Authentic Professional Competence in Clinical Neuropsychology†

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Abstract

Authentic Professional Competence in Clinical Neuropsychology was Dr Denney’s 2009 presidential address at the Annual Conference of the National Academy of Neuropsychology. In his address, he highlighted the need for clinical neuropsychologists to strive for authentic professional competence rather than a mere pretense of expertise. Undisputed credibility arises from authentic professional competence. Achieving authentic professional competence includes the completion of a thorough course of training within the defined specialty area and validation of expertise by one’s peers through the board certification process. Included in the address were survey results regarding what the consumer believes about board certification as well as survey results regarding the experiences of recent neuropsychology diplomates. It is important for neuropsychologists to realize that the board certification process enhances public perception and credibility of the field as well as personal growth for the neuropsychologist. Lastly, he urged all neuropsychologists to support the unified training model and pursue board certification.

Keyword: Professional issues

Good evening my colleagues. I wish to start out with a question: How do we as clinical neuropsychologists define authentic professional competence? Authentic refers to genuine, the “real deal.” Authentic is defined this way in Merriam-Webster’s Online Dictionary:

- Function: adjective (Here modifying Professional Competence);
- Etymology: Middle English autentik, from Anglo-French, from Late Latin authenticus, from Greek authentikos, from authentēs perpetrator, master, from aut-++-hentēs (akin to Greek anyein to accomplish, Sanskrit sanoti he gains).

In short: Undisputed Credibility.

How do we as clinical neuropsychologists have undisputed credibility, both individually and as a profession? In 2008, Sullivan and I published a chapter entitled, “a final word on authentic professional competence in criminal forensic neuropsychology” (Sullivan & Denney, 2008). We noted the goal that our text would “serve to assist interested and motivated neuropsychologists working in the criminal forensic area to pursue, develop, and maintain authentic professional competence rather than a ‘mere pretense of expertise’” (p. 391). We then raised the question, what procedures and resources can we employ to attest to the attainment of authentic professional competence?

We were presenting our thoughts as it related to providing neuropsychological expertise to the criminal forensic courts. Frankly, the whole reason why I wanted to create that book and also why I presented criminal forensic workshops during...
the National Academy of Neuropsychology (NAN) annual conferences as well as other professional conferences over the recent years was because of seeing otherwise presumably competent neuropsychologists entering an arena in which it became painfully clear they “hadn’t a clue”. It is not limited to just neuropsychologists, I have seen psychologists and neuropsychologists alike provide “expert” opinions on topics which were marginally related to the legal topic at hand. Many times, I have seen so-called experts provide forensic opinions based on the legal standards that were simply not in effect within that jurisdiction. The issue is not one-sided, however, as I have also seen forensic psychologists stepping into the specialty of neuropsychology wholly unprepared.

Understanding the Boundaries of Our Competence

How are we to determine the boundary of our competence? Ethical Principles of Psychologists and Code of Conduct (American Psychological Association, 2002) section 2.01 provides this well-known guideline related to competent delivery of services:

2.01 Boundaries of Competence (a) Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience.

The Code provides this guidance when a psychologist is expanding his or her practice to new areas:

Section 2.01c. Psychologists planning to provide services, teach, or conduct research involving populations, areas, techniques, or technologies new to them undertake relevant education, training, supervised experience, consultation, or study.

This section directs us to understand the qualifications established and expected within that new specialty. Neither of these sections provide guidance about how much education, training, supervised experience, consultation, or study is needed to move from one area of practice to another. It does, however, outline the fact that one’s competence is based on some combination of education, training, supervised experience, consultation, study, and professional experience. I believe we can all agree with that conclusion.

How do you know you are competent to practice neuropsychology? “Well it comes from my training.” But how much training is needed? Not to make light of this question, but I must tell you my 11-year-old son wants to be a marine biologist. He is set on it. He loves animals. He loves those that live in the sea even more. He is convinced he will be a marine biologist. The problem is he says he hates math. Even more, he says he hates school! I like to think he really doesn’t, but the fact is there is a serious disconnect here between what he thinks is going to happen and what he wants to do to achieve it. We have a problem if we are competent to practice neuropsychology, forensic psychology, or forensic neuropsychology simply because we think we are. Competence requires more than a consensus of $N = 1$.

Competency is defined by Rodolfa and colleagues (2005) in this way:

Competency is generally understood to mean that a professional is qualified, capable, and able to understand and do certain things in an appropriate and effective manner. Simply having knowledge or skill is insufficient for someone to be considered competent. Rather, there is the implication that competency requires action and in some public way verification of what is achieved by that action. (p. 348)

Applying this to our psychology profession, the authors continue:

In a profession, competency also connotes that behaviors are carried out in a manner consistent with standards and guidelines of peer review, ethical principles, and values of the profession, especially those that protect and otherwise benefit the public. (p. 349)

Although each of us is admonished to practice within our areas of competence, my own view of my own competence is by its own very definition, subjective and unreliable. Rather than coming from the inside, our sense of competency must come from the outside. Again, how do we know then, that we are competent?

Rodolfa and colleagues (2005) presented a cube model for competency development in professional psychology. This model contained two domains (foundational and functional), which spell out the core areas of knowledge and practice skills. The third dimension of the cube includes the stages of professional development (p. 350):

Stages of Professional Development

• Doctoral Education
• Doctoral Internship/residency
Post Doctoral Supervision
Residency/Fellowship
Continuing Competency

The authors provided this point in regard to the profession:
The cube model of competency development may be useful to assist the profession in understanding the sequence of training resulting in
competent general and specialty practice in professional psychology. In particular, as specialty practice in psychology grows, the profession’s
development of specialties must occur within the context of three systems: One for recognizing the specialty, one for identifying those programs
that demonstrate adequate training in the specialty, and one for certifying the competence of graduates of specialty preparation through
credentialing. (p. 353)
You will notice the clear emphasis on training within this model. Each of the core areas of knowledge and skill occur over
the course of doctoral training, residency training, and continuing life-long education. While competency is not guaranteed by
training, lack of competency is guaranteed by lack of training.
The position of Rodolfa and colleagues (2005) can be condensed down to three points: (i) an organized specialty; (ii)
demonstratively adequate training; and (iii) certified competence.

An Organized Specialty

Manfred Meier (1998) presented the history of the early organization of applied neuropsychology. He noted that the
International Neuropsychological Society (INS) was formed in the mid-1960s partially because there was no such avenue
of focus within the American Psychological Association. As you know, INS became multidisciplinary and international in
scope with the primary focus of sharing new scientific knowledge rather than professional practice issues. By the 1970s,
the need to focus on professional issues became apparent, and INS created a Task Force on Education, Accreditation, and
Credentialing. In a parallel endeavor, the NAN was founded in 1975. The bylaws of NAN indicate that the purpose of
NAN is to advance neuropsychology as a science and health profession, to promote human welfare, and to generate and disseminate knowledge of brain–behavior relationships. The INS Task Force advocated APA for a new division focusing on neuropsychology, and Division 40 (Clinical Neuropsychology) was established in 1980. Eventually, responsibility for the Task Force was largely transferred to Division 40, and thereafter, the first set of guidelines was published (INS-Division 40 Task Force, 1987).
The American Board of Clinical Neuropsychology (ABCN) was incorporated in 1981, and the American Board of
Professional Neuropsychology (ABPN) was incorporated in 1982. Both organizations had as their goal to certify competence
in applied neuropsychology. ABCN then became affiliated with American Board of Professional Psychology (ABPP) in 1983 (Meier, 1998).

Our field continued to mature during the 1980s as post-doctoral training programs were developed. ABPP sponsored the
Conference on Postdoctoral Education and Training in Minneapolis in 1991. Out of this conference, the Interorganizational Council for Postdoctoral Education in Professional Psychology (IOC) was created. Thereafter, the Association for Postdoctoral Programs in Clinical Neuropsychology (APP CN), the Association of Internship Training Clinical Neuropsychology (AITCN), and the Association for Doctoral Education in Clinical Neuropsychology (ADECN) were created. These different neuropsychology groups ultimately became more integrated via the Clinical Neuropsychology Synarchy (CNS). NAN is a current member of the CNS.

All of the above work laid the foundation for the establishment of neuropsychology as a specialty. In the 1990s, APA created
the Commission for the Recognition of Specialties and Proficiencies in Professional Psychology (CRSPP). Division 40 insti-
tuted a planning committee that created a mission statement and addressed the CRSPP guidelines. Clinical neuropsychology
then became a formal specialty area after approval of the APA Council of Representatives in 1996. The history of clinical
neuropsychology makes it clear that professional neuropsychology is an organized specialty.

Demonstratively Adequate Training

Training also is a required component of competence. But how much training is enough? As our sense of competence must
come from objective sources, the answer to how much training is sufficient must come from a consensus of the field. We cannot
simply rely on the statement, “I have enough training because I believe I have enough training.”
In the early 1980s, we saw the initial INS Task Force report (Meier, 1981) and ultimately the INS-Division 40 Guidelines (INS-Division 40 Task Force, 1987) pertaining to the minimum required training for the professional delivery of neuropsychology services. The purpose of these guidelines was to bring some sense of organization to the newly defined clinical specialty area of clinical neuropsychology within the broader scope of clinical psychology. Those guidelines served us well. They became a consensus document that spelled out what could be expected of a practitioner in the area of professional neuropsychology. Given the large changes that occurred in the late 1980s and the early 1990s, it was determined that a fresh look at our training model was needed (Bieliauskas, 1998; Meier, 1998).

In September 1997, the Houston Conference was held to recreate, from the ground up, an integrated training model that would include the full scope of training from doctoral level coursework, internship experience, and residency experience. “The aim of the Houston Conference was to advance an aspirational, integrated, model of specialty training in clinical neuropsychology” (Hannay et al., 1998; p. 160).

This Policy Statement spelled out an updated definition of neuropsychologist as well as the specific knowledge base and skills required to practice clinical neuropsychology.

(i) Knowledge Base
   (a) Generic Psychology Core
   (b) Generic Clinical Core
   (c) Foundations for the study of brain–behavior relationships
   (d) Foundations for the practice of clinical neuropsychology

(ii) Skills
   (a) Assessment
   (b) Treatment and Interventions
   (c) Consultation
   (d) Research
   (e) Teaching and Supervision

The content areas could be spread out over differing training levels, such as doctoral coursework, and intern and residency levels. Internships are largely considered to provide the foundational broad training that a clinical psychologist must receive, but with the hope that it would “extend specialty preparation in science and professional practice in clinical neuropsychology” (p. 163).

The residency “training is designed to provide clinical, didactic, and academic training to produce an advanced level of competence in the specialty of clinical neuropsychology and to complete the education and training necessary for independent practice in the specialty” (pp. 163–164). This training is expected to last for the equivalent of two full-time years. Entrance to a neuropsychology residency requires the completion of an APA or Canadian Psychological Association (CPA) accredited doctoral program and an APA or CPA accredited internship. The Statement noted this expectation for neuropsychology residencies (p. 164):

(1) The faculty is comprised of a board-certified clinical neuropsychologist and other professional psychologists;
(2) Training is provided at a fixed site or on formally affiliated and geographically proximate training sites, with primarily on-site supervision;
(3) There is access to clinical services and training programs in medical specialties and allied professions;
(4) There are interactions with other residents in medical specialties and allied professions, if not other residents in clinical neuropsychology;
(5) Each resident spends significant percentages of time in clinical service, clinical research, and educational activities, appropriate to the individual resident’s training needs.

Specific exit criteria for the residency were spelled out (p. 164):

(1) Advanced skill in the neuropsychological evaluation, treatment, and consultation to patients and professionals sufficient to practice on an independent basis;
(2) Advanced understanding of brain–behavior relationships;
(3) Scholarly activity, for example, submission of a study or literature review for publication, presentation, submission of a grant proposal, or outcome assessment;
A formal evaluation of competency in the exit criteria 1 through 3 shall occur in the residency program;
(5) Eligibility for state or provincial licensure or certification for the independent practice of psychology;
(6) Eligibility for board certification in clinical neuropsychology by the ABPP.

The Houston Statement was presented as an aspirational document that would help guide the continued development of the specialty of clinical neuropsychology for the coming years, but concerns about the document and the process of its development became quickly apparent.

In a letter to Dr Hannay, Chair of the Houston Conference Planning Committee, then NAN president Dr George Prigatano provided these words:

The Board of Directors of the National Academy of Neuropsychology clearly supports and endorses this view of education and training…The Houston Conference Policy Statement is a valuable working document in progress. It requires continued development and modification in order to be responsive to the needs of our profession, while at the same time providing appropriately high standards for training, education and credentialing. We reaffirm the importance and value of high standards for the field, the need to obtain APA approved predoctoral internship training and the value of psychologists obtaining post-doctoral residency training to further develop their academic and clinical competencies.

Although the NAN Board endorsed the Houston Statement, there were also concerns focused around these issues (Prigatano, 1998):

(1) The perception that delegate selection for this Conference was done by psychologists not elected to represent them concerning matters of training, education, or credentially [sic];
(2) The perception that the process of selection was not done in a democratic way;
(3) Diversity of opinion did not appear to be sought or encouraged, beyond those attending the meeting;
(4) The potential acceptance and application of this Policy Statement seemed to be occurring before the field had adequate opportunity to reflect or vote on it.

These concerns came out of a survey pertaining specifically to the nature of the conference created by Dr Ralph Reitan that went to the NAN membership (Reitan, Hom, Van De Voorde, Stanczak, & Wolfson, 2004). Additionally some survey respondents were apparently concerned about these two pointed issues (Prigatano, 1998):

(1) The traditionally held view that accomplishment of a doctorate degree in psychology and obtaining licensure is, in and of itself, adequate to practice; and
(2) The freedom of practicing neuropsychologists to use the title of neuropsychologist and to choose which credentialing agency to apply to for further documentation of their professional competency.

This latter concern clearly refers to people’s ability to feel free to pursue board certification with the ABPN because of the Statement’s emphasis of the ABPP. Given NAN’s history of remaining “board neutral,” there were undoubtedly Board concerns about this emphasis. Additional criticisms materialized in 2000, which were ultimately published by Dr Reitan and colleagues in 2004.

In October 2001, NAN Board of Directors passed the following resolution:

Be it resolved that the Executive Board of the National Academy of Neuropsychology, while meeting in open session and having been a sponsor of the Houston Conference, views the requirement for employment that a Neuropsychologist “be trained in accordance with the principles of the Houston Conference” or similar statements to be premature. The Houston Conference Training Guidelines are properly considered as aspirational and should not be subject to rigid application.

In 2002, the ABCN endorsed the Houston Statement as the current model of training in neuropsychology to become effective for individuals graduating after December 31, 2004.

So where are we now with the Houston Statement after 10 years? I am pleased to say that the Interorganizational Summit on Education and Training (ISET) Steering Committee, chaired by our own past president, Dr Bill Perry, was developed with representatives from NAN, Division 40, APPCN, ABPN, American College of Professional Neuropsychology, AITCN, ABCN, American Academy of Clinical Neuropsychology, and ADECN.

The initial goal was to include a wide representation from clinical neuropsychology thus addressing some of those previous concerns. The goals and objectives of the steering committee were established and included creating a mechanism to collect
information to determine the degree to which the Houston Policy Statement guidelines have been assimilated into the training of neuropsychologists at all three levels (graduate, internship, and residency). Once relevant data are collected, the aim is to engage in discussions to determine whether revisions to the training model may be useful.

ISET met in February 2007 and reviewed data from surveys conducted by ADECN and APPCN. They concluded that some surveys were several years old, did not specifically address the Houston guidelines, the majority of information came from program directors with little input from trainees or professionals in the field, the impact of CPT and reimbursement-related issues on training needs to be addressed, and there needs to be a work analysis (i.e., determine what training neuropsychologists believe was valuable in preparing them to function in their current roles). They agreed it is healthy to re-examine the Houston document and any potential subsequent documents on an ongoing basis. The recognized some rewriting is likely necessary. They also recognized multiple brief surveys sent out via multiple organizations would increase the chance of input from the broadest and most representative sample of the field. Data should come from multiple sources, including practitioners, academics, and program directors, but the emphasis would be on those who received their training in the last 5 years. Some suggested interest in an entirely new model, but all agreed we cannot advocate for people to obtain the majority of their training from continuing education. I understand the first of these ISET surveys is complete and should go out to the neuropsychological community in the next couple of weeks.

We, the clinical neuropsychology community, have an established training model. It is a living document that can be responsive to the needs of our field, particularly with the collaborative efforts of ISET. Does some of the wording need changing? Yes. Do I have frustrations because of some of it? Yes. I agree with the decision of the NAN Board that an implied “requirement” for employment (or practice more broadly) was premature in 1998. I would argue that this requirement is no longer premature. Our field has matured since that time. We, NAN, along with the larger neuropsychology community, need to embrace the training model with the hope and plan to improve it for the future. Adhering to a systematic training model in neuropsychology will improve our field by increasing the overall consistency of clinical neuropsychological competence. Our field must do this to mature further.

Certified Competence

If I have not upset some of you with what I have said so far, I will likely do it now. The last aspect of verifying authentic professional competence is having your work reviewed and approved by people who are established experts in the field. Although I disagree with the specific wording of the Houston Policy Statement that training should lead to eligibility for certification by ABPP, I agree it should lead to eligibility for board certification in neuropsychology.

When I talk about board certification, I mean certification with a genuine board that certifies psychologists as competent expert providers of clinical neuropsychology. How is this done? Let me present you with a quote from the National Benchbook on Psychiatric and Psychological Evidence and Testimony (Parry, 1998) to introduce the issue:

The court should be aware that while specialty board certification is prestigious within the various professions, witnesses who have not obtained this level of credentialing are not automatically presumed to be deficient by comparison, nor are they unsuited per se to provide expert testimony. Judges must also be wary of witnesses claiming certification by various “mail-order” boards that do not require an oral examination or other indicia of a rigorous qualifying process. (p. 55)

The courts value authentic professional competence, not vain attempts to appear more “qualified” than is truly the case. We all remember Zoe D. Katz, PhD, the cat who had “earned” board certification from American Psychotherapy Association (Eichel, 2002; Hanson, 2002). Such credentials are repugnant. Additionally they fail to meet muster under the most basic of ethical principles (Denney, 2005). The Ethical Principles of Psychologists and Code of Conduct (APA, 2002) makes this abundantly clear:

5.01 Avoidance of False or Deceptive Statements (b) Psychologists do not make false, deceptive, or fraudulent statements concerning (1) their training, experience, or competence; (2) their academic degrees; (3) their credentials; (4) their institutional or association affiliations; (5) their services; (6) the scientific or clinical basis for, or results or degree of success of, their services; (7) their fees; or (8) their publications or research findings. (Emphasis added)

Let me give you a real world example from a hearing in U.S. District Court:

Attorney: What does board certification mean?
Witness: I am a diplomate in forensic neuropsychology.
Attorney: Doctor, what does that mean?
Witness: Well there are three different board certification organizations that grant diplomate status in neuropsychology. They are all about the same, and I am board certified in forensic neuropsychology.
At that time, there were only two board certifying bodies in neuropsychology that examined a professional’s education/training, actual work samples, and also completed a face-to-face oral examination. This “expert,” on the other hand, was certified by the umbrella organization that certified Zoe. I would argue this man misrepresented his qualifications before the court. But, I imagine he could say, “There is nothing unethical about presenting the fact that I have diplomate status from this organization.” “I am misrepresenting nothing.” Yes, I would say, you are right, but what is it you are trying to convey from this credit card credential? And what would he be conveying? What does board certification mean in the public’s eye?

Nature of board certification. What does the consumer believe about board certification? I surveyed individuals attending various social functions, graduate school open houses, and a Mental Health in Corrections Conference via a blinded paper survey and obtained 123 responses. The mean age was 33 (SD = 9.8); 68% were women. Their mean education was 16 years (SD = 2.2). I asked them the general question of “How do doctors become board certified?” and provided them options. They could endorse as many as they wanted. These results are listed in Table 1. It is clear from these peoples’ responses that most believe clinicians must pass a written and oral examination that was developed and carried out by board-certified specialists. Conversely, most believed clinicians are not certified by examinations that were developed by noncertified specialists, nor are they certified simply by paying money for a certificate or winning an award.

I then asked them to rate three statements based on how they think/feel using a Likert Scale with 1 (strongly disagree) through 5 (strongly agree). There was a strong agreement to the first statement, “Only those doctors who have been evaluated regarding their skill and knowledge by experts in the field should be allowed to present themselves as ‘board certified’” (M = 4.63, SD = 0.78). There was also a strong agreement to the second statement, “I would be upset to find out my doctor was ‘certified’ by paying money rather than by an examination of his/her skills” (M = 4.49, SD = 0.9). Surprisingly, the third statement resulted in a majority agreement, although there was greater variability, “It should be illegal for a doctor to present himself/herself as board certified if the certification was based only on paying a fee” (M = 4.29, SD = 1.12).

The above survey results demonstrate that presenting certifications based on little substance is a misrepresentation given the lay understanding of board certification. Doing so is an attempt to misrepresent by bolstering one’s background with the implication of enhanced past training and accomplishment. The survey results also suggest that the lay population would be upset at learning their doctor was not genuinely board certified when board certification was presented as an earned accomplishment. In my opinion, such a misrepresentation constitutes an ethical violation under the APA Ethical Principles and Code of Conduct (2002), section 5.01. Again, do not accept a mere pretense of professional competence, but strive for authentic professional competence.

Importance of genuine board certification in neuropsychology. “Why should I run the risk of potentially embarrassing myself by going through that process?” A trusted colleague asked me this very good question. Why should someone face the added expense, time commitment, and risk of “failure” by going down that road? I would like to highlight this answer from three different perspectives: Public perception, credibility of the field, and personal growth.

Public perception. Although our board certifications are not in medical disciplines, I believe the public view of board certification of physicians is relevant for neuropsychologists. It was reported that in 2002, 85% of practicing physicians were board certified (Horowitz, Miller, & Miles, 2004). However, this number did not include those individuals who were certified at one time but let their certification lapse. I think we can agree that it is the expectation of the public that physicians should

Table 1. Survey to lay persons regarding their perception of becoming board certified (N=123)

<table>
<thead>
<tr>
<th>Options as to How Doctors Become Board Certified</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pass a written test in the specialty area (created by BC specialists)</td>
<td>113</td>
<td>10</td>
</tr>
<tr>
<td>Pass a lengthy oral examination by examiners who are BC in the specialty</td>
<td>87</td>
<td>36</td>
</tr>
<tr>
<td>Complete a multiple choice test (made by BC experts in the specialty)</td>
<td>67</td>
<td>56</td>
</tr>
<tr>
<td>Mail in work samples (records) for review by BC experts in the specialty</td>
<td>61</td>
<td>62</td>
</tr>
<tr>
<td>Have their supervisor review and rate their work</td>
<td>54</td>
<td>68</td>
</tr>
<tr>
<td>Pay money and get a certificate</td>
<td>33</td>
<td>90</td>
</tr>
<tr>
<td>Complete a multiple choice test made by nonboard-certified experts</td>
<td>5</td>
<td>118</td>
</tr>
<tr>
<td>Pass a written test that was not created by a board-certified expert</td>
<td>5</td>
<td>118</td>
</tr>
<tr>
<td>Mail in work samples that are reviewed by doctors who are not board certified</td>
<td>3</td>
<td>120</td>
</tr>
<tr>
<td>Pass a lengthy examination not made by board-certified experts</td>
<td>2</td>
<td>121</td>
</tr>
<tr>
<td>Win an award</td>
<td>1</td>
<td>122</td>
</tr>
<tr>
<td>Make their own certificate on a computer</td>
<td>1</td>
<td>122</td>
</tr>
</tbody>
</table>
be board certified, particularly when they are specialists. The American Board of Internal Medicine commissioned the Gallup organization to poll the general public about their views on physician certification (Brennan et al., 2004). Some of the findings included the view “that certification and the maintenance of certification were highly valued by the public” (p. 1042). The authors provided these conclusions:

Respondents indicated that they would be likely to change their own behavior to ensure that they are treated by a certified physician. Most claimed they would change physicians if their current physician or specialist failed to maintain certification, and when given the choice between a board-certified physician or a noncertified physician recommended by a trusted friend or family member, the majority reported that they would choose the former. (p. 1042)

The skeptic could easily say, “There is no credible evidence to suggest that board certification in neuropsychology actually demonstrates competency or improves quality of patient care.” I agree; the relationship between board certification and clinical outcome is complicated. The same concerns exist within medicine, but research is beginning to include studies that can be analyzed in this regard. These studies are suggesting a more positive relationship than negative relationship between these two issues (Sharp, Bashook, Lipsky, Horowitz, & Miller, 2002). I am also aware of the controversy pertaining to our own board certification in neuropsychology (McSweeny, Ris, Ricker, & Westerveld, 2004; Rohling, Lees-Haley, Langhinrichsen-Rohling, & Williamson, 2003). These issues are simply growing pains as we strive through our adolescence as a specialty. We are simply further behind the progress of our medical colleagues, whose first board certification was in ophthalmology in 1917 (Brennan et al., 2004).

The fact is, who among us would say it did not matter if the physician was board certified when it was your family member who needed surgery for cancer? I agree that board certification does not guarantee a competent provider, but at least you can say that the individual’s knowledge, work product, and to some degree, skill, have been evaluated by others. From the public perception, there is credibility to genuine board certification.

Credibility of the field. If you have not figured it out yet, it is my belief that providers in neuropsychology should do what it takes to become board certified. I believe it gives credibility to our field.

During the last 10 years, there has been a silent change in the healthcare world. I don’t mean billing or reimbursement issues. Recently, allied health professions have been adopting the doctorate as the standard of level of training for clinical practice. In 2000, the American Physical Therapy Association enacted changes in their training model. They instituted a transitional Doctor of Physical Therapy (DPT) degree program for physical therapists who practice based on a bachelor- or master-level degree and called for all physical therapy programs to adopt the DPT degree. Currently, physical therapists are graduating as doctors. This same trend occurred in pharmacy. Previously, only those with advanced training, particularly in pharmacotherapeutics, were granted the Pharmacy Doctor degree. By 2004, the Doctor of Pharmacy (PharmD) became the sole professional degree accredited by the Accreditation Council for Pharmacy Education (Pradel et al., 2004). Pharmacists were struggling with issues of board certification at that time as well. The same thing has occurred in Audiology. The mission of the Accreditation Commission for Audiology Education is “to assure the public that only those programs that have complied with this agency’s standards and that graduate competent audiologists trained at the Doctor of Audiology (Au.D.) level will be accredited” (American Academy of Audiology, 2009). There are now 71 audiology doctoral programs in the USA.

There has been degree creep as everyone wants to become a doctor. Whether for personal reasons or professional standing reasons, there is a pending change in the healthcare arena. Psychologists are currently considered licensed independent practitioners by the Joint Commission on the Accreditation of Health Care Organizations, capable of admitting and discharging patients, writing orders for seclusion, suicide precautions, and even restraints. This was largely due to the fact that we shared something in common with our physician colleagues. We are licensed as independent practitioners, and we are doctors. This situation could change in the future.

I believe that increasing the rates of board-certified practitioners in neuropsychology will enhance the credibility of not only the public’s perception of who we are individually, but also of the profession.

Personal growth. Last, I want to speak to the importance of personal growth. The Cube training model and the training model we have in neuropsychology call for continued education and growth after our graduation with a doctoral degree. Board certification is encouraged because it is widely presumed that going through a genuine board certification process enhances one’s knowledge and skill.

ABCN survey results. Two weeks ago I sent out a survey of recent diplomates of the ABCN to inquire about their own personal growth and perception of the board certification process. I received 67 email addresses from the ABPP office for the most recent 67 diplomates. I asked six questions using a Likert scale, and I provided a text box for them to provide a personal narrative.
response. This survey was done through a web-based survey company to ensure anonymity. There were five email failures. I received 49 responses for a 79% response rate, not counting the email failures. I provided these instructions:

For the following questions, please consider your experience preparing for each aspect of the ABCN board certification exam (written, work samples, oral) and actually taking the examination as one entire process, even if you had to retake portions of the examination.

The specific questions asked and participant responses are listed in Table 2. These data suggest that people perceived a growth in their knowledge of substantive aspects of the core neuropsychological content domains (neuroanatomy, behavioral neurology, and neuropsychological principles). They believe their practice of neuropsychology has improved for the most part. They believe their level of confidence in their neuropsychological understanding and skill has increased.

I then provided a free text box and asked them to please provide any comments about how they thought they changed regarding their skills by going through the examination process, if at all. Twenty-one of the 49 respondents provided answers. I will quote only six of these, but they were largely representative of the 21 respondents.

(1) This was a transformational experience for me professionally. I wanted to become ABPP certified to better ensure that I am actively pursuing expertise in my practice and ensuring the quality of care for my patients. The process was very challenging and as I studied, I became more effective in my care of patients and consultations with colleagues, which has made the process very satisfying. The letters beside my name are nice, but really, I am very happy for the process of honing my skills and ensuring that I am practicing at the highest ethical level. Thanks! Keep it challenging, it is a good neuropsychology “muscle building” workout so to speak. I also made a number of friends and new colleagues in the process. I thought that the process was very challenging and rewarding.

(2) I welcomed the opportunity to have to fully review the subject matter associated with the practice of neuropsychology. It is not something I would have undertaken on my own without a good “excuse” to do so. Certainly, I would have (and continue to) review things as I feel a need, but who can afford the time to review everything and pull that knowledge together in such a manner without a really good reason to do so? In addition, I feel more comfortable in my abilities to present my knowledge after surviving orals. Finally, going through the process of preparing for the various stages of the exam reminded me of how much I “don’t” know and could stand to brush up on more. I’m so glad I went through the process, and not just for a few initials that now follow my name.

(3) Even when at times I did not perform at my best through out the entire process, I learned what I needed to in order to raise my game to the highest standards that I set “for myself.” I learned what I’m made out of: Pluck, determination, and humility.

(4) On the other hand, I found the oral examination to be a tremendous growth experience. It provided me an opportunity to critically examine my own work, and become more mindful of issues most salient to practice such as test and norm selection, reliability, and validity of the measures for heterogeneous patients and clinical syndromes, and how individual difference and clinical factors impact test interpretation and recommendations. In addition, I gained

Table 2. Survey results of recent ABCN diplomates

<table>
<thead>
<tr>
<th>Questions asked</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly agree</th>
<th>Rating average</th>
<th>Response (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>My personal experience of my recent ABCN examination (including study/preparation and exam itself) was positive</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>18</td>
<td>26</td>
<td>4.37</td>
<td>49</td>
</tr>
<tr>
<td>I learned a great deal about the substantive aspects of neuropsychology (neuroanatomy, behavioral neurology, neuropsychological principles) by going through the examination process (study/preparation and exam itself)</td>
<td>1</td>
<td>0</td>
<td>6</td>
<td>9</td>
<td>33</td>
<td>4.49</td>
<td>49</td>
</tr>
<tr>
<td>My practice of neuropsychology has improved in quality as a result of going through the examination process (study/preparation and exam itself)</td>
<td>1</td>
<td>1</td>
<td>6</td>
<td>16</td>
<td>24</td>
<td>4.27</td>
<td>48</td>
</tr>
<tr>
<td>My level of confidence in my neuropsychological understanding has increased because of going through the examination process (study/preparation and exam itself)</td>
<td>0</td>
<td>5</td>
<td>6</td>
<td>10</td>
<td>28</td>
<td>4.24</td>
<td>49</td>
</tr>
<tr>
<td>My level of confidence in my neuropsychological skill has increased because of going through the examination process (study/preparation and exam itself)</td>
<td>0</td>
<td>2</td>
<td>5</td>
<td>14</td>
<td>28</td>
<td>4.39</td>
<td>49</td>
</tr>
<tr>
<td>Based on my own experience, I would recommend to a neuropsychologist colleague who I know well that she or he should take the ABCN examination</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>6</td>
<td>40</td>
<td>4.71</td>
<td>49</td>
</tr>
</tbody>
</table>
heightened awareness of how ethical issues impact practice on a daily basis. This process was invaluable and has increased my confidence as a neuropsychologist and teacher.

(5) I truly believe that going through the ABCN process made me a better neuropsychologist. Before going through the process, I did not appreciate how much my knowledge base would be expanded and how much more confidence I would have in my skills. It was the best thing I could have done for my training and for my career.

(6) Going through this process has made me a better and more confident neuropsychologist. I think achieving this benchmark has been a turning point for me and I am more likely to pursue research and other endeavors. I highly recommend the process to all of my trainees and look forward to being a mentor as well. I had a fabulous mentor who I never met until after the Orals!

Although I will concede these statements are potentially biased due to cognitive dissonance, I believe these testimonies provide a reasonably accurate picture of how the board certification process can enhance our skills. Going “through boards” is not a one time event. One must understand it as a process. I believe the only individuals who actually “fail the examination” are those who choose to give up during the process rather than face the emotional set back (and sometimes narcissistic injury), relearn the needed material, and step back up to the plate for another swing.

We, as a profession, need to “grow up.” Board certification as an expected standard is a sign of increased maturity of our field. Frankly, it does not matter to me which board in neuropsychology you choose to pursue as long as it is a genuine board certification examination. This process should include a formal credential verification, written examination, critical review of work samples, and thorough oral examination of your substantive neuropsychology-related and ethics-related knowledge base and diagnostic/therapeutic thinking skills.

I will leave you now with a quote from the 2001 NAN Policy and Planning Committee in regard to their 2001 definition of a clinical neuropsychologist (Barth et al., 2001):

Board certification (through formal credential verification, written and oral examination, and peer review) in the specialty of clinical neuropsychology is further evidence of the above advanced training, supervision, and applied fund of knowledge in clinical neuropsychology. (p. 555)

While important in 2001, I believe genuine board certification has become imperative today. Authentic professional competence in clinical neuropsychology is established by the culmination of a defined specialty area of practice, a thorough training model, and validation of expertise by one’s peers through the board certification process. We have a defined training model; it is time for all clinical neuropsychologists to rally around one training model and to do what it takes to become board certified.

Thank you, and good evening.

Conflict of Interest
None declared.

References


