

VA Maryland Health Care System and the University of Maryland, Baltimore Psychology Internship Consortium

2013-2014 Brochure



The VAMHCS/UMB Psychology Internship Consortium is accredited by the
American Psychological Association.

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I. INTRODUCTION

The Veterans Affairs Maryland Health Care System (VAMHCS)/University of Maryland-Baltimore (UMB) Psychology Internship Training Consortium is composed of three divisions of the VAMHCS (the Baltimore VA Medical Center and Annex Building, Perry Point VA Medical Center, and the Loch Raven VA Community Living and Rehabilitation Center) and the Department of Psychiatry at the School of Medicine at the University of Maryland Baltimore. The Baltimore VA Medical Center, the Baltimore VAMC Annex Building, and the UMB campus are located in the west downtown area of Baltimore City, and the Perry Point VA Medical Center is located 45 miles north of the city in Perryville, MD. Prior to the formation of the Consortium, all three of these sites had APA-accredited training programs and offered psychology intern training.

The Baltimore VA Medical Center is the acute medical and surgical care facility of the VAMHCS and has one of the largest research and development programs in the VA system, including specific research programs in serious mental illness, diabetes, immunology, oncology, virology, cellular biology and infectious diseases. The Baltimore VA Medical Center offers a number of specialized programs and services including: primary care services through a team approach, a women veterans evaluation and treatment program, a comprehensive cancer program, inpatient and outpatient mental health care services, a residential trauma recovery program, and an outpatient substance abuse detoxification and treatment program. The Baltimore Annex Building offers outpatient programming in the following specialty areas: trauma recovery, neuropsychology, psychosocial rehabilitation and recovery center, as well as the Mental Illness Research and Education Clinical Center (MIRECC). Located next to the University of Maryland Medical Center with a walkway connecting the two facilities, the medical center maintains an active affiliation with the University in the sharing of staff, resources and technology. The Perry Point VA Medical Center offers long- and short-term outpatient and residential mental health care, including a residential alcohol and substance abuse treatment program that is unique in the Mid-Atlantic region. A new inpatient mental health care facility offers specialized treatment programs, rehabilitation services and enhanced patient privacy for veterans in a comfortable, state-of-the-art setting. The Perry Point VA Medical Center also offers a full range of inpatient medical programs and intermediate- and long-term care programs, including a nursing home, a chronic ventilator unit, and a hospice care section. The Loch Raven VA Community Living and Rehabilitation Center specializes in providing rehabilitation and post-acute care for patients in the VA Maryland Health Care System. The center coordinates the delivery of rehabilitation services, including physical therapy, occupational therapy, kinesiotherapy and recreation therapy, to achieve the highest level of recovery and independence for Maryland's veterans. The center also provides hospice and nursing home care to veterans requiring non-acute inpatient care, in addition to offering specialized treatment for patients with Alzheimer's disease and other forms of dementia.

Statistics for FY 2010 show that the Baltimore VA recorded 110,774 separate patient encounters with over 22,000 unique patients, with Perry Point recording 34,852 and over 7500 unique patients for the same time period. The sheer volume of patients seen in the variety of VA clinics ensures that our trainees are exposed to a wide breadth of diversity of patient demographics, encounter a spectrum of degrees of complexity in presenting mental health and medical problems and see certain problems and types of patients frequently enough to establish good baseline knowledge of a variety of psychological phenomena.

The University of Maryland School of Medicine is the oldest public school of medicine in the United States and recently celebrated its bicentennial year. Through its hospitals and clinics, the UM School of Medicine offers a large pool of patients with over a quarter of a million patient encounters per year. The school educates and trains more than half of Maryland's practicing physicians, including approximately

700 post-graduate training residents per year, and ranks 3rd of all public medical schools in total research funding according to the Association of American Medical Colleges.

Consortium interns are exposed to clinical and research experience in their work within a number of centers at both the VAMHCS and University of Maryland School of Medicine. The VAMHCS has been awarded a variety of national centers by VA Central Office (VACO) that bring to bear the expertise of nationally recognized leaders in the field of clinical care and/or research in various clinical conditions or areas of specialty. These include:

1. **The Mental Illness Research Education and Clinical Centers (MIRECC)** which supports research to improve the quality and cost-effectiveness of services for veterans with schizophrenia and their families
2. **The Geriatric Research, Education, and Clinical Center (GRECC)** with a focus on promoting health and enablement models in older veterans living with disability
3. **The Multiple Sclerosis Center of Excellence – East (MSCoE East)** which is the coordinating center for all MS Centers of Excellence in the region and for a number of studies related to the diagnosis, monitoring, and treatment of Multiple Sclerosis
4. **The Seizure Center of Excellence – East**, a newly funded center of excellence that will coordinate studies in the Eastern United States and serve as the primary surgical center for veterans diagnosed with epilepsy who require that level of intervention
5. **The VA Maryland Exercise and Robotics Center of Excellence (MERCE; VA Rehabilitation and Research Development Service funded)** focused on rehabilitation of individuals with chronic deficits as a result of stroke with additional developing programs in Parkinson’s Disease, Multiple Sclerosis, Chronic Pain, and Traumatic Brain Injury

The four centers at the School of Medicine are the Division of Services Research (DSR), the Center for School Mental Health (CSMH), the Maryland Psychiatric Research Center (MPRC), the Center for Behavioral Treatment of Schizophrenia (CBTS), and the Center for Infant Studies (CIS). Each of these centers is engaged in active research programs and involves our interns in both research and service delivery. Intern access to these centers with their range of mental health, medical, and neurological problems allows our trainees to develop the Consortium’s scientist-practitioner model in an environment that supports it.

The Consortium offers the following training tracks:

- Comprehensive/General (VA)
- Neuropsychology (VA)
- PTSD/Trauma Recovery (VA)
- Health Psychology (VA)
- Serious Mental Illness (VA)
- Adult Outpatient/Community (UM)
- Child Outpatient/Community (UM)
- School Mental Health

The VAMHCS/UMB Psychology Internship Consortium is accredited by the American Psychological Association. Additional information about accreditation and a list of accredited programs may be

obtained by contacting the APA Office of Program Consultation and Accreditation, 750 First Street, NE, Washington, DC, 20002-4242; Phone: 202-336-5979; <http://www.apa.org/ed/accreditation/>.

Our program was reaccredited in 2009 and our next site visit will take place in 2016.

II. TRAINING OBJECTIVES AND PHILOSOPHY

The VAMHCS/UMB Psychology Internship Consortium has adopted a scientist-practitioner model of training. Our internship has the dual goals of training and refining skills in assessment, treatment, and consultation, as well as facilitating the development of interns from trainees to independent psychologists. Our program philosophy is to base both the process and the content of training on research, in the service of developing psychologists who apply scientific method and knowledge to the assessment and treatment of maladaptive behavior. Studies of methods of training have consistently demonstrated that the modeling of desired behaviors, opportunities to practice those behaviors in a supervised environment, and specific feedback all result in changes in trainee behavior. Therefore, interns will be able to observe psychologists, be observed, and receive timely feedback. Specific training in assessment or treatment for a particular presenting problem will be grounded in research, VA clinical practice guidelines, and expert consensus on that problem. In addition, to foster interns' development as independent scientist-practitioners, didactics and supervision will focus on what it means to function independently as a psychologist in a multidisciplinary hospital setting.

We believe that evidence-based best practice guidelines for the psychological treatment of mental illness and other conditions are crucial to the effective care of our patients. Our consortium supervisors are well versed in a number of theoretical orientations, and value the use of scientific literature to inform clinical practices. We also believe that evidence-based practice requires that psychologists maintain the skills to interpret relevant research findings and treatment developments, as well as the skills to contribute to this expanding knowledge base. We require our interns to engage actively in research that in some way supports their ability to (1) identify and clearly describe the disorders and conditions presented by our patients, (2) select or create reliable and valid outcomes measures that are sensitive to changes in the patient's disorder or condition, and (3) identify and successfully administer treatments to improve these disorders or conditions. To round out existing scientific and clinical abilities, extensive efforts are made to tailor the internship training experience to each individual intern's needs and allow a reasonable amount of focused specialization in each intern's area of emphasis. Graduates of our program may pursue careers in research or clinical service, but in either case, their training will have prepared them to make a meaningful contribution to the effective care of patients. Our goal is to develop well-rounded and competent psychologists who represent the scientist-practitioner model.

As an internship training program recognized by the Academy of Psychological Clinical Science, we are committed to advancing a scientist-practitioner model of training. We are particularly interested in applicants from graduate programs that place an equally strong emphasis on a sound foundation in scientific psychology and broad clinical training. For the scientist component, we expect that applicants will have a combination of peer-reviewed publications and professional presentations that clearly demonstrates their skills as a psychological scientist. For the practitioner component, we expect applicants to be well trained and skilled across a broad range of clinical populations in evidence-based practice, and in a wide range of objective psychological assessments. Each of these requisite skills—research and clinical—must be clearly addressed in the application and in letters of recommendation.

Role of the intern: Interns in the Consortium are expected to assume the role of professional psychologists within their training assignments. This role requires awareness of and adherence to the highest principles of professional ethics, conduct, and competence, as well as a sincere interest in the welfare of clients. Interns have the opportunity to learn new clinical skills and techniques from their supervisors and other staff, as well as the opportunity to improve and modify existing skills. The

majority of an intern's time is focused on expansion of clinical competencies. Though interns are expected to conduct themselves professionally, their tasks are primarily learning-oriented. To the extent that interns deliver services, such service delivery is considered to be incidental to the learning process. Interns are not expected to assume the same quantity of duties, workload, or responsibilities normally assigned to the professional psychology staff.

Role of the Staff: Psychology Service staff members provide the interns with models of (1) ethical and responsible clinical and scientific conduct, (2) participation in self-regulatory and professional review activities, such as those in the Quality Assurance Program, (3) commitment to continued professional self-development through participation in training and educational activities, and (4) activities promoting professional autonomy, such as active involvement with local, state, and national organizations, legislative efforts, and licensure activities.

Expectations: Interns are expected to be involved in their clinical training assignments to the benefit of both the VAMHCS and UMB health care delivery systems and their own learning experiences. They are expected to participate in training meetings and to present material in case presentations, seminars, or other formats during their tenure, and to engage willingly in dialogue with staff in the service of professional training and development. Interns are expected to adhere to the ethical guidelines established for psychologists by the American Psychological Association and to the policies and procedures of their host institution and clinics.

III. PROGRAM OVERVIEW

The Consortium represents the integrated training experience of psychology across four primary sites, including two medical centers and a medical school. Each training site coordinates its training efforts through the Consortium Training Committee to support the overall goals and objectives of the Consortium. Interns in the VA-based training tracks (Comprehensive/General, Neuropsychology, PTSD/Trauma Recovery, Health Psychology and Serious Mental Illness) complete three four-month rotations during the year (two rotations based at Baltimore and one at either Perry Point or Loch Raven) and their major clinical activities are based at VA facilities, with some opportunities for minor clinical rotations or research activities based at the School of Medicine. VA interns select rotation experiences based on their interest, availability, institutional need, and APA policy requiring that training occur at more than one core training site. Interns in University-based tracks (Adult Outpatient/Community, Child Outpatient/Community and School Mental Health) complete year-long rotations at clinics and centers affiliated with the School of Medicine and University of Maryland Medical System, with some opportunities (depending on the track) for clinical minors or research activities based at the VA. All interns are required to attend the Consortium Seminar Series at the Baltimore VA Medical Center as their main form of didactic education, and interns are encouraged to take advantage of educational activities unique to specific sites and rotations.

The Consortium is a full-time, twelve-month training program. The full-time internship program is 2,080 hours. This length is consistent with the majority of other psychology internships in the United States and allows interns to meet state licensure requirements.

Interns spend approximately 24 hours per week engaged in clinical activities at their major rotation/clinic. The remaining 16 hours include minor clinical rotations (up to 6 hours per week), seminars (3 or more hours per week), and research activities (up to 6 hours per week) and administrative activities. Interns are required to complete at least 6 comprehensive, integrated assessments for successful completion of the training year.

VA-based interns will have the opportunity to prioritize their preferences for rotation assignments at the beginning of the training year and the final scheduling decisions will be made by the Director of

Training. Some constraints are made on rotation scheduling due to the requirements of specialty training tracks and availability of rotations.

The VAMHCS offers the following training rotations (described in detail in Section IX):

The following rotations are typically offered each year:

Baltimore VA Medical Center

- Addictions Treatment Program
- Inpatient Psychiatry
- Medical Psychology
- Neurology/Chronic Pain
- Opioid Agonist Treatment Program

Baltimore VA Annex Building

- Neuropsychology
- Outpatient Trauma Recovery Program
- Psychosocial Recovery and Rehabilitation Center

Perry Point VA Medical Center:

- General Mental Health/Mental Health Clinical Center
- Geropsychology/Neuropsychology
- Geropsychology – Community Living Center
- Inpatient Treatment for Serious Mental Illness
- Psychosocial Recovery and Rehabilitation Center
- Trauma Recovery Program

Loch Raven Community Based Outpatient Clinic:

- Palliative Care

These rotations are offered on a regular basis and are generally available during each training year; however, there are times when staffing issues will require cancellation of a rotation without advance notice. In addition, to ensure an optimal training experience, the number of interns that can be assigned to each rotation is limited; therefore it isn't always possible for every intern to do all of their preferred rotations. The Director of Training works with each intern upon their arrival to determine the best possible selection and scheduling of rotations.

Interns in the Comprehensive/General track can complete three rotations of their choosing. Interns in the Neuropsychology track are expected to complete two major rotations in Neuropsychology at the Baltimore VA Medical Center Annex Building, a year-long minor rotation in Neuropsychology, plus one rotation of their choice, and to conduct their research project in an area related to Neuropsychology. Interns in the PTSD/Trauma Recovery track will complete two PTSD-related rotations, a year-long minor rotation in PTSD, plus one rotation of their choice. Interns in the Health Psychology track will complete two health-related rotations, plus one rotation of their choice. Interns in the SMI track will complete the Psychosocial Rehabilitation Recovery Center (PRRC) rotation at the Baltimore VA Medical Center Annex Building and an SMI-focused rotation (either the Inpatient treatment program or the Psychosocial Recovery and Rehabilitation Center) at the Perry Point VAMC, plus an additional rotation of their choice.

University of Maryland School of Medicine

The combination of a broad range of treatment programs, client needs, and psychology personnel ensure opportunities for intensive and extensive experiences that can meet most professional training needs. The multiple placement sites of the internship provide the intern with numerous opportunities for experience with comprehensive, wide-ranging, multidisciplinary services to clients. As well as performing many supervised functions at his or her placement sites, each intern participates in interdisciplinary staff conferences, and thus has the opportunity for formal interaction with staff members. Informal interactions are also encouraged to enable interns to develop and exercise their own unique abilities and skills. One week is devoted to orientation to provide interns with an overview of the program, including training sites, supervisors, program instructors, and available seminars. An individualized training program is developed for each intern and may be reviewed for modification, if necessary.

The Department of Psychiatry at the University of Maryland School of Medicine has a long history of serving patients in the public sector in the Baltimore metropolitan area. The UMB adult track interns participate in year-long rotations at one of two University of Maryland Medical System mental health clinics (either the adult psychiatry clinic or the community psychiatry clinic, formerly known as the Fayette Clinic, both located at 701 West Pratt Street). The focus of both placements is adult psychology and community psychiatry. Both sites assist individuals 18 and older with a wide range of mental health problems. At the Fayette Clinic, approximately 65-75 percent of the individuals served are seriously and persistently mentally ill. Individual, group and family therapies are available, as well as medication management, case management, and substance abuse services. The track is structured to include involvement in clinical research projects conducted by DSR, CBTS and/or MIRECC faculty. These interns may have the opportunity to implement manualized research treatments in addition to their regular clinical placement.

The UMB child track interns participate in two concurrent year-long rotations. Two interns will complete the school mental health rotation within the University of Maryland Center for School Mental Health, and one will intern complete outpatient rotations within the Taghi Modarressi Center for Infant Study and the Child and Adolescent Outpatient Service. These training experiences are described in Section IX.

IV. RESEARCH TRAINING

The research training component of the internship provides each intern with the opportunity to complete a research project during the course of the training year. Supervisors for research activities include VA and UM staff, including psychologists, psychiatrists, pharmacologists, and health economists. At the beginning of the year, each intern is matched with a research mentor with whom they will develop a research idea, plan a project and carry out the research. There is considerable flexibility in the content, scope, and focus of intern projects, however, it is expected that it will consist of a project independent of the dissertation. Up to six hours per week can be used by interns as research time. Toward the end of the year, each intern presents the results of their research to a forum of their fellow interns and faculty. Many interns choose to participate in a poster presentation at the University of Maryland research colloquium, during which time they may present the results of their research or dissertation project. Many intern research projects have led to presentations at local, regional, and national research meetings as well as publications and ongoing collaborations. Drs. Deborah Medoff and Marc Testa coordinate the research training experience.

V. DIDACTIC OPPORTUNITIES

Three hours each week are reserved for the Consortium Seminar Series. The seminar series is a year-long series of presentations and discussions intended to expose interns to a wide range of clinical and

research topics and to stimulate discussion and professional development. Topics include legal and ethical issues, assessment and treatment of various Axis I disorders in children and adults, cultural competence, stigma, couples, family and group treatment modalities, as well as career development issues (e.g., post-doctoral fellowships, job talks, licensure, research funding). Presenters are faculty and staff from the University of Maryland, the VA, and guests from local universities and community organizations (such as the National Alliance for the Mentally Ill and the American Psychological Association). Drs. Ann Aspnes and Sam Korobkin coordinate the weekly seminar.

There are many other educational opportunities available at VA and University locations including departmental grand rounds, journal clubs, and various symposia. The VA Mental Illness Research, Education, and Clinical Center organizes a twice-monthly meeting (September through May) at which invited speakers and local researchers present research findings, discuss grants or other projects on which they are working to get input from peers, practice upcoming talks, or discuss other research-related issues. The UM Division of Services Research journal club meets Fridays at noon. This group meets to discuss articles on a range of mental health services topics, with special emphasis on methodology issues. There is also a journal club focused on cognitive neuroscience, with emphasis on schizophrenia that meets at the Maryland Psychiatric Research Center. The School of Medicine Office of Faculty Affairs and Professional Development offers monthly Psychiatry Grand Rounds and seminars throughout the year on topics such as writing a successful grant application, time management, and teaching methods. The schedule for these activities can be viewed here:

<http://medschool.umaryland.edu/career/>. The Neuropsychology service participates in a series of didactics via teleconference that is hosted by the Walter Reed Army Medical Center. These sessions provide the post-doctoral fellows and interns an opportunity to review readings and journal articles related to neuropsychology practice in the Department of Defense and VA settings and discuss clinical cases. The Trauma Recovery service coordinates a series of advanced didactics on the applied learning and practice of evidenced-based treatments for PTSD, as well as a process group for staff and trainees of all levels (postdoctoral fellows, interns and externs).

VI. CLINICAL SUPERVISION AND SUPPORT

Interns receive a minimum of four hours per week of supervision, at least two hours of which is individual, face-to-face supervision with a licensed psychologist. Supervisors are readily available to respond to interns' questions and provide impromptu guidance. When an intern's primary supervisor is on leave, back-up coverage is clearly delineated. At the beginning of a training rotation, the supervisor and intern jointly assess the intern's training needs and establish individualized training goals. Over the course of the rotation, the intern is expected to become more independent in his or her activities. As this process of attaining graduated levels of responsibility unfolds, the supervision becomes less directive and more consultative. Written evaluation of the intern's progress is conducted midway through the rotation and at the end. The intern also provides written feedback about the quality of supervision received from each supervisor. The form interns use to evaluate the supervisory process can be found in Appendix D.

Staff psychologists with appropriate clinical privileges provide primary supervision to interns. Credentialed clinicians from allied professions and non-staff psychology consultants provide supplemental training expertise. Responsibility for ensuring adequacy of supervision rests with the Consortium Training Committee, under the leadership of the Director of Training. Consortium faculty uses various modes and models of supervision in the training of interns, including co-therapy, analysis of audiotaped or videotaped sessions, supervisor "shadowing," and "junior colleague." In all cases, interns work closely with supervisors initially, and then gradually function more independently as their skills develop. There are opportunities for additional supervisory consultation with psychologists working outside the intern's normal assignment area.

VII. EVALUATION PROCEDURES

Intern progress is monitored throughout the year, with the goal of facilitating the learning process. VA-based interns receive written evaluations halfway through each rotation and at the end of each rotation. UM-based interns receive written evaluations four, eight and twelve months after starting. Interns are evaluated by supervisors in areas of clinical/research competence and professional development, using a standard form consisting of structured and unstructured evaluative comments. The form used for intern evaluation is included in Appendix C. The criteria for successful completion of the internship, based on these ratings, are described on this evaluation form. If the supervisor perceives that there is a significant deficiency in the interns' competency, the supervisor is to complete the evaluation form (without waiting for the scheduled evaluation) and review it with the intern then with the Director of Training so that a remediation plan can be put into place. At the end of each rotation, each intern provides his or her evaluative comments about their supervisors and, at the completion of the year, interns provide written feedback about the program. The Consortium Director of Training maintains communication with the interns' graduate program by providing a letter at the beginning of the year which describes the intern's training plan, a letter mid-way through the year which describes the intern's progress, and a letter at the completion of the year to confirm completion of the internship.

VIII. STIPEND AND BENEFITS

The intern stipend is \$26,068. The internship is for a 12-month period, and interns must work at least 2,080 hours. Please note: only the first 2,080 hours are funded. Any work beyond 2,080 hours is not compensated. Interns accrue 4 hours bi-weekly of annual leave (13 days total), 4 hours bi-weekly of sick leave (13 days total), 10 federal holidays, and up to 5 professional development days to attend conferences, present papers, or to defend their dissertations. Interns at both the VAMHCS and UMB have access to the health insurance coverage at their respective institutions. There is good public transportation to the Baltimore VA Medical Center and the UMB campus, and interns can utilize a transit reimbursement program if they choose to use public transportation. Parking is not provided but is available downtown in for-pay parking garages.

IX. TRAINING PROGRAMS AND FACILITIES

The Consortium faculty will make every effort to ensure that the rotations described in this brochure will be offered for the 2012-2013 training year, but occasionally staffing and scheduling issues will require rotations to be cancelled after the brochure is finalized and distributed.

ROTATIONS AT THE BALTIMORE VA MEDICAL CENTER AND ANNEX BUILDING

Addictions Treatment Program

Patient Population

The primary setting for this rotation is the intensive outpatient (IOP) component of the Acceptance and Commitment Program (ACT) at Baltimore. The ACT Program is a 12-week dual diagnosis program (substance abuse and PTSD) beginning with the four- to five-week IOP for veterans with substance use disorders. Over 90% of ACT patients are male, 75% are members of a racial or ethnic minority group, and the median age is 45 years old. The most commonly encountered substances of abuse include alcohol, heroin (opiates), and cocaine. Other presenting addictions include to benzodiazepines, marijuana, and prescription narcotics. The majority of this population is medicated for co-occurring psychiatric illness, including PTSD, depression, bipolar illness, and severe mental illness.

Assessments, Treatments, & Supervision

During this rotation, interns will be provided with training in individual and group psychotherapy for the treatment of substance addictions as well as dual diagnoses, including

PTSD, mood disorders, and other mental illnesses. Training and supervision will include systematic didactic and psychotherapeutic exposure to the following empirically validated psychotherapeutic approaches to treatment:

- a. The fundamentals and core change components of group psychotherapy, as researched by Yalom (1995).
- b. The fundamentals of interpersonal process therapy (IPT) in individual and group settings (Klerman et al., 2004).
- c. Methods of working with resistance and clarification of goals and values, through empirically demonstrated mindfulness strategies (Breslin, Zack, & McCain, 2002; Brown & Ryan, 2003; Hayes, 2003; Wilson, Hayes, & Byrd, 2000) within the framework of Acceptance and Commitment Therapy (ACT), Functional Analytic Psychotherapy (FAP; Kohlenberg, Hayes, & Tsai, 1993), as well as Dialectical Behavior Therapy (DBT; Linehan, 1993).
- d. Cognitive-behavioral interventions for the prevention of relapse (Brownell, Marlatt, Lichtenstein, & Wilson, 1986) focusing on the primacy of negative affect in relapse.
- e. Interns will also be trained in the fundamentals and application of Motivational Enhancement Therapy (MET; Miller & Rollnick, 1991), particularly the technique of motivational interviewing as it applies to the phases of change model of motivation (Prochaska, DiClemente, & Norcross, 1992).

Interns will participate on an interdisciplinary treatment team and will co-facilitate group therapy three times weekly, co-facilitate at least two psychoeducation groups monthly, and carry individual patient caseloads.

Interns will conduct full psychosocial assessments to include the diagnosis of, and differentiation of substance use, abuse, and dependence disorders, learn the pharmacological correlates of behavior for major classes of substance abuse, and differentiate and understand the phenomenological comorbidity of substance abuse, PTSD, mood disorders, and other psychiatric disorders. Interns will employ the use of such standard instruments as the Beck Depression Inventory (Beck *et al.*, 1961), Beck Anxiety Inventory (Beck & Steer, 1990), Minnesota Multiphasic Personality Inventory-2 (Butcher *et al.*, 1989), Personality Assessment Inventory (PAI, Morey, 1991), etc., and learn how to assess for PTSD using the Clinician-Administered PTSD Scale (CAPS; Blake *et al.*, 1995) and various other trauma measures.

Each intern will case manage six to eight individual patients through the four to five week intensive outpatient program, and will follow two to three individual patients following this rehabilitation through the stages of early recovery as part of their aftercare. Interns will also be responsible for co-facilitating three groups per week and two psychoeducation groups. They will also receive two hours of face-to-face individual supervision per week in addition to two hours of group supervision per week.

Supporting Literature

Project MATCH represents one of the largest and most comprehensive substance abuse treatment outcome studies to date (Project MATCH Research Group, 1997). Investigators followed over 1,700 alcohol-dependent clients for up to 3 years after they received treatment in one of three conditions: 12-Step Facilitation (TSF), Cognitive Behavioral Coping Skills Therapy (CBT), or Motivational Enhancement Therapy (MET). It was hypothesized that when clients are matched with the appropriate treatment approach, that outcomes would improve. On the

contrary, clients in all of the treatment conditions improved, regardless of matching, and there was little difference in outcome among the three approaches.

The addiction intensive outpatient program at Baltimore has sought to improve patient outcomes by utilizing elements of TSF, CBT, and MET in its treatment programming. In 2004, when tasked with integrating aspects of its programming with that of the PTSD/Substance Abuse Residential Rehabilitation Treatment Program (PRRTP), it was decided that a more unified treatment model was needed that: 1) would be relevant in the conceptualization and treatment of both PTSD and substance abuse, as well as other emotional/behavioral disorders; and 2) would provide a less fragmented, more coherent treatment experience. In collaboration with the Trauma Recovery team, the principles and strategies of Acceptance and Commitment Therapy (2008) were adopted.

Supervisors' Training & Experience

James Finkelstein, Psy.D. is the primary supervisor for this rotation. Dr. Finkelstein earned his Psy.D. in 2003 from Loyola College in Maryland and completed his internship here at the Baltimore VA. He has continued to work as the lead psychologist in the ACT Program, supervising interns and externs in group and individual therapy, as well as facilitating an ongoing ACT consultation and training group. He has published research in the area of etiology of PTSD, psychopharmacology in psychological practice, and ethics in clinical practice.

Interns also benefit from consultation with other members of an experienced interdisciplinary treatment team, including nurses, social workers, and addiction therapists. They also participate in a weekly interdisciplinary supervision group led by Dr. Paul Benson, who has worked as a psychologist in the area of substance abuse treatment since 1989.

Neurology – Health Psychology

Patient Population

Interns will have the opportunity to work with two medical populations during this rotation: individuals with chronic non-cancer pain, including headaches, and individuals with sleep disorders. There also may be an opportunity to work with individuals with multiple sclerosis.

Patients with chronic pain: These patients have been referred by their primary care providers to the VAMHCS chronic pain specialty clinic. The age range is 20s to 80s, 20 to 25% of the patients are female, and approximately 50% are African-American. The most common presenting medical complaint is spinal pain. The most common co-occurring psychiatric disorders are Major Depressive Disorder and PTSD.

Patients with sleep disorders: These patients are seen in the Neurology Sleep clinic. The age range is 20s to 80s, 80% of the patients are male, approximately 50% are African-American. The most common diagnoses are insomnia, nightmares, and apneas. The most common co-occurring psychiatric disorders are Major Depressive Disorder and Anxiety Disorders/PTSD.

Assessments, Treatments, & Supervision

Chronic Pain Clinic: Interns will perform a comprehensive psychological evaluation of patients who are presenting to the Pain Clinic for their initial visit. This evaluation consists of: a semi-structured interview, a review of the patient's electronic medical chart, the Beck Depression Inventory (BDI-II; Beck *et al.*, 1961), the Beck Anxiety Inventory (BAI; Beck & Steer, 1990), the PTSD Checklist (PCL-C; Weathers *et al.*, 1994), and the Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP-R; Butler *et al.*, 2008). In addition, all patients are asked to complete the numerical pain scale and interference items from the Brief Pain Inventory to assess pain severity and impact on function. Based on their interests, interns have the opportunity to use other pain-specific assessment instruments, such as the Multidimensional Pain Inventory (MPI;

Kerns, Turk, & Rudy, 1985) and the Short Form McGill Pain Questionnaire (SF-MPQ; Melzack, 1987). Interns can expect to complete at least five comprehensive evaluations of pain patients.

Interns will receive training in a variety of empirically-supported behavioral interventions for the treatment of chronic pain patients. Individual treatments offered to pain patients may include biofeedback, relaxation training, cognitive-behavioral therapy of depression and chronic pain. Expected caseload is three patients. In addition, interested interns may receive training in assessment and treatment of chronic patients with co-occurring substance abuse issues.

Sleep Clinic: In this setting, interns will learn to complete focused psychological assessments of patients with sleep disorders by conducting clinical interviews supplemented by sleep and fatigue instruments such as the Insomnia Severity Index (Morin *et al.*, 2001), The Pittsburgh Sleep Quality Index (PSQI; Buysse *et al.*, 1989), and the Epworth Sleepiness Scale (ESS; Johns, 1994), as well as psychiatric instruments such as the BDI-II and BAI. Interns will provide verbal and written feedback and recommendations to the patients' physicians based on the results of their assessments. Interns will also have the opportunity to conduct individual psychotherapy as well as group therapy (CBT for Insomnia). Expected caseload is three patients.

MS Center of Excellence: The MSCoE-E, housed within the department of Neurology, is the coordinating center for all MS Centers of Excellence in the region and for a number of studies related to the diagnosis, monitoring, and treatment of Multiple Sclerosis. Interested interns may find opportunities for assessment and intervention within this service.

Supporting Literature

Chronic Pain Clinic: There is ample empirical support for the use of cognitive-behavioral therapy in patients with chronic pain, whether in individual sessions or in a group format (*e.g.*, Basler, Jaekle, & Kroener-Herwig, 1997; Keefe *et al.*, 1990; Turk, 2003). Also, a CBT intervention specifically targeted to treat insomnia has been found efficacious for sleep disturbances secondary to pain (Currie *et al.*, 2000). Relaxation training is widely recognized as useful for treating chronic pain and a recent Cochrane evidence-based medicine review supported its use (Ostelo *et al.*, 2005). Biofeedback training (which incorporates relaxation) has been found to be clinically useful for the treatment of tension or vascular headaches (as reviewed in Arena & Blanchard, 2002) as well as for chronic musculoskeletal pain (Flor & Birbaumer, 1993). Finally, emerging evidence suggests that Acceptance and Commitment Therapy-based interventions also are promising for treating a chronic pain population (Dahl, Wilson, & Nilsson, 2004).

Sleep Clinic: The Behavioral Model of Insomnia (Spielman, *et al.*, 1987) is the most widely cited theory regarding the etiology of chronic insomnia. Cognitive Behavioral Treatment of Insomnia (CBT-I; see Morin *et al.*, 2008), an empirically-supported behavioral treatment for insomnia, utilizes components such as Stimulus Control Therapy (SCT), Sleep Restriction Therapy (SRT), Sleep Hygiene Education, Relaxation Training, and Cognitive Therapy.

Supervisor's Training & Experience

Interns on this rotation will receive two hours of scheduled, individual face-to-face supervision each week from Sara Clayton, Ph.D. Dr. Clayton is also available for additional supervision or consultation as needed, by phone or in person.

Dr. Clayton earned her doctorate in clinical psychology from the University of Wyoming, focusing on behavioral and psychological factors related to HIV during her graduate training. She completed her internship at the Baltimore VA Medical Center, health psychology track, with training in the psychological assessment and treatment of various patient populations, including primary care, HIV/AIDS, chronic pain, transplant candidates and substance abuse. She went on to complete a postdoctoral fellowship at the University of Maryland School of Medicine, where her research and clinical duties involved patients with HIV, depression, and substance abuse. Dr.

Clayton also has experience working with adolescent medical patients. Dr. Clayton has presented her research at meetings of the Society of Behavioral Medicine and the Association for Behavioral and Cognitive Therapies.

Neuropsychology

General

The Neuropsychology Specialty Track within the VAMHCS/UMMS Consortium adheres to criteria and guidelines developed by Division 40 of the American Psychological Association, the Association of Internship Training in Clinical Neuropsychology, and the Houston Conference on Specialty Education and Training in Clinical Neuropsychology. Accordingly, interns will spend a minimum of 50% of their training year involved in clinical, didactic, and research endeavors in Neuropsychology. The program is designed to prepare students for post-doctoral fellowships in Neuropsychology. To achieve this objective, interns in this program will complete two full major rotations in neuropsychology at the Baltimore VA Medical Center. During the third rotation, the intern completes a major rotation in another clinical service while maintaining a neuropsychology minor focusing on assessment of neurodegenerative diseases. Participation in neuropsychology-specific research is encouraged and opportunities for publication will be provided. Interns are encouraged to attend regional and national conferences. Our previous interns have successfully obtained post-doctoral fellowships at APPCN member programs. For interns who are considering research-focused careers, opportunities may also exist for interns to develop their own research funding to support post-doctoral training endeavors.

Patient Population

Neuropsychology is a consult service that evaluates patients referred from various clinics and units throughout the medical center. Diagnoses include: neurodegenerative, endocrine, infectious, seizure, vascular disease, tumor, head trauma, and neuropsychiatric disorders. We also assess patients referred for war-related injuries and complaints. We work with male and female veterans from all service eras. Our patient population is ethnically diverse and ranges in age from 22 to 95, with a substantial number of patients 50 years of age and older.

Assessments, Treatments, & Supervision

Neuropsychology is primarily a consult and assessment service. Test batteries vary depending on the level of impairment of the patient and the nature of the referral question. Interns learn test administration via direct observation and mentoring. Once they can function autonomously, interns interview patients with the attending and then proceed with the assessment. The attending and intern review patient histories and examination findings together. Interns write reports that are reviewed in detail by their attending. Typically, interns assess two to three patients per week: one in a specialty clinic and one to two outpatient or inpatient consults. We have recently added a rehabilitation service to our department and there are opportunities to provide group or individual treatment supervised by a rehabilitation neuropsychologist.

In addition to patient specific supervision, interns will participate in the following activities at various intervals:

1. Neuropsychology Fellowship Video-Teleconference with VA/DoD Sites
2. Neuropsychology case conference
3. Neuropsychology research meetings
4. Neuropsychology journal club
5. Neurology grand rounds

6. Neuropathology rounds
7. Geriatric psychiatry rounds
8. Psychiatry Neuroscience Course
9. Select meetings of the MS Center of Excellence

Interns may also be involved in the following research projects:

1. Assessment of Persian Gulf Veterans exposed to depleted uranium
2. Longitudinal study of neurocognitive functioning in veterans with multiple sclerosis
3. Study of cognitive change as a result of aerobic exercise training in chronic hemiparetic stroke (includes multiple projects)
4. Study of early cognitive findings in Parkinson's Disease
5. Study of the effects of exercise on cognition in Parkinson's Disease
6. Longitudinal study of recovery following mild to moderate head trauma in conjunction with the National Emergency Medicine Study Center
7. Geriatric Assessment
8. Cognitive assessment of veterans with Human Immunodeficiency Virus
9. Effects of exercise on cognition in veterans with type 2 diabetes mellitus
10. Effects of a yoga intervention on metabolic, cognitive, and emotional functioning in postmenopausal women

Supporting Literature

The literature supporting our assessment procedures is substantial. The training model is based on information and recommendations from: The American Board of Professional Psychology, Division 40 of the American Psychological Association, the Association of Internship Training in Clinical Neuropsychology, and the Houston Conference on Specialty Education and Training in Clinical Neuropsychology.

Supervisors' Training & Experience

Dr. Moira Dux earned her Ph.D. in Clinical Psychology from Rosalind Franklin University of Medicine and Science, in the program's neuropsychology track. She completed her pre-doctoral training (neuropsychology track) at the VA Maryland Health Care System/ University of Maryland Medical Center. She then completed a research neuropsychology fellowship at the Baltimore VA. Dr. Dux is presently a staff neuropsychologist and the recipient of a VA Career Development Award examining the effects of high-intensity aerobic exercise on autonomic, cognitive, and affective function post-stroke. Other research interests include mechanisms of cognition and affect in healthy elderly, effects of highly active antiretroviral therapy (HAART) on cognition in persons who are HIV+, and intraindividual variability in cognitive test performance.

Dr. Anjeli Inscore is the Director of Training for the Neuropsychology Service. She completed a one-year research postdoctoral fellowship in rehabilitation psychology and neuropsychology at the Johns Hopkins Department of Physical Medicine and Rehabilitation. She completed a two-year clinical postdoctoral fellowship in neuropsychology at the Johns Hopkins Department of Psychiatry and Behavioral Sciences. Dr. Inscore holds an appointment as a Research Associate at the University of Maryland, School of Medicine. Her research is in conjunction with the University of Maryland and the VA Geriatric Research Education and Clinical Center (GRECC) with a primary interest in the neurocognitive, psychological, and health benefits of exercise in overweight and obese individuals. She is the recent recipient of a Nutrition Obesity Research

Center (NIDDK-funded) Pilot and Feasibility grant to study yoga as an intervention to treat obesity in postmenopausal women. She also has a research interest in geriatrics/dementia and is in the process of creating archival and prospective databases that will include medical, functional, and cognitive data on patient's evaluated in the Geriatric Assessment and Dementia Evaluation, Management, and Outreach (DEMO) clinics.

Dr. Terry Lee-Wilk is the Acting Director of the Neuropsychology Service. She graduated with a doctoral degree in Clinical Psychology from the University of Maryland College Park. She then completed one year of postdoctoral work at Children's National Medical Center in the Department of Neuropsychology. Subsequently, she completed a two-year Neuropsychology postdoctoral fellowship at the VAMHCS/UMMS. She serves as the primary neuropsychology liaison to the VA Multiple Sclerosis Center of Excellence-East. She is a Clinical Instructor at the University of Maryland, Department of Pediatrics and supports a project related to the early initiation of HAART in adolescents who are HIV positive. She also serves as the attending neuropsychologist at the VA's Infectious Disease clinic. Finally, Dr. Lee-Wilk continues to work with the Serial Assessment of Mild Head Injury study in conjunction with the University of Maryland National Study Center for Trauma and EMS.

Dr. Kristen Mordecai earned her Ph.D. in Clinical Psychology from Rosalind Franklin University of Medicine and Science, in the program's neuropsychology track. She completed her pre-doctoral training in clinical psychology focused in general and geriatric neuropsychology within the Boston Consortium in Clinical Psychology at the Veterans Affairs Boston Health Care System. Her two-year postdoctoral fellowship in neuropsychology was completed at the Veterans Affairs Maryland Health Care System within the Integrated Fellowship in Traumatic Brain Injury and Trauma Recovery in Returning Veterans program. Her research interests include cognitive aging, dementia, Parkinson's disease, stress and memory, and the effects of sex steroid hormones on cognition and brain function.

Dr. Patricia Ryan works primarily with the interdisciplinary Polytrauma Support Clinic Team serving veterans with traumatic brain injury. She also provides assessment within the general Neuropsychology service and oversees the individual and group cognitive rehabilitation treatment program for veterans of all eras. She earned her master's degree at Teachers College, Columbia University, and her doctoral degree in counseling psychology at Fordham University. She completed her internship and additional postdoctoral training at the Rusk Institute of Rehabilitation Medicine, New York University Medical Center. Dr. Ryan then held a two-year postdoctoral fellowship in rehabilitation psychology and neuropsychology at the Johns Hopkins Department of Physical Medicine and Rehabilitation. Her clinical and research interests include the efficacy of various cognitive remediation modalities, as well as depression after TBI and stroke.

Dr. S. Marc Testa earned a Ph.D. in clinical psychology from the University of Cincinnati. He completed a clinical neuropsychology internship at VA Maryland Health Care System/University of Maryland and a post-doctoral fellowship in the Department of Psychiatry and Behavioral Sciences at Johns Hopkins University, School of Medicine where he still retains an adjunct faculty appointment. Dr. Testa works closely with the VA Northeast Epilepsy Center of Excellence in both clinical and advisory capacities. His research interests include developing new approaches for examining neuropsychological test data, material-specific memory functioning, and psychological functioning in psychogenic disorders. Dr. Testa has published numerous journal articles and has presented his research at national conferences.

Opioid Agonist Treatment Program

Introduction

The OATP rotation is intended for predoctoral internship students who plan to specialize in substance abuse assessment, treatment, and research, or who wish to gain more experience and training in this area. It will provide interns a working knowledge and basic competency in the provision of opioid agonist therapy (OAT), a treatment with extensively documented “gold standard” efficacy for chronic opiate dependence. Opioid agonist therapy effectively reduces illicit opiate use, reduces crime, enhances social productivity, and reduces the spread of viral diseases such as AIDS and hepatitis (CSAT, 2005). In our clinic, the majority of OAT patients are prescribed methadone maintenance therapy (MMT), but we also follow a number of patients on Suboxone (buprenorphine and naltrexone) maintenance, as well.

The OATP Major Rotation will afford students the opportunity to work with a population that is significantly underserved in community settings across the country and which is frequently a target of stigmatization far exceeding that associated with psychiatric and other substance use disorder (SUD) populations. Due to the frequency of chronic co-occurring psychiatric and medical disorders, the chronic nature of SUDs, and the associated disability/dysfunction that often spans all life domains, this is a highly challenging population with which to work. It is also often an extremely rewarding population to serve. In particular, it offers a unique opportunity to develop skills in both specific substance abuse treatment and more general interdisciplinary collaboration.

Upon completion of this major rotation, interns will have a working knowledge of evidence-based “best-practices” in OATP (e.g., clinical indications and contra-indications for MMT and buprenorphine, procedures for adjusting dosage, effects, side-effects, medical and drug interactions, indications and contra-indications for MMT and buprenorphine discontinuation). They will be familiar with the philosophy and competent in the clinical application of the stages of change model of addiction and recovery, including motivational enhancement interventions. In addition, this major provides the opportunity to work in and consult with a dynamic and highly varied interdisciplinary team, as well as work with other relevant specialty clinics within the hospital (e.g., Pain Management, Infectious Disease Clinic). We currently have an active study on HIV medication compliance, and often work closely with ID staff to ensure proper medical follow-up and coordination for diseases such as HIV/AIDS and Hepatitis C. We also have a permanent member on the Interdisciplinary Pain Team monthly conferences, and follow a large number of patients with dual substance use and pain issues.

Time commitment and pace are quite flexible. We can work with you to help structure the experience so that it meets your specific training needs and fits in with your other activities.

Patient Population

The programs’ patient population consists of men and women with opiate dependence, mostly men, with modal age of late 40s-early 50s and considerable range (early 20s-80s). Our patient population is ethnically and racially diverse, with over 50% of patients of African-American descent. Veterans served in OATP typically have histories of chronic and severe polysubstance dependence and many are dually diagnosed with one or more psychiatric disorders. The type and severity of co-occurring psychiatric conditions varies considerably and is comparable to what is seen in our Mental Health outpatient and inpatient clinics. Many also have significant concurrent acute and chronic medical disorders. Interns in this rotation will have the opportunity to work with patients new to OAT (through the “Gateway Program”) as well as more long-term OAT patients.

Assessments, Treatments, & Supervision

Interns will receive training and supervision in evidence-based best practices in OAT (*i.e.*, clinical indications and contra-indications for OAT, procedures for adjusting dosage, effects, side-effects, medical and drug interactions, indications and contra-indications for OAT discontinuation; CSAT, 2005). Clinical training and supervision will be provided in the philosophy and techniques of motivational interviewing and motivational enhancement therapy (MET, Miller & Rollnick, 1991; CSAT, 1999), particularly as it applies to the transtheoretical model of change (TTM, Prochaska, DiClemente & Norcross, 1992; CSAT 1999). Formal integrative psychological assessment is a required part of this rotation. Students may complete comprehensive psychological assessments using the MMPI-II and the Mini International Neuropsychiatric Interview (MINI, Sheehan *et al.*, 1997) and other measures as clinically indicated. Interns will be expected to follow individual patients, providing both individual therapy and case management. Co-facilitation of a therapy group; participation in Admissions Committee, Recent Admissions Group, and Gateway Review Committee; and psychological assessment training will be provided based on the student's individual training needs. Individual face-to face supervision with Dr. Aghevli will be scheduled as is appropriate to students' level of training and case-load. Typically, this is two hours per week for interns throughout their rotation. Interns also typically receive one hour per week scheduled group supervision. PRN consultation and supervision with Dr. O'Connor or Dr. Aghevli or members of OATP's multidisciplinary team is always available and encouraged.

Supervisors' Training & Experience

Minu Aghevli, Ph.D. earned her Ph.D. from University of Maryland at College Park in 2004, and completed her internship at the Baltimore VA. She spent several years post-doctorate working in clinical substance abuse research and substance abuse treatment policy with Dr. Liberto, and has published in the area of severe mental illness. She became a staff psychologist in the OATP in 2006. Interns also benefit from consultation with other members of an experienced interdisciplinary treatment team, including other psychologists, psychiatrists, nurse-practitioners, nurses, social workers, and addiction therapists.

Psychosocial Rehabilitation and Recovery Center

Patient Population

The Psychosocial Rehabilitation and Recovery Center (PRRC) treats veterans who present with a broad spectrum of psychiatric illnesses. Our population includes veterans with schizophrenia, mood disorders, anxiety disorders including PTSD, and personality disorders. Many of the veterans also have a co-morbid substance abuse problem. The PRRC is an outpatient transitional learning center designed to support recovery and integration into meaningful self determined community roles for veterans challenged with severe mental illness. Referrals to PRRC are for veterans who need additional support, education, therapy and care coordination to manage in the community. Veterans remain in the PRRC for a time limited duration per their individual needs and recovery goals and participate in daily intensive programming. Aftercare/transition plans include participation in identified groups or activities consistent with their recovery plans. Some interns on this rotation may be able to participate in activities of the Mental Health Intensive Case Management (MHICM) team. This program provides community based case management for veterans with SMI who need intensive services and have a history of frequent or extended psychiatric hospitalizations and have been minimally responsive to the hospital based treatment.

Assessment and Intervention Training

In the PRRC, interns will be provided with training in individual, family, systems and group therapy for the treatment of serious mental illness (SMI). Group experiences can include cognitive therapy groups, social skills training (Bellack, 2004), mental health recovery groups (Frese *et al.*, 2001) as well as co-leading an ACT treatment protocol for individuals with SMI (Bach & Hayes, 2002). The intern is also expected to develop and lead their own group bases on their interests and the veteran's needs. The intern will be supervised in individual therapy including the application of cognitive therapy for treatment of SMI (Bellack, 2004; Kingdom & Turkington, 2005). Also, interns will be trained in supportive individual therapy, psychoeducation group therapy, and supportive family therapy. Interns can develop the rotation based on their interests and needs. The patient load will include 2-4 assessments, 3-4 individual psychotherapy patients in addition to co-leading at least 3 groups. Supervision will include 1-2 hours per week with Dr. Weissman and additional supervision depending on clinical activities.

Supporting Literature

The PRRC is guided by the Recovery Philosophy (Bellack, 2006) . We attempt to assist veterans in defining and pursuing a self determined personal vision and mission for their lives. It is the role of the clinician in the PRRC to collaborate with the veteran to promote realization of their goals thru support, education an effective treatment. . There is support in the literature for various types of interventions, including: problem-solving skills; cognitive-behavioral therapy that includes support and education and is aimed at specific areas of deficit (*e.g.*, medication non-compliance, treatment-refractory auditory hallucinations, paranoid ideation, etc.); social skills training as a targeted treatment for social impairment; and family intervention programs that provide a combination of education about the illness, emotional support for the family, crisis intervention and motivational enhancement. (see Lehman *et al.*, 2003, Schizophrenia Patient Outcomes Research Team: Updated Treatment Recommendations for a review, also Bellack, 2004). Interns will receive training in all of these interventions and more. In addition, frequent questions arise as to the accuracy of diagnosis for specific patients. A number of issues complicate the diagnostic picture, including co-morbid substance abuse, overlap with other major mental illness (*e.g.*, mood disorders with psychotic features), and dementia. It is therefore important that the intern become familiar with the criteria for serious mental illnesses, including schizophrenia-spectrum disorders, bipolar disorder, and major depression, as well as substance use disorders as described in the DSM-IV.

Supervisors' Training & Experience

Dr. Neil Weissman has been an attending psychologist for the VA since 1992 and has supervised interns for these 19 years. He has completed a post doctoral fellowship in the treatment of SMI from Sheppard Pratt and has received specialized training in CBT from the Beck Institute in Philadelphia. Dr. Weissman is also a certified supervisor in Emotionally Focused Couples Therapy from the International Center for Excellence in Emotionally Focused therapy.

Posttraumatic Stress Disorder/Trauma Recovery Program Specialty Track

The specialty track in PTSD/Trauma Recovery adheres to the APA Guidelines for Accreditation for Internships, with respect to offering “professionally supervised training experiences that are properly administered, planned, structured, and programmed” consisting of a sequence of clinical activities that are “characterized by greater depth, breadth, duration, frequency, and intensity than practicum training” focused on the assessment and treatment of PTSD. The program is designed to prepare students for post-doctoral fellowships and careers with specialization in PTSD. The specialty track allows for up to two interns during each training year. The interns will participate in a variety of training experiences during the internship year, including formal training and supervision in assessment, empirically supported treatments,

research, and program development within the field of PTSD. In order to achieve this objective, interns will complete two rotations in the Trauma Recovery Program (one at the Baltimore VA Medical Center, description below, and one at the Perry Point VA Medical Center; description located under Perry Point rotation descriptions). For their third rotation, interns in the track may choose either another rotation focused on PTSD or may choose a rotation without a trauma focus for a more generalist internship year. During the internship year, the interns will maintain a minor in the Trauma Recovery Program, with a focus on a specialty area within PTSD, such as treatment of veterans with MST or co-occurring PTSD and Traumatic Brain Injury. The intern will be assigned a primary supervisor for the internship year. The interns will be matched with primary supervisors based on their specific interests and then meet with their primary supervisors at the beginning of the year to select major and minor rotations that meet the interns' training goals.

Patient Population

The Trauma Recovery Program (TRP) at the VAMHCS (Baltimore Division) consists a specialized outpatient PTSD clinic that serves both male and female veterans with a principal diagnosis of PTSD related to a variety of traumatic experiences, including combat, military sexual trauma (MST), and childhood abuse. Many patients in the PCT have other co-occurring diagnoses and are active in treatment in other areas of mental health (*e.g.*, Substance Abuse Treatment Program, Psychosocial Rehabilitation and Recovery Center, Mental Health Clinic). Our patient population is ethnically and racially diverse, with over 50% of patients of African-American descent. An increasing number of the patients seen are those service members recently returning from Operations Iraqi Freedom and Enduring Freedom, as well as veterans seeking services for Military Sexual Trauma (MST).

Assessments, Treatments, & Supervision

Interns will participate in the PTSD Assessment Clinic, where he or she will conduct several intake interviews to learn appropriate methods for diagnosing PTSD. The intern will complete at least two full-scale comprehensive PTSD assessments using semi-structured interviews, personality assessment, and standardized self-report instruments. Comprehensive assessment skills for this rotation will include training and supervision in the use of the Clinician-Administered PTSD Scale (CAPS; Blake *et al.*, 1995) and the Anxiety Disorders Interview Schedule (ADIS), the PTSD Checklist (PCL; Blanchard *et al.*, 1996), the Mississippi Scale for Combat-Related PTSD (MISS; Keane *et al.*, 1988), the Minnesota Multiphasic Personality Inventory-2 (Butcher *et al.*, 1989), the Beck Depression Inventory (Beck *et al.*, 1961), and the Beck Anxiety Inventory (Beck & Steer, 1990).

The rotation will consist of core training experiences involving outpatient group therapies and individual treatment. Outpatient rotations are in the PTSD Clinical Team and Cognitive Rehabilitation Clinics, where interns can gain experience with patients diagnosed with comorbid PTSD and mild traumatic brain injury. Elective experiences and minor rotations will be selected to round out the training plan for each intern. Available minor rotations include Dual Diagnosis, Military Sexual Trauma, Rural Mental Health, and Cognitive Rehabilitation foci. Interns will be provided with training in evidenced-based practices for PTSD. They will receive supervision in the two modes of treatment for PTSD with the most empirical support: exposure therapy and cognitive processing therapy. They will also receive specific training in approaches to the treatment of dually-diagnosed veterans with PTSD and substance abuse/dependence, including Seeking Safety, as well as interventions based in mindfulness and Dialectical Behavior Therapy.

The patient load will include two to four individual psychotherapy patients in addition to co-leading two to four outpatient groups. Interns will receive at least two hours of individual supervision each week with a clinical psychologist listed below in order to review cases, provide further assessment and intervention training, and establish concrete treatment plans for group and individual patients. Additional supervision will be provided by other TRP staff psychologists, with several additional opportunities for group supervision available each week.

Interns will participate in a number of training opportunities during the rotation, including monthly didactics, a process group and consultation groups. Monthly didactic seminars will focus on the applied learning and practice of empirically supported treatments, assessment administration, research and professional development (e.g., supervision) within the field of trauma work. Consultation groups focused on the delivery of Prolonged Exposure and Dialectical Behavior Therapy are also offered to trainees at all levels. Drs. Nett and O'Connor also facilitate a process group for staff and trainees, focused on discussing how working within the field of PTSD can impact one's self care and work with patients. Finally, the TRP has an extensive library of resources, including articles, manuals, and training videos that are available to interns.

Supporting Literature

Exposure therapy (ET; Foa *et al.*, 1991; Keane *et al.*, 1989) has been consistently demonstrated as an effective treatment for addressing specific traumatic memories; this approach has been endorsed by the Division 12 Task Force as an efficacious treatment for PTSD. Cognitive therapy (CT), Imagery Rehearsal Therapy (IRT) and Stress Inoculation Training (SIT) have consistently shown high rates of efficacy for symptoms reduction as well, and all four treatments have been adopted as best clinical practices by the VA/DoD Clinical Practice Guidelines (VA/DoD Clinical Practice Guideline, Management of Posttraumatic Stress, 2010). Additionally, the use of anxiety management training has been empirically supported in the PTSD and other anxiety research literature (Foa *et al.*, 2000). Although there is limited evidence surrounding efficacious treatment for dual-diagnostic patients with PTSD and substance use disorders, the Seeking Safety protocol (Najavits, 2002) has demonstrated promising longitudinal outcome data. While preliminary studies were limited to small sample sizes, and few addressed veteran populations, more recent studies include larger samples and a variety of veteran populations. Coping skills that are part of the Seeking Safety program are similar in content to anxiety management training and make an important link between PTSD and substance abuse/dependence.

In addition to the above-mentioned interventions, interns will be learning specific coping skills from Dialectical Behavior Therapy (DBT), which was originally designed for the treatment of borderline personality disorder but which can be applied to other patient populations (Linehan, 1993); principles of Acceptance and Commitment Therapy (ACT) as it applies to PTSD (Batten, Orsillo, & Walser, 2005; Hayes *et al.*, 1999); relaxation procedures, including progressive muscle relaxation and guided imagery; and other cognitive-behavioral approaches, including skills such as cognitive reframing and behavioral activation (Foa *et al.*, 2000).

Related to PTSD assessment, the CAPS has been shown to have excellent reliability and validity (convergent and discriminative validity) within trauma populations; it is considered the "gold standard" of interviews for PTSD (Weathers *et al.*, 2001). The PCL (*e.g.*, Ruggiero *et al.*, 2003) and MISS (*e.g.*, Norris *et al.*, 1996), both symptom self-report measures, have demonstrated utility in the assessment and diagnosis of PTSD, with good evidence for reliability and validity. Finally, the BDI and BAI are commonly used self-report measures that involve a general assessment of depressive and anxiety symptoms, useful as adjunct data in the comprehensive assessments of veterans and for detection of possible co-occurring diagnoses. A comprehensive review of

assessment procedures for trauma and PTSD can be found in *Assessing Psychological Trauma and PTSD* (Wilson & Keane, 2004).

Supervisors' Training & Experience

Interns' individual therapy will be supervised by one of the psychologists in the Trauma Recovery Program. The TRP staff has received extensive training in the use of exposure therapy and other above-mentioned interventions through graduate school education, internship training, postdoctoral training, and specific workshops and training experiences that have enhanced their knowledge and expertise in the treatment of PTSD. Trauma psychologists will conduct one hour of peer consultation per week to maintain proficiency in evidence-based practices for PTSD.

Melissa Decker, Psy.D. is the Director of Training for the VA/UMB Psychology Internship Program, as well as Director of Training for the Postdoctoral Fellowship in PTSD in Returning Veterans. She completed a psychology internship and postdoctoral fellowship in the Trauma Recovery Program at the VA Maryland Health Care System. She received supervision and training in empirically supported treatments for PTSD, as well as co-morbid PTSD and substance use, medical illness, and health behavior change. She has trained with Drs. Foa and Hembree to become a certified Prolonged Exposure consultant for the VA National Rollout Trainings. Dr. Decker has received training in Acceptance and Commitment Therapy (ACT), CPT, PE and DBT over the course of her graduate studies, and her doctoral dissertation investigated the role of worry in experiential avoidance. Her research interests include treatment outcome research for innovative ESTs for PTSD, as well as the relationship between PTSD and comorbid health concerns. Dr. Decker was honored to be the recipient of the Outstanding Supervisor Award, awarded by the 2009-2010 VA/UMB Internship Consortium class.

Aaron M. Jacoby, Ph.D. is the Coordinator of the Trauma Recovery Program as well as the Acting Deputy Director, Mental Health Clinical Center (MHCC), Baltimore Division. Dr. Jacoby's primary duties include overseeing trauma recovery program delivery across VA Maryland Healthcare System (VAMHCS). In his Acting Deputy Director, MHCC, Baltimore role, he oversees the Consultative, Inpatient, Outpatient, and Special Programs Sub-product lines with programs at the Baltimore VA Medical Center, Perry Point VA Medical Center, and all affiliated Community Based Outpatient Clinics (CBOCs). Dr. Jacoby provides direct oversight over 150 staff members and directly assists the Director, Mental Health Clinical Center (MHCC), in day-to-day operations of the MHCC. Most recently, Dr. Jacoby served as Acting Clinical Manager for Special Programs, where he oversaw trauma recovery and substance abuse programming at VAMHCS. Aside from currently managing and supervising a large staff of dedicated and talented clinicians who provide an array of services to Veterans from all eras, Dr. Jacoby provides direct patient care for Veterans diagnosed with PTSD and Substance Dependence and promotes the utilization of evidence-based treatments for PTSD and substance abuse across VAMHCS. He has served as clinical consultant for the Baltimore and Baltimore County Vet Centers. Dr. Jacoby has participated in research on PTSD assessment, patient satisfaction, suicide assessment and treatment, treatment-resistant depression, and bipolar disorder for over 17 years. Over the past 6 years, Dr. Jacoby has participated as an active member of the National Center for PTSD's VA mentorship program. He has been trained in the delivery of evidence-based psychotherapies for PTSD including Prolonged Exposure (PE) therapy and Cognitive Processing Therapy (CPT) and uses these approaches in his treatment of Veterans from across all service eras. Dr. Jacoby has been affiliated with Veterans Affairs (VA) since 1999 when he completed his pre-doctoral internship at VA Pittsburgh Healthcare System (VAPHS). Prior to his current positions in VAMHCS, he had worked in a number of capacities in VA, including study coordinator for a Food and Drug Administration (FDA) trial on vagal

nerve stimulation therapy for treatment resistant depression, study coordinator for comorbidity studies in the Mental Illness Research, Education, and Clinical Center (MIRECC) at VAPHS, staff psychologist in the Posttraumatic stress disorders Clinical Team (PCT) at VAPHS, and mental health Point of Contact (POC) for PTSD services in Veterans Integrated Service Network (VISN) 4. Dr. Jacoby earned his Doctorate in Clinical Psychology from Catholic University of America in 2004. He is licensed in the state of Pennsylvania.

Erika Morton, Ph.D. completed her graduate education at Saint Louis University. She completed a pre-doctoral internship at the Washington, D.C. VAMC and a postdoctoral fellowship in trauma at the Pittsburgh VAMC. Her dissertation research focused on the effects of racial microaggressions and colorblindness on the working alliance of cross-racial counseling dyads. She received supervision and training in empirically supported treatments for PTSD, specifically Cognitive Processing Therapy and Prolonged Exposure therapy. She has also received training in Dialectical Behavior Therapy. In August 2011, Dr. Morton was hired as a staff psychologist in the Trauma Recovery Program (TRP) at the Baltimore VAMC. She has assumed the role of coordinator within the PTSD Assessment Clinic and has started a monthly journal club exploring up-to-date research pertaining to the assessment, diagnosis, and treatment of PTSD.

Sara Nett, Psy.D is the MST Coordinator for the VAMHCS. She completed her graduate training in Clinical Psychology at Indiana State University. She completed an integrated postdoctoral fellowship in trauma recovery and traumatic brain injury at the VA Maryland Health Care System, following the completion of a predoctoral internship at the Salem VA Medical Center. Dr. Nett has received training in a variety of evidence based treatments for trauma and comorbid substance use disorders, including Acceptance and Commitment Therapy, Prolonged Exposure Therapy, Cognitive Processing Therapy, Dialectical Behavior Therapy, and Seeking Safety. Her clinical and research interests include the use of evidence based treatments for Posttraumatic Stress Disorder, the role of experiential avoidance in maintaining symptoms of PTSD, treatment of sexual trauma, and treatment of personality disorders.

Dave O'Connor, Ph.D. earned his graduate degree in Clinical Psychology at the Florida State University in Tallahassee Florida. He completed his internship at the Baltimore VAMHCS in 2002 with specialized training in the assessment and treatment of substance use disorders (SUD), neuropsychological assessment, and medical psychology. Dr. O'Connor was hired here after internship and provided general assessment, individual and group SUD treatment, and student training in the Opiate Agonist Treatment Program. During this work he developed an interest in the treatment of co-morbid SUD and PTSD and was very excited in 2009 to accept the position of Addiction Psychologist assigned to the Trauma Recovery Program in which, he focuses on providing care to this dual diagnosis population. Dr. O'Connor has received training in Motivational Enhancement, Prolonged Exposure, Cognitive Processing Therapy, and Relapse Prevention. Provision of and training in psychological assessment has always been one of Dr. O'Connor's areas of interest and he has served on the Training Committee as Assessment Coordinator for the VA/UMB Internship Consortium since 2009. He was highly gratified to be the recipient of the Outstanding Supervisor Award, awarded by the 2008-2009 VA/UMB Internship Consortium class.

Erin Romero, Ph.D. received her doctoral degree from Northwestern University Feinberg School of Medicine, Department of Psychiatry and Behavioral Sciences, Division of Psychology. While at Northwestern, Dr. Romero received generalist clinical training in several treatment settings, including a community mental health center, college counseling center and an intensive

outpatient treatment program for eating disorders and weight management. She completed a psychology predoctoral internship at the VA Maryland Health Care System (VAMHC) and obtained specialized training in substance use, serious mental illness, and PTSD. She received further specialized training in PTSD during her integrated postdoctoral fellowship in traumatic brain injury and PTSD in returning veterans at the VAMHC. Dr. Romero has received training in a variety of treatment models, including Acceptance and Commitment Therapy, Prolonged Exposure Therapy, Cognitive Processing Therapy, Virtual Reality Exposure Treatment, Seeking Safety, Dialectical Behavior Therapy, Wellness Recovery Action Planning, and Social Skills Training. Dr. Romero's research has focused on racial/ethnic health disparities. Her research on the mental health needs and HIV/AIDS risk behaviors of delinquent youth has resulted in multiple peer-reviewed publications and conference presentations. Her doctoral dissertation investigated the role of incarceration in HIV/AIDS risk behaviors. Since working with veterans during her pre-doctoral internship, Dr. Romero has increasingly become interested in the effectiveness of EBTs in PTSD symptom reduction and in barriers to treatment in returning veterans. Dr. Romero is the Team Lead for the Baltimore PTSD Clinical Team.

Andrew Santanello, Psy.D. completed a psychology internship and a post-doctoral fellowship at the Baltimore VAMC and is a licensed psychologist in Maryland. He has received training in Acceptance and Commitment Therapy, Prolonged Exposure Therapy (PE), and Cognitive Processing Therapy (CPT) and is listed on VA national rosters of certified clinicians for both PE and CPT. In addition to empirically-based psychotherapies for Posttraumatic Stress Disorder (PTSD), Dr. Santanello has a strong interest in mindfulness-based psychotherapy. He has served Maryland's veterans in various roles and locations within the VA Maryland Health Care System (VAMHCS) in the past including Addictions/Trauma specialist for the PTSD Clinical Team at the Perry Point VA Medical Center and Local Evidenced-Based Psychotherapy Coordinator for both the Baltimore and Perry Point VA Medical Centers. Currently, Dr. Santanello is Coordinator for the Services for Returning Veterans Mental Health Program (SeRV-MH) across the VAMHCS and the Acting Team Lead for the Baltimore PTSD Clinical Team. The SeRV-MH program focuses on treatment engagement (including outreach), consultation/crisis management and providing evidenced based treatment for returning veterans from the OEF/OIF wars and other combat areas that are part of the Global War on Terrorism.

Jade Wolfman-Charles, Ph.D completed her degree in Clinical and Community/Social Psychology at the University of Maryland, Baltimore County in 2009. Her research focused on individual and community level risk and protective factors of substance use with a specific focus on African Americans. Dr. Wolfman-Charles is also interested in action-oriented research, and served as assistant coordinator on a team responsible for disseminating evidence-based and culturally sensitive practices to community-based clinics throughout Maryland. She has specialized training in Cognitive Behavioral Therapy and Motivational Enhancement Therapy as well as the Transtheoretical Model of Change. She completed her predoctoral internship at the VA Maryland/University of Maryland Consortium where she received additional training in Acceptance and Commitment Therapy. Dr. Wolfman-Charles is now serving as a Coordinator for the VITAL Program at the Baltimore VA within the Returning Veterans Mental Health Program (SeRV-MH).

ROTATIONS AT THE PERRY POINT VA MEDICAL CENTER

Geropsychology, Long Term Care and Outpatient
Patient Population

The primary training sites for interns on this rotation are the outpatient mental health clinic (MHC) and the Geriatric Evaluation and Management Unit, both located at the Perry Point VAMC. Most patients are 65+, male, and approximately two-thirds are European-American, although occasionally interns would work with younger and/or female patients. Presenting problems include affective and adjustment disorders, co-morbid substance abuse issues, previously undiagnosed Axis II spectrum issues, and dementias. Interns should expect to see approximately six patients for neurocognitive and/or personality assessment, and six to seven outpatient cases for individual psychotherapy for the full range of aging and mental health issues/problems. The intern may have the opportunity to work with patients with terminal illnesses or who are at risk for sudden death due to multiple, chronic health problems. Interns may occasionally be assigned cases from other inpatient units if they present important unusual clinical issues or otherwise offer important training opportunities.

Assessments, Treatments, & Supervision

The APA Draft Policy on Evidence-Based Practice in Psychology (EBPP) states “the goal of EBPP is to enhance psychological practice through effective integration of best available research evidence with clinical expertise to provide services tailored to the unique patient. Successful integration requires that psychologists recognize the strengths and limitations of clinical expertise and different types of research and appreciate the value of multiple sources of evidence. Individual problems, co-occurring disorders and concerns, and clinical presentations frequently require decisions and interventions not directly addressed by the available research.” This excerpt captures the tone/approach used in supervision on this rotation to highlight the necessary interplay between clinical work and research.

Interns will be provided with training/supervision in case conceptualization and treatment in an Interpersonal/Sullivanian model. This treatment approach also relies on Erikson’s life-span developmental theories and Butler’s work on Life Review treatment for the elderly as theoretical underpinnings. Similarities and differences with Interpersonal Therapy (IPT; Klerman et al., 1984) are highlighted. Treatments are usually time-limited (less than 15 sessions) and most cases are concluded prior to the intern’s completion of the rotation. If not already acquainted, interns are introduced to the relevant Clinical Geropsychology and Neuropsychology of Aging literatures, as well as emerging practice guidelines for working with older adults (e.g., Interdivisional Task Force on Practice in Clinical Geropsychology, APA, 2004; La Rue, 1992; Molinari, et al., 2003).

In this form of treatment, there is a de-emphasis on predetermined interventions targeted only at symptom reduction, and a focus on assisting the patient in gaining greater understanding of rigid, maladaptive patterns of coping. These patterns become evident in the history, in interactions with other staff and patients, and, most usefully, in the treatment relationship with the intern therapist. Supervision is used to help the intern identify these salient aspects of the patient’s presentation in sessions and how to help the patient utilize growing insight to elect changes in his/her relations with others. The working alliance/relationship with the patient is seen as the key reparative element in psychotherapy (e.g., Stiles et al., 1998). Interns make audio recordings of all assessment and treatment contacts for review during supervision. Supervision has a process orientation with an emphasis on the intern’s growing awareness of her/his interpersonal impact, perceptions/expectations about aging, in addition to acquisition of case conceptualization and treatment application skills, knowledge of how the patient’s aging affects the treatment process, etc.

Death and dying issues often present particular difficulties for interns (most of whom have had little or no experience in this area) and require close supervision/further focused readings, etc.

Recent research conducted in Canada points out the very high importance dying patients place on Life Review, but also implies the important consultative role psychology can play in facilitating communication among terminally ill patients, their families, and their caregivers (i.e., Heyland, et al., 2006).

Interns will typically complete six neurocognitive screenings and/or personality assessments during a rotation. Neurocognitive screenings are conducted using an expanded Consortium to Establish a Registry for Alzheimer's Disease (CERAD) battery. This battery has proven to be psychometrically sound in research with our local data base (i.e., Jones and Votolato, 2005; Jones and Ayers, 2006). Focused supervision, practice administration with the battery, and background reading on the various dementias augments the intern's other training.

Personality assessment, when needed, is undertaken using standard psychometric instruments such as the Personality Assessment Inventory (Morey, 1991). Interpersonal diagnosis is also conceptualized via circumplex models of interpersonal behavior (e.g., Benjamin, 1993; Orford, 1986).

Interns begin the rotation with many different backgrounds, professional interests, and degrees of preparation in clinical geropsychology. Major and minor rotations are available, both for interns who are planning a career in geropsychology and those just seeking to gain "some experience" with this population.

Supporting Literature

For numerous reasons unrelated to pure treatment efficacy, behavioral and cognitive behavioral treatment modalities have been the most studied treatment approaches with the elderly. Nevertheless, in an early meta-analysis of psychosocial treatments for depression in the elderly, Scogin and McElreath (1994) concluded that there was "no clear superiority for any system of psychotherapy in the treatment of geriatric depression" (p. 72). Also, in a recent review of psychological interventions for late-life anxiety, Wetherell et al. (2005) concluded that CBT treatment effects are typically half as large as those with younger cohorts (p. 75). Some researchers have concluded this may be due to cognitive limitations in the elderly and that a "super-CBT" treatment protocol with more interventions, review of techniques, and so forth, is the answer to this limitation. However, long clinical experience suggests that aging cohorts may have expectations about treatment, or are in developmental eras in their lives, in which a treatment approach more focused on the treatment relationship and self-examination are more fruitful.

Gatz and colleagues (1998) found that brief psychodynamic therapy, life review, and reminiscence therapy were all "likely to be effective," in addition to cognitive and behavioral approaches. Frazer and colleagues (2005) reached a similar conclusion. Interpersonal psychotherapy (IPT) has demonstrated effectiveness with depression, including with elderly patients who have responded poorly to SSRIs (Scocco and Frank, 2002) and whose depression was secondary to coronary disease (Koszycki et al., 2004). These IPT interventions have followed the Klerman manualized approach, apparently to enhance treatment "purity" and because of its evidence base. Strupp and Anderson (1997) have detailed the limitations of therapy manuals, and interns on the Geropsychology rotation will return to the source material upon which IPT was originally based, Sullivan's (1953) *The Interpersonal Theory of Psychiatry*, Clinical Studies in Psychiatry (1956), and Fromm-Reichmann's (1950) *Principles of Intensive Psychotherapy*. These broader theoretical statements simply inform trainees in a fuller way about a general interpersonal approach to psychotherapy but remain consistent with the IPT approach.

Interns often find the original Sullivan works difficult and an introductory chapter on Sullivan's theories by Rychlak (1981) also helps to introduce another element in the supervision, an emphasis on metapsychological analysis of this and other theories of treatment. The recent controversies within psychology as a field on evidenced-based practice suggest even more than previously that interns must become critical consumers of the research literature before they can make informed contributions to our discipline. Thus, APA's draft policy statement on evidence-based practice is a starting point for these supervision discussions, as well as works by Westen and colleagues (2004), Slife and colleagues (2005), and others, as time and the intern's interest permit.

The research base for neuropsychological assessment with the elderly is enormous and growing. The research papers referenced above demonstrate the usefulness of the battery that interns use on the rotation. Selected other articles are suggested to interns, as needed, to further their knowledge about syndromes such as delirium in the elderly, clinical and psychometric manifestations of the various dementias, and differentiation of functional psychological problems versus neurocognitive deficits versus combinations.

Supervisor's Training and Experience

Dr. Scott Jones will provide supervision to interns on the rotation. Individual supervision is scheduled for four hours per week, two of which is face to face supervision, but typically considerably more supervision occurs, especially early in the rotation, on an as-needed basis.

Dr. Jones earned a Graduate Certificate of Training in Gerontology from the Scripps Foundation Gerontology Center at Miami University in 1985 during work on his Ph.D. in clinical psychology (1989) at the same university. His predoctoral internship was an NIMH-funded program in Clinical Geropsychology at Hutchings Psychiatric Center, Syracuse, New York (1987-88). In addition to year-long involvement in various geriatric mental health programs, he also completed a six month rotation in Neuropsychology while an intern. From 1988 to 1991, Dr. Jones helped to develop a geriatric day treatment program and directed its multidisciplinary staff at the Bangor Mental Health Institute, Bangor, Maine. He has served as the staff Geropsychologist at Perry Point VAMC since that time. Dr. Jones has supervised over 20 interns in major Geropsychology rotations, first in Perry Point's internship program and presently in the VAMHCS/UMB consortium. Dr. Jones completed a year of postdoctoral training in Neuropsychology with Dr. Robert Kane at the Baltimore VAMC in 1999 and has since served as Perry Point's Neuropsychologist. Dr. Jones has published five papers in peer-reviewed journals, six abstracts, and one book review. Current research projects include examining learning characteristics on the CERAD word list-learning task, predicting mortality from neuropsychological data, and a conceptual paper using Pepper's Root Metaphor theory to analyze Sullivan's concepts.

Gero-neuropsychology – Community Living Center

Patient Population

The primary training site for interns is the community living center (CLC) at the Perry Point VAMC. Residents are males, 55 and older, who have varied ethnic and racial backgrounds with the majority being Caucasian and African American. Interns would occasionally have an opportunity to provide services to some younger residents (twenty-five to fifty-years old). A majority of the residents present with mild to severe cognitive impairment secondary to a variety of conditions, including degenerative neurological disease, cerebrovascular disease, metabolic conditions, nutritional deficiencies and traumatic brain injury. In addition, approximately half of the residents have a history of serious and chronic psychiatric conditions in addition to their medical issues. The types of co-existing psychiatric problems include depression, anxiety, PTSD, schizophrenia, schizoaffective disorder, bipolar disorder, and substance abuse/dependence. Other

psychological problems that are often presented include grief and bereavement, pain disorder and adjustment disorders. The intern may have the opportunity to work with residents who have terminal illnesses and/or their families.

Assessments, Treatments, & Supervision

During the CLC gero-neuropsychology rotation, interns will function as an integral part of a medical inpatient, inter-disciplinary team (IDT), which includes the attending physician, social worker, chaplain, occupational and recreational therapist and nursing staff. In this role, the intern will also provide support for the CLC cultural transformation change process by providing consultation and in-service training to unit staff and by participating in activities to create a home-like atmosphere in the CLC neighborhoods (i.e., units). The intern will be expected to attend weekly IDT meetings, address consults for assessments as requested by the attending physician, carry a caseload of residents for individual psychotherapy and provide consultation to the IDT and nursing staff for residents who present with challenging and disruptive behaviors.

Interns will conduct cognitive and mood screenings for a minimum of twelve residents to assist in making recommendations for additional assessment and/or mental health intervention. These cognitive and mood screenings will consist of a formal mental status examination (e.g, MMSE, SLUMS, Mini-cog), the Clock Drawing Test, the Geriatric Depression Scale –Short-Form and/or the VA clinical reminder screening tools. In addition, it is anticipated that interns will conduct more in depth neuropsychological assessments for another four residents with an emphasis on evaluating their decision-making capacity and developing recommendations to assist with discharge planning. These neuropsychological assessments will utilize a flexible battery approach with the specific instruments being selected to most efficiently answer the referral question and which are most appropriate in consideration of the resident's age, language and sensory-motor functioning. The intern will be provided supervision and practice administering, scoring and interpreting the various instruments that are used while ensuring adherence to the APA Guidelines with regard to assessing older adults (APA 2008; Knight et.al., 1995).

Interns will also provide individual psychotherapy and/or behavioral intervention consultation to interdisciplinary treatment teams for six to eight residents addressing a variety of issues that may include psychosis, mood and anxiety disorders, adjustment disorders and bereavement as well as disruptive behaviors secondary to cognitive impairment. The psychotherapeutic intervention training/supervision will focus on case conceptualization and treatment utilizing a cognitive-behavioral model. Specifically, interns will be exposed to the CBT literature addressing anxiety, depression and pain management as well as the application of this approach to working with older adults and in long-term care environments (Gallagher-Thompson and Thompson 2009; Knight et.al., 1995; Laidlaw, et al 2003; Meeks & Depp, 2003; Meeks & Teri, 2004). In addition, the intern will provide both formal and informal consultation services to the IDT and nursing staff to assist in the identification and implementation of behavioral/environmental interventions in order to address challenging and disruptive behaviors being displayed by residents (Attix and Welsh-Bohmer, 2006; Conn et al., 2007; Meeks & Teri, 2004; Nordhus et al., 1998). The PPVAMC is one of the STAR-VA pilot sites for implementation of an evidence-based approach to addressing disruptive behaviors secondary to dementia. The intern will be provided training and gain experience in implementing the STAR-VA approach to managing challenging behaviors.

Interns may choose either a major or minor rotation in CLC gero-neuropsychology as is consistent with their level of career interest. The intern will be provided a minimum of two hours of face-to-face individual supervision. However, it is anticipated that additional supervision will be provided, as needed, based on the intern's level of experience.

Supporting Literature

Long-term care settings are currently undergoing a cultural transformation designed to transition the nursing home care environment from that of an institutionalized medical model to a more home-like environment that is focused on client-centered service delivery (Baker, 2007; Thomas, 2007). Psychologists can play a pivotal role in supporting this change process through direct services to residents as well as by providing indirect support to long-term care staff (Attix and Welsh-Bohmer, 2006; Conn et al., 2007; Knight et.al., 1995; Nordhus et al., 1998). Specifically, individual cognitive and behavioral interventions have demonstrated efficacy in addressing the psychiatric issues which are often presented in long-term care settings, such as mood disorders, depression, anxiety, and pain management (Gallagher-Thompson and Thompson 2009; Karel et al., 2002; Knight et.al., 1995; Laidlaw, et al, 2003; Meeks & Depp, 2003; Meeks & Teri, 2004). In addition, literature has shown that the provision of proactive behavioral and environmental mental health services to residents with dementia can be effective in addressing challenging and disruptive behaviors (Attix and Welsh-Bohmer, 2006; Conn et al., 2007; Nordhus et al., 1998). As a result, the reliance on psychotropic medications can be reduced; thus decreasing the risk of detrimental side effects, including shortened life span (Knight et.al., 1995).

The use of neuropsychological assessment with the elderly as applied to decision-making capacity and discharge planning is growing (APA 2008; Attix and Welsh-Bohmer, 2006). Interns will be encouraged to gain familiarity with the literature addressing differential diagnosis and clinical and neuropsychological presentations of delirium, psychiatric disorders, mild cognitive impairment and various dementia syndromes (APA, 2008; Attix & Welsh-Bohmer 2006; Lezak et al., 2004; Ricker, 2004; Storandt & VandenBos, 1994).

Supervisor's Training and Experience

Dr. Jodi L. French earned her doctorate in clinical psychology from the Virginia Consortium for Clinical Psychology in 1991. She completed a major rotation in gero-neuropsychology during her predoctoral internship at the Perry Point VAMC, which she completed in 1990. Dr. French also completed a two-year postdoctoral residency in clinical neuropsychology at the Fielding University in 1998. In addition, she worked as a consultant psychologist to community nursing homes and assisted living facilities in Virginia and Florida from 1995 to 1998. Since then, Dr. French has provided outpatient mental health services to aging adults and their families and caregivers in a private practice setting. In May 2008, she was appointed to the newly created CLC Clinical Psychologist position for the Perry Point VAMC and has been providing services to over 100 CLC residents living in at least four different long-term care neighborhoods (units). In addition, she has received training in the evidenced-based STAR-VA approach for addressing challenging and disruptive behaviors due to dementia that are displayed by residents in community living centers. Dr. French has specialized Neuropsychology privileges and has conducted outpatient neuropsychological assessments in a private practice setting since 1998.

Psychosocial Rehabilitation and Recovery Center – Perry Point

Patient Population

The Perry Point Psychosocial Rehabilitation and Recovery Center (PRRC) serves Veterans with serious mental illness (SMI) including schizophrenia, affective disorders, and some severe forms of anxiety disorders. A portion of PRRC Veterans have a co-occurring substance use disorder which may also be a focus of treatment. Veterans served by the PRRC typically have a Global Assessment of Functioning score of 50 or below (i.e., serious psychiatric symptoms or any serious impairment in social, occupational, or school functioning) and thus experience a range of functional limitations. The majority of Veterans are male and ages range from 20s to 70s.

Assessments, Treatments, and Supervision

PRRCs represent one of VA's many efforts to implement the goals of the President's New Freedom Commission on Mental Health including the principle that mental health care should be individualized and recovery focused. As such, PRRCs offer a daily menu of treatment alternatives with sufficient variety to support meaningful choice. Veterans are encouraged to set personally relevant recovery goals and select the groups and classes that will assist them with meeting these goals. As part of these treatment choices PRRC's are tasked with providing evidence-based interventions designed for the SMI population.

The intern will receive training in the following SMI focused interventions: social skills training and cognitive behavior therapy (CBT). The latter delivered in either group based or individual formats. The intern will also co-lead Illness Management and Recovery (IMR) psychoeducation, co-occurring disorder groups and mindfulness based interventions. The intern will see 3-4 individual psychotherapy cases and co-lead groups with their supervisor. There will be additional opportunities to co-lead similar groups (anger management, co-occurring disorders etc.) through the Perry Point campus wide *Recovery Center* (see description below). In addition to delivering these evidence based interventions the intern will provide case management to Veterans participating in PRRC. As part of case management interns will collaborate with Veterans in identifying personal recovery goals. These goals inform the veteran's individualized treatment plan and how the program is tailored to their needs. The intern will also participate on the PRRC interdisciplinary treatment team. With regard to assessment, interns will have the opportunity to use standard psychological assessment measures such as the WAIS, WMS, PAI and MMPI as well as more brief screening instruments (e.g., RBANS) in order to inform treatment planning for certain cases. Finally, the PRRC rotation offers the intern the opportunity to learn about a recovery focused approach to mental health.

Support from Literature

As reviewed above, the PRRC is tasked with delivering evidence based interventions for SMI. Social skills training, CBT, and treatments for co-occurring disorders among others are recommended interventions for schizophrenia (Dixon et al., 2010). There is strong support for use of social skills training for individuals with schizophrenia and related SMI (Kurtz & Mueser, 2008). This modality uses behaviorally-based instruction, modeling, rehearsal, corrective feedback, and positive reinforcement to teach a variety of interpersonal skills. Many Veterans served by the PRRC, while not in an acute phase of illness, still experience depressive and anxiety symptoms and have been able to learn and benefit from CBT strategies. The evidence base for CBT for depression and anxiety is substantial including support for use of group based CBT interventions. The evidence base for use of CBT for individuals with SMI is expanding and also includes group based interventions (Granholm, et al., 2005) and there is moderate meta-analytic support for the use of CBT for psychotic symptoms (Wykes et al., 2008). There is a high rate of substance use among individuals with SMI and individuals with co-occurring disorders should be offered substance abuse treatment tailored for SMI related impairments (Dixon et al., 2010). For these Veterans skills based, psychoeducation, and coping skills components of the Behavioral Treatment for Substance Abuse in Schizophrenia (Bellack et al., 2006) are provided. Finally, while the evidence base for Illness Management and Recovery (IMR) interventions is preliminary this psychoeducation and skills based group is well grounded in evidence based principles (Hasson Ohayon, 2007; Levitt et al., 2009).

The importance of the recovery focus also warrants a brief comment. Recovery based services are not an evidence based practice per se but rather represent a paradigm shift in mental health

care. Recovery has been defined by SAMHSA to include: hope, self-direction, individualized and person-centered, empowerment, holistic, non-linear, strengths-based, peer support, respect, and responsibility. As such, recovery is the context within which the above mentioned interventions are delivered and informs the manner in which, for example, treatment choices are presented and the way cases are conceptualized.

Supervisors' Training and Experience

Supervision for group based and individual interventions and assessment will be provided by Dr. Christine Calmes and Dr. Jason Peer.

Dr. Calmes received her doctorate from the State University of New York-Buffalo and completed her pre-doctoral internship at the University of Maryland/VA Maryland Healthcare System (VAMHCS) consortium through the VA serious mental illness track. She completed one year of a post-doctoral fellowship through the MIRECC in which her research and clinic interests focused on family involvement in the mental health care of Veterans with serious mental illness and internalized stigma associated with mental illness. Dr. Calmes has continued involvement in research with MIRECC investigators and is involved with program evaluation efforts through the PRRC. She also serves as the VAMHCS Evidence Based Practice coordinator.

Dr. Peer completed his Ph.D. in clinical psychology at the University of Nebraska-Lincoln where his training and research focused on psychosocial interventions for schizophrenia and related SMI. Dr. Peer completed a year-long internship with a SMI focus at the University of Maryland Baltimore/VAMHCS Psychology Internship Consortium and a three year post-doctoral fellowship in Mental Health Research and Treatment at the VISN 5 Mental Illness Research Education and Clinical Center. In both internship and fellowship he received extensive training in CBT, skills based and psychoeducation focused interventions for SMI and substance abuse. He has been active in research and has published several peer reviewed papers related to cognitive impairment, psychosocial treatment response, vocational functioning, and substance use in SMI. He continues to collaborate with MIRECC investigators on research projects and is active in Perry Point program evaluation activities.

Inpatient Unit –Ward 364A

The Mental Health Clinical Center, VAMHCS, exists to serve veterans' mental health care needs, including substance abuse and homelessness, by providing an integrated continuum of quality, comprehensive, evidence-based and compassionate mental health services; an environment that nurtures competent staff dedicated to the provision of mental health services; state-of-the-art, evidence-based mental health services through research, education, and technology. Within that clinical center, the role of Perry Point VA Medical Center Ward 364A (PP 364A) is to provide high- quality sustained inpatient psychiatric treatment. PP 364A serves the needs of veterans who no longer meet criteria for acute inpatient psychiatric treatment but still require treatment in a secure inpatient environment for further stabilization of their psychiatric symptoms.

A multidisciplinary treatment team works together on PP 364A to promote provision of recovery-oriented, patient-centered, evidenced-based mental health care. This team includes one Psychiatrist, one Psychologist, two Social Workers, one Physician Assistant, one Nurse Practitioner, one Nurse Manager, and nursing staff. Other providers who serve the veterans on PP 364A include a Recreational Therapist, a Dietetic Technician, a Kinesiotherapist, a Horticultural Therapist, an Occupational Therapist, and a Chaplain. This staff welcomes students, including those from Psychology service, Social Work service, and Nursing Service.

The staff of PP 364A have the privilege and responsibility of serving a diverse veteran population. Although the physical space can accommodate a maximum of forty veterans, the current census is capped at thirty to accommodate anticipated improvements to the physical environment (construction expected March 2011 – March 2012). This veteran population includes men and women ranging from early twenties to mid-eighties. Common diagnoses include Psychotic Disorders, Mood Disorders, Anxiety Disorders, Personality Disorders, and Substance Abuse Disorders. A growing portion of this veteran population also presents with cognitive symptoms that interfere with desired functioning. Veterans on PP 364A present with a variety of medical and social needs, as well.

The treatment milieu of PP 364A is designed to promote safety and recovery from mental health symptoms. This is a locked door unit, and veterans are escorted by staff to any outside appointments. This ward has a structured daily routine, including opportunities for hygiene, education, therapy, recreation, physical exercise, medication, and socialization. The goal is to promote those behaviors which will best promote future success in the veteran's community of choice.

The changing nature of the veteran needs necessitates flexibility on the part of the Psychologist. Services provided to veterans include: individual psychotherapy, group psychotherapy, patient education, family meetings, treatment planning, and psychological assessment. Services provided to staff include: education and training. In addition, the ward Psychologist serves as part of the Perry Point campus-wide *Recovery Center* (see description below), which includes opportunities for therapeutic and educational groups. All of these opportunities are available to Psychology interns, and may be modified to meet the individual's training goals and interests.

The relationship between intern and supervisor on the unit may be characterized as collaborative in nature, with much of the “supervision” obtained in the course of working together on various activities throughout the day. Various modes of supervision are used, including audiotape, co-therapy, and supervisor “shadowing” (direct supervision). The intern will work quite closely with the supervisor initially, and then gradually function more independently as time goes on. The intern’s progress will be indicated through greater participation in all areas, and through the ability to work effectively with both veterans and staff. The predominant theoretical orientation is behavioral/cognitive-behavioral within an overarching bio-psycho-social approach to the treatment of severe mental illness. This rotation supports the Scientist-Practitioner model through the use of such empirically-supported treatments as cognitive behavioral therapy and acceptance and commitment therapy.

Supporting Literature

The staff of PP 364A are dedicated to providing the highest quality mental health services as a means towards promoting mental health recovery. As such, evidence-based therapeutic interventions are offered to address the treatment goals most frequently identified by veterans. Interns on ward 364A are encouraged to familiarize themselves with Cognitive behavioral therapy (CBT), Acceptance and Commitment Therapy (ACT), and psychosocial interventions for schizophrenia. The following information is representative of only a small portion of available research evidence.

Cognitive-Behavioral Therapy (CBT) is a time-limited, evidence-based intervention. CBT is an effective treatment for Depression (Butler et al., 2006; Chambless et al., 2001; Gloaguen et al., 1998). Given the nature of the aging veteran population, it is important to recognize that this finding applies to a geriatric population as well as a general adult population (Chambless et al., 2001). CBT is also an effective treatment for various anxiety-related symptoms and disorders, including Generalized Anxiety Disorder, Panic Disorder, Agoraphobia, and Panic Disorder with

Agoraphobia (Butler et al., 2006; Chambless et al., 2001; Gloaguen et al., 1998). There is also evidence to support its use in the treatment of Social Anxiety and Social Phobia (Butler et al., 2006; Chambless et al., 2001; Gould et al., 1997). CBT may also be used, in conjunction with medication management, for the treatment of Bipolar Disorder (Chambless et al., 2001; Lam et al., 2003).

While Acceptance and Commitment Therapy (ACT) has not been formally accepted as an empirically-supported treatment, emerging research evidence is promising (Hayes et al., 2006). ACT is used on ward 364A in conjunction with other interventions (such as cognitive behavioral therapy and medication management). The first-line treatment for Schizophrenia is neuroleptic medication. A majority of patients also benefit from the inclusion of psychosocial interventions that include support, education, case management, and behavioral/cognitive skills training for functional improvement in targeted areas (Lehman et al., 2003). Family psycho-education is also important (Lehman et al., 2003; Pitschel-Walz et al., 2001).

Supervisor's Training and Experience

Supervision for this rotation is provided by Lisa Falconero, Psy.D. Dr. Falconero is a full-time staff psychologist on ward 364A. She completed her undergraduate training at Johns Hopkins University and her master's and doctoral training at La Salle University. Dr. Falconero received her internship training through the VA Maryland Health Care System/University of Maryland Baltimore Psychology Internship Consortium (SMI track). She completed her post-doctoral training through the Psychosocial Rehabilitation Fellowship at the VA Connecticut Health Care System. Dr. Falconero has worked at the Perry Point VAMC since 2008 and has served on inpatient and residential levels of care. She is licensed in Maryland.

Trauma Recovery Program/PTSD

Patient Population

The Trauma Recovery Program (TRP) at the VAMHCS (Perry Point Division) consists of a specialized outpatient PTSD clinic (PCT) and a newly developed residential treatment program. The program offers individual and couples treatment as well as a variety of groups for veterans with military-related PTSD. Patients within the PCT include male and female veterans and active service members who have a primary diagnosis of PTSD (25% due to sexual trauma; 17% due to non-combat and nonsexual trauma). Many patients in the PCT have other comorbid diagnoses and are active in treatment in other areas of mental health (e.g., SATP, PRRC, Mental Health Clinic, etc.). Our patient population is ethnically diverse with almost half (42%) of the patient population of African American descent. Interns will have the opportunity to see individual psychotherapy patients from this program. On this rotation, there is also an opportunity for with our Services for Returning Veterans Mental Health Program (SeRV-MH) program.

Assessments, Treatments, & Supervision

Interns will participate in the PTSD Assessment Clinic, where he or she will conduct several intake interviews to learn appropriate methods for diagnosing PTSD. The intern will complete at least two full-scale comprehensive PTSD assessments using semi-structured interviews, personality assessment, and standardized self-report instruments. Comprehensive assessment skills for this rotation will include training and supervision in the use of the Clinician-Administered PTSD Scale (CAPS; Blake et al., 1995) and the Anxiety Disorders Interview Schedule (ADIS), the PTSD Checklist (PCL; Blanchard et al., 1996), the Mississippi Scale for Combat-Related PTSD (MISS; Keane et al., 1988), the Minnesota Multiphasic Personality

Inventory-2 (Butcher et al., 1989), the Beck Depression Inventory (Beck et al., 1961), and the Beck Anxiety Inventory (Beck & Steer, 1990).

In the PCT, interns will be provided with training in individual and group psychotherapy for the treatment of PTSD. Interns will be involved in co-leading sexual trauma, coping skills and dual diagnosis (PTSD/substance abuse) groups. They will receive supervision in the two modes of treatment for PTSD with the most empirical support: exposure therapy and cognitive processing therapy. They will also receive specific training in approaches to the treatment of dually-diagnosed veterans with PTSD and substance abuse/dependence, including Seeking Safety and Acceptance and Commitment Therapy. Interns will also have the opportunity to co-lead groups for OIF/OEF veterans and active service members.

The patient load will include three to four individual psychotherapy patients in addition to co-leading outpatient groups. Interns will receive at least two hours of supervision per week with Dr. Castro in order to review cases, provide further assessment and intervention training, and establish concrete treatment plans for group and individual patients. In addition, interns will have the opportunity to provide supervision to externs on the rotation.

Support from Literature

Exposure therapy (ET; Foa *et al.*, 1991; Keane *et al.*, 1989) has been consistently demonstrated as an effective treatment for addressing specific traumatic memories; this approach has been endorsed by the Division 12 Task Force as an efficacious treatment for PTSD. Cognitive therapy (CT), Imagery Rehearsal Therapy (IRT) and Stress Inoculation Training (SIT) have consistently shown high rates of efficacy for symptoms reduction as well, and all four treatments have been adopted as best clinical practices by the VA/DoD Clinical Practice Guidelines (VA/DoD Clinical Practice Guideline, Management of Posttraumatic Stress, 2010). Additionally, the use of anxiety management training has been empirically supported in the PTSD and other anxiety research literature (Foa *et al.*, 2000). Although there is limited evidence surrounding efficacious treatment for dual-diagnostic patients with PTSD and substance use disorders, the Seeking Safety protocol (Najavits, 2002) has demonstrated promising longitudinal outcome data. While preliminary studies were limited to small sample sizes, and few addressed veteran populations, more recent studies include larger samples and a variety of veteran populations. Coping skills that are part of the Seeking Safety program are similar in content to anxiety management training and make an important link between PTSD and substance abuse/dependence.

Psychological theories have increasingly recognized multiculturalism as an important factor in defining behavior, personality and development. Indeed, research has shown that practicing multiculturalism results in client retention and enhanced treatment outcomes (Zang & Dixon, 2001). Further, ethical standards of the American Psychological Association (2003) and the Surgeon General's Supplement to Mental Health Report (2001) emphasize the importance of multicultural practice. Interns will be learning how multicultural issues influence PTSD and recovery.

Related to PTSD assessment, the CAPS has been shown to have excellent reliability and validity (convergent and discriminative validity) within trauma populations; it is considered the "gold standard" of interviews for PTSD (Weathers et al., 2001). The PCL (e.g., Ruggiero et al., 2003) and MISS (e.g., Norris et al., 1996), both symptom self-report measures, have demonstrated utility in the assessment and diagnosis of PTSD, with good evidence for reliability and validity.

Finally, the BDI and BAI are commonly used self-report measures that involve a general assessment of depressive and anxiety symptoms, useful as adjunct data in the comprehensive assessments of veterans and for detection of possible comorbid diagnoses. A comprehensive review of assessment procedures for trauma and PTSD can be found in *Assessing Psychological Trauma and PTSD* (Wilson & Keane, 2004).

Supervisors' Training and Experience

Rachel Thompson, Ph.D. received her doctoral degree in Clinical Psychology from The Catholic University of America. She completed her predoctoral psychology internship at the Georgia Health Sciences University/Charlie Norwood VA Medical Center Psychology Residency Consortium, where she pursued a clinical emphasis in PTSD and women's issues. She received further training in the assessment and treatment of PTSD and related disorders during her postdoctoral fellowship in Trauma Recovery in Returning Veterans at the VA Maryland Health Care System. Dr. Thompson has received specialized training in a variety of treatment models, including Prolonged Exposure, Cognitive Processing Therapy, Acceptance and Commitment Therapy, Seeking Safety, and Dialectical Behavior Therapy. She has strong clinical and research interests in the utility of mindfulness and acceptance-based techniques for both the prevention and treatment of PTSD.

Jill (Panuzio) Scott, Ph.D. is the PTSD-SUD Specialist on the Perry Point campus. She received her Ph.D. in Clinical Psychology from the University of Nebraska-Lincoln in 2011, where her clinical and research efforts centered on the relationship between trauma-related psychopathology and family violence. Dr. Scott completed a clinical internship at the Boston Consortium in Clinical Psychology, with a focus on substance use disorders and posttraumatic stress disorder. Following internship, she completed a postdoctoral fellowship at the National Center for Posttraumatic Stress Disorder, VA Boston Healthcare System. Dr. Scott's interests include empirically supported assessment and treatment for veterans with dual diagnoses. She has received training in several ESTs for PTSD and substance use disorders over the course of her training, including Behavioral Couples Therapy for Alcohol and Drug Abuse, Cognitive Behavioral Therapy, Cognitive Processing Therapy, Motivational Interviewing, Relapse Prevention, and Seeking Safety.

Perry Point Supplemental Training Opportunities:

The Recovery Center

The Mental Health Recovery Center is a recent VAMHCS clinical initiative implemented to increase access to, efficiency in, and satisfaction with mental health services at the Perry Point campus. In brief, the Recovery Center is designed to be a "one-stop shop" for multidisciplinary mental health psychoeducational and therapeutic services. Veterans from across the Perry Point campus (both inpatient and residential settings) and surrounding community are able to select from a "course catalog" of treatment groups and classes relevant to their personal recovery goals. Groups and classes include evidence based mental health interventions, skills based, wellness/recovery oriented and supportive therapy groups addressing a wide range of psychosocial issues that Veterans are faced with. These include for example, mood, anxiety, trauma, chronic pain, substance use, co-occurring medical conditions, TBI and other skills related (e.g., budgeting) and relationship issues. In addition to offering a comprehensive array of services, the Recovery Center also strives to make accommodations so that no Veteran is deemed "inappropriate" for services in order to maximize access to services. The rationale for this

method of service delivery is to enhance the VAMHCS' ability to provide a continuum of care designed to be more accessible and individualized for Veterans seeking mental health services.

As a point of clarification, the Recovery Center is not designed to replace specialized treatment programs such as, for example, addictions and trauma but rather is an opportunity for Veterans to supplement this treatment with additional groups and classes. This arrangement enhances efficiency by removing the redundancy of offering multiple groups targeting the same problem (e.g., anger management) across programs and units. Also the Recovery Center is distinct from the PRRC in that it serves all Veterans regardless of diagnosis or functional impairment, whereas the PRRC is tasked with serving Veterans with severe mental illness and resulting functional impairment. However, Veterans enrolled in PRRC are not excluded from participating in Recovery Center groups as well.

Opportunities for interns

Interns who select rotations at the Perry Point campus will have the opportunity, with input from their primary supervisor, to supplement their training with Recovery Center clinical activities. These opportunities include co-facilitating groups such as Seeking Safety, Sleep Hygiene, CBT for depression and anxiety, mindfulness meditation, Anger Management, and Chronic Illness Support Group. For particularly industrious interns there may also be opportunities to develop and implement (with supervisor support) a specific time limited group during their rotation.

For the interested intern there are also program evaluation and program development opportunities within the Recovery Center as well as in other Perry Point programs (e.g., PRRC). These include, for example, measuring Veteran satisfaction with services, needs assessment, evaluating outcomes, assessing program efficiency and related performance improvement activities. These are small scale and time limited clinically focused projects but are an opportunity to get ones' hands dirty with real world data. Interns would have the opportunity to participate in several ongoing workgroups associated with the Recovery Center including a program evaluation and needs assessment workgroup or a clinical programming workgroup.

COMMUNITY BASED VA OUTPATIENT CLINIC

Hospice/Palliative Care Rotation

Patient Population

The patient population of the hospice program spans a wide range of diagnostic categories, level of functioning, and severity of illness. The age range of veterans on the hospice unit is generally between early 50's to late 80's. Many of the veterans admitted suffer from chronic liver disease, cardiovascular disease and/or some form of cancer, generally lung or pancreatic with metastases. The older veterans may also have an underlying form of dementia or related cognitive disorder. Interns working on the hospice rotation will work with a wide range of mental health disorders, including a history of Substance Abuse, Depression, Anxiety, and Post Traumatic Stress Disorder. Also, interns will have the opportunity to work with patients' families and staff members to deliver interventions for caregiver support and burnout.

Assessments, Treatment and Supervision

This major rotation is designed to provide interns the opportunity to work predominantly with patients on a 12 bed inpatient hospice unit and to interact collaboratively with an interdisciplinary team. Interns will evaluate patients upon admission to the hospice unit for underlying psychopathology (i.e. depression, anxiety, adjustment disorders, suicidal ideation vs.

desire for dying process to be over, PTSD, personality disorders, chronic mental illness, underlying delirium). From those evaluations, a caseload will be assigned for the intern to follow. Depending on the schedule, interns will also be expected to attend weekly hospice rounds and interdisciplinary team/family meetings. The interns will have weekly supervision and will develop knowledge and skills for working with normative and non-normative grief and bereavement. In addition, assessment of specific psychosocial and mental health issues common in patients with chronic, life limiting or terminal illness and their families will also be addressed. Interns will also develop the ability to modify practice to accommodate end of life context with regard to self-disclosure, boundaries, structure, ability to communicate effectively with medical and non-medical professionals without psychological jargon, etc. The turnover rate on the hospice unit can be rather fast with patients staying on the unit anywhere from months to days. If necessary, caseload can be expanded with residents in the rehabilitation or nursing home units. In addition to initial evaluations, interns will have the opportunity to conduct evaluations associated with decisional capacity and factors contributing to/complicating decisions.

In addition, the intern will be responsible for leading a weekly caregiver support group which is offered to family members of current and past patients of the hospice unit as well as other family members of the CLC patients who have been diagnosed with a terminal illness. The intern will also have the opportunity to participate in a monthly support group offered to hospice staff members.

Supporting Literature

Journal of Palliative Medicine, Psychooncology, Journal of Pain and Symptom Management

APA online end-of-life training modules

Stanford End-of-Life Care curriculum (<http://www.growthhouse.org/stanford/modules.html>)

National Cancer Institute Education in Palliative and End-of-Life Care for Oncology (EPEC-O)

End of Life/Palliative Education Resource Center (EPEC)

End of Life Nursing Education Consortium (ELNEC)

Duke Institute on Care at the End of Life (<http://www.iceol.duke.edu/>)

Fast Article Critical Summaries for Clinicians in Palliative Care (PC-FACS)

Supervisor's Training and Experience

Steven Butz, Psy.D. is the Clinical Geropsychologist and Neuropsychologist for the Loch Raven Community Living and Rehabilitation Center. He obtained his doctorate degree in clinical psychology from Loyola University of Maryland where he is also an affiliate faculty member. He completed a post-doctoral fellowship in geropsychology through the VA Boston Healthcare System/Harvard Medical School. His clinical work has been conducted in both outpatient and inpatient settings with responsibilities that have included neuropsychological testing, decisional capacity evaluations, psychotherapy, and behavioral management for residents in a variety of outpatient and inpatient settings, including independent living, assisted living, nursing home, rehabilitation and hospice units.

YEAR-LONG DIVERSITY MINOR ROTATION

The Diversity Minor Rotation was developed in the spirit of integrating diversity more fully into the training experience. As psychologists, we are tasked with the ethical responsibility of providing culturally informed and appropriate treatments for our clients and the communities with which we engage. However, clinicians often cite concerns about their abilities to apply knowledge of diversity to daily practice. This minor rotation will provide interested interns an opportunity to bridge the gap between knowledge and application.

Core Components

The Diversity Minor Rotation was designed to be flexible, allowing interested interns an opportunity to create an experience fitting with personal and professional goals, prior training experience, and expectations. This is also consistent with a multicultural psychology approach, in which the client is seen as an expert collaborating in their treatment. Generally, though, an intern would participate in this rotation for a period of six months to a year and approximately three to six hours per week. Core components include the following:

1. *Development of a year-long project, culminating in a presentation for your peers, supervisors, and VA psychologists.* The nature of this project will be determined by the intern in collaboration with the rotation supervisor, but may include a research project, psychotherapeutic intervention, development of a paper, program evaluation/needs assessment, etc.
2. *Participation in the development of a VAMHCS Mental Health Diversity Committee.* This multidisciplinary committee will aim to integrate diversity into the spectrum of activities in which VAMHCS psychologists and social workers engage.
3. *Readings of seminal diversity and multicultural literature.* The reading list will inform and support the work being done within the Diversity Minor Rotation.

Objectives

Upon completion of the Diversity Minor Rotation, interns will understand more deeply the necessity for a more inclusive practice of psychology. Interns will have working knowledge of the general concerns within the field of multicultural psychology as well as specific challenges implementing culturally-based approaches to treatment and research in a large medical setting. Interns will have developed a particular skill-set in the application of multicultural psychology, as a result of participation in supervision and developing a specific expertise with regards to their year-long project.

Supervision

Supervision will be conducted using a motivational enhancement and multicultural approach, emphasizing how best to apply empirically supported treatments to a diverse, urban population. The frequency and intensity of supervision will vary, based on the intern's level of experience and training. An intern would be expected to meet for face-to-face supervision once a week for one hour; administrative or research projects may be less frequent, depending on need and developmental level of the trainee. Spot supervision will be available as well.

Supervisor's Training and Experience

Dr. Jade Wolfman-Charles completed her Ph.D. in Clinical and Community/Social Psychology at the University of Maryland, Baltimore County in 2009. Her research focused on individual and community level risk and protective factors of substance use with a specific focus on African Americans. Dr. Wolfman-Charles is also interested in action-oriented research, and served as assistant coordinator on a team responsible for disseminating evidence-based and culturally sensitive practices to community-based clinics throughout Maryland. She has specialized training in Cognitive Behavioral Therapy and Motivational Enhancement Therapy as well as the Transtheoretical Model of Change. She completed her predoctoral internship at the VA Maryland/University of Maryland Consortium where she received additional training in Acceptance and Commitment Therapy. Dr. Wolfman-Charles is now serving as a Staff Psychologist at the Baltimore VA within the Opioid Agonist Treatment Program (OATP), where she continues her focus on the assessment and treatment of addictions, using client-centered, motivational, and culturally sensitive approaches.

Reading List

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CLINICAL MINORS

We offer several minor rotations which vary in their duration and workloads. The specific minors that are offered vary from year to year, but in recent years, options for minors have included:

Assessment Rotation

The assessment rotation is designed to offer psychology interns an intensive training experience in empirical personality testing of a broad range of mental health disorders. Interns will gain experience utilizing objective personality assessment measures (e.g., MMPI-2-RF, PAI) for differential diagnosis of complex Axis I and Axis II disorders, and can tailor the minor to meet their clinical interests and training needs. Referrals for assessments come from a variety of clinical settings (acute inpatient psychiatric setting, general mental health outpatient treatment, structured domiciliary programs) and provide both breadth and depth of training in data-driven assessment and integrative report writing. Assessments completed through this rotation will

count toward the assessment requirement for the internship year.

Supervisor's Training and Experience

Dr. William Canter received his Ph.D in Clinical Psychology from Wayne State University in 1984. He completed a postdoctoral fellowship in 1985 at the University of Michigan. He has been a clinical psychologist at the VAMHCS since 1985 and is an Assistant Clinical Professor at the University of Maryland School of Medicine. His research in the VAMHCS has focused on multivariate empirical prediction of treatment outcomes among heroin and cocaine abusers. His current area of clinical interest is in individual psychotherapy with Vietnam veterans.

Behavioral Medicine Rotation

**(This minor is only available to UM interns)*

This minor rotation is designed to allow interns to see patients in a primary care setting, and to teach and work collaboratively with primary care physicians. Interns will see 2 -3 patients per week that are referred within the primary care clinic. Common diagnoses include Posttraumatic Stress Disorder, Sexual Dysfunction, Substance Abuse, Obesity, Anxiety, Maladaptive Health Behaviors affecting a Medical Condition, and Depression. Clinicians will have supervision each week, and will learn how to collaborate with primary care physicians to treat these patient's medical and psychological conditions. While the exact availability of patients with different diagnoses cannot be guaranteed, this clinic does receive a fair number of referrals for the treatment of Vaginismus, and interns with an interest in this area may be able to request a patient with this diagnosis to learn about the specific treatment of sexual dysfunction.

Interns will also have an opportunity to help in the teaching of Family Medicine Physicians. Interns will learn about key skills physicians need for effective medical interviewing and intervention, including: structuring a medical interview, SBIRT (screening, brief intervention, and referral to treatment for substance use), asking sensitive questions, and motivational interviewing for health behavior change. Physicians will then be observed during medical interviews and interns will provide feedback and teaching on these skills.

Supervisor's Training and Experience

Adrienne A. Williams, Ph.D. is the Director of Behavioral Science in the Department of Family and Community Medicine at the University of Maryland, School of Medicine. She completed her Bachelor's degree at Yale University, and her Master's and Doctorate degrees in Clinical Psychology at Duke University. She completed a post-doctoral fellowship in Health Psychology and Behavioral Medicine/Primary Care Psychology at Michigan State University Consortium for Advanced Psychology training. Dr. Williams' clinical and interests include: behavioral medicine, sexuality and gender issues, pre-surgical evaluation, and memory testing. She specializes in treatment of Sexual Dysfunctions and PTSD. As an Assistant Professor in the School of Medicine, Dr. Williams teaches Family Medicine Residents and medical students in Behavioral Medicine.

Clinical Supervision

This minor rotation is designed to offer psychology interns the opportunity to further cement their identities as budding psychologists by engaging in clinical supervision of psychology externs. Participating psychology interns will garner hands on experience in modeling, mentoring, teaching, training, and evaluating psychology externs on a number of supervisory domains. These include (but are not limited to): case conceptualization, clinical acumen,

professional development, administrative tasks, ethical and legal issues, and multicultural awareness.

Veterans to receive treatment through this service will be newly enrolled patients in the Mental Health Clinic (MHC) at the Baltimore VA Medical Center. These veterans will have recently received an updated psychosocial assessment through the Mental Health Assessment and Referral Clinic (MHARC), attended the MHC entry group, and been diagnosed with a mood and/ or anxiety disorder (and/ or symptoms thereof) for which individual psychotherapy will be identified as a beneficial modality of treatment. These veterans will be identified by Dr. Sam Korobkin, in conjunction with BT MHC coordinator, Dr. Matthew Raney, as being appropriate training cases meeting the above criteria. Psychology externs will be assigned a caseload of one to two of these individual psychotherapy cases at a time, which will then be directly supervised by respective psychology interns engaged in this minor rotation.

Treatment offered to the veterans will be individual psychotherapy from an integrative model approach (primarily cognitive-behavioral). Psychology interns will meet with their assigned psychology externs for one-to-one in-person supervision on a weekly basis, as well as avail themselves for additional "spot" supervision of their respective psychology externs. To that end, interns enrolled in this rotation will be given a pager that they must wear during regular business hours in order to be fully available to their respective externs, and to denote the gravity of the responsibility that they are undertaking. Supervision time offered to externs will be a minimum of one hour a week. Psychology interns will then meet with Dr. Korobkin in a group for one hour a week for clinical supervision of their supervisory activities with their respective externs. Total time interns can expect to commit to this rotation is 3-4 hours per week. Please note that interns who enroll in this minor rotation must be willing to do so for the entire academic year. Dr. Korobkin will officially serve as the primary supervisor and co-signer for all clinical activities provided by the psychology externs (and supervisory interns) within this modality of treatment. Dr. Korobkin will additionally be available on a consultation basis, and by pager, to discuss any emergency or crisis issues that may arise which may fall beyond the scope of practice of the supervisory intern (and/ or for which the intern may not feel capable of dealing with independently).

Supervisor's Training and Experience

Samuel B. Korobkin, Ph.D. is the Director of the Psychology Externship Program at the VA Maryland Health Care System (VAMHCS) and the co-coordinator of the VAMHCS/ UMB Psychology Internship Consortium didactic seminar series. He provides direct care services to veterans and their families as a clinical psychologist for the VAMHCS Family Intervention Team (FIT). He also serves as a VA Central Office national consultant for the Integrative Behavioral Couples Therapy (IBCT) evidence based practice roll out initiative, supervising VA clinicians nationally in providing IBCT services. He is further collaborating with the VISN5 MIRECC on building an evidence-base for the utility of Wellness Recovery Action Planning (WRAP) as an adjunct service for the seriously mentally ill within a VA rehabilitation setting. Additionally, he maintains a small private practice providing adult individual and couples psychotherapy. Dr. Korobkin completed his Bachelor's degree at University of Maryland Baltimore County, and his Master's and Doctorate degrees in Clinical Psychology at St. John's University. He completed a pre-doctoral internship at the Baltimore VA Medical Center and a post-doctoral fellowship in Chronic Pain Management at the West Los Angeles VA Medical Center. He has worked in various medical and private practice settings both in California and Maryland and has served as a clinical supervisor for psychology interns. Dr. Korobkin's specific clinical interests include family psychotherapy, health psychology, and recovery-oriented interventions.

EFT Couples Therapy Minor

The minor rotation is designed to give interns the opportunity to learn an empirically supported approach to working with couples. Interns will learn Emotionally Focused Couples Therapy (EFT) developed by Sue Johnson, Ed.D. This evidenced based treatment is based on the integration of attachment theory, humanistic psychology and systems theory. During the summer, students will discuss EFT literature, use the EFT training workbook, review and discuss professional training tapes and will develop and practice skills thru small group discussion and role plays. During the course of the year, the clinician will work with one or two couples. There will be weekly group supervision and scheduled individual supervision. Supervision modalities include discussion of the case and review of videotaped sessions. The minor requires an intern to commit to 5 hours a week for a full year. The treatment population will be couples who have the psychological resources to benefit from this course of treatment. These veterans will usually be relatively higher functioning (GAF above 60). Wide range of possible diagnoses.

Supervisors' Training & Experience

Dr. Neil Weissman has been an attending psychologist for the VA since 1992 and has supervised interns for these 19 years. He has completed a post doctoral fellowship in the treatment of SMI from Sheppard Pratt and has received specialized training in CBT from the Beck Institute in Philadelphia. Dr. Weissman is also a certified supervisor in Emotionally Focused Couples Therapy from the International Center for Excellence in Emotionally Focused therapy.

Long Term Psychoanalytic Supervision Rotation

The minor rotation in long term psychoanalytic supervision is designed to provide a year-long experience in structured supervision in the conceptualization and treatment of long term clients from a psychoanalytic perspective. Interns will see at least one patient throughout the year, and participate in one hour of supervision with a licensed clinical psychologist. Clients are provided through referrals through the Mental Health Clinic. Supervision occurs at the Baltimore VA Medical Center, on Tuesday evenings; therefore, interns interested in this minor must commit to Tuesday evening supervision appointments and limited telephone supervision.

Supervisor's Training & Experience

Dr. Mark Nolder received his Ph.D from Texas Tech University in 1990. He completed a clinical internship at the Audie L. Murphy VA Medical Center in San Antonio, Texas. He is currently a staff psychologist in the outpatient program at the Fort Howard Community Based Outpatient Clinic. He is also an Adjunct Professor at Towson University and has his own private practice in Harford County. Dr. Nolder's research and clinical interests include: Psychoanalytic metapsychology, evidence-based psychoanalytic psychotherapy, evidence based psychotherapy relationship factors, psychotherapy supervision, psychology of music, individual psychoanalytic psychotherapy.

Mental Health Assessment and Referral Clinic

Training in this minor rotation will focus on competency as a generalist in outpatient practice. Core skills will include assessment utilizing structured diagnostic interviews, bio-data, and objective psychological tests and psychotherapy using cognitive-behavioral model, psychodynamic, and/or integrative models. Interns will conduct at least one intake per week, have an opportunity to integrate interview, bio-data and psychometric assessment to assist in case formulation for treatment and consultation to other mental health disciplines, and carry a limited clinical caseload for treatment. Ideally this will include following several cases from

intake to resolution, including assessment, psychotherapy and case-management. The program is also currently moving toward more group-based models of treatment, so experience in leading (and possibly developing) a treatment group may also be a part of this experience. Training/education in administrative, program development, and leadership roles in psychology may also be available as an optional part of the rotation for the interested student, via Dr. Raney.

This rotation will emphasize evidence based practice in assessment and treatment. Primary psychological instruments used will include brief structured interviews and objective psychometric tests (the PAI, MMPI-2, and NEO-PI-R). This will include integration of well-validated computerized expert system test interpretation programs. Treatment modalities will emphasize evidence-based cognitive and behavioral techniques that have broad application across a number of diagnoses. The time frame and scope of the rotation is flexible lasting between 6 and 11 months with a time commitment between 4 and 8 hours per week. Rotation scope, time commitment, objectives and core skills, will be developed depending upon intern needs and skill level.

An average of 180 MHARC intakes occur a month. Past demographic information of the population seen in the MHARC included a mean age of 48 years; roughly 85% were male, 15% female. Approximately two-thirds of patients were African American, about a quarter White, and the rest Hispanic, Asian, and Native American. The diagnostic breakdown in past years was 38% substance abuse, 18% Major Depression, 16% PTSD, 14% Other anxiety disorders and adjustment disorders, and 6% Bipolar and schizophrenia. The demographics have been changing with patients becoming younger and an increasing number of Hispanic and female patients. An increasing number of the patients seen are those soldiers recently returning from Operations Iraqi Freedom and Enduring Freedom.

Supervisor's Training and Experience

Dr. David J. Pollin received his PhD in clinical psychology from Duke University. He interned at Walter Reed Army Medical Center in 1986 and afterwards served as a uniformed psychologist in the U.S. Army. He was chief psychologist at Evans US Army Community Hospital in Colorado Springs, and treated casualties during the Grenada and Panama campaigns, and the Gulf War. His area of concentration was psychological assessment and brief therapy. From 2003 – 2008, Dr. Pollin consulted on loan to the Army from the VA, part time at the Behavioral Health Clinic at Kirk US Army Clinic at Aberdeen Proving Ground. At APG he provided treatment and fitness for duty evaluations to advanced students, cadre, and OIF/OEF returning soldiers. Dr. Pollin completed a certification course and multiple workshops in Cognitive Therapy. Dr. Pollin has also had EMDR, Cognitive Processing therapy, and Prolonged Exposure training. He is a subject matter expert in assessment of police applicants and officers and was recently a member of panel presenting a national VA satellite broadcast to train VA psychologists in this area. Dr. Pollin has been at VAMHCS for the past 17 years and works in the Perry Point and Baltimore outpatient mental health clinics and PTSD programs. Principal duties include initial evaluation and referral, consultation in assessment and psychological testing, and pre-hire and fitness for duty assessment to the VAMHCS Police Department (40% combined). In addition to training and supervision (10%) a principal role is providing individual and group psychotherapy (50%)

Dr Matthew Raney, Outpatient Mental Health Clinic Coordinator, is secondary supervisor. Dr.

Raney completed his Ph.D. at the University of North Carolina-Chapel Hill and internship at the Baltimore VA Medical Center in 2003. He thereafter worked in the Substance Abuse Treatment Program at the Baltimore VAMC until 2005, at which time he helped create and subsequently coordinated the Health Improvement Program. During this time, he also implemented the Mental Health Assessment and Referral Clinic (MHARC) intake model at the Perry Point VAMC and coordinated that program. In 2008, he began serving as the Associate Director of the VAMHCS/UMB Psychology Internship Consortium, and left the Health Improvement Program to serve as the Acting Coordinator (and subsequently Coordinator in 2009) of the Mental Health Clinic (MHC) and MHARC at the Baltimore VAMC. Dr. Raney's current interests primarily relate to his present role, and therefore focus on administrative, program development, and leadership roles in psychology.

Opioid Agonist Treatment Program

The minor in the Opioid Agonist Treatment Program represents the opportunity to gain specialized training in treating the cognitive, emotional and physical sequelae of serious mental illness on a smaller scale. The time commitment for a minor in the OATP will consist of approximately 3-6 hours per week, and will be decided between the intern and supervisor. Please see page 20 for a full description of the OATP major rotation for additional information.

Supervisor's Training and Experience

Minu Aghevli, Ph.D. is the primary supervisor for this rotation. Dr. Aghevli earned her Ph.D. from University of Maryland at College Park in 2004, and completed her internship at the Baltimore VA. She spent several years post-doctorate working in clinical substance abuse research and substance abuse treatment policy with Dr. Liberto, and has published in the area of severe mental illness. She became a staff psychologist in the OATP in 2006. Interns also benefit from consultation with other members of an experienced interdisciplinary treatment team, including other psychologists, psychiatrists, nurse-practitioners, nurses, social workers, and addiction therapists.

Primary Care Minor (Loch Raven)

The VA Community-based Outpatient Clinic (CBOC) provides general primary care and mental health treatment for veterans in a community setting. CBOCs are multidisciplinary standalone clinics allowing veterans to receive their medical care close to where they live and work. The Loch Raven CBOC is staffed by internal medicine physicians, nurse practitioners, pharmacists, audiologists, social workers and nurses. Mental Health Services are embedded in the clinic, and the mental health clinician's role as a co-located specialist is to provide assessment, consultation and treatment for veterans accessing the clinic. This rotation affords interns the opportunity to work as part of a fully integrated health care team, directly interacting with medical staff regarding psychological and medical patient care. Collaboration with medical providers occurs through interdisciplinary case conferences, consultations and in some cases, conjoint appointments. Patients benefit by improved access to behavioral health services, decreased stigma and improved communication across disciplines.

Training goals for the minor rotation include (a) gaining experience with a wide range of behavioral health presenting problems such as nicotine dependence, weight management, sleep disorders, diabetes management, compliance with medical treatment, and adjustment to chronic disease; (b) providing services through an Integrative Care model of treatment and/or (c) providing weight management services through the MOVE! program. The time commitment for this rotation is somewhat flexible, and depends on the focus of training the intern chooses, but

can range from 4 months to a full year commitment. Best days to be on site for this minor are Monday-Wednesday.

Training and supervision will include systematic didactic and psychotherapeutic exposure to the following empirically validated psychotherapeutic approaches to treatment:

1. Cognitive Behavioral Treatment of Obesity as researched by Judith Beck, 2007
2. The fundamentals of Cognitive Behavioral Treatment (Beck, A 1979; Beck, J 1995)
3. Interns will also be trained in the fundamentals and application of Motivational Enhancement Therapy (MET; Miller & Rollnick, 1991), particularly the technique of motivational interviewing as it applies to the phase of change model of motivation (Prochaska, Diclemente, & Norcross, 1992).

Interns can expect to be exposed to a number of different clinical responsibilities including leading psychoeducational groups, providing brief individual interventions in a primary care setting, and receiving one hour of supervision per week as well as providing consultation and assessment to Primary Care Staff. Interns may also be expected to provide crisis interventions such as assessment of suicidal/homicidal ideation and plans. Interns may choose to co-facilitate the MOVE Clinic (Managing Obese/Overweight for Veterans Everywhere) or may choose to focus their minor experience on the implementation of brief cognitive therapy through an integrative care model. The diverse nature of the presenting problems within the Primary Care Clinic will allow interns to receive training in a variety of approaches to empirically supported treatments for their individual cases. The variety of individual treatments available will likely include one or more kinds of relaxation training exercises, behavioral coping skills training, motivational interviewing, cognitive-behavioral psychotherapy and crisis intervention (Miller & Rollnick, 1991; Budman & Gurman, 1988; Barlow, Hayes, & Nelson, 1984).

Supporting Literature

The CBOC rotation focuses on primarily cognitive behavioral and psychoeducational interventions both of which have solid empirical support for a wide variety of health problems as well as traditional mental health presentations. For depression related to medical issues, Dobson (1989) and Beck et al. (1979) offer solid support for cognitive behavioral therapy as an effective treatment. Barlow (1988) provides extensive research evidence indicating effectiveness of cognitive-behavioral therapy for a wide range of anxiety disorders, which often accompany medical conditions. Cognitive-behavioral approaches to the psychological treatment of obesity demonstrate the effectiveness of patient self-monitoring, contingency management, stimulus control and cognitive restructuring techniques (Beck, 2007). Interns will also utilize relaxation procedures, including progressive muscle relaxation and guided imagery; and other cognitive-behavioral approaches, including skills such as cognitive reframing and behavioral activation (Foa et al., 2000).

Supervisor's Training and Experience

Interns will be supervised by Dr. Cheryl Lowman, who received her Ph.D. in Counseling Psychology from the State University of New York at Albany in 1990. The graduate faculty was cognitive-behavioral in orientation and provided extensive training in this evidenced-based approach. Dr. Lowman completed her psychology pre-doctoral internship at the VA Maryland Healthcare System Internship Consortium in 1990. Dr. Lowman has had over 17 years experience in the VA working with veterans and has applied her training to diverse populations. She has previously worked with inpatient and outpatient substance abusers, Inpatient Psychiatry Women's

Program, Women Veterans Programming, Sexual Trauma Team programming, Domiciliary Care and Outpatient Mental Health before coming to the CBOCs.

In her 22 years since attaining her Ph.D., Dr. Lowman has further enhanced her knowledge and range of cognitive behavioral interventions with the primary care population by attending CME activities. Most recently she has enrolled in a 6 month intensive CBT training project through the VA Office of Mental Health Services.

Dr. Lowman has had 18 years of experience supervising pre-doctoral interns as a long-time member of the Perry Point Pre-Doctoral Internship Training Committee. She has previously supervised major rotations in Substance Abuse, Inpatient Psychiatry and the Homeless Domiciliary. Dr. Lowman is also providing consultation services to the Baltimore Vet Center where she provides case consultation and treatment planning. She has functioned as a facilitator for the VISN 5 High Performance Development Program (HPDM) program, Internship Training Committee, Women Veterans Coordinator as well as teaching for Harford Community Colleges and local businesses.

Psychosocial Rehabilitation (Harbor City)

*(*This minor is only available to UM interns)*

The minor in Psychosocial Rehabilitation involves providing clinical services at Harbor City Unlimited (HCU), a psychosocial rehabilitation program that is affiliated with the University of Maryland School of Medicine Department of Psychiatry's Division of Community Psychiatry. HCU provides psychiatric rehabilitation services including residential rehabilitation, a day program, off-site supported living, and vocational rehabilitation services to adults with SMI. The day program provides access to and assistance with social, recreational, educational and personal adjustments into the community, and offers a clubhouse model organized into units responsible for the daily operation of the program. Interns have the opportunity to do a minor rotation at Harbor City, leading social skills training and other behavioral health oriented groups to consumers with serious mental illness who attend this program. HCU is located approximately one mile from the main campus (approximately a 5 minute drive); the clinic has ample parking available.

Supervisor's Training and Experience

Melanie Bennett, Ph.D. is an Associate Professor of Psychiatry at the University of Maryland, School of Medicine, and a researcher at the Center for the Behavioral Treatment of Schizophrenia. Her work has focused on the assessment and treatment of substance use disorders in individuals with serious mental illness, with a particular emphasis on tailoring empirically supported interventions and motivational enhancement approaches for this group of substance abusers. Dr. Bennett supervises half of the therapy caseload for the Outpatient Psychiatry Clinic (2nd floor) and half of the therapy caseload for the Community Psychiatry Fayette Clinic (3rd floor).

Psychosocial Rehabilitation and Recovery Center (Health Focus)

A minor in the PRRC with a health focus would benefit interns who would like to gain experience working with individuals with serious mental illness who have comorbid physical illnesses, including diabetes, high blood pressure, infectious diseases, and obesity. This minor rotation is offered in the PRRC in Baltimore on Tuesdays with Dr. Calmes who has a special interest in comorbid physical and mental health concerns. Interns involved in this minor rotation would spend one day per week with Dr. Calmes co-leading MOVE! Weight management groups, a monthly Hepatitis C support group, Social Skills training (SST) focused on improving

communication with health care providers, and a chronic illness support group. There are also opportunities for individual case management during this minor rotation.

Supervisor's Training and Experience

Dr. Christine Calmes received her doctorate from the State University of New York-Buffalo and completed her pre-doctoral internship at the University of Maryland/VA Maryland Healthcare System (VAMHCS) consortium through the VA serious mental illness track. She completed one year of a post-doctoral fellowship through the MIRECC in which her research and clinic interests focused on family involvement in the mental health care of Veterans with serious mental illness and internalized stigma associated with mental illness. Dr. Calmes has continued involvement in research with MIRECC investigators and is involved with program evaluation efforts through the PRRC. She also serves as the VAMHCS Evidence Based Practice coordinator.

Sexual Offenders Clinic

*(*This minor is only available to UM interns)*

The Special Offenders Clinic at the University of Maryland School of Medicine provides evaluation and treatment for sexual offenders who have been referred to treatment as a condition of their parole or probation. The Clinic operates only on Tuesday evenings. Interns are required to attend from 4:45 to 6:45, during which they will attend the staff's team meeting, or evaluate offenders for admission into the program, and cofacilitate one group. Trainees will learn how to evaluate, conduct standardized risk assessments, and do treatment with sexual offenders. Interns do not conduct individual interviews with offenders until they indicate they are comfortable doing so.

Supervisor's Training and Experience

Supervision is provided by Dr. James Fleming. Dr. Fleming received his Ph.D. in Clinical Psychology from the California School of Professional Psychology, San Diego in 1995. For the past 17 years he has worked in forensics and corrections and made many presentations on the risk assessment and treatment of sex offenders and violent offenders. In addition to working at the Special Offenders Clinic, he is Psychology Services Chief at Patuxent Institution, Maryland's treatment-oriented maximum security prison, and an advisor to the Governor's Sexual Offender Advisory Board.

Telemental Health

The primary setting for this rotation is virtual. While stationed at Baltimore, the Baltimore Annex, Loch Raven or Glen Burnie, psychology interns will meet with veterans in the Tele Mental Health (TMH) program. Therapy sessions will occur via video teleconference to one of two VA Community-based Outpatient Clinics (CBOC) : 1) the Cambridge CBOC; and/or 2) the Pocomoke CBOC, both located on the Eastern Shore of Maryland. The Eastern Shore CBOCs are staffed by psychologists, psychiatrists, medical and mental health social workers, physicians, nurse practitioners, and a pharmacist. Mental Health services are integrated into the primary care clinic. The role of the supervising psychologist within the TMH program is to provide Specialty Mental Healthcare related to PTSD/SUDS. However, the intern may also have the opportunity to work with patients struggling with more general mental health conditions. In addition, this rotation affords interns the opportunity to work as part of an integrated healthcare team, directly interacting with both primary and mental healthcare providers, as well as staff specifically designated to TMH services.

Veterans seeking care at the Cambridge and Pocomoke CBOCs are generally high functioning, motivated and employed or retired. Interns will have the opportunity to work with both male and female veterans, who live in a rural setting and who have mental health issues that are sometimes exacerbated by issues associated with rural living. The veterans are generally 18 and older and varied in their ethnic and racial backgrounds, with the majority being Caucasian. Interns can expect to gain experience with a variety of diagnostic and treatment issues, including PTSD, Substance Abuse (the most common substances of abuse among these veterans include alcohol, marijuana, prescription drugs, and some use of cocaine and heroin); Depression, Anxiety, and Bipolar Disorder. Actively psychotic and/or suicidal veterans are not generally seen via TMH. However, in the event that a patient becomes suicidal, support staff and licensed providers on the patient side are readily available to assist with emergencies. During this rotation, interns will function as an integral part of a TMH team, which includes the attending prescriber, the supervising psychologist, the TMH psych tech, and the TMH health tech. The intern will serve as the primary therapist for veterans seeking treatment for one or more diagnoses, including substance dependence, PTSD, mood disorders, and other mental illnesses. Training and supervision may include didactics and hands-on exposure to the following evidenced-based therapies:

- a. The basics of the TMH modality, including the TMS training that is required prior to providing TMH services.
- b. The fundamentals of the Motivational Interviewing approach to treating addictions (MET; Miller and Rollnick, 1991), particularly as it applies to the phase of change model of motivation (Prochaska, Diclemente, and Norcorss, 1992).
- c. The tenets of exposure-based therapies for the treatment of PTSD and other anxiety disorders, including the use of Prolonged Exposure Therapy via TMH (Foa, Hembree, Rothbaum, 2007; Craske and Barlow, 2007)
- d. The essentials of Cognitive Behavioral Treatment (Beck, A., 1979; Beck, J., 1995;)
- e. The fundamentals of Seeking Safety therapy for the concurrent treatment of PTSD/SUDS (Najavits, L., 2002)
- f. The use of Mindfulness approaches to treat depression, anxiety, and other mental health disorders (Segal, Williams, Teasdale, 2002; Linehan, 1993; Hayes, 2005).

Ideally, interns will do a year-long rotation in the TMH minor rotation, however, shorter rotations may be possible. Interns will carry an individual patient caseload, and possibly conduct group therapy via TMH as the TMH program expands (currently there are no TMH groups). Interns will conduct full psychosocial assessments to include the diagnosis of and differentiation between substance use, abuse and dependence disorders; the distinctions between PTSD, GAD, Depression, other Anxiety Disorders, and TBI; and differentiate and understand co-morbidity and the need for concurrent treatment of substance abuse, PTSD, mood disorders and other psychiatric disorders. Interns will use assessment tools such as the Beck Depression Inventory; Beck Anxiety Inventory; the Life Events Check list, and the PCL and Clinician-Administered PTSD Scale.

Supporting Literature

The majority of our nation's veterans are from rural areas, where patients may have to drive long distances to meet with a mental health provider. In the VA, telemental health (TMH) is an increasingly common mode of treatment delivery, and has been shown to be an effective mode of delivery treatment (Shore et al., 2012). Studies to date are promising, and have shown no significant differences in patients' perceptions of the therapeutic alliance, post-session mood, or

overall satisfaction with services when telemental health and face-to-face modalities are compared (Morgan, Patrick, Amber and Magaletta, 2008). Additionally, providing evidenced-based therapy via telemental health to combat veterans in a rural setting has been shown to be practicable and to produce outcomes that are as good as in-person delivery of the same treatment (Morland, Greene, Rosen, Foy, Reilly, Shore, He, and Frueh, 2010).

Supervisor's Training and Experience

Dr. Ann E. Smith is a clinical psychologist at the Cambridge CBOC, where she co-supervises an ongoing PTSD/SUDS externship program, which includes opportunity for externs to participate in TMH. Prior to joining the VAMHCS, Dr. Smith was the PTSD/SUDS specialist at the Bronx VA, in New York City. She developed the Integrated Recovery Services program, designed to provide concurrent treatment for veterans with both disorders. Dr. Smith was part of the PTSD research team, and also taught and supervised psychology interns in the Bronx VA internship training program. Previously, Dr. Smith was a Senior Psychologist at the North Bronx Healthcare Network, and a clinical supervisor in the Growth and Recovery Program. She led a year-long experiential psychotherapy seminar that was an integral part of the psychology internship training program. She was formerly a thesis advisor for Pratt Institute in New York City, and on faculty at New School University and the Institutes for the Arts in Psychotherapy. Dr. Smith received her doctorate at Fielding Graduate University and completed her doctoral internship at Columbia Presbyterian Medical Center in Manhattan, where she fulfilled a year-long rotation in Dialectical Behavior Therapy (DBT). As part of her ongoing training as a psychologist, she has trained in Prolonged Exposure Therapy (through the VA's PE Initiative), Mindfulness-based Cognitive Therapy, and Motivational Interviewing. Additionally, she incorporates other evidence based therapies into her work with veterans, such as Cognitive Processing Therapy and Seeking Safety.

University of Maryland Substance Abuse Treatment

*(*This minor is only available to UM interns)*

The Outpatient Addiction Treatment Services (OATS) offers a full continuum of outpatient addiction services to adult patients with a variety of substance use disorders. This program supports the patients in their pursuit to improve their biopsychosocial quality of life. The program utilizes a "phase" system whereby the treatment intensity may increase or decrease based on progress towards treatment goals. Phase 1 includes clients who are initiating treatment or are still engaging in use. A client who is abstinent may remain in Phase 1 because of concerns that may still impact recovery. In Phase 2, clients have generally achieved abstinence and begin to address emotional and interpersonal issues that may impact recovery. A client may attend Phase 2 but still use because he or she has demonstrated progress since admission such as significant reduction in use and the issues presented may be better addressed in this Phase. In Phase 3, clients have obtained and maintained abstinence and are developing plans for relapse prevention and ways to obtain goals such as employment, housing or family reunification. On average a client may remain in a particular phase of treatment for 6-8 weeks. Structured treatment can range from one to 20 hours per week, depending on the phase of treatment. A multidisciplinary approach to treating addiction is utilized, with services including: individual therapy, gender specific group therapies, dual diagnosis groups, case management, education, acupuncture, parenting classes, trauma counseling, and groups targeting grief and loss. Suboxone or methadone maintenance in conjunction with therapy can be provided for clients who meet criteria. Services are provided by a multidisciplinary team of psychiatrists, social

workers, addiction counselors, a child life specialist, an acupuncturist and master's level clinicians. Interns can be involved in providing individual and group treatment at OATS. Supervision is provided by Melanie Bennett and Michael Papa.

UNIVERSITY OF MARYLAND ADULT PSYCHOLOGY TRACK

Overview

The University of Maryland Adult Psychology Track is located within the Department of Psychiatry at the University of Maryland, School of Medicine. The Department of Psychiatry has a long-standing commitment to the scientific study and treatment of individuals with serious and persistent mental illness, and so provides a particularly rich environment for clinical training and research on schizophrenia and other serious mental illnesses. Two clinical sites within the Department of Psychiatry are part of the University of Maryland Adult Psychology Track: The University of Maryland General Adult Psychiatric Clinic and the University of Maryland Community Psychiatry Fayette Clinic. These clinics have a long history of serving the mental health needs of individuals in the public sector in the Baltimore metropolitan area and adhere to a Recovery Model that emphasizes strength, hope, respect, and empowerment. Within this model, recovery is considered a process, not an end state or outcome. Services at both clinical sites are provided with an emphasis on evidence-based practice and client involvement in the treatment process, including collaboration on the selection of treatment targets and intervention strategies.

The population served at both clinics is diverse with regard to both diagnosis and illness severity. The location of these clinics in downtown Baltimore means that they serve an urban population that experiences significant barriers to mental health care and recovery. Both clinics serve adults age 18 and over who present with a broad range of emotional and behavioral problems, including mood disorders, anxiety disorders and post-traumatic stress disorder, schizophrenia and other psychotic disorders, personality disorders and co-occurring psychiatric and substance use disorders. Referrals to these clinics come from a many sources, including the department's Psychiatric Assessment and Referral Center, Psychiatric Emergency Services, the Inpatient Psychiatry Unit at the University of Maryland Medical Center, clinics within the department's Child and Adolescent Psychiatry Division, programs within the University of Maryland Medical Center, and the surrounding community. Both clinics provide intake and diagnostic evaluation, individual and group therapy, medication evaluation and management, and case management services. In addition, both clinics adhere to a multidisciplinary team model that includes psychiatrists, psychiatric residents, social workers, and nurses along with the psychology intern. Importantly, both clinical sites work to incorporate empirically validated interventions as part of clinical service, and function within a mental health service delivery system that is adapting to the demands of an ever changing mental health care environment.

Each Adult Psychology Track intern has a year-long placement at one of these two clinics. At both, the intern serves as an integral member of the clinic's multidisciplinary team and functions with increasing independence as the year progresses. Both interns gain supervised experience providing a range of services including intake and diagnostic evaluation, individual and group cognitive-behavioral and behavioral interventions, and psychological assessment. Interns can co-lead behaviorally oriented treatment groups on topics related to coping and symptom management, trauma, CBT for psychosis, dual disorder, social skills training, and health behavior change topics such as smoking cessation. Interns may be afforded the opportunity to develop group treatments that they hold interest or expertise in as well. Opportunities also exist for co-leading groups related to coping with grief and loss, empowerment, fighting self-stigma, and recovery. As part of the treatment team, interns attend team meetings and present at case conferences. Interns at both sites are also involved in aspects of case

management for many clients in order to support their engagement and success in mental health treatment. Interns at both clinics maintain a caseload of approximately 20 individual therapy cases and co-lead two groups. They receive approximately two to three hours of individual supervision and one to two hours of group supervision per week from psychologists and, when applicable, other mental health professionals. Additional administrative supervision is also provided to ensure that interns function in accordance with clinic procedures. Overall, the opportunity to complete a year-long placement at these clinics allows the intern to function as the face of psychology within the larger treatment team, and to provide services with the context of a community mental health clinic for an extended period of time.

University of Maryland General Adult Psychiatric Clinic (701 W. Pratt Street, 2nd Floor)

The 701 General Adult Psychiatric Clinic is a clinical program that provides comprehensive assessment, psychiatric diagnostic evaluation and a variety of treatment interventions for a wide range of mental health problems. Located on the western side of downtown Baltimore, Maryland the program serves a mixed population including the local community composed of predominantly inner city poor as well as serving sister programs within the University of Maryland Medical Center in need of outpatient mental health services, such as the Shock Trauma Center and Womans Health Center. Service recipients are between 18 and 65 years of age, the majority being diagnosed with affective and anxiety disorders. The staff is composed of psychologists, a psychiatric nurse, social work, third year psychiatric residents, a psychology intern and staff psychiatrists. The clinic has developed a trauma informed approach to care given that the majority of our clients have been subjected to childhood and/or adult trauma that influences their symptoms and response to treatment.

Treatment modalities in the clinic include individual psychotherapies (psychodynamic, interpersonal, supportive, brief and CBT) group therapy (both trauma and substance abuse focused) and medications prescribed by on site clinic psychiatrists. Additional training opportunities exist for learning DBT, motivational interviewing and other empirically supported interventions. Interns will have opportunities to facilitate specialty groups, do comprehensive assessments for anxiety, PTSD and depression and assist with a limited amount of psychological testing.

The Psychology Intern is a full member of the treatment team, providing individual and group treatment as well as intake and psychological assessments. Clients present with a wide array of difficulties and diagnoses. Most common are moderate to severe mood and anxiety disorders and bipolar spectrum disorders. Substance abuse histories are not uncommon. Most clients report a developmental history of trauma that affects emotion regulation and their ability to function effectively in their environments and with others. A typical case load usually has 20-25 clients, who are most frequently low-income minority women with children living in urban settings, but not exclusively. There are opportunities to do couples therapy and family sessions with other adult family members. A strong relationship with the child clinic on the same floor has been fostered such that children of adult clients can be referred for treatment in-house and/or the family as a whole can be referred to treatment. On the treatment team, the Psychology Intern plays an important role in providing a psychological perspective of the development of psychopathology and of recovery and trauma-informed treatment, and is expected to actively participate in all aspects of treatment plan development and relevant clinic operations.

University of Maryland Community Psychiatry Fayette Clinic (701 W. Pratt Street, 3rd Floor)

The Fayette Clinic specializes in the treatment of seriously and persistently mentally ill adults residing in and around the western side of downtown Baltimore, Maryland. Overall, 41% of service recipients

are between 18 and 45 years of age, 47% are between 46 and 60, and almost 400 (25%) are diagnosed with a schizophrenia spectrum disorder. Poverty and other social problems complicate the clinical picture of many clients, as well as a variety of somatic problems, including HIV+/AIDS. As noted above, a number of services are available at the Fayette Clinic, and the intern is involved in providing all of these services to individuals on his/her caseload.

The Psychology Intern is a full member of the Adult Team at the Fayette Clinic, carrying a caseload of approximately 20 clients who experience serious mental illness. The multidisciplinary team of psychiatrists, social workers, and clinical nurses works together to provide psychological and psychiatric care. This is a very cohesive clinic where many staff members have worked for decades. The intern provides a significant amount of case management/care coordination services, which may be in concert with other services within the Division of Community Psychiatry, including the Continuous Care Team for those who use services more frequently (described above), intensive case management services, the Child/Adolescent Team, and an affiliated Psychosocial Rehabilitation Program located nearby. The intern also works with social workers on the team to identify appropriate resources in the community. The clinic has a strong dedication to dual diagnosis services, with a specialist in this area and several groups for clients at different stages of change in their addictions.

The Fayette Clinic runs alongside two specialty teams in the Division of Community Psychiatry that provide services for individuals requiring increased intensity of services: the Continuous Care Team (CCT) and the Program of Assertive Community Treatment (PACT). CCT is an intensive psychiatric treatment and case management service located on the 3rd floor alongside working closely with the Fayette Clinic. It is designed to assist individuals with serious and persistent mental illness. The goal of the CCT is to reduce the incidence of psychiatric hospitalizations and to improve individuals' ability to function in the community by providing consistent outreach and coordination of care in all aspects of treatment. PACT is an interdisciplinary mobile outreach treatment team that is staffed by psychiatrists, nurses, social workers, counselors and an employment specialist. The PACT Team was initially a federally funded research project to determine the effectiveness of a PACT model with homeless mentally ill adults. As of August 1993, it has become a freestanding treatment service in the Division of Community Psychiatry. In addition, interns work closely with staff at a psychiatric rehabilitation center run by the Division called Harbor City Unlimited (HCU). HCU provides psychiatric rehabilitation services including residential rehabilitation, a day program, off-site supported living, and vocational rehabilitation services to adults with SMI. The day program provides access to and assistance with social, recreational, educational and personal adjustments into the community, and offers a clubhouse model organized into units responsible for the daily operation of the program. Interns often have individual clients who also attend HCU, as well as have the opportunity to do a minor rotation there.

Supervision

Clinical supervision is provided by several University of Maryland Faculty. The main Adult Track supervisors are as follows:

Laura Anderson, Ph.D. Dr. Anderson is a psychologist at the Outpatient Psychiatry Clinic (2nd floor). She conducts group supervision, postgraduate training, and individual/group psychotherapy. Her interests include treatment of complex trauma, dialectical behavior therapy, psychodynamic conceptualization, mindfulness, therapeutic alliance, supervision and training. Dr. Anderson supervises half of the therapy caseload for the Outpatient Psychiatry Clinic (2nd floor).

Melanie Bennett, Ph.D. Dr. Bennett is an Associate Professor of Psychiatry at the University of

Maryland, School of Medicine, and a researcher at the Center for the Behavioral Treatment of Schizophrenia. Her work has focused on the assessment and treatment of substance use disorders in individuals with serious mental illness, with a particular emphasis on tailoring empirically supported interventions and motivational enhancement approaches for this group of substance abusers. Dr. Bennett supervises half of the therapy caseload for the Outpatient Psychiatry Clinic (2nd floor) and half of the therapy caseload for the Community Psychiatry Fayette Clinic (3rd floor).

Alicia Lucksted, Ph.D. Alicia is a clinical-community psychologist, research faculty at the UMB Psychiatry Dept. Center for Mental Health Services Research, and the VISN-5 VA MIRECC. She supervises half of the individual therapy caseload for the Community Psychiatry Fayette Clinic (3rd floor).

Administrative supervision is provided for each intern by a member of that clinic's administrative and clinical staff.

Assessment

Consistent with the overall Consortium assessment requirements, both UM Adult Track interns will complete 6 assessment batteries and reports during the internship year. Often, interns will receive referrals from their clinic's team. Assessment referrals range from in-depth diagnostic assessment of complex situations to assessment of personality to testing for cognitive and intellectual functioning. Interns complete supervised assessment and write up of assessment findings, as well as provide feedback and education regarding recommendations to clients and other clinicians on the treatment team.

Minor Rotations

UM Adult Track interns can opt to participate in minor rotations/placements throughout the year and can tailor these experiences to their interests and schedule. A description of options for minor rotations/placements that are currently open to UM Adult Track interns is presented on Page 43-49. In addition, interns can create a minor in an area of their interest, pending scheduling, availability of supervision, etc. Minor rotations are discussed after the internship formally begins.

UNIVERSITY OF MARYLAND CHILD OUTPATIENT PSYCHOLOGY TRACK

Patient Population

The Child Outpatient Program at the University of Maryland School of Medicine consists of rotations in specialized outpatient clinics (Affective Disorders, Trauma), the Taghi Modarressi Center for Infant Study/Secure Starts, and the Maryland Psychological Assessment and Consultation Clinic. Patients seen during these rotations include children from birth to age 18 and their families. Although we see families from diverse ethnic and racial backgrounds, over 75% of patients are of African-American descent.

Assessment and Intervention Training

The 701 Outpatient Rotation will allow the intern to participate two days a week in specialty clinics (the trauma clinic and the affective disorders clinic) for children ages 6 to 18. The Child and Adolescent Psychiatry Clinic serves children and adolescents (ages 5 through 18) with emotional, behavioral, developmental or learning problems. The Clinic offers a range of services: evaluation, psychological assessment, consultation, and brief or long-term therapy. Treatment includes individual, family and group therapy and parent counseling. Specialized group therapy and multi-family groups are offered for children, adolescents and parents. Specialty clinics include Affective Disorders and PTSD/Trauma. There are approximately 5,000 patient visits per year in the Child Psychiatry clinic. Therapeutic

modalities include family systems and cognitive behavioral approaches. These are combined with psychopharmacological intervention when indicated. Family involvement is emphasized for both diagnostic and therapeutic services. In addition, collaborative working relationships are developed with schools, physicians and other programs and communities. The patient load will include 12 to 14 individual psychotherapy patients in addition to co-leading outpatient groups. Interns will receive supervision a minimum of one-half hour per week with Dr. Kiser for work in the Trauma clinic and one hour per week with Dr. Phillips for work in the Affective Disorders Clinic in order to review cases, provide further intervention training, and establish concrete treatment plans. Additional supervision will be provided by other clinic staff.

The intern will be placed two days a week in the Secure Starts Clinic within the larger Taghi Modarressi Center for Infant Study (CIS). This placement will allow the intern to specialize in work with children from birth to age five. Secure Starts provides traditional outpatient therapy as well as consultation and more intensive work at the community level. Secure Starts provides multidisciplinary care in an outpatient setting for children from birth to age five with emotional and behavioral concerns. The program encourages active participation of parents and caregivers and works collaboratively with involved agencies. The CIS offers a range of services: diagnostic assessment, psychological testing, consultation, and brief and long-term psychotherapy. Treatment includes individual, family and group therapy, as well as play therapy and parent counseling. Interns will participate in an early childhood mental health consultation project in community settings such as a pre-school setting or a homeless or domestic violence shelter. Current research activities involve assessment of the relationship between social competence and behavior problems, parenting factors and parenting stress, and a study of routines and other related behaviors in preschool children. The patient load will include 10 to 12 individual psychotherapy patients in addition to co-leading outpatient groups. The intern will receive supervision at least one hour per week with Dr. Kiser in order to review cases, provide further intervention training, and establish concrete treatment plans for individual patients and their families. Additional supervision will be provided by other Secure Starts staff.

Both programs for child interns involve interdisciplinary training experiences and the opportunity to work as part of a team. Within the CIS and the Outpatient Rotation, there is opportunity available to be part of various research initiatives.

Support from Literature

Cognitive-behavioral therapy (CBT) is one intervention for childhood PTSD with empirical support. Numerous detailed descriptions of CBT approaches with traumatized children exist (Cohen, Berliner, & Mannarino, 2000; Parson, 1997). Several manualized interventions are available (Deblinger & Heflin, 1996; March, Amaya-Jackson, Murray, & Schulte, 1998). One CBT model, Trauma Focused-Cognitive Behavioral Therapy (TF-CBT), has been studied in numerous randomized, controlled clinical trials (RCT); multiple published studies support its effectiveness (Cohen, Deblinger, Mannarino, & Steer, 2004; Cohen & Mannarino, 1996; Cohen & Mannarino, 1996; Cohen & Mannarino, 1997; Cohen & Mannarino, 1998; Cohen, Mannarino, & Knudsen, in press; Deblinger, Steer, & Lippman, 1999). In general, the treatment manualization, control design, training of clinicians, fidelity checks, and follow-up in these studies were exemplary.

Participants in these RCTs included children between the ages of 8 and 17 years; one study focused on 3 to 7 year olds. All of the children experienced sexual abuse. One sample included 229 multiply traumatized children with sexual abuse-related PTSD symptoms. Racial composition of these samples was mixed but predominantly Caucasian. The non-offending parent/primary caretakers participated in all of the trials.

Randomized controlled trials compared TF-CBT (12 weeks) with nondirective supportive therapy (NST), consisting of play therapy for children and supportive therapy for parents, child centered supportive therapy (CCT), and community treatment as usual (TAU). One RCT compared multiple formats of TF-CBT including treatment with child only, mother only, and both child and mother. Results indicated that TF-CBT was significantly better than NST, CCT, and TAU for improving children's PTSD, internalizing, externalizing, and sexual problems. Differences were sustained for up to 24 months. TF-CBT for child and parent was superior to TF-CBT for either parent or child alone. Currently, RCTs of TF-CBT are being conducted on TF-CBT plus sertraline versus TF-CBT plus placebo for 10 to 18 year olds with sexual abuse-related PTSD, TF-CBT versus TAU for children with domestic violence-related PTSD symptoms, and TF-CBT versus treatment without exposure components, 8 versus 16 sessions (K02 MH1938 (Cohen), R01 MH72590 (Cohen), R01 MH64635 (Mannarino)). Given the positive findings across multiple RCTs conducted by several research groups, TF-CBT is labeled an evidence-based practice (Bisson, 2005; Chadwick Center for Children and Families, 2004; Saunders, Berliner, & Hanson, 2004; Substance Abuse and Mental Health Services Administration, 2005).

CBT and medication are the most common forms of treatment for patients in the Affective Disorders Clinic (Hollon, Garber & Shelton, 2005; Kazdin & Weisz, 2003; Lewis, 2003; March, 1995; Melvin *et al.*, 2006; Rohde, Feeny, & Robins, 2005).

Supervisors' Training & Experience

Interns' individual therapy will be supervised by Dr. Laurel Kiser and Dr. Sheridan Phillips, as well as other multi-disciplinary staff, including Ms. Kay Connors, and Ms. Vickie Beck.

The staff in the Secure Starts and Subspecialty Clinics have received extensive training in the use of specific and tested interventions through graduate school education, internship training, postdoctoral training, and specific workshops and training experiences that have enhanced their knowledge and expertise in the treatment of these specific populations and diagnostic conditions.

Catherine Weiss, Ph.D., co-directs the Maryland Psychological Assessment and Consultation Clinic. She received her Ph.D. in clinical/community-social psychology from the University of Maryland, Baltimore County in 2004. She completed her clinical internship and two-year postdoctoral fellowship at the University of Maryland School of Medicine. Dr. Weiss provides clinical supervision and training in implementing school-based mental health services and school-wide climate initiatives. She also provides collaborative mental health care in a primary care clinic.

Vickie Beck, A.P.R.N., B.C., is currently a lead clinician in the Child Subspecialty Clinics. She has almost over 35 years experience as a clinical nurse specialist working with abused children and their parents.

Kay Connors, L.C.S.W., is the Program Director of the CIS and a senior clinician in the Trauma Clinic, and has over 20 years of experience working with traumatized children and their families. Ms. Connors has provided mental health treatment to children and families in a variety of settings, including hospital, residential treatment, private practice, clinic, and home-based programs. Ms. Connors has directed programs, supervised staff, participated in outcome research as well as trained students and audiences locally and nationally.

Laurel Kiser, Ph.D., M.B.A., received a Ph.D. in psychology from Indiana University and a M.B.A. from the University of Memphis. She completed internship and two years of post-doctoral training in child clinical psychology. She is an Associate Professor in Psychiatry at UMB. Dr. Kiser's career focus has been on the provision and evaluation of treatment for youth living in poverty, victims of neglect, physical and sexual abuse, with moderate to severe psychiatric and behavior disorders. Her research is on the protective

role of rituals and routines for coping with trauma and she is supported by an NIMH K-23 Award for developing a manualized, multi-family skills-based intervention for traumatized families. Dr. Kiser is co-Principal Investigator of the National Child Traumatic Stress Initiative Category II Family Informed Trauma Treatment (FITT) Center. Clinically, she co-directs the Trauma Clinic. Dr. Kiser is also active in teaching and supervising Division trainees on childhood trauma in multiple venues. She provides trauma education in community settings for clinicians on assessment and treatment of young children impacted by violence exposure.

Sheridan Phillips, Ph.D., received her Ph.D. in experimental psychology from the State University of New York at Stony Brook in 1974. She then completed postdoctoral respecialization training and an internship in clinical child psychology at SUNY Stony Brook. She is an Associate Professor in the Department of Psychiatry, at the University of Maryland School of Medicine. Dr. Phillips has published extensively in the areas of behavioral pediatrics and adolescent medicine. She provides teaching and supervision to trainees in the Division of Child and Adolescent Psychiatry, primarily regarding normal child development, empirically supported treatments, anxiety disorders, and research methodology. Dr. Phillips supervises the intern's cases (typically six to eight) in the Affective Disorders Clinic. Her interests include cognitive behavioral treatment of children and adolescents, behavioral pediatrics, and adolescent medicine.

UNIVERSITY OF MARYLAND SCHOOL MENTAL HEALTH TRACK

The School Mental Health Program (SMHP) offers a considerable opportunity to provide clinical services to youth and families directly in the community through school-based services. The SMHP provides comprehensive mental health evaluation and treatment services to elementary, middle, and high school students in 25 Baltimore City Public Schools. The school program is part of the expanded school mental health movement and provides services to students to augment the services available within the school setting. The SMHP staff includes clinical psychologists, counselors, social workers and psychiatrists, as well as a diverse array of graduate trainees. The School Mental Health internship program was awarded the 2010 Award for Distinguished Contributions for the Education and Training of Child and Adolescent Mental Health Psychologists by the American Psychological Association.

Center for School Mental Health (CSMH): The Center for School Mental Health is a national resource center for advancing school mental health training, research, policy, and practice. The mission of the Center is to strengthen policies and programs in school mental health to improve learning and promote success for America's youth. Through participation in and development of a broad and growing Community of Practice, the CSMH analyzes diverse sources of information, develops and disseminates policy briefs, and promotes the utilization of knowledge and actions to advance successful and innovative mental health policies and programs in schools. The CSMH works with a wide range of stakeholders invested in integrated approaches to reduce barriers to student learning, including families, youth, educators, mental health and other child system staff, advocates, legislators, researchers and government officials. There are numerous research programs related to school mental health, including programs to address trauma (prevention and treatment), to provide universal, selected, and indicated evidence-based interventions in schools, to reduce suspensions and expulsions in students, and to document the treatment effectiveness of school mental health services.

Population Served

The University of Maryland School Mental Health Program includes children between the ages of 5 and 19 years and their families. Although we see families from diverse ethnic and racial backgrounds, approximately 85% to 90% of patients are of African-American descent. Typical presenting problems of students receiving individual and group services include: depression, anxiety, posttraumatic stress, disruptive behaviors, family conflict, peer conflict, bereavement, abuse and neglect, family and community violence, substance abuse, and academic challenges. A majority of clients meet criteria for an Axis I diagnosis.

The Center for School Mental Health is a research and policy center that serves a diverse array of stakeholders including: teachers, clinicians, families, youth, policy makers, researchers, advocates, administrators, health providers, child welfare staff, juvenile service staff, and others at local, state, national, and international levels.

Assessments, Treatments, & Supervision

The School Mental Health Rotation will allow the intern to participate three days a week in a mental health rotation within one school. A full range of mental health services will be provided within the school, including group and family therapies, prevention and mental health promotion activities, consultation, crisis intervention, and referral to appropriate community resources. Mental health interventions are focused on variables that have been shown to be important for inner city youth. Evidence-based practice, preventive services and group therapies are emphasized and all staff participate on school teams related to mental health and strive to be effective partners within the school. The intern who participates in the SMHP is responsible for coordinating and responding to referrals for mental health services as well as providing the direct services described above. There are also opportunities for participation on school teams and to be involved in the implementation of school-wide mental health promotion and prevention programs to improve the school climate (*e.g.*, violence prevention programs, mentoring, positive behavioral interventions and supports). Primary therapeutic modalities include cognitive behavioral and family systems approaches. These are combined with psychopharmacological intervention when indicated. Family involvement is emphasized for both diagnostic and therapeutic services. In addition, collaborative working relationships are developed with school staff, community agencies and programs, advocacy organizations, and other university programs. The patient caseload will include individual and group psychotherapy clients, with an expectation that eight students are seen each day. The intern will receive supervision of approximately two hours per week with Drs. Lever and Weiss to review cases, provide further intervention training, and establish concrete treatment plans. Additional supervision and support will be provided by other SMHP staff.

The School Mental Health Program offers numerous interdisciplinary training experiences and the opportunity to work as part of a team. Within the School Mental Health Program, there is time and opportunity available to be part of various research initiatives.

The Center for School Mental Health offers the intern an opportunity to complete a one-day, year-long rotation at the CSMH (with increased time during the summer and school vacations). As part of this rotation the intern will participate on various projects and initiatives related to advancing mental health in schools at local, state, and national levels. The CSMH offers numerous publication and presentation opportunities and an opportunity to advance research, training, policy, and practice in the field. The intern will have significant opportunity to advance knowledge and skills related to quality and evidence-based practice in school mental health. The intern may also benefit from participation in a regional and a national conference supported by the CSMH.

Support from Literature

School mental health, which involves the delivery of a full continuum of mental health services to children in regular and special education, has become an increasingly prevalent service delivery model of mental health care for children and adolescents. It is argued that schools are second only to families in shaping children's development (Cowen *et al.*, 1996) and, therefore, make an ideal treatment setting. Because of the co-location of mental health services within a school setting, many of the traditional barriers to care (*e.g.*, access, stigma, and continuity) are significantly reduced allowing for an enhanced access to mental health services for youth (Nabors & Reynolds, 2000). Research indicates that although only 16% of all children receive mental health services, 70 to 80% of those receiving care do so in the school setting (Rones & Hoagwood, 2000).

Integrating mental health services within the school also promotes a natural, ecologically grounded approach to helping children and families (Atkins, Adil, Jackson, McKay, & Bell, 2001). That is, youth and families are able to access services in their own community, providers are able to work with youth in a natural setting, and interventions can be implemented and monitored in an environment where youth are actually experiencing dysfunction. Given this ecologically grounded approach, treatment gains are more likely to be generalized and maintained (Evans, 1999). Some reasons for this improved generalizability include that when providers are based in schools they are better able to observe problem behaviors as they occur rather than rely on retrospective reports, can better manage contingencies in the environment, and can provide better guidance on alternative behaviors that are likely to be successful in the school environment.

Given the emphasis on prevention in the school mental health model, the capacity for school mental health providers to engage in prevention and mental health promotion is increased (Weare, 2000). Most, if not all, youth in the school building can benefit from services that highlight healthy and positive behaviors. The presence of school mental health programs has been associated with improved school climate where students and teachers reported that they felt they were in a positive learning environment (Bruns, Walrath, Siegel, & Weist, 2004). In addition, Bruns and colleagues (2004) also found that school mental health has been associated with a reduction in inappropriate special education referrals. Teachers in schools with school mental health programs were less likely to refer students to the special education eligibility process because of emotional or behavioral problems. The positive effects may be due to a perception that resources are available to support teachers and to help students who have emotional and behavioral problems.

An average student enrolled in a social and emotional learning program ranks at least 10 percentile points higher on achievement tests, has better attendance and classroom behavior, likes school more, has better grades and is less likely to be disciplined (Weissberg & Shriver, 2005). In addition to school related outcomes, school mental health programs have also been associated with high service satisfaction by students and families (Nabors & Reynolds, 2000). School mental health services have been demonstrated to be effective on an individual level and increasingly there is a recognition of the importance of using evidence based programs and practices and effectively documenting outcomes. In a national survey of ESMH programs, 63 percent of respondents reported using evidence based practices as part of their work. Advancing evidence-based practices and programs and developing effective models for supervision, coaching, and training that support evidence-based work is a priority and key research goal of the Center for School Mental Health.

Supervisors' Training and Experience

Interns' individual therapy will be supervised by Drs. Lever and Weiss. Research will be supervised by Drs. Stephan and Lever. There will also be additional supervision and support provided by psychologist Dr. Dana Cunningham and our multi-disciplinary staff, including Associate Directors of the SMHP Tom Sloane and Michael Green and Managing Director Ellie Davis.

Dana Cunningham, Ph.D., is the Coordinator of the Prince George's School Mental Health Initiative (PGSMHI). The PGSMHI is designed to provide intensive school-based counseling and supports to students in special education. Dr. Cunningham graduated from Southern Illinois University at Carbondale with a doctoral degree in Clinical Psychology in 2004. Following the completion of her internship at the VAMHCS/UMB Consortium, she completed a two-year postdoctoral fellowship at the Center for School Mental Health. She is currently an Assistant Professor in the Department of Psychiatry. Dr. Cunningham's research and clinical interests are in the area of resilience, empirically supported treatments for ethnic minority youth, and school mental health.

Ellie Davis, L.C.S.W.-C., is the Managing Director for the Center for School Mental Health and the University of Maryland School Mental Health Program. Ellie has been working in school mental health for over ten years and served as the primary school mental health clinician at Walbrook High School for over five years. She is a graduate of the University of Maryland School of Social Work. She is able to blend her clinical and business skills to help develop effective management strategies for the programs.

Michael Green, L.C.S.W.-C., is an Associate Director of the University of Maryland School Mental Health Program and is playing a key role in advancing quality assessment and improvement. For over five years, Michael has provided school mental health services at Franklin Square Elementary/Middle School. He completed his graduate training at University of Maryland School of Social Work. He is a founding member of the Rites of Passage Group at Franklin Square, a step group and resiliency focused leadership program at the school. Areas of clinical interest include promoting resilience in youth, family engagement and collaboration, and evidence-based practice in schools. Michael is a sought-after speaker on children's mental health issues in schools and is a passionate advocate for children and families.

Sharon Hoover Stephan, Ph.D., received her Ph.D. in clinical psychology from the University of Maryland Baltimore County in 2002, completing her clinical internship and two-year postdoctoral fellowship at the University of Maryland School of Medicine at the Center for School Mental Health (CSMH) and the School Mental Health Program. She is currently the Director of Research and Analysis at the CSMH and an Assistant Professor in the Department of Psychiatry. Dr. Stephan's clinical and research focus is in the area of implementing empirically-supported interventions in school-based settings, with a particular emphasis on serving traumatized youth and youth from health-disparate populations. She conducts research and clinical training in the area of mental health-primary care collaboration and integration. Dr. Stephan is also the Co-Director of the Maryland Psychological Assessment and Consultation Clinic.

Nancy Lever, Ph.D., is the Co-Director of the University of Maryland School Mental Health Program, Director of Training and Outreach of the Center for School Mental Health, and an Associate Director of the VAMHCS/UMB Psychology Internship Consortium. She completed her doctoral training in clinical psychology at Temple University in 1997. She completed her internship and postdoctoral training at the University of Maryland School of Medicine before joining the Department of Psychiatry as an Assistant Professor in 1998. Within the Division, she has been very active in promoting training related to school mental health and has coordinated training experiences for psychology interns, psychiatry fellows, and postdoctoral fellows. She has presented and written extensively about school mental health. Research interests include: quality assessment and improvement, reducing suspension and expulsions, school mental health and foster care connections, and promoting resiliency.

Tom Sloane, L.C.P.C., is an Associate Director of the University of Maryland School Mental Health Program (SMHP). Tom is the training coordinator for the SMHP's graduate psychology externship program, and also serves as a part-time high school counselor. He completed his graduate training in counseling psychology at Loyola College in 1984. He has worked in the SMHP since 1997, and has been employed by the University of Maryland since 1983. He is an active member of the Licensed Clinical Professional Counselors of Maryland. Areas of clinical interest include promoting resilience in youth, graduate psychology externship training in school mental health, and adolescent mental health. Tom has made numerous presentations on a variety of child and adolescent mental health issues.

Catharine Weiss, Ph.D. is the Director of the MPACC and a Clinical Assistant Professor in the Department of Psychiatry. She received her Ph.D. in clinical/community-social psychology from the University of Maryland, Baltimore County in 2004. She completed her clinical internship and two-year postdoctoral fellowship at the University of Maryland School of Medicine. Dr. Weiss provides clinical

supervision and training in implementing school-based mental health services and school-wide climate initiatives. She delivers direct intervention and prevention services across a range of settings, including providing collaborative care for children, families, and adults in a neighborhood primary care clinic.

Child Psychology: Maryland Psychological Assessment Clinic Rotation

Patient Population

Both the outpatient child psychology track intern and the school mental health track intern participate in the Maryland Psychological Assessment and Consultation Clinic (MPACC) which offers a year-long experience providing assessment and consultation services to children and adolescents served through outpatient programs within the University of Maryland. Interns will spend approximately six hours per week in this clinic. Their time will be devoted to conducting psychological assessments of children and adolescents (ages 5 to 18), consulting with school and treatment staff, scoring, interpreting and writing reports, and providing feedback to families and treatment teams. Each intern will be responsible for approximately one assessment per month. Clients are referred to MPACC from child and adolescent mental health programs in the University of Maryland System, including the 701 Outpatient Clinic, the School Mental Health Program, the Community Psychiatry Clinics (Fayette Street Clinic and Carruthers Clinic), and the clinic that serves families of university employees.

Assessments, Treatments, & Supervision

MPACC referral questions are very diverse and can include differentiating between the breadth of clinical disorders and screening for learning problems, and making recommendations for school and treatment services. Tests administered include, but are not limited to:

Autism Diagnostic Observation Schedule, NEPSY-II, Wechsler Intelligence Tests (WPPSI-III, WISC-IV, WAIS-IV), Personality Assessment Inventory, Wechsler Individual Achievement Test-III, Woodcock Johnson III - Tests of Achievement, Vineland Adaptive Behavior Scales, and a wide variety of behavior checklists. Feedback sessions involve the family and referring clinicians and emphasize the strengths and needs of the children and families.

Supervisors' Training and Experience

Catharine Weiss, Ph.D. is the Director of the MPACC and a Clinical Assistant Professor in the Department of Psychiatry. She received her Ph.D. in clinical/community-social psychology from the University of Maryland, Baltimore County in 2004. She completed her clinical internship and two-year postdoctoral fellowship at the University of Maryland School of Medicine. Dr. Weiss provides clinical supervision and training in implementing school-based mental health services and school-wide climate initiatives. She delivers direct intervention and prevention services across a range of settings, including providing collaborative care for children, families, and adults in a neighborhood primary care clinic.

X. CONSORTIUM ADMINISTRATION

The VAMHCS/UMB Consortium administrative structure is as follows.

Consortium Steering Committee: This committee has the authority and responsibility to ensure the quality of all aspects of the Consortium training program. The members of the committee are:

Alan Bellack, Ph.D., Professor of Psychiatry and Director of the Division of Psychology, University of Maryland School of Medicine; Director, MIRECC

Melissa Decker, Psy.D, Director of Training, VAMHCS/UMB Psychology Internship Consortium

Joseph Liberto, M.D., Associate Chief of Staff for Education and Academic Affiliations, VAMHCS

Marsden Maguire, M.D., Director, VAMHCS Mental Health Clinical Center

Samuel Stern, Ph.D., Psychologist Executive, VAMHCS

Consortium Training Committee: This committee is responsible for the day-to-day operation of the internship and for maintaining the Consortium's compliance with the criteria for accreditation of the American Psychological Association (APA) and with the guidelines of the Association of Psychology Postdoctoral and Internship Centers (APPIC). The Training Director and Training Committee closely oversee the recruitment process and the selection process to assure equitable treatment of all applicants and adherence to the standards of both the APPIC and the APA. The Consortium Director at the Baltimore VAMC with the Associate Directors at UMB and VAMHCS and the Curriculum Coordinator, the Research Coordinator, and the Assessment Coordinator monitor the training experiences of the interns. The Committee is responsible for coordinating material and human resources, selection of interns, evaluating facilities for continued participation in the Consortium, the content of the Core Curriculum Seminars, and ensuring the quality of the clinical supervision within the internship.

Associate Director of Training - UMB: In addition to sharing the responsibilities of the Training Committee, this individual is responsible for coordinating interns and training staff assigned to UMB clinics, including communicating with administrative staff regarding hiring, orientation, and payroll. She is available to address any concerns raised by interns or training staff at UMB sites.

Associate Director of Training – VAMHCS: Similar to the Associate Director of Training role described above, this individual assists with issues that arise among VA-based interns and staff, with special attention to internship activities at the Perry Point VAMC, since the Director of Training is typically based in Baltimore.

Assessment Coordinator: The Assessment Coordinator is responsible for coordinating the interns' training activities in the area of psychological assessment. He insures that interns are informed of the year-long assessment requirement and the criteria for assessments, tracks the completion of assessments throughout the year, works with supervisors and staff to optimize assessment opportunities, and provides supervision on assessment-related topics.

Seminar Coordinator(s): The Seminar Coordinators are responsible for developing core educational activities for interns, both across and within sites. The Coordinators collaborate with the Director of Training and Training Committee in regards to the content of the seminars and relationship between the content of the core curriculum and training objectives. The Coordinators are responsible for the selection and scheduling of consultants, faculty seminars, and guest speakers.

Research Coordinator(s): The Research Coordinators contribute to the Consortium's overall mission by creating a scientist-practitioner environment for trainees. The Coordinators are responsible for establishing research opportunities that have relevance to clinical practice across the VAMHCS and UMB; guiding and mentoring interns in their research involvements; and evaluating interns' progress.

Cultural Competence Coordinator: The Cultural Competence Coordinator contributes to the Consortium's overall mission of excellence in training in issues of diversity. The Coordinator is responsible for retention of students dedicated to training in cultural competence, implementing a curriculum that provides training in all areas of diversity, and serving as a mentor and supervisor to students that participate in the Diversity Minor training experience; may represent the Consortium at local and national conferences dedicated to diversity and cultural competence for recruitment of interns.

Intern Representative: One or more intern volunteers are identified at the beginning of the training year to serve as representative(s) to the Training Committee. They provide invaluable input from the trainees' perspective into the Training Committee's discussions and decisions and serve as a conduit for any concerns that the interns may want to bring to the Training Committee.

Training Committee members for the 2012-2013 training year are:

Melissa Decker, Psy.D., Director of Training

Nancy Lever, Ph.D., Associate Director of Training, University of Maryland
Jason Peer, Ph.D., Associate Director of Training, VAMHCS
David O'Connor, Ph.D., Assessment Coordinator
Ann Aspnes, Ph.D., Seminar Coordinator
Sam Korobkin, Ph.D., Seminar Coordinator
Deborah Medoff, Ph.D., Research Coordinator
S. Marc Testa, Ph.D., Research Coordinator
TBD, Cultural Competence Coordinator
Kathleen Benson, M.A., Intern Representative
Amber Norwood, M.A., Intern Representative
Viara Quinones-Jackson, M.A., Intern Representative

XI. CONSORTIUM STAFF

ADMINISTRATIVE AND SUPERVISORY PSYCHOLOGY STAFF

MELISSA L. DECKER, PSY.D

La Salle University, 2007. Clinical Psychology.

Director of Training, VAMHCS/UMB Psychology Internship Consortium.

Director of Postdoctoral Fellowship in PTSD in Returning Veterans.

Licensed Psychologist in Maryland.

Interests: Dissemination of empirically supported treatments for PTSD, research and treatment on comorbid PTSD and medical disorders.

JOSEPH LIBERTO, M.D.

University of Maryland, 1986. Psychiatry.

Associate Chief of Staff for Education & Academic Affairs

Interests: Pharmacological treatment of addictions, health care services for addictions.

MARSDEN MCGUIRE, M.D.

University of North Carolina, 1988. Psychiatry.

Director, Mental Health Clinical Center

Interests: Translation of research findings into clinical practice. Education of primary care providers.

Use of technology to aid diagnosis and monitor treatment outcomes. International teaching and practice of psychiatry.

SAMUEL N. STERN, PH.D.

University of Alabama, Tuscaloosa, 1974. Clinical Psychology.

Psychologist Executive, VAMHCS BRECC and Geriatric Mental Health.

Licensed Psychologist in Maryland, New York, and Michigan; National Register of Health Service Providers in Psychology.

Interests: Geriatric mental health, health care management, supervision, training, crisis intervention, research.

ALAN S. BELLACK, PH.D. , A.B.P.P.

Pennsylvania State University, 1970. Clinical Psychology.

Professor and Director, Division of Psychology, University of Maryland School of Medicine

Licensed Psychologist in Maryland and Pennsylvania.

Interests: Psychosocial aspects of schizophrenia, research ethics in schizophrenia, work outcome in schizophrenia brain structure/function.

CLINICAL AND TRAINING STAFF - VAMHCS

MINU AGHEVLI, PH.D.

University of Maryland, 2004. Clinical Psychology.

Coordinator, Opioid Agonist Treatment Program

Licensed Psychologist in Maryland.

Interests: Treatment engagement, motivational enhancement, substance abuse, dual diagnosis.

ANN ASPNES, PH.D.

Duke University, 2008, Clinical Psychology

Staff psychologist, Trauma Recovery Program

Seminar Coordinator; VAMHCS/UMB Psychology Internship Consortium Training Committee

Licensed Psychologist in North Carolina

Interests: Treatment and assessment of older adults with PTSD; Treatment of Axis II disorders; Treatment of complex and military sexual trauma.

PAUL R. BENSON, PH.D.

Catholic University, 1988. Clinical Psychology.

Acting Clinical Manager, Special Programs Subproduct Line.

Clinical Assistant Professor, Department of Psychiatry, University of Maryland School of Medicine.

Licensed Psychologist in Maryland.

Interests: Marital and family therapy, and in marital interactions and transition-to-parenthood research.

CHRISTINE CALMES, PH.D.

University at Buffalo: The State University of New York, 2008, Clinical Psychology

Staff psychologist, Health Improvement Program

Licensed Psychologist in Maryland

Interests: Helping individuals with serious mental illness to manage their medical and psychiatric symptoms in order to reach their recovery goals.

SARA CLAYTON, PH.D.

University of Wyoming, 2009. Clinical Psychology.

Staff Psychologist, VAMHCS Chronic Pain Service/University of Maryland Adolescent and Young Adult Center HIV Clinic

Licensed Psychologist in Maryland.

Interests: Behavioral treatments for HIV and chronic pain

JAMIE D. DAVIS, PH.D.

Oklahoma State University, 1997. Clinical Psychology.

Acting Team Lead, Trauma Services at Perry Point.

Clinical Psychologist, Trauma Recovery Program Cambridge and Pocomoke Community Based Outpatient Clinics.

Licensed Psychologist in Maryland.

Interests: Dissemination of empirically supported treatments for PTSD; lifespan development and the role of culture in the treatment and recovery of trauma-related disorders; rural mental health.

MOIRA DUX, PH.D

Rosalind Franklin University of Medicine and Science, 2009, Neuropsychology.

Staff Neuropsychologist, Baltimore VA Medical Center.

Interests: Mechanisms of cognition and affect in healthy elderly, effects of highly active antiretroviral therapy (HAART) on cognition in persons who are HIV+, and intraindividual variability in cognitive test performance.

LISA FALCONERO, PSY.D.

La Salle University, 2007, Clinical Psychology

Clinical Psychologist, Inpatient Unit, Perry Point.

Licensed Psychologist in Maryland.

Interests: Recovery-oriented treatment of individuals with serious mental illness.

JODI FRENCH, PSY.D

Virginia Consortium in Clinical Psychology, 1991.

Neuropsychologist, Community Living Center.

Licensed Psychologist in Maryland and Virginia.

Interests: Capacity Assessments, Behavioral Interventions for Challenging Behaviors in Long-Term Care; Use of Embedded Symptom Validity Tests, Cognitive-Behavioral Interventions for Mood and Anxiety Disorders; Caregiver Support and Bereavement Counseling.

JAMES FINKELSTEIN, PSY.D.

Loyola College in Maryland, 2003. Clinical Psychology.

Staff Psychologist, Acceptance and Commitment Therapy Program.

Licensed Psychologist in Maryland.

Interests: Substance use disorders, mindfulness-based interventions.

ANJELI INSCORE, PH.D.

Loyola College, 2002. Clinical Psychology.

Licensed Psychologist in Maryland.

Interests: Assessment of conditions associated with dementia and the effects of metabolic dysfunction on neurocognition.

AARON JACOBY, PH.D.

Catholic University of America, 2004, Clinical Psychology

Coordinator of VAMHCS trauma recovery programs

Licensed Psychologist in Pennsylvania

Interests: Evidence-based psychotherapies for PTSD including prolonged exposure therapy and cognitive processing therapy; PTSD assessment; patient satisfaction; Program development.

SCOTT JONES, PH.D.

Miami University of Ohio, 1989. Clinical Psychology. Gero/Neuropsychology.

Staff Psychologist, Perry Point VA Medical Center

Licensed Psychologist in Maryland.

Interests: Psychotherapeutic styles with older adults.

DEBORAH L. KALRA, PH.D.

Syracuse University, 1991. Clinical Psychology.

Coordinator, Women Veterans Evaluation and Treatment Program.

Licensed Psychologist in Maryland and New York.

Interests: Individual and group psychotherapy, women's issues, and PTSD.

SAM KOROBKIN, PH.D.

St. John's University, 2000. Clinical Psychology.

Staff Psychologist, Family Intervention Team.

Seminar Coordinator; VAMHCS/UMB Psychology Internship Consortium Training Committee

Licensed Psychologist in Maryland and California.

Interests: Recovery from serious mental illness, health psychology, and couples/individual psychotherapy.

MARY LAMBERT, PH.D.

University of Maryland, 2002. Clinical Psychology.

Coordinator, Perry Point PRRC and Recovery Center

Licensed Psychologist in Maryland.

Interests: Serious mental illness, mindfulness-based approaches to psychotherapy.

TERRY LEE-WILK, PH.D.

University of Maryland, 2002. Clinical Psychology.

Neuropsychologist

Licensed Psychologist in Maryland.

Neurocognitive correlates of Multiple Sclerosis, HIV infection, and mild traumatic brain injury.

STEVAN M. LEVY, PH.D.

Catholic University, 1975. Clinical Psychology.

Licensed Psychologist in Maryland.

Interests: Milieu therapy, group psychotherapy, and supervision.

CHERYL LOWMAN, PH.D.

State University of New York at Albany, 1989. Counseling Psychology.

Acting Coordinator, CBOC Mental Health.

Licensed Psychologist in Maryland.

Interests: Health psychology, psychology in the primary care setting, community mental health, and women's issues.

KRISTEN MORDECAI, PH.D.

Rosalind Franklin University of Medicine and Science, 2007, Clinical Psychology (neuropsychology).

Staff Neuropsychologist, VAMHCS.

Licensed psychologist in Maryland.

Interests: Cognitive aging, dementia, Parkinson's disease, stress and memory, and the effects of sex steroid hormones on cognition and brain function.

SARA NETT, PSY.D.

Indiana State University, 2008, Clinical Psychology.

Staff Psychologist, Trauma Recovery Program

Licensed Psychologist in Maryland.

Interests: recovery from posttraumatic stress disorder; Treating veterans with comorbid personality disorders and history of complex trauma.

MARK NOLDER, PH.D

Texas Tech University, 1990, Counseling Psychology.

Staff Psychologist, Fort Howard Community Based Outpatient Clinic.

Licensed Psychologist in Maryland.

Interests: Psychoanalytic metapsychology, evidence-based psychoanalytic psychotherapy, evidence based psychotherapy relationship factors, psychotherapy supervision, psychology of music, individual psychoanalytic psychotherapy.

DAVID O'CONNOR, PH.D

Florida State University, 2002. Clinical Psychology.

Staff psychologist

Assessment Coordinator, VAMHCS/UMB Psychology Internship Consortium Training Committee

Licensed Psychologist in Maryland.

Interests: Addictions, stages of change.

PRITI PAREKH, PH.D.

Duke University, 2001. Clinical Psychology.

Staff psychologist, Health psychology

Licensed Psychologist in Maryland.

Interests: Behavioral medicine as applied to chronic pain, HIV, and transplant populations.

JASON PEER, PH.D

University of Nebraska-Lincoln, 2006. Clinical Psychology.

Staff psychologist, Perry Point PRRC and Recovery Center

Associate Director, VAMHCS/UMB Psychology Internship Consortium Training Committee

Licensed Psychologist in Maryland.

Interests: serious mental illness, psychosocial treatment response, vocational functioning in SMI, program evaluation.

MATTHEW L. RANEY, PH.D.

University of North Carolina at Chapel Hill, 2003. Clinical Psychology.
Coordinator, Baltimore VA Mental Health Assessment and Referral Clinic/Mental Health Clinic
Licensed Psychologist in Maryland.
Interests: Serious mental illness, behavioral medicine, substance abuse.

PATRICIA RYAN, PH.D.

Fordham University, 2006, Counseling Psychology
Neuropsychologist, VAMHCS
Licensed Psychologist in Maryland
Interests: Neuropsychological assessment and cognitive rehabilitation for traumatic and acquired brain injury; post-stroke depression; adjustment and coping with physical and cognitive disabilities.

ERIN ROMERO, PH.D.

Northwestern University Feinberg School of Medicine, 2009, Clinical Psychology
Psychologist, Trauma Recovery Program;
Coordinator, Services for Returning Veterans Mental Health Program
Interests: Barriers to mental health treatment; Virtual reality treatment for PTSD.

TOM RUSSO, PH.D.

Temple University, 1987, Counseling Psychology
Psychologist/Coordinator, General Outpatient Substance Abuse Program
Licensed psychologist in Maryland
Interests: Substance use disorders; Family therapy.

ANDREW SANTANELLO, PSY.D.

La Salle University, 2006, Clinical Psychology
Psychologist, Trauma Recovery Program
Licensed psychologist in Maryland
Interests: Promotion and dissemination of evidence-based psychotherapy and mindfulness-based psychological treatments.

JILL SCOTT, PH.D.

University of Nebraska-Lincoln, 2011, Clinical Psychology
Psychologist, PTSD-SUD Specialist, Trauma Recovery Program
Interests: Empirically supported assessment and treatment for veterans with dual diagnoses

MARC TESTA, PH.D.

University of Cincinnati, 2004, Clinical Psychology (neuropsychology focus)
Neuropsychologist, VAMHCS
Instructor in the Department of Psychiatry and Behavioral Sciences at Johns Hopkins University School of Medicine
Research Coordinator, VAMHCS/UMB Psychology Internship Consortium Training Committee
Licensed Psychologist in Maryland
Interests: General neuropsychology, functioning among individuals with seizure disorders, and development of regression-based test norms.

RACHEL THOMPSON, PH.D.

The Catholic University, 2011, Clinical Psychology
Staff Psychologist, Perry Point Trauma Recovery Program.
Licensed psychologist in Maryland.

Interests: The utility of mindfulness and acceptance-based techniques for both the prevention and treatment of PTSD.

NEIL WEISSMAN, PSY.D.

Yeshiva University, 1990. Clinical Psychology.

Staff psychologist, Psychosocial Rehabilitation and Recovery Center

Licensed Psychologist in Maryland.

Interests: The Recovery Model for individuals with SMI. Emotionally Focused Couples Therapy (EFT) for couples with PTSD.

JADE WOLFMAN-CHARLES, PH.D.

University of Maryland, Baltimore County, 2009, Human Services Psychology

Staff psychologist, Opioid Agonist Treatment Program

Interests: Evidence-based and culturally sensitive practices in the treatment of addictive disorders; Motivational interviewing; Transtheoretical Model of Change.

CLINICAL AND TRAINING STAFF- MIRECC

MELANIE BENNETT, PH.D.

Rutgers University, 1995. Clinical Psychology.

Assistant Professor, Department of Psychiatry, University of Maryland School of Medicine.

Licensed Psychologist in Maryland.

Interests: Etiology and treatment of substance use disorders and serious mental illness, screening for substance use disorders, prevention of substance use disorders.

AMY DRAPALSKI, PH.D

George Mason University, 2006. Clinical Psychology.

Administrative Core Manager, VISN 5 MIRECC

Clinical Assistant Professor, Department of Psychiatry, University of Maryland School of Medicine.

Licensed Psychologist in Maryland.

Interests: Serious mental illness and recovery, stigma and other barriers to mental health care, family services.

RICHARD GOLDBERG, PH.D.

University of Maryland-College Park, 1994. Clinical/Community Psychology.

Associate Professor, Division of Services Research, Department of Psychiatry.

Director, Clinical Core VISN 5 MIRECC.

Co-Director, Hub Site for the VA Interprofessional Fellowship Program in Psychosocial Rehabilitation and Recovery.

Licensed Psychologist in Maryland.

Interests: Mental health services research, somatic comorbidity, behavioral health and wellness interventions, SMI/public sector psychiatry, group psychology, research and clinical supervision.

CLINICAL AND TRAINING STAFF- UNIVERSITY OF MARYLAND, BALTIMORE

LAURA ANDERSON, PH.D.

University of Denver, 2005

Clinical Research Specialist, University of Maryland, Baltimore Systems Evaluation Center

Licensed Psychologist in Maryland.

Interests: trauma, dialectical behavior therapy, mindfulness, therapeutic alliance, supervision and training.

VICKI BECK, A.P.R.N., B.C.

Texas Women's University, 1975.

Board Certified Child and Adolescent Clinical Nurse Specialist.

Administrative Director, Child Psychiatry Outpatient Clinic.

Interests: Children and adolescents, aggression management, evidence-based practice in outpatient settings, trauma.

MELANIE BENNETT, PH.D. (see MIRECC staff)

KAY CONNORS, L.C.S.W.

New York University, 1985

Assistant Professor, Department of Psychiatry, University of Maryland School of Medicine

Program Director, Taghi Modarressi Center for Infant Study, Department of Psychiatry.

Interests: Early childhood mental health services, trauma treatment, family, parent-child and group therapies and clinical supervision.

JEN COX, L.C.S.W.-C.

University of Maryland School of Social Work, Baltimore, MD, 2006.

Associate Director of the University of Maryland School Mental Health Program (SMHP).

Interests: Promoting resilience in youth, family engagement and partnership, and developing effective funding models.

DANA CUNNINGHAM, PH.D.

Southern Illinois University-Carbondale, 2004. Clinical Psychology.

Assistant Professor, Department of Psychiatry, University of Maryland School of Medicine

Coordinator, Prince's George's County School Mental Health Initiative.

Licensed Psychologist in Maryland.

Interests: School-based mental health, resilience, community building, special education.

ELEANOR DAVIS, M.S.W., L.C.S.W.-C.

University of Maryland School of Social Work-Baltimore, Maryland, 1995. Social Work.

Managing Director, Center for School Mental Health/University of Maryland School Mental Health Program.

Interests: School mental health, cost effectiveness, business management of mental health programs, staff development.

NICOLE EVANGELISTA, PH.D.

Ohio University, 2009.

Program Manager, Center for School Mental Health

Training Director, University of Maryland School Mental Health Program.

Interests: Family engagement, quality and evidence-based practice in school mental health, and workforce development.

RICHARD GOLDBERG, PH.D. (see MIRECC staff)

MICHAEL GREEN, M.S.W., L.C.S.W.-C.

University of Maryland School of Social Work- Baltimore, Maryland, 2003. Social Work.

Associate Director, University of Maryland School Mental Health Program.

Clinician, Franklin Square Elementary/Middle School.

Interests: School mental health, student leadership, meaningful activity involvement, resiliency, family engagement and collaboration, and evidence-based practice in schools.

LAUREL KISER, PH.D., M.B.A.

Indiana University, 1981. School Psychology.

Associate Professor, Center for Mental Health Services Research, Department of Psychiatry, University of Maryland School of Medicine.

Principal Investigator, Children's Outcome Monitoring Center

Interests: Children and adolescents, services research, family ritual and routine, chronic illness, PTSD.

NANCY LEVER, PH.D.

Temple University, 1997. Clinical Psychology.

Associate Director VAMHCS/UMB Psychology Internship Consortium.

Director of Training and Outreach, Center for School Mental Health.

Director, University of Maryland School Mental Health Program.

Associate Professor, Department of Psychiatry, University of Maryland School of Medicine.

Licensed Psychologist in Maryland.

Interests: School based mental health services, dropout prevention, quality assessment and improvement, evidence-based practice in schools, resiliency, resource development.

DEBORAH MEDOFF, PH.D.

University of Maryland College Park, 1989, Quantitative Psychology.

Research Coordinator, VAMHCS/UMB Psychology Internship Consortium

Assistant Professor, Department of Psychiatry, Division of Services Research

Professional interests include developing research designs to minimize consent bias, analytic techniques for missing data in longitudinal research and the trajectories of recovery for persons with serious mental illness.

CARRIE MILLS, PH.D

University of North Carolina at Chapel Hill, 2007.

Assistant Professor, Division of Child and Adolescent Psychiatry.

Interests: Integration of education and mental health supports and services, the promotion of high quality, empirically-supported interventions in schools, program evaluation, and the development of preventive interventions for children of parents with mental health disorders.

SHERIDAN PHILLIPS, PH.D.

State University of New York at Stony Brook, 1974. Experimental Child Psychology.

Director, Mental Health Consultation Service - Pediatric ER.

Associate Professor, Department of Psychiatry and Department of Pediatrics, University of Maryland School of Medicine.

Licensed Psychologist in Maryland and New York

Interests: Cognitive-behavioral treatment of children and adolescents, behavioral pediatrics, adolescent medicine.

TOM SLOANE, M.S., L.C.P.C.

Loyola College, Baltimore, Maryland, 1984. Counseling Psychology.

Associate Director, University of Maryland School Mental Health Program.

Clinician, Digital Harbor High School Campus.

Director, University of Maryland School Mental Health Externship Program.

Interests: School mental health, promoting resilience in youth, graduate externship training, and adolescent mental health.

SHARON STEPHAN, PH.D.

University of Maryland Baltimore County, 2002. Clinical Psychology

Director of Research and Analyses, Center for School Mental Health, University of Maryland School of Medicine.

Director, Maryland Psychological Assessment and Consultation Clinic.

Licensed Psychologist in Maryland.

Interests: School Mental Health, Evidence-based practice in school mental health, trauma and youth.

CATHERINE WEISS, PH.D.

University of Maryland Baltimore County, 2004. Clinical/Community Psychology.

Supervisor/Consultant, University of Maryland School Mental Health Program.

Instructor, Department of Psychiatry, University of Maryland School of Medicine.

Interests: Staff wellness, evidence-based practice in school mental health, professional development for school staff, reducing suspensions and expulsions in schools.

XII. APPLICANT ELIGIBILITY

1. The VAMHCS/UMB Psychology Internship Consortium will be participating in the APPIC National Matching Service (NMS). Applicants must be registered with NMS and apply through the online APPIC portal. Applicants may register with NMS on the following website: **www.natmatch.com/psychint**. Only those applicants who register for the Match prior to the Rank Order List deadline for Phase I of the Match, and do not obtain a position in Phase I (e.g., applicants who withdraw or remain unmatched in Phase I) will be eligible to participate in Phase II of the Match with our site.
2. Applicants must be students in good standing in an APA-accredited doctoral program in clinical, counseling or school psychology and approved for internship by their graduate program training director.
3. We will only review applications from students who have successfully defended their dissertation proposals prior to the application deadline.
4. **We will only review applications from students who have completed more than a total of 500 combined intervention and assessment hours, at least 50 of which are assessment hours.** Hours completed at the Masters and Doctoral level will count toward this requirement. *Please keep in mind that the minimum number of intervention and assessment hours provided for our program in the APPIC online directory are set low to accommodate the different priorities of the various Consortium training tracks. For example, an applicant with 200 intervention hours might be competitive for the neuropsychology track but probably wouldn't be competitive for the more intervention-intensive tracks. Similarly, an applicant with 50 assessment hours would not be competitive for the neuropsychology track but might be competitive for another track.*
5. Interns in VA-based tracks must be citizens of the United States and will have to present documentation of U.S. Citizenship prior to beginning the internship. VA is unable to consider applications from anyone who is not currently a U.S. citizen. Verification of citizenship is required following selection. All interns and fellows must complete a Certification of Citizenship in the United States prior to beginning VA training.
6. A male applicant born after 12/31/1959 must have registered for the draft by age 26 to be eligible for any US government employment, including selection as a paid VA trainee. Male applicants must sign a pre-appointment Certification Statement for Selective Service Registration before they can be processed into a training program. Exceptions can be granted only by the US Office of Personnel Management; exceptions are very rarely granted.
7. Interns and Fellows are subject to fingerprinting and background checks. Match result and selection decisions are contingent on passing these screens.
8. The VA conducts drug screening on randomly selected personnel. Interns are not required to be tested prior to beginning work, but once on staff they are subject to random selection.

XIII. APPLICATION PROCEDURES

Track Preference Assignments

Applicants who are interested in any of the five adult-focused programs offered by the consortium should **clearly indicate the track for which they wish to be considered in their cover letter.**

****Applicants submitting applications to VA Comprehensive, Neuropsychology, Trauma Recovery and Health Psychology Tracks:**

Please indicate in your cover letter only one track that you wish to be considered for.

****Applicants submitting applications to VA SMI and/or UMB Adult Tracks:**

You may be considered for both tracks if you wish. Please clearly state in your cover letter which track is your top preference. You may not be considered for all tracks that you rank. Please note, applicants may not be considered for multiple tracks outside of VA SMI/UMB Adult tracks (for e.g., application to VA SMI and VA Comprehensive tracks will not be allowed this year).

****Applicants submitting applications to Child Psychology Tracks:**

You may be considered for both tracks if you wish. Please clearly state in your cover letter which track is your top preference. You may not be considered for all tracks that you rank. Please note, applicants may not be considered for multiple tracks outside of child-focused tracks (for e.g., application to SMHP and adult tracks will not be allowed this year).

Please think carefully about your choices and do not rank tracks that you do not have a serious interest in completing. It is perfectly acceptable to rank only one track if there is only one in which you are interested.

Rotation Requirements

There are a total of 11 adult-focused intern slots. The five VA-based tracks will have a total of nine intern slots available; the UMB-based track will have two adult-focused intern slots available.

- Interns in the VA Comprehensive track can choose any combination of three VA rotations.
- Interns in the Neuropsychology track will complete two neuropsychology rotations and a third rotation of their choice.
- Interns in the SMI track may choose 2 or 3 SMI-focused rotations.
- Interns in the PTSD/Trauma Recovery track will complete PTSD-related rotations at the Baltimore VA and at the Perry Point VA plus one rotation of their choice.
- Interns in the UMB Adult track will be assigned to either the University of Maryland General Adult Psychiatric Clinic or University of Maryland Community Psychiatry Fayette Clinic for the entire internship year.

There are a total of 3 child-focused intern slots. The School Mental Health Program (SMHP) will have a total of two intern slots; the UMB-based Child Outpatient (CIS) track will have one intern slot available.

- Interns in the SMHP and CIS tracks will be assigned to their respective clinics for the entire internship year, and will complete minor assessment rotations in the Maryland Psychological Assessment and Consultation Clinic.

APPIC Program Codes

**Although our consortium is a unified and integrated internship, the training tracks listed below are treated as separate programs by the APPIC matching process.

VA Comprehensive (2 slots available)

APPIC program code: 134711

VA PTSD/Trauma Recovery Program (2 slots available)

APPIC program code: 134719

VA Serious Mental Illness (2 slots available)

APPIC program code: 134718

VA Neuropsychology (2 slots available)

APPIC program code: 134717

VA Health Psychology (1 slot available)

APPIC program code: 134713

UMB Adult Outpatient/Community Psychiatry (2 slots available)

APPIC program code: 134712

UMB School Mental Health Program/Center for School Mental Health (2 slots available)

APPIC program code: 134716

UMB Center for Infant Study (Secure Starts)/Outpatient Program (1 slot available)
APPIC program code: 134715

In addition to the on-line AAPI, the following supplemental materials are required: A work sample (either a case summary or an assessment report). Please remove the client's name and any identifying information. It is helpful if relevant demographic information and the name of the clinic is included unless that information would identify the client to a likely application reviewer.

All applications materials should be submitted through the on-line APPIC portal: www.appic.org

Please do not submit more than three letters of recommendation for our program.

Please feel free to contact Dr. Decker with any questions about the program or our application procedures but please do not contact Dr. Decker to request to be put into contact with our current interns. If you are selected for an interview, you will have the opportunity to talk with current interns.

The deadline for submission of applications is November 1, 2012.

Selection procedures: A separate committee of internship training staff from each track reviews and evaluates each application on the domains of clinical experience, research experience, letters of recommendation, quality of graduate program, coursework and grades, life experiences, and fit with training program. Each committee decides which applicants will be invited for interviews and decisions regarding interviews will be communicated via email on or before December 15, 2012. Interviews will be conducted in January 2013. Each applicant meets with up to three supervisors from the track(s) which they indicate interest in being considered for and also has an opportunity to meet with current Consortium interns. The VAMHCS/UMB Psychology Internship Consortium abides by the policies stated in the Association of Psychology Post Doctoral and Internship Centers (APPIC) Match Policies. This internship site agrees to abide by the APPIC policy that no person at this training facility will solicit, accept, or use any ranking-related information from any intern applicant. Applicants are referred to the APPIC website, www.appic.org, for a detailed description of policies pertaining to the match. The VAMHCS and UMB are Equal Opportunity Employers. Our internship program values cultural and individual diversity and welcomes applicants from all backgrounds.

If you have any questions about our application procedures or documents, please contact Dr. Decker at (410) 637-1224 or by email at melissa.decker@va.gov.

uncertain; Occasionally over- or under-estimates need for supervision.

- I** Generally accepts supervision well, but occasionally defensive. Needs supervisory input for determination of readiness to try new skills.
- E** Needs intensive supervision and guidance, difficulty assessing own strengths and limitations.
- R** Frequently defensive and inflexible; Resists important and necessary feedback.

OBJECTIVE: USES POSITIVE COPING STRATEGIES

Demonstrates positive coping strategies with personal and professional stressors and challenges. Maintains professional functioning and quality patient care.

- A** Good awareness of personal and professional problems. Stressors have only mild impact on professional practice. Actively seeks supervision and/or personal therapy to resolve issues.
- HI** Good insight into impact of stressors on professional functioning, seeks supervisory input and/or personal therapy to minimize this impact.
- I** Needs significant supervision time to minimize the effect of stressors on professional functioning. Accepts reassurance from supervisor well.
- E** Personal problems can significantly disrupt professional functioning.
- R** Denies problems or otherwise does not allow them to be addressed effectively.

OBJECTIVE: PROFESSIONAL RESPONSIBILITY AND DOCUMENTATION

Responsible for key patient care tasks (e.g. phone calls, letters, case management), completes tasks promptly. All patient contacts, including scheduled and unscheduled appointments, and phone contacts are well documented. Records include crucial information.

- A** Maintains complete records of all patient contacts and pertinent information. Notes are clear, concise and timely. Takes initiative in ensuring that key tasks are accomplished. Records always include crucial information.
- HI** Maintains timely and appropriate records; may forget some minor details or brief contacts (e.g. phone calls from patient), but recognizes these oversights and retroactively documents appropriately. Records always include crucial information.
- I** Uses supervisory feedback well to improve documentation. Needs regular feedback about what to document. Rarely, may leave out necessary information, and occasionally may include excessive information. Most documentation is timely.
- E** Needs considerable direction from supervisor. May leave out crucial information.
- R** May seem unconcerned about documentation. May neglect to document patient contacts. Documentation may be disorganized, unclear or excessively late.

OBJECTIVE: EFFICIENCY AND TIME MANAGEMENT

Efficient and effective time management. Keeps scheduled appointments and meetings on time. Keeps supervisors aware of whereabouts as needed. Minimizes unplanned leave, whenever possible.

- A** Efficient in accomplishing tasks without prompting, deadlines or reminders. Excellent time management skills regarding appointments, meetings and leave.
- HI** Typically completes clinical work/patient care within scheduled hours. Generally on time. Accomplishes tasks in a timely manner, but needs occasional deadlines or reminders.
- I** Completes work effectively and promptly by using supervision time for guidance. Regularly needs deadlines or reminders.
- E** Highly dependent on reminders or deadlines.
- R** Frequently has difficulty with timeliness fashion. Or tardiness or unaccounted absences are a problem.

OBJECTIVE: KNOWLEDGE OF ETHICS AND LAW

Demonstrates good knowledge of ethical principles and state law. Consistently applies these appropriately, seeking consultation as needed.

- A** Spontaneously and consistently identifies ethical and legal issues and addresses them proactively. Judgement is reliable about when consultation is needed
- HI** Consistently recognizes ethical and legal issues, appropriately asks for supervisory input.
- I** Generally recognizes situation where ethical and legal issues might be pertinent, is responsive to supervisory input.
- E** Often unaware of important ethical and legal issues.
- R** Disregards important supervisory input regarding ethics or law.

OBJECTIVE: ADMINISTRATIVE COMPETENCY

Demonstrates a growing ability to accomplish administrative tasks. Prioritizes appropriately. Shows a growing autonomy in management of larger administrative, research or clinical projects.

- A** Independently assesses the larger task to be accomplished, breaks the task into smaller ones and develops a timetable. Prioritizes various tasks and deadlines efficiently and without need for supervisory input. Makes adjustments to priorities as demands evolve.
- HI** Identifies components of the larger task and works independently on them. Needs some supervisory guidance to successfully accomplish large tasks within the timeframe allotted. Identifies priorities but needs input to structure some aspects of task.
- I** Completes work effectively, using supervision time to identify priorities and develop plans to accomplish tasks. Receptive to supervisory input to develop own skills in administration.
- E** Trainee takes on responsibility then has difficulty asking for guidance or accomplishing goals within timeframe.
- R** Deadline passes without task being done. Not receptive to supervisory input about own difficulties in this process.

GOAL: COMPETENCE IN INDIVIDUAL AND CULTURAL DIVERSITY

OBJECTIVE: PATIENT RAPPORT

Consistently achieves a good rapport with patients.

- A** Establishes quality relationships with almost all patients, reliably identifies potentially challenging patients and seeks supervision.
- HI** Generally comfortable and relaxed with patients, handles anxiety-provoking or awkward situations adequately so that they do not undermine therapeutic success.
- I** Actively developing skills with new populations. Relates well when has prior experience with the population.
- E** Has difficulty establishing rapport.
- R** Alienates patients or shows little ability to recognize problems.

OBJECTIVE: SENSITIVITY TO PATIENT DIVERSITY

Sensitive to the cultural and individual diversity of patients. Committed to providing culturally sensitive services.

- A** Discusses individual differences with patients when appropriate. Acknowledges and respects differences that exist between self and clients in terms of race, ethnicity, culture and other individual difference variables. Recognizes when more information is needed regarding patient differences and seeks out information autonomously. Aware of own limits to expertise.
- HI** In supervision, recognizes and openly discusses limits to competence with diverse clients.
- I** Has significant lack of knowledge regarding some patient groups, but resolves such issues effectively through supervision. Open to feedback regarding limits of competence.
- E** Is beginning to learn to recognize beliefs which limit effectiveness with patient populations.
- R** Has been unable or unwilling to surmount own belief system to deal effectively with diverse patients.

OBJECTIVE: AWARENESS OF OWN CULTURAL AND ETHNIC BACKGROUND

Aware of own background and its impact on clients. Committed to continuing to explore own cultural identity issues and relationship to clinical work.

- A** Accurately self-monitors own responses to differences, and differentiates these from patient responses. Aware of personal impact on clients different from self. Thoughtful about own cultural identity. Reliably seeks supervision when uncertain.
- HI** Aware of own cultural background. Uses supervision well to examine this in psychological work. Readily acknowledges own culturally-based assumptions when these are identified in supervision.
- I** Uses supervision well to recognize own cultural background and how this impacts psychological work. Comfortable with some differences that exist between self and clients and working well on others. May occasionally deny discomfort with patients to avoid discussing relevant personal and patient identity issues.
- E** Growing awareness of own cultural background and how this affects psychological work. Can make interpretations and conceptualizations from culturally-based assumptions. Responds well to supervision.
- R** Has little insight into own cultural beliefs even after supervision.

GOAL: COMPETENCE IN THEORIES AND METHODS OF PSYCHOLOGICAL DIAGNOSIS AND ASSESSMENT

OBJECTIVE: DIAGNOSTIC SKILL

Demonstrates a thorough working knowledge of psychiatric diagnostic nomenclature and DSM multiaxial classification. Utilizes historical, interview and psychometric data to diagnose accurately.

- A** Demonstrates a thorough knowledge of psychiatric classification, including multiaxial diagnoses and relevant diagnostic criteria to develop an accurate diagnostic formulation autonomously.
- HI** Has a good working knowledge of psychiatric diagnoses. Is thorough in consideration of relevant patient data, and diagnostic accuracy is typically good. Uses supervision well in more complicated cases involving multiple or more unusual diagnoses.
- I** Understands basic diagnostic nomenclature and is able to accurately diagnosis many psychiatric problems. May miss relevant patient data when making a diagnosis. Requires supervisory input on most complex diagnostic decision-making.
- E/R** Has significant deficits in understanding of the psychiatric classification system and/or ability to use DSM-IV criteria to develop a diagnostic conceptualization.

OBJECTIVE: PSYCHOLOGICAL TEST SELECTION AND ADMINISTRATION

Promptly and proficiently administers commonly used tests in his/her area of practice. Appropriately chooses the tests to be administered.

N/A Not applicable.

A Proficiently administers all tests. Completes all testing efficiently. Autonomously chooses appropriate tests to answer referral question.

HI Occasional input needed regarding fine points of test administration. Occasionally needs reassurance that selected tests are appropriate.

I Needs continued supervision on frequently administered tests. Needs occasional consultation regarding appropriate tests to administer.

E/R Test administration is irregular, slow, or often needs to recall patient to further testing sessions due to poor choice of tests administered.

OBJECTIVE: PSYCHOLOGICAL TEST INTERPRETATION

Competently interprets the results of psychological tests used in his/her area of practice.

N/A Not applicable

A Skillfully and efficiently interprets tests autonomously. Makes accurate independent diagnostic formulations on a variety of syndromes. Accurately interprets and integrates results prior to supervision session.

HI Demonstrates knowledge of scoring methods, reaches appropriate conclusions with some support from supervision.

I Completes assessments on typical patients with some supervisory input, occasionally uncertain how to handle difficult patients or unusual findings. Understands basic use of tests, may occasionally reach inaccurate conclusions or take computer interpretation packages too literally.

E/R Significant deficits in understanding of psychological testing, over-reliance on computer interpretation packages for interpretation. Repeatedly omits significant issues from assessments, reaches inaccurate or insupportable conclusions.

OBJECTIVE: ASSESSMENT WRITING SKILLS

Writes a well-organized psychological report. Answers the referral question clearly and provides the referral source with specific recommendations.

N/A Not applicable

A Report is clear and thorough, follows a coherent outline, and is an effective summary of major relevant issues. Relevant test results are woven into the report as supportive evidence. Recommendations are related to referral questions.

HI Report covers essential points without serious error, may need polish in cohesiveness and organization. Readily completes assessments with minimal supervisory input, makes useful and relevant recommendations.

I Uses supervision effectively for assistance in determining important points to highlight.

E/R Inaccurate conclusions or grammar interfere with communication or reports are poorly organized and require major rewrites.

OBJECTIVE: FEEDBACK REGARDING ASSESSMENT

Plans and carries out a feedback interview. Explains the test results in terms the patient and/or caregiver can understand, provides suitable recommendations and responds to issues raised by patient or caregiver.

N/A Not applicable

- A** Plans and implements the feedback session appropriately. Foresees areas of difficulty in the session and responds empathically to patient or caregiver concerns. Adjusts personal style and complexity of language and feedback details to accommodate patient or caregiver needs.
- HI** With input from supervisor, develops and implements a plan for the feedback session. May need some assistance to identify issues which may become problematic in the feedback session. May need intervention from supervisor to accommodate specific needs of patient or family.
- I** Develops plan for feedback session with the supervisor. Presents basic assessment results and supervisor addresses more complex issues. Continues to benefit from feedback on strengths and areas for improvement.
- E** Supervisor frequently needs to assume leadership in feedback sessions to ensure correct feedback is given or to address emotional issues of patient or caregiver.
- R** Does not modify interpersonal style in response to feedback.

**GOAL: COMPETENCE IN THEORIES AND METHODS OF
EFFECTIVE PSYCHOTHERAPEUTIC INTERVENTION**

OBJECTIVE: PATIENT RISK MANAGEMENT AND CONFIDENTIALITY

Effectively evaluates, manages and documents patient risk by assessing immediate concerns such as suicidality, homicidality, and any other safety issues. Collaborates with patients in crisis to make appropriate short-term safety plans, and intensify treatment as needed. Discusses all applicable confidentiality issues openly with patients.

- A** Assesses and documents all risk situations fully prior to leaving the worksite for the day. Appropriate actions taken to manage patient risk situations (e.g. escorting patient to ER) are initiated immediately, then consultation and confirmation of supervisor is sought. Establishes appropriate short-term crisis plans with patients.
- HI** Aware of how to cope with safety issues, continues to need occasional reassurance in supervision. Asks for input regarding documentation of risk as needed. Sometimes can initiate appropriate actions to manage patient risk, sometimes needs input of supervisor first. May occasionally forget to discuss confidentiality issues promptly.
- I** Recognizes potentially problematic cases, but needs guidance regarding evaluation of patient risk. Supervision is needed to cope with safety issues; afterwards trainee handles them well. Can be trusted to seek consultation immediately if needed, while patient is still on site. Needs to refine crisis plans in collaboration with supervisor. Needs input regarding documentation of risk. Occasionally needs prompting to discuss confidentiality issues with patient.
- E** Delays or forgets to ask about important safety issues. Does not document risk appropriately but does not let patient leave site without seeking "spot" supervision for the crisis. Does not remember to address confidentiality issues, needs frequent prompting. Fear may overwhelm abilities in patient crises.
- R** Makes inadequate assessment or plan, then lets patient leave site before consulting supervisor.

OBJECTIVE: CASE CONCEPTUALIZATION AND TREATMENT GOALS

Formulates a useful case conceptualization that draws on theoretical and research knowledge. Collaborates with patient to form appropriate treatment goals.

- A** Independently produces good case conceptualizations within own preferred theoretical orientation, can also draw some insights into case from other orientations. Consistently sets realistic goals with patients.
- HI** Reaches case conceptualization on own, recognizes improvements when pointed out by supervisor. Readily identifies emotional issues but sometimes needs supervision for clarification. Sets appropriate goals with occasional prompting from supervisor, distinguishes realistic and unrealistic goals.
- I** Reaches case conceptualization with supervisory assistance. Aware of emotional issues when they are clearly stated by the patient, needs supervision for development of awareness of underlying issues. Requires ongoing supervision to set therapeutic goals aside from those presented by patient.
- E/R** Responses to patients indicate significant inadequacies in theoretical understanding and case formulation. Misses or misperceives important emotional issues. Unable to set appropriate treatment goals with patient.

OBJECTIVE: THERAPEUTIC INTERVENTIONS

Interventions are well-timed, effective and consistent with empirically supported treatments.

- A** Interventions and interpretations facilitate patient acceptance and change. Demonstrates motivation to increase knowledge and expand range of interventions through reading and consultation as needed.
- HI** Most interventions and interpretations facilitate patient acceptance and change. Supervisory assistance needed for timing and delivery of more difficult interventions.
- I** Many interventions and interpretations are delivered and timed well. Needs supervision to plan interventions and clarify interpretations.
- E/R** Most interventions and interpretations are rejected by patient. Has frequent difficulty targeting interventions to patients' level of understanding and motivation.

OBJECTIVE: EFFECTIVE USE OF EMOTIONAL REACTIONS IN THERAPY (COUNTERTRANSFERENCE)

Understands and uses own emotional reactions to the patient productively in the treatment.

- A** During session, uses countertransference to formulate hypotheses about patient's current and historical social interactions, presents appropriate interpretations and interventions. Able to identify own issues that impact the therapeutic process and has ideas for coping with them. Seeks consultation as needed for complex cases.
- HI** Uses countertransference to formulate hypotheses about the patient during supervision sessions. Can identify own issues that impact therapeutic process. Interventions generally presented in the following session.
- I** Understands basic concepts of countertransference. Can identify own emotional reactions to patient as countertransference. Supervisory input is frequently needed to process the information gained.
- E** When feeling anger, frustration or other intense emotional response to the patient, blames patient at times. Welcomes supervisory input and can reframe own emotional response to the session.

R Unable to see countertransference issues, even with supervisory input.

OBJECTIVE: GROUP THERAPY SKILLS AND PREPARATION

Intervenes in group skillfully, attends to member participation, completion of therapeutic assignments, group communication, safety and confidentiality. If the group is psychoeducational, readies materials for group, and understands each session's goals and tasks.

- A** Elicits participation and cooperation from all members, confronts group problems appropriately and independently, and independently prepares for each session with little or no prompting. Can manage group alone in absence of cotherapist/supervisor with follow-up supervision later.
- HI** Seeks input on group process issues as needed, then works to apply new knowledge and skills. Needs occasional feedback concerning strengths and weaknesses. Generally prepared for group sessions.
- I** Welcomes ongoing supervision to identify key issues and initiate group interaction. Actively working on identifying own strengths and weaknesses as a group leader. Identifies problematic issues in group process but requires assistance to handle them. May require assistance organizing group materials.
- E** Has significant inadequacies in understanding and implementation of group process. Unable to maintain control in group sufficient to cover content areas. Preparation is sometimes disorganized.
- R** Defensive or lacks insight when discussing strengths and weaknesses. Frequently unprepared for content or with materials.

**GOAL: COMPETENCE IN SCHOLARLY INQUIRY AND APPLICATION OF
CURRENT SCIENTIFIC KNOWLEDGE TO PRACTICE**

OBJECTIVE: SEEKS CURRENT SCIENTIFIC KNOWLEDGE

Displays necessary self-direction in gathering clinical and research information practice independently and competently. Seeks out current scientific knowledge as needed to enhance knowledge about clinical practice and other relevant areas.

- A** Fully dedicated to expanding knowledge and skills, independently seeks out information to enhance clinical practice utilizing available databases, professional literature, seminars and training sessions, and other resources.
- HI** Shows initiative, eager to learn, beginning to take steps to enhance own learning. Identifies areas of needed knowledge with specific clients. Asks for and responsive to supervisor's suggestions of additional informational resources, and pursues those suggestions.
- I/E** Open to learning, but waits for supervisor to provide guidance. When provided with appropriate resources, willingly uses the information provided and uses supervisor's knowledge to enhance own understanding.
- R** Unwilling to acquire or incorporate new information into practice. Resists suggestions to expand clinical perspective. Procrastinates on readings assigned by supervisor.

OBJECTIVE: DEVELOPS AND IMPLEMENTS RESEARCH PLAN

Develops and implements plan for research or other professional writing or presentation.

- A** Develops research plan alone or in conjunction with a colleague. Is a full and equal participant in the project.
- HI** Provides substantive input into the plan. Demonstrates ability to execute at least one aspect of the project independently.
- I/E** Provides helpful suggestions regarding design and implementation of a colleague's plan. Provides significant assistance in the accomplishment of the project.
- R** Does not follow-through with responsibilities in development or implementation of plan.

GOAL: COMPETENCE IN PROFESSIONAL CONSULTATION

OBJECTIVE: CONSULTATION ASSESSMENT

Performs an assessment of the patient referred for consultation, incorporating mental status exam, structured interview techniques or psychological assessment, as needed, to answer the referral question.

- N/A** Not applicable.
- A** Chooses appropriate means of assessment to respond effectively to the referral question; reports and progress notes are well-organized and provide useful and relevant recommendations with minimal supervisory input.
- HI** Occasional input is needed regarding appropriate measures of assessment and effective write-up of report or progress notes to best answer the referral question
- I/E** Needs continued supervision regarding appropriate assessment techniques to complete consultations as well as input regarding integration of findings and recommendations.
- R** Consultation reports and progress notes are poorly written and/or organized. Fails to incorporate relevant information and/or use appropriate measures of assessment necessary to answer the referral question.

OBJECTIVE: CONSULTATIVE GUIDANCE

Gives the appropriate level of guidance when providing consultation to other health care professionals, taking into account their level of knowledge about psychological theories, methods and principles.

- N/A** Not applicable.
- A** Relates well to those seeking input, is able to provide appropriate feedback.
- HI** Requires occasional input regarding the manner of delivery or type of feedback given.
- I/E** Needs continued guidance. May need continued input regarding appropriate feedback and knowledge level of other professionals.
- R** Unable to establish rapport.

-
GOAL: COMPETENCE IN PROVIDING CLINICAL SUPERVISION

OBJECTIVE: SUPERVISORY SKILLS

Demonstrates good knowledge of supervision techniques and employs these skills in a consistent and effective manner, seeking consultation as needed. Builds good rapport with supervisee.

N/A Not applicable.

A Spontaneously and consistently applies supervision skills. Supervisee verbalizes appreciation of trainee's input.

HI Consistently recognizes relevant issues, needs occasional guidance and supervisory input. Well thought of by supervisee. Supervisee recognizes at least one significant strength of trainee as a supervisor as documented on evaluation form.

I/E Generally recognizes relevant issues, needs guidance regarding supervision skills. Supervisee finds input helpful. Trainee is rated by supervisee at the satisfactory or higher level in all areas.

R Unable to provide helpful supervision.

ROTATION-SPECIFIC GOALS AND SKILLS

Please list the major goals of your rotation and rate the intern's performance on meeting them.

1. Goal:

Comments:

Rating: _____ Advanced
 _____ High intermediate
 _____ Intermediate
 _____ Entry level
 _____ Needs remedial work

2. Goal:

Comments:

Rating: _____ Advanced
 _____ High intermediate
 _____ Intermediate
 _____ Entry level
 _____ Needs remedial work

3. Goal:

Comments:

Rating: _____ Advanced
 _____ High intermediate
 _____ Intermediate
 _____ Entry level
 _____ Needs remedial work

4. Goal:

Comments:

Rating: _____ Advanced
 _____ High intermediate
 _____ Intermediate
 _____ Entry level
 _____ Needs remedial work

5. Goal:

Comments:

Rating: _____ Advanced
_____ High intermediate
_____ Intermediate
_____ Entry level
_____ Needs remedial work

Please list the skills that your rotation is designed to teach and rate the intern's success at learning and performing them.

1. Skill:

Comments:

Rating: _____ Advanced
_____ High intermediate
_____ Intermediate
_____ Entry level
_____ Needs remedial work

2. Skill:

Comments:

Rating: _____ Advanced
_____ High intermediate
_____ Intermediate
_____ Entry level
_____ Needs remedial work

3. Skill:

Comments:

Rating: _____ Advanced
_____ High intermediate
_____ Intermediate
_____ Entry level
_____ Needs remedial work

4. Skill:

Comments:

Rating: _____ Advanced

- _____ High intermediate
- _____ Intermediate
- _____ Entry level
- _____ Needs remedial work

5. Skill:

Comments:

- Rating:
- _____ Advanced
 - _____ High intermediate
 - _____ Intermediate
 - _____ Entry level
 - _____ Needs remedial work

SUPERVISOR COMMENTS

Summary of strengths:

Areas needing additional development or remediation, including recommendations:

Remedial Work Instructions: In the rare situation when it is recognized that a trainee needs remedial work, a competency assessment form should be filled out **immediately**, prior to any deadline date for evaluation, and shared with the trainee and the director of training. In order to allow the trainee to gain competency and meet passing criteria for the rotation, these areas must be addressed proactively and a remedial plan needs to be devised and implemented promptly. One month after a remediation plan is in place, the supervisor will complete a follow-up evaluation with the intern and will provide a copy to the Director of Training. If the minimal threshold for competency is not met at that time, the trainee and supervisor will continue with the remediation plan and subsequent monthly evaluations and reporting to the Director of Training. For VA interns, if the rotation ends before competencies are met, the Director of Training will work with the supervisor for the next rotation to put a training plan in place that addresses areas of weakness identified in the previous rotation.

Goal for intern evaluations done at mid-rotation (VA interns) or mid-year (UM interns): All competency areas will be rated at a level of competence of **I** or higher. No competency areas will be rated as **R** or **E**.

Goal for intern evaluations done at the end of rotation (VA interns) or at the end of the internship year (UM interns): At least 80% of competency areas will be rated at level of competence of **HI** or higher. No competency areas will be rated as **R** or **E**. Note: exceptions would be specialty area rotations that would take a more intensive course of study to achieve this level of competency and the major supervisor, training director and trainee agree that a level of **I** is appropriate for that particular rotation, e.g. a neuropsychology rotation for a comprehensive track trainee.

_____ The trainee HAS successfully completed the above goal for this evaluation period. We have reviewed this evaluation together.

_____ The trainee HAS NOT successfully completed the above goal for this evaluation period. We have made a joint written remedial plan as attached, with specific dates indicated for completion. Once completed, the rotation will be re-evaluated using another evaluation form, or on this form, clearly marked as an updated evaluation. We have reviewed this evaluation together.

Supervisor _____

Date _____

Trainee Comments Regarding Competency Evaluation (if any):

I have received a full explanation of this evaluation. I understand that my signature does not necessarily indicate my agreement.

Trainee _____

Date _____

Supervisor Feedback Form

2012-2013

Intern name: _____ Supervisor name: _____

Rotation/Clinic: _____

Evaluation time point: UM interns: First mid-year (Oct.)
 Second mid-year (Feb.)
 Final

VA interns: 1st rotation mid final
 2nd rotation mid final
 3rd rotation mid final

Please use the Likert scale below to rate the supervision you received on this rotation.

Very Ineffective	Not Effective	Somewhat Effective	Effective	Very Effective	Not Applicable
1	2	3	4	5	N/A

Supervisory Responsibilities

The supervisor was at supervisory meetings promptly and reliably.
 1 2 3 4 5
 N/A

The supervisor was available for "spot supervision."
 1 2 3 4 5
 N/A

The supervisor educated me fully about documentation and confidentiality issues.
 1 2 3 4 5
 N/A

The supervisor clarified roles, process of supervision and a plan to meet my training needs at the start of the rotation.
 1 2 3 4 5
 N/A

Comments:

Supervisory Content

The supervisor discussed ethical issues pertaining to patient care.
 1 2 3 4 5
 N/A

The supervisor discussed diversity issues related to my training experience.
 1 2 3 4 5
 N/A

The supervisor educated me about coping with risk issues such as suicidality and homicidality in therapy, including assessment, documentation, contracting and addressing the issue therapeutically.
 1 2 3 4 5
 N/A

The supervisor provided didactic material (i.e., readings, trainings) that was effective in expanding my knowledge base in the field and/or the specialty area he/she provides supervision in.

We have reviewed the above evaluation together.

Intern _____ Date _____

Supervisor _____ Date _____