the most recent advances in the development of research and practice. We also welcome the Baby Boomer crowd (and those who are as old as one gets) to contribute the wisdom that can be obtained only through years of practice. We welcome diversity, international perspectives, and anyone who seeks continual professional advancement. As the youngest among us say, "Forensic psychologists rock." As the oldest among us say, "Rock on, forensic psychologists."

References


American Board of Police & Public Safety Psychology News

Dave Corey, PhD, ABPP, President
APA Specialty Recognition

On July 31, 2013, the APA Council of Representatives voted to accept the recommendation of the Commission on Recognition of Specialties and Proficiencies in Professional Psychology to recognize Police & Public Safety Psychology as a specialty. This completes our specialty’s eight-year effort to affiliate as an ABPP specialty board, to obtain a seat on the Council of Specialties in Professional Psychology (CoS), and to obtain APA specialty recognition. We now focus our energies on advancing and implementing our education and training model, and establishing new doctoral education and postdoctoral training programs, while also working to increase the number of applicants and candidates pursuing board certification in our specialty.

Dr. Eileen M. Gupton Memorial Scholarship Fund in Police & Public Safety Psychology

A memorial scholarship fund in honor of the late Dr. Eileen Gupton—a beloved police psychologist and tireless advocate of the specialty—was established in November 2012 through the ABPP Foundation. The purpose of the fund is to support the pursuit of board certification in police and public safety psychology, particularly by graduate students and early career psychologists. Early career psychologists are eligible for an award from the Fund in the amount of $500 upon written notice from ABPP of satisfactory completion of all requirements for certification as a specialist in police and public safety psychology by the ABPPSP.

In an effort to sustain the scholarship fund, an anonymous donor has pledged to match the fund’s balance as of October 29, 2013. Please consider making a tax-deductible donation to the Fund at the ABPP website: www.abpp.org. Click on ABPP Foundation, then “online donations.” Credit cards accepted.

Dr. Eileen Gupton was an independent, dynamic and spirited woman. She was a beloved friend to so many, including her husband, Dr. Herb Gupton, who serves as the founding Secretary of the ABPPSP. Eileen left a special impression on her police psychology colleagues during her more than 30 years of professional practice. She made significant contributions to our field through her quiet efforts to bring young talent to police and public safety psychology. She lives on in our memories and through her lasting contributions to our specialty.
# New Board Certified Specialists

## January 2013 – June 2013

### Clinical Child & Adolescent Psychology
- Holly M. Antal, PhD
- Steven Behling, PhD
- Ginger A. Carlson, PhD
- Leafar F-J Espinoza, PhD
- Celeste Flachsbart, PsyD
- Scuddy F. Fontenelle, PhD
- Rod A. Gragg, PhD
- Elizabeth L. McQuaid, PhD
- Eric Oglesbee, PsyD
- Elizabeth M. Schilling, PhD
- Carnigee A. Truesdale, PsyD
- Gia Washington, PhD
- Karen Weiss, PhD
- Krystal White, PhD
- Nicole L. Frazer, PhD
- Lekeisha A. Sumner, PhD

### Clinical Health Psychology
- Sarah S. Avey, PhD
- Sarah J. Banks, PhD
- Holly Barnard, PhD
- Dawn Bowers, PhD
- Angela LH Buffington, PhD
- Elise Caccappolo, PhD
- M. Allison Cato Jackson, PhD
- Jeremy J. Davis, PsyD
- Kristen H. Demertzis, PhD
- Bradley S. Folley, PhD
- John B. Fulton, PhD
- Lisa G. Hahn, PhD
- Anjeli B. Inscore, PsyD
- Joette D. James, PhD
- Laura E. Kenealy, PhD
- Robyn B. Kervick, PhD
- Mohan Krishnan, PhD
- Megan A. Marlow-O’Connor, PhD
- Joseph E. Moldover, PhD
- David S. Sabsevitz, PhD
- Maxmillian Shmidheiser, PsyD

### Clinical Neuropsychology
- Delia M. Silva, PsyD
- Thomas E. Sullivan, PhD
- Karen D. Sullivan, PhD
- Stacey E. Woodrome, PhD

### Clinical Neuropsychology (con’t)
- David T. Andersen, PhD
- Earl J. Banning, PsyD
- John I. Bateman, PhD
- Maria A. Bergman, PhD
- Lindsay Braden, PsyD
- David M. Burke, PsyD
- Paul Cantz, PsyD
- Matthew A. Carlson, PsyD
- Wendell W. Carpenter, PsyD
- Roger B. Chaffee, PsyD
- William D. Charmak, PhD
- Paula I. Christian-Kliger, PhD
- Sarah E. Dunn, PhD
- Lawrence A. Edwards, PhD
- Chamarlyn L. Fairley, PhD
- Carlo A. Giacomoni, PsyD
- Jeffery Harvey, PsyD
- Jeremy S. Haskell, PsyD
- Charles A. Howard, PhD
- Laura Johnson, PsyD
- Katherine E. Ledlie, PsyD
- Robert D. Lippy, PhD
- Elizabeth Lynch, PsyD
- Elizabeth G. Merrill, PsyD
- Daniel B. Michel, PsyD
- Dianne S. O’Connor, EdD
- Sol Rappaport, PhD
- Rose Rice, PhD
- Sarah J. Slagle-Arnold, PhD
- Loren G. Soeiro, PhD
- Kris C. Stankiewicz, PsyD
- Stephen M. Stouder, PsyD

### Cognitive & Behavioral Psychology
- Daniella A. Cortez Cavenagh, PhD
- Colleen Ehrnstrom, PhD

### Cognitive & Behavioral Psychology (con’t)
- Richard C. Ney, PhD
- Dena C. Rabinowitz, PhD
- William A. Satterfield, PhD
- Jenny C. Yip, PsyD

### Counseling Psychology
- Linda "Lynne" Carroll, PhD
- Stephen S. Jenkins, PhD
- Joan B. Mizrahi, PhD
- Charles A. Waehler, PhD

### Forensic Psychology
- Trayci A. Dahl, PhD
- Michelle R. Guyton, PhD
- Jeffrey J. Haun, PsyD
- Philip J. Kinsler, PhD
- Joan H. Leska, PsyD
- Tricia L. Peterson, PhD
- Emily J. Wisniewski, PsyD

### Group Psychology
- Anne M. McEneaney, PhD

### Organizational & Business Consulting Psychology
- Jay M. Finkelman, PhD

### Psychoanalysis in Psychology
- John M. Watkins, PhD
- Kaveh Zamanian, PhD

### Rehabilitation Psychology
- Teresa Ashman, PhD
- Charles Filanosky, PhD
- Kelly Hoffmann, PsyD
- Laurie Nash, PhD
- Nathan M. Parmer, PsyD
- Amber Gerber Richgels, PsyD

### School Psychology
- Nichole Adams, PsyD
- Susan L. Calhoun, PhD
In Memory of Vytautas J. Bieliauskas, PhD, ABPP Clinical Psychology

Vytautas J. Bieliauskas, Chairman of the Psychology Department at Xavier University from 1959 to 1978, and President of the Lithuanian World Community when the Soviet Union broke apart in 1989, died in hospice at Drake Center in Cincinnati, Ohio, on April 25, 2013. He was 92 years old.

Born in 1920 in Marijampole, in newly-independent Lithuania, Vytautas was the eldest of four children of Antanas and Anele Bieliauskas. Upon completing Rygiskio Jonas High School, Vytautas entered the Vilkaviškis seminary but transferred to Vytautas the Great University in Kaunas in 1940. He completed a Ph.D. at the University of Tübingen in Germany in 1943 and taught courses in the nascent field of psychology at the University of Munich from 1944 to 1948.

With the outbreak of World War II, and his home country subjected to multiple occupations by the Soviets and the Nazis, Vytautas turned to assisting the flood of Lithuanian refugees flowing into Germany as “DPs” (Displaced Persons). Together with other volunteers, he founded the Lithuanian publication Aidai to provide vital information for new arrivals and, more importantly, news from Lithuania. Once established, Aidai passed into other hands, and it evolved into a journal of arts and culture that published the works of prolific Lithuanian writers and artists who were scattered throughout the DP camps in Germany.

It was during these activist years that he met the young medical student who would become his wife, Danute Sirvydaite. They married in Munich in April of 1947, and had a son, Linas, born the following year.

Although the Allied victory of WWII brought peace to Western Europe, it ushered in 50 years of Soviet subjugation to Lithuania. A return to their homeland thwarted by the possibility of imprisonment or deportation to Siberia, the young couple, now with an infant son, were sponsored by distant relatives in Wilkes-Barre, Pennsylvania, to emigrate to the United States in 1949.

Upon arriving in the United States through Ellis Island, Vytautas established himself professionally first at Richmond Professional Institute (now VCU) in Richmond, Va., where three more children were born. Receiving an appointment at Xavier University, Bieliauskas moved his family to Cincinnati, Ohio, in 1957 and settled in Groesbeck, where Danute opened a medical practice. Both continued to be active in their professional fields until age 70.

Vytautas also found it important to serve his newly-adopted country, and he joined the U.S. Army Reserves, achieving the rank of Lieutenant Colonel in the Medical Corps.

Ever mindful of the perils faced by occupied Lithuania, Bieliauskas served as Executive Vice President of the Lithuanian-American Community, Inc. in the U.S. and worked to help restore Lithuania’s independence. He was president of the Lithuanian World Community during the intensive years of 1988-1992.
A part of the Xavier family for 47 years, Vytautas taught and counseled countless psychology students, always leaving time to advise freshmen. Professionally, he is perhaps best known for his research on the House-Tree-Person Personality Test, which is used internationally for personality evaluation. Following the race riots in Cincinnati in 1967 and 1968, he was instrumental in arranging sensitivity training workshops for the Cincinnati police force through XU’s psychology department.

Board-certified in clinical psychology and family therapy by the American Board of Professional Psychology, Vytautas was also a fellow of the American Psychological Association, the Ohio Psychological Association, the Cincinnati Academy of Professional Psychology and the Cincinnati Psychological Association. He held a wide range of offices in professional organizations, including head of the Ohio State Board of Psychology. Vytautas has published more than 100 articles in English, French, German and Lithuanian, and he received Outstanding Educator of America awards in 1971, 1972 and 1974. He was a member of the Catholic Academy of Sciences in the U.S. In 1990, he received the Ellis Island Medal of Honor, an award given to honor the contribution made to America by immigrants and the legacy they leave behind.

Vytautas Bieliauskas is survived by his wife of 67 years, Dr. Danute Bieliauskas, a sister, Aldona Laukaitiene, in Lithuania, his sons Linas and Cornelius (Sarah Schrand), his daughters Diana and Aldona, grandchildren Nina and Anton Bieliauskas (Shannon), Mantas and Nida Vidutis, and Hana, Abe, and Jonas Bieliauskas. The first great grandchild is expected to be born any day.

IN LIEU OF FLOWERS, DONATIONS CAN BE MADE TO:

Bieliauskas Fund, Xavier University, 3800 Victory Parkway, Cincinnati, OH 45207-5430
Or
Baltic Jesuit Advancement Project, 1380 Castlewood Drive, Lemont, IL 60439-6732, USA
All donations are TAX deductible as allowed by law. (Federal Tax Exempt #36-2257083)

In Memory of Sydney J. Merien, PhD, ABPP Clinical and Clinical Neuropsychology

Sidney J. Merin, 85, of Tampa passed away on December 31, 2012. Born and reared in Altoona, Pennsylvania, he was first generation American of parents who immigrated from Lithuania. He served in WWII in Europe; returned to attend college graduating from Penn State University with a Ph.D. in psychology. The second psychologist in Tampa he maintained a private practice; was an adjunct professor for USF for several years; earned a Diplomate in Clinical and Neuropsychology; served as president of the FPA; and was a distinguished Forensic Psychologist until his retirement two years ago. He married Arlene Merrow and settled in Tampa Florida. He is survived by his loving wife, Arlene; his children, Cheryl Barr (David), Debra Merin, Michele Smith (Jack) and Jeffrey Merin; his grandchildren, Tristan, Ryan (Andrea), Jarred (Angela), Elliot and Emory; four great-grandchildren, nieces and nephews. He was preceded in death by his parents, 4 sisters and a brother. Sidney enjoyed friends, good food, music, history finding the humor in life, and above all his family. He is dearly loved and will be sorely missed by us all. Gathering of friends and family at the Blount & Curry Funeral Home, 605 S. MacDill Avenue in Tampa from 6:30 p.m. until 8:00 p.m. on Thursday, January 3, 2013. Contributions in Sidney’s name may made in lieu of flowers to LifePath Hospice or The Shriners.