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Cleveland and northeast Ohio are rich with cultural, educational, culinary, and recreational opportunities. Louis Stokes Cleveland VA is located in University Circle, at edge of the Rockefeller Cultural Gardens, along with such esteemed neighbors as Cleveland's renowned and newly expanded Museum of Art, Cleveland Botanical Gardens, Museum of Natural History, Western Reserve Historical Society, Case Western Reserve University, Cleveland Institute of Art, and Cleveland Institute of Music. Kent State University, Cleveland State University and the University of Akron are major educational institutions within easy driving distance.

Severance Hall at University Circle is the winter home of the Cleveland Orchestra, one of the world’s finest. In the summer the orchestra plays at Blossom Music Center, alternating with other popular music concerts. Cleveland’s music scene stretches across a multitude of genres and venues including the Rock and Roll Hall of Fame, Cain Park Arts Center, Beachland Ballroom, House of Blues and many other intimate nightclubs featuring big name acts. The Scene Magazine keeps the pulse of the local entertainment scene, reporting on venues and styles to suite many different tastes. Playhouse Square is the largest performing arts center outside of New York, and hosts dozens of productions yearly including Broadway greats and nationally touring celebrities.

Sports fans have their choice of excitement with the Cleveland Browns, Indians, and Cavaliers, as well as numerous opportunities for other affordable second tier professional sports. Outdoor recreation opportunities abound including beaches and boating on Lake Erie, hiking, running, and biking in the Cleveland Metropark’s “Emerald Necklace”, Cuyahoga Valley National Park, and numerous nearby state parks and recreational sites. There is a Nordic skiing center in the just east of Cleveland in the Metropark, four alpine ski areas within an hour’s drive, and more alpine and Nordic skiing within three hours. Canoeing and kayaking have become increasingly popular, with several livers around Cleveland.

History, diversity, and culinary delights are found in Cleveland neighborhoods such as Slavic Village, Detroit Shoreway, Warehouse District, Little Italy, Collinwood, Ohio City, Shaker Square, Stockyards, and Tremont. The diversity of ethnic groups established in the Cleveland area adds to the community's charm as well as to its culinary pleasures. These neighborhoods and the nearby suburban areas offer a wide range of accommodations, including apartments, condominiums, and single-family dwellings. Many trainees have been pleasantly surprised by lower housing costs and living expenses than are found in many metropolitan areas, and have remained in the community to begin their professional careers.
Live Cleveland stated it well: “The City of Cleveland is an exceptional Midwestern community . . . made up of many vibrant neighborhoods, each offering fantastic amenities and various lifestyle opportunities. Diversity is evident throughout, as Cleveland is home to more than 75 different nationalities and ethnic communities . . . Our wonderful neighborhoods are filled with engaging residents, a thriving business community with an energetic workforce, and an amazing collection of arts, culture, entertainment and recreational opportunities.”

Northeast Ohio suburbs lead state in ethnic diversity, census numbers show. By Dave Davis, Cleveland Plain Dealer, October 27, 2011. “Northeast Ohio is hands-down the most ethnically diverse area in the state . . . Six of Ohio's seven most ethnically diverse cities were Cleveland-area suburbs - Solon, Brunswick, Parma, North Olmsted, Avon and Wadsworth. . . . The current challenge is to be American,” said Kenneth Kovach, executive director of the International Community Council, an umbrella organization for the 117 ethnic groups that call northeast Ohio home. . . . Kovach added that the ethnic fabric remains strong . . . [through] cultural organizations [that] continue to teach the language and traditions of their homeland.” PD Article

The Medical Center is an HEI 2013 Leader in LGBT Healthcare Equality. Chaplain Service supports religious diversity with staff spiritual consultation in major religions and through community partnerships for religions not represented among staff. They have won a Best Practices Award in spiritual assessment.

The Cleveland-Akron-Elyria Metro area is the 18th largest urban area in the U.S. based on 2010 census data with 20.1% African-American, 4.7% Hispanic, 2.0% Asian, .2% American Indian/Native Alaskan, and 2.0% multiracial. Psychology Service staff consists of 30% ethnic minority, with approximately the same percentage among trainees. The Cleveland Cultural Gardens commemorate ethnic groups whose immigrants have contributed to national and local heritage. Festivals celebrating Cleveland diversity and inclusion include the Cleveland One World Festival (September), and Annual Latino Heritage Festival (Fall), and Freedom Festival.

Psychology Service sponsors the Diversity Committee whose aim is to develop, recruit, and promote diversity in the Psychology Department and in the training. We encourage people with disabilities and from other diverse backgrounds to apply. We do not discriminate based on disability. We provide reasonable accommodations as needed to people with disabilities. Our site is wheelchair accessible and ASL interpreters are available as needed. Our trainees and staff reflect a wide range of socioeconomic, cultural, and religious affiliations, including people with disabilities.
LOUIS STOKES CLEVELAND VA MEDICAL CENTER

The LSCVAMC is the third largest and diverse in the VA system, with a full array of services consolidated at our renovated and greatly expanded Wade Park Campus in University Circle. The hospital complex houses over 600 inpatient beds and provides comprehensive inpatient and outpatient care to medical and psychiatric patients. In spring 2012, an entirely new facility with comprehensive primary and specialty outpatient care services was opened in the nearby suburb of Parma. The Medical Center includes thirteen community-based satellite outpatient clinics situated across Northeast Ohio. Under the umbrella of one coordinated healthcare system, it provides comprehensive health care services to veterans and their families from a broad spectrum of socioeconomic and ethnic groups in this large catchment area. For mental health services alone, 20,000 veterans amass over 100,000 visits per year at our facility.

The Medical Center is heavily invested in training health care professionals and in basic and applied research, and supports several Centers of Excellence in healthcare. Residents and medical students from affiliated Case Western Reserve University School of Medicine train at the Medical Center in all major specialties. Affiliations are maintained with a large number of universities for professional training in a number of other health care disciplines including psychology, social work, nursing, dentistry, audiology and speech pathology, optometry, pharmacology, physical and occupational therapy, and nutrition. Over 1,000 health care profession students per year train at the Medical Center.

The VA is the largest provider of health care training in the United States, including the nation’s most extensive psychology training program. VA medical facilities are teaching hospitals affiliated with 107 of the nation's 126 medical schools. Training programs address critical training needs for skilled health care professionals who serve the entire nation. In recent years, support for education increased greatly and new internship and residency training program positions have been created. These additional positions have encouraged innovation in education to improve patient care, promote interdisciplinary training, and incorporate state-of-the-art models of clinical care. These include emphasis on evidence based practices, quality improvement, patient safety programs, and an unparalleled electronic medical record system.

During Public Service Recognition Week our medical center Director and Chief of Staff noted that the LSCVAMC provided “excellent care to more than 112,000 Northeast Ohio Veterans . . . you place the mission first, caring for our nation’s heroes. As a result of great, compassionate teamwork, Louis Stokes Cleveland VA:

• Has more Centers of Excellence in Care, Research and Education than any other VA;
• Cares for more than 5,500 unique Veterans each day;
• Maintains a 5 Star Quality Rating;
• Leads VHA in virtual/telehealth;
• Maintains the largest HBPC and MHICM programs;
• Is 1st VHA to receive Center of Excellence for ALS”

In 2016 surveyors from Joint Commission reviewed the outpatient and inpatient locations of care, made visits to Veteran’s homes, and talked to many Veterans and staff. LSCVAMC was reviewed under four
different Joint Commission Manuals: Hospital, Home Care, Behavioral Health, and Long Term Care. Together these four manuals encompass more than 1,200 elements of performance, and the only findings were a small number of easily correctable items. The surveyors all expressed their acknowledgement and sincere appreciation for the safe, quality and efficient care provided to veterans at the LSCVAMC. In July 2017 the Cleveland VA underwent an accreditation survey by the Commission on Cancer, American College of Surgeons and received a Full Accreditation with silver level of commendation until 2020. Our research program is among the largest in the Department of Veterans Affairs, with clinical and basic researchers known nationally and internationally for their contributions to science. The total research budget from all sources is ten million dollars.

The Wade Park facility is the main hospital located five miles east of downtown Cleveland within University Circle, a major healthcare, educational, and cultural area of the city. Services include inpatient and partial hospitalization units treating serious mental illness and dual diagnosis conditions, a psychiatric emergency room, the Veterans Addiction Recovery Center - a comprehensive inpatient and outpatient substance abuse program including a national Gambling Addiction Program, our PTSD Clinical Team residential unit, acute and intermediate medicine, surgery, spinal cord injury, geriatrics, neurology, and physical medicine and rehabilitation. Outpatient services focus on mental health and on primary medical care with psychologists as full participants on these teams. Special clinical programs and services include a Pain Management Center, the Day Hospital partial hospitalization program, cardiothoracic surgery, a Women’s Health Clinic, radiology service, and an innovative ambulatory surgery short stay unit. The Campus also includes the Community Living Center (our nursing home) and Domiciliary, both housed in newly constructed buildings. There are also two community-based Vet Centers which provide readjustment counseling for Vietnam, Korea, Desert Storm, and OEF/OIF veterans.

The Parma Outpatient Clinic is located southwest of Cleveland in an adjacent suburb. It provides comprehensive outpatient primary care, mental health, and substance abuse services, with psychologists involved in all of the programs. Specialized neuropsychological services are also available.

The community-based satellite outpatient clinics (CBOCs) including Akron, Canton, and Youngstown provide a range of outpatient medical, dental, mental health, and rehabilitation services to patients in those geographical areas. All locations are connected by high capacity broadband networking capable of providing real time conferencing and Clinical Video Telehealth (CVT) connections. Clinical Video Telehealth, Telemental Health, and Home Telehealth operations are being implemented across the system. Telehealth educational and evidence-based intervention practices are being implemented via CVT to better serve our rural and home-bound veterans, and to continue to provide services during unanticipated extreme weather events.
The Medical Center is organized around both service delivery and professional identity, with mental health programs in Outpatient Psychiatry, the Veterans Addiction Recovery Center, PTSD Clinical Team, Recovery Resource Center, Neuropsychology, General Medicine, Geriatrics, Cardiology, Pain Management, Spinal Cord Injury, Infectious Disease clinics, and Rehabilitation services. Over 70 psychologists in our service provide comprehensive services to patients and their families in these areas and other specialty clinics throughout the Medical Center. They serve as members of interdisciplinary treatment teams in psychiatric care, as consulting and unit psychologists in specialized medical units, and as coordinators or program managers of several patient care programs. In addition to clinical and administrative duties, psychologists are also actively involved in research and training. The variety of program involvement creates a wide range of professional activities in which an intern may engage, and a large, diverse, and experienced staff with whom to interact. Psychology Service is the direct administrative umbrella for most psychologists in the main medical centers. The Chief of Psychology Service is ultimately responsible for discipline-specific professional activity including hiring, credentialing and privileging, program assignments, performance and peer reviews, and training programs. The Director of Psychology Training manages the day-to-day operation of the Psychology Internship Program and Psychology Postdoctoral Residency Training Programs.
LSCVAMC Psychology Service provides pre-doctoral internship and post-doctoral training in professional psychology. All programs are fully accredited by the American Psychological Association.

MISSION
The mission of the LSCVAMC Psychology Training Programs is to provide the highest quality general, focus area, and specialty training to diverse cohorts of doctoral and postdoctoral psychology trainees to prepare them for independent professional practice.

VISION
Our programs will be recognized for their scope, depth, and quality by virtue of (1) achieving and maintaining APA Accredited status, (2) embodying and modeling leadership through the introduction and implementation of innovative and empirically validated treatments, and (3) acknowledgment by national, regional, and local administrative entities both within and outside the VA.

VALUES
Providing supervised clinical experiential training, the delivery of which serves the holistic needs of the diverse Veteran population, by (a) evaluating presenting issues with the most valid techniques, (b) preventing and ameliorating health care problems, (c) empowering Veterans with coping skills for behavior change, (d) providing person-centered care, and (e) fostering recovery. Developing, enhancing, and maximizing trainee competencies including diversity competence, appropriate to their program of study and level of training. Recruiting and selecting the highest quality trainees, emphasizing appointment of maximally diverse cohorts as a core value to provide multiple perspectives. Imparting knowledge to trainees in (a) the application of psychological science to practice, (b) professional comportment and decorum, and (c) ethically responsible judgment in decision-making. Maintaining and enhancing the competencies of supervisors through support of their continuing professional development.

GOALS
The goal of the Postdoctoral Residency Programs in Clinical Health Psychology, Clinical Psychology, and Rehabilitation Psychology is to provide an intensive and extensive core of specialized expertise in clinical work with the relevant populations, including assessment, intervention, consultation, and interdisciplinary team experience, as well as scholarly, teaching, and research activities. The goal of the Postdoctoral Residency Program in Clinical Neuropsychology is to provide science and research based specialized expertise in clinical work with the relevant populations, including assessment, consultation, intervention, and interdisciplinary team experience, as well as scholarly, teaching, and research activities.
RESIDENCY PROGRAMS

LSCVAMC Psychology Service offers residency programs in the APA Council of Specialties defined professional practice areas of Clinical Psychology, Clinical Health Psychology, Clinical Neuropsychology, and Rehabilitation Psychology. Each program is separately APA accredited. Geropsychology is currently a focus area in Clinical Health Psychology, however we have applied for separate accreditation. Psychology Service recognizes that specialty area practice requires advanced knowledge, skills, attitudes, and behaviors applicable to these distinct populations and problem areas. The programs seek to provide supervised experience that fosters advanced professional development of competencies applicable to the respective areas. Training curriculum is organized within each specialty area and informed by the associated professional training guidelines.

CORE PROGRAM REQUIREMENTS FOR ALL RESIDENCIES

SUPERVISION

Formal individual in-person supervision is provided to the resident by the rotation supervisor for a minimum of two hours weekly, with further consultation readily available. Residents also develop supervisory skills by participating in umbrella supervision of interns or practicum students consistent with their respective level of training. When practical, residents will be paired with supervisees providing psychological services within the same specialty or focus areas as the resident. Residents have the opportunity to facilitate small group didactic and case presentations with psychology interns.

Supervisors and residents develop a learning plan at the beginning of a training experience, including discussion of foundational and advanced competencies to be developed. Opportunity is provided for residents to develop more detailed training objectives building on the competencies. This permits the residents to tailor the training experience to allow more individualized professional goals.

EVALUATION

Assessment of competencies and training needs is a required component at each stage of our evaluation process. At the mid-point of training at each rotation, supervisor and resident collaborate on formal written evaluation of the resident’s progress. Residents whose performance are not at an expected level of competence will be advised regarding the problem areas in their performance, and a specific plan to remediate those weaknesses will be developed. At the end of each training rotation, residents participate in final ratings, including evaluation of the Site of Training.

FOUNDATIONAL, SPECIALTY, AND FOCUS AREA COMPETENCY DEVELOPMENT

Residents should already possess an independent practice level of competence in profession-wide foundational competencies. Program training objectives include the continued development of foundational profession-wide competencies, as well as specialty competencies and advanced competencies in individual focus areas. Programming is designed to encourage continued development of foundational competencies, provide the opportunity to solidify their emerging professional identities, and acquire advanced specialized skills. Advanced specialty and focus area competencies are described.
within the focus areas. The foundational competency domains that are included in evaluations are as follows:

**I. Science of Psychology:** The scientific knowledge and methods for understanding of research, research methodology, techniques of data collection and analysis, biological bases of behavior, cognitive-affective bases of behavior, and development across the lifespan.

**II. Ethical and legal standards:** The APA Ethical Principles and Code of Conduct and other relevant ethical/professional codes, standards and guidelines, laws, statutes, rules, and regulations.

**III. Individual and cultural diversity:** Professional awareness, sensitivity, and skill in working with diverse individuals and groups who represent broadly defined cultural and personal background characteristics that include age, disability, ethnicity, gender, gender identity, language, national origin, race, religion, culture, sexual orientation, and socioeconomic status.

**SCHOLARLY RESEARCH PROJECT**

All residents must complete a scholarly research or program evaluation project. Residents are provided 8 hours per week to develop, implement, and finish their projects. The projects may be original scientific research, program evaluation, quality improvement, or a program development project. All projects must involve literature review, research design, methods, data, and data analysis in a format similar to a publication submission. The resident must complete mandatory training in good clinical practice and human subject protection and VA research credentialing required by the local Institutional Review Board. By the third month of the residency, the resident should have a plan for a defined research or program evaluation project. The finished project must be presented in a venue open to all staff, usually Psychiatry Grand Rounds. Presentation of the research project must be sufficiently thorough and rigorous to qualify for State of Ohio Psychologist Continuing Education credits.

**CORE CURRICULUM REQUIREMENTS**

1. **Professional Issues Seminar:** A mandatory monthly seminar for all residents is conducted with the Director of Psychology Training. Topics include both professional issues and content areas of shared interest. This seminar is open to supervisors and staff.

2. **Supervision Seminar:** A mandatory monthly seminar for all residents is conducted encompassing both didactic and experiential components of supervision. Residents (Clinical Psychology, Clinical Neuropsychology) rotate responsibility for presenting a case example of trainee supervision and facilitating a discussion of relevant supervision issues. This seminar is open to supervisors and staff.

3. **Continuing Education:** Ongoing education is integral to the Residency program. In addition to the monthly Professional Issues and Supervision Seminars, attendance at least one other formal continuing education activity is required each month. The resident and Major Preceptor will discuss training needs and preferences throughout the Residency year, as well as relevant scheduled educational options.
TEACHING AND SUPERVISION EXPERIENCES

1. **Colloquium/Staff Education Presentation**: As indicated above, each resident prepares a Continuing Education-level presentation in an area of expertise acquired during the Residency year. This will be presented at a suitable venue, such as a regularly-scheduled Grand Rounds, in the latter months of the Residency year.

2. **Umbrella Training Supervision of Predoctoral Interns**: The residents provide formal supplementary “umbrella” training supervision to one or more predoctoral psychology interns. This umbrella supervision training experience occurs under the direct supervision of a rotation supervisor, with feedback both from the supervisor and supervisee.

3. **Group consultation with interns**: residents rotate in moderating a biweekly group case consultation discussion with Psychology Interns, affording experience with this supervision modality.

ADDITIONAL DIDACTIC EXPERIENCES

1. **The Louis Stokes Cleveland GRECC**: The GRECC was established to develop, implement and disseminate innovative programs to maintain independence, prevent disability, and improve quality of life for older veterans. Clinical demonstration programs include preventive and rehabilitative interventions, as well as new protocols to improve medication compliance, and other successful initiatives including the Hospice/Palliative Care Initiative. The education arm of the GRECC strives to advance quantity and quality of education in geriatrics and gerontology across the disciplines, with continued emphasis on training of medical and associated medical trainees. The GRECC cosponsors the Topics in Geriatric Medicine Series (See 3, below). Considerable interaction among the disciplines occurs.

2. **Psychiatry Grand Rounds**: This series provides a variety of content relevant to mental health. It is approved for continuing education credit by the Ohio Psychological Association, as well as for most healthcare professions within the state. Presenters include local and national VA staff, affiliated university educators, and outside consultants.

3. **Topics in Geriatric Medicine Series**: This series offers weekly seminars on subjects relevant to working with the elderly. Local experts as well as nationally renowned figures present on topics such as dementia, delirium, older persons’ capacity to drive, perceptual functioning and information processing, affective disorders and substance abuse.

4. **Psychology Intern Seminars**: Interns attend a weekly two-hour seminar that provides in-depth treatment of a range of topics across all specialties. The seminars are primarily by psychologist expert staff, with occasional speakers from other medical disciplines.

5. **Institutional Review Board**: Residents may observe a meeting of the local Institutional Review Board (IRB). The IRB is comprised of professional and community members who share the responsibility for insuring that human studies research at this medical center is conducted under the most rigorous ethical standards to assure the protection of the rights, welfare, and safety of the veteran patients under our care. Psychologists’ roles within the Human Studies Subcommittee will be discussed with an active IRB psychologist member.

6. **Educational Events**: Psychology Service sponsors continuing education events featuring nationally prominent presenters. In recent years, the following experts have presented workshops or lectures in this series:
2008  Morgan Sammons, M.D., Ph.D. on Prescriptive Authority for Psychologists
2009  William Miller, Ph.D. on Motivational Interviewing
       James Prochaska, Ph.D. on Stages of Change
       Stephen Behnke, J.D., Ph.D. on Multidisciplinary Professional Ethics
2010  Steven Hayes, Ph.D. on Acceptance and Commitment Therapy
       Stephanie Covington, Ph.D. on Addiction and Trauma in Women
2010  Scott Stuart, M.D. on Interpersonal Psychotherapy
2014  Kenneth Adams, Ph.D. on Ethical Treatment Across the Lifespan
2014  Yossef Ben-Porath, Ph.D. on the MMPI-2-RF
2015  Bob Stinson, Psy.D., ABPP on Mandatory Reporting
2016  Frederick Leong, Ph.D., Cross Cultural Psychotherapy Part II
2016  Melinda Moore, Ph.D. Collaborative Assessment and Management of Suicidality
2017  Peter Gutierrez, Ph.D. Suicide Assessment, Safety Planning, & Treatment Planning
APPLICATION PROCEDURES

Prospective residents may apply to, and be considered for, more than one residency specialty program and for more than one special focus area within a residency specialty program. Applicants must submit separate letters of interest and separate work samples for each application.

The Clinical Health, Clinical Psychology, and Rehabilitation Residency Programs will follow the APPIC Postdoctoral Selection Guidelines. Please carefully review these guidelines, we will begin making offers at 10:00 AM Eastern time on Monday February 26, 2018. If you receive an offer elsewhere prior to that time and our program is your top ranked choice, contact us immediately. The guidelines allow us to make a reciprocal offer immediately. Applicants may hold offers for 24 hours, and will be notified when they are no longer in consideration. We ask the same consideration from applicants - please notify us when you are no longer considering coming to the LSCVAMC.

The Clinical Neuropsychology Residency and Rehabilitation Psychology Programs are two-year programs, and we are accepting applications for both programs for the 2018-2019 year. The Clinical Neuropsychology Residency participates in the Association of Postdoctoral Programs in Clinical Neuropsychology Residency Match that releases results on APPCN Match Day February 2018.

Eligibility Requirements

1. U.S. citizenship.
2. Successful completion of an APA-accredited Doctoral program in Clinical or Counseling Psychology, including APA-accredited Doctoral Internship.
3. All requirements for the doctoral degree must be completed prior to the start date.

Application Requirements

1. Curriculum Vitae
2. Statement of applicant’s interest in the program focus area to be pursued. (a separate distinct letter for each application/area of interest)
3. Letter of recommendation from the Director of Training of the applicant’s internship program
4. Two letters of recommendation from supervisors who can address the applicant’s capability in the focus area to which he/she is applying.
5. A work sample of psychological assessment (a separate one for each application/area of interest)
6. Official transcripts of graduate work.

You may apply to more than one area and submit one total package, however you must make clear you are doing so and send separate letters of interest and work samples for each area.

Training occurs in a health care setting where patients could succumb to common illnesses like influenza. It is important to be able to document that your vaccinations are up to date and that you have been screened for active tuberculosis prior to starting your training. Securing a statement from university student health center, your regular health provider, or an urgent care clinic can expedite your appointment. Additionally, maintaining a current flu vaccination during the training year or additional
preventative measures will be required. Human Resources also requires the Training Qualifications and Credentials Verification Letter (TQCVL) at the time of onboarding. The letter documents postdoctoral resident readiness for starting clinical work at a VA facility. There are requirements for such things as Hepatitis B vaccination (or signing a declination form), TB screening, screening against the List of Excluded Individuals and Entities database.

**APPA - CAS Online**

The Clinical Psychology, Clinical Health Psychology, and Rehabilitation Psychology Residencies are registered with the online APPIC Psychology Postdoctoral Application Centralized Application System. Applicants should use that system for their applications, and may include all application materials with the APPA. If there is any problem with completing the online application, please scan and submit documents directly by email to Ms. Rosen and the Director of Training.

**Application materials should be received by FRIDAY JANUARY 12, 2018.**

**Application Address**

Director of Psychology Training 116B (W)  
James DeLamatre, Ph.D., Director of Training  
Louis Stokes Cleveland VAMC  
James.delamatre@va.gov  
10701 East Blvd.  
Cleveland, Ohio 44106  
Judith Rosen, Program Assistant  
216-791-3800 x6822  
Judith.Rosen2@va.gov  

**Questions regarding the accreditation of the Residencies may be addressed to:**

Office of Program Consultation and Accreditation  
American Psychological Association  
750 First Street N.E.  
Washington, D.C. 20002-4242  
Phone: (202) 336-5979  
Email: apaaccred@apa.org  
Web: [www.apa.org/ed/accreditation](http://www.apa.org/ed/accreditation)

Telephone inquiries about our program are invited at (216) 791-3800, x6822. We encourage diversity in our Residency cohort and invite application by qualified ethnic minority group members.

**Start Date**

Early-September 2018

**Stipend**

$ 43,982  First Year  
$ 46,359  Second Year

**Benefits**

Health insurance benefits, 13 days paid Annual Leave and up to 13 days of Sick Leave, 5 days if Authorized Absence with pay for attendance at approved conferences.
RESIDENCY ADMISSIONS, SUPPORT, AND INITIAL PLACEMENT DATA

Internship Program Admissions
Date Program Tables are updated: November 15, 2017
Briefly describe in narrative form important information to assist potential applicants in assessing their likely fit with your program. This description must be consistent with the program’s policies on resident selection and practicum and academic preparation requirements:

Our selection process is a rational one in which the residency preceptors rate applications on a standard set of criteria that relates to success in our VA residencies. We look for applicants whom have well-rounded experience in assessment, intervention, integrated psychological reports, a diverse array of clients, and settings pertinent to specialty and focus area to which they are applying.

Describe any other required minimum criteria used to screen applicants:
At a minimum, the applicant must have successfully completed APA accredited doctoral and internship programs. We have no specific required minimum criteria, it is dependent on the applicant pool and the judgement of the training committee members. Please see selection procedures description above.

Financial and Other Benefit Support for Upcoming Training Year*

<table>
<thead>
<tr>
<th>Benefit Support</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Stipend/Salary for Full-time Residents</td>
<td>$43,982</td>
</tr>
<tr>
<td>Annual Stipend/Salary for Half-time Residents</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Program provides access to medical insurance for resident? | Yes
If access to medical insurance is provided:
- Trainee contribution to cost required? | Yes
- Coverage of family member(s) available? | Yes
- Coverage of legally married partner available? | Yes
- Coverage of domestic partner available? | Yes

<table>
<thead>
<tr>
<th>Benefit Support</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hours of Annual Paid Personal Time Off (PTO and/or Vacation)</td>
<td>104</td>
</tr>
<tr>
<td>Hours of Annual Paid Sick Leave</td>
<td>104</td>
</tr>
</tbody>
</table>

In the event of medical conditions and/or family needs that require extended leave, does the program allow reasonable unpaid leave to interns/residents in excess of personal time off and sick leave? | Yes

Other Benefits (please describe): We follow Family Friendly Medical Leave guidelines for extended leave without pay. Extended leave beyond above will require an extension of internship.

*Note. Programs are not required by the Commission on Accreditation to provide all benefits listed in this table
Initial Post-Residency Positions

<table>
<thead>
<tr>
<th>Position</th>
<th>PD</th>
<th>EP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community mental health center</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Federally qualified health center</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Independent primary care facility/clinic</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>University counseling center</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Veterans Affairs medical center</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Military health center</td>
<td></td>
<td>21</td>
</tr>
<tr>
<td>Academic health center</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other medical center or hospital</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Psychiatric hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Academic university/department</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Community college or other teaching setting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Independent research institution</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Correctional facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>School district/system</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Independent practice setting</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Not currently employed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Changed to another field</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
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<td>7</td>
</tr>
</tbody>
</table>

Note: “PD” = Post-doctoral residency position; “EP” = Employed Position. Individuals represented in this table are counted once. For former trainees working in more than one setting, the setting represents their primary position.

RESIDENCY SELECTION PROCEDURES

Overall, our selection process is a rational review of applications by our training staff. We rate the application materials on a standard set of criteria and conduct a performance based interview (PBI). The PBI is a standard set of questions for all residents, with an additional set of questions unique to the specialty and focus area. Applicants are then ranked and the top applicant is offered the residency on the APPIC uniform notification day. We use the APPA-CAS application system and follow all APPIC guidelines for application including honoring the uniform notification day. An applicant has the best chance of matching with us by having a well-rounded background pertinent to working at the VA, strong justification or experience for the specialty or focus area, attention to diversity issues, and professional presentation of themselves. More detail on selection is provided in the Operating Procedures.
Psychologists have been embedded within medical care delivery units at this medical center since 1974, and have served as internship supervisors for over 30 years. Health Psychologists assigned to these areas are available for resident supervision. The philosophy of our program is first to develop a well-versed generalist psychologist with advanced skills in assessment and treatment of common health problems. The resident works as a member of an interprofessional health care team with emphasis on the biopsychosocial model of evidence-based clinical care along with quality scholarship and empiricism.

The goals of the program are multifaceted. They are to educate the resident in the many roles played by a health psychologist specialist working in an interdiscipliary team; acknowledge the importance of and utilize the developmental, biopsychosocial, and systemic approaches to patient care in various specialty clinics; appreciate and learn the practice of acute to chronic care of patients with both life-threatening and life-long disease processes; foster clinical and empirical collaboration; learn how to intervene in practitioner-patient-family dynamics; and learn how to import expertise as a behavioral health specialist to the health care team.

The resident participates in a year-long clinical training program (32 hours weekly) in various specialty clinical areas detailed below. All rotations include teaching, scholarly and intern supervisory activities in addition to clinical experiential training. In addition to the seminars required of all residents, residents in the health psychology focus areas are also required to attend:

**Clinical Health Psychology Residents Seminar:** residents in Primary Care, Specialty Medical Clinics, Geropsychology, and Rehabilitation Psychology attend an additional monthly Health Psychology Seminar, emphasizing pertinent contemporary topic presentations, discussion of the literature, and case presentations.

In addition to the foundational competencies specified for all residencies, the following competencies are common to all Clinical Health Psychology specialty and focus areas.

**CLINICAL HEALTH PSYCHOLOGY PROGRAM**

**CLINICAL HEALTH PSYCHOLOGY SPECIALTY (Functional) COMPETENCIES**

1. **Professional values appropriate to health psychology settings.** Understanding professional values and behaviors relevant to competent practice within interdisciplinary treatment teams.

2. **Advanced science and knowledge in health psychology.** Acquiring foundational knowledge bases covering the biological, psychological, and social aspects of health conditions and behaviors across the lifespan.

3. **Advanced Health Psychology Assessment.** Acquiring foundational knowledge bases and clinical skills relevant to empirically supported biopsychosocial assessment strategies, diagnoses, case conceptualizations, and communication of findings.

4. **Advanced Health Psychology Interventions.** Acquiring foundational knowledge bases and clinical skills for behavioral interventions relevant to disease management, health promotion, and prevention of health-related issues.
I. SPECIALTY MEDICINE CLINICS

(1 resident)

The resident participates in a year-long clinical training program (32 hours weekly) in several specialty clinical areas. The resident trains concurrently across multiple interdisciplinary specialty medical clinics with a range of clinical experiences. Residents engage in interdisciplinary didactics, intern supervisory activities, complex clinical training, and creation of his/her scholarly research project.

SPECIALTY MEDICINE CLINICAL TRAINING EXPERIENCES

The resident participates the following core clinical training experiences.

A. Cardiology/Solid Organ Transplant Team

(16 hours per week; full year duration)

The resident will be part of a team treating patients with severe cardiac problems. The treatment environment may be an inpatient ward, a coronary intensive care unit, or outpatient cardiology clinic. Additionally, the resident will participate in assessment of patients’ readiness for solid organ transplantation. The resident will assess patient readiness for heart, liver, lung, and kidney transplantation and follow those patients post-operatively as necessary. The Residents will assess and treat patients individually as well as in group formats (e.g., Heart Failure Group, Heart Failure Boot Camp).

B. Hematology-Oncology/Palliative Care/Hospice

(8 hours per week; full year duration)

The resident will be serve multiple roles within the Hematology/Oncology and Palliative Care teams. Within Hem/Onc, the resident will function as a member of the interdisciplinary team that provides treatment to veterans with an oncology diagnosis in both inpatient and/or outpatient settings. Additionally, the resident may conduct a Psychological Evaluation of Bone Marrow Transplant Candidacy as well as Capacity Evaluations. The resident will assess and conduct treatment within individual, family, couple and group modalities. Finally, as a member of the interdisciplinary Palliative Care team, the resident will conduct psychological assessments when inpatient Palliative Care consults are entered.

V. Advanced health psychology consultation. Acquiring foundational knowledge bases and skills in psychological consultation within the context of a health care setting.

VI. Advanced Health Psychology Research/Program Evaluation. Understanding the role of health psychology in the development and communication of health-related research and program evaluation in interdisciplinary treatment settings.

VII. Reflective Practice/Self-Assessment/Self-Care. Understanding and utilization of information gained from self-reflection on clinical skills used, boundaries of competence, and impact of one’s own well-being.
C. Sleep Clinic

(8 hours per week; full year duration)

Within an interdisciplinary treatment team setting, the resident will assess and treat sleep disorders as well as assist patients coping with other chronic pulmonary problems that are seen in the sleep clinic. The resident will gain specific familiarity with Cognitive Behavioral Therapy for Insomnia (CBT-I) and other behavior-based interventions emphasizing first line non-pharmacological treatments of insomnia. Additional experience will be gained in assisting with treatment adherence across a broad range of sleep disorders.

D. Scholarly Research Project

(8 hours per week; full year duration)

The research requirement is described here.

II. PRIMARY CARE CENTER OF EXCELLENCE

(3 residents)

Seven Centers of Excellence in Primary Care Education (CoEPCE), established by the Veterans Affairs’ Office of Academic Affiliations, were created as part of a national initiative to implement and test innovative approaches for interdisciplinary, collaborative, patient-centered practices that provide coordinated longitudinal care. At the Cleveland VA site, psychology fellows train as part of an interdisciplinary cohort working from the core assumption that psychology is an integral participant in the primary care team. This track includes both clinical training/supervision, as well as participation in an interprofessional, interactive, curriculum shaped by four pre-defined educational domains (competencies): 1) Shared Decision Making; 2) Interprofessional Collaboration; 3) Performance Improvement; and 4) Sustained Relationships. Our curriculum adds 6 dimensions to help clarify the above competencies and skills needed for the 21st century: Unified Care, Quality Care Improvement, Real Time Real Patient Care, Proactive Care, Virtual Health, Culture and Health. The cross of these dimensions and domains serves as the foundation for a longitudinal, clinical outpatient curriculum. The resident participates in a year-long core clinical training in the Outpatient Medicine Clinic, a rotation in Geriatrics, and eight hours per week in research. Core clinical training and optional rotations also include teaching, scholarly and supervisory activities.

PRIMARY CARE CLINICAL TRAINING EXPERIENCES

A. Primary Care Center of Excellence

(28 hours/week; year-long duration)

The Primary Care Center of Excellence (COE) interdisciplinary primary care medicine clinic is staffed by attending physicians, health psychologists, GIM Residents, nurse practitioners, PharmDs, dietitians, and social workers. The resident is involved in the following activities in the primary care clinic:

1. Accepting warm hand-offs in the Primary Care Clinic to complete an initial Primary Care Mental Health Integration (PC-MHI) functional assessment that focuses on the referral problem; This
may include health psychology focused assessments (smoking cessation, obesity, adherence, barriers to diabetes self-management) or brief assessment of mental status, substance use, functional status, health and well-being, and mental health. Residents will follow a PC-MHI Consultation model for initial and follow-up appointments (5As, functional assessment, consultation vs psychotherapy, brief time-limited sessions).

2. Facilitation of interdisciplinary shared medical appointments for hypertension and diabetes as well as MOVE groups
3. Interdisciplinary team meetings and teaching rounds with COE faculty and fellow learners.
4. Supportive and time limited psychological tx (problem solving tx, behavior activation, CBT, Health psychology interventions).
5. Consultation with nursing and medical staff.
6. Performing cognitive evaluations and capacity evaluations.
7. Completing psychological evaluations for appropriateness of bariatric surgery.
8. Participation in the Preventive Medicine Clinic for smoking cessation, obesity and nonadherence.
9. Facilitation of tobacco cessation groups.
10. Participation in COE Team Huddles.
11. Completion of Yellow Belt Six Sigma Training (Quality improvement methodology) and an interdisciplinary Quality Improvement Project.
12. Participation in four hours weekly interprofessional COE didactic sessions.

B. Geriatric Outpatient Clinic
(8 hours per week, 4 month duration)
Within the COE, during one 4-month rotation, residents will participate in the Geriatric Outpatient Clinic for 8 hours per week. Geriatrics functions as an outpatient consultation service and is also a PACT primary care setting. The resident will participate in the evaluation of medical, cognitive, psychological, and physical functioning of older adults, many of whom are medically compromised and with complex psychosocial histories. The resident will learn how to quickly assess cognitive and mood issues, develop interventions, and integrate findings into an interdisciplinary care plan. There are also opportunities to engage the caregiving network in treatment as well as to provide caregiver support directly to family. The resident manages their own clinic two days a week with supervision and is involved in the following activities:

1. Psychological evaluation of new patients including clinical interview; cognitive and psychological screening; history; and interview with the partner, family, caregiver, or other collateral.
2. Interdisciplinary staffing of patients to develop a treatment plan.
3. Ongoing psychological interventions including individual therapy, couple’s and family therapy, management of behavioral problems, cognitive testing, and personality assessment as indicated.
5. Consultation and treatment of patients who develop emotional or cognitive difficulties once established in the clinic.

6. Warm hand-offs of patients with acute psychological concerns.

**C. Scholarly Research Project**

(8 hours per week; full year duration)

The research requirement is described [here](#).

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### III. HEPATITIS C AND HIV

(1 resident)

The resident participates in year-long ongoing involvement in Hepatitis C (HCV) specialty medicine clinic, HIV Primary Care clinic, and Substance Use Disorder treatment center. This residency includes opportunities to develop innovative programs, work in rapidly advancing areas of medicine, and collaborate with interdisciplinary teams of medical providers committed to optimizing care for veterans with infectious diseases. Given the interplay of substance use and risk for HIV and HCV, a goal of this residency is to provide advanced training in these complementary areas to enhance a holistic approach to Veterans’ care. The resident will work closely with Peer Support Specialists in developing outreach programs to expand services and assist veterans struggling with medical adherence and sobriety. There are also multiple opportunities to participate in research and/or program improvement. Current research projects in HIV clinic include focus on screening options for HIV-Associated Neurocognitive D/O (HAND), optimizing medication adherence for patients with HAND, and opportunities to provide education and consultation to primary care providers on tenants of behavioral medicine. Many providers in HCV are trained in Six Sigma performance improvement, making performance improvement a standard aspect of care in this clinic.

### HIV/HepC CLINICAL TRAINING EXPERIENCES

**A. Hepatitis C Clinic**

(14 hours per week; full year duration)

In this clinic, the psychology Resident will participate in interdisciplinary Shared Medical Visits (SMV) to educate veterans on the current treatment and management options for HCV and psychosocial risk factors for nonadherence to HCV treatment. S/he will also perform brief psychosocial assessments regarding patient readiness for HCV treatment, develop a disposition plan, address substance abuse and mental health risk factors, and coordinate with other substance use disorder, mental health, and medical providers to optimize treatment success. Within the Hepatitis C clinic, the Resident will gain supervised experience in:

2. Biopsychosocial assessments for HCV treatment candidacy.
3. Motivational interviewing
4. Harm reduction techniques to reduce risk for reinfection
B. HIV Clinic
(10 hours per week; full year duration)

In this clinic, the resident will collaborate with our interdisciplinary primary care team in assessing and treating behavioral health, mental health, and substance use concerns and disorders in patients living with HIV. Common therapeutic concerns include adjustment to HIV, medical adherence, smoking cessation and other substance use disorders, mood issues, stress, partner and family issues, as well as cognitive changes related to HIV. The resident will also participate in regular interdisciplinary seminars regarding advancements in HIV management.

Within the HIV clinic, the resident will gain supervised experience in these specific modalities:

2. Safety (suicide/homicide risk) assessment.
3. Motivational Interviewing for SUD and/or medication adherence
5. HIV psychoeducational/support group and individual psychotherapy
6. Cognitive and other neuropsychological screening assessments
7. Psychological capacity evaluations.
8. Other aspects of Primary Care Mental Health Integration (PC-MHI) and Patient Aligned Care Team (PACT) interventions and collaborations.

C. Veterans Addiction Recovery Center
(8 hours per week; full year duration)

This overarching substance use disorder treatment center provides a vast range of potential clinical experiences for a resident, depending on prior internship familiarity and training with this population. The incidence of patients with HIV or HCV with comorbid substance use disorders is extremely high, making it important for the resident to build at least a foundational skill set to work with patients with SUD issues. This includes effective and efficient SUD screening, understanding of the available evidence-based SUD treatments, and motivational interviewing skills to help patients increase readiness to change substance use behaviors. Specific programs in which a resident could be involved, depending on prior experience, include the following:

1. Intake/Assessment in a Primary Substance Abuse Program.
2. Acute Detoxification, with assessment and early engagement emphasis.
3. Residential (28-Day) Primary Substance Abuse Treatment Program.
4. Women’s Addiction Treatment Program.
5. Intensive Outpatient Program.
6. Gambling Treatment Program.
7. Opioid Replacement Program.

The resident will gain supervised experience in these specific modalities within the training milieu:

2. Motivational Interviewing/Motivational Enhancement.
3. Integrated treatments, such as DBT and Mindfulness, and their utility in treatment.
4. Social skills training.
5. Psychoeducation.

D. Scholarly Research Project

(8 hours per week; full year duration)
The research requirement is described here.

IV. GEROPSYCHOLOGY

(1 resident)

Geropsychology focus provides curriculum consistent with the Pikes Peak Model (Karel, Knight, Duffy, Hinichsen, & Zeiss, 2010) standards of practice in geropsychology. Residents are afforded year-long experiences working in multiple geriatric training locations that allow intensive follow-up and care planning opportunities. Geropsychology residents are expected to take advanced professional roles in geriatrics settings. They are encouraged to fully embrace taking a professional role in interdisciplinary consultation, education, and team meetings, in-service education for nursing staff, and umbrella supervision for interns. In addition, the geropsychology resident often oversees the behavioral management interdisciplinary team on the Dementia unit. The resident functions like a beginning staff member by being engaged with curb-side consultation, risk assessment, and patient care coordination scenarios at a more advanced level of service delivery than is required of internship trainees.

Patient issues provide opportunity for the resident to participate in coordination and outreach with non-VA agencies involved in geriatric care such as the Alzheimer’s Association, Adult Protective Services, Cuyahoga County Probate court, and the State of Ohio Bureau of Motor Vehicles. The resident has opportunity to serve on the local county adult protective service interdisciplinary or attend local hoarding connection groups.

The resident participates in year-long ongoing involvement in core clinical training in the Geriatric Evaluation and Management Unit (10 hours), Geriatric Outpatient Clinic (10 hours), and the Driving Evaluation Clinic (4 hours). The resident selects one 12-month, or two 6-month, optional rotations (8 hours weekly). In addition, there is an eight-hour weekly year-long scholarly research/program development component spent developing a project with a definable work product. Core clinical training and optional rotations also include teaching, scholarly, program development, and supervisory activities. Residents manage their own outpatient clinics, take leadership on the inpatient geriatric rehabilitation unit, and administratively manage the outpatient driver evaluation clinic.

Over the course of the training year the resident develops increasing autonomy in their ability to practice independently.
GEROPSYCHOLOGY SPECIALTY AND FOCUS AREA (Advanced Functional) COMPETENCIES

1. **Knowledge**: Demonstrate knowledge of biopsychosocial development as a life-long process, and including both gains and losses over the lifespan using different theories of late-life development and adaptation based on relevant research on adult development and aging. Ability to understand the unique experience of each individual based upon demographic, sociocultural, and life experiences, including historical influences affecting particular cohorts. Demonstrate knowledge of normal versus pathological aging processes using the biopsychosocial model.

2. **Assessment**: Demonstrates ability to conduct efficient, comprehensive, geropsychology assessment methods using both semi-structured and standardized assessment tools.
   
   a. Demonstrates ability to complete a variety of cognitive screens (RBANS, DRS, MOCA) as clinically indicated. Assessment is specific to older adults using a multi-modal approach considering biopsychosocial factors. Demonstrates the ability to effectively conduct and clarifies differential diagnosis. Demonstrates the ability to communicate (verbally and written) cognitive testing results into practical conclusions and recommendations for patients, families, and other care providers.
   
   b. Demonstrates skill of differential presentation, associated features, age of onset, and course of common psychological and functional disorders and syndromes in older adults (e.g., anxiety, depression, dementia, etc.).
   
   c. Demonstrates ability to conduct evaluation and appropriate treatment of safety and risk factors in the geriatric population, including self-neglect (capacity for self-care including ADLs/IADLs and medical decision making), elder abuse (emotional, physical, sexual, financial, and neglect), as well as suicide and homicidal risk and the unique presentation and base rates among the geriatric population.

3. **Interventions**: Develops and implements evidence based individual, couples, and family interventions appropriate to client need relevant to the aging population including interventions to cope with dementia, loss, grief, end-of-life, and loss of physical and instrumental activity of daily living function. Demonstrates the ability to prioritize treatment goals and integrate relevant treatment modalities and modify evidence-based and clinically informed intervention strategies to accommodate patient needs.

4. **Consultation**: Demonstrates the ability to process a referral question and demonstrate effective translation and communication of relevant findings as they pertain to the consultation/liaison referral question from a geropsychology perspective. Demonstrate the ability to incorporate environmental/milieu and interdisciplinary factors. Demonstrate the ability to work collaboratively with an interdisciplinary team.

GEROPSYCHOLOGY CLINICAL TRAINING EXPERIENCES

A. **Geriatric Evaluation and Management (GEM) Unit**

(10 hours/week; year-long duration)
The GEM is an 8-bed inpatient unit at the Wade Park campus that accepts referrals from acute care units for conditions such as change in mental status, dementia, inability to perform activities of daily living, and medical conditions that affect functioning. The unit provides diagnostic assessment, therapy, and rehabilitation and discharge planning with goals of improved medical and functional status, strengthening of social supports, and facilitating the least restrictive placement which adequately addresses the patients’ needs. This unit received a Program of Excellence Award for the high quality of care dedicated to the geriatric veterans. The resident takes a leadership role on the unit under supervision and is involved in the following activities:

1. New patient assessment including biopsychosocial history, mental status, substance use, history, functional status, cognitive screening, and testing as needed, personality evaluation, and assessment for psychiatric illness.

2. GEM interdisciplinary weekly team meeting with physicians, nurses, the social worker, the psychologist, the dietician, rehabilitation medicine therapists, the clinical pharmacist, Doctor of Pharmacy residents, the geriatric Resident, medical students, social work interns, and interns in dietary/nutrition.

3. GEM interdisciplinary weekly teaching rounds with a geriatrician.

4. Ongoing direct patient care including evidence based psychotherapy with patients, caregivers, and families.

5. Consultation with nursing and medical staff to educate and develop interventions around behavioral and patient management issues.

6. Conduct Montessori-based dementia programming group therapy activity with current GEM inpatients.

7. Capacity evaluations and completion of Statement of Expert Evaluation forms for competency hearings as needed.

8. Attend interdisciplinary family meetings to facilitate family understanding of patients care needs, provide feedback regarding interventions and level of care, and support the patients and their families to enhance wellness and optimal physical, psychological, and cognitive.

9. Develop and facilitate treatment and discharge plans as a member of the interdisciplinary team.

B. Geriatric Outpatient Clinic

(10 hours/week; year-long duration)

The Geriatric Outpatient Clinic provides interdisciplinary assessment and primary care for an ethnically diverse population of veterans 65 years of age and older. The resident will participate in evaluation of medical, cognitive, psychological, and physical functioning of older adults, many who are medically compromised with complex social histories. This rotation will provide an opportunity to experience a real world primary care setting. The resident will learn how to quickly assess cognitive and mood issues, develop interventions, and integrate findings into an interdisciplinary care plan. There will be opportunities to develop prevention based programming and to assist caregivers in providing positive support for their family’s changing needs. The resident manages their own clinic two days a week with supervision and is involved in the following activities:
1. Psychological evaluation of new patients including clinical interview, cognitive and psychological screening, history, and interview with the spouse, family or caregiver
2. Interdisciplinary staffing of new patients to develop a treatment plan
3. Ongoing psychological interventions including individual therapy, couple’s and family therapy, management of behavior problems, cognitive testing, and personality assessment
4. Capacity evaluations and completion of statement of expert evaluation forms for competency hearings
5. Consultation and treatment of patients who develop emotional or cognitive difficulties once in the clinic
6. Warm hand-offs of veterans with acute psychological concerns

C. Drivers Evaluation Clinic
(4 hours/week; year long duration)

The resident is responsible for receiving referrals, coordinating the clinic, conducting the initial clinical evaluation, and making recommendations to the client, family, and medical team. Drivers’ evaluations begin with the resident assessing cognition, visual perception, walking speed, and reaction time. The patient is then referred to Physical Medicine and Rehabilitation Service for the second phase of the driving evaluation which includes an on the road evaluation or a driving simulator assessment. Over the course of the year the resident will gain competency in this assessment and experience with ethical aspects associated with driving and the older adult.

D. Scholarly Research Project
(8 hours per week; full year duration)

The research requirement is described here. In addition to the research requirements for all residents, the resident in Geriatrics will perform evaluations in the Geriatric Driving Clinic as one facet of the research experience.

E. Optional Rotations
(8 hours/week; 12-month or 6-month duration)

1. **Neuropsychological Evaluation:** The resident may elect to train with the neuropsychology team to enhance skill in complex evaluation of elderly patients with compromised brain function. The resident will provide neuropsychological consultation for patients, testing as needed for competency evaluations, report writing, and patient, family, and clinical provider feedback. There is also small-group didactic supervision/discussion of clinical cases.

2. **The Community Living Center:** The CLC provides care to patients needing long-term rehabilitation designed to maintain, restore, or prevent decline in optimal functioning. Patients on the CLC are referred for a variety of issues and range in age and complexity of problems. Presenting issues include complex biopsychosocial histories, multiple comorbidities, and dual psychiatric diagnoses (serious mental illness, substance use, and dementia). Common medical conditions include Parkinson’s disease, stroke, cancer, chronic physically debilitating conditions, and complications of amputation. The resident may be involved in new patient assessment
involving initial interview and cognitive or personality testing. Typical interventions are long-term, individual, group, and family therapy to address coping with chronic illness. Residents may participate in hospice and palliative care interventions, consultation with staff regarding behavior management and environmental issues, weekly interdisciplinary treatment and discharge planning meetings, behavior management groups, staff education, and discharge planning.

3. **Hospice/Palliative Care Team**: The Hospice/Palliative Care Team is comprised of a nurse practitioner, psychologist, social worker, geriatrician, and chaplain. Patients are in the end-stages of cancer, dementia, cardiopulmonary, liver, or renal diseases. The resident may work with the patient or family on newly emerging or chronic issues. End of life pain management is a common referral issue. The resident is involved in consultation regarding assessment and treatment of anxiety, depression, delirium, competency with concomitant questions of healthcare-related decisional capacity, surrogacy, and advanced directives. The resident also provides intervention for anticipatory grief and bereavement for patients’ families and friends. There are opportunities to provide in-service education to nursing staff and members of the interdisciplinary teams.

V. PAIN PSYCHOLOGY

(1 resident)

The Pain Management Center operates under the Division of Pain Medicine at the Wade Park medical facility. The Psychology Section of the program is typically comprised of three full time psychologists, one postdoctoral resident, and a predoctoral psychology intern, all operating in the context of a biopsychosocial model of pain management. The pain psychology resident will interact daily with health psychologists, board certified anesthesiologists, physician extenders, and nurses with specialized training in pain management. The Pain Management Center serves outpatients with a variety of chronic pain disorders; co-morbid mood disorders and/or substance use disorders are common. Although the model of the Pain Management Center is primarily consultative, there is opportunity for the pain psychology resident to follow select patients on a time-limited basis for behavioral management of pain in individual treatment and, at times, family therapy. There will also be involvement with telehealth, an innovative way of providing services to patients in rural settings.

Pain psychology residents will conduct comprehensive behavioral/psychometric assessments of new patients for the purpose of evaluating functioning, mood or behavioral problems, identifying risks for opioid analgesics, spinal cord stimulation, and making recommendations for a comprehensive plan of care. Treatment plans for individual treatment of veterans who choose to continue with pain psychology beyond the assessment include evidence based treatments such as CBT-CP, biofeedback, behavioral modification, relaxation training, and family counseling. The pain psychology resident will facilitate psychoeducation CBT groups for the CARF accredited Intensive Outpatient Program (PMC IOP). These groups cover topics such as the chronic pain cycle, cognitive restructuring, stress management, activity pacing, anger management, and effectively communicating with providers and family. The resident will participate in weekly interdisciplinary team meetings as part of the PMC IOP. The resident has the option of facilitating the pain psychoeducation group for veterans in the medical center’s addiction recovery treatment programs, in cooperation with the Veterans Addiction Recovery Center (VARC). The
pain psychology resident will attend weekly VA ECHO training sessions that introduce specialty pain management training to mental health and medical providers in rural settings.

There will be opportunities for quality improvement projects. Umbrella supervision of the predoctoral intern will be an expected part of the residency. The resident will participate in a biweekly group supervision with the psychology section of the Pain Management Center. Topics for these meetings include biofeedback, assessment, pain literature updates, treatment approaches, and the discussion of challenging cases.

**Key Curricular Components:**

- **Virtual Healthcare:** The resident will participate in telehealth sessions to provide services to patients in rural settings. The resident will attend weekly VAECHO sessions in which providers in rural settings receive training in the provision of specialty pain management services.

- **Assessment and interventions:** The resident will evaluate new and returning patients to the Pain Management Center to identify obstacles to care and contribute to a comprehensive biospsychosocial treatment plan. This will include evaluations for appropriateness of implantable devices. Treatment conducted as part of the multidisciplinary treatment team can include evidence-based interventions like CBT-CP, biofeedback, behavioral strategies (e.g., time-based pacing, energy conservation), and other pain-specific techniques. Additionally, the resident can facilitate a chronic pain psychoeducation and support group for veterans in the medical center’s addiction recovery programs (VARC).

- **Tertiary services** The resident will facilitate psychoeducation groups as part of the CARF accredited Intensive Outpatient Program (PMC IOP). This will include weekly interdisciplinary team meetings.

- **Consultation:** The resident will work closely with the medical team to offer recommendations for care. This may include warm handoffs from the medical team.

- **Scholarly Research Project (8 hours per week; full year duration)** The research requirement is described [here](#).

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**CLINICAL HEALTH PSYCHOLOGY STAFF**


**DIAZ, Rosalie C., Psy.D.,** Adler School of Professional Psychology, 2004. Assignments: Primary Care-Mental Health Integration in Women’s Veterans Health Clinic, G.I.V.E. (Gender Identity Veteran’s Experience) Clinic, and Mental Health Ambulatory Care Center. Theoretical orientation: Integrative, Adlerian, Cognitive-Behavioral. Clinical specializations: Primary Care/Health Psychology; Chronic Pain; iRest Yoga Nidra and Mindfulness. Publications and research interests: Psychological factors in the...

Teaching and supervision interests: Individual and group psychotherapy, somatic experiencing and mind-body interventions.


HUCKINS-BARKER, Jamie, Ph.D., Ohio University, 2014. Assignments: Pain Management Center; Co-Chair Pain Care Advisory Board, Facilitator VARC Pain Management Group. Theoretical orientation: Integrative, cognitive-behavioral. Clinical specializations: health psychology, currently assessment and treatment of contributors to chronic pain through in person or telehealth sessions, group supportive therapy, relaxation and stress management, chronic disease management & health promotion, multidisciplinary teams and provider education. Publications and research interests: clinical utility of therapeutic interventions, behavioral and cognitive therapies for chronic disease management and health promotion, psychological factors that affect chronic disease self-management (promote or inhibit). Professional organizations: American Psychological Association, Ohio Psychological Association, Society of Behavioral Medicine. Teaching and supervision interests: Evidence-based therapies for chronic disease management, health psychology assessment, brief assessment, individual and group psychotherapies, supervising learners and supporting them in developing fundamental competencies to succeed as healthcare providers in a medical setting as part of a multidisciplinary team.

LEA, Erin, Ph.D., Case Western Reserve University, 2013. Assignments: Clinical Health Psychologist for HIV PACT and HCV Clinics; Rotation Supervisor for HCV/HIV; Member of Bioethics Committee. Theoretical orientation: ACT, Behavioral and Interpersonal. Clinical specializations: Behavioral Medicine,
harm reduction, psychological assessment, capacity evaluations, chronic pain management, brief interventions for SUD, smoking cessation and geropsychology. Current research and grants: Identifying cognitive impairment in HIV-positive population, developing novel interventions to manage complex medical and psychosocial factors, predictive utility of assessments, & harm reduction. Teaching and supervision interests: Integration of behavioral medicine in interdisciplinary teams; Teaches graduate level Adult Cognitive Assessment at Case Western Reserve University.


PRZYBYSZ, Jeff, Psy.D. Immaculata University, 2014. Assignments: Community Living Center, Mental Health Outpatient Clinic- Geriatrics, Rotation Supervisor for CLC, Compensation and Pension evaluations. Theoretical Orientation: Integrative with emphasis on cognitive-behavioral and humanistic orientations. Clinical Specializations: Geropsychology, long term care psychology, CBT-I, evaluation of decision making capacity, individual and group psychotherapy with geriatric population, caregiver burden along with assessment and interventions, dementia education, neuropsychological assessment, personality assessment, and behavior management interventions for individuals with neurocognitive disorders. Publications and research interests: Older LGBT population, aging and subjective-wellbeing, assessment of caregiver burden. Professional Organizations: Psychologists in Long Term Care. Teaching and supervision interests: individual psychotherapy, cognitive and personality assessment, behavior management including STAR-VA.

PURDUM, Michael, Ph.D., ABPP, University of North Texas, 2010. Assignments: Primary Care Mental Health Integration (PCMH). Theoretical orientation: CBT, brief problem-focused psychotherapy, health behavior change. Clinical specializations: Health psychology, primary care mental health, chronic disease management & health promotion, motivational interviewing, smoking cessation. Publications and research interests: Psychological factors that complicate chronic disease management, psychological factors that promote chronic disease self-management, PCMH quality improvement & implementation, smoking cessation outcomes. Professional organizations: American Psychological Association; American Board of Professional Psychology in Health Psychology. Teaching and supervision interests: Motivational interviewing, behavioral therapies for chronic disease, supervising trainees on developing the
fundamental competencies (collaboration & MH integration) to succeed as a health care providers in primary care.

ROUSH, Laura E., Ph.D., University of Cincinnati, 2008. Assignments: Polytrauma, Neurology; Program Director, Clinical Health Psychology Postdoctoral Residency Program; Major Preceptor, Infectious Disease Psychology Postdoctoral Fellowship; health psychologist, Cleveland VA SCAN-ECHO Diabetes team; member, Diabetes Advisory Board. Theoretical Orientation: Cognitive-behavioral. Clinical specializations: Health psychology with emphasis in headaches, mTBI, pain management, stress management, relaxation training, promotion of healthy behaviors, coping with chronic medical conditions, individual therapy, treatment of psychological factors affecting physical health, and biofeedback. Publications and research interests: Psychological factors in the assessment and treatment of chronic pain, non-pharmacologic headache treatments, interdisciplinary treatment or training delivery formats including shared medical appointments and SCAN-ECHO. Professional organizations: Ohio Psychological Association, APA Division 38. Teaching and supervision interests: Health psychology, individual psychotherapy, biofeedback, working with a multidisciplinary team, work-life balance.


THOMAS, Farrah, Psy.D., Chicago School of Professional Psychology, 2005. Assignments: Physical Medicine & Rehabilitation Service – inpatient Acute Rehabilitation and Amputation System of Care (inpatient and outpatient) including Amputation Shared Medical Appointment; Primary Care - facilitator for Hypertension Shared Medical Appointment; Health Behavior Coordinator, Cleveland VA system; Co-Chair, Health Promotion Disease Prevention Committee; Assistant Clinical Professor of Medicine, Case Western Reserve University School of Medicine. Theoretical orientation: Behavioral and Cognitive Behavioral. Clinical specializations: health psychology/behavioral medicine and rehabilitation psychology; individual and group psychotherapy; coping with chronic medical conditions; stress management; relaxation training; adherence; self-management. Publications and research interests: Caffeine use and epilepsy, self-management with the amputee population, coping and adjusting to chronic medical issues. Professional organizations: American Psychological Association, Division 38 – Health Psychology, Ohio Psychological Association, National Register for Health Service Providers in Psychology. Teaching and supervision interests: Motivational Interviewing and behavior change, coping and adjusting to chronic medical issues, working with multidisciplinary/interdisciplinary teams, the difficult patient, and professionalism.

appointments with patients outside of the Cleveland area, biofeedback, individual, group and family therapy, stress management, relaxation techniques, program development, multidisciplinary teams and provider education. Publications and research interests: effectiveness of interdisciplinary care, program outcomes. Professional organizations: American Psychological Association, Ohio Psychological Association committee chair for Technology and Communications. Teaching and supervision interests: comprehensive pain assessment, mind-body interventions, individual and group therapies, biofeedback.

WHITE, Karen P., Psy.D., ABPP. Indiana State University in Clinical Psychology, 2009. Assignments: Geriatric Evaluation and Management Unit and Dementia Care Coordination Team, Rotation Supervisor and Pre-doctoral Training Committee Member, Major Preceptor for the geriatric fellowship and Post-doctoral Training Committee member, Member of the Bioethics Committee, Chair of the Geriatric Ethics Task Force- Subcommittee of the Louis Stokes Cleveland VA Bioethics Committee, Member of the Cleveland VA Dementia Committee, Member of the Psychology Professional Standards Board, Cuyahoga County Adult Protective Services Interdisciplinary Team and Steering Committee Member. Theoretical orientation: Integrative with emphasis on cognitive-behavioral, evidence based, and humanistic orientations. Clinical specializations: Geropsychology, Dementia Care and Education, long term care psychology, health/behavioral medicine, capacity evaluation, and coping with chronic illness. Publications and research interests: Dementia Care Coordination program evaluation. Teaching and supervision interests: Psychology training recruitment and selection, Professional development, and comprehensive geriatric care aligning with the Pike’s Peak Model.
The Clinical Neuropsychology Residency Program is a TWO-YEAR PROGRAM. We will select a new resident in the 2018 APPCN match for the 2018-2019 training year.

The mission of the Clinical Neuropsychology Residency Program is to provide depth of training for advanced competence in the Specialty of Clinical Neuropsychology. Our program incorporates a number of focus areas emphasized in the VA Mental Health Strategic Plan: Neuropsychology, Traumatic Brain Injury (TBI), OIF/OEF Needs, Interprofessional Care, and PTSD. The resident is accepted for a two-year program, with reappointment for the second year contingent upon satisfactory performance during the first year.

The Clinical Neuropsychology Residency is accredited by APA and operates in accordance with the INS-Division 40 guidelines (The Clinical Neuropsychologist, 1987, 1, 29-34) and the goals espoused by the Houston conference (Archives of Clinical Neuropsychology, 1998, 2, 203-240). Our program is designed to provide Residents with the didactic and experiential opportunities necessary to develop evidence-based clinical interpretative and consultation skills at a professional level, while under the supervision of experienced neuropsychologists. This is accomplished through an extensive reading of the research literature that is relevant to each of the cases evaluated by the resident. In addition, specific training goals include active involvement in clinical research and relevant educational opportunities within the context of a nationally known tertiary medical center.

SPECIALTY AREA (Advanced Functional) COMPETENCIES

1. **Scholarly Base**: Demonstrates knowledge of the history of Clinical Neuropsychology as well as the recent scientific and scholarly developments in the field and applies that knowledge to clinical practice.

2. **Professional Base**: Demonstrates awareness of current issues facing the profession and considers how they identify with and contribute to the profession, (i.e., membership in professional organizations, teaching and supervision, advocacy, continuing education in the field, etc.).

3. **Knowledge Base**: Demonstrates awareness of the common neurological and non-neurological disorders affecting brain functioning and behavior (including etiology and pathology) as well as the relevant neurodiagnostic and biomarker findings associated with those disorders.

4. **Neuropsychological Testing**: Understands and chooses the best appropriate assessment battery based upon knowledge of presenting issues/concerns, normative group, and statistical appropriateness of the assessment tools.
5. **Neuropsychological Diagnosis**: Effectively integrates neuropsychological findings with the neurological/medical data as well as behavioral data, psychosocial history, and diversity issues, ethical/legal issues, and knowledge of neurosciences in order to clarify differential diagnoses of psychiatric disorders and medical/ neurologic disorders (e.g., such as dementia and the various subtypes of dementia as well as the neurocognitive effects of stroke and other neurological conditions).

6. **Forensic Neuropsychological Applications**: Applies the knowledge and skills of a neuropsychologist to the forensic arena, (e.g., civil competency of person and estate, veterans’ disability determination). Understands the differences in approach between clinical and forensically oriented evaluations, opinions, and recommendations.

7. **Treatment & Intervention**: Applies neuropsychological skills and knowledge to address the cognitive and behavioral problems revealed on assessment in order to make the most appropriate treatment recommendations for intervention, disposition and placement.

8. **Patient Communication**: Helps patients and families understand the meaning and implications of neurological conditions and/or assessment results in a clear and understandable manner.

9. **Interdisciplinary Consultation**: Demonstrates the ability to communicate and apply Clinical Neuropsychological knowledge in consultation with other health care professionals across multiple disciplines.

10. **Research**: Develop research skills with a focus on neuropsychological topics. Understands and applies relevant research to clinical practice/assessment.

Neuropsychologists employ specialized testing procedures and a nomothetic, disease-impact framework. They strive to integrate medical, neurological, and behavioral data with neuropsychological test findings, based upon the literature, in order to answer complex referral questions. Referrals for services typically consist of, but are not limited to, questions concerning:

- Differential diagnoses (e.g., depression versus dementia (Dementia of the Alzheimer's type, Cerebrovascular Dementia, Frontotemporal Dementia, Lewy-Body Dementia, Huntington’s Dementia, etc.).
- Delineation of spared and impaired cognitive functions secondary to known central nervous system dysfunction related to traumatic brain injury (TBI) or stroke, etc.
- Establishment of a neuropsychological baseline against which to monitor recovery or progression of central nervous system dysfunction.
- Assessment of cognitive/behavioral functions to assist with rehabilitation, management strategies, and placement recommendations (i.e., nursing home, group home, etc.).
- Evaluation of cognitive status for the purpose of Compensation & Pension and/or Competency of Person and Estate evaluations and, in conjunction with the Summit County Court of Common Pleas Psycho-Diagnostic Center, Competency to Stand Trial and Sanity at the Time of the Act. An opportunity will also be provided for exposure to civil tort cases via attendance at pre-deposition and pre-trial conferences with attorneys as well as attending trial testimony.

Neuropsychologists provide inpatient and outpatient consultation and evaluation services for multidisciplinary staff at the Wade Park campus, and consultation services for the Parma Outpatient
Clinic and Community Based Outpatient Clinics (CBOC) located throughout the northeast Ohio. The rich clinical referral base and an innovative service delivery model allow them to evaluate more than 500 patients annually, many with complex conditions. Aging Vietnam-era veterans make up the largest VA cohort, and clinicians have increased neuropsychological service requests due to the accompanying higher incidence of dementia. Referrals are also received for evaluation of TBI in younger veterans. The LSCVAMC has been designated as a Polytrauma Network Site, designed to provide long-term rehabilitative care to veterans and service members who experienced multiple injuries to more than one organ system. Neuropsychologists have a role in conjunction with outpatient PTSD treatment and the Polytrauma initiative to assess veterans with mild TBI and Posttraumatic Stress Disorder (PTSD).

Neuropsychology has a critical role in the evaluation of patients diagnosed with Parkinson’s disease who are undergoing the evaluation process to determine their fitness for the Deep Brain Stimulation surgery to improve some their symptoms.

The program employs a flexible battery approach based upon a disease-impact model (e.g. the differential impact of CVD versus DAT on neurocognitive functioning in early or Mild Cognitive Impairment stages), as well as a syndrome-based approach. The application of this model requires an extensive knowledge of the Neuropsychology and Neurology/Neuropsychiatry literature. The training program stresses extensive reading of relevant research, resulting in clinical reports that are integrative and conceptual in nature. Assessments are framed within a forensic format with an emphasis on evidence-based conclusions derived from scientific principles. We also emphasize a cognitive neuropsychological model which conceptualizes neurocognitive functioning from a neural network perspective.

On average, a minimum of 70% of the Resident’s time will be devoted to direct clinical service, which fulfills ABPP’s Clinical Neuropsychology requirements as well as state licensure requirements. This will include general clinical cases as well as cases suited to the specialized interests of the Resident. During the first year of the residency, the resident will carry out all aspects of evaluation, including record review, interviews of patients and collateral informants, test selection, test administration, and report writing. Reports are framed within a forensic format with an emphasis on evidence-based conclusions based upon scientific principles.

During the second year, the resident will further develop sophisticated case conceptualization and report writing skills. Throughout the program, direct patient contact is emphasized in order to develop a strong clinical understanding of process variables and patient behaviors that underlie test performance. In all Neuropsychology activities (e.g., testing, report writing, case conceptualization, etc.), the resident will receive training in how best to provide education and feedback about diagnostics and functional strengths and restrictions to veterans and their families.

With respect to workload, the Residency embraces the goals of teaching/training rather than high volume service-delivery. The number of patients seen on a weekly basis depends upon multiple factors including patient endurance and case complexity. It is expected that the number of patients seen during the second year will double compared to the first year. As a frame of reference, because of case complexity and the intensity of supervision on each case, our neuropsychology track predoctoral interns complete an average of 20 neuropsychological evaluation reports per 4-month rotation.

There is a substantial emphasis on required background readings in neuroscience and related fields as well as readings conceptually targeted to particular cases and their relevant differential diagnostic
Consultation with other health-care professionals constitutes another important aspect of this postdoctoral experience. The resident will have multiple opportunities to interact with a broad range of disciplines that utilize the services of the Neuropsychology section, including Neurology, Rehabilitation, Psychiatry, Geropsychiatry, Geriatric Medicine, Primary Care, etc. Some rotation experiences and/or enrichments will provide the resident with the opportunity to work on interdisciplinary treatment teams throughout the two-year residency.

During placement within each of the Core Training Areas, the resident will meet weekly for supervision with the Major Preceptor, in addition to supervision with the psychologist supervisor for that site of training (described below). Regular meetings will also transpire with a designated research supervisor throughout the residency. The resident will be located at the Parma site while receiving their initial training/supervision in the areas of Geriatric Neuropsychology, Forensics/Compensation & Pension, and TBI. Training in these areas will continue along with increased training/supervision in consultation to Neurology and in the area of Behavioral Medicine area while the resident is located at the Wade Park campus. The resident will spend at least 6 months each in Neurology/Behavioral Medicine, Neuropsychiatric Neuropsychology, and Geriatric Neuropsychology, with the final rotations in Rehabilitation Neuropsychology, TBI, and Compensation & Pension.

The Neuropsychology Residency utilizes a vertical supervision model, wherein staff neuropsychologist supervisors, Neuropsychology resident and Intern, and occasionally the Rehabilitation and Geropsychology resident and/or Intern are all present during the supervision of cases.

CLINICAL TRAINING EXPERIENCES

The resident in Clinical Neuropsychology will be active in core clinical training, receiving cases from each of the Core Training Areas below, in sequence. If the resident elects, Optional Clinical Training choices are also available for one day per week for 6-month or 12-month rotations, as described below. In addition, Research activities for one day per week are part of the curriculum across the first and second year.

NEUROPSYCHOLOGY CORE TRAINING FIRST YEAR

A. Geriatric Neuropsychology

(24 or 32 hours/week; 6-month duration)

Geriatric Neuropsychology training provides experience in the evaluation of elderly patients with possible compromised brain functioning referred from one of the inpatient long-term care units or one of the outpatient geriatric primary care services. The resident will gain competency in the complex differential diagnosis of the common conditions in this populations (i.e. Alzheimer's Dementia, Cerebrovascular Dementia, Lewy Body Dementia [LBD], Frontotemporal Dementia [FTD], etc.). The resident will also become proficient in competency/capacity evaluations in terms of decision-making related to healthcare and financial management. The resident will also develop skills in offering placement recommendations, such as independent living versus nursing home placement, etc.
B. Neurology

(24 or 32 hours/week; 6-month duration)

The Neurology Service is a tertiary referral center for VISN-10 and portions of western Pennsylvania and West Virginia, serving veterans with a full spectrum of neurological disorders. Neuropsychology primarily sees veterans on an outpatient basis, including those with any of the variety of dementias, stroke, head injuries, epilepsy, multiple sclerosis, etc. Inpatients from general medicine, psychiatry, rehabilitation and spinal cord services are also seen. We are focused on providing diagnostic and prognostic information, and rehabilitation recommendations. Results may be interpreted and management strategies demonstrated with veterans and their families. VA medical records provide access to a full selection of radiological data (CT, MRI, PET, and angiography) and EEGs.

C. Scholarly Research Project

(8 hours per week; full year duration)

The research requirement is described [here](#). In addition to the research requirements for all residents, neuropsychology residents must present a research project in both years. The resident may complete one project and present preliminary results during the first year, or present two separate projects. Continuing the project through the second year allows for the resident to develop a more complex project, with consideration for presentation at one of the major neuropsychological professional meetings (AACN, INS, NAN) or publication in a peer-reviewed journal.

NEUROPSYCHOLOGY CORE TRAINING SECOND YEAR

A. Neuropsychiatric Neuropsychology

(16-24 hours/week; 6-month duration)

Neuropsychiatric Neuropsychology training provides evaluation experience with veterans referred from one of the four acute/subacute psychiatric units, and from the outpatient psychiatric programs, such as the Day Hospital Program for severely mentally ill veterans. The resident will gain experience with the neuropsychological evaluation of psychopathology as well as the often complex process of understanding the neurocognitive aspects of psychiatric disorders.

B. Rehabilitation Neuropsychology/Spinal Cord Injury and Disorders Unit

(8-16 hours/week; 6-12 month duration)

This is a newly designated Center of Excellence for comprehensive medical care and rehabilitation of veterans with spinal cord injuries (SCI). This rotation offers experience in providing psychological services to people with disabilities, including neuropsychological assessment of patients with TBI and spinal cord injury (SCI). Residents will become familiar with the medical aspects of SCI as well as the acute and long-term psychological problems associated with this disability, such as depression, anxiety, and substance abuse. The rotation emphasizes working within an interdisciplinary team in order to promote positive treatment outcomes and program development.
C. TBI Evaluation

(16-24 hours/week; 6-month duration)

Traumatic brain injury (TBI) is an acquired condition that can occur via any of a number of mechanisms and result in a broad spectrum of cognitive, psychological, and behavioral symptoms and disabilities. The resident will gain proficiency in understanding the various mechanisms that can result in TBI of different levels of severity, the expected neurocognitive/behavioral consequences, and the typical course of recovery of these injuries. Since psychiatric comorbidities (e.g., PTSD, Depression, Somatic symptoms) are a common condition in individuals with Mild-Moderate TBI, the resident will gain competency in the recognizing the convergent and divergent factors in TBI and psychological assessment.

D. Compensation & Pension

(8-16 hours/week; 6-12 month duration)

Compensation & Pension (C&P) training provides experience evaluating veterans requesting compensation for disability believed to be related to military duty. A significant proportion of these requests involve disabilities related to neurocognitive impairment, such as TBI or dementia from a variety of causes. The assessments are used as evidence in the medico-legal process of determining monetary awards for problems considered to be directly related to military duty, and general disability for those who are unable to work due to non-military problems. They are also used to determine the need for aid and attendance in elderly veterans with dementia. The Neuropsychologist provides an opinion about existence and severity of claimed disability, and the relationship to military service. The emphasis is on the more pragmatic aspects of providing a comprehensive assessment within a limited time frame required of C&P assessments.

E. Scholarly Research Project

(8 hours per week; full year duration)

The research requirement is described here. Research activities described above may continue from the first year through conclusion of the program.

NEUROPSYCHOLOGY OPTIONAL CLINICAL TRAINING EXPERIENCES

Comprehensive exposure to the Core Training Areas described above is a requirement. However, the resident may also choose to expand their experience by electing one 12-month, or two 6-month rotations in the following areas:

1. Polytrauma Team (8 hours/week): The Polytrauma System of Care specializes in the treatment for veterans and returning service members with injuries to more than one physical or organ system, which result in medical, cognitive, psychological, and/or psychosocial impairments and functional disability. The LSCVAMC has been designated as a Polytrauma Network Site, designed for the assessment, treatment, and rehabilitation of service members and veterans with subacute injuries. Cognitive assessment is critical for those veterans who have, or are suspected to have, received a traumatic brain injury (TBI) due to blast concussions. The resident will gain competency in cognitive and psychological assessment population, as well take an active role on
the Polytrauma Treatment Team of interdisciplinary specialists charged with the assessment, treatment and rehabilitation of these injured service members and veterans.

2. **Cleveland Clinic Foundation Epilepsy Center (8 hours/week):** The Cleveland Clinic Foundation Medical Center is an internationally renowned medical center. The Lou Ruvo Center for Brain Health provides comprehensive diagnosis and treatment of brain disorders, including comprehensive and detailed neuropsychological evaluations. Typical opportunities would be to observe neurosurgical procedures such as temporal lobectomy and implantation of deep brain stimulation devices, and to participate in ongoing research and epilepsy case conferences. ABPP Board Certified clinical neuropsychologists are available to provide supervision to the resident.

**TEACHING ACTIVITIES**

1. **Colloquium/Staff Education (Required):** Each resident prepares a Continuing Education-level presentation based on an appropriate topic area. This will be presented at the Psychiatry Grand Rounds, toward the end of the Resident’s two-year residency.

2. **Intern Training Seminar (Required):** The resident presents a neuropsychology-related lecture to the predoctoral psychology interns at one or more of the weekly intern seminars.

3. **Umbrella Training Supervision of Predoctoral Interns (Required):** The resident has the opportunity to provide formal supplementary “umbrella” training supervision to predoctoral psychology interns. This umbrella supervision training experience will occur under the direct supervision of a rotation supervisor, with feedback both from the supervisor and supervisee.

4. **Psychiatry resident Seminar (Optional):** The resident has the option to prepare and present a Neuropsychology-related lecture to advance psychiatry residents in the CWRU School of Medicine.

**Additional Didactic Opportunities**

1. **Case Western Reserve University.** University Hospitals Neurology Grand Rounds: Weekly Grand Rounds within the Neurology Department at the world-renowned University Hospitals. Presentations focus primarily on neurological topics conducted by world-class researchers and practitioners, as well as case presentations. Past topics have included the role of basal temporal areas in language functions, efficacy of varied medication regimens for the treatment of cerebrovascular disease, and malingering of neurologic disorders.

2. **Case Western Reserve University School of Medicine Grand Rounds.** This series provides a variety of content relevant to mental health. It is approved for continuing education credit by the Ohio Psychological Association (OPA) and the American Psychological Association (APA) as well as for most healthcare professions within the state. Presenters include local and national VA staff, affiliated university educators, and outside consultants. In these grand rounds there is a considerable emphasis on issues related to Biological Psychiatry.

7. **Psychology Intern Seminars:** Interns attend a weekly two-hour seminar that provides in-depth treatment of a range of topics across all specialties. The seminars are primarily by psychologist expert staff, with occasional speakers from other medical disciplines.
3. **Neuroanatomical Dissection Course.** The resident may participate in a three-day intensive course in the anatomical dissection of the brain and spinal cord conducted at the Marquette University Medical College of Wisconsin. The course also includes a review of recent advances in functional neuroscience. Course faculty consists of neuroscientists and clinicians qualified and experienced in the teaching of Neuroanatomy.

4. **Neuropathology Laboratory.** The resident has the opportunity to attend a neuropathology laboratory at the University Hospitals Institute of Pathology located on the nearby Case Western Reserve University campus. While at the lab, the Fellow will observe brain dissections performed by an attending physician alongside medical residents, encompassing a range of medical and neurologic disorders from pediatric and adult cases.

5. **National Academy of Neuropsychology Online Neuroanatomy Course.** The goal of this course is to provide students with a working knowledge of the basic neuroanatomic structures of the central nervous system as well as the consequences of damage to that system.

6. **Civil-Forensic (Tort) Didactic Experience.** The resident will have the opportunity to gain exposure to Civil Tort evaluations in an independent practice setting in the greater Cleveland area. The resident will not directly assess and/or test clients, but will be exposed to Neuropsychology in practice in civil tort cases via attendance at pre-deposition and pre-trial conferences and review of deposition transcripts. The supervision will be provided by a board certified (ABPP) neuropsychologist and a neuropsychologist who have extensive experience in conducting Civil Tort neuropsychological evaluations. This didactic experience will allow the resident exposure to an area in which neuropsychology has been in increasing demand over the years. This didactic experience is intermittently available on weekends or weekday evenings.

**NEUROPSYCHOLOGY STAFF**


MERBITZ (HANSEN), Nancy K., Ph.D., University of Notre Dame, 1993. Assignments: Spinal Cord Injury Long Term Care; Transitional Care Unit. Theoretical orientation: Integrative (humanistic-existential and behavioral). Clinical specialization: Rehabilitation Psychology, with emphasis on behavioral medicine, person-centered psychotherapy, geropsychology, and neuropsychology (assessment, monitoring and patient/team/family education regarding conditions with acute or chronic CNS effects). Publications: rehabilitation after critical illness and intensive care, adherence, benefits of assistance dogs, measurement of rehabilitation process and outcomes, quality improvement. Research interests: assistive technologies and access to digital communication, measurement and research design in rehabilitation interventions, the impact of diminished cognitive abilities on learning, coping and adherence. Professional organizations: APA Division 22: Rehabilitation Psychology (member Executive Board 2014 - present; member Strategic Planning Task Force 2015 - present), APA Division 38: Health Psychology (member APA Interdivisional Health Care Committee 2007-2012), Association of Spinal Cord Injury Professionals, Standard Celeration Society (Precision Teaching), Association for Behavior Analysis International. Teaching and supervision interests: adapted psychotherapy, team collaboration and education, assessing and responding to reduced cognitive abilities in medically-complex patients.

influenced structure of personality, TBI and PTSD in OEF/OIF veterans exposed to blast wave injuries. Professional Organizations: American Psychological Association (Division 6 – Behavior Neuroscience and Comparative Psychology & Division 40 - Clinical Neuropsychology), International Neuropsychological Society, National Academy of Neuropsychology. Academic Appointment: Clinical Instructor in Psychiatry, Case Western Reserve University School of Medicine. Teaching and supervision interests: Cognitive/neuropsychological assessment with geriatric patients with comorbid psychiatric illness and/or dementia.
The Clinical Psychology Program provides training in assessment and intervention with a wide variety of psychiatric, behavioral, and environmental problems. It is designed to enable the resident to develop advanced skills in the differential diagnosis of psychopathological disorders, treatment planning, and evidence-based intervention. Theoretical and therapeutic approaches will vary with the training setting and types of problems typically encountered. Supervisors will work with the resident to develop an individual learning plan for developing advanced skill in psychological assessment, individual and group interventions, marital or family interventions, case management, vocational screening, multidisciplinary treatment team planning, and patient education. Our program won the 2016 APA Division 18 Excellence in Training Award for providing recovery-oriented, evidence-based services to adults diagnosed with serious mental illnesses. In addition to the seminars required of all residents, clinical psychology residents are also required to attend:

**Clinical Psychology Resident Seminar.** Residents in the SMI, PTSD, and Substance Abuse SEA’s attend an additional monthly Clinical Psychology Seminar, focusing on specialized content areas, advanced techniques, and presentation of scholarly topics.

**CLINICAL PSYCHOLOGY SPECIALTY (Functional) COMPETENCIES**

1. Assessment and conceptualization: Demonstrates case conceptualization and diagnostic assessment grounded in science-based theory, an in-depth understanding of assessment methods, standardized assessment and understanding of the construct being assessed, psychometrics and appropriate normative data. Able to convey in written reports and articulate verbally the diagnostic, assessment and conceptualization limitations.

2. Intervention: Demonstrates knowledge of evidence-based practice and performs evidence-based modality psychotherapy or environmental modification interventions.

3. Consultation: Demonstrates knowledge of science base of consultation and the ability to serve as a consultant for other professionals such as those who provide psychological services, health care professionals from other disciplines, or educational personnel, and individuals in other institutions and settings.

4. Research: Successfully engages in research designed to systematically improve the knowledge base of the profession or evaluates the effectiveness of programs and activities.

5. Supervision: When supervising other trainees, demonstrate the ability to communicate and apply knowledge of the purpose, roles, and procedures in the practice of supervision.
The resident participates in a series of clinical and rehabilitation rotations to maximize both breadth and depth of training in assessment, treatment and rehabilitation with persons living with severe mental illness. Training emphasis is given to evidence-based practices for persons with severe mental illness, with primary training rotations offering competency development in psychosocial skills training and cognitive-behavioral psychotherapy. Supplemental training experiences include literature review and site visits with additional evidence-based practice programs offered through this VA, including assertive community treatment, supported employment, and family psychoeducational programs. Our psychosocial rehabilitation programs assist veterans as they progress toward their individual recovery goals through enhanced empowerment, community integration, work and meaningful activity, and familial and social supports. Rotations and supplemental training sites offer experience across the domains of treatment and recovery. The training curriculum includes a site visit with the Summit County Recovery Project, community-based consumer-run activities, where the resident may interface with nationally recognized consumer advocate psychologist Dr. Frederick Frese. The preceptor for this residency is a voting member of the IRB, which provides the resident with the opportunity to directly experience the VA research review process. The residency incorporates enhanced professional role development, teaching, and supervisory activities.

**PSI FOCUS AREA (Advanced Functional) COMPETENCIES**

1. Demonstrate competence in psychosocial skills training, including assessment of needs and preferences, rehabilitation planning, psychosocial intervention, and evaluation of outcomes across a continuum of care.

2. Demonstrate competence in cognitive-behavioral psychotherapy interventions for persons with severe mental illness.

3. Demonstrate competence in differential diagnosis of psychotic spectrum conditions utilizing traditional psychological assessment techniques.

4. Cognitive-behavioral therapy: Demonstrates understanding and skills in individual and/or group cognitive-behavioral interventions for persons with SMI, including knowledge related to selection and effective implementation of specific interventions, and monitoring of progress and outcomes.

5. Psychosocial rehabilitative skills training: Demonstrates competence in rehabilitative skills training for persons with SMI (e.g. illness management and recovery, communication and social skills, relapse prevention and planning, stress management, cognitive re-training, etc.), including incorporation of assessed needs and preferences, effective implementation, and monitoring of progress and outcomes.

7. Collaboration and consultation: Able to collaborate and consult with other disciplines, service recipients, advocates, families and agencies, demonstrating a flexible and comprehensive view of treatment, rehabilitation, and mental health recovery.

Optional/Supplementary FOCUS AREA (Advanced Functional) COMPETENCIES

1. **Psychopharmacology**: Demonstrates consultative-level knowledge and skills of in basic psychopharmacology and psychopharmacotherapy for SMI.

2. **Family services**: Demonstrates skill in family psychoeducation and/or behavioral family therapy.

CLINICAL TRAINING EXPERIENCES

**A. Inpatient Psychiatry**

(32 hours/week; first-month; then 16 hours/week; 3-month duration)

The resident initially gains intensive treatment and evaluation experience with veterans in an acute phase of illness on a 30-bed locked inpatient psychiatric unit. The primary training focus of this rotation is to provide the resident with both experience and comfort with the acute phases of psychopathology of severe mental illnesses. This rotation includes diagnostic evaluation of psychopathology and psychosocial issues, rapid assessment training, interdisciplinary care planning, and individual and group psychotherapeutic interventions. The resident’s training includes:

1. Screening assessments including mental status, cognitive and neuropsychological screening, psychiatric symptom inventory, substance use, functional status, and psychosocial support system review.
2. Psychological evaluation of hospitalized veterans including clinical interviewing, psychosocial history, collateral family/support interviews, personality evaluation, and assessment of psychopathology. Training includes rapid psychological assessment techniques.
4. Interdisciplinary team participation, including staffing and development of multidisciplinary treatment plans.
5. Acute psychological interventions including individual and group psychotherapy, and behavioral management planning.
6. Capacity evaluations for competency hearings and risk assessment for civil commitment hearings.

**B. Consultation/Liaison Team**

(16 hours/week; 3-month duration starting second month)

This supplementary rotation coincides with the Inpatient Psychiatry experience, to broaden the resident’s exposure to severe mental illness and acute psychopathology as it is encountered in a diverse
healthcare system. The resident serves as a psychologist on this multidisciplinary team (including psychiatrists). The Consultation/Liaison Team provides mental health consultation to medical units at the Wade Park campus for hospitalized veterans presenting with emergent psychiatric issues. The resident conducts bedside assessments of the veteran’s conditions, including diagnosis and recommendations for management or triage to alternative level of care. These assessments include rapid psychological assessment methodology, and training in evaluation of functional capacities relative to legal competency is offered. Interprofessional consultation and communication skills are emphasized.

C. Day Hospital
(32 hours/week; 4-month duration)

The Psychiatry Day Hospital is a four-week intensive partial hospitalization program for veterans with serious mental illness, and is fully accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) under Partial Hospital standards. Opened in 1996 in response to the closing of several inpatient psychiatric units, the Day Hospital was given three primary tasks: 1) prevent hospitalization; 2) reduce length of stay for inpatient psychiatric hospitalization; and 3) aid in and improve transition from an inpatient stay back into the community. The Day Hospital has continued success in meeting these goals by employing a multidisciplinary team consisting of a psychologist program manager, clinical nurse specialist, social worker, peer support specialist, and a part-time prescriber. Fully embracing the recovery model, veterans are provided with education, information, and psychotherapy along with psychopharmacological interventions. The psychiatric population of the Day Hospital consists primarily of individuals with schizophrenia, schizoaffective disorder, major depression, and bipolar disorder. Residents are considered to be integrated team members and develop professional identity through experiences in multidisciplinary team consultation on psychotherapy and diagnosis. Residents gain supervision experience through umbrella supervision of pre-doctoral interns. The resident will develop skills in:

1. Initial psychosocial assessments, including triage for Day Hospital versus other levels of care (e.g. inpatient).
2. Full psychological evaluations and report writing including the use of MMPI-2 and other measures, usually for diagnostic purposes.
3. Opportunities for coordinating the involvement of family and other support networks.
4. Training in cognitive-behavioral psychotherapy (CBT) with persons with severe mental illness in both individual and group modalities.
5. Skills-based group facilitation and individual psychotherapy.
6. Clinical training supervision through umbrella supervision opportunities.
7. Daily interdisciplinary rehabilitation planning.
8. Outreach and liaison with community resources.
9. Leadership with the Psychologist Program Manager will be emphasized.
10. Opportunity for program evaluation and development experience.
D. Program for Recovery Skills and Recovery Resource Center

(32 hours/week; 4-month duration; option for either or both settings)

- **The Program for Recovery Skills** is fully CARF accredited (under Residential standards) intensive residential rehabilitation program for persons with severe mental illness (SMI). This is a comprehensive program that employs evidence-based strategies for this population, including illness management and recovery skills training, with an empirically supported integrated dual disorders treatment (IDDT) component for those veterans with SMI and co-occurring addiction. The training rotation emphasizes program development opportunities in the areas of the evidence-based practice recommendations for illness management and recovery, and integrated dual disorder curricula from the Substance Abuse and Mental Health Services Administration (SAMHSA). The 20-bed general psychiatric Psychosocial Residential Rehabilitation and Treatment Program (PRRTP) is the residential component, housed within a 37-bed unit, offering an enhanced rehabilitative milieu facilitating recovery for veterans with mental health and/or addiction rehabilitation goals. This model program applies stage-wise intervention strategies for addiction and illness management issues, with an emphasis on early engagement, individual values and goals, and persuasion interventions. Comprehensive, recovery-oriented psychosocial assessment, motivational enhancement, cognitive-behavioral psychotherapy, and group facilitation skills are primary training opportunities in this setting. The resident is a full member of the interdisciplinary team including a psychologist team leader, psychiatrist, social worker, counselor and rehabilitation providers, peer support specialist, and 24-hour residential nursing staff.

- **The Recovery Resource Center** is a fully CARF accredited (under Community Integration standards) Psychosocial Rehabilitation and Recovery Center (PRRC) that offers intensive outpatient mental health services to veterans with serious mental illness. The PRRC is a transitional learning environment that is designed to empower veterans using an individualized, person-centered approach. The PRRC strives to support mental health recovery and integrate veterans into meaningful community roles. This program offers wellness and recovery programming with an emphasis on realizing individualized recovery goals and full community integration. Programming includes social skills training, integrated dual disorders treatment (IDDT) and Cognitive Enhancement Therapy (CET). The program also offers individualized recovery planning and recovery-oriented services coordination. As a member of the fully engaged interdisciplinary team based in the community, the resident works with the psychologist team leader, advanced practice nurse, social workers, and certified peer support specialist providers, and gains experience in learning to effectively engage, assess, and intervene with clients in their natural environment.

In this four-month rotation, the resident gains extensive experience in evidence-based psychosocial skills training interventions across a range of rehabilitative milieus and modalities; as well as professional psychological experience as a full-member of multidisciplinary teams. The resident’s training includes, but is not limited to, the following:

1. Comprehensive initial and ongoing recovery-oriented biopsychosocial assessments.
2. Interdisciplinary rehabilitation and recovery planning based upon the veterans’ assessed needs, preferences and goals across psychosocial domains.
3. Psychosocial skills training and psychoeducation in individual and group formats, also including integrated dual disorders treatment and social skills training.

4. Individual psychotherapy, including cognitive behavioral psychotherapy interventions.

5. Psychological assessment, including differential diagnosis of psychotic spectrum conditions utilizing traditional psychological assessment techniques.

6. Program development and outcomes evaluation.

E. Scholarly Research Project

(8 hours per week; full year duration)

The research requirement is described here.

F. Supplemental Training Experiences

1. Summit County Recovery Project (Optional: 1 site visit). The residency has partnered with the Summit County Recovery Project, which was developed to assist persons who are recovering from mental illness to return to dignified, contributing roles in the local community, to the best of their ability. Frederick J. Frese III, Ph.D., nationally recognized psychologist-consumer is the Summit County Recovery Project Coordinator and liaison for the consumer-operated business entities. This training experience will afford the residents both exposure to selected consumer-run activities and initiatives in the community with consumers who are in the later phases of the recovery process. The site visit includes Choices (a drop-in, consumer-operated community center) and the Consumer Educational Outreach Center (a reading room/lending library).

2. Evidence-Based Practices for Persons with Severe Mental Illness (Optional: 1-3 site visits each). The LSCVAMC offers a spectrum of interventions for veterans with severe mental illness, in accordance with nationally recognized clinical guidelines and recommendations. In primary training rotations, the resident gains competence in two widely recommended evidence-based practices for this population: cognitive-behavioral psychotherapy and psychosocial skills training, as well as practical experience in best practice recommended integrated dual diagnosis treatment approaches. The residency curriculum includes required literature review relevant to evidence-based practice areas. Clinical experiences across the year include interface and referral of veterans to supplementary rehabilitation programs in accordance with veterans’ personal rehabilitation and recovery goals. To enhance the resident’s practical exposure to additional evidence-based interventions, one to three site visits are optionally scheduled with each of the following programs:

   a. Mental Health Intensive Case Management (MHICM). An assertive community treatment-model case management program offered through community-based outpatient clinics for veterans with severe mental illness. This program has also instituted an Integrated Dual Disorders Treatment case management initiative.

   b. Supported Employment. Our supported employment program achieves excellent fidelity ratings for best-practice in this evidence-based employment services for persons
with severe mental illness. Vocational employment specialists work closely with numerous clinical programs for persons with severe mental illness.

c. Family Education/Psychoeducation. Family psychoeducation and education programs are intermittently offered for veterans with severe mental illness and their supports through a community-based outpatient clinic and/or in partnership with the National Alliance on Mental Illness (NAMI).

3. Ohio Suicide Prevention Foundation (Optional; 1 or more site visits): The Ohio Suicide Prevention Foundation (OSPF) was established in 2005 to promote suicide prevention as a public health issue and to advance awareness to support suicide prevention activities. Ohio Department of Mental Health partnered with Ohio State University, the state Suicide Prevention Team, suicide survivors and advocacy groups, and numerous private and public agencies in this initiative. The resident has the opportunity to attend an OSPF Advisory Committee meeting with a Residency major preceptor who serves on this state panel. Education regarding suicide prevention initiatives and expanded professional roles for psychologists in public health policy is the focus of this experience.

II. COMMUNITY INCLUSION FOR THE SERIOUSLY MENTALLY ILL

(1 Resident)

This Interprofessional Post-Doctoral Residency in Clinical Psychology is in partnership with Social Work and Chaplain Service, and is focused on Community Inclusion with Veterans who experience SMI. Residents in this program will learn and work alongside other social work and chaplain trainees to assist individuals with attaining self-determined goals and roles in their communities of choice. In general, interprofessional care requires providers to demonstrate in-depth understanding of various professional disciplines on the team and effectively involve, engage, and integrate those other providers to improve case-specific client outcomes. Inter-professional collaboration also aims to bring disciplines together to address needs within a system of care.

The resident will develop competency in or have significant exposure to many of the traditional and evidence-based psychosocial interventions for individuals who experience serious and persistent mental illness (i.e., schizophrenia spectrum disorders, bipolar disorder, severe PTSD, major depressive disorder), co-occurring addictive disorders, homelessness and various health or life challenges. Fellows will learn or be exposed to interventions in Illness Management and Recovery, Integrated Dual Diagnosis treatment, Assertive Community Treatment, Supported Employment, Cognitive-Behavioral Therapy, Social Skills Training, just to name a few.

The primary focus for the resident in this fellowship is to develop skills and competencies that help individuals with complex psychosocial challenges flourish in their natural environments. Residents will hone assessment skills using various cognitive, personality (projective, objective) and recovery-oriented measures and use those findings to develop meaningful treatment recommendations. Residents will also develop skills in stage-wise assessment and treatment of co-occurring addictive disorders. Special emphasis will be placed on developing measurable, person-centered care plans that address an individual’s needs and reflect an understanding of the various stages of change. In addition to improving
knowledge of community-based work and interventions, residents will engage in rotations and clinical experiences that expose them to the entire continuum of psychiatric care. The PRRC, a primary rotation site, also offers telehealth services at a remote location so residents will obtain valuable experience conducting mental health assessments and session by video. During the SMI Inclusion Inter-professional Residency, residents will learn a great deal about organizational systems, program design, implementation, evaluation, developing community partnerships, and managing a mental health program.

**FOCUS AREA (Advanced Functional) COMPETENCIES**

1. Demonstrates understanding of community inclusion domains and principles, and utilizes effective intervention strategies that increase opportunities for community participation and include resources within the person’s community of choice. Interventions are community-based when feasible and aim to increase independence.

2. Demonstrates knowledge of Psychosocial Rehabilitation (PSR) principles and competence in PSR skills training for persons with SMI (e.g. illness management and recovery, communication and social skills, relapse prevention and planning, cognitive re-training, motivational interventions, etc.).


4. Demonstrates an ability to incorporate strengths, needs, abilities and preferences of the individual into the care plan. Demonstrates understanding of the holistic needs of the individual, various stages or change/treatment and effectively monitors progress/outcome. Collaboratively engages other disciplines, advocates, services, families and supporters in the individual’s recovery process when warranted.

5. Demonstrates in-depth understanding of various professional disciplines on the team and can effectively involve, engage, and integrate other providers to improve case-specific client outcomes. Possesses the ability to work with other disciplines on a common project to improve systems of care for individuals with SMI.

**Optional/Supplementary FOCUS AREA (Advanced Functional) COMPETENCIES**

1. Demonstrates understanding of Integrated Dual Diagnosis Treatment (IDDT) principles, stages of change and is able to correctly identify stages of treatment for individuals with dual disorders. Demonstrates competence/skill in basic substance abuse interventions and able to develop appropriate stage-wise interventions.

2. Demonstrates skill in family psychoeducation and/or behavioral family therapy. Can effectively incorporate supports into recovery plans and treatment interventions.

3. Demonstrates knowledge and understanding of Vocational Rehabilitation and Supported Employment principles, conducts appropriate vocational needs assessments, develops appropriate employment goals, uses effective coaching techniques to improve job performance and job retention, and can coordinate with vocational staff and employers to improve vocational/employment outcomes.
4. Demonstrates understanding of the biological bases of Schizophrenia-spectrum mental illnesses, can administer Cognitive Enhancement Therapy (CET) interviews and assessments, develop treatment plans and conduct psychosocial skills groups in a manner that meets fidelity with CET.

CLINICAL TRAINING EXPERIENCES

A. Psychosocial Rehabilitation & Recovery Center (PRRC), 4-6 months:
   1. Individual interventions focused on engagement strategies and longer term therapeutic interventions, as individuals are usually in PRRC for a year or longer, as opposed to much shorter duration in other VA programs.
   2. Projective & Objective personality assessment.
   3. Groups focusing on Evidenced Based Practices for individuals with SMI.
   4. Community-based interventions to increase skills in the community (In-vivo skills training, home evaluation when appropriate, etc.).
   5. Telehealth assessments and interventions (group, individual).
   6. Conducting a Bridge Group on the Inpatient Psychiatry Unit and participating in treatment teams when appropriate.
   7. Additional opportunities may include family programming, Cognitive Enhancement Therapy (CET), Equine-Assisted Psychotherapy, etc.

B. Specialized Evidence-Based Psychosocial Rehabilitation services, 3-4 months:
   2. Comprehensive Homeless Center Outreach Program – Hud/Vash, Housing First, Veterans Justice Outreach, Grant & Per Diem, Community Resource & Referral Center (8 hrs) - Assist with specialized assessments, care planning and outreach w/ emphasis on brief interventions for veterans who are formerly homeless, homeless or at risk of homelessness.
   3. Supported Employment (8 hrs) - Emphasis on vocational assessment, care planning and interventions to increase skills to maintain employment.

C. Other Homeless and Community-Based Experiences, 3-4 months:
   1. Home-Based Primary Care – HBPC (16 hours): Individual home-based assessments, care planning, and interventions on a multidisciplinary team of health professionals.
   2. Homeless Domiciliary (16 hours): Program development focused on individuals with SMI who are homeless. Brief therapy and assessments aimed at helping veterans manage psychosocial issues/problems and plan for transition to the community.
D. Other Homeless and Community-Based Experiences, 3-4 months:

1. Completing a year-long program evaluation or research project (One day, 8 hrs/week).
2. Developing 1-2 groups based on needs/preferences of person served with rationale that is based on relevant literature and PRRC model of care.
3. Developing a community partnership and gaining exposure to local mental health and homeless continuum of care (attending meetings at the local mental health board or office of homeless services with preceptor), including providing presentations to one of the local boards, programs, and continuum of care.
4. Providing umbrella supervision to psychology interns.

E. Scholarly Research Project (8 hours per week; full year duration)

The research requirement is described [here](#).

III. POSTTRAUMATIC STRESS DISORDER

(1 resident)

The PTSD Special Focus Area is a multifaceted training program that involves many psychologists across three treatment units within the LSCVAMC: the PTSD Clinical Team (PCT), the Mental Health Clinical Care Team (MHACC), and the Polytrauma Center. All residents will spend the year in these three main rotations and the length of time and activities within each will be individualized according to the resident’s training plan. In addition, an optional women’s trauma rotation is available for those interested in more in depth training and application of skills in this domain. The PCT offers short-term (on average 3-6 months) evidenced-based therapies in individual and group formats, and includes a fully integrated PTSD/SUD residential program. The MHACC offers a wide variety of long and short-term individual and group therapies (Acceptance and Commitment Therapy, Dialectical Behavior Therapy, as well as psychodynamic approaches). The Polytrauma Center provides exposure to assessment and individual psychotherapy with veterans suffering from mild traumatic brain injuries and PTSD. The PTSD resident will participate in an individualized combination of experiences that include these three units. The intention is to maximize the scope and depth of expertise obtained from working with men and women of all eras who present with a broad range of stress disorders, including complex cases who struggle with comorbid conditions.

Our training model encourages assessment of physiological, psychological, familial, and resilience factors to guide an integrated, interdisciplinary treatment plan with special emphasis on empirically-based treatments. We begin by carefully designing the particular combination of experiences based on the resident’s needs and interests for the training year. Initially this will include focused training in assessment (which may include Compensation and Pension Examinations), Prolonged Exposure, Cognitive Processing Therapy (with Image Rehearsal Therapy/Nightmare Resolution available), Acceptance and Commitment Therapy (ACT), and Dialectical Behavior Therapy (DBT). These core skills will then be tailored to fit the populations and clinical conditions of the veterans during subsequent rotations. Those rotations will include exposure to OIF/OEF/OND veterans of the Afghanistan and Iraq wars, men and women with military and/or childhood sexual trauma, traumatic brain injuries, Vietnam and WWII veterans, as well as the wide range of PTSD from non-military traumas, many of which entail
widely varying combinations of mental health disorders. Treatment modalities will include an unusually wide array of group formats along with individual and marital psychotherapy. With the core evidence-based therapy skills mastered, residents will be able to apply themselves to each of the rotations described below in a flexible manner, individually creating a combination of training experiences to meet their training needs and interests.

**FOCUS AREA (Advanced Functional) COMPETENCIES**

1. **Evidence-based psychotherapy:** Demonstrates understanding of research-base and skills in delivery of Prolonged Exposure for PTSD, and Cognitive Processing Therapy, in both individual and group formats.

2. **Assessment and treatment planning for commonly co-occurring disorders:** Able to recognize, assess and make treatment recommendations regarding commonly co-occurring disorders, including traumatic brain injury (TBI), substance use disorders, and depressive disorders. Demonstrates familiarity with the clinical practice guidelines for these co-occurring conditions, and consistently consults with appropriate providers.

3. **Adjunctive treatments for PTSD:** Demonstrates knowledge of the Clinical Practice Guidelines (CPG) for PTSD and the role of adjunctive therapies. Demonstrates skills in delivery of a minimum of two adjunctive therapies for PTSD outlined in the CPG.

**Optional/Supplementary FOCUS AREA (Advanced Functional) COMPETENCIES**

1. **Psychopharmacology:** Demonstrates consultative-level knowledge and skills in basic psychopharmacology and psychopharmacotherapy for PTSD.

2. **Family services:** Demonstrates skill in family psychoeducation and/or couples-based therapy for those with PTSD.

3. **DBT/ACT:** Demonstrates skill in the delivery of Acceptance and Commitment Therapy as it relates to PTSD and/or Dialectical Behavioral Therapy for persons with histories of severe trauma.

**CLINICAL TRAINING EXPERIENCES**

**A. PTSD Clinical Team**

(8-24 hours/week; 4-month to full year duration)

The PCT provides time-limited and empirically supported treatments for PTSD. Residents work within an interdisciplinary team comprised of psychologists, social workers and psychiatrists. The client population includes men and women whose military experiences span World War II, Korea, Iraq, and Afghanistan. The PCT gives treatment priority to those who had sustained traumatic experiences in the military, including but not limited to combat and military sexual trauma. Patients may have severe, acute, and/or treatment-resistant PTSD as well as co-morbid diagnoses including substance use disorders. Treatments are offered in both individual and group format, and include: cognitive processing therapy, prolonged exposure therapy, nightmare resolution therapy and several approaches to integrated care for PTSD/SUD (Seeking Safety, Motivational Interviewing, Relapse Prevention, and psychoeducation). Patient care and support services are tailored to meet the individuals’ needs, taking into account their
cultural, ethnic, gender and age-related characteristics. The resident conducts comprehensive assessments to arrive at accurate diagnosis, appropriate disposition for level of care, and referrals if indicated. Team members are involved in empirical research and outcome studies, and residents are encouraged to participate.

The PTSD Clinical Team also provides a nine-week cohort-based residential integrated PTSD/SUD program that involves therapeutic interventions 6 hours per day, five days per week. The resident can gain competence in working intensively using empirically-based therapies (PE and CPT) with male veterans who suffer from PTSD and multiple social and personal coping skills deficits. The treatment program is open to male veterans from all eras whom have experienced combat or non-combat traumatic events during their service. The resident works with a psychologist on a multidisciplinary team that includes a psychiatrist, social worker, and occupational therapist. The resident conducts intake assessments, facilitates trauma-focused and educational groups, and provides case management, along with individual and family counseling, as needed. Clients accepted into the Program suffer from chronic PTSD and co-morbid substance abuse, as well as other mood and personality disorders. The Program strives to help individuals manage the social, vocational, and physical effects of their stress disorder. Interventions focus on resolution of interpersonal, social, and vocational problems associated with acute and chronic PTSD through the integration of exposure-based, cognitive restructuring, and mindfulness techniques.

**B. Mental Health Ambulatory Care Center Rotation**

(4-8 hours/week; 4-month to full year duration)

This outpatient rotation is focused on doing multifaceted psychotherapy with opportunities to engage in group and individual psychotherapy with male and female veterans. Veterans present with complex cases of PTSD, including sexual trauma, OIF/OEF/OND veterans at all stages of recovery, and comorbid diagnoses. We have specialties in acceptance-based approaches such as Acceptance and Commitment Therapy, programming based on Dialectical Behavior Therapy, mindfulness interventions, and Prolonged Exposure Therapy. There are groups that focus on sexual trauma, depression and anxiety conditions, anger, and values. The MHACC is often the veteran’s first encounter with treatment in the VA system, and provides a unique opportunity to work with patients at initial contact, in protocol-driven treatments, and longer-term working-through modalities of psychotherapy. The resident will be involved in assessment, advanced case conceptualization, development and implementation of meaningful treatment plans, individual psychotherapy, and as a co-therapist in group therapy formats.

**C. Women’s trauma treatment**

(4-8 hours/week; 2-6 month duration)

The resident will have opportunities to provide treatment to women survivors of trauma across a variety of other rotations. The women’s trauma rotation affords residents more depth in training experiences in additional treatment environments. Residents in this rotation will have the opportunity to work within the Women’s Health Clinic to offer short term treatments within a behavioral health setting and consultation to providers within the Medical Center. Residents have the option of providing services in a newly developed women’s intensive outpatient program for those who have experienced interpersonal trauma. This program integrates mindfulness/body work, DBT skills and cognitive behavioral interventions. Additional opportunities include working on special projects, program development, and
initiatives with the Military Sexual Trauma coordinator and the Interpersonal Violence/Domestic Violence lead.

**D. Scholarly Research Project**

(8 hours per week; full year duration)

The research requirement is described [here](#).

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### IV. SUBSTANCE ABUSE and PROCESS ADDICTIONS

(1 resident each program)

The resident participates in a series of rotations to maximize the scope and depth of training in the assessment and treatment and rehabilitation of individuals coping with a broad range of substance use disorders and behavioral addictions. Training emphasizes the use of empirically-validated approaches to conceptualizing, assessing and treating individuals with addictive disorders. Residents are afforded the opportunity to develop and enhance their competence in motivational interviewing and enhancement techniques, cognitive-behavioral interventions, relapse prevention skills training, mindfulness based relapse prevention, and use of Twelve-Step facilitation approaches. The Substance Abuse interdisciplinary approach also offers the resident the opportunity to gain experience with developing comprehensive, integrated treatment plans based upon individual recovery goals. Training rotations offer the development of competence in diagnosis of substance use disorders and gambling disorder, as well as differential diagnosis of complex co-occurring psychiatric disorders and their relationship to the addictive disorder. The residency experience also incorporates enhanced professional psychological role development, teaching, and supervisory activities. Special emphasis is placed on gaining experience in program development, implementation, and outcomes monitoring.

A broad range of addiction programming is available in this setting, across the spectrum from clinical detoxification interventions, early engagement, outpatient and residential primary addiction rehabilitation services, and aftercare. The addiction recovery programs at LSCVAMC are among the largest in the VA healthcare system, and include the only veterans’ residential treatment program for gambling disorder in the nation for both the VA and Department of Defense (DOD). Psychology training has been an emphasis within our addiction services for over 35 years. The Substance Abuse resident participates in training rotations to maximize the breadth and depth of experience in assessment, treatment, and rehabilitation of veterans with the range of addictive disorders.

**SUBSTANCE ABUSE FOCUS AREA (Advanced Functional) COMPETENCIES**

1. Develop competence in differential diagnosis, case conceptualization and prioritization of treatment planning and goals of comorbid disorders found among individuals with addictions including but not limited to substance dependence and/or pathological gambling.

2. Develop competence in the implementation of treatment interventions for substance abuse and behavioral addictions utilizing evidenced-based motivational, cognitive-behavioral, mindfulness, and Twelve Step strategies.
3. Develop or enhance individual, group, couples and family intervention skills, including harm reduction, abstinence, relapse prevention, and support networks strategies for veterans with primary and comorbid addictive disorders.

4. Psychosocial Intervention- Cognitive Behavioral Treatment: Demonstrates understanding and skills in individual and/or group cognitive-behavioral interventions for persons with addictions, including knowledge related to selection and effective implementation of specific interventions, and monitoring of progress and outcomes.

5. Psychosocial Intervention-Motivational Interviewing: Demonstrates MITI competence (achieving an average score of 4 on a 5 point scale) scoring on taped and/or live therapeutic interactions. This would include competence in MI scales measuring autonomy, direction, empathy, spirit, and responding to and inviting change talk.

6. Advanced Addictions Screening and Assessment: Demonstrates competence in the selection and implementation of screening and assessment tools, including competencies in risk assessment, and utilization of biopsychosocial assessment instruments to then inform treatment plans and prioritize a complex set of problems and goals.

7. Care coordination and consultation: Demonstrates competence to collaborate and consult with other disciplines, service recipients, advocates, families and agencies, demonstrating a flexible and comprehensive view of treatment, rehabilitation, and recovery.

Optional/Supplementary FOCUS AREA (Advanced Functional) COMPETENCIES

1. Psychosocial Intervention- Contingency Management: Demonstrates an understanding of contingency management (CM) or motivational incentives including participation in the CM program as a facilitator and/or program developer.

2. Psychosocial Intervention-Mindfulness Based Relapse Prevention: Demonstrates skill in mindfulness-based relapse prevention (Marlatt) in group and/or individual treatment.

SUBSTANCE ABUSE CLINICAL TRAINING EXPERIENCES

Several rotation options are available for trainees, designed to meet their individual training needs and preferences. Each rotation is available for two 6-month rotations or three 4-month rotations. As such, the resident may choose two or three of the following experiences:

A. Gambling Treatment Program (GTP)

The GTP was the first program of its kind in the nation and remains the only residential program for treatment of pathological gambling within the VA system, receiving national referrals of veterans and active duty military service members for this specialty treatment program. Veterans and active duty service members present with a broad array of complex comorbid conditions. The resident is an interdisciplinary team member, utilizing empirically-validated approaches to the treatment of pathological gambling including motivational enhancement and motivational interviewing, cognitive-behavioral strategies, mindfulness, relapse prevention, money protection and harm reduction, and Twelve Step integration. Intensive motivational interviewing training including taping and coded feedback is available. Option A: 4 months 32 hours per week; Option B: 6 months 32 hours per week.
The resident’s training includes:
1. Screening, assessment and diagnosis of gambling disorder and comorbid disorders using interviewing and psychological testing.
2. Interdisciplinary team staffing and treatment planning.
3. Individual therapy, group facilitation, family interventions, and development of continuing care plans.
4. Program development, implementation, and outcomes monitoring.

B. PRRTP/Program for Recovery Skills
The Program for Recovery Skills is an intensive residential program for persons with severe mental illness (SMI). The resident is an interdisciplinary team member in this comprehensive residential rehabilitation program that employs evidence-based strategies for veterans with SMI, including illness management and recovery skills training, with an empirically supported integrated dual disorders treatment (IDDT) component for those veterans with SMI and co-occurring addiction Option A: 4 months 32 hours per week; Option B: 6 months 32 hours per week.

The resident will develop skills in:
1. Comprehensive initial and ongoing biopsychosocial assessments.
2. Psychological assessment, including substance use assessment and differential diagnosis of a broad spectrum of co-occurring disorders using traditional psychological techniques.
3. Integration of recovery skills in both addictive disorders and serious mental illness.
4. Relapse prevention interventions in group, family and individual formats.
5. Psychosocial skills training, relapse prevention planning, motivational enhancement and psychoeducational interventions in group and individual formats.
6. Program development and evaluation.

C. Primary Substance Abuse Programs
One of the largest substance abuse programs in the VA Healthcare System, we offer a broad range of experiences ranging from brief intervention to Intensive Outpatient Programming (IOP), and Residential Treatment. Experience includes options for Early Intervention, Acute Detoxification, the Women’s Addiction Treatment Program, the Residential (Male) Primary Substance Abuse Treatment Program, and/or the Intensive Outpatient Program. Option A: 4 months 32 hours per week; Option B: 6 months 32 hours per week.

Primary Substance Use Disorder Treatment Programs Options:
1. Women’s Addiction Treatment Program. The Women’s Addiction Treatment Program (WATP) is a residential program that was created exclusively for women to eliminate typical treatment barriers including shame, hopelessness, fear and despair through providing a safe, non-confrontive environment that helps women explore the discrepancy between their sober values and continuation of substance abusing behaviors. Our focus is addiction recovery integrated with consideration to other psychopathology. This program’s goal is to help women veterans achieve and maintain a sober lifestyle through the evidence-based treatment model Helping
Women Recover (Covington), supplemented by Motivational Interviewing and Enhancement, Mindfulness, and Dialectical Behavior Therapy.

2. **Residential Primary Substance Abuse Treatment Program or Intensive Outpatient Program.** The Residential Primary Treatment Programs and Intensive Outpatient Treatment Program are primary addiction treatment programs that offer a full-range of services to male veterans in recovery from primary addictive disorders. In addition to primary educational and skills training interventions, these programs offer programming that emphasizes social skills training, other coping strategies, and brief motivational interventions.

Residents in this rotation gain experience across a range of recovery services and populations. The resident has the opportunity to elect from a range of sites and populations, to support their personal training goals. The resident’s training on these rotations includes:

1. Screening for substance use, gambling and other process addictions, psychiatric symptoms, and support network problems;
2. Comprehensive biopsychosocial/spiritual assessment;
3. Differential diagnosis of comorbid psychiatric disorders;
4. Motivational enhancement, relapse prevention skills training, 12-Step facilitation, mindfulness based relapse prevention and cognitive behavior therapy;
5. Interdisciplinary team participation, including staffing and development of multidisciplinary treatment plans.

These programs may include the following experiences in both acute detoxification and intake/assessment, again depending on the resident’s training needs:

1. **Acute Detoxification** including clinical detoxification protocols, with an emphasis on acute assessment and early engagement;
2. **Intake/Assessment** including general intake and early engagement for veterans presenting to the addictions programs or to the primary care or other healthcare clinics in the medical center.

**D. Optional Supplemental Training Experiences**

The following professional development, training and educational activities and opportunities are available as part of options A, B and C above:

1. **Smoking Cessation Program.** Smoking cessation is offered in a variety of settings at this facility. The resident may elect to participate in a primary smoking cessation intervention program, as an adjunct to training during one primary rotation.
2. **Ohio Council on Problem Gambling.** The Ohio Council on Problem Gambling is a state advocacy organization. The resident may elect to attend one or more community advocacy activities or training events, and may be afforded the opportunity to co-present at state or national conferences.
3. **Criminal Justice Outreach.** Community outreach for veterans with forensic Issues through the Cuyahoga County Justice Center.
4. **Homeless Shelter Veteran Outreach.** Community outreach for homeless veterans.

5. **Organ Transplant.** Participate in the recovery skills group for veterans referred to the organ transplant list due to substance use concerns.

**E. Scholarly Research Project**

(8 hours per week; full year duration)

The research requirement is described [here](#).

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**V. FAMILY AND COUPLES COUNSELING SERVICES**

(1 resident)

The resident participates in an interprofessional training program comprised of practitioners and trainees from Psychology, Chaplain Service, and Social Work. The resident will be part of the Clinical Psychology, Special Focus Area Residency Program with the intention that collaborative work across these three disciplines will enhance the provision of Family and Couples Counseling Services (FCCS) at the Louis Stokes Cleveland Veterans Affairs Medical Center (LSCVAMC). Currently, Psychology, Chaplain, and Social Work services provide independent FCCS. The FCCS interprofessional team will provide independent and conjoint treatments, including therapy, pastoral counseling, family education and consultation to our Behavioral Health Interdisciplinary Program (BHIP) Teams, the Posttraumatic Stress Disorder (PTSD Clinical Team (PCT) and the Gerontology Team in the General Mental Health Clinic. The training curriculum and experiences for the FCCS resident will emphasize systems and communication interventions designed for couples and families, as well as clinical pastoral counseling and family education within an interprofessional framework.

Currently, our professionals include practitioners trained in and practicing all of the VA endorsed evidence-based practices for families and couples: Behavioral Family Therapy (BFT), Integrated Behavioral Couples Therapy (IBCT), Family Education/Psychoeducation through Veterans Support and Family Education (VSAFE), and VA-NAMI Family to Family Education Program Partnership. Additionally, we offer other evidence-based couples interventions derived from the work of Drs. John & Julie Gottman, Strategic Family Therapy, Emotionally Focused Couples Therapy, and Warrior 2 Soulmate (W2SM) couples workshop. Our current FCCS assists veterans, their partners, and/or families (family “members” are identified and defined by the veteran) through direct work on relationship struggles, as well as family and couples counseling that assists in managing factors that can significantly impact relationship dynamics and quality, such as serious mental illness (SMI) and Posttraumatic Stress Disorder (PTSD).

**FCCS FOCUS AREA (Advanced Functional) COMPETENCIES**

The educational objectives of this training program are expected to produce practitioners well-versed in evidence based models of care for families and couples undergoing debilitating stress to the family system. Objectives will be for trainees to:

- Gain an understanding of how couples and family systems operate and maintain equilibrium in behaviors and cognitions that either promote or hinder well-being among family members.
• Gain an understanding of how evidence-based interventions can modify family and couples communication and behaviors to establish or restore beneficial interactions.
• Gain expertise, through practice and pedagogy, in utilizing appropriate couples and family interventions to change disabling couples and family dynamics.
• Develop knowledge and skills in treatment planning and strategic goal setting for couples and families in therapy.

Core Competencies
Specific core competencies are in accordance with the American Association for Marriage and Family Therapy’s December, 2004 Marriage and Family Therapy Core Competencies, and are recommended by the American Psychological Association as guidelines for psychologists who practice family and couples therapy.

1. Demonstrate competence in understanding and utilizing systems concepts, theories, and techniques that are foundational to the practice of marriage and family therapy. This will include development of hypotheses regarding relationship patterns, examination of extra therapeutic factors that can influence treatment, and contextual assessment of systemic problems.

2. Demonstrate competence in the utilization of individual, couple, and family assessment instruments appropriate to the presenting concerns, practice setting, and cultural context through the application of effective and systemic interview techniques and strategies, and administration and interpretation of appropriate assessment instruments. This will include utilization of models and instruments related to the assessment and diagnosis of mental health disorders, substance use, and relational functioning, as well as assessment of safety issues (interpersonal violence (IPV); child, elder, and/or abuse of a vulnerable person; suicidality; risk to others).

3. Demonstrate competence in the application and use of models, modalities, and/or techniques most effective for presenting problems including evidence-based therapies and culturally sensitive approaches that match the family or couple’s needs, goals, and values with sensitivity to special cultural considerations.

4. Collaboratively develop treatment goals, treatment plans, measurable outcomes, and aftercare plans utilizing a systemic perspective. This will include prioritization of treatment goals, continual subjective and objective evaluation of progress towards treatment goals, recognition when and how treatment goals and plans should be renegotiated, and development of termination and aftercare plans.

5. Collaborate and consult with other disciplines, service recipients, advocates, families and agencies, when necessary with particular attention to the potential need for referral(s) to other VA and non-VA resources and/or professionals.

6. Work within professional, ethical, and legal boundaries as well as within VA policies and procedures. Recognize ethical dilemmas, appropriately use supervision and consultation, understand the limits of confidentiality in couples and family therapy, and develop safety plans when needed.
**FCCS Optional/Supplementary FOCUS AREA (Advanced Functional) COMPETENCIES**

1. Psychopharmacology: Demonstrates consultative-level knowledge and skills in basic psychopharmacology.

2. Interprofessional services: Demonstrates understanding and appreciation for the services and skills offered by other disciplines working with individuals, couples, and families.

**FCCS CLINICAL TRAINING EXPERIENCES**

The Residency rotations and supplemental trainings are designed to allow for flexibility in experiences and attention to the manner in which FCCS are delivered for extended periods of time. Training emphasis is given to evidence-based practices. Attention is also given to multicultural issues, including same-sex and transgendered relationships. The specific training curriculum includes provision of outpatient FCCS, participation as a presenter at the quarterly W25M workshops, and collaboration with our intensive outpatient programs (IOPs), residential programs (addiction, Domiciliary, and residential SMI treatment), and the Psychosocial Recovery Resource Center (PRRC). The Major Preceptor for this Residency is a psychologist involved with family and couple services in the Cleveland VA Health Care System.

In addition to clinical practice, residents, as practitioner-scholars, are required to conduct a year-long research project or engage in program development in which they develop a project with a definable work product. This provides the opportunity for the resident to experience the VA research review process, identify an area of need in couples and family services, implement some form of treatment or intervention to fulfill this need, and survey the results of the intervention.

Last, the Residency also incorporates enhanced professional role development, teaching, and potential supervisory activities. As a member of an interprofessional program, the resident participates in monthly professional and clinical development seminars with residents and interns from our Social Work and Chaplain departments. Learning how to collaboratively work with these other disciplines is crucial to professional development and a major mission of this program. Residents may also have the chance to supervise predoctoral psychology interns who choose an enrichment in family and couples services.

**Supplemental Training Experiences**

The resident may elect to devote a portion of their time to working with families and couples in other programs at the Cleveland VA. This may include working with the families of veterans on our inpatient psychiatric unit, those residing in our nursing home (Community Living Center), veterans and families involved in the Family Caregivers program, and creation of supplemental treatments for couples and families, such as parenting skills classes, multifamily counseling, and psychoeducation on mental illness, communication skills, or other topics of professional interest to the resident.

**Scholarly Research Project (8 hours per week; full year duration)**

The research requirement is described [here](http://example.com).


BISCARO, Michael, J., Psy.D., ABPP. Xavier University, 2005. Assignments: Program Coordinator, Recovery Resource Center (PRRC); Major Preceptor, Community Inclusion & Serious Mental Illness (SMI); CARF Behavioral Health Continuous Readiness Committee Chair. Theoretical Orientation: Integrative with emphasis on cognitive behavioral, dynamic, and systems theories. Clinical specializations: Board Certified (ABPP) in Forensic Psychology; Psychological Assessment; Psychosocial Rehabilitation; Serious and Persistent Mental Illness. Publications and Research Interests: Evidence-based practices in treating serious mental illness; process/outcomes in psychosocial rehabilitation and recovery, and identifying predictors for problem drinking. Professional Organizations: American Board of Professional Psychology, American Academy of Forensic Psychology. Teaching and Supervision Interests: Psychosocial rehabilitation and the recovery model; Evidence-based practices in treating SMI, Group and individual psychotherapy, Psychological assessment and forensic psychology; Program development, implementation, & evaluation.


Consultant with the National Council on Problem Gambling, Member/Trainee Motivational Interviewing Network of Trainers. Other professional activities outside VA: independent practice, national leader in professional training, consultation and supervision (gambling disorder, motivational interviewing and evidenced based addictions treatments, military and veteran culture). Teaching and supervision interests: Gambling disorder/Addictions, motivational interviewing, group dynamics, individual and group psychotherapy.


Teaching and supervision interests: Group dynamics and psychotherapy, motivation, substance use treatment for women, psychopharmacology.

**KNETIG, Jennifer, Ph.D.** Fielding Graduate University, 2012. Assignment: Military Sexual Trauma Coordinator; Domestic Violence/Intimate Partner Violence Program Assistance Coordinator; Women’s Health Clinic; Mental Health Ambulatory Care Center. Theoretical orientation: Psychodynamic. Clinical Specializations: Sexual Trauma; PTSD; Complex Trauma; Dialectical Behavioral Therapy; Cognitive Processing Therapy; Group Psychotherapy. Publications and Research Interests: Psychotherapy; Complex Trauma. Professional Organizations: American Psychological Association; Ohio Psychological Association (Advocacy Committee.) Teaching and Supervision Interests: Psychodynamic Psychotherapy.


**MCCUTCHEON, Kevan, Ph.D.** University of Cincinnati, 1989. Assignments: Mental Health Ambulatory Care Center, Team Leader of Dialectical Behavior Therapy (DBT) program. Theoretical orientation:


RENNER, Kerry, Ph.D., Northern Illinois University, 2 residential treatment programming 008. Assignments: Clinical Psychologist on the Posttraumatic Stress Disorder Clinical Team; Local Evidence-based Psychotherapy Coordinator; Regional Cognitive Processing Therapy Trainer/Consultant and National Consultant. Theoretical orientation: Cognitive-Behavioral integrated with Interpersonal. Clinical Specialization: Assessment and treatment of PTSD, Trauma, and Anxiety disorders; Evidence-Based Practice in general and the use/development of Evidence-Based Psychotherapies (e.g., CPT, PE, CBT-Insomnia, etc.), veteran reintegration/adjustment post-service, understanding the impact of moral injury on recovery. Publication/Research Interests: Effective treatments for PTSD (Current research includes CERV-PTSD Study examining PE and CPT in veteran population; Local Site Investigator for this 17-site Cooperative Studies Program research), integrated treatments for PTSD/SUD, patient satisfaction & program development, integrated care for OEF/OIF veterans, persistent guilt/moral injury. Professional Membership: American Psychological Association, International Society for Traumatic Stress Studies. Training/Supervision Interests: Individual and group psychotherapy, evidence-based treatments for PTSD (CPT/PE), program development, evidence-based practice through an information scientist approach, diagnostic assessment.

RIDLEY, Josephine, Ph.D., Clinical Psychology, West Virginia University, 1997. Assignments: Program Manager, Psychiatry Day Hospital; Associate Professor, Dept. of Psychological Sciences, Case Western Reserve University; Chair, Psychology Service Diversity Committee; Program Director, Clinical Psychology Postdoctoral Residency; Major Preceptor, Psychosocial Rehabilitation for the Seriously Mentally Ill Residency; Member, LSCVAMC Institutional Review Board. Theoretical Orientation: Cognitive-Behavioral; Behavioral; Integrative. Clinical Specialization: Hospital Privileged in Nicotine Replacement Therapy; individual and group therapy with seriously mentally ill; CBT for Psychosis; Master Trainer for the Suicide Prevention Resource Center’ Assessment and Management of Suicide Risk (AMSR) Workshop. Publications and Research Interest: Depression, Suicide, Anxiety Disorders, PTSD. Professional Organizations: Association of Black Psychologists (ABPsi); Ohio Suicide Prevention Foundation Advisory Committee. Teaching & Supervision Interests: Differential Diagnosis/Psychological Assessment; Assessment & Management of Suicide Risk; Cognitive-Behavioral Therapy (CBT); CBT for Psychosis; Individual and Group Psychotherapy.
SLEPECKY, Rachel, Ph.D., University of Akron, 2007. Assignments: Inpatient Psychiatry (WCT6), ward psychologist; Mental Health Outpatient Clinic – individual and couples and family therapy; Major preceptor for Family and Couples Counseling Services Postdoctoral Residency; Co-coordinator of the VA Psychology Training Mentorship Program. Theoretical Orientation: Integrative with components of cognitive-behavioral and humanistic orientations. Clinical Specializations: Individual, couples, and family therapy; Diagnostic assessment; Consultation; Consultation and interprofessional team dynamics; group psychotherapy. Publications and Research Interests: Severe Mental Illness (SMI) and personality disorders. Professional Organizations: Ohio Psychological Association. Teaching and supervision interests: Differential diagnosis and use of psychological testing for this purpose; Mentorship; Umbrella supervision and supervisor support/growth; Group psychotherapy; Interprofessional consultation; professional development issues.


YAMOKOSKI, Cynthia, Ph.D., University of Akron, 2006. Assignment: Program Manager (outpatient PTSD and residential PTSD/SUD program; specialty mental health); Supervisory Psychologist; National Center for PTSD mentor; VISN 10 PTSD community of practice workgroup lead; major preceptor of Clinical Psychology Postdoctoral Residency Special Emphasis in PTSD; Senior Clinical Instructor, Case Western Reserve University, School of Medicine. Theoretical orientation: integrative with predominant components of cognitive-behavioral and humanistic orientations. Clinical specialization: PTSD assessment and treatment, combat-related guilt and moral injury, suicidology. Publication/research interests: PTSD, moral injury, suicidal thoughts and behaviors, interaction of cognitive processes and affect/emotions in psychological disorders, therapist self-care. Training/supervision interests: individual and group psychotherapy, evidence-based practices, diagnostic assessment.
The mission of the Rehabilitation Psychology Residency is to implement a biopsychosocial model aimed at improving the health, independence, quality of life, and productivity of people with disabilities, from acute care throughout the lifespan. The program is based on functional competencies as defined by the American Board of Rehabilitation Psychology. Consistent with 2012 APA training guidelines, program duration is two years in order to provide depth and breadth of experience at a specialist level. Residents will attain competencies to engage in specialty practice focused on core rehabilitation diagnoses, including spinal cord injury, traumatic brain injury (TBI), amputation, stroke, multiple sclerosis, and orthopedic disorders. The resident advances to an independent practice level through a program of supervision and didactics that affords increasing autonomy in decision-making and provision of services.

**REHABILITATION SPECIALTY COMPETENCIES**

1. Gain working knowledge about the medical aspects of disability for various disorders, encompassing pathophysiology, epidemiology, impairments, functional status, expected outcomes, complications, disease course, and rehabilitative therapies.

2. Conduct rehabilitation-oriented assessments, focusing on the medical, psychological, social, and environmental variables that affect adjustment to disability, such as nature/extent of preserved abilities, personality/emotional functioning, cognitive abilities, substance abuse, pain, sexuality, family dynamics, community context, and cultural background.

3. Provide treatment to patients and families that incorporates disability-specific knowledge and seeks to maximize the individual's participation and quality of life, based on an individualized assessment of strengths/challenges and using evidenced-based behavioral, existential-humanistic, psychoeducational, cognitive, or other approaches as necessary. Treatment formats include individual, group, and telehealth interventions.

4. Develop interdisciplinary team consultation skills, working with physicians, therapists, etc. to promote psychological understanding of persons served and becoming a resource for addressing behavioral barriers.

5. Contribute to rehabilitation program development and program evaluation activities.

6. Acquire an appreciation for consumer protection and ethics in rehabilitation and advanced knowledge of APA's Ethical Principles. Become familiar with relevant laws affecting persons with disability (e.g., the Americans with Disabilities Act).

7. Engage in professional development through organizations such as APA’s Division 22 (Rehabilitation Psychology) and/or the Academy of Spinal Cord Injury Professionals.

8. Provide effective teaching and supervision to interns.

9. Conduct a scholarly or research project focusing on a physical disability-related topic.
PROGRAM STRUCTURE

The program is divided into four six month blocks over years one and two. Year One centers on the acquisition of required competencies for serving acute inpatient rehabilitation programs, specifically the Spinal Cord Injury (SCI) Unit and the Physical Medicine and Rehabilitation (PM&R) Service. For the initial six months, the resident works exclusively on the inpatient SCI Unit. For the second six-month block, the resident provides service to the inpatient PM&R Unit. An eight-hour per week enrichment during the second half of Year One offers advance experience in pain assessment and rehabilitation. By the end of Year One, the resident will have proficiency in providing rehabilitation psychology services in an inpatient context.

Year Two offers experience in outpatient and long-term care settings. The first six months develops skills in working with persons who have brain impairment, with clinical time divided between the Polytrauma Rehabilitation program and the Neuropsychology Service. The final six months takes place in the SCI Clinic and Long Term Care settings. By the end of Year Two, the resident will have experience over the entire continuum of care in rehabilitation and exposure to a wide range of disability diagnoses and clinical situations.

For the entire two years, the resident will have eight hours per week of protected time for research. Presentation of a scholarly project in a Grand Rounds format is required, and at least one poster presentation at a professional meeting during the two years is highly encouraged. Additional activities include postdoctoral seminars on general practice issues, supervision skills, and rehabilitation psychology.

Rehabilitation Psychology Seminar: Rehabilitation Psychology residents and Program Faculty rotate in making presentations on rehabilitation competency areas, such as the history of Rehabilitation Psychology specialty, adjustment to disability, assessment, and case conceptualization.

CLINICAL TRAINING EXPERIENCES

A. Spinal Cord Injury Unit

(32 hours/week for 6 months acute inpatient, Year One; and 32/hours/week Outpatient and Long-term care in Year Two)

Cleveland’s Spinal Cord Injury Center is one of 24 specialty care hubs within the VA Spinal Cord System of Care and is one of the few designated as a Center of Excellence. The Center has a lengthy history of service, founded in the early 1970s to treat injured veterans returning from Vietnam, and psychology has been an integral part of the unit since its inception.

The Center consists of an outpatient clinic for primary care of SCI veterans, a 32-bed inpatient unit devoted to a CARF-accredited acute rehabilitation program and sustaining care of long-term secondary complications of SCI, and a 26-bed long term care unit. The unit is served by three full-time psychologists. All patients are evaluated at least annually by psychology, with services ranging from brief screening to intensive inpatient treatment in conjunction with the interdisciplinary team. The resident will provide a mixture of services: annual preventive health screenings; individual psychotherapy; group...
psychotherapy; and inpatient consultation and treatment, including neuropsychological assessment of co-occurring traumatic brain injury.

The Spinal Cord Center has active research programs on management of pressure ulcers, telehealth, and vocational rehabilitation. The Transitional Care Unit is a post-critical care rehabilitation program serving individuals who are transitioning form the intensive care unit to a more permanent living situation.

**B. Physical Medicine and Rehabilitation Service**

(24 hours/week for 6 months, Year One)

The Physical Medicine and Rehabilitation Service operates a 10-bed, CARF-accredited general rehabilitation program serving veterans with amputation, TBI, stroke, orthopedic problems, neuromuscular disorders, and debility. The resident will function as an integral team member, assessing every person admitted to the program, addressing psychological barriers such as depression, anxiety, substance use, adherence issues, etc, and attending interdisciplinary rounds. The unit provides an ideal context for broad exposure to typical disability populations in short-term inpatient rehabilitation. In addition, the resident may facilitate a psychotherapy group for veterans with amputation.

**C. Pain Management Enrichment**

(8 hours/week for 6 months, Year One)

A significant percentage of people with disabilities experience chronic pain, and pain assessment is a competency mandated by the American Board of Rehabilitation Psychology. The resident will receive advanced training in pain evaluation and management. The Pain Management Center is a clinic within the Anesthesia Department. The resident will assess and treat patients with various chronic pain disorders both individually and as part of an interdisciplinary team in a CARF-accredited outpatient program. Treatment modalities include learning to utilize various biofeedback interventions; using evidence-based cognitive behavioral techniques for managing pain; teaching self-regulatory techniques such as self-hypnosis, autogenic training, and progressive muscle relaxation. The resident may participate in a weekly interdisciplinary journal club. Topics include biofeedback, assessment, pain literature updates, treatment approaches, and discussion of challenging cases.

**D. Neuropsychology Service**

(16 hours/week for 6 months, Year Two)

The experience will focus neuropsychological assessment of traumatic brain injury as well as advanced practice in capacity evaluation. The resident will gain expertise in the differential diagnosis of PTSD and cognitive impairments arising from TBI. In addition, residents will develop skill in generating recommendations to guide the rehabilitation process.

**E. Scholarly Research Project**

(8 hours per week; full year duration)

The research requirement is described [here](#).


KUEMMEL, Angela, Ph.D., ABPP, Nova Southeastern University, 2009. Diplomate – Rehabilitation Psychology (ABPP). Assignment: SCI Unit; Assistant Director of Psychology Training and Education, Program Director of Rehabilitation Psychology Internship Track, Diversity Committee Member. Theoretical orientation: Eclectic. Clinical specialization: Rehabilitation Psychology. Publications: Training and supervision, international accessibility, and abuse of people with disabilities. Research interests: Supervision of students with disabilities, disability and sexuality, adjustment to disability, and chronic pain management in patients with SCI. Professional Organization Leadership Roles: American Psychological Association, Policy and Planning Board member; Division 22 (Rehabilitation Psychology), Past Awards Committee Chair, Past Co-Chair and Public Interest Representative on APA’s Committee for Early Career Psychologists. Teaching and supervision interests: Supervision of students with disabilities, post-doctoral training guidelines for rehabilitation psychology.

MERBITZ (HANSEN), Nancy K., Ph.D., University of Notre Dame, 1993. Assignments: Spinal Cord Injury Long Term Care; Transitional Care Unit. Theoretical orientation: Integrative (humanistic-existential and behavioral). Clinical specialization: Rehabilitation Psychology, with emphasis on behavioral medicine, person-centered psychotherapy, geropsychology, and neuropsychology (assessment, monitoring and patient/team/family education regarding conditions with acute or chronic CNS effects). Publications: rehabilitation after critical illness and intensive care, adherence, benefits of assistance dogs, measurement of rehabilitation process and outcomes, quality improvement. Research interests: assistive technologies and access to digital communication, measurement and research design in rehabilitation interventions, the impact of diminished cognitive abilities on learning, coping and
adherence. Professional organizations: APA Division 22: Rehabilitation Psychology (member Executive Board 2014 - present; member Strategic Planning Task Force 2015 - present), APA Division 38: Health Psychology (member APA Interdivisional Health Care Committee 2007-2012), Association of Spinal Cord Injury Professionals, Standard Celeration Society (Precision Teaching), Association for Behavior Analysis International. Teaching and supervision interests: adapted psychotherapy, team collaboration and education, assessing and responding to reduced cognitive abilities in medically-complex patients.

OTHER STAFF QUALIFICATIONS


DILLON, Gina, Psy.D., Xavier University, 2010. Assignments: Parma Mental Health Ambulatory Care Center. Theoretical orientation: Eclectic, with emphasis on Acceptance and Commitment Therapy (ACT); Dialectical Behavior Therapy and Evidence Based Treatments for PTSD. Clinical specializations: Treatment and assessment of PTSD; individual and group psychotherapy; provider status in Cognitive Processing Therapy for PTSD. Publications/research interests: PTSD; the role of supportive/adjunctive groups during intensive PTSD treatment; attitudes of providers working with the SMI population. Professional organizations: Ohio Psychological Association. Teaching and supervision interests: treatment and assessment of PTSD; individual and group psychotherapy; professional identity/development issues.


STAFFORD, Kathleen P., Ph.D., Kent State University, 1977. Diplomate – Forensic Psychology (ABPP). Assignments: Wade Park Mental Health Ambulatory Care Clinic; Thursday Evening Primary Care Mental Health Integration Clinic. Theoretical orientation: Cognitive-Behavioral. Clinical specializations: Assessment, individual/group psychotherapy, forensic psychology, addictions, risk assessment, evaluation of competencies. Academic appointment: Adjunct Associate Professor of Psychology, Kent
State University. Publications and research interests: Chapters on civil commitment, mandated outpatient treatment, trial competency, criminal responsibility, psychological testing. Articles in refereed journals on mental health courts, symptom validity tests, and personality inventories. Professional organizations: American Psychological Association, Divisions 12 and 41; Past Chair, APA Ethics Committee; Past President - American Board of Forensic Psychology/ American Academy of Forensic Psychology. Teaching and supervision interests: Psychological assessment, forensic psychology, psychotherapy, risk assessment, professional standards and ethics.


AUTHORITIES

Administrative
Administrative issues include such things as terms of employment, leave, benefits, computer access, security, privacy, clinical privileges, and business ethics. Administrative authority is the bailiwick of the Psychology Service administrative staff, administrative supervisors, the Director of Psychology Training Programs (DoT), the Chief of Psychology, and successively higher VA administrative offices such as the Office of Personnel Management. All employees, including psychology trainees, are bound by VA policy and Federal rules.

Clinical
Clinical supervisors have the immediate and direct responsibility for your clinical work and professional psychology clinical training experience. Your clinical supervisor oversees the quality of clinical work, training experiences, and acceptability of professional comportment. Note that most clinical supervisors are not administrative supervisors, but have limited daily operational authority for trainee work life.

Terms of Appointment
Trainees are granted one-year appointments that include leave, health, and life insurance benefits. For two-year residencies the appointment is renewed after successful completion of the first year. Trainee appointments are for a calendar year, eight hours per day, five days per week, for a total of 2,080 hours. Trainees cannot be credited for experience in excess of eight hours per day or 40 hours per week.

ATTENDANCE, TIME, and LEAVE

For leave questions, your timekeeper is Ms. Judith Rosen at extension 820-6821.

Trainees are employees of the VA and subject to VA time, leave, and attendance rules. Appropriate adherence to attendance rules is part of the foundation upon which your training experience depends.

The trainee workday or ‘tour of duty’ is from 8:00am to 4:30pm, which includes a 30 minute unpaid lunch break. Hours worked beyond the regular workday cannot be credited toward your 2,080 hours, and trainee appointments do not include provision for “overtime” remuneration. Any departure from the 8:00am to 4:30pm tour of duty must be discussed with your supervisor, requested in writing, and approved by the DoT. If approved, The DoT will convey this to the timekeeper. The timekeeper is not authorized to make changes to trainee schedules.

Calling Off Work
If you are ill or late, you must call Psychology Service at 820-6822, and also notify your clinical supervisor. Calling off in excess of three days for sick leave requires a doctor’s verification of your illness. Annual leave may be used in lieu of sick leave, but you must indicate that when you call.
Leave Accrual
Trainees accrue four hours of paid annual leave (AL, vacation, or personal time) and four hours of paid sick leave per two-week pay period. Planned leave should be requested 45 days in advance. For leave requests under that timeframe, work with your clinical supervisor to ensure patient care policies are followed. The hospital policy for cancelling patient care is quite strict. Trainees may only use leave they have accrued, they may not be granted advanced leave.

Authorized Absence
Trainees can be granted a limited amount of authorized absence to attend professional psychology events. Interns are allowed up to three days (24 hours) for professional events and five days (40 hours) for job interviews. Residents are allowed up to five days (40 hours) for professional events and five days (40 hours) for job interviews. Requests for authorized absence must be made in writing to the DoT and include documentation of the event.

Extended Leave for a Health Condition
For trainees with qualified health conditions and/or serious family circumstances, the Chief of Psychology and DoT may elect to approve up to 12 weeks (480 hours) of combined paid (annual and/or sick leave) and unpaid (leave without pay) leave. Leave in excess of 208 hours will require an extension of training beyond one calendar year. In non-emergency circumstances, trainees should submit a plan to the DoT in writing at least 30 days in advance of the anticipated absence. The plan should include a formal request for the leave, dates for the leave, the type of leave requested, the intended completion date for any extension of training, and with supporting documentation. Since stipends are based on the training year, extensions of the training year might not be paid.

Terminal Leave
If a trainee has annual leave remaining at the end of the training year and all other requirements are completed, the trainee may elect to take up to one week of terminal leave. The trainee may also elect to continue working to the end of the training year and will be paid for any remaining annual leave. In the past trainees were able to carry over leave balances to new VA appointments, but this is dependent on the human resources department in the receiving VA facility. Inquire with your timekeepers and Human Resources contacts at both locations to coordinate any possible transfer of leave. Sick leave may not be used at the end of the training year except as defined in human resources policy.

Hours Credited
Our training programs are defined as one calendar year, or 2,080 hours, and we make allowances for leave. Trainees are granted four hours of sick leave, four hours of annual (personal) leave per two-week pay period, and 10 Federal holidays. If you were to use all your leave during residency, here is the result:

- Calendar year: 2,080
- Federal holidays: 80
- Annual leave: 104
- Sick leave: 104
- Total hours: 2,080 – 80 – 104 – 104 = 1,792 hours

Trainees must be on duty for at least 1,792 hours to successfully complete a program year.
**Licensing Hours**
State board requirements for licensure are unique to each state and vary greatly. Some licensing boards require a year of supervised post-doctoral experience, and others allow all experience to be pre-doctoral. When verifying hours for licensure, pre-doctoral internship is generally credited as a full year as part of your degree requirements.

The number of post-doctoral supervised hours required for licensure ranges from 1500 to 2000 hours, and licensing rules often do not contain clear direction about how to account for leave. When verifying post-doctoral hours of experience, some licensing boards ask only for the total hours; however some ask for an accounting of hours such as leave, supervision received, and client contact hours. If a licensing board asks for an accounting of hours, we will report it. It is your responsibility to determine the requirements for licensure and ensure you accrue enough supervised hours to meet them. If you have carried over leave from internship and you take this leave during residency, there is the possibility that you will not accrue enough hours to meet state licensure requirements.

**REQUIRED ACTIVITIES**

Trainees are required to attend the specified meetings and seminars. Timeframes vary for each, check the curriculum description for details and training calendar for final schedules. Clinical supervisors do not have the authority to exempt a trainee from attendance or to schedule conflicting clinical activities during these times. You must clear anticipated absences personally with the DoT. *Detailed description of curriculum components is provided in the operating procedures.*

**Intern Required Seminars**
- Weekly Training Didactic Seminar
- Diversity Rounds
- Grand Rounds as assigned
- Journal Club
- Group Discussion Case Conference
- Service Trainings as assigned

**Intern Required Clinical Cases**
- Initial Assessment Case Report
- Intern Case Presentations
- Oral Final Competency Examination
- Monthly Meeting with the Director of Psychology Training

**Residency Seminars Required for ALL Residents**
- Professional Issues Seminar
- Supervision Seminar
- Group Case Conferences

**Residency Specialty and Focus Area Seminars**
The following seminars are required for the specialty program or focus area in which you are enrolled. These seminars are not required for other residents, although residents are welcome at many of them.
For seminars outside your specialty area, check with the preceptor organizing the seminar to inquire about attendance.

Clinical Psychology Seminar
Inter-Professional Residencies Seminar
Clinical Health Psychology Seminar
Geropsychology Seminar
Rehabilitation Psychology Seminar

REQUIRED DOCUMENTATION

In addition to clinical documentation, trainees and their supervisors are required to complete documentation of training activities. Timeframes and specific document formats are in a table in the appendices. At the beginning of the rotation, the trainee and supervisor should collaborate on developing a learning plan with a few personalized goals specific to the training rotation. The learning plan should be a compliment to the development of profession-wide, specialty, and focus area competencies that supervisors evaluate. Trainees are required to track their weekly hours of leave, supervision, patient contact hours, and other supplemental activities. Most didactic presentations will have some form of evaluation, either for the speaker or other participants. Other surveys are very important for feedback to the supervisors, to inform program development, or to satisfy the requirements of accreditation. We appreciate your diligence in completing all documents in timely fashion.

SUPERVISION

Clinical supervision in psychology training programs is managed in accord with policy outlined in VHA Handbook 1400.04, Ohio law, and applicable accreditation regulations. Clinical supervisors are required to maintain current independent licensure as a psychologist. Trainees are registered with the State of Ohio Board of Psychology as a psychology trainee practicing under an Ohio licensed psychologist. At the end of the year, documentation of your completed training experience is sent to the Board. We verify residency experience to other state boards when requested.

Your clinical supervisor is responsible for your clinical work and provides frequent professional consultation to foster professional competency learning. Many other administrative concerns have different lines of authority as outlined elsewhere in this document. Supervision serves to maintain the quality of training experiences and foster ongoing development of clinical competencies. Clinical supervisors should at a minimum:

a. ensure that trainees are aware of the program standards and operating procedures contained in this document.

b. ensure that trainees are aware that clinical staff is obligated to report to the DoT or Chief of Psychology all incidents of unacceptable professional conduct, care below an accepted standard, professional ethical transgressions, violation of law, possible sexual harassment, discrimination against a protected group, or patient abuse.
c. ensure that trainees receive at least two hours per week of individual in-person supervision, and arrange for two hours of other supervision. If there are multiple supervisors, ensure that individual supervision is coordinated to total at least two hours. Supervisors must be proximally available for consultation as stipulated in hospital policy, and provide an intensity and content appropriate to the trainee’s professional development in compliance with VHA Handbook 1400.04, Ohio Law, and APA accreditation standards.

d. designate supervisory coverage for absences. Clinical supervisors should make clear who will be the clinical supervising psychologist during their absence. For unexpected absences in which there is a question about the designated clinical supervisor, trainees should clarify with Psychology Service.

e. collaborate on a written learning plan that stipulates training goals, and provide regular progress review and clear performance feedback in relation to those goals.

f. document supervision in accordance with state law and applicable program standards to include the number of hours spent in supervision, types of supervision provided, activities supervised, and clients reviewed.

g. regularly evaluate the trainees’ professional competencies and provide feedback regarding the content of the evaluations. For interns, this is at the mid-point and end-point of the rotation. For residents it is at least every three months.

h. address problems in performance and professional conduct by providing specific objective feedback, guidance to assist with improvement, or a formal remediation plan.

Trainees ordinarily establish a productive working relationship with their supervisors. In the event that relationship difficulties emerge or evolve, we encourage the trainee and supervisor to resolve the issues in the context of the supervisory relationship. If the pair cannot reach a satisfactory resolution and working relationship, the DoT should be consulted. The DoT or another designee may serve as a mediator. If mediation fails, the trainee may pursue formal grievance procedures outlined in this document.

Communication with clinical staff cannot be considered confidential. Clinical staff is obligated to report instances of information regarding potential EEO concerns, sexual harassment, patient abuse, or other matters seriously affecting training or patient care. There are also formal civil service EEO and sexual harassment procedures that may be pursued through the EEO office or Human Resources. We hope that you consult with clinical supervisor or Psychology Service administration before pursuing other avenues of complaint; however, you are free to consult with Human Resources or the EEO office for advice on appropriate administrative offices for your concern.

Self-Care Responsibility
Adequate mental health is part of the foundation for successful functioning as a psychologist. Supervisors should support self-awareness and self-care that foster good mental health. Trainees should accept personal responsibility for self-care that fosters good mental health, including behavior change or obtaining professional help. In emergency situations or instances in which patient care is substantially affected, the clinical supervisor should inform their administrative supervisor, DoT, or Chief of Psychology Service, and the trainee may be removed from patient contact. If the aforementioned
determine that the problems are substantial enough to suggest professional impairment, the trainee may be referred to Employee Health or for a ‘fitness for duty’ examination as required in human resources policy. Results of such evaluation will determine subsequent action by the program, which may include termination.

**MENTORING PROGRAM**

We recognize that professional development benefits from consultation with someone who has no direct evaluative role with the trainee. All trainees will have the opportunity to be paired with someone who will serve as a mentor who is not their direct supervisor and has no evaluative role. Residents may elect to have a psychologist, and interns may choose either a staff member or a postdoctoral resident. Mentors serve as a nonjudgmental source of support and often help mentees develop personally and professionally. Mentorship consultation might include career planning, leadership development, administrative skills, balancing work and family, or other professional development skills.

Mentee and mentor participation is voluntary. At the beginning of the year trainees will be provided a list of staff names, biographical information, areas of mentoring interest, and availability. During the second round of matching, the names of postdoctoral trainees interested in being a mentor will also be provided. Trainees will submit their top two selections to the mentorship program coordinators who will attempt to match each trainee with their choices. The coordinators will facilitate the initial email meeting and act as liaisons in the mentoring program. We welcome all trainees to participate in the mentoring program; however, participation is not required.

**PROFESSIONAL PRACTICE EVALUATION**

Professional practice evaluation and feedback is an integral part of professional psychology training. It is the method through which trainee progress is tracked and provides a source of data to inform program improvement. All training programs use competency focused evaluation instruments and may rate trainees on profession-wide foundational, specialty, or focus area competencies. Supervisors also collaborate with the trainee to set individualized training goals that are a source of progress review.

We expect that each individual trainee possesses a unique combination of skills, abilities, knowledge, and experience commensurate with their professional developmental level. We also expect that trainees will work to improve competencies that fall below a level sufficient for independent practice. Acceptable performance ratings are required for successful completion of a training experience.

**COMPETENCY AND WORKLOAD**

The practice of professional psychology requires a person possess the skills, abilities, knowledge, and experience necessary for competent general practice. Practice competencies do not include a description of the volume of work a psychologist is expected to complete. We recognize that the amount of work a person can complete is dependent on skill level, situational experience, task complexity, and personal drive. Trainees are expected to devote energy to the tasks assigned; however, we recognize that excessive workload demands are counterproductive to learning. Professional practice evaluation is based on the quality of work a trainee produces while maintaining a reasonable quantity of work. A general guideline is that 25% of trainees’ time should be in direct patient contact.
**INTERNSHIP PERFORMANCE REQUIREMENTS**
Interns are evaluated using rating scales for a list of profession-wide foundational competencies. Other training goals developed with a clinical supervisor may relate directly to the profession-wide competencies, but are not required. Goals other than the profession-wide competencies have no minimum performance requirement for successful completion of the internship.

Performance evaluation and feedback are completed midway through and at the end of each rotation. The rating scales are anchored to professional developmental level (see rating anchors in appendices). To successfully complete the internship, interns must receive a year-end rating of 5-competent on all profession-wide foundational competencies.

**INTERN Acceptable Minimum End-of-Year Rating on Foundational Competencies**
5 – COMPETENT in all but non-routine cases, with supervisor providing overall management of trainee’s activities. Trainee demonstrates increasing ease and integration of advanced skills, and proficiency is emerging in routine cases or area of specialty interest. Supervision/consultation may be necessary in non-routine situations, though depth of supervision varies as clinical needs warrant. While the trainee may not possess the specific skill set required for independent practice in a specific rotation setting, this level represents the minimum competency for independent general psychological practice.

**Intern Acceptable Progress**
Interns are expected to maintain acceptable progress on all professional competencies. Difficulties with progress on items rated below 5-competent should be addressed during performance feedback. Ratings of 2-3 are acceptable in the first rotation if it is demonstrated that progress is being made. However, ratings of 2-3 at the mid-point of the second rotation are problematic. At that point there must be a written plan for skill development that will result in end-of-the-year ratings of 5-competent. The intern should be achieving a significant majority of ratings at 4 or above on all profession-wide foundational competencies by the end of the second rotation. Failure to achieve those ratings, after sufficient opportunity for improvement or remediation has been given, constitutes one basis for termination from the program.

**Intern Remediation Plan**
Ratings of 1-skill deficit at any time during the year require a written remediation plan. The written remediation plan should include description of the methods the intern will use to improve the deficiency, the supervisor participation in those methods, and a reasonable timeframe to achieve sufficient ratings on the competencies. The plan should be developed by the supervisor with concurrence among the supervisor, preceptor, coordinators, and DoT within 10 business days of receiving written notification of the deficiency.

**RESIDENCY PERFORMANCE REQUIREMENTS**
Residents are expected to have prior satisfactory performance on all profession-wide foundational competencies. Specialty and focus area performance is evaluated using rating scales for the related competencies. Other training goals may be developed with a clinical supervisor and relate directly to the specialty and focus area competencies.
Performance evaluation and feedback for residents are completed at least quarterly, but may take place midway through and at the end of each rotation. The rating scales are anchored to professional developmental level (see rating anchors in appendices). To successfully complete the residency, residents must receive a year-end rating of 6-proficient on all specialty and focus area required competencies.

**RESIDENT Acceptable Minimum End-of-Year Rating on Required Competencies**
6 – PROFICIENT Emerging proficiency even in non-routine cases. Supervisor oversees trainee’s activities, but trainee manages day-to-day activities with emerging autonomy. Supervision resembles peer consultation with in-depth supervision necessary only in unusually complex situations.

While we accept a rating of “6-Proficient” as passing, we expect that residents will work to achieve a rating of “7-Emerging Advanced” rating by the end of the residency year.

**Expected Achievable End-of-Year Rating on All Required Competencies**
7 – EMERGING ADVANCED Proficiency in a skill or area of specialty interest is developing. Competency in all global competency areas at full VA psychology staff privilege level is achieved; however, as an unlicensed trainee, supervision is required while in training status. Supervisor remains responsible for trainee’s activities, but trainee demonstrates autonomy in all routine day-to-day activities. In-depth supervision is required infrequently and occasional discussion of advanced topics.

**Resident Acceptable Progress**
It is recognized that residents may attain variable levels of competency depending on previous experience, rotations pursued, the modalities they entail, and prior experience on similar rotations. Residents receive a formal evaluation at least quarterly and should be able to demonstrate progress toward developing an acceptable performance level. Difficulties with making progress toward achieving the required minimum ratings should be addressed during formal evaluations. If performance difficulties include a formal rating of 3-skilled or below, formal written remediation plan is required.

**Resident Remediation Plan**
For items rated at 3 or below, the written remediation plan should include description of the methods the resident will use to improve the deficiency, the supervisor participation in those methods, and a reasonable timeframe to achieve sufficient ratings on the competencies. The plan should be developed with concurrence among the supervisor, preceptor, coordinators, and DoT within 10 business days of receiving written notification of the deficiency.

**Resident Acceptable Progress and Advancement**
Residents are expected to maintain acceptable progress on all specialty competencies. Difficulties with progress should be addressed during performance feedback. Failure to maintain sufficient performance on all profession-wide foundational competencies is one basis for termination from the program. Failure to achieve reasonable progress on specialty and focus area competencies, after sufficient opportunity
for improvement or remediation has been given, constitutes another basis for termination from the program.

For the Clinical Neuropsychology and Rehabilitation Psychology Residencies, successful performance in the first year of the residency is a prerequisite for being retained for the second year. In addition to the above criteria for the one-year residencies, the Clinical Neuropsychology and Rehabilitation Psychology residents must achieve a rating of “5-Competent” on all specialty and focus area competencies to progress to the second year of residency.

**PROFESSIONAL PERFORMANCE DUE PROCESS**

Training programs follow due process guidelines in managing problematic trainee performance to ensure fair and nondiscriminatory decisions. Professional performance guidelines are outlined in the evaluation section and other problematic behavior is described here.

**Definition of Problematic Behaviors**

Problematic behaviors are those that are unacceptable in a trainee’s professional role and risk the trainee’s ability to perform required job duties such as acceptable quality of the clinical services, positive relationships with peers, supervisors, or other staff, and ability to comply with appropriate professional standards. Behaviors become problematic when the trainee does not acknowledge, understand, or address an issue, the behavior cannot be rectified by training, the behavior does not improve with remediation, or remediation of the problem requires unreasonable amounts of supervisor time. In addition to performance issues described in the Professional Practice Evaluation section, examples of problematic behavior are (but not limited to): acts prohibited by APA ethics code, violation of patient confidentiality, failure to identify and report patients’ high risk behaviors, failure to appropriately complete written work, disrespect of patients, peers, or supervisors, plagiarizing, repeated tardiness, or unauthorized absences.

**Notice of Problem**

When a supervisor rates the trainee below minimum acceptable standards on a competency, the supervisor must inform the trainee and DoT in writing of the deficiency along with the intended course of action. When a staff member notes other problematic trainee behavior they should report it in writing to the DoT or Chief of Psychology, who will coordinate notification of appropriate training team or committee members. An outline of intended course of action (e.g., a remediation plan) and notice to the trainee should be completed within 10 business days of the formal evaluation or written notification of the behavior to the DoT. The trainee will be allowed the opportunity for remediation of the problematic behavior or deficiency. Written remediation plans should be developed in coordination with the training team including as needed supervisor, preceptor, coordinators, and DoT.

**Hearing**

The supervisor will usually provide feedback about the problematic behavior or deficiency. If the trainee contests the deficiency or problematic behavior, the trainee may request a hearing. The supervisor will collaborate with team coordinator, one other team member, and the DoT to arrange a hearing about the deficiency within 10 business days of the request. For problematic behaviors noted by other staff, the reporting staff member will be included in the hearing. The coordinators and DoT should always be apprised of the request for a hearing. The trainee will be provided a written decision from the hearing
within 10 business days of the hearing. If the discussion confirms the supervisor’s rating or problematic behavior, the trainee may appeal that decision.

Appeal
Trainees may appeal hearing decisions through higher levels of authority outlined in the Training Programs Structure section. Appeals should be formally requested within 10 business days of the hearing result notification. We believe it would be very unusual for a supervisor to rate as unacceptable a trainee’s overall performance or clinical competence for an entire rotation. If that should occur, there will be a mandatory review of the ratings by the specialty area training team, DoT, and two representatives from other training teams. Written appeal may be made through the Chief of Psychology Service, who may convene Training Committee members or other service psychologists as needed to fairly consider the appeal. This procedure will also be utilized if a trainee was being considered for termination from the program. The trainee may further appeal a termination decision to higher administrative levels outlined in the Program Structure section, but these authorities may choose to decline further review.

Resolution
Trainees should be formally evaluated on their progress in accomplishing the objectives of the remediation plan twice if necessary. The plan and subsequent ratings should contain the supervisor’s narrative comments about the outcome of remediation efforts. It should describe any further recommendations for training in the competency area, including recommendations for changes in rotation assignments or other features of the curriculum.

Consultation
Trainees may request assistance or consultation from outside of the program. Resources for outside consultation include:

Department of Veterans Affairs Office of Resolution Management (08)
810 Vermont Avenue, NW
Washington, DC 20420
1-202-501-2800 or Toll Free 1-888- 737-3361
http://www4.va.gov/orm/

ORM provides a variety of services to prevent, resolve, and process workplace disputes including prevention, early resolution, and Equal Employment Opportunity (EEO) complaint processing. Alternative dispute resolution (ADR) mediation is available to all VA employees. Mediation is a process in which an impartial person, the mediator, helps people having a dispute to talk with each other and resolve their differences. The mediator does not decide who is right or wrong but rather assists the persons involved create their own unique solution to their problem. VA mediators are fellow VA employees who have voluntarily agreed to mediate workplace disputes. They are specially trained and skilled in mediation techniques and conflict resolution. In electing to use mediation, an employee does not give up any other rights.

The Association of Psychology Postdoctoral and Internship Centers (APPIC) provide both an Informal Problem Consultation process and a Formal Complaint process in order to address issues and concerns that may arise during the internship training year.
Please note that union representation is not available to trainees as they are not union members under conditions of their VA term-appointment. Documentation related to remediation and formal counseling becomes part of the trainee’s permanent file with Psychology Service.

The DoT may also consult with the Chief of Staff, Human Resources, regional counsel, other members of hospital leadership (e.g., Privacy Officer, Safety Officer, EEO Officer, or Facility Director), VA OAA, APA, APPIC, or an intern’s graduate program. Verified ethical or criminal violations may be grounds for immediate dismissal. The DoT may limit the trainee to administrative duties or place them on administrative leave while the infraction is being investigated. The program may be required to alert our accrediting body (APA) or other professional organizations (e.g., APPIC, state licensing boards) regarding unethical or illegal behavior on the part of a trainee. If information regarding unethical or illegal behavior is reported by an intern’s graduate program, the internship program may have to follow their policies and procedures regarding clinical duties, probation, and/or termination.

**COMPLAINTS AND GRIEVANCES**

Trainees may encounter other problematic situations about which they have a complaint. A grievance is a trainee complaint against the training program. The grievance process is used when a trainee has a specific complaint or problem with a supervisor, other resident, preceptor, team coordinator, DoT, or with the program itself. Examples of such situations include, but are not limited to, failure to provide adequate supervision or perceived improper conduct by a supervisor, perceived incompetent administration, or failures to provide formally promised training that are not a result of unforeseen medical center changes or unsatisfactory trainee performance. Trainees who have an issue which they feel must be addressed should proceed as follows:

1. **Informal Problem Resolution** - Initially the trainee should seek to discuss the issue with the individual(s) involved. If this effort is not feasible or does not result in a satisfactory outcome for the trainee, the trainee may consult with other training team members or higher levels of authority as professionally deemed necessary. Trainees may consult the DoT or Chief of Psychology at any point in the process, and have confidence that they will be respectful of professional autonomy and privacy.
In any matters of potential EEO concerns, sexual harassment, patient abuse, or other issues seriously affecting training or patient care, the matter should be discussed immediately with the DoT, or if the complaint is against the DoT, with the Chief of Psychology. Formal EEO and sexual harassment procedures may need to be pursued through the EEO office or Human Resources. We hope that a trainee will confer with Psychology Service administration before pursuing other avenues of complaint; however, trainees are free to consult with Human Resources or the EEO office for advice on appropriate administrative offices for their concern.

2. Formal Grievance - If informal means do not resolve the issue to the trainee’s satisfaction, the trainee may submit a written grievance to the Director of Training. If the grievance is with the DoT, it should be submitted directly to the Chief of Psychology Service.

The DoT or a designee will convene a meeting of the individual(s) involved in an attempt to resolve the matter to the satisfaction of all involved. The DoT will provide a determination of the outcome of the grievance meeting in writing to the trainee and involved individuals.

If the written determination is unsatisfactory to the trainee, or if a satisfactory recommendation is not implemented, the trainee may appeal in writing to the Chief of Psychology. The Chief may choose to resolve the grievance with the trainee or convene a grievance meeting with at least four representatives from the Training Committee. If individual(s) who are the object of the grievance are Training Committee members, they will recuse themselves from the deliberations and decision.

The Chief of Psychology Service will ordinarily be the last level of appeal. In very extraordinary circumstances when the written decision from the Chief of Psychology or grievance meeting is unsatisfactory to the trainee, a trainee may appeal to higher administrative levels described in Training Program Structure, but those parties may choose to decline further review.

**PROGRAM COMPLETION REQUIREMENTS**

**INTERNSHIP COMPLETION REQUIREMENTS**

1. Successful completion of the initial assessment module prior to the end of the first rotation.
2. Satisfactory performance on the two end-of-rotation case presentations, journal club presentations, and the final case presentation oral examination.
3. Acceptable overall minimum level of performance rating on end-of-the-year profession-wide foundational competency ratings. Failure to achieve interim required levels on any one rotation, after sufficient opportunity for remediation is given, constitutes a possible basis for termination from the program.
4. Completion of all required hours tracking, rotation evaluations, surveys, and exit interview.
5. Completion of a training year consisting of at least 1,792 hours on duty.

**RESIDENCY COMPLETION REQUIREMENTS**

1. Acceptable maintenance of competency on all profession-wide foundational competencies and acceptable minimum performance ratings on all specialty and focus area required competencies. Failure to achieve the required levels on any one rotation, after sufficient opportunity for remediation is given, constitutes a possible basis for termination from the program.
2. An overall rating of successful minimum performance accounting for individual program requirements.
3. Completion of all required hours tracking, rotation evaluations, surveys, and exit interview.
4. Completion of a training year consisting of at least 1,792 hours on station.

**INCOMPLETE TRAINING YEAR**
If for any reason a trainee is unable to fulfill the requirements above, the individual circumstances will be considered by the DoT and Chief of Psychology. In some circumstances a trainee can receive credit for supervised hours toward licensure. A trainee who has been terminated from a program because of unethical or unacceptable professional behavior cannot be credited for those supervised hours toward licensure.
LSCVAMC has an APA accredited internship program and four accredited residency programs in specialty practice areas recognized by the American Board of Professional Psychology (ABPP) and Commission for the Recognition of Specialties and Proficiencies in Professional Psychology. The postdoctoral residency specialty practice areas are Clinical Health Psychology, Clinical Neuropsychology, Clinical Psychology, and Rehabilitation Psychology. Geropsychology is currently a focus area within the Clinical Health Psychology program, and is seeking independent accreditation.

<table>
<thead>
<tr>
<th>Program</th>
<th>Accredited</th>
<th>Next Site Visit</th>
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<td>2019</td>
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<tr>
<td>Clinical Health</td>
<td>5 years 2013</td>
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<tr>
<td>Clinical Neuropsychology</td>
<td>7 years 2011</td>
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<td>2018</td>
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<tr>
<td>Rehabilitation</td>
<td>5 years 2013</td>
<td>2018</td>
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**Authorities**

The Director of Psychology Training Programs (DoT) has overall responsibility for administrative operations, program quality, instructional effectiveness, trainee conduct, regulatory adherence, and implementation of accreditation standards for all residencies. The Chief of Psychology Service, Associate Chief of Staff for Education, Chief of Staff, and Medical Center Director are successively higher levels of oversight and authority.

**Psychology Training Committee**

The Psychology Training Committee is made up of psychology staff with a stake in the training of health service psychologists. Stakeholders are organized into training teams that serve the pre-doctoral internship and postdoctoral specialty practice residencies. Training teams have some combination of coordinator, preceptor, clinical supervisors, and other contributors as needed to accomplish specific program needs. Team member expertise is representative of the team focus.

The DoT serves as the chair of the Psychology Training Committee and ensures training staff have the resources and support needed to effectively accomplish training program operations. Training Committee members are appointed by the Chief of Psychology with recommendation from the DoT and are selected to best serve supporting the program mission, vision, and values. Training staff are selected to ensure effective program operations, procedure implementation, quality curriculum, effective instruction, selection of qualified trainees, program evaluation, program improvement, and valuing of diversity in staff, trainees, and programming. Training staff role commitments are for three years staggered as is practical to encourage staff participation in training, encourage diversity in membership, maintain specialty expertise, and preserve institutional knowledge. Psychology Training Committee members will normally be solicited and selected at the beginning of the training year, but may be
appointed as needed to enhance programming or fill vacancies. Committee members may serve consecutive terms at the discretion of the DoT and Chief of Psychology.

Decisions regarding program content are reached by team consensus. For programming issues that cannot be resolved by consensus, the coordinators and preceptors have a formal voting role on the committee. All decisions and votes made by the committee are subject to approval in the larger contexts of Psychology Service and administrative structure of the VA, including the DoT, Chief of Psychology, Office of Academic Affiliations, Human Resources, and other federal administrative authorities. Program issues that affect all programs must have concurrence with the DoT and Chief of Psychology.

**Program Responsibilities**
Training staff share responsibility for acting in the spirit of the program mission, vision, and values. Staff strives to insure program quality, fidelity in professional training, integrity of policy and procedures, quality content and programming, effective instruction, selection of qualified trainees, and valuing diversity in staff, trainees, and program content. Training team members offer unique contributions and share responsibility for maintaining an inclusive, supportive, and effective learning environment. Team members assume responsibility for program tasks that ensure quality programming. Coordinators coordinate task completion and facilitate team communication. Teams are responsible for ensuring that specialty area focus, comprehensiveness, supervision emphasis, and evaluative components are consistent within and across specialty areas. Staff strive to clarify their specific contributions and responsibilities both within the team and with the Director of Training.

**Coordinators**
Program coordinators (previously called program directors or program heads) work with the DoT and preceptors to assure an appropriate sequence, intensity, duration, pattern, and frequency of training experiences. They help ensure that training seminars are planned and implemented, and help coordinate the applications and selection process. Residency program coordinators have the responsibility to collaborate with preceptors, supervisors, and the DoT to reach the final end-of-the-year evaluation that determines residency completion status.

**Preceptors**
Preceptors are content experts in their focus area. They develop and document the resident’s individual training plan, including learning and competency objectives, training rotation dates, schedules, and responsible supervisors. They ensure that a resident completes required activities and research projects. They collaborate with coordinators, supervisors, and DoT as needed to adjust training plans, performance evaluation, and preferences.

The preceptor will meet with the resident at least quarterly to ensure training experiences are fostering development of required competencies. They coordinate with clinical supervisors in developing the learning plan, rotation transitions, and evaluations. They ensure that professional performance evaluations are completed and collected from supervisors and site of training evaluation forms are completed at the conclusion of each rotation.

**Clinical Supervisor**
The clinical supervisor is directly responsible for the trainee’s clinical work including co-signing clinical documentation. Clinical supervisors oversee the rotation training experience during a defined time period and medical center location, and ensure that trainees have professional experiences appropriate to their program and developmental stage. Trainees are provided with two hours of in-person individual
supervision and two hours of group or other supervision experience. The clinical supervisor completes periodic professional competency evaluations and ensures timely discussion of identified training needs, professional development, and performance targets. They communicate the competencies evaluations to the preceptor, coordinators, training committee, and DoT as needed to ensure success in professional training.

Trainee Representatives
While any trainee may approach the DoT with an issue they desire to be resolved, we recognize the need for formally designated representatives. The intern and residency cohorts will elect by consensus a primary and alternate representative to the training committee. The representatives serve as an additional liaison between the trainee cohorts and the training committee, and strive to facilitate communication. The DoT may assign duties to the representatives such as facilitating the collection of seminar feedback forms. Trainees should not expect the representatives to solve trainee problems or be the sole source of communication with the training committee. Representatives should encourage trainees to be assertive and instrumental in communicating concerns directly to appropriate resources described herein.

Communication
Open communication is encouraged among the training committee members and trainees, and trainee input is essential for program improvement and development. If trainees have ideas for improvement, they are welcome to communicate it directly to any committee member. The program exists, however, within large federal agency with many regulations. There may be a myriad of issues to consider when making program changes. A particular training committee member may not have the answer to your question or the authority to make a change. The DoT maintains, as is practical, an open door policy regarding communication. Training committee members should strive to clarify duties and manage responsibilities by consensus with concurrence from the Director of Training. Program resource needs are determined by consensus among the program staff, consultation with the DoT, and concurrence from the Chief of Psychology. The DoT communicates program issues and changes to the Education Office, Office of Academic Affiliations, Commission on Accreditation, and other regulatory bodies as required by those agencies.

**INTERNSHIP CURRICULM**

**REQUIRED SEMINARS AND MEETINGS**
Interns are required to attend the following meetings and seminars. Your supervisor does not have the authority to exempt an intern from attendance or to schedule conflicting clinical activities for you during these times. You must clear anticipated absences personally with the DoT.

**Weekly Intern Didactic Seminars**
Thursday, 8:00am to 10:00am
**Usually** in Room 3AC-344A
Check training calendar for final topics, times, and place.

**Monthly Journal Club**
Journal Club meets once per month and all interns are required to attend. At the beginning of each rotation, the interns will caucus with the moderators to devise a schedule. The moderators complete an evaluation form of the competencies demonstrated and provide feedback to the presenter.
**Group Discussion Case Conference**
Monthly case discussion groups are conducted with two subgroups of interns who bring clinical material suitable for presentation and discussion. Staff supervisors coordinate these groups and serve as initial moderators, after which Postdoctoral Residents conduct the group. To encourage frank sharing of clinical data and opinions, no formal evaluation of intern performance accompanies this activity.

**In-service Training**
Occasionally, we have special educational events that interns are required to attend.

**REQUIRED CLINICAL CASES**

**Initial Assessment Case Report**
Near the beginning of the year, you will be assigned a staff member to supervise an assessment case. The format and requirements will be stipulated in detail elsewhere. The purpose of the assessment case is to evaluate your basic skills in performing an intake assessment interview and integrating the results of a major psychological test into the assessment report. To successfully complete the exercise, the supervisor must judge the interview and case report as being of sufficient quality for a beginning intern. This must be completed before the end of the first rotation.

**Intern Case Presentations**
Toward the end of the first two rotations, each intern makes a case presentation with one of our other staff psychologists serving as consultant. Interns attend a subset of these presentations, depending on the Emphasis Area being pursued. The consultant will complete an evaluation form of the competencies demonstrated, and feedback will be provided to the intern.

**Oral Final Competency Examination**
In lieu of a third rotation Intern Case Presentation, interns will take a Final Oral Competency Examination in June, at the halfway point of the third rotation. The intern is expected to demonstrate entry level psychological knowledge, skills, behaviors, and attitudes across a range of professional competencies.

**Meetings with the Director of Psychology Training**
The DoT schedules a monthly meeting with the interns as a group. The purpose is to communicate any collective issues or concerns and share reflections on the internship experiences. Interns are always welcome to talk to the DoT individually by dropping in to the office, calling, sending an e-mail, or requesting a meeting in person.

**RESIDENCY CURRICULM**
Curriculum is designed to best accomplish the development of professional competences. Residents are expected to be independent with foundational profession-wide competencies. For residency, the focus is the development of advanced competencies in a specialty practice area.
**Required Common Seminars**

All residents are required to attend the monthly seminars numbered 1-3 below. Your rotation supervisors and major preceptors do not have the authority to exempt you from attendance, nor should they schedule conflicting clinical activities during seminar times.

1. **Professional Issues Seminar** - This seminar is moderated by the Director of Psychology Training and incorporates both discussion of preselected topics on professional issues and an update on administrative details of the program. The seminar is also open to supervisors and staff.

2. **Supervision Seminar** - This seminar encompasses both didactic and experiential components of supervision. For the first four months, staff present didactic material and moderate a discussion of the issues raised. For the remainder of the year, residents rotate responsibility for presenting a case example of trainee supervision and facilitating a discussion of relevant supervision issues. The seminar is open to supervisors and staff.

Learning in the intern/resident Case Conferences and Residency Seminar is built upon the idea that confidentiality is practiced as it promotes safety and self-disclosure. Confidentiality of veteran information and trainee self-disclosures should be maintained by all participants. This would include being mindful when offering feedback if you are aware of extenuating case circumstances or personal information from other contexts. It, also includes being able to speak openly and freely about experiences knowing your privacy and confidentiality are being maintained. One notable exception, though, is the case when ethical boundaries or incompetence become apparent in these discussions. In those cases, the staff, trainee supervisors, or trainees involved should seek consultation regarding the need to approach the DOT with such information. If a case was made for doing so, please also know this would be discussed with the individual(s) involved prior to going to the DOT.

We have all been impressed by everyone’s openness to sharing about their cases and readiness to give and receive feedback. This reminder is meant as a formal means of stating something we have all been implicitly practicing.

3. **Group Case Conference** – Clinical Health, Rehabilitation, and Clinical Neuropsychology residents rotate moderating the group of Health, Geropsychology, Rehabilitation and Neuropsychology track interns; Clinical Psychology residents moderate the group of Clinical Psychology Track interns. Interns select cases to present, and are not evaluated on their case presentation within this conference.

**Specialty and Focus Area Seminars**

The following seminars are required for the specialty program or focus area in which you are enrolled. These seminars are not required for other residents, although residents are welcome at many of them. For seminars outside your specialty area, check with the preceptor organizing the seminar for those you may attend.

1. **Clinical Psychology Seminar** - Residents from the Clinical Psychology Specialty (SMI, PTSD, and Addictions) are required to attend this monthly seminar. It includes staff presentations on general and clinical special emphasis area topics, resident case presentations entailing group supervision, and resident presentations on self-generated clinical or professional topics.

2. **Inter-Professional Residencies Seminar** - The Inter-professional residents (SMI Inclusion, Couples & Family) attend this seminar moderated by staff involved in the inter-professional training programs.
including Psychology, Social Work, and Chaplain Services. The two inter-professional residencies will meet as a group to review administrative issues related to the fellowship programs and participate in inter-professional didactics. Special emphasis will be placed on case reviews conducted by the various disciplines from the two programs.

3. **Clinical Health Psychology Seminar** - Residents from the Clinical Health Psychology Specialty (Primary Care, COE, and Specialty Medical Clinics) are required to attend this seminar moderated by the Program Director of the CHP residency. It includes didactic and practice-oriented content specific to clinical health psychology, as well as resident case presentations and related articles for discussion. The seminar is open to preceptors, residents, and staff.

4. **Geropsychology Seminar** – Geropsychology and COE residents attend this seminar moderated by the geropsychology major preceptor.

5. **Rehabilitation Psychology Seminar** – The Rehabilitation Psychology resident is required to attend this seminar, but it is open for other residents and staff to attend. The resident and program faculty rotate in making presentations on rehabilitation-specific competency areas, such as the history of the Rehabilitation Psychology specialty, adjustment to disability, assessment, and case conceptualization.

### SELECTION PROCEDURES

**Application**
- Applications are submitted to APPIC for interns and APPA-CAS for residents
- Application deadlines:
  - Internship the first week of November
  - Residency the first week of January

**Initial Ranking**
- Two training staff rate materials using the applicant rating form.
- Selection workgroup creates an initial rank order of applicants.
- Selection workgroup determines who to interview and/or invite to an open house.

**Interviews**
- Interviews may be in-person, by video, or telephone.
- Applicants are given at least two weeks’ notice for in-person interviews.
- Staff conducts a performance based interview, using a standard interview ratings form.
- Selection workgroups collaborate to coordinate multiple interviews.

**Final Rankings**
- Selection workgroup creates final rank order based on the entire application and interview.
- For Residency, leads meet with DoT to create a final plan for order of offers across all programs, since applicants may be considered for more than one residency and focus area.

**Internship**
- Final rank order lists submitted to National Matching service
- APPIC Friday match results received
- DoT contacts matched interns for formal offer
Residency

- After ranking, be prepared for a possible reciprocal offer to our top ranked applicant if they have an offer from another program. We may require validation of the offer.
- Preceptors or team representative begins offers 10:00am Eastern Time on APPIC Monday.
- Avoid making concurrent competing offers to the same applicant.
- Applicants may hold offers for 24 hours.
- Notify applicants whom are no longer in consideration and when all positions are filled.