

ARMY CLINICAL PSYCHOLOGY INTERNSHIP MANUAL



WALTER REED NATIONAL MILITARY MEDICAL CENTER

BETHESDA, MARYLAND

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I. PREFACE

The following Manual describes in detail the Walter Reed National Military Medical Center, Bethesda Army predoctoral clinical psychology internship. This internship integrates, as much as possible, residents from both Army and Navy services in an effort to more fully prepare graduates to provide world class behavioral health services to soldiers and sailors.

This site is not a *Consortium*, as defined by the American Psychological Association (APA). While the two internship programs share a nearly identical curriculum and faculty, each maintains separate APA accreditation.

Addresses of interest (Also listed in the APPIC Directory)

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II. TRAINING PHILOSOPHY

1. Overview. The internship is organized around a **Practitioner-Scholar** model. Day-to-day training emphasizes increasing skills in clinical practice and increasing familiarity with research underpinnings for that practice. We recognize and emphasize that science and practice are interlocking skills forming the foundation of psychological knowledge and practice. The training faculty expects residents to learn to practice clinical psychology in a manner that is informed by psychological theory and research. Although research is not required as part of the internship, we expect residents to learn about evidence-based practice and to become familiar with interventions that have been supported by research. The training faculty supports residents getting their own personal psychotherapy during the internship year, if they wish to do so. The training director can help identify no-cost sources for this endeavor.

Before starting internship, selected applicants are commissioned as Army Captains in the Medical Service Corps. During the internship (and subsequent service as active duty Army psychologists), residents receive full pay and benefits as Army officers rather than as psychology residents. Up-to-date information about pay and benefits can be found at www.defenselink.mil/militarypay/pay/. Annual pay raises occur as determined by the U.S. Congress.

Inquiries regarding accreditation may be addressed to the American Psychological Association's Committee on Accreditation at the following address or phone number:

Office of Program Consultation and Accreditation
American Psychological Association
750 First Street, N.E.
Washington, D.C., 20002-4242
(202) 336-5979

2. Specifics

- a. The internship program in clinical psychology is a twelve month period of academic and clinical training in a military setting designed to meet two broad goals. The first goal is to provide the trainee with the experiences and skills necessary to meet the general requirements endorsed by the American Psychological Association. The second goal is to equip the trainee with specific skills needed to practice within the military health care system.
- b. The following doctoral degree requirements must be completed prior to entrance into the Army. These include: (1) all required coursework (2) written and oral comprehensive examinations (3) pre-internship practica and (4) acceptance of dissertation proposal and data collection in progress (there should be assurance that data collection will be finalized preferably before the start of internship). Whenever possible, the dissertation should be completed prior to internship, but completion is not required. Occasionally, time will be provided to help the resident complete the dissertation during the internship year.
- c. Army internship graduates can pursue one of three options following timely completion of the internship and graduation from their doctoral program. Option 1: The graduate can elect to attend the Clinical Psychology Residency Program (CPRP) where they spend 3 month rotations at the following locations: WRNMMC, Ft Belvoir, Ft Meade, and Ft Drum. Option 2: Apply and be accepted to the operational psychology residency at Ft. Bragg. Option 3: Decline from participation in a residency year and immediately obtain licensure and Permanent Change of Station (PCS) to next assignment.
- d. The internship is one of a set of supervised experiences, and supervision continues past the internship. The process includes obtaining the doctorate, required postdoctoral supervised experience, licensure, and credentialing by the hospital command. Review and re-credentialing is then required at least every two years or when the psychologist transfers to a new duty station. The intent of the internship program is to support this continuous process of professional growth by providing those skills necessary to perform satisfactorily wherever the Army officer is assigned.
- e. The major rotations (subject to change) reflect areas of clinical practice in which military clinical psychologists provide services: outpatient, assessment, neuropsychology, and primary care/health psychology. By concentrating the resident's experiences sequentially while simultaneously providing ongoing experiences in each

area throughout the year of training, the best balance for achieving the learning goals occurs.

III. PROGRAM DESCRIPTION

1. Overview. Following a nine week orientation to the Army at Basic Officer Leadership Course (BOLC) in San Antonio, Texas, trainees report to Walter Reed National Military Medical Center (WRNMMC). The internship year is comprised of a two-week long orientation period followed by the clinical rotations. The year is 52 weeks long. The didactic portion consists of lectures and seminars throughout the year. Additionally, there are transrotational experiences to expand therapy and assessment skills. The residents typically spend approximately one week at Ft Bragg learning about opportunities that exist as an operational psychologist. While the program described below is planned for the coming year, it is subject to change since the internship is always seeking to improve based on faculty and trainee input.
2. Orientation. The orientation period is the two-weeks before clinical work on the internship begins and covers such topics as: departmental structure, hospital command orientation, rotation overview, dissertations, schedule of didactics, office assignments, etc.
3. Clinical Rotations
 - a. Outpatient Rotation. During this rotation, residents will learn how to do mental health evaluations and follow-up treatment/disposition of patients referred from a large number of sources, including self-referral, with a wide variety of presenting problems. Residents will carry a caseload of individual psychotherapy patients, and in addition, may engage in supervised outpatient experiences in group therapy and couples therapy. Residents will learn how to assess and manage risk for self-directed and other-directed aggression on an outpatient basis, as well as learn how and when to move patients to more intensive or controlled treatment environments. In addition, residents will learn how to conduct military-specific evaluations for a variety of purposes, including Security Clearances, Disability/Medical Retirement evaluations, Fitness for Duty, and suitability screenings.
 - b. Assessment Rotation. After interviewing a patient and reviewing the medical record, the resident provides psychological testing of patients referred from a variety of sources. Testing results and recommendations address the referral questions and may suggest additions or changes to the treatment plan. Testing feedback is routinely provided to the patient, unless it is a command referral. Feedback to patients should follow the model of therapeutic test interpretation.
 - c. Primary Care/Health Psychology. During this rotation, residents work in the Primary Care clinic for six weeks practicing a collaborative population health approach to behavioral health. Residents serve as consultants to primary care providers who rapidly evaluate patients' symptoms and functioning. Residents address patients' needs with regard to chronic health conditions and behavioral health conditions. Residents increase motivation for behavioral change, provide brief, targeted interventions and dispositional recommendations. Problems addressed include

headaches, pain, anxiety, insomnia, weight reduction, treatment adherence, and lifestyle management. The remaining six weeks of the rotation are electives and include psycho-oncology, pre and post operative assessment, pain treatment, sleep clinic, tobacco cessation, and diabetes/obesity. The mini-rotation skills and experiences, though brief and highly specific, translate to any clinical setting.

- d. Neuropsychology. Residents will have the opportunity to evaluate a variety of outpatients with neurological complaints or diagnoses as they participate in three sub-rotations. The first sub-rotation will expose residents to inpatient evaluations of patients with acute injuries; the second sub-rotation will involve evaluation of outpatients who have suffered traumatic brain injuries (TBI); and the third sub-rotation will involve evaluation of non-TBI related neurological complaints. By the end of the rotation, residents will be able to accurately diagnose traumatic brain injuries and perform basic neuropsychological evaluations.
4. Didactic Training Presentations. A comprehensive program of regularly scheduled seminars, lectures, and workshops accompanies the intensive direct supervision inherent in the several rotations. These didactic presentations are designed to provide the resident with state-of-the-art information and training relevant to effective functioning as a psychologist in the Army. There are several varieties: (1) extended seminar series each of which is comprised of a number of sessions and which cover different topics such as psychodiagnostic testing tools, neuropsychology, short-term treatment models, (2) individual lectures which focus on special topics, such as suicide evaluation and management, assessment and treatment of insomnia, military psychology, etc., and (3) workshops, such as Rorschach interpretation, MMPI-2, MCMI III, empirically validated treatments for PTSD, psychodynamic theory and practice, etc. The presenters of these didactic programs are principally distinguished colleagues from the civilian clinical and academic communities. Seminar presentations are scheduled and announced in advance, and invitations are issued to neighboring Navy and Marine Corps Commands (e.g., Naval Academy, Patuxent River Naval Air Station, Quantico Marine Corps Base), Andrews Air Force Base, WRNMMC Army interns and faculty, Washington Veterans Administration Hospital, and local universities and internship programs.

In addition, there are twice monthly psychotherapy seminars attended by the Army residents. During the first half of the year there is a psychodynamic psychotherapy seminar followed in the second half of the year by a cognitive behavioral therapy seminar. Didactics in operational psychology are conducted twice monthly. Rotation-specific didactics are also presented.

5. Operational Orientation. As part of the internship year, Army residents will participate in an orientation to the opportunities that exist as an operational psychologist at Ft. Bragg. During this week, residents will tour the many training facilities for the Army's Special Forces. An overview of the APA accredited operational psychology residency will be provided. Interested residents will have the opportunity to interview for the residency positions during this visit. A one week didactic with Deployment Health (CDP) will present relevant topics like approaches to treating PTSD, family perspectives on effects on the family during deployment, etc. Feedback about student participation will be provided by those operational psychologists at Ft. Bragg

6. Transrotational Requirements.

- a. Long-Term Individual Therapy Case. Each resident is expected to carry one long-term, psychodynamic outpatient case during the year (long-term means at least 9 months). The Director of Training will coordinate the assignment of long-term cases and insure weekly supervision is provided.
- b. Therapy for Posttraumatic Stress Cases. Each resident is expected to carry cases of patients suffering from PTSD. Whenever possible, a case will be treated to completion before the next is begun. Each case will be treated using a different evidence-based model. The cases may be supervised by one supervisor or separate supervisors, depending on the model used and the expertise of the supervisor.
- c. Professional Development Seminar. Every other week the residents meet with the seminar leader. Readings may be provided for discussion. This seminar provides the residents with the opportunity to discuss issues related to being a psychologist in the Army, work on interpersonal issues with each other, discuss concerns about the internship, etc.
- d. Operational Psychology Seminar. A didactic curriculum will be followed, exposing the residents to the different roles, experiences, and jobs military psychologists can perform outside of the traditional mental health setting. Psychologists will be invited to speak about their personal operational assignments to help acquaint the residents with different operational experiences.

7. Internship Meetings. All residents attend a weekly meeting with the Director of Psychology Training, MAJ Yeaw.

The Chief Resident attends the weekly psychology faculty meeting as the resident representative. The Chief Resident is expected to bring resident questions, issues, and concerns to that meeting and to carry back information from the faculty.

8. Grand Rounds. The mental health staff meets weekly for Grand Rounds. A staff member, trainee, or invited speaker presents a topic. Rotation supervisors will inform residents if they are to attend while on the specific rotation.
9. Additional Functions, Roles and Support.

- a. Chief Resident. Each resident will function as the Chief Resident alongside their Navy Adjutant counterpart. As such, the resident serves as the senior member of the class and as a conduit for information between the staff and the residents. Specific responsibilities include the following:
 - Attend the weekly faculty meeting (usually for the first few minutes of that meeting) to brief faculty regarding residents' status/questions.
 - For the seminar series, the Chief Resident is responsible for attendance sheets, lecture evaluation forms from residents, continuing education forms for staff, and equipment needed by the presenter. The Chief Resident conveys weekly seminar information to Air Force, Navy, Army, and VA Interns.
 - Organize all paperwork and travel for operational activities for the internship class.

- Maintain an email and phone list for Air Force, Navy, Army, and VA Interns.
 - Maintain the ER float schedule.
- b. ER Watch. The resident will be assigned to share ER watch with psychiatry residents on specific days throughout the year for a time period that will begin at 1550 on 7W and extend no later than 2300. Supervision will be provided by the on call staff psychiatrist.
 - c. Medical Service Corps Membership. Since the psychology residents are Medical Service Corps (MSC) officers, it is strongly encouraged that they interact professionally and socially with other MSC officers assigned to the hospital. Such interaction is not only important to the smooth and effective performance of the psychologist's job when it extends beyond the behavioral health clinic but also serves to increase the resident's appreciation of other non-physician specialists in the Army health care system just as it increases others' awareness of the psychologist's role.
 - d. Support. There are clerical and support personnel who assist staff and residents in making appointments, checking patients in, contacting residents when patients arrive, when phone calls come in to the front desk, etc.

IV. OBJECTIVES

Appendix A describes the competencies, knowledge, skills and abilities required of residents who successfully complete the training program. Appendix A covers the rotational and transrotational requirements.

V. EVALUATION

1. The method for evaluation has two components: evaluation of resident performance and evaluation of the internship program.
2. Resident Performance Evaluation. Residents will be evaluated by the following methods:
 - a. Weekly supervision. During each clinical rotation the resident receives several hours of weekly supervision. This supervision, in part, reviews progress toward rotational competencies and learning goals. At mid-rotation, the resident and supervisor will have a formal session to review progress on competencies and learning goals.
 - b. Professional Performance Evaluation. Each supervisor will perform a mid-rotation written evaluation to help the resident gauge how he/she is doing. These evaluations are not submitted to the Director but are for purposes of feedback. The end-of-rotation performance evaluation is submitted to the Director of Training by the rotation supervisors and reflects input from all staff having supervised the resident on requirements for a specific rotation (see Appendix A). These written evaluations are

shared with the residents and then with the Director of Training and are filed in the residents' training files.

- c. Officer Evaluation Report: (see Appendix B). As military officers, residents are also rated on their military traits and performance. Officer Evaluation Reports (OER) become part of their permanent military service record and are used in the promotion process.
3. Internship Program Evaluation. At mid-year and at the end of the internship, each resident will submit written critiques of the training program. Trainee identification on the critiques is optional. Rating scale and open-ended critique forms are included in Appendix C.

VI. POLICIES

1. Provision and Documentation of Supervision

- a. Rotation Supervision. Ongoing case supervision will be coordinated by the faculty member in charge of the rotation to which the resident is assigned. Over the course of the year, the resident should receive supervision from most of the psychology faculty and perhaps some of the psychiatry and social work staff as well.

IT IS VERY IMPORTANT TO NOTE THAT IN ADDITION TO SCHEDULED SUPERVISION TIMES, THE STAFF IS AVAILABLE FOR AND STRONGLY ENCOURAGES ADDITIONAL SUPERVISION WHENEVER NEEDED.

In order to graduate from the internship, residents are required to successfully complete all of the rotations. While assigned to a rotation, one or more independent privileged providers, usually Psychologists, supervise all of the resident's clinical work.

- b. Primary Care/Health Psychology Rotation. Professional services are part of the interdisciplinary Primary Care Clinic. Rapid evaluation and documentation for patients seen in a medical clinic is emphasized. For ongoing treatment cases, an independent privileged provider (usually the Primary Care Psychologist) will document supervision by countersigning the initial note, all progress notes, and transfer or termination note in the patient's computerized health record. Evaluation and progress notes will be entered in the patient's computerized health record after each patient contact. A similar procedure is used on the elective health psychology specialty areas.
- c. Outpatient Rotation. During this rotation, residents will learn how to do rapid evaluations of patients referred from a large number of sources with a wide variety of presenting problems. After evaluating a patient, the resident may provide treatment, refer the patient to an appropriate military or civilian health care provider, or facilitate discharge of the patient from the service. Residents may engage in supervised outpatient group, family, couples, and individual psychotherapy.
- d. Assessment Rotation. Assessment referrals will come from different sources. Assessments will be in response to a written consult from the Outpatient Clinic, Inpatient Psychiatric Unit, Inpatient Psychological Health-Traumatic Brain Injury

Program, or from outside of the WRNMMC (surrounding clinics). A psychological testing battery will be constructed to optimally answer referral questions, and residents will learn to use a wide range of self-report and performance-based tests. Examples of the former include MMPI-2, PAI, and MCMI III while examples of the latter include Rorschach, WAIS-IV, and academic achievement tests. Reports will be prepared in writing and signed by the psychology resident and supervising independent privileged psychologist prior to distribution.

- e. Neuropsychology Rotation. On this rotation, the resident is assigned responsibility, under supervision, for evaluating outpatients with neuropsychological test batteries and neuropsychological screening instruments. Inpatients are evaluated and treated under the supervision of licensed psychologists and neuropsychologists. All notes are countersigned by the independent privileged supervisor.
- f. Transrotational Supervision. During the year, the psychology residents will carry one individual psychodynamic psychotherapy case outside of and across the rotations. The supervisor will be an independent privileged provider who will document supervision by countersigning the initial note, every progress note, and the termination note in the computerized health record.

2. Supervisee Limits of Confidentiality

- a. Overview. Resident performance is discussed at weekly faculty meetings with regard to professional behavior (e.g., clinical skills, ethical conduct, areas of proficiency, areas in need of improvement) and military bearing (e.g., appearance and behavior befitting an officer).
- b. Professional and Military Performance. Professional and military performance are discussed in faculty meetings in order to ensure that faculty who are supervising or will be supervising a resident are aware of the trainee's strengths and potential areas for growth. Regarding the latter, discussion is focused on identifying the best approaches to be used to help the resident. Strengths and areas for growth are documented and filed in the resident's training file. Each rotation head will review the goals, objectives, and expectations with the resident at the beginning of the rotation. The resident's performance and progress are documented on the evaluation forms, and these are filed in the trainee's training folder after the resident has signed them.
- c. Personal Information. Personal information that a resident shares with a faculty member will generally be kept confidential. Personal information will not be shared with other faculty unless the resident gives permission, or there is a discussion with the trainee about the need to share the information and the impact on the resident's training if the information were not shared. Otherwise, except for unusual and extraordinary circumstances (e.g., if physical harm, abuse or court order is involved, if there is an ethical violation or legal issue involved, or if the supervisor must violate confidentiality to defend against legal action taken before the court), confidentiality will be maintained.

Personal information about the resident that is revealed during supervision will not be shared with other members of the faculty or the Training Director unless doing so is deemed necessary to further the resident's training. The decision to convey personal information about the trainee to other faculty members or the Training Director will be

discussed with the resident in advance. The discussion will include reasons why the resident's training would benefit from such disclosure. In most cases, the resident's personal history and family issues are not relevant beyond the individual supervision in which they were disclosed and will be kept confidential

- d. Audio/Video Recordings. In cases where a video or audio medium is used for supervision, the recording will be erased after it is reviewed in supervision, to the extent that the medium will allow this. The resident, not the supervisor, maintains control over the medium. If for any reason, the supervisor wishes the data saved, this must be discussed with the resident and the two must agree. Possible exceptions would be if the recording is being archived for teaching purposes or to document deficiencies in the trainee's skills and their remediation. In any case, the resident would be made aware of this before such archiving was begun and that the purpose is for training or documentation of deficiencies and progress in remediation.
- e. Written Evaluations. Formal written evaluations will be completed by rotation supervisors and transrotational supervisors at the midpoint and end of rotation. These will be shared with and signed by the resident before they are given to the Training Director who will review and sign them. The Training Director will give them to the Administrative Officer for filing in the resident's training folder. This folder is maintained for future reference when documentation of internship and training experiences and/or recommendations are requested by the resident or a potential employer. In the event that the resident feels due process has not been followed, refer to the next section on Management of Deficient Resident Performance in the internship manual for directions on how to proceed.

3A. MANAGEMENT OF RESIDENT INSUFFICIENT PERFORMANCE

1. Purpose. The purpose of this section is to prescribe policy and procedures for the management of Psychology Department fellows, residents, and interns (trainees) who are making insufficient progress in their respective training programs. This departmental guide is meant to supplement and complement the policies and regulations of Walter Reed National Military Medical Center (WRNMMC) and the Army Medical Department (AMEDD) which should be reviewed for a complete understanding of policy and procedures.
2. Applicability. This guidance applies to all trainees enrolled in a professional training program conducted or overseen by the Department of Psychology. This includes the Clinical Psychology Internship Program (CPIP), the Clinical Psychology Residency Program (CPRP), the Clinical Neuropsychology Fellowship, and the Forensic Psychology Fellowship. This guidance does not apply to practicum students or interns on rotation from other services, departments, or organizations in the Department.
3. References. Note that some references are Walter Reed Army Medical Center (WRAMC) documents that have been adopted for use by WRNMMC Department of Psychology until such time as new guidance is issued. You'll be notified as soon as these become available.
 - a. [DoD Directive 1332.18](#) Separation or Retirement for Physical Disability
 - b. DoD Directive 6490.1 Mental Health Evaluations of Members of the Armed Forces

- c. [DoD Instruction 1332.38](#) Physical Disability Evaluation
 - d. AR 351-3 Professional Education and Training Programs in the Army Medical Department
 - e. WRAMC Regulation 351-3 (Supplement)
 - f. WRNMMC Army Clinical Psychology Internship Manual
 - g. WRAMC Clinical Psychology Residency Program Description and SOP
 - h. WRAMC Post-doctoral Training Program in Clinical Neuropsychology Description and SOP
 - i. WRAMC Post-doctoral Training Program in Forensic Psychology Description and SOP
 - j. American Psychological Association, Ethical Principles of Psychologists and Code of Conduct
 - k. American Psychological Association, Manual for the Accreditation of Internships
4. Definitions.
- a. Insufficient progress means failure to successfully complete academic course work required by the training program and/or failure to master a substantial portion of the knowledge and clinical skills appropriate to a trainee's level of training. A designation of insufficient progress is not necessarily a global indictment of the skills and knowledge of a trainee. However, it does indicate that there are critical areas of skill or knowledge that do not meet acceptable standards and need improvement. When trainees (usually fellows) are enrolled in academic courses in which the instructor gives grades, each Program Director (PD) will inform trainees in advance of the standards he/she will use to determine successful completion. Different standards (grades) may apply to different academic courses.
 - b. A disciplinary matter may result from an act or pattern of acts that demonstrates willful failure to adhere to training requirements, culpable violation of professional ethics, negligence in patient care, misconduct, or serious failure to adhere to the standards of quality care demanded by the program or the Army Medical Department.
 - c. Probation means a period of time during which a trainee, having been designated as making insufficient progress, undertakes a formal remediation plan and is evaluated for retention in the program. The hospital Professional Education and Training Committee (PETC) may place a trainee on probation when attempts to improve performance at the departmental level have proven ineffective or when the type or seriousness of the deficiencies warrants such action.
5. General Principles.

- a. It is the goal of each training program in the department to educate and graduate its trainees. The faculty recognizes its duty to provide special assistance to trainees who are having difficulty learning. When a trainee is determined to be making insufficient progress, staff supervisors and the trainee involved will cooperatively attempt to find the reasons for the difficulties to develop a well reasoned plan for remediation. It is expected that trainees will apply themselves especially diligently when their performance does not meet the standards of the program.
 - b. The directors of training and the department chief will address individual training deficiencies at a level consistent with the nature and seriousness of the problem(s). Most matters can be resolved with the collaboration of the trainee, clinical supervisor(s), and the PD. Should a particular issue be deemed serious or prove intractable, it will be referred to the hospital Professional Education and Training Committee (PETC) for action. It should be recognized that the Hospital Commander, through the PETC, has the ultimate authority by regulation to make decisions regarding probation, dismissal, and disciplinary action. The relevant regulations also provide for the trainee's rights and procedures that must be followed.
 - c. It is the intent of this policy to separate failure to learn and progress from disciplinary matters. The latter are handled through command channels and may result in formal counseling statements, letters of reprimand, or even nonjudicial punishment by the Commander through the Uniform Code of Military Justice. On the other hand, it is recognized that not all transgressions or ethical violations should be viewed simply as disciplinary matters. Some may be due to ignorance or misunderstanding and therefore legitimately require concurrent remedial training under this SOP.
6. Insufficient Progress Due to Personal Problems or Conflicts.
- a. Principle 2.06 of the American Psychological Association's Ethical Principles of Psychologists and Code of Conduct places an affirmative duty on trainees to maintain competent performance of clinical duties and to minimize the influence on their clinical performance of any personal problems they may have or be facing. When either a trainee or a supervisor becomes aware that the trainee's personal problems are or may be interfering with their performing duties adequately, the trainee takes appropriate measures, such as obtaining professional consultation or assistance, and determines an appropriate course of action. Supervisors will support the trainee in taking appropriate measures. If the trainee requests information regarding professional consultation resources, the supervisor will provide resource information.
 - b. In situations where a supervisor becomes aware that a trainee does not appear to be meeting their duty to maintain competent performance of clinical duties by minimizing the influence of any personal problems they may have or be facing, supervisors may take appropriate actions by advising the student to seek professional consultation or assistance, or by having the trainee's clinical duties temporarily limited or suspended. Supervisors do not request that trainees reveal personal information unless the information is necessary to evaluate or obtain assistance for trainees whose personal problems could reasonably be judged to be preventing them from performing their training or professionally related activities in a competent manner or posing a threat to the trainee or others. If recommendations for psychotherapy or other behavioral health care are given, these will include providers at other treatment facilities rather than members of the faculty or others within the supervisory chain.

- c. Concerns regarding deficient performance due to personal problems, which include medical and behavioral health matters and readiness/eligibility for training, are ultimately the responsibility of the trainee's Company Commander. Consideration may be given, when appropriate, to refer the trainee for evaluation in accordance with DoD Directive 6490.1, Mental Health Evaluations of Members of the Armed Forces. The final decision regarding referral for evaluation will be made by the trainee's Company Commander, however, consultation to the commander will be provided by the PD, faculty, and the PETC. It is expected in many cases that providing additional resources will enable the trainee to succeed in meeting standards of the training program in accordance with applicable policies and regulations. The report of medical or mental health evaluation including diagnosis and recommendations is delivered to the commander for his/her consideration. It is not delivered to the PD. Although treatment may be mandated or recommended by the commander, there is no ultimate obligation on the part of the Army to offer accommodations to a trainee. If a medical or behavioral health condition is judged to be possibly service disqualifying, procedures described in [DoD Directive 1332.18](#), Separation or Retirement for Physical Disability, and [DoD Instruction 1332.38](#), Physical Disability Evaluation will be followed.

7. Responsibilities.

a. Chief, Department of Psychology.

- i. Formally decides whether a trainee is making insufficient progress in the training program. Considers the formal or informal input of the trainee and other knowledgeable individuals in making his/her judgment.
- ii. Communicates his/her decision and directives in writing to trainees who have been considered for insufficient progress status.
- iii. Approves the plan for remediation prepared by the PD.
- iv. Communicates all findings and actions to the Hospital Professional Education and Training Committee (PETC). Recommends action to the PETC (including probation) based on the results of the remediation effort and other data.
- v. Implements the decisions of the PETC.

b. Program Director (PD)

- i. Periodically apprises the Chief, Department of Psychology of the progress of each trainee.
- ii. In accordance with the SOP or other directives for the individual program, initiates and justifies in writing the recommendation that a trainee be placed on insufficient progress or probationary status.
- iii. Formulates a plan for remediation aimed at removing the identified deficiencies and achieving needed competencies. The proposed plan will:
 - (a) Adhere to the guidance of the PETC, if given.

- (b) Specify the nature of the trainee's deficiencies and summarize how they were ascertained.
 - (c) Summarize previous relevant grievance actions by the trainee and their outcomes (if any).
 - (d) Specify what actions the trainee must take to improve (e.g., increased reading, tutorials, increased supervision, etc.).
 - (e) Specify the means to be used for evaluating progress.
 - (f) Provide a timetable for periodic (if used) and final evaluations and recommendations.
- iv. Implements, revises, and extends the plan as needed.
 - v. Prepares complete and accurate documentation of remediation training evaluations, decisions, and actions, which are maintained in the individual's training file.
 - vi. Recommends disciplinary action as appropriate.
- c. Fellows, Residents, and Interns
- i. Communicate with the PD in good faith regarding their training needs and difficulties.
 - ii. Actively collaborate in designing and implementing a plan for improvement and remediation when warranted.
 - iii. Acknowledge in writing communications from the Chief or PD, which address training deficiencies or insufficient progress.
 - iv. Diligently follow plans for remediation and seek modifications from the PD should parts of the plan prove unworkable.

3B. GRIEVANCE PROCEDURES

Grievances and Appeal Processes. Grievance procedures for charges of harassment or other EEO issues are covered in Army Regulation, which is available on line through the Army Publishing Directorate or a hard copy can be obtained from the Administrative Officer for the Behavioral Healthcare Service. The grievance and appeal process for residents who have been placed on remediation or probation is covered in the previous section of this manual (3A).

Residents wishing to make a complaint or file a grievance against the Internship Program or a specific supervisor for any other reason should follow the procedure described below. The first two steps of the procedure constitute the informal mechanisms for resolution of

the dissatisfaction. The procedures thereafter are more formal ones and extend beyond the Behavioral Healthcare Department and Psychology staff.

Initially, the resident should speak to the supervisor about concerns regarding the supervisor's conduct or expectations. If these discussions do not lead to a mutually acceptable solution, the resident should bring the complaint to the Director of Psychology Training. The Director will make every effort to hear both sides and determine the most appropriate resolution to the concern/complaint. In general, the Director has only a few possible options available to him/her. He/she may find in favor of the resident and instruct the supervisor in how to modify or correct the situation. He/she may find in favor of the staff member and explain to the resident why the supervisor's behavior is appropriate or acceptable within the training model. Alternatively, the Director might find that clearer understanding between the parties is necessary and can lead to a compromise that will be mutually acceptable and allow the training process to move forward. The Director of Training will hold a meeting with the parties concerned and facilitate such a resolution if the parties so wish. In extreme and unusual cases, the grievance may be so severe as to lead to an investigation and possible dismissal of the supervisor.

If these informal channels fail to bring a resolution that is satisfactory to the resident, the next step in the process would be for the resident to make a formal complaint to the Graduate Medical Education (GME) Department. This body will review the complaint and the documentation of attempts to deal with the problem on the local level, and will engage in an investigation of the problem. The GME will make a formal determination and inform all parties of the results and recommendations. In the event that the resident is still dissatisfied, a final appeal can be made to the Inspector General's Office (IG). This will lead to an independent investigation from outside the Hospital. This constitutes the final link in the grievance chain. If the IG finds in favor of the resident, steps will be taken to remedy the situation. If the IG finds in favor of the supervisor/Program, the resident will have no further recourse.

4. RESIDENT ABSENCES

1. The following guidelines have been developed to help residents and faculty evaluate requests by psychology residents for time away from the internship. Leave and special pass policy for residents is as follows: residents will be allowed up to ten days leave per year. A leave request (DA31) is submitted to the Training Director once the rotation supervisor has approved this absence. If approved, the Training Director will forward the leave form to Student Company.
 - a. Residents are required to plan their absences, if any, well in advance and to submit their requests in a manner that will allow adequate review. Otherwise, requests may be denied.
 - b. The following guideline for the internship year is suggested. The rotation supervisor must approve all requests for leave. Leave requests should be made on an official leave form (DA31) and be submitted to the Training Director after first clearing this absence with the rotation supervisor. Leave is typically approved for the following:

- Residents who have not completed their dissertations to return to their university and complete work on their degrees.
 - Graduation from their doctoral program.
 - Discretionary leave up to 10 days if not used for the above.
- c. Residents are not expected to work on official Government Holidays, unless they are standing a watch/ER call on a holiday. Brief extensions of a holiday may be requested through rotation supervisors and will be considered on a case by case basis at weekly faculty meetings (as part of the 10 days of leave per year). Two leave periods should not normally be requested during the same rotation.
 - d. All requests for absences are contingent upon the projected requirements of the resident's training assignments and upon progress in the internship. Above all, patient care responsibilities are primary.
 - e. If, for any reason, a resident needs to take more than the allowed 10 days of leave and the faculty agrees to the request, the resident must make up the extra days at the end of the internship year by extending the internship by that many days.

5. PSYCHOLOGY INTERNSHIP SEMINAR SERIES

1. The purpose of the seminar series is to provide the psychology residents with didactic training in areas relevant to the practice of psychology in the Army and in general. The seminars will be structured as self-contained modules. Either a staff or adjunct/guest faculty member teaches the seminars. The length of each module will be sufficient to meet the learning objectives. The following principles have been established for the series:
 - a. Learning objectives will be established so that each module is practice oriented. The 3-5 learning objectives will complement the overall learning objectives for the internship.
 - b. The residents will be exempted from scheduled clinical responsibilities during the workshop/seminars. Any exception must be cleared with the Training Director.
 - c. Attendance is mandatory unless leave is approved in advance. Clinical responsibilities should be scheduled so they do not conflict with the seminar schedule.
 - d. Internship seminar topics may include:
 - Ethics and Professional Practice
 - Credentials and Professional Boards
 - Medical and Administrative Boards
 - Clinical Diagnosis
 - Psychodynamic Formulations
 - Suicide Evaluation and Management
 - Evaluation for Security Clearance
 - Self report and Performance-based Personality Testing
 - Evaluation of Malingering on Psychological Tests

- Neuropsychological Screening
- Neuropsychological Testing
- Cognitive Remediation of Brain Dysfunction
- Hypnotherapy
- Cognitive Behavioral Therapy
- Group Psychotherapy
- Marital and Family Therapy
- Brief Psychodynamic Psychotherapy
- Health Psychology/Behavioral Medicine
- Forensic Psychology
- Military Psychology/Operational Psychology
- Cultural Competency in Psychotherapy
- Women's Issues in Psychotherapy
- Men's Issues in Psychotherapy
- Obesity and Weight Management
- Orofacial Pain/TMD
- Posttraumatic Stress Disorder/Combat Stress
- Critical Incident Stress Management
- Transition to Practice: OERs, professional contacts, advice on getting started at next duty station.

6. RECOMMENDATIONS FOR SELECTION OF MILITARY INTERNSHIP FACULTY

1. The following criteria are suggested for consideration in the selection of military faculty for the Clinical Psychology Internship Program:
 - a. Doctoral level psychologist with an active state license.
 - b. Able to actively participate in all phases of the program.
 - c. Willing to devote time outside of normal working hours to the program.
 - d. Eligibility for or possession of Board Certification is highly desirable.
 - e. Strong commitment to career as an Army psychologist.
 - f. Demonstrated performance in Education, Supervision, and Clinical Training, such as postdoctoral fellowship level training.
 - g. Experience in a variety of operational and administrative assignments.
2. The same criteria pertain to civilian psychologists working with the residents, with the exception of criteria e. and g. Supervisors are expected to be knowledgeable about and support the mission of Army Psychology.

7. RESOURCES FOR THE TRAINING PROGRAM

1. The following adjunctive staff members are considered critical in the internship program as presently outlined.
 - a. Psychiatry Department: Staff Psychiatrists and Social Workers.
 - b. Outside Consultants: Professionals providing didactics and supervision in areas identified by the faculty.

8. QUALITY ASSURANCE

1. In order to assure the maintenance of the standards of quality patient care, the following steps will be taken by the training faculty. The Director of Training is responsible for assuring that each step is accomplished.
 - a. Supervisors will submit a written end-of-rotation evaluation to the resident and the Director of Training.
 - b. At midyear and at the end of the internship year, each resident will submit to the Director of Training a formal evaluation of the training received.
 - c. Each year the Director of Training will also provide the Chief, Department of Psychology with an inventory of resources required for support of the internship program. Resource shortages will be highlighted and plans for acquiring additional resources will be presented.

VII APPENDICES

- A. Clinical Psychology Resident's End-of-Rotation Professional Performance Evaluation
- B. Officer Evaluation Report and Support Form
- C. Clinical Psychology Internship Program Critique Forms
- D. Internship Reading List

APPENDIX A
CLINICAL PSYCHOLOGY RESIDENT'S ASSESSMENT
PROFESSIONAL PERFORMANCE

Resident's Rank and Name: _____

Rotation Service:

Year _____ 1st _____ 2nd _____ 3rd _____ 4th _____

OVERALL PROFESSIONAL PERFORMANCE **MET (M) NOT MET (NM)**

Comments by the Resident Concerning the Evaluation (optional) _____

I have reviewed this evaluation. My comments are above.

Date: _____ Resident's Signature: _____

Supervisor's Comments Concerning Discussion with Evaluated Resident

Date: _____ Supervisor's Name & Signature: _____

Date: _____ Training Director's Name & Signature: _____

Clinical Psychology Resident's Assessment
Professional Performance Report

Assessment Rotation Learning Objectives

Resident's Rank and Name: _____ SSN: _____

Supervisor's Name: _____ Date: _____

RATINGS

NM – Intern has not met the training goal. Feedback and help have been given but performance has not improved to acceptable levels.

M- Intern has met the training goal.

COMMENTS

Following the rating is a comment section in which the supervisor is to note (a) particular areas of strength and (b) areas still needing improvement.

LEARNING OBJECTIVES FOR FUNCTIONAL CORE COMPETENCIES

ASSESSMENT, DIAGNOSIS, AND CASE CONCEPTUALIZATION

1. Demonstrates the ability to synthesize all assessment data into an integrated written report using proper grammar, punctuation, and clear professional language.	<u>M</u>	<u>NM</u>
2. Understands the possible influence of substances in the development and treatment of psychiatric disorders, and is able to elicit the required information to assess for substance abuse and dependence in an outpatient setting.	<u>M</u>	<u>NM</u>
3. Demonstrates understanding of the influences of culture in the development, maintenance and treatment of mental illnesses.	<u>M</u>	<u>NM</u>
4. Demonstrates knowledge of influences of medications on cognitive and emotional functioning.	<u>M</u>	<u>NM</u>
5. Demonstrates skill in psychological evaluation by interview.	<u>M</u>	<u>NM</u>
6. Demonstrates skill in developing comprehensive case conceptualizations.	<u>M</u>	<u>NM</u>
7. Demonstrates skill in integrating case conceptualizations into recommendations for treatment planning and therapy interventions.	<u>M</u>	<u>NM</u>
8. Demonstrates ability to assess personality functioning, including perceptual and cognitive accuracy, cognitive processes, emotional and affective states, problem solving, self-image, and interpersonal functioning.	<u>M</u>	<u>NM</u>
9. Demonstrates ability to administer, score, and interpret WAIS IV.	<u>M</u>	<u>NM</u>
10. Demonstrates ability to administer, score, and interpret MMPI-2 and PAI.	<u>M</u>	<u>NM</u>
11. Demonstrates ability to select, administer, score, and interpret a battery including some of the following: PCL-M, incomplete sentences, Beck Depression Inventory,	<u>M</u>	<u>NM</u>

Detailed Assessment of Posttraumatic Stress, projective drawings, Thematic Apperception Test, MCMI III.		
12. Demonstrates ability to reliably administer and code Rorschach using Exner's Comprehensive System (CS) and/or the Rorschach Performance Assessment System (RPAS).	<u>M</u>	<u>NM</u>
13. Demonstrates ability to interpret the Rorschach using CS and/or RPAS.	<u>M</u>	<u>NM</u>

INTERVENTIONS

1. Demonstrates skill in recommending the appropriate treatments for the patient based on testing results.	<u>M</u>	<u>NM</u>
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CONSULTATION

1. Demonstrates skill in writing factual, clear, succinct consultation reports using non-technical language that directly answers the referral questions.	<u>M</u>	<u>NM</u>
2. Demonstrates skill in liaison with commands/referral sources.	<u>M</u>	<u>NM</u>

RESEARCH AND EVALUATION

1. Is aware of and utilizes research literature to inform case conceptualization.	<u>M</u>	<u>NM</u>
2. Is aware of and utilizes research literature to inform treatment planning.	<u>M</u>	<u>NM</u>
3. Is aware of and utilizes research literature to inform test selection and interpretation.	<u>M</u>	<u>NM</u>
4. Is aware of and utilizes research literature to inform selection of intervention modalities being recommended.	<u>M</u>	<u>NM</u>

SUPERVISION AND TEACHING

1. Demonstrated ability to benefit from supervision and integrate feedback into assessments.	<u>M</u>	<u>NM</u>
2. Offer feedback to all patients and provide feedback to pt in a way that maximizes chance that patient will understand and accept recommendations.	<u>M</u>	<u>NM</u>
3. Demonstrates skill providing supervision for externs and other trainees.	<u>M</u>	<u>NM</u>
4. Effectively teaches others about assessment in grand rounds, rotation meetings, etc.	<u>M</u>	<u>NM</u>

MANAGEMENT AND ADMIN SKILLS

1. Is aware of the resources that are available for substance abusers at NNMC and in the surrounding community, and how to refer patients to these resources.	<u>M</u>	<u>NM</u>
2. Efficiency in work organization.	<u>M</u>	<u>NM</u>
3. Solves problems creatively.	<u>M</u>	<u>NM</u>
4. Demonstrates reliability (e.g., makes contacts and sets up appointments with patients when assigned referrals, sets up soonest supervision and drafts report in 24 hrs, completes progress notes and intake assessments by close of business for outpatients).	<u>M</u>	<u>NM</u>

FOUNDATIONAL CORE COMPETENCIES

SELF ASSESSMENT

1. Willingness to learn.	<u>M</u>	<u>NM</u>	<u>N/O</u>
2. Demonstrates good judgment (e.g., notifies supervisor when patient shows suicidal danger BEFORE patient leaves, checks with supervisor about priorities and follows supervisor's direction).	<u>M</u>	<u>NM</u>	<u>N/O</u>
3. Capacity to engage in self-examination and utilize the information to become more effective in professional work.	<u>M</u>	<u>NM</u>	<u>N/O</u>

SCIENTIFIC KNOWLEDGE AND METHODS

1. Demonstrates skill in presenting a case in conference and in supervision.	<u>M</u>	<u>NM</u>	<u>N/O</u>
2. Demonstrates knowledge of scientific underpinnings of psychometric testing instruments.	<u>M</u>	<u>NM</u>	<u>N/O</u>
3. Demonstrates ability to review and incorporate scientific literature concerning psychometric testing instruments.	<u>M</u>	<u>NM</u>	<u>N/O</u>

CAPACITY FOR EFFECTIVE RELATIONSHIPS

1. Determines what patient wishes to learn from psychological testing and provides response to these questions in feedback session.	<u>M</u>	<u>NM</u>	<u>N/O</u>
2. Offer feedback to all patients and provide feedback to patient in a way that maximizes chance the pt will understand and accept recommendations (e.g., use plain, non-technical language, use understanding of patient to determine best way to present evaluation results-narcissistic pts told how others misunderstand their intentions, depressed pts told what issues are causing the depression and what interventions successfully address this, etc).	<u>M</u>	<u>NM</u>	<u>N/O</u>
3. Demonstrates ability to work cooperatively with staff.	<u>M</u>	<u>NM</u>	<u>N/O</u>
4. Demonstrates ability to work cooperatively with peers.	<u>M</u>	<u>NM</u>	
5. Demonstrates empathy and connectedness with patients.	<u>M</u>	<u>NM</u>	
6. Assumption of responsibility.	<u>M</u>	<u>NM</u>	<u>N/O</u>
7. Professional bearing and appearance.	<u>M</u>	<u>NM</u>	<u>N/O</u>

ADHERENCE TO LEGAL AND ETHICAL STANDARDS

1. Demonstrates good judgment in applying ethics (e.g., checks self report tests and notifies supervisor when patient endorses suicidal thoughts BEFORE patient leaves, checks with supervisor about priorities and follows supervisor's direction).	<u>M</u>	<u>NM</u>	<u>N/O</u>
2. Adheres to APA ethical guidelines.	<u>M</u>	<u>NM</u>	<u>N/O</u>
3. Adheres to military regulations and Uniform Code of Military Justice.	<u>M</u>	<u>NM</u>	<u>N/O</u>

RESPECT FOR CULTURAL DIVERSITY

1. Provides patient feedback in a manner and with language that is sensitive to diversity issues.	<u>M</u>	<u>NM</u>	<u>N/O</u>
2. Interview and testing reflect sensitivity to individual's cultural background and beliefs.	<u>M</u>	<u>NM</u>	<u>N/O</u>
3. Demonstrates skill in cultural diversity issues (e.g., military, different military services, gender, religion, national origin, race, etc.).	<u>M</u>	<u>NM</u>	<u>N/O</u>

INTERDISCIPLINARY FUNCTIONING

1. Demonstrates the ability to obtain pertinent information on a patient's previous and current levels of functioning from a multitude of sources: referral sources, medical evaluators, patient records (health records, service records), collateral sources, and patient interview.	<u>M</u>	<u>NM</u>	<u>N/O</u>
2. Demonstrates skill in summarizing information from all resources, i.e., medical charts, physicians, ward staff, command, and patients.	<u>M</u>	<u>NM</u>	<u>N/O</u>
3. Demonstrates skill in working with providers in other disciplines and institutions, i.e., physicians, ward staff, commands, SHARP, FAP offices, etc.	<u>M</u>	<u>NM</u>	<u>N/O</u>

COMMENTS

Date: _____ Supervisor's Name & Signature: _____

Date: _____ Training Director's Name & Signature: _____

**CLINICAL PSYCHOLOGY RESIDENT'S QUARTERLY
PROFESSIONAL PERFORMANCE
Transrotational Learning Objectives**

Resident's Rank and Name: _____ SSN: _____

Supervisor's Name: _____ Date: _____

Rotation Service:

Year _____ 1st _____ 2nd _____ 3rd _____ 4th _____

OVERALL PROFESSIONAL PERFORMANCE MET (M) NOT MET (NM)

Comments by the Resident Concerning the Evaluation (optional)

I have reviewed this evaluation.

I have no comments. My comments are above. (Circle one)

Date: _____ Resident's Signature: _____

Supervisor's Comments Concerning Discussion with Evaluated Intern:

Date: _____ Supervisor's Name & Signature: _____

Date: _____ Training Director's Signature: _____

Clinical Psychology Resident's Quarterly
Professional Performance
Transrotational Learning Objectives

Resident's Rank and Name: _____ SSN: _____

Supervisor's Name: _____ Date: _____

LEARNING OBJECTIVES FOR FUNCTIONAL CORE COMPETENCIES

Assessment, Diagnosis, and Case Conceptualization

1. Keeps regular, clear, relevant progress notes consistent with diagnosis and treatment plan that the resident has derived.	<u>M</u>	<u>NM</u>
2. Demonstrates ability to conceptualize the case based on the treatment model.	<u>M</u>	<u>NM</u>
3. Demonstrates ability to plan treatment goals.	<u>M</u>	<u>NM</u>

Interventions

1. Demonstrates competence in the mechanics of psychotherapy (i.e., scheduling of appointments, handling missed sessions, etc.).	<u>M</u>	<u>NM</u>
2. Demonstrates an organized conceptual understanding of patient's problems and uses this in treatment.	<u>M</u>	<u>NM</u>
3. Ability to discriminate among various intervention strategies to facilitate treatment.	<u>M</u>	<u>NM</u>

Consultation -NA

Research and evaluation-NA

Supervision and teaching

1. Presentation of case to faculty and residents during the year.	<u>M</u>	<u>NM</u>
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Management and Administrative Skills

1. Is punctual for patient and supervisor appointments (Inform supervisor <u>before</u> event if unavoidable delay occurs and make arrangements to fulfill obligation, e.g., reschedule appointment).	<u>M</u>	<u>NM</u>
2. Progress notes are timely (within 24 hours of patient meeting).	<u>M</u>	<u>NM</u>

FOUNDATIONAL CORE COMPETENCIES

Self-Assessment

1. Able to identify therapeutic problems (e.g., impasse) and work toward their resolution.	<u>M</u>	<u>NM</u>
2. Able to maintain appropriate therapeutic boundaries.	<u>M</u>	<u>NM</u>
3. Is aware of own impact on the treatment process.	<u>M</u>	<u>NM</u>
4. Capacity to engage in self-examination and utilize the information for more effective professional work.	<u>M</u>	<u>NM</u>
5. Willingness to learn.	<u>M</u>	<u>NM</u>
6. Demonstrates good judgment (e.g., assures suicidal patient is safe before allowing him/her to leave clinic; checks with supervisor or other staff member if there is any reason to question patient's or other's safety).	<u>M</u>	<u>NM</u>

Scientific Knowledge and Methods

1. Can discuss the theory and research relevant to the case.	<u>M</u>	<u>NM</u>
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Capacity for Effective Relationships

1. Approaches supervision in an open and collaborative manner.	<u>M</u>	<u>NM</u>
2. Comes to supervision appropriately prepared.	<u>M</u>	<u>NM</u>
3. Responsive to feedback.	<u>M</u>	<u>NM</u>
4. Use supervision feedback to improve clinical effectiveness.	<u>M</u>	<u>NM</u>
5. Takes initiative in developing the content of the supervisory sessions.	<u>M</u>	<u>NM</u>

Adherence to Legal/Ethical Standards- See #6 under Self Assessment.

Respect for Cultural Diversity

1. Demonstrates skill in cultural diversity issues on the case.	<u>M</u>	<u>NM</u>
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Interdisciplinary Functioning- NA

COMMENTS

Date: _____ Supervisor's Name & Signature: _____

Date: _____ Training Director's Signature: _____

**CLINICAL PSYCHOLOGY RESIDENT'S QUARTERLY
PROFESSIONAL PERFORMANCE PRIMARY CARE/HEALTH**

Resident's Rank and Name: _____

Rotation Service:

Year _____ 1st _____ 2nd _____ 3rd _____ 4th _____

OVERALL PROFESSIONAL PERFORMANCE MET (M) NOT MET (NM)

Comments by the Resident Concerning the Evaluation (optional) _____

I have reviewed this evaluation. My comments are above.

Date: _____ Resident's Signature: _____

Supervisor's Comments Concerning Discussion with Evaluated Resident:

Date: _____ Supervisor's Name & Signature: _____

Clinical Psychology Resident's Quarterly
Professional Performance Report

Primary Care/Health Psychology Rotation Learning Objectives

Resident's Rank and Name: _____ SSN: _____

Supervisor's Name: _____ Date: _____

RATINGS

NM – Intern has not met the training goal. Feedback and help have been given but performance has not improved to acceptable levels.

M- Intern has met the training goal.

COMMENTS

Following the rating is a comment section in which the supervisor is to note (a) particular areas of strength and (b) areas still needing improvement.

LEARNING OBJECTIVES FOR FUNCTIONAL CORE COMPETENCIES

CLINICAL SKILLS

1. Applies principles of population based care (e.g., Uses Assess, Advise, Agree, Assist, Arrange model for most referrals to provide Care for everyone along a continuum from acute need, sub clinical problems & prevention to those who are healthy).	<u>M</u>	<u>NM</u>
2. Defines Behavioral Health Consultant Role with patient before starting assessment (able to say intro accurately; e.g., deliver memorized script content in 1 minute or less).	<u>M</u>	<u>NM</u>
3. Rapid problem identification (able to determine if referral problem is what the patient sees as the problem in the first minute after the intro script is finished for 90% of all first consultation appointments).	<u>M</u>	<u>NM</u>
4. Uses appropriate assessment questions (e.g. Ask questions geared towards current problem referral and functioning & how the patient's physical condition, thoughts, emotions, behaviors, habits, and environment are impacting/influencing the identified problem and functioning).	<u>M</u>	<u>NM</u>
5. Limits problem definition/assessment (focuses on presenting problem). Does not assess other areas (except suicide and homicide as indicated for depressed and stressed individuals) until assessment of initial referral problem is complete and as time allows.).	<u>M</u>	<u>NM</u>

6. Focuses recommendations and interventions on functional outcomes and symptom reduction [e.g., Improve ability to work, improve performance on responsibilities at home, increase frequency or improve quality of social interactions (friends), increase intimate/familial interactions (spouse, children), increase exercise, enjoyable or spiritual activities, improved sleep, decreased autonomic arousal, decreased pain exacerbation, improved mood].	<u>M</u>	<u>NM</u>
7. Teaches self-management skills/home-based practice as the prime method for decreased patient symptoms and improved functioning (e.g., deep breathing, cue controlled relaxation, cognitive disputation, sleep hygiene, stimulus control, eating behavior changes, increased physical activity, problem solving, and assertive communication). The majority of what the patient does to decrease symptoms and improve functioning is done outside of the consultation appointment.	<u>M</u>	<u>NM</u>
8. Interventions are specifically (operationally) defined and supportable by primary care team members (e.g., <u>increase fun activities</u> [read Mon, Wed, Fri from 1300-1330 in home office], <u>increase exercise</u> [Mon-Fri from 1700-1730, 30-minutes on stair-stepper], use relaxation skills).	<u>M</u>	<u>NM</u>
9. Shows understanding of relationship of medical and psychological systems (e.g., biopsychosocial model of physiological disorders, can describe to the patient the relevant factors, physical, behaviors, thoughts, environment, interactions with others, impacting symptoms, and functional impairments).	<u>M</u>	<u>NM</u>
10. Shows basic knowledge of medicines (can name basic anxiolytic and antidepressant meds and what might be a first line recommendation for specific symptom presentations).	<u>M</u>	<u>NM</u>

PRACTICE MGT SKILLS

1. Uses 30-minute appointment efficiently (e.g., identify problem, how functionally patient is impaired, symptoms, summarizes to patient understanding of problem at the 15-20 minute point, uses next 5-10 minutes to develop and start a behavioral change plan).	<u>M</u>	<u>NM</u>
2. Stays on time when conducting consecutive appointments.	<u>M</u>	<u>NM</u>
3. Demonstrates capacity to consistently use intermittent visit strategy (e.g., see patient in 2 wks or in 1 month instead of every week).	<u>M</u>	<u>NM</u>
4. Appropriately suggests the patient seek specialty behavioral health care when the intensity of service needed to adequately address the patient's problem is beyond what can be done in consultation appointments. (e.g., PTSD, OCD, Marital Counseling, ETOH abuse/dependence).	<u>M</u>	<u>NM</u>
5. Uses community resources referral strategies (e.g., Military One Source, community retirement center for those using primary care for social contact, self-help divorce group, etc.).	<u>M</u>	<u>NM</u>

CONSULTATION SKILLS WITH REFERRING PROVIDER

1. Focuses on and responds to referral question (e.g., specifically talks about evaluation regarding initial referral question).	<u>M</u>	<u>NM</u>
2. Tailors recommendations to work pace of primary care (e.g., recommendations given to PCMs be done in 1-2 minutes by the PCM when/if they see the patient again).	<u>M</u>	<u>NM</u>
3. Conducts effective feedback consultations (e.g., when giving feedback keep to 1 minute or less and use specific straight-forward short explanations).	<u>M</u>	<u>NM</u>
4. Willing to aggressively follow up with physicians, when indicated (e.g., medication recommendations for depression/anxiety, significant side effects for meds, alarming medical symptoms).	<u>M</u>	<u>NM</u>

5. Focuses on recommendations that reduce physicians' visits and workload (e.g., recommend patient see you in two weeks to assess symptoms and functional changes and response to medications instead of seeing PCM).	<u>M</u>	<u>NM</u>
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DOCUMENTATION SKILLS

1. Writes clear, concise medical record notes (e.g., focus on referral problem, frequency, duration, acute or long-term, functional impairment, short specific recommendations).	<u>M</u>	<u>NM</u>
2. Types notes in AHLTA while assessing patient.	<u>M</u>	<u>NM</u>
3. AHLTA notes are consistent with feedback to the PCM (e.g., note is a general outline of the verbal information or email you give/send the PCM).	<u>M</u>	<u>NM</u>

RELIABILITY

1. Arrive at clinic at least 10 minutes before the first patient appointment to: Review caseload and plan for the day. And/Or Find exam room in which you will be seeing patients for that day, prepare word documents for note writing, set-up exam room, etc. Do whatever you have to do so you are ready to start seeing patients when your first patient arrives.	<u>M</u>	<u>NM</u>
2. Must have everything prepared in order to start seeing the first patient on time and in order to stay on time with consecutive patients (i.e., have immediate access to or copies of various handouts, etc.).	<u>M</u>	<u>NM</u>
3. You must have deep breathing script and BHC introductory script <u>memorized</u> on the date set for you to demonstrate mastery. This may involve significant practice on your own before demonstration.	<u>M</u>	<u>NM</u>
4. All first-time patients and anyone who subsequently reports depressed, anxious, or stressed mood during follow-up appointments must be asked if they are suicidal.	<u>M</u>	<u>NM</u>

JUDGEMENT

1. Any individual that reports any suicidal thought, plan, intent or attempt in the assessment must be discussed with rotation supervisor before the patient leaves the clinic.	<u>M</u>	<u>NM</u>
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SELF ASSESSMENT

1. Willingness to learn.	<u>M</u>	<u>NM</u>
2. Capacity to engage in self-examination and utilize the information to become more effective in professional work.	<u>M</u>	<u>NM</u>

COMMENTS

Date: _____ Supervisor's Name & Signature: _____

Date: _____ Training Director's Signature: _____

**CLINICAL PSYCHOLOGY RESIDENT'S
PROFESSIONAL PERFORMANCE: OUTPATIENT ROTATION**

Resident's Rank and Name: _____

Rotation Service: Outpatient Rotation

Date of evaluation: _____

(Check one) Mid-eval _____ Final eval _____

Supervisors' Names: _____

Supervisor Signature: _____ Date _____

Supervisor Signature: _____ Date _____

Training Director's Signature _____ Date _____

OVERALL PROFESSIONAL PERFORMANCE **MET (M) NOT MET (NM)**

Comments by the Resident Concerning the Evaluation (optional) _____

I have reviewed this evaluation. My comments are above.

Date: _____ Resident's Signature _____

Supervisors' Comments Concerning Discussion with Evaluated Resident:

Supervisor Signature: _____ Date _____

Director of Training Signature: _____ Date _____

Clinical Psychology Resident's Quarterly
Professional Performance Report: Outpatient Rotation

RATINGS

M- Intern has met the training goal.

NM – Intern has not met the training goal. Feedback and help have been given but performance has not improved to acceptable levels.

N/O—Not observed

COMMENTS

To the right of each rating and at the end of the form, supervisor can note (a) particular areas of strength and (b) areas still needing improvement.

LEARNING OBJECTIVES FOR FUNCTIONAL CORE COMPETENCIES

ASSESSMENT, DIAGNOSIS, AND CASE CONCEPTUALIZATION

1. Demonstrates appropriate level of knowledge of DSM-IV criteria.	M	NM	N/O
2. Demonstrates skill in arriving at an accurate DSM-IV diagnosis, appropriately using differential diagnosis methodology.	M	NM	N/O
3. Demonstrates the ability to conduct comprehensive psychiatric evaluation in an outpatient setting.	M	NM	N/O
4. Demonstrates the capacity to experience and communicate empathy during the intake process in order to enhance therapeutic rapport and facilitate patient openness.	M	NM	N/O
5. Demonstrates the ability to select, administer, score and interpret brief assessment/outcome measures used in general outpatient settings.	M	NM	N/O
6. Demonstrates the ability to differentiate between physical illnesses and psychiatric conditions, including identifying medical illnesses commonly presenting with psychiatric symptoms.	M	NM	N/O
7. Demonstrates skill in risk assessment.	M	NM	N/O
8. Demonstrates the ability to appropriately disposition cases.	M	NM	N/O
9. Offer feedback to all patients and provide feedback to patient in a way that maximizes chance that patient will understand and accept recommendations.	M	NM	N/O
10. Satisfactorily performs or observes/discusses specialty evaluations (e.g., DONCAFs, TDRLs, fitness for duty, suitability evaluations, medical boards, BCNRs, CDEs, etc.).	M	NM	N/O
11. Demonstrates the ability to synthesize all assessment data into an integrated written report using proper grammar, punctuation, and clear professional language.	M	NM	N/O
12. Understands the possible influence of substances in the development and treatment of psychiatric disorders, and is able to assess for substance abuse/dependence.	M	NM	N/O

13. Demonstrates understanding of the influences of culture in the development, maintenance, clinical presentation, and treatment of mental illnesses.	M	NM	N/O
14. Demonstrates skill in developing comprehensive case conceptualizations.	M	NM	N/O

INTERVENTIONS

1. Demonstrates skill in providing cognitive-behavioral therapy on an individual basis.	M	NM	N/O
2. Demonstrates skill in providing dynamic/existential/interpersonal therapy on an individual basis.	M	NM	N/O
3. Demonstrates skill in providing supportive therapy on an individual basis (can be integrated with other approach).	M	NM	N/O
4. Demonstrates skill in integrating case conceptualizations into treatment planning and therapy interventions.	M	NM	N/O
5. Demonstrates skill in providing group psychotherapy.	M	NM	N/O
6. Demonstrates an appreciation of the impact of cultural and other diversity factors on treatment.	M	NM	N/O
7. Demonstrates adequate understanding of psychopharmacological intervention.	M	NM	N/O
8. Demonstrates adequate skill in intervention with marital/couples issues.	M	NM	N/O
9. Demonstrates skill in outpatient management of suicidal patients.	M	NM	N/O
10. Demonstrates skill in outpatient management of potentially violent patients.	M	NM	N/O

WRITING

1. First drafts of intake reports consistently meet professional standards as per peer review criteria.	M	NM	N/O
2. First drafts of progress notes consistently meet professional standards as per peer review criteria.	M	NM	N/O
3. Demonstrates skill in writing factual, clear, succinct reports or notes using non-technical language that appropriately reflect the purpose of the report or note.	M	NM	N/O
4. Effectively proofreads all writing for typos, spelling, grammar prior to submission.	M	NM	N/O
5. Demonstrates professional level of writing competency.	M	NM	N/O
6. Applies supervisory feedback on writing to future writing.	M	NM	N/O

CONSULTATION

1. Demonstrates skill in liaison with commands/referral sources.	M	NM	N/O
2. Makes appropriate consultation referrals and follows up as needed.	M	NM	N/O
3. Responds to consultation requests appropriately.	M	NM	N/O

RESEARCH AND EVALUATION

1. Is aware of and utilizes research literature to inform case conceptualization.	M	NM	N/O
2. Is aware of and utilizes research literature to inform treatment planning, including intervention modalities.	M	NM	N/O

SUPERVISION AND TEACHING

1. Demonstrates ability to benefit from supervision and integrate feedback into assessments and interventions.	M	NM	N/O
2. Open and nondefensive in supervision.	M	NM	N/O
3. Eagerness to learn.			
4. Demonstrates skill providing supervision for externs and other trainees.	M	NM	N/O

5. Effectively teaches others about assessment, psychotherapy interventions, or other selected topics in grand rounds, rotation meetings, etc.	M	NM	N/O
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MANAGEMENT AND ADMIN SKILLS

1. Is aware of substance abuse resources (military and community) and refers patients as appropriate.	M	NM	N/O
2. Is aware of other resources (military and community) and refers patients as appropriate.	M	NM	N/O
3. Efficiency in work organization.	M	NM	N/O
4. Solves problems creatively.	M	NM	N/O
5. Demonstrates reliability and responsibility.	M	NM	N/O

FOUNDATIONAL CORE COMPETENCIES

SELF ASSESSMENT

1. Eagerness to learn, openness to new ideas/approaches.	M	NM	N/O
2. Demonstrates good judgment (e.g., notifies supervisor when patient shows suicidal danger BEFORE patient leaves, checks with supervisor about priorities and follows supervisor's direction).	M	NM	N/O
3. Capacity to engage in self-examination and utilize the information to become more effective in professional work.	M	NM	N/O

SCIENTIFIC KNOWLEDGE AND METHODS

1. Demonstrates skill in presenting a case in conference and in supervision.	M	NM	N/O
2. Demonstrates knowledge of scientific underpinnings of psychotherapy interventions and etiological theories for mental illnesses.	M	NM	N/O
3. Demonstrates ability to review and incorporate scientific literature concerning psychotherapy interventions and etiological theories for mental illnesses.	M	NM	N/O

CAPACITY FOR EFFECTIVE RELATIONSHIPS

1. Determines what patient wishes to learn from outpatient evaluation and provides response to these questions in follow up.	M	NM	N/O
2. Offer feedback to all patients and provide feedback to patient in a way that maximizes chance the pt will understand and accept recommendations (e.g., use plain, non-technical language, use understanding of patient to determine best way to present evaluation results-narcissistic patients told how others misunderstand their intentions, depressed patients told what issues are causing the depression, and what interventions successfully address this, etc.).	M	NM	N/O
3. Demonstrates ability to work cooperatively with staff.	M	NM	N/O
4. Demonstrates ability to work cooperatively with peers.	M	NM	N/O
5. Demonstrates empathy and connectedness with patients.	M	NM	N/O
6. Assumption of responsibility.	M	NM	N/O
7. Professional bearing and appearance.	M	NM	N/O

ADHERENCE TO LEGAL AND ETHICAL STANDARDS

1. Demonstrates good judgment in applying ethics.	M	NM	N/O
2. Open to discussing difficult ethical dilemmas in supervision.	M	NM	N/O
2. Adheres to APA ethical guidelines.	M	NM	N/O

3. Adheres to military regulations and Uniform Code of Military Justice.	M	NM	N/O
4. Demonstrates integrity.	M	NM	N/O

RESPECT FOR CULTURAL DIVERSITY

1. Provides patient feedback in a manner and with language that is sensitive to diversity issues.	M	NM	N/O
2. Interview, therapy, and testing reflect sensitivity to individual's cultural background and beliefs.	M	NM	N/O
3. Demonstrates knowledge and skill in cultural diversity issues (e.g., military, different military services, religion, national origin, race, etc.).	M	NM	N/O

INTERDISCIPLINARY FUNCTIONING

1. Demonstrates the ability to obtain pertinent information on a patient's previous and current levels of functioning from a multitude of sources: referral sources, medical evaluators, patient records, (health records, service records), collateral sources, & patient interview.	M	NM	N/O
2. Demonstrates skill in summarizing information from all resources, i.e., medical charts, physicians, ward staff, command, and patients.	M	NM	N/O
3. Demonstrates skill in working with providers in other disciplines and institutions, i.e., physicians, ward staff, commands, SHARP, FAP offices, etc.	M	NM	N/O

COMMENTS

Date: _____ Supervisor's Name & Signature: _____

Date: _____ Training Director's Signature: _____

**CLINICAL PSYCHOLOGY RESIDENT'S NEUROPSYCHOLOGY ROTATION
PROFESSIONAL PERFORMANCE**

Resident's Rank and Name: _____

Rotation Service:

Year: _____ 1st _____ 2nd _____ 3rd _____ 4th _____

OVERALL PROFESSIONAL PERFORMANCE MET (M) NOT MET (NM)

Comments by the Resident Concerning the Evaluation (optional) _____

I have reviewed this evaluation. My comments are above.

Date: _____ Resident's Signature: _____

Supervisor's Comments Concerning Discussion with Evaluated Resident:

Date: _____ Supervisor's Name & Signature: _____

Date: _____ Training Director's Name & Signature: _____

Clinical Psychology Resident's NEUROPSYCHOLOGY ROTATION
Professional Performance Report

Resident's Rank and Name: _____ SSN: _____

Supervisor's Name: _____ Date: _____

RATINGS

NM – Intern has not met the threshold for the skill set/training goal. Feedback and help have been given but performance has not improved to acceptable levels.

M- Intern has met the threshold for skill set/training goal.

N/O-not observed

COMMENTS

Following the rating is a comment section in which the supervisor is to note (a) particular areas of strength and (b) areas still needing improvement.

LEARNING OBJECTIVES

ASSESSMENT, DIAGNOSIS, CASE CONCEPTUALIZATION, and COMMUNICATION SKILLS

ASSESSMENT

1. Establishes rapport.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
2. Communicates clearly with patient (comprehension level, type of question).	<u>M</u>	<u>NM</u>	<u>N/O</u>	
3. Proficiency in conducting the clinical neuropsychological interview; obtains relevant neurological and psychological history.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
4. Proficiency in acquiring relevant patient history per DoD TBI criteria for determining differential diagnoses.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
5. Clarifies assessment issues and accurately uses neuropsychological test data to answer referral questions, including fitness for duty and level of disability.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
6. Acquires data regarding personality functioning.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
7. Makes relevant behavioral observations and correctly assesses mental status in patients referred for neuropsychological evaluation.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
8. Selects appropriate assessment methods.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
9. Proficiency in the administration of core tests in	<u>M</u>	<u>NM</u>	<u>N/O</u>	

the neuropsychological battery.				
10. Proficiency in the scoring of core tests in the neuropsychological battery.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
11. Obtains collateral information, to include relevant neurological and psychological history.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
12. Aware of legal and regulatory issues.	<u>M</u>	<u>NM</u>	<u>N/O</u>	

Resident Comments:

CONCEPTUALIZATION SKILLS/ DIAGNOSIS

1. Formulates working hypotheses.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
2. Recognizes gaps and inconsistencies (and seeks to resolve them).	<u>M</u>	<u>NM</u>	<u>N/O</u>	
3. Analysis and synthesis of neuropsychological testing data into case conceptualization.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
4. Incorporates data regarding personality functioning.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
5. Proficiency in the interpretation of core neuropsychological battery tests.				
6. Develops conceptualization (logical and theoretically sound).	<u>M</u>	<u>NM</u>	<u>N/O</u>	
7. Relates current behavior to its presumed origins and maintaining factors.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
8. Diagnoses appropriately with differentials.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
9. Proficiency in diagnosing TBI to include severity level.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
10. Formulates clear conclusions/well considered recommendations.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
11. Formulates appropriate treatment recommendations.	<u>M</u>	<u>NM</u>	<u>N/O</u>	

Resident Comments:

COMMUNICATION SKILLS

<i>Verbal:</i>				
1. Feedback to patients (clear and appropriate).	<u>M</u>	<u>NM</u>	<u>N/O</u>	
2. Obtains and communicates information with other professionals.	<u>M</u>	<u>NM</u>	<u>N/O</u>	

3. Presents information in supervision (organized, logical, and thought out).	<u>M</u>	<u>NM</u>	<u>N/O</u>	
4. Presentation at weekly DVBIC clinical meeting.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
5. Participation at weekly seminars.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
6. Presentation at End-of-Rotation Case Presentation.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
Written:				
1. Writes integrated, well-organized, clear neuropsychological test reports.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
2. Conveys conclusions and recommendations clearly.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
3. Accurately uses neuropsychological test data to answer referral questions, including fitness for duty and level of disability as applicable.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
4. Appropriate for referring agency.	<u>M</u>	<u>NM</u>	<u>N/O</u>	

Resident Comments:

RESPECT FOR CULTURAL DIVERSITY/ CULTURAL COMPETENCY

1. Takes culture into account in test selection and interpretation of psychological testing results and recommendations.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
2. Interview and feedback reflect sensitivity to individual's cultural background and beliefs.				

Resident Comments:

CONSULTATION SKILLS

1. Knowledge and handling of consultation role.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
2. Knowledge of institutional and system dynamics and functions.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
3. Awareness of cultural environment in which services are provided.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
4. Provides practical and accurate diagnoses and recommendations.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
5. Collaborates actively with colleagues.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
6. Demonstrates openness to viewpoints and expertise of others.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
7. Provides timely response to consultees.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
8. Recognizes the need for medical referral.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
9. Recognizes need for consultation with other mental health professionals (e.g., psychiatry, social work, drug and alcohol).	<u>M</u>	<u>NM</u>	<u>N/O</u>	

10. Utilizes feedback from other professionals in a constructive manner.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
11. Establishes rapport with other professionals.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
12. Understands role of neuropsychologist on an interdisciplinary team.	<u>M</u>	<u>NM</u>	<u>N/O</u>	

Resident Comments:

INTERVENTION

1. Handles patient relationship with sensitivity and objectivity.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
2. Establishes rapport with patient.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
3. Appropriately interacts with patient and family members in an inpatient setting, to include psychoeducation about patient diagnoses as applicable.	<u>M</u>	<u>NM</u>	<u>N/O</u>	

Resident Comments:

RESEARCH AND EVALUATION

1. Is aware of and utilizes research literature to inform case conceptualization.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
2. Is aware of and utilizes research literature to inform test interpretation.	<u>M</u>	<u>NM</u>	<u>N/O</u>	

Resident Comments:

SUPERVISION AND TEACHING

1. Demonstrated ability to benefit from supervision and integrate feedback into assessments.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
2. Cooperation with supervision.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
3. Communication with supervisor.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
4. Preparation for supervision.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
5. Seeks out additional consultation and supervision when appropriate.	<u>M</u>	<u>NM</u>	<u>N/O</u>	

Resident Comments:

PROFESSIONAL MANAGEMENT AND ADMINISTRATIVE SKILLS

1. Awareness/adherence to APA Ethics and Professional Standards.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
2. Adheres to military regulations and Uniform Code of Military Justice.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
3. Professional manner and conduct.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
4. Demonstrates integrity and good judgment.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
5. Maintains and understands when to suspend confidentiality.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
6. Follows established procedures for meeting administrative requirements, charts, notes.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
7. Maintains workload and fulfills clinical responsibilities.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
8. Budgets time effectively.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
9. Punctual for patient contacts and meetings.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
10. Demonstrates initiative and motivation.	<u>M</u>	<u>NM</u>	<u>N/O</u>	
11. Demonstrates maturity, willingness to learn, and good judgment.	<u>M</u>	<u>NM</u>	<u>N/O</u>	

Resident Comments:

ADDITIONAL COMMENTS

Date: _____ Supervisor's Name & Signature: _____

Date: _____ Training Director's Signature: _____

APPENDIX C

EVALUATION OF INTERNSHIP

INTERNSHIP YEAR _____

DATE _____

TRANSROTATIONAL SUPERVISOR(S)

INDIVIDUAL THERAPY:

NAME: 1. _____

2. _____

3. _____

4. _____

SKILLS LEARNED

AREAS THAT COULD BE IMPROVED

EVALUATION OF SUPERVISOR(S)

STRENGTHS

WEAKNESSES

GROUP THERAPY:

- NAME: 1. _____
2. _____
3. _____
4. _____

SKILLS LEARNED

AREAS THAT COULD BE IMPROVED

EVALUATION OF SUPERVISOR(S)

STRENGTHS

WEAKNESSES

COUPLES/FAMILY THERAPY:

NAME: 1. _____

2. _____

SKILLS LEARNED

AREAS THAT COULD BE IMPROVED

EVALUATION OF SUPERVISOR(S)

STRENGTHS

WEAKNESSES

SEMINAR SERIES

OVERALL EVALUATION

BEST SEMINARS AND WHY

WEAKEST SEMINARS AND WHY

PROFESSIONAL DEVELOPMENT SEMINAR

OVERALL EVALUATION

STRENGTHS

WEAKNESSES

RECOMMENDATIONS FOR IMPROVING THE INTERNSHIP

Date: _____ Training Director's Signature: _____

**CLINICAL PSYCHOLOGY RESIDENT'S CRITIQUE
OF PRIMARY CARE/HEALTH PSYCHOLOGY ROTATION**

Supervisor's Name: _____ Date: _____

Rotation Service:

Year _____ 1st _____ 2nd _____ 3rd _____ 4th _____

OVERALL PROFESSIONAL PERFORMANCE MET NOT MET

Comments by the Resident Concerning the Evaluation (optional)

Date: _____ Supervisor's Name & Signature: _____

Date: _____ Training Director's Signature: _____

Clinical Psychology Resident's Critique
Primary Care/Health Psychology Learning Objectives

Supervisor's Name: _____ Date: _____

LEARNING OBJECTIVES FOR FUNCTIONAL CORE COMPETENCIES

CLINICAL SKILLS, PRACTICE MANAGEMENT SKILLS, CONSULTATION WITH REFERRING PROVIDER, AND DOCUMENTATION SKILLS

1. Taught the principles of population based care.	<u>M</u>	<u>NM</u>
2. Taught the Behavioral Health Consultant Role.	<u>M</u>	<u>NM</u>
3. Taught rapid problem identification.	<u>M</u>	<u>NM</u>
4. Taught the use of appropriate assessment questions (e.g., ask questions geared towards current problem referral and functioning and how the patient's physical condition, thoughts, emotions, behaviors, habits, and environment are impacting/influencing the identified problem and functioning.).	<u>M</u>	<u>NM</u>
5. Taught how to limit problem definition/assessment and not assess other areas until assessment of initial referral problem is complete and as time allows (except suicide and homicide as indicated for depressed and stressed individuals).	<u>M</u>	<u>NM</u>
6. Taught how to focus recommendations and interventions on functional outcomes and symptom reduction.	<u>M</u>	<u>NM</u>
7. Taught self-management skills/home-based practice that can be used by the patient.	<u>M</u>	<u>NM</u>
8. Taught interventions that are specifically (operationally) defined and supportable by primary care team members.	<u>M</u>	<u>NM</u>
9. Taught the relationship between the medical and psychological systems (e.g., biopsychosocial model of physiological disorders, can describe to the patient the relevant factors, physical, behaviors, thoughts, environment, interactions with others, impacting symptoms and functional impairments).	<u>M</u>	<u>NM</u>
10. Taught basic knowledge of medicines.	<u>M</u>	<u>NM</u>
11. Taught how to use a 30-minute appointment efficiently (e.g., identify problem, how functionally patient is impaired, symptoms, summarize to patient understanding of problem at the 15 minute point, use next 10 minutes to develop and start a behavioral change plan).	<u>M</u>	<u>NM</u>
12. Taught how to remain on time when conducting consecutive appointments.	<u>M</u>	<u>NM</u>
13. Taught how to use intermittent visit strategy (e.g., see patient in 2 wks or in 1 month instead of every week).	<u>M</u>	<u>NM</u>
14. Taught how to appropriately suggest the patient seek specialty behavioral health care when the intensity of service needed to adequately address the patient's problem is beyond what can be done in consultation appointments.	<u>M</u>	<u>NM</u>
15. Taught the use of community resources referral strategies (e.g., Military One Source, community retirement center for those using primary care for social contact, self-help divorce group, etc.).	<u>M</u>	<u>NM</u>
16. Taught how to focus on and respond to referral question (e.g., specifically talks about evaluation regarding initial referral question).	<u>M</u>	<u>NM</u>
17. Taught how to tailor recommendations to work pace of primary care.	<u>M</u>	<u>NM</u>
18. Taught how to conduct effective feedback consultations.	<u>M</u>	<u>NM</u>
19. Taught how to aggressively follow up with physicians,	<u>M</u>	<u>NM</u>

when indicated (e.g., medication recommendations for depression/anxiety, significant side effects for meds, alarming medical symptoms).		
20. Taught how to focus on recommendations that reduce physicians' visits and workload (e.g., recommend patient see you in two weeks to assess symptoms and functional changes and response to medications instead of seeing PCM).	<u>M</u>	<u>NM</u>
21. Taught how to write clear, concise medical record notes.	<u>M</u>	<u>NM</u>
22. Taught how to type notes in AHLTA while assessing patient.	<u>M</u>	<u>NM</u>
23. Taught how to ensure that AHLTA notes are consistent with feedback to the PCM.	<u>M</u>	<u>NM</u>
24. Taught that all first-time patients and anyone who subsequently reports depressed, anxious, or stressed mood during follow-up appointments must be asked if they are suicidal.	<u>M</u>	<u>NM</u>

FOUNDATIONAL CORE COMPETENCIES

SELF ASSESSMENT

1. Supervisors interested me in learning.	<u>M</u>	<u>NM</u>
2. Learned to use good judgment and check with supervisors in instances that were not clear.	<u>M</u>	<u>NM</u>
3. Supervisors helped me in self-examination and to utilize the information to become more effective in professional work.	<u>M</u>	<u>NM</u>
4. Environment was conducive to learning.	<u>M</u>	<u>NM</u>
5. I felt treated with respect.	<u>M</u>	<u>NM</u>

SCIENTIFIC KNOWLEDGE AND METHODS

1. Taught and encouraged in developing knowledge of evidence based interventions.	<u>M</u>	<u>NM</u>
2. Encouraged to review and incorporate scientific literature concerning presenting problem and interventions.	<u>M</u>	<u>NM</u>

CAPACITY FOR EFFECTIVE RELATIONSHIPS

1. Discussed cooperative work with staff and how to best negotiate it in specific situations.	<u>M</u>	<u>NM</u>
2. Discussed cooperative work with peers and how to best negotiate it in specific situations.	<u>M</u>	<u>NM</u>
3. Discussed developing empathy and connectedness with patients.	<u>M</u>	<u>NM</u>
4. Given responsibility.	<u>M</u>	<u>NM</u>
5. Feedback on professional bearing and appearance.	<u>M</u>	<u>NM</u>

ADHERENCE TO LEGAL AND ETHICAL STANDARDS

1. Given feedback on your judgment (e.g., did you notify supervisor when patient shows suicidal danger BEFORE patient leaves, check with supervisor about priorities and follow supervisor's direction).	<u>M</u>	<u>NM</u>
2. Discuss adherence to APA ethical guidelines when appropriate.	<u>M</u>	<u>NM</u>
3. When relevant, discussed military regulations and UCMJ.	<u>M</u>	<u>NM</u>

RESPECT FOR CULTURAL DIVERSITY

1. Discussed how to give feedback in a manner sensitive to cultural issues of the specific patient.	<u>M</u>	<u>NM</u>
2. Discussed how to make interview and testing sensitive to individual's cultural background and beliefs.	<u>M</u>	<u>NM</u>
3. Taught skills in cultural diversity issues (e.g., military, branch of military, gender, religion, national origin, race, etc.).	<u>M</u>	<u>NM</u>

INTERDISCIPLINARY FUNCTIONING

1. Supervision on obtaining pertinent information on a patient's previous and current levels of functioning from the following sources: referral sources, medical evaluators, patient records, (health records, service records), collateral sources, & patient interview.	<u>M</u>	<u>NM</u>
2. Feedback on skill in summarizing information from all resources, i.e., medical charts, physicians, ward staff, command, and patients.	<u>M</u>	<u>NM</u>
3. Feedback on skill in working with providers in other disciplines and institutions, i.e., physicians, ward staff, commands, SHARP, FAP offices, etc.	<u>M</u>	<u>NM</u>

SUPERVISION STYLE

1. Openly discusses and is respectful of differences in style.	<u>M</u>	<u>NM</u>
2. Balances instruction with supervisee's formulation/presentation.	<u>M</u>	<u>NM</u>
3. Encourages questions and gives explanations.	<u>M</u>	<u>NM</u>
4. Allows supervisee to structure the supervisory time, as appropriate.	<u>M</u>	<u>NM</u>
5. Encourages reflection on alternate hypotheses.	<u>M</u>	<u>NM</u>
6. Makes supervision a collaborative enterprise.	<u>M</u>	<u>NM</u>
7. Offers feedback with respect.	<u>M</u>	<u>NM</u>
8. Openly processes any conflict that arises in the supervisory relationship.	<u>M</u>	<u>NM</u>
9. Admits errors or limitations without undue defensiveness.	<u>M</u>	<u>NM</u>
10. Respectful of differences in culture, ethnicity or other individual diversity.	<u>M</u>	<u>NM</u>

SUPERVISION CONDUCT

1. Reliably available for scheduled meetings.	<u>M</u>	<u>NM</u>
2. Available in emergencies.	<u>M</u>	<u>NM</u>
3. Makes decisions and takes responsibility when appropriate.	<u>M</u>	<u>NM</u>
4. Makes concrete and specific suggestions when needed.	<u>M</u>	<u>NM</u>
5. Maintains useful and appropriate focus in supervisory sessions.	<u>M</u>	<u>NM</u>
6. Assists supervisee in making case formulations based on assessment results.	<u>M</u>	<u>NM</u>
7. Raises ethical and legal issues, as appropriate.	<u>M</u>	<u>NM</u>
8. Offers practical and useful recommendations for patient when supervisee has not thought of them.	<u>M</u>	<u>NM</u>
9. Can present theoretical and research rationale for interpretations.	<u>M</u>	<u>NM</u>

COMMENTS

Date: _____ Supervisor's Name & Signature: _____

Date: _____ Training Director's Signature: _____

**CLINICAL PSYCHOLOGY RESIDENT'S CRITIQUE
OF ASSESSMENT ROTATION**

Supervisor's Name: _____ Date: _____

Rotation Service:

Year _____ 1st _____ 2nd _____ 3rd _____ 4th _____

OVERALL PROFESSIONAL PERFORMANCE MET NOT MET

Comments by the Resident Concerning the Evaluation (optional)

Date: _____ Supervisor's Name & Signature: _____

Date: _____ Training Director's Signature: _____

Clinical Psychology Resident's Critique
Assessment Learning Objectives

Supervisor's Name: _____ Date: _____

LEARNING OBJECTIVES FOR FUNCTIONAL CORE COMPETENCIES

ASSESSMENT, DIAGNOSIS, AND CASE CONCEPTUALIZATION

1. Taught the ability to assess the patient's personality functioning in the following areas: (a) perceptual & cognitive accuracy, (b) cognitive processes, (c) emotional & affective states, (d) problem solving, (e) self-image, (f) interpersonal functioning.	<u>M</u>	<u>NM</u>
2. Taught to administer, score, and interpret WAIS IV.	<u>M</u>	<u>NM</u>
3. Training to administer, score, and interpret the MMPI-2 and PAI.	<u>M</u>	<u>NM</u>
4. Taught the ability to select, administer, score, and interpret a personality battery consisting of some of the following: Sentence Completion Test, Beck Depression, House-Tree Person, Draw-A-Person, PCL-M, DAPS, Thematic Apperception Test, MCMI III.	<u>M</u>	<u>NM</u>
5. Training in the ability to reliably administer and code a Rorschach using Exner's Comprehensive System (CS) and/or Rorschach Performance Assessment System (RPAS).	<u>M</u>	<u>NM</u>
6. Taught interpretation of a Rorschach using Exner's Comprehensive System (CS) and/or Rorschach Performance Assessment System (RPAS).	<u>M</u>	<u>NM</u>
7. Taught to synthesize all assessment data into an integrated written report using proper grammar, punctuation, and clear professional language.	<u>M</u>	<u>NM</u>
8. Taught possible influences of substances in development and treatment of psychiatric disorders and taught to elicit the required information to assess for substance abuse and dependence in an outpatient setting.	<u>M</u>	<u>NM</u>
9. Taught influences of culture in development, maintenance and treatment of mental illness.	<u>M</u>	<u>NM</u>
10. Taught skill in developing comprehensive case conceptualizations.	<u>M</u>	<u>NM</u>
11. Taught skill in integrating case conceptualizations into treatment planning and therapy interventions.	<u>M</u>	<u>NM</u>
12. Taught influences of medications on cognitive and emotional functioning.	<u>M</u>	<u>NM</u>
13. Taught skill in psychological evaluation by interview.	<u>M</u>	<u>NM</u>

INTERVENTIONS

1. Taught skill in recommending appropriate treatments for patients based on testing results.	<u>M</u>	<u>NM</u>
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CONSULTATION

1. Taught skill in writing factual, clear, succinct consultation reports using non-technical language that directly answers the referral questions.	<u>M</u>	<u>NM</u>
2. Taught skill in liaison with commands/referral sources.	<u>M</u>	<u>NM</u>

RESEARCH AND EVALUATION

1. Taught and gave opportunity to use research literature to inform case conceptualization.	<u>M</u>	<u>NM</u>
2. Taught and gave opportunity to use research literature to inform treatment planning.	<u>M</u>	<u>NM</u>
3. Taught and gave opportunity to use research literature to inform test selection and interpretation.	<u>M</u>	<u>NM</u>
4. Taught and gave opportunity to use research literature to inform selection of interventions being recommended.	<u>M</u>	<u>NM</u>

SUPERVISION AND TEACHING

1. Taught to seek what patient wishes to learn from testing and provide response to these questions in the feedback session.	<u>M</u>	<u>NM</u>
2. Taught to give feedback to all patients and provide feedback to patient in a way that maximizes chance that patient will understand and accept recommendations (e.g., use plain, non-technical language, use understanding of patient from testing to determine best way to present findings—narcissistic patients told how others misunderstand the patient’s intention, depressed patients told what issues are causing the depression and what interventions can successfully address this).	<u>M</u>	<u>NM</u>
3. Taught skill providing supervision.	<u>M</u>	<u>NM</u>
4. Given support and guidance as needed in making presentations in grand rounds, rotation meetings, etc.	<u>M</u>	<u>NM</u>

MANAGEMENT AND ADMIN SKILLS

1. Made aware of the resources that are available for substance abusers at NNMC and in the surrounding community, and how to refer patients to these resources.	<u>M</u>	<u>NM</u>
2. Taught efficiency in work organization.	<u>M</u>	<u>NM</u>
3. Encouraged to solve problems creatively.	<u>M</u>	<u>NM</u>
4. Given expectations of reliability (e.g., makes contacts and sets up appointments with patients when assigned referrals, scores protocols within a day when feasible, sets up soonest supervision, and drafts report in 24 hrs).	<u>M</u>	<u>NM</u>

FOUNDATIONAL CORE COMPETENCIES

SELF ASSESSMENT

1. Supervisors interested me in learning.	<u>M</u>	<u>NM</u>
2. Learned to use good judgment and check with supervisors in instances that were not clear.	<u>M</u>	<u>NM</u>
3. Supervisors helped me in self-examination and to utilize the information to become more effective in professional work.	<u>M</u>	<u>NM</u>
4. I felt treated with respect.	<u>M</u>	<u>NM</u>

SUPERVISORY LEARNING ENVIRONMENT

1. Promotes a sense of acceptance and support.	<u>M</u>	<u>NM</u>
2. Establishes clear, appropriate boundaries.	<u>M</u>	<u>NM</u>
3. Recognizes my strengths.	<u>M</u>	<u>NM</u>
4. Establishes clear, reasonable expectations for my performance.	<u>M</u>	<u>NM</u>
5. Conveys active interest in helping me learn.	<u>M</u>	<u>NM</u>
6. Conveys active interest in helping me grow professionally.	<u>M</u>	<u>NM</u>
7. Sensitive and adaptive to stresses on the internship.	<u>M</u>	<u>NM</u>

8. Treats mistakes as a learning experience.	<u>M</u>	<u>NM</u>
9. Reviewed the explicit expectations and intern evaluation form for the rotation.	<u>M</u>	<u>NM</u>

SUPERVISION STYLE

1. Openly discusses and is respectful of differences in style.	<u>M</u>	<u>NM</u>
2. Balances instruction with tester's formulation/presentation.	<u>M</u>	<u>NM</u>
3. Encourages questions and gives explanations.	<u>M</u>	<u>NM</u>
4. Allows supervisee to structure the supervisory time, as appropriate.	<u>M</u>	<u>NM</u>
5. Encourages reflection on alternate hypotheses.	<u>M</u>	<u>NM</u>
6. Makes supervision a collaborative enterprise.	<u>M</u>	<u>NM</u>
7. Offers feedback with respect.	<u>M</u>	<u>NM</u>
8. Openly processes any conflict that arises in the supervisory relationship.	<u>M</u>	<u>NM</u>
9. Admits errors or limitations without undue defensiveness.	<u>M</u>	<u>NM</u>
10. Respectful of differences in culture, ethnicity or other individual diversity.	<u>M</u>	<u>NM</u>

SUPERVISION CONDUCT

1. Reliably available for scheduled meetings.	<u>M</u>	<u>NM</u>
2. Available in emergencies.	<u>M</u>	<u>NM</u>
3. Makes decisions and takes responsibility when appropriate.	<u>M</u>	<u>NM</u>
4. Makes concrete and specific suggestions when needed.	<u>M</u>	<u>NM</u>
5. Maintains useful and appropriate focus in supervisory sessions.	<u>M</u>	<u>NM</u>
6. Assists supervisee in making case formulations based on assessment results.	<u>M</u>	<u>NM</u>
7. Raises ethical and legal issues, as appropriate.	<u>M</u>	<u>NM</u>
8. Offers practical and useful recommendations for patient when supervisee has not thought of them.	<u>M</u>	<u>NM</u>
9. Can present theoretical and research rationale for interpretations.	<u>M</u>	<u>NM</u>

SUPERVISION IMPACT

1. Teaching/supervision has strengthened general testing and clinical skills.	<u>M</u>	<u>NM</u>
2. Concern shown for personal development as well as internship performance.	<u>M</u>	<u>NM</u>
3. Facilitates self-confidence to accept new challenges.	<u>M</u>	<u>NM</u>
4. Assists in supervisee's developing a more crystallized professional identity.	<u>M</u>	<u>NM</u>

SCIENTIFIC KNOWLEDGE AND METHODS

1. Helped with skills in presenting a case in conference and in supervision.	<u>M</u>	<u>NM</u>
2. Taught and encouraged in developing knowledge of scientific underpinnings of psychometric testing instruments.	<u>M</u>	<u>NM</u>
3. Encouraged to review and incorporate scientific literature concerning psychometric testing instruments.	<u>M</u>	<u>NM</u>

CAPACITY FOR EFFECTIVE RELATIONSHIPS

1. Discussed cooperative work with staff and how to best negotiate it in specific situations.	<u>M</u>	<u>NM</u>
2. Discussed cooperative work with peers and how to best negotiate it in specific situations.	<u>M</u>	<u>NM</u>
3. Discussed developing empathy and connectedness with patients.	<u>M</u>	<u>NM</u>
4. Given responsibility.	<u>M</u>	<u>NM</u>
5. Feedback on professional bearing and appearance.	<u>M</u>	<u>NM</u>

ADHERENCE TO LEGAL AND ETHICAL STANDARDS

1. Given feedback on your judgment (e.g., did you notify supervisor when patient shows suicidal danger BEFORE patient leaves, check with supervisor about priorities and follow supervisor's direction).	<u>M</u>	<u>NM</u>
2. Discuss adherence to APA ethical guidelines when appropriate.	<u>M</u>	<u>NM</u>
3. When relevant, discussed military regulations and UCMJ.	<u>M</u>	<u>NM</u>

RESPECT FOR CULTURAL DIVERSITY

1. Discussed how to give feedback in a manner sensitive to cultural issues of the specific patient.	<u>M</u>	<u>NM</u>
2. Discussed how to make interview and testing sensitive to individual's cultural background and beliefs.	<u>M</u>	<u>NM</u>
3. Taught skill in cultural diversity issues (e.g., military, branch of military, gender, religion, national origin, race, etc.).	<u>M</u>	<u>NM</u>

INTERDISCIPLINARY FUNCTIONING

1. Supervision on obtaining pertinent information on a patient's previous and current levels of functioning from the following sources: referral sources, medical evaluators, patient records, (health records, service records), collateral sources, & patient interview.	<u>M</u>	<u>NM</u>
2. Feedback on skill in summarizing information from all resources, i.e., .medical charts, physicians, ward staff, command, and patients.	<u>M</u>	<u>NM</u>
3. Feedback on skill in working with providers in other disciplines and institutions, i.e., physicians, ward staff, commands, SHARP, FAP offices, etc.	<u>M</u>	<u>NM</u>

COMMENTS

Date: _____ Supervisor's Name & Signature: _____

Date: _____ Training Director's Signature: _____

CLINICAL PSYCHOLOGY RESIDENT'S CRITIQUE
Trans-rotational Learning Objectives

Supervisor's Name: _____ Date: _____

Rotation Service:

Year _____ 1st _____ 2nd _____ 3rd _____ 4th _____

OVERALL PROFESSIONAL PERFORMANCE MET NOT MET

Comments by the Resident Concerning the Evaluation (optional)

Date: _____ Supervisor's Name & Signature: _____

Date: _____ Training Director's Signature: _____

Clinical Psychology Resident's Critique
Trans-rotational Learning Objectives

Supervisor's Name: _____ Date: _____

LEARNING OBJECTIVES FOR FUNCTIONAL CORE COMPETENCIES

Assessment, Diagnosis and Case Conceptualization

1. Expected to keep regular, clear, relevant progress notes consistent with diagnosis and treatment plan that the resident has derived.	<u>M</u>	<u>NM</u>
2. Helped to conceptualize the case based on the treatment model.	<u>M</u>	<u>NM</u>
3. Helped ability to plan treatment goals.	<u>M</u>	<u>NM</u>

Interventions

1. Discussed issues of competence in the mechanics of psychotherapy, i.e., scheduling of appointments, handling missed sessions, etc.	<u>M</u>	<u>NM</u>
2. Helped with an organized conceptual understanding of patient's problems and applying this in treatment.	<u>M</u>	<u>NM</u>
3. Helped resident to discriminate among various intervention strategies to facilitate treatment.	<u>M</u>	<u>NM</u>

Consultation -NA

Research and evaluation-NA

Supervision and teaching- N/A

Management and Administrative Skills

1. Is punctual for supervisory appointments, reschedules appointment.	<u>M</u>	<u>NM</u>
2. Is clear that progress notes should be timely (within 24 hours of patient meeting).	<u>M</u>	<u>NM</u>

FOUNDATIONAL CORE COMPETENCIES

Self-Assessment

1. Helps identify therapeutic problems (e.g., impasse) and works with resident toward their resolution.	<u>M</u>	<u>NM</u>
2. Helps resident to maintain appropriate therapeutic boundaries.	<u>M</u>	<u>NM</u>
3. Helps resident be aware of own impact on the treatment process	<u>M</u>	<u>NM</u>
4. Encourages self-examination and helps utilize the information for more effective professional work.	<u>M</u>	<u>NM</u>
5. Encourages learning.	<u>M</u>	<u>NM</u>
6. Provides feedback to improve good judgment (e.g., assure suicidal patient is safe before allowing him/her to leave clinic; check with supervisor or other staff member if there is any reason to question patient's or other's safety).	<u>M</u>	<u>NM</u>

Supervisory Atmosphere for Learning

1. Promotes a sense of acceptance and support.	<u>M</u>	<u>NM</u>
2. Establishes clear boundaries.	<u>M</u>	<u>NM</u>
3. Recognizes therapist's strengths.	<u>M</u>	<u>NM</u>
4. Establishes clear and reasonable expectations of therapist performance.	<u>M</u>	<u>NM</u>
5. Conveys active interest in helping therapist with clients.	<u>M</u>	<u>NM</u>
6. Conveys active interest in helping therapist grow professionally.	<u>M</u>	<u>NM</u>
7. Sensitive and adaptive to stresses of internship.	<u>M</u>	<u>NM</u>
8. Treats mistakes as a learning experience.	<u>M</u>	<u>NM</u>
9. Reviewed forms and provides verbal and written evaluation.	<u>M</u>	<u>NM</u>

Supervision Style

1. Openly discusses and is respectful of differences in style, orientation and case conceptualization.	<u>M</u>	<u>NM</u>
2. Balances instruction with exploration and therapist's needs.	<u>M</u>	<u>NM</u>
3. Encourages therapist to question supervisor's opinions.	<u>M</u>	<u>NM</u>
4. Allows therapist to structure sessions, as appropriate.	<u>M</u>	<u>NM</u>
5. Encourages reflection on alternative interventions.	<u>M</u>	<u>NM</u>
6. Makes supervision a collaborative enterprise.	<u>M</u>	<u>NM</u>
7. Offers feedback with respect.	<u>M</u>	<u>NM</u>
8. Openly processes any conflicts that arise in supervisory relationship.	<u>M</u>	<u>NM</u>
9. Admits errors or limitations without undue defensiveness.	<u>M</u>	<u>NM</u>
10. Enables relationship to evolve over the year.	<u>M</u>	<u>NM</u>
11. Openly discusses and is respectful of differences in culture, ethnicity, or other individual diversity.	<u>M</u>	<u>NM</u>

Supervision Conduct

1. Reliably available for scheduled meetings.	<u>M</u>	<u>NM</u>
2. Available for emergencies.	<u>M</u>	<u>NM</u>
3. Makes decisions and takes responsibility when appropriate.	<u>M</u>	<u>NM</u>
4. Makes concrete and specific suggestions when needed.	<u>M</u>	<u>NM</u>
5. Maintains appropriate and useful level of focus in sessions.	<u>M</u>	<u>NM</u>
6. Assists therapist in making case formulation.	<u>M</u>	<u>NM</u>
7. Defines and clarifies problems in treatment.	<u>M</u>	<u>NM</u>
8. Raises ethical and legal considerations as appropriate.	<u>M</u>	<u>NM</u>
9. Offers practical, useful case-centered suggestions.	<u>M</u>	<u>NM</u>
10. Can present theoretical/research rationale for suggestions.	<u>M</u>	<u>NM</u>
11. Addresses countertransference issues.	<u>M</u>	<u>NM</u>
12. Provides general knowledge about psychotherapy.	<u>M</u>	<u>NM</u>
13. Raises cultural and individual diversity issues, as appropriate.	<u>M</u>	<u>NM</u>

Supervision Impact

1. Provides teaching/supervision that generalizes to other cases.	<u>M</u>	<u>NM</u>
2. Shows concern for therapist's personal development as well as internship performance.	<u>M</u>	<u>NM</u>
3. Furthers therapist's self-understanding as a professional.	<u>M</u>	<u>NM</u>
4. Facilitates therapist's self-confidence to accept new challenges.	<u>M</u>	<u>NM</u>
5. Assists therapist in forming a more crystallized professional identity.	<u>M</u>	<u>NM</u>

Scientific Knowledge and Methods

1. Supervisor discusses the theory and research relevant to the case and encourages same from supervisee.	<u>M</u>	<u>NM</u>
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Capacity for Effective Relationships

1. Approaches supervision in an open and collaborative manner or in a manner consistent with the model taught.	<u>M</u>	<u>NM</u>
2. Supervisor is appropriately prepared.	<u>M</u>	<u>NM</u>
3. Supervisor is open and responsive to feedback.	<u>M</u>	<u>NM</u>
4. Supervision feedback has improved resident’s clinical effectiveness.	<u>M</u>	<u>NM</u>
5. Allows resident to take initiative in developing the content of the supervisory sessions.	<u>M</u>	<u>NM</u>

Adherence to Legal/Ethical Standards- See #6 under Self Assessment.

Respect for Cultural Diversity

1. Provides skill in cultural diversity issues on the case.	<u>M</u>	<u>NM</u>
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Interdisciplinary Functioning- NA

COMMENTS

Date: _____ Supervisor’s Name & Signature: _____

Date: _____ Training Director’s Signature: _____

**CLINICAL PSYCHOLOGY RESIDENT'S EVALUATION OF
OUTPATIENT ROTATION**

Resident's Rank and Name: _____

Rotation Service: Outpatient Rotation

Date of evaluation: _____

Director of Rotation: _____

Additional supervisors: _____

CRITERIA	Met	Not Met	Comments
Supervisors demonstrated proficient level of knowledge of DSM-IV criteria and knowledge of differential diagnosis.			
Supervision helped enhance my diagnostic abilities.			
Supervision helped enhance my case conceptualizations.			
Supervision helped me improve my writing.			
Clinical experiences and supervision provided me with opportunities to enhance my therapy skills.			
Supervisors paid attention to both general clinical training and military-specific issues.			
Appropriate balance between respecting my therapeutic style and encouraging me to explore new approaches.			
Addressed issues related to empathy and rapport.			
Addressed issues of transference and countertransference and other issues/feelings related to the therapeutic relationship.			
Created safe environment for me to discuss issues and explore reactions/feelings.			
Created safe environment for me to admit to areas of discomfort and to ask questions.			

CRITERIA	Met	Not Met	Comments
Provided feedback in supportive and helpful manner.			
Provided useful feedback on writing with sufficient opportunity to discuss.			
Cultural/diversity issues were adequately addressed.			
Impact of medical issues on assessment and treatment was addressed.			
Risk assessment was adequately addressed.			
Outpatient risk management, including safety planning, was adequately addressed.			
Disposition planning was adequately discussed.			
Supervision/didactics on specialty evaluations was adequate.			
Impact of substance abuse on assessment and treatment was addressed.			
Group therapy experiences and supervision were useful.			
Importance of liaison with psychiatry and understanding of medication addressed.			
Addressed military and ethical issues related to contact with command.			
Addressed other ethical issues.			
Supervisor was open to feedback.			
Supervisor was reliable and responsible.			
Supervisor was available (scheduled weekly supervision sessions and was available at other times).			
Supervisor respected my other responsibilities outside of the rotation.			

APPENDIX D

Walter Reed National Military Medical Center Army Internship Reading List

You should be generally acquainted with the content of each of the below books as you will be expected to have some working knowledge of the information inside them and know where to find out the information when asked.

The list is as follows:

Military Psychology: Clinical and Operational Applications, Kennedy and Zilmer.

The Rorschach: A Comprehensive System. Vol. 1, 3rd Edition 1993, J.E. Exner, Wiley; Vol. 2, 3rd Edition, 2005, Exner & Erdberg, Wiley.

The Rorschach Workbook: A Comprehensive System, 5th Edition, 2001, J.E. Exner, Rorschach Workshops.

The MMPI 2: An Interpretive Manual, 3rd Edition, 2011, R. Greene, Allyn & Bacon.

PDR Drug Guide for Mental Health Professionals, 3rd Edition, 2007, Thompson Healthcare Inc.

Clinical Handbook of Psychological Disorders: A Step-by-Step Treatment Manual. 3rd Edition. Editor David Barlow, 2001, Guilford Press.

Psychodynamic Psychiatry in Clinical Practice 4th Edition, 2005, Glen Gabbard, American Psychiatric Publishing, Inc.

Principles of Psychotherapy, 2nd Edition, 1998, Irving Weiner, Wiley & Sons.

Cognitive Therapy: Basics & Beyond. J.S. Beck, 1995, Guilford Press.

Essentials of Treatment Planning. Mark Maruish, 2002, Wiley & Sons.

Diagnostic and Statistical Manual, Fourth Edition.

Behavioral Consultation and Primary Care: A Guide to Integrating Services. Patricia Robinson and Jeffrey Reiter, 2007.