

**Naval Medical Center Portsmouth
Psychology Department**

**CLINICAL PSYCHOLOGY
POSTDOCTORAL FELLOWSHIP**

PROGRAM MANUAL

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TABLE OF CONTENTS

Introduction.....	4
The Naval Medical Center Portsmouth.....	5
Psychology Department NMCP.....	6
Postdoctoral Fellowship: Program Description	
Goals and Objectives.....	6
Competency Assessment Toolkit.....	12
Structure of the Training Program	
Overview.....	13
Orientation.....	14
Clinical Rotations	14
Severe Psychiatric Disorders	14
Posttraumatic Stress Disorder	14
Depression	14
Mild Traumatic Brain Injury	15
Chronic Pain	15
Family Issues.....	15
Substance/Alcohol Abuse.....	16
Clinical Leadership Training Experience.....	16
Supervision.....	16
Didactics.....	17
Operational Experiences.....	18
Extra Military Duties.....	18
Grievances and Appeal Processes.....	19
Deficient Performance and Due Process.....	20
Program Evaluation by Fellows.....	21
Policy on Vacation Time.....	21
Applicant Qualifications, Application Process, and Benefits	22
Equal Opportunity Policy.....	23
Participating NMCP Staff and Consultants.....	25
Appendices	
Appendix A. Sample of Supervision Contract and Ratings	30
Appendix B. Clinical Work Samples Rating Form	36
Appendix C. Case Presentation Rating Form	54
Appendix D. Competency Self-Assessment.....	65
Appendix E. Patient Perception Survey.....	72
Appendix F. Interdisciplinary Team Member Survey	77
Appendix G. Consultation Services Survey.....	80
Appendix H. Support Staff Survey	83
Appendix I. Clinical Supervision Rating Form.....	86
Appendix J. Mid-year and End-of-Year Competency Assessment Scale	88
Appendix K. Weekly Supervision Form	99
Appendix L. Fellow’s Evaluation of Rotation Supervisor Form.....	101
Appendix M. Fellow’s Mid-Year Evaluation of Program Form.....	104
Appendix N. Fellow’s End-of-Year Evaluation of Program Form.....	107

Appendix O. Program Outcomes and Monitoring Questionnaire.....112

INTRODUCTION

The Psychology Department of the Naval Medical Center, Portsmouth, VA offers a Postdoctoral Fellowship in Clinical Psychology. The program is organized around a Practitioner-Scholar model and provides an intensive twelve-month in-service period of clinical, didactic, and leadership experiences. The mission of the program is the development of advanced competencies across a broad spectrum of professional competency domains. The context of clinical skill/competency development is organized around the theme of treating the returning war fighter. In particular, training addresses the assessment and treatment of posttraumatic stress disorder (PTSD), depression, mild traumatic brain injury (mTBI), chronic pain, family issues, and substance/alcohol abuse. It also provides an orientation to severe mental health conditions requiring inpatient psychiatric treatment within a military facility. A unique aspect of the training experience is exposure to the practice of clinical psychology in operational settings—fellows spend several days aboard a major Navy combatant vessel working with the ship's psychologist and also visit a Marine or Navy SEAL base where other psychologists practice. The program additionally prepares the fellow to become a clinical leader. Clinical leadership entails abilities in evaluating existing clinical programs, developing new programs, providing effective supervision of other practitioners, and organizing resources so that clinical and administrative objectives may be met. The targeted professional competencies combined with skills developed through prior internship experiences provides the foundation needed for practice within the military mental health system yet are sufficiently broad to prepare the fellow for advanced practice in diverse non-military clinical settings. Furthermore, this program prepares the fellow for licensure as a psychologist in the state of his/her choosing, and is conducive to eventual attainment of Board Certification in clinical psychology. Prospective fellows must apply for and be accepted as Naval officers prior to initiating this training program. Three years of obligated service as a Navy psychologist are required following the training year.

This fellowship is accredited by the American Psychological Association (APA) as a postdoctoral residency. Inquiries regarding accreditation may be addressed to the American Psychological Association's Commission 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

THE NAVAL MEDICAL CENTER PORTSMOUTH

The Naval Medical Center, Portsmouth, Virginia (NMCP) is situated beside the Elizabeth River, near downtown Portsmouth, across the river from the city of Norfolk, and not far from the largest naval base in the world. The hospital buildings on the compound are predominant landmarks on the Portsmouth waterfront. One is a high rise structure that was built in the early sixties but extensively renovated within the past 5 years and houses various outpatient clinics, including clinics operated by the Psychology Department. Adjacent to this structure is the Charette Health Center, which was completed and occupied in 1999. This 330 million-dollar, five story, one million square foot structure is a state of the art hospital, and its completion makes the Naval Medical Center at Portsmouth the largest medical treatment facility in the Navy. A short distance away situated on "Admiral's Point" is the original hospital building, dating from 1827 and distinguished as the first Naval Hospital in the United States. The original hospital provided continuous health care from 1830 to 1999, when it became a historical monument and administrative building. The buildings around the hospital house support services, enlisted staff living quarters, a Navy exchange, an indoor swimming pool, a superb gym, a parking garage, a consolidated club, and various support services. In addition to the core hospital, there are 11 branch medical clinics in the Naval Medical Center Command which are located in reasonable proximity to the main hospital complex.

The Medical Center is a major teaching facility with fourteen accredited medical residency programs serving over 250 physicians in training. Training programs are also offered for nurses, physician assistants, radiology technicians and other allied health professions. It is affiliated with the Eastern Virginia Medical School, which has its main campus in Norfolk. Both the Medical School and Old Dominion University, also located in Norfolk, are located nearby, allowing close proximity to university graduate level education in both general and health care fields. As part of its commitment to health care education, the Psychology Department's postdoctoral fellowship program has the full financial support of the Department of the Navy.

Naval Medical Center Portsmouth is the principal defense health care resource serving the Atlantic area. The foremost missions of the medical center are to provide health care to its beneficiaries, train its personnel to meet operational commitments worldwide, and conduct basic and advanced educational programs for the professional development of its staff. Additionally it advocates for the prevention of injury and illness, and promotes fitness and well being through the awareness of healthy lifestyles. It exists to keep active duty military members fit to fight and to care for them when they are injured or ill. It ensures comprehensive care for their families and others entrusted to its care. Its beneficiaries range in age from the newborn to the elderly and come from a wide range of socioeconomic, ethnic and racial backgrounds. The clinical issues that are common to any large teaching hospital are available for teaching purposes. Additionally, the distinctive issues that are relevant to military medicine receive an emphasis that brings the practitioner in training to a high state of readiness for his or her next assignment. In brief, NMCP offers a rich clinical training environment plus a sincere commitment to the training of diverse health care professionals.

PSYCHOLOGY DEPARTMENT NMCP

The Psychology Department is administratively housed within the Medical Center's Mental Health Directorate along with the Psychiatry Department and the Substance Abuse Rehabilitation Program. In concert with the medical center's missions, the Psychology Department provides direct patient care, prepares its staff for operational contingencies, is an APA approved sponsor of continuing education for psychologists, and provides training to Postdoctoral Fellows and Psychology Interns through APA accredited programs. Staff consists of both uniformed (Navy, United States Public Health Service) and civilian psychologists. Currently, there are seven uniformed and nine civilian doctoral level clinical psychologists providing services in a general outpatient mental health clinic and in subspecialty clinics in health psychology, child/family psychology, and neuropsychology. Support personnel include active duty psychiatry technicians, civilian psychology technicians, a nurse case manager, several office clerks, a training administrative assistant, an assistant office manager, and an office manager.

Though Psychology has a presence in several of the Medical Center's branch clinics, the majority of the Psychology Department staff works at the core hospital in Portsmouth, and this is where fellows receive their training. The Psychology Department has attractive offices for fellows, up-to-date computers, digital recorders and high definition video cameras for recording training sessions, and other technological resources to carry out its mission.

Postdoctoral Fellowship: Program Description

Overview: NMCP's Clinical Psychology Postdoctoral Fellowship follows a Practitioner-Scholar training model designed to provide the "generalist" clinician advanced skills across a broad array of foundational and functional professional competencies as delineated in the work by Fouad and colleagues (Fouad, Grus, Hatcher, Kaslow, Hutchings, Madison, Collins, & Crossman, 2009, *Competency Benchmarks: A Model for Understanding and Measuring Competence in Professional Psychology Across Training Levels, Training and Education in Professional Psychology, 3(sup), S5-S26*) and expanded by this program. The clinical context of training within which competencies are developed and expressed is organized around the theme of treating the returning war-fighter. To this end, there are two major, problem-focused rotations (i.e., Posttraumatic Stress Disorder and Depression) supplemented by five minor rotation experiences (i.e., Mild Traumatic Brain Injury (mTBI), Chronic Pain, Family Issues, Alcohol/substance Abuse, Family Issues, and Severe Psychiatric Illness) and other learning experiences. An emphasis on evidence-based practice permeates the training program.

Goals and Objectives: The program has three primary objectives: 1.) the development of advanced professional competencies; 2.) the preparation of the fellow for a career of life-long learning as a psychologist; and 3.) the maintenance of a high quality training program as signified by maintenance of its APA accreditation status.

Every aspect of our training model is informed by the notion of professional competence. Training objectives and assessments of trainee performance throughout the training year and at its conclusion are delineated according to specific competency benchmarks. Benchmarks used in this program include those developed by Fouad and colleagues plus our program's extensions of

these benchmarks. Competency attainment is assessed with instruments that parallel those recommended in the manuscript, *Competency Assessment Toolkit for Professional Psychology* (Kaslow, Grus, Campbell, Fouad, Hatcher, & Rodolfa, 2009). Though training in accordance with these benchmarks and assessment instruments is not mandated by official policy of the APA, we believe these published resources and the logical extensions developed to be applicable to the post-intern psychology trainee offer a solid basis for structuring our program. Core competency domains are arranged according to seven Foundational competencies (i.e., Professionalism; Reflective practice/Self-assessment/Self-care; Scientific Knowledge and Methods; Relationships, Individual and Cultural Diversity; Ethical Legal Standards and Policy; and Interdisciplinary systems) and eight Functional competencies (i.e., Assessment; Intervention; Consultation; Research/evaluation; Supervision; Teaching; Management-administration; and Advocacy). The published benchmarks span three developmental levels—Readiness for Practicum, Readiness for Internship, and Readiness for Entry to Practice.

In order to apply this model to our postdoctoral training program, we have extended developmental levels to include two additional categories—Readiness for Fully Autonomous Practice and Readiness for Life-long Learning/Master Clinician. Specific criteria (i.e., benchmarks) for these developmental levels were formed by Psychology Department professional staff members by making logical extensions of criteria provided in the published Benchmarks Document. These expanded benchmarks, in hyper-texted electronic form or in a printed manual, are available from the Psychology Training Director upon request. Additionally, to facilitate communication of developmental levels and to make them more reflective of fine-grained developmental changes, we have made the assumption that developmental stages are continuous and can be subdivided into intermediate levels separating the major stages.

We have chosen to describe placement along the full developmental continuum with a numerical system, as follows:

- 1.00 Meets criteria for Readiness for Practicum
- 1.25 Mildly exceeds some criteria for Readiness for Practicum
- 1.50 Mid-way between Readiness for Practicum and Readiness for Internship
- 1.75 Approaches or meets some criteria for Readiness for Internship
- 2.0 Meets criteria for Readiness for Internship
- 2.25 Mildly exceeds some criteria for Readiness for Internship
- 2.50 Mid-way between Readiness for Internship and Readiness for Entry to Practice
- 2.75 Approaches or meets some criteria for Readiness for Entry to Practice
- 3.00 Meets criteria for Readiness for Entry to Practice
- 3.25 Mildly exceeds some criteria for Readiness for Entry to Practice

- 3.50 Mid-way between Readiness for Entry to Practice and Readiness for Entry to Fully Autonomous Practice
- 3.75 Approaches or meets some criteria for Readiness for Entry to Fully Autonomous Practice
- 4.00 Meets criteria for Readiness for Fully Autonomous Practice
- 4.25 Mildly exceeds some criteria for Readiness for Fully Autonomous Practice
- 4.50 Mid-way between Readiness for Fully Autonomous Practice and Readiness for Life-long Learning
- 4.75 Approaches or meets some criteria for Readiness for Entry to Life-long Learning
- 5.00 Meets criteria for Entry to Life-long Learning/Master Clinician

It is important to note that assignment of developmental levels per the above numerical scale is based on supervisor judgment. We are not implying that this is a psychometrically precise measurement scale. Supervisors must compare the descriptively anchored, benchmarked standards against data obtained through direct observation of trainee activities, informed by other data sources (e.g., ratings made by interdisciplinary team members, outcome data for patients seen by trainees) and render a developmentally-anchored conclusion regarding trainee competence. We believe that our criterion-referenced scale has sufficient ordinal, and possibly interval, properties to permit the use of descriptive statistics and, accordingly, we use mathematical averages to summarize judgments offered by multiple supervisors and to average across differing sets of discrete competencies.

Regarding the first goal, as stated above, we have 15 specific objectives conforming to the competency benchmarks. The first 10 are designated as primary competencies and the program's clinical and didactic curriculum targets the developmental level of readiness for Fully Autonomous Practice (i.e., a rating of 4.0 on the above scale) when the fellow completes the year of training. The remaining five competency domains are designated as secondary. These domains receive less attention in our curriculum and end-of-year developmental targets are lower—we expect fellows to be at a developmental level of readiness for entry to practice. Though on the surface this would not appear to reflect the advanced competency expected of a fellowship program, as it is a level typically expected of a graduating intern, we designate readiness for entry to practice as an advanced level of competency for secondary competencies based on the level we expect of the graduates of our APA accredited internship. For our interns, readiness for entry to practice (which corresponds to a rating of 3.0 on our metric) is the target for the end of year competency rating of each primary competency. In contrast, for secondary competencies we target a competency level that is mid-way between readiness for internship and readiness for entry to practice (i.e., a rating of 2.5 on our metric). With this in mind, we now target readiness for fully autonomous practice (a rating of 4.0) as the target for postdoctoral fellows on all primary competencies and a rating of 3.00 (readiness for entry to practice) as the target for secondary competencies. From our perspective, ratings above 2.5 are actually indicative of “advanced competency” for secondary competency domains.

With the above in mind, our 15 specific training objectives are as follows:

1. Professionalism—The fellow will: 1.) Habitually monitor and resolve situations that challenge professional values and integrity; 2.) Be viewed by colleagues as highly professional; 3.) Be recognized as a role model for independently and consistently demonstrating personal responsibility; 4.) Demonstrate forward thinking with regard to problems; keeping the ability to safeguard the welfare of others as the foremost priority; and 5.) Exhibit full consolidation of identity as a psychologist; be broadly knowledgeable about issues central to the field; and consistently integrate science and practice.

2. Reflective Practice/Self-Assessment/Self-Care— The fellow will: 1.) Consistently exhibit reflectivity in context of professional practice (reflection-in-action); habitually act upon reflections and use self as a therapeutic tool; 2.) Exhibit unusually accurate self-assessment of competence in all competency domains; habitually integrates self-assessment in practice; and 3.) Reliably self-monitor issues related to self-care and execute prompt interventions when disruptions occur

3. Scientific Knowledge and Methods— The fellow will: 1.) Independently and consistently apply scientific methods to practice; 2.) Articulate advanced knowledge of core science; and 3.) Know and understand scientific foundations, and consistently and independently apply this knowledge to practice in a flexible manner

4. Relationships— The fellow will: 1.) Develop and maintain highly effective relationships with a wide range of clients, colleagues, organizations and communities; 2.) Manage unusually difficult communication; possess clearly advanced interpersonal skills; and 3.) Exhibit unusually articulate and eloquent command of language and ideas.

5. Individual and Cultural Diversity— The fellow will: 1.) Independently and consistently monitor and apply knowledge of self as a cultural being in assessment, treatment, and consultation; 2.) Independently and consistently monitor and apply knowledge of others as cultural beings in assessment, treatment, and consultation. 3.) Independently and consistently monitor and apply knowledge of diversity in the others as cultural beings in assessment, treatment, and consultation; and 4.) Skillfully apply knowledge, skills, and attitudes regarding intersecting and complex dimensions of diversity; for example, the relationship between one's own dimensions of diversity and one's own attitudes towards diverse others to professional work

6. Ethical Legal Standards and Policy— The fellow will: 1.) Habitually utilize and apply the APA Ethical Principles and Code of Conduct and other relevant ethical, legal and professional standards and guidelines of the profession; 2.) Apply an ethical decision making model in integrating ethics knowledge into professional work; and 3.) Proactively model and teach the integration of ethical/legal standards policy with all foundational and functional competencies.

7. Interdisciplinary Systems— The fellow will: 1.) Exhibit in depth knowledge of multiple and differing worldviews, professional standards, and contexts and systems plus advanced level

knowledge of common and distinctive roles of other professionals; 2.) Show comprehensive knowledge of and ability to display skills that support effective interdisciplinary team functioning, including communicating information in a clear and professional manner, assisting the team in resolving disagreements in diagnosis and treatment goals, and eliciting and using perspectives of other team members; 3.) Demonstrate advanced level ability to recognize and engage in opportunities for effective collaboration with other professionals toward shared goals; and 4.) Evidence ability to develop, support, and advance collaborative relationships across time with differing disciplines.

8. Assessment— The fellow will: 1.) Verbalize a technical rationale for selecting and implementing differing methods and means of evaluation in ways that are responsive to and respectful of diverse individuals, couples, families and groups and context; 2.) Advanced knowledge of administration and scoring of traditional assessment measures, models and techniques, including clinical interviewing and mental status exam; 3.) Independently and skillfully administer a variety of assessment tools and integrate results to accurately evaluate presenting question appropriate to the practice site and broad area of practice; 4.) Utilize case formulation and diagnosis for advanced intervention planning in the context of stages of human development and diversity; 5.) Exhibit advanced skills in using assessment data to form case conceptualizations and recommendations; and 6.) Demonstrate ability to communicate results in written and verbal form with a high degree of both clarity and accuracy, and in a conceptually appropriate manner.

9. Intervention— The fellow will: 1.) Apply advanced knowledge of evidence-based practice, including empirical bases of intervention strategies, clinical expertise, and client preferences; 2.) Evidence usually strong understanding of the relationship between case conceptualization and intervention planning; 3.) Exhibit advanced helping skills; 4.) Implement interventions with both strong fidelity to empirical models and a high degree of flexibility to adapt where appropriate; 5.) Incorporate strong understanding of outcome measurement and tailor outcome measures to the needs of the case; Provide conceptually appropriate treatment goals even in the absence of an established outcome measure; Evaluate treatment progress and modify planning as indicated, even in the absence of empirically validated outcome measures.

10. Consultation— The fellow will: 1.) Skillfully determine situations that require different role functions and adeptly shift roles accordingly; 2.) Exhibit advanced knowledge and consistent ability to select appropriate and contextually sensitive means of assessment/data gathering that answers the consultation referral question; 3.) Skillfully, promptly, and effectively provide assessment feedback that demonstrates advanced knowledge and leads to highly appropriate recommendations; and 4.) Apply literature to provide effective consultative services (assessment and intervention) in all routine and most complex cases.

11. Research/Evaluation (Secondary Competency)—The fellow will: 1.) Exhibit an understanding of the generation of knowledge; and 2.) Exhibit ability to evaluate outcomes.

12. Supervision (Secondary Competency)—The fellow will: 1.) Understand complexity of the supervisory role including ethical, legal and contextual issues; 2.) Express knowledge of

procedures and practices of supervision; 3.) Engage in professional reflection about one’s clinical relationships with supervisees, as well as supervisees’ relationships with their clients; 4.) Understand other individuals and groups and intersection dimensions of diversity in the context of supervision practice; able to engage in reflection on the role of one’s self on therapy and in supervision; 5.) Provide supervision independently to others in routine cases; and 6.) Exhibits knowledge of outcome assessment of teaching effectiveness relevant to ethical, legal, and professional standards and guidelines pertaining to supervision.

13. Teaching (Secondary Competency)—The fellow will: 1.) Demonstrate knowledge of outcome assessment of teaching effectiveness; and 2.) Evaluate effectiveness of learning/teaching strategies addressing key skill sets.

14. Management-Administration (Secondary Competency)—The fellow will: 1.) Manage direct delivery of professional services; exhibit awareness of basic principles of resource allocation and oversight; 2.) Demonstrate awareness of principles of policy and procedures manual for organizations, programs, or agencies; exhibit awareness of basic business, financial and fiscal management issues; 3.) Develop mission, goal-setting, implementing systems to accomplish goals and objectives; Demonstrate team-building and motivational skills; and 4.) Develops own plans for how best to manage and lead an organization

15. Advocacy (Secondary Competency)—The fellow will: 1.) Intervene with client to promote action on factors impacting development and functioning; 2.) Promote change at the level of institutions, community, or society

Fellows receive feedback regarding progress in these competency domains at the end of each training experience (i.e., rotation). Additionally, at the mid-way point of the training year and then at the end of the program they are evaluated by a Competency Committee composed of two clinical supervisors and the Training Director. A competency assessment tool-kit, as described below, guides this evaluation process. To successfully complete the training program, trainees must receive no unacceptable supervisor ratings of rotation performance, and no more than two minimally acceptable ratings (see pages 14-16 for a description of rotations and appendix A for a sample supervision contract specifying the basis for rotation ratings). Additionally, fellows are evaluated by their competency committee according to the following expected, and minimally acceptable levels of competency using the developmental competency rating scale outlined above. The expected and minimally acceptable levels are presented in the table, below.

Expected* and Minimally Acceptable Competency Ratings

	Mid-Year	End-of-Year
Primary Competencies	3.5 (3.0**, 3.25)	4.0 (3.5, 3.75)
Secondary Competencies	2.75 (2.25, 2.5)	3.00 (2.5, 2.75)

* Ratings are based on consensus judgments made by the fellow’s competency committee

** The first number in parentheses specifies the lowest acceptable rating for an individual competency domain and the second number specifies the lowest acceptable average rating across all the primary or secondary domains, respectively.

Competency Assessment Toolkit: A multifaceted approach to competency assessment is incorporated in this program. Rotation supervisors evaluate trainees at the end of each major and minor rotation. These evaluations are organized around the 15 competency domains and performed by individual rotation supervisors in a manner outlined by supervision contracts completed for each training experience and yield judgments of Unacceptable, Marginally Acceptable, or Acceptable for demonstrating advanced practice (see Appendix A for a sample supervision contract). Competency evaluations performed by the fellow's competency committee are conducted in the middle and then end of the training year, and are guided by supervisors' direct observations over the course of training but also by examination of specific work samples and other sources of information. Specific instruments and processes used by the fellow's competency committee for these two evaluations are outlined below.

Mid-year and End-of-Year Competency Assessment Rating Scale: This is our primary tool for assessing fellow competency by competency committees. Using the numerical system described above (e.g., 4.00 represents readiness for entry to Fully Autonomous Practice) and referencing the benchmarks document, supervisors use information obtained from direct observation plus findings from instruments/procedures described below to assign a developmental level to each of 15 training objectives/competency domains. All ratings are made by consensus of the committee. (See Appendix J of this manual for a copy of this rating scale).

Self-Study: At the beginning of the training year, at the mid-point, and at the end of the program, fellows complete a self-assessment addressing the 15 training objects/competency domains addressed in this training program. They are required to compare themselves against the competency benchmarks for each competency domain and then assign a competence rating (i.e., 3.00 for Readiness for Entry to Practice) for each. The basis for each rating must also be provided. See Appendix D for a copy of the form used to record this self assessment.

Work Samples: Fellows maintain copies of draft reports and progress notes in an access-protected computer share drive, where they also maintain audiotapes of their diagnostic and treatment sessions. Three diagnostic interviews are selected by the Competency Committee for review—written reports and audio tapes, along with 3 therapy cases. Structured rating scales are used to evaluate the adequacy of clinical documentation and audio/video taped case samples. A specific rating tool has been developed for this material and is presented in Appendix B of this manual.

360-Degree-like "Customer" Perception Surveys: Four brief survey instruments are administered prior to competency ratings performed mid-year and at the end of the year. Surveys are administered as structured interviews to five patients, two interdisciplinary team members, two referral sources, and two support personnel. (See Appendices E- H of this manual, for these instruments).

Case Presentations: Two formal case presentations are required—mid-year and end-of-year. Fellows select a clinical case to present to peers and supervisors. As part of the case presentation, the fellow must summarize the findings of a focused literature review (and provide references plus a 2-page written summary) addressing an issue directly related to the clinical case being presented. This will be done in a manner that demonstrates the fellow’s ability to engage in scholarly activity. Additionally, during the case presentation the fellow must address at least one ethical issue (incorporating an ethical decision-making model), one diversity issue, and comment on indications for consultation and advocacy. Evidence of ability to incorporate appropriate outcome measures must also be provided. Last, the fellow must present a progress or final report regarding their Leadership project. The case presentation will be evaluated using the Case Presentation Rating Scale completed by competency committee members. (See Appendix C of this manual for a copy of this rating scale).

Supervision Skills Rating Form: During the second half of the training year, fellows engage in clinical supervision sessions with intern-level trainees, under the guidance of their major rotation supervisor. Four audio/video tapes from supervision sessions will be submitted for evaluation at the end of the training year. A rating scale addressing the quality of supervision will be completed by both the supervised intern and the fellow’s supervisor following the completion of the fourth peer supervision session. Ratings using this same scale for the final supervision audio tape will also be made by the Training Director or Assistant Training Director. All ratings will be examined by the fellow’s competency committee prior to completing the end of year competency assessment. See Appendix I for this form.

Navy Fitness Report: In addition to the assessment of psychological competencies, as outlined above, all Navy officers receive annual Fitness Reports, an evaluation of their performance both in their areas of specialization (i.e., the practice of clinical psychology) and, more generally, regarding their leadership abilities, team work, and capabilities as an officer. These reports are prepared by the Department Head, Psychology Department, with input from both the fellow and the Psychology Training Director.

Structure of the Training Program:

Overview: Upon entering the program fellows spend approximately two weeks completing an orientation period, after which they participate in a series of problem-focused clinical rotations. Subsequent to the orientation period they spend one month on an inpatient psychiatric unit working with severe psychiatric disorders. Following this, fellows spend approximately 5 months each working within the two major rotations of the training program—Posttraumatic Stress Disorder and Depression. During these 2 major rotations they also spend one day per week in a series of three “minor” rotations(i.e., Mild Traumatic Brain Injuries, Chronic Pain, and Family Issues). Additionally, they participate in clinical leadership activities, and attend a number of didactic and operational offerings. They will spend the last month of their training working with substance abuse/dependence issues 4 days a week, with one day spent in closing out cases remaining from their last major rotation and completing their leadership project. Each fellow is assigned a primary supervisor, who, along with the Psychology Training Director, coordinates these training experiences. Specific descriptions of these training elements follow:

Orientation: The fellow initially spends from 7-10 days completing hospital-wide mandated trainings (e.g., HIPPA training, Command Orientation, computerized medical record training) and receiving an introduction to psychological practice within the Navy. During this period the fellow completes a detailed self-assessment addressing each of the 15 Foundational and Functional competency domains.

Clinical Rotations:

Severe Psychiatric Disorders (Minor Rotation): As part of this learning experience, fellows work under the supervision of their primary supervisor in addition to receiving supervision from attending inpatient psychiatrists. This training experience is sequenced at the beginning of the training year and requires functioning on an inpatient psychiatric unit for a month. The psychiatric units provide intensive inpatient psychiatric treatment for patients with primary Axis I or Axis II disorders and dually diagnosed patients (i.e., patients diagnosed with a substance use disorder plus an Axis I or Axis II psychiatric disorder) and service both active duty and adult family members. The fellow will attend and participate in morning rounds, interview new patients, develop and monitor treatment/discharge plans, provide individual therapy/crisis intervention, co-facilitate process groups on the ward with psychiatry trainees, and conduct psychological testing as needed. The fellow will consult with other professionals on the interdisciplinary team and other medical specialists within this facility to provide integrated mental health services. The fellow will also consult with family members and the commands of active duty service members to make decisions regarding military disposition. In addition, the fellow will stand 24-hour “on call” duty for emergency room psychiatric consultations with psychiatric residents once a month on weekends during this rotation and then for the rest of the training year.

Posttraumatic Stress Disorder (Major Rotation): Training will occur within the multidisciplinary Trauma and Occupational Stressors (TAOS) Clinic housed in the same building as the Psychology Department. This clinic services active duty service members from the Navy, Army, Marines, Coast Guard, and Air Force. Over the course of a 5-month training experience, the fellow will spend four days per week within this treatment environment. The fellow will conduct diagnostic interviews and provide treatment to patients with PTSD and, for the sake of breath of training, will also see some patients with other anxiety disorders. The fellow will conduct initial diagnostic interviews to establish diagnoses and to determine symptom severity, suicide/homicide risk factors, and substance use issues. The fellow will also develop appropriate treatment plans and provide evidence based treatments such as Prolonged Exposure Therapy and Cognitive Processing Therapy to patients suffering from PTSD. Additionally, fellows will utilize other treatment techniques, such as Cognitive Behavioral Therapy and group therapy, as appropriate, to treat PTSD and other anxiety disorders. Fellows will co-lead a Life After Combat group for service members returning from combat related deployments.

Depression (Major Rotation): Training is offered within the Outpatient Psychology Clinic. Over the course of a 5-month training experience, the fellow spend four days per week in this setting in which he/she conducts diagnostic interviews and provide treatment to patients with depressive disorders, though trainees are also exposed to the general outpatient population expected within a military health care setting. Interview-based diagnostic interviewing skills are

stressed, though opportunities to perform psychological testing as part of diagnostic work-ups will also be provided. An emphasis is placed on the assessment of suicide risk/protective factors and the management of suicidal patients. The fellow is expected to develop appropriate treatment plans and provide evidence based treatments such as Cognitive Behavioral Therapy (CBT) and Interpersonal Psychotherapy (IPT). Though evidence-based treatment of depression is emphasized, fellows also must demonstrate the ability to use a variety of treatment modalities when patients are not appropriate for CBT or IPT interventions. Additionally, the fellow is provided with specific Cognitive Behavioral Therapy training from Dr. Barbara Cubic, Eastern Virginia Medical School, in the form of six three-hour seminars, and 12 one-hour individual consultation sessions.

Mild Traumatic Brain Injury (Minor Rotation): For this training objective, Fellows spend one day per week for approximately 3 months working in the multidisciplinary Traumatic Brain Injury and Related Disorders (TBIRD) Program, which provides services for military personnel with known or suspected TBIs secondary to combat deployments. Supervision is provided by a licensed psychologist who is credentialed by the Medical Center to provide neuropsychological services. During this rotation fellows develop skills in concussion assessment/management, administration and interpretation of common neuropsychological screening instruments, and consultation with multidisciplinary team members.

Chronic Pain (Minor Rotation): Fellows will spend one day per week in the Health Psychology Pain Management Clinic for approximately 3 months during which they will acquire skills in the psychological management and treatment of chronic pain. Supervision is provided by a licensed psychologist who is credentialed by the Medical Center in Health Psychology. The fellow will conduct assessments on and provide treatment to patients with a variety of pain syndromes. Referrals for psychology pain management services typically come from the following hospital clinics: Anesthesia Department, Neurology, Orthopedics, Spine Clinic, Psychiatry, Internal Medicine, Dentistry, Gynecology, and branch clinics. As part of this rotation, the fellow will participate in the weekly Pain Clinic multidisciplinary patient care meeting and will present evaluations and treatment recommendations of mutual patients. The fellow will co-lead the health psychology pain management group and will be responsible for presenting material on how to use cognitive-behavioral techniques in the context of chronic pain.

Family Issues (Minor Rotation): The fellow will spend one day per week for approximately 3 months working within the Child and Family Psychology clinic at NMCP. Supervision is provided by a licensed child/family psychologist. This rotation prepares the fellow to provide basic assessment, intervention and consultation with families of active duty service members. Fellows will develop skills in the areas of intake processing, psychological evaluation/assessment, individual, group and/or family therapy, and in consultation with primary medical care providers, commands and local school districts. Additional opportunities for familiarization and consultation with other military and local community child and family resources are provided as appropriate.

Substance/Alcohol Abuse (Minor Rotation): For this rotation the fellow will spend 4 days per week for one month at the end of the training year within the Substance Abuse Rehabilitation Program (SARP) located at Naval Medical Center Portsmouth. The 5th day of the

week will be spent wrapping up outpatient cases and finishing his/her leadership project. Supervision is provided by a licensed psychologist assigned to SARP. SARP is an 80-bed substance abuse treatment facility that provides a full range of treatment services to active duty military personnel and their family members. The fellow will be oriented to the field of substance abuse treatment and will develop skills necessary to provide substance abuse treatment to adult clients. Initially, all fellows participate in a set of core didactic trainings offered at SARP and subsequently participate in a broad range of professional services including substance abuse assessment, treatment planning, individual therapy, and group therapy. Fellows are also exposed to the nonclinical roles assumed by psychologists within this treatment environment. Specifically, they gain experience in the areas of addictions counselor training, and participate in peer review, process improvement, and business plan meetings.

Clinical Leadership Training Experience:

Fellows will spend 4- hours per week over the course of the training year participating in clinical leadership activities. This training objective has three distinct components. Each Fellow will propose and execute a Program Development project designed to improve clinical functioning among patients or professional competence among psychological staff or they will develop and execute a Program Evaluation project designed to evaluate a component of an existing psychological service offered through the Psychology Department. Fellows have the option of structuring this task as a research project, in which case an appropriate research protocol must be submitted for review by the Institutional Review Board (IRB). However, formal research is not required and fellows may chose to pursue this project as part of the department's Process Improvement efforts. For the second component of this training objective, fellows will receive instruction in and practice performing clinical supervision. Their supervisees will be junior department members and/or intern level trainees. Lastly, fellows will be instructed in management procedures required for operating a clinical service within this treatment environment. As part of this latter component they will learn how to process electronic requests for services, how to establish schedules for individual providers, and how to monitor provider case-loads. Additionally, they will be exposed to procedures involved in the ordering of supplies and other basic administrative duties. Following this training they will "run" a clinic for one month. Supervision is provided in a group format by a licensed psychologist.

Supervision: Fellows will receive a minimum of four hours of supervision each week. At least two of these hours will be individual supervision provided by a licensed psychologist who is part of our training faculty. The remaining two hours will be provided in either an individual or group format and may be provided by a licensed psychologist or a licensed practitioner in a related discipline; e.g., a psychiatrist or clinical social worker. The only exception to these supervision hours will be for weeks that are primarily devoted to nonclinical activities; e.g., the orientation period, or while attending training workshops. Supervision is provided on a prorated basis for weeks that are partly clinical and partly nonclinical in nature. Fellows can also expect significant amounts of unscheduled supervision between scheduled supervision appointments. **Supervisors are available immediately for all emergency situations that arise.** Supervisors submit forms each week documenting supervision hours (see Appendix K). These forms also document various aspects of the week's supervision, such as whether or not audio/video recordings of clinical work were reviewed, whether or not supervisors provided direct feedback

to fellows, and whether or not issues in the supervisor-supervisee relationship were addressed. Additionally, supervisors are required to summarize the relative emphasis of the week's supervision efforts from the perspective of the 15 Foundational and Functional competencies that form the basis of our competency determinations. This information is entered into a data base by the Training Administrative Assistant and may be accessed by fellows if need arises and by supervisors and the Training Director for program evaluation and process improvement purposes. Submission of supervision forms also provides a means of ensuring that the minimum supervision hours have been met for each training week. The Administrative Assistant scrutinizes the training hours submitted each week and if the minimum requirement has not been met the Training Director and the fellow's primary supervisor are promptly informed. The primary supervisor then establishes a plan for making-up the missed hours and the Administrative Assistant collects documentation attesting to the success of this plan.

In addition to clinical supervision, fellows receive 1-hour each week of clinical leadership supervision over the course of this training objective. This is provided primarily on a group basis and supervision time is not counted toward the required 4 hours of clinical supervision. Nonetheless, the supervisor of the Clinical Leadership training objective documents supervision hours and other aspects of the supervisory process. This information is data based in a manner that facilitates the separation of clinical supervision hours from clinical leadership supervision time.

Didactics: Fellows spend more than 120 hours attending didactic presentations over the course of the training year. Specific didactic offerings include:

Prolonged Exposure Therapy for PTSD. Two-day workshop at NMCP provided by the Center for Deployment Psychology, Bethesda, MD.

Cognitive Processing Therapy for PTSD. Two-day workshop at NMCP provided by the Center for Deployment Psychology, Bethesda, MD.

Cognitive Behavioral Treatment of Depression. Six 3-hour presentations provided at NMCP by Dr. Barbara Cubic, Director of the Eastern Virginia Medical School Center for Cognitive Therapy, Norfolk, VA.

Professional Organization Seminar. An initial, 8 hour didactic presentation is provided for fellows during the orientation period to introduce them to clinical psychology at NMCP and, in general, Clinical Psychology in the Navy. This is followed by monthly 2-hour presentations provided on the last Tuesday of each month. These monthly presentations address a wide range of issues germane to the practice of clinical psychology within a large organizational setting, such as the US Navy.

Psychology CE Presentations. Quarterly 2-hour presentations and/or workshops of varying durations are offered through the Psychology Department's APA-approved Continuing Education sponsorship. Presentations addressing diversity issues, professional ethics, and clinical supervision are included among the offerings each year.

Other recent topics have included the role of exercise in the treatment of depression, combat-related TBI, and EMDR treatment for PTSD.

Psychiatry Grand Rounds: Weekly 1-hour presentations provided by psychiatry residents and staff. Fellows are required to attend 5 of these presentations over the training year. A wide range of mental health topics are addressed during these presentations.

“Brown Bag” Discussion Series: Fellows participate, along with faculty members of the training program, in weekly noon-time discussion groups. Over the course of the month, one day is devoted to diversity issues, one day to ethics, and two days are spent reviewing a wide spectrum of psychological competency areas. A staff member serves as coordinator for these discussions and assigns fellows, as well as staff members, leadership roles for these discussions on a rotating basis.

Center for Deployment Psychology Workshop: All fellows will attend an 8-day workshop sponsored by the Center for Deployment Psychology, which is held in Bethesda, MD. This workshop addresses multiple military and clinically specific aspects of deployment experiences the fellows can expect during their active duty military service.

Additional didactic opportunities will arise over the training year within the local psychological community and via trainings offered through the Department of Defense and Department of the Navy. Fellows can expect to spend approximately 10 hours attending didactic presentations in addition to the specific offerings noted above.

Operational Experiences: Fellows will receive a minimum of two operational experiences during the training year. They will spend 3-5 days aboard an aircraft carrier during which the fellow will experience actual shipboard living conditions and stresses, work in the ship’s Medical Department, interact with, and be educated by, successfully adapted sailors about the industrial and psychological demands of their work, and deliver psychological services under the direction of the ship’s psychologist. Fellows will also spend 3-5 days with psychologists at a Marine or Navy SEAL base. Particular emphasis will be placed on gaining familiarity with the operational plans and stresses unique to the Marine Corps or Special Forces, and on developing skills for effective consultation with these commands.

Extra Military Duties: All trainees are active duty Navy officers. Over the course of the training year fellows will stand watch as the Officer of the Day (OOD) of the Medical Center one day per month. Additionally, they may be assigned military-specific duties by the leadership of the Psychology Department. Such duties are outside of the training curriculum and may be assigned without consultation with the training director or clinical supervisors and without advanced notification. Examples of assigned military duties include representing the department at military functions and preparing short-fused informational briefs for leadership. It is the duty of each trainee to ensure that patient safety and welfare are maintained at all times, even in the presence of conflicting military duties. Accordingly, trainees must promptly inform clinical supervisors of circumstances that will result in a disruption in clinical activities and/or an inability to participate in planned program elements (e.g., scheduled supervision, didactic

presentations). Missed training activities generally cannot be made up. The frequency and duration of military assignments are not expected to significantly interfere with the trainee's ability to successfully complete the training program or meet the minimum number of training days required for graduation.

GRIEVANCES AND APPEAL PROCESSES

Grievance procedures for charges of harassment or other EEO issues are covered in BUMED Instruction 1524.1B, which is available on line through the internet at <http://navymedicine.med.navy.mil/default.cfm?selmod=706435D4-8C78-A781-8663C37197B239CD&seltab=Directives>. Fellows wishing to make a complaint or file a grievance against the Psychology Training 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 Psychology Department and Psychology staff.

Initially, the fellow 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 fellow should bring the complaint to the Psychology Training Director. 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 fellow 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 fellow 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 Psychology Training Director 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 a fellow has a complaint with the Training Director, the Psychology Department Head will follow the above guidelines in resolving the issue.

If these informal channels fail to bring a resolution that is satisfactory to the fellow, the next step in the process would be for the fellow to make a formal complaint to NMCP's 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 fellow 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 fellow, steps will be taken to remedy the situation. If the IG finds in favor of the supervisor/program, the fellow will have no further recourse.

In addition to the above, at any point in the training year fellows may request a review of any program policy by the Postdoctoral Training Committee. Requests to address this committee are communicated to the Training Director who then establishes this request as an item of business for the next scheduled committee meeting. Fellows are informed of the time and place of this meeting. After stating their request to the committee, the fellow is excused from the room while committee members debate the issue. The fellow is recalled to the meeting when a decision has been reached. If the issue is not resolved to the fellow's satisfaction, the above grievance policy may be applied.

DEFICIENT PERFORMANCE AND DUE PROCESS

In order to receive a certificate of completion, all training elements must be satisfactorily completed (i.e., performance must exceed minimally acceptable levels). In the event that deficient performance is noted by a supervisor during a clinical rotation, the supervisor is responsible for communicating specific examples of the problem(s) and suggestions for improvement to the fellow and documenting such on weekly supervision forms (see Appendix K). Performance concerns are also shared by the supervisor with members of the fellow's Competency Committee and other training faculty during regularly scheduled Training Committee meetings. This is an informal process and does not result in placement of the fellow into a remedial or probationary status.

Fellows remain in good standing within the training program unless they 1) perform at an unsatisfactory level in a major or minor rotation, as rated by the rotation supervisor at the end of the training experience; 2.) Obtain a minimally satisfactory supervisor rating in a major rotation or two minimally satisfactory ratings in minor rotations; or 3.) obtain competency ratings at the mid-year or end of year evaluations that fall below the minimally acceptable levels, as outlined above. In the event that one of these criteria is met, the fellow is placed on Departmental Remediation and a specific, written, remediation plan is developed by his/her competency committee. This plan clearly outlines the essential features of each deficient competency domain or subpar aspect of rotation performance and specifies the following the nature of the assistance provided by the training faculty geared toward the remedial effort, a time frame for completing the remediation process, and the methods by which the trainee will be evaluated. The fellow and members of the Competency Committee sign this plan. The Graduate Medical Education Committee (GMEC) is notified of this event but does not take any actions in this regard. Successful completion of the remediation plan returns the fellow to good standing in the program. Failure to remediate performance deficiencies may lead to a second period of departmental remediation or, at the discretion of the Training Committee, a referral to the Graduate Medical Education Committee with a recommendation that the committee place the fellow in a Command Probation status. In the event of probation, the fellow's competency committee develops a second, written remedial plan which, again, outlines specific deficiencies, offers a time-frame and plan for remediating them, and delineates the manner in which performance will be evaluated. Failure to successfully complete the probationary periods is likely to result in a request from the Psychology Training Committee to the GMEC for termination from the fellowship. It is possible that a trainee will require an extension of the training year to complete the program if placed on either departmental remediation or Command

Probation, especially if the performance deficiency is revealed at or near the end of the training year. Training year extensions must be approved by the GMEC. The fellow's rights to due process protections are maintained throughout all actions initiated for deficient performance. Fellows are entitled to representation by a Navy legal officer (attorney), free of charge.

In addition to the above, a fellow may be recommended for termination from the program at any time for exhibiting flagrantly unethical behavior or illegal acts. Administrative actions in response to such behaviors are handled through the GMEC and involve the military chain of command with input from the Judge Advocate's office. As is the case for all Navy service members, poor performance or unacceptable personal behavior will be reflected in the fellow's fitness reports which are prepared by the Psychology Department Head.

PROGRAM EVALUATION BY FELLOWS

Fellows provide feedback regarding the adequacy of their training experiences at various points during the training year. At the completion of each training rotation the fellow completes a supervisor evaluation form which is, after review with supervisor, submitted to the Training Director (example provided in Appendix L). Additionally, at the mid-point of the training year fellows complete a mid-year feedback form that addresses satisfaction with their training experiences to date and offers recommendations for program improvement (see Appendix M). Lastly, at the end of the training year fellows complete a final evaluation of the training experiences (see Appendix N). The fellows' evaluations of supervisors and of the program include an assessment of the degree to which the 15 competency domains were addressed. Following graduation, fellows are surveyed yearly for 7 years to determine the relevancy of the training program to their current and anticipated future professional functioning. (See Appendix O for a copy of the Program Outcomes and Monitoring Questionnaire)

POLICY ON VACATION TIME

The following guidelines have been developed to help staff evaluate requests by psychology fellows for time away from the training program. Fellows are required to plan their absences, if any, well in advance and to submit their requests in a manner that will allow adequate review by rotation supervisors, the Training Director, and the Psychology Department Head. It is the policy of the program to grant no more than ten working days for personal leave/vacation. Five of these days may be spent at the end of the training year for the purpose of obtaining housing at a new duty station. As a general rule, two leave periods should not be requested during the same rotation. This implies that if a request for house hunting is going to be made during the last rotation, other requests for leave should be made earlier in the training year. All requests for absences are contingent upon the projected requirements of the fellow's training assignments and upon the fellow's progress in the training program. Above all, patient care responsibilities are primary. Consideration of additional time away, such as time for attending graduation ceremonies or in the event of an unusual family emergency, will be on a case-by-case basis. In addition to the 10 days designated for personal leave, fellows may be absent for 5 days over the course of the training year for medical reasons. If more than a total of 15 days are expended on personal and medical leave, it may be necessary to extend the training year. Fellows should note

that they will accrue 30 days of leave/vacation over the course of the year and thus will have available leave to use at their first regular duty station.

APPLICANT QUALIFICATIONS, APPLICATION PROCESS AND BENEFITS

Individuals interested in applying for our postdoctoral training program must submit a resume/CV, graduate school transcript, three letters of recommendation, documentation certifying completion of a Ph.D. or Psy.D. in Clinical or Counseling Psychology from an APA-accredited doctoral program, and documentation certifying completion of an APA-accredited pre-doctoral internship. For individuals currently enrolled in a pre-doctoral internship, letters in support of the applicant must be received from training directors of both the doctoral program and the internship program. The letter from the doctoral program training director must state that all requirements for the doctorate will be met upon successful completion of the internship. This statement may be included in a letter of recommendation from the doctoral program training director and thereby qualify as one of the three required letters of recommendation. Additionally, the letter from the internship training director must state that the individual is in good standing in the internship and is expected to graduate from the internship on time. This statement may be included in a letter of recommendation from the internship training director and additionally qualify as one of the three required letters of recommendation. Individuals who have completed, or are currently enrolled in, non-APA-accredited internships will be considered on a case-by-case basis. Applicants must be no older than 42 and meet the physical requirements necessary for commissioning as a Lieutenant in the Navy Medical Service Corps. Applications must be completed by February 1st and applicants will be informed of acceptance status by March 1st. The training year begins in the following September/October time frame. Late applications will be considered for training positions left unfilled subsequent to the March date.

Prospective applicants should contact the Navy Recruiting Office in their local areas. This office can typically be found in the Government Pages of the local telephone directory. Applicants should specifically ask for the person in charge of Medical Officer Recruiting. Often, small recruiting offices will not have Medical Officer Recruiters, but can easily direct the applicant to the closest Medical Officer Recruiter. As part of the application process, interview appraisal from two Navy psychologists (active duty or civilian) must be submitted. At least one of the interviews should be face-to-face. Navy Recruiters will arrange for these interviews.

Prior to beginning the Postdoctoral Fellowship, prospective fellows are commissioned as Lieutenants (0-3) in the Navy Medical Service Corps and attend a 5 week training program through the Officer Development School (ODS) at Newport, Rhode Island. Upon completion of ODS, fellows are assigned to serve at Naval Medical Center Portsmouth, Virginia. Fellows have a 3-year military service obligation following completion of the one-year fellowship. Continued service as a Navy psychologist beyond this initial 4-year commitment is an option. At the end of the fellowship year, fellows will be assigned to serve in one of a variety of positions in support of the mission of the Navy and Marine Corps, including work in stateside clinics or hospitals, overseas service, and deployment with operational forces. Unlicensed fellows are expected to

complete licensure requirements in the state of their choice within 18 months of enrollment in this program. Annual compensation here in the Portsmouth area is about \$65,000. Persons with prior military service may receive more. Health care expenses are fully covered for all fellows and family members, and there are other financial benefits that go along with active duty service in the Navy, such as access to military exchanges for discounts on food and other goods, life insurance, and free access to a number of legal services.

EQUAL OPPORTUNITY POLICY

The Clinical Psychology Postdoctoral Fellowship operates in accordance with Naval Medical Center, Portsmouth's Equal Opportunity Policy, which is as follows:

- In a positive and effective work environment, all persons are treated with respect, dignity, and basic courtesy. Discrimination on the basis of a person's race, color, nation of origin, gender, age, or disability fundamentally violates these essential core values of respect and dignity. Discrimination demeans any work environment and degrades the good order and discipline of the military service.
- It is policy that all members of this command will conduct themselves in a manner that is free from unlawful discrimination. Equal opportunity and treatment will be provided for all personnel. We will actively seek ways to foster a positive, supportive, and harassment-free environment for all personnel, military and civilian, staff and patient. The rights of individuals to file grievances are ensured and preserved. Whenever unlawful discrimination is found, it will be eliminated and its effects neutralized. All personnel of this command hold a shared responsibility to ensure that any unlawful discrimination is eradicated and that accountability is appropriately assessed.

FOR ADDITIONAL INFORMATION

All further inquiries for information regarding this training program should be directed to:

Gregory Caron, Psy.D.
Training Director
Psychology Department (Code 128Y00A)
Naval Medical Center
620 John Paul Jones Circle
Portsmouth, VA 23708-2197
(757) 953-7641
gregory.caron@med.navy.mil

Additional questions regarding the application process may be directed to:

Eric Getka, Ph.D.
National Training Director
Department of Psychology, (Code 0208)
National Navy Medical Center
8901 Wisconsin Avenue
Bethesda, MD 20889-5600
(301) 295-2476
eric.getka@med.navy.mil

Participating NMCP Staff

Harold J. Addington, Ph.D. - Child and Adolescent Psychologist. Graduate of Virginia Commonwealth University, 1987. Completed *Post Doctoral Residency in Clinical Psychology* at the Psychiatric Institute of Richmond, Richmond, VA. *Research and Professional Interests include* Psychological and Neuropsychological assessment of children, adolescents, and adults; treatment of emotional, behavioral, and substance abuse problems. *Professional Affiliations:* American Psychological Association: Division 53 (Society of Clinical Child/Adolescent Psychology), Division 55 (American Society for Advancement of Psychopharmacology), Division 42 (Psychologists in Independent Practice). *Other Professional Activities:* First responder to USS Cole attack aftermath and National Guard crash crisis; Suicide Prevention Brief Presenter; Former clinical professor teaching a number of psychology courses at the College of William and Mary and St. Leo University.

Maria A. Alavanja, MD. – Staff Psychiatrist, Behavioral Health Clinic, Naval Medical Center Portsmouth. Graduate of the Uniformed Services University (USU), 2004; MS in Neuroscience, University of Pennsylvania, 2000. *Other professional activities include* supervision of PGY4 psychiatric residents, participation in a research project addressing IPT group therapy in the Treatment of PTSD, global supervision of rising PGY2 residents in NMCP psychiatry residency program; winner of “Person of Excellence, 2008” by the Uniformed Services University; small group leader, Behavioral Health Class, Uniformed Services University (2006-2008); Instructor for USU 3rd year medical students rotating in Psychiatry on topics of personality disorders, psychosis, delirium, and dementia. 2006-2008

Mary Y. Brinkmeyer, Ph.D. - Deployment Behavioral Health Psychologist Sponsored by the Center for Deployment Psychology, Uniformed Services University. Graduate of the University of Florida, 2006. Completed *Post Doctoral Residency in Health Psychology*, University of Florida. *Research and Professional Interests include* multidisciplinary treatment of chronic pain in military populations; assessment and treatment of co-morbid chronic pain and PTSD. *Professional Affiliations:* American Psychological Association. *Other Professional Activities:* Health Psychologist in the Department of Orthopedics, Naval Medical Center Portsmouth (2008-2012), associate investigator in randomized control trial of multidisciplinary intervention for acute and sub-acute nonspecific low back pain.

Roger A. Bryant, Psy.D. – Director of Comprehensive Services, Substance Abuse Rehabilitation Service. Graduate of Biola University, Rosemead School of Psychology, 1992: *Research and Professional Interests include* addictions counseling; combat stress; psychological assessment; psychotherapy; anger/stress management; conflict and communication skills. *Professional Affiliations:* Christian Association for Psychological Studies (CAPS); Center for Bioethics and Human Dignity Basic Member; Doctoral Addictions Counselor, American College of Certified Forensic Counselors (ACFC/NAFC). *Other Professional Activities:* Co-developed Outreach Program to returning soldiers of OEF/OIF; Established comprehensive Biofeedback Program at Fort Sill, OK; Instructed, trained and supervised numerous graduate level students.

Gregory R. Caron, Psy.D. – Psychology Training Director. Virginia Consortium for Professional Psychology, 1995. *Professional Affiliations:* American Psychological Association: Division 12 (Clinical Psychology), Division 36 (Psychology of Religion), Division 19 (Military Psychology), Division 48 (Peace Psychology); Society for Personality Assessment, American Academy of Clinical Psychology. *Other Professional Activities:* member Navy Psychology Work Group, Navy Psychology, Senior Executive Committee, associate investigator with research team from USARIEM, Natick MA on project entitled: “Effect of Tyrosine Supplementation on Cognitive Performance and Mood During Military Stress”, participant in Navy Psychology Mentorship Program, consultation for curriculum development and member Joint Personnel Recovery Agency (JPRA) Human Factors Advisory Board (2007-2010).

Michael Foster, Ph.D. – Counseling Services Director, Substance Abuse and Rehabilitation Program. Kent State University, 1999: Clinical Psychology. *Research and Professional Interests:* Substance Abuse; Psychological Trauma; Psychological Outcomes; Group, individual and couples therapy. *Other Professional Activities:* Trauma Treatment Program Coordinator (2000-2005); Staff trainer of numerous programs at Substance Abuse Rehabilitation Program (2005-2008) and at the Federal Prison Camp Alderson (2000-2005); Adjunct instructor of varied psychology courses at Mary Baldwin College (2002-2004), University of Pittsburgh-Johnstown (1999-2000), and Kent State University (1996-1997).

Elizabeth Hain, Ph.D. – Head of Health Psychology Division. Graduate of Boston University, 1978. *Research and Professional Interests:* hypnosis; chronic pain; chronic illness; psychological aspects of bariatric surgery. *Professional Affiliations:* American Psychological Association; American Society of Clinical Hypnosis. *Other Professional Activities:* psychology consultant to weight management group; Clinical assistant professor of psychology and consultant in the Department of Neurology at Georgetown University Medical Center (1991-1997); Instructor in Psychology, Department of Psychiatry, Harvard Medical School (1981-1986).

David W. Hess, Ph.D., ABBP– Assistant Head, Psychology Department. Graduate of Nova Southeastern University, 1991. Completed *Post Doctoral Residency in neuropsychology and rehabilitation psychology*, Hahnemann University Medical Hospital, Philadelphia, PA. *Research and Professional Interests:* Traumatic injuries (TBI, SCI, Burn); hypnosis; pain management; biomarkers as indicators of levels of adjustment with anxiety. *Professional Affiliations:* American Psychosocial Oncology Society; American Board of Professional Psychology – Rehabilitation; American Association of Spinal Cord Injury Psychologists and Social Workers; American Psychological Association: Committee on Accreditation, Division 40 (Neuropsychology), Division 22 (Rehabilitation Psychology); National Academy of Neuropsychology; Virginia Psychology Association. *Other Professional Activities:* Member of military TBI task force; inpatient Director of Neuropsychology and Rehabilitation Psychology, Rehabilitation and Research Center (1997-2008); assistant professor at Virginia Commonwealth University (2003-2008) and Eastern Virginia Medical School (1996-1997); Supervision of numerous graduate students; National, regional, and local presentations on a variety of topics in rehabilitation and neuropsychology.

Gary L. Munn, M.D. – Staff Psychiatrist. Graduate of New York Medical College, 1988. *Research and Professional Interests:* Crisis intervention; substance abuse; electroconvulsive therapy; military psychiatry; spirituality. *Professional Affiliations:* American Psychiatric Association; Psychiatric Society of Virginia; Alpha Omega Alpha Honor Medical Society. *Other Professional Activities:* Various courses, seminars, and workshops taught on different aspects of Psychiatry at Naval Medical Center Portsmouth, U.S. Naval Hospital Sigonella, Italy, and Camp Lejeune, North Carolina; associate clinical faculty at Eastern Virginia Medical School; Clinical faculty member, Uniformed Services University of the Health Sciences (2004-2005).

Ingrid B. Pauli, Psy.D. – Staff Psychologist. Graduate of the University of Kansas, 2001. *Professional Affiliations:* American Psychological Association: Division 17 (Counseling Psychology), Division 41 (Law Society). *Other Professional Activities:* primary author of chapter on substance abuse services and gambling treatment in the Military, in *Military Psychology: Clinical and Operational Applications (2nd Ed)*. Staff Psychologist at US Naval Hospital, Yokosuka, Japan (2004-2005): assistant investigator, Quality Assurance Investigation; Team Leader, Root Cause Analysis), Team Leader, Critical Incident Stress Management Team, Statistical Advisor, Strategic Planning Committee; US Naval Hospital, Bremerton, WA: Staff Psychologist.

Hsuehmei Price, Psy.D. – Assistant Psychology Training Director. Long Island University, 2003: Clinical Psychology. *Research and Professional Interests:* cultural/diversity issues related to the military, interpersonal psychotherapy for depression, and improving competency based training of military psychology interns and fellows. *Other Professional Activities:* Navy Psychologist, Naval Medical Center San Diego (2004-2007), Division Officer, Fleet Mental Health at Marine Corps Recruit Depot, Naval Medical Center San Diego (2007-2010), Deployment Behavioral Health Psychology, Center for Deployment Psychology, Bethesda, MD (2010-2011).

Michelle Sampson-Spencer, Psy.D. – Warriors in Transition Psychologist. Wright State University, 1991: Clinical Psychology. *Research and Professional Interests:* Women's Issues; Dialectical Behavior Therapy; Eye Movement Desensitization and Reprocessing; Violence Prevention. *Professional Affiliations:* American Psychological Association, Division 35 (Society for the Psychology of Women). *Other Professional Activities:* Residential Treatment Center, Director of Women's Services (2002-2008); Associate Professor and Coordinator of "Positive Adolescent Choices (PACT)" at Wright State University (1996-1998); Program development and evaluation at Wright State University (1996-1998), The Pines Residential Treatment Center, Portsmouth, VA (1998-2002) and Naval Medical Center Portsmouth (2008-present).

Consultants

Robert P. Archer Ph.D. – Professor, Department of Psychiatry and Behavioral Sciences, Eastern Virginia Medical School. University of South Florida, 1977: Clinical Psychology. *Research and Professional Interests:* Forensic evaluation and consultation; Characteristics of adult psychopathology; MMPI assessment of adolescents and adults. *Professional Affiliations:* Virginia Child Custody Evaluation Workgroup; American Board of Professional Psychology – Clinical; American Psychological Society; American Psychological Association: Division 1

(General Psychology), Division 5 (Evaluation, Measurement and Statistics), Division 8 (Personality and Social Psychology), Division 12 (Clinical Psychology), Division 41 (American Psychology – Law Society); Society for Personality Assessment; American Board of Medical Psychotherapists; Association of Medical School Professors of Psychology; Virginia Academy of Academic Psychologists; Council of Directors of Health Psychology Training; Virginia Psychological Association; Southeastern Psychological Association. *Other Professional Activities*: Principal Investigator and Co-Investigator on numerous mental health research grants; Chair for graduate level students dissertation committees; Numerous journal articles, publications, books, book chapters, computer programs, and technical manuals in various areas of mental health; Member of editorial consultant/senior advisory boards for *Journal of Consulting and Clinical Psychology* (1983-1985), *Psychological Assessment: A Journal of Consulting and Clinical Psychology* (1990-1991), *Journal of Clinical Psychology in Medical Settings* (2006-present), *Journal of Personality Assessment* (2003-present), *Assessment* (1992-2003); Clinical Associate member of the Association for the Treatment of Sexual Abusers; Various professional psychological consultations; Faculty at Virginia Consortium for Professional Psychology; Professor and Psychology Division Director in the Department of Psychiatry and Behavioral Sciences at Eastern Virginia Medical School; Supervision of post doctoral level students.

Barbara A. Cubic, Ph.D. – Associate Director, Clinical Psychology Internship, Eastern Virginia Medical School. Louisiana State University, 1992: Clinical Psychology. *Research and Professional Interests*: Cognitive Therapy; Behavioral Medicine; Eating Disorders; Professional Development. *Professional Affiliations*: Association of American Medical Colleges, Council of Academic Societies; Association of Psychologists in Academic Health Centers; Association of Medical School Psychologists; American Psychological Association – Division 12 (Clinical Psychology); Academy of Cognitive Therapy; Association of Behavioral and Cognitive Therapies (Special Interest Group in Eating Disorders); Association for the Advancement of Behavioral Therapy. *Other Professional Activities*: Numerous books, chapters, articles, presentations, and workshops in varied areas of mental health – predominately Cognitive Behavioral Therapy; Post Doctoral Students’ dissertation chair or committee member; Instructor at Louisiana State University (1990-1991); Professor of various courses at Eastern Virginia Medical School (1992-present).

James E. Dobbins, Ph.D., ABPP – Director of Post Doctoral Training, School of Professional Psychology, Wright State University. University Pittsburgh, 1977: Clinical Psychology. *Research and Professional Interests*: Family Issues; Professional Development; Cross-cultural and multi-cultural issues. *Professional Affiliations*: Association of Black Psychologists; American Psychological Association: Division 43 (Family Psychology); National Council of Schools and Programs of Professional Psychology; Association of Post Doctoral and Internship Centers; American Orthopsychiatric Association; American Board of Professional Psychology – Family. *Other Professional Activities*: Adjunct Professor, Union Graduate School; Associate Professor, School of Professional Psychology, Wright State University; Adjunct Professor, Antioch University Masters Degree Program; Former Director of General Services, Duke E. Ellis Human Development Institute School of Professional Psychology, Wright State University (1989-1992); Site Visitor, Commission on Accreditation, American Psychological Association; Vice President for Diversity, Division 43, American Psychological Association (2008-2010);

President-Elect , National Council of Schools and Programs of Professional Psychology (2007); Commissioner for Minority Health, Ohio Commission for Minority Health (1987-1989); Numerous grants, publications and presentations in areas such as diversity, family dynamics and health promotion.

Kathleen A. Malloy, Ph.D., ABPP – Director of Practicum Training, School of Professional Psychology, Wright State University. Ohio University, 1986: Clinical Psychology. *Research and Professional Interests:* Domestic Violence; Feminist Therapy; Gender Issues. *Professional Affiliations:* Association of Women in Psychology; American Board of Professional Psychology – Clinical; National Council of Schools and Programs of Professional Psychology; American Psychological Association; Ohio Psychological Association; Ohio Women in Psychology. *Other Professional Activities:* Editorial board member for *Journal of Abuse, Maltreatment and Trauma*; Examiner for ABPP; Numerous presentations, publications and book chapters in topics such as women’s issues, diversity, and training; Directed and developed a treatment program for perpetrators of domestic violence (1990-2005); Private practice therapy with child, adolescent and adult clients with special needs; Professor of an array of graduate level courses at the School of Professional Psychology, Wright State University; Previously chaired dissertation and clinical comprehensive committees; Provided formal supervision to multiple levels (pre-doctoral trainees, pre-doctoral interns, post doctoral residents) of students.

APPENDIX A

Sample of Supervision Contract and Ratings

**SAMPLE SUPERVISION CONTRACT:
PSYCHOLOGY POSTDOCTORAL FELLOWSHIP
PSYCHOLOGY DEPARTMENT
NAVAL MEDICAL CENTER
PORTSMOUTH, VA**

Rotation: Depression

This is an agreement between LT _____, hereafter referred to as fellow, and Dr. _____, hereafter referred to as supervisor. This agreement was signed on _____ after a period of observation by the supervisor. The purpose of supervision is to prepare the fellow, as a clinical psychologist, for independent and advanced practice in working with individuals who have varying degrees of depressive symptoms. Though a primary goal of this training is preparation for service within the United States Navy, supervision and clinical experiences will be sufficiently broad to enhance professional competencies in a wide range of clinical settings within which depression and associated disorders may be encountered.

Training will occur in the outpatient psychology clinic, Building 3, 3rd deck of NMCP. This clinic services active duty service members from the Navy, Army, Marines, Coast Guard, and Air Force, plus a smaller number of family members and retirees. Over the course of a 5-month training experience, the fellow will conduct diagnostic interviews and provide treatment to patients with depressive disorders and, for the sake of breadth of training, will also see some patients with other Axis I and II disorders. The fellow will conduct initial diagnostic interviews to establish diagnoses and to determine symptom severity, suicide/homicide risk factors, and substance use issues. He/She will also develop appropriate treatment plans and provide evidence based treatments such as Cognitive Behavioral Therapy or Interpersonal Psychotherapy. Additionally, the fellow will be provided with specific Cognitive Behavioral Therapy training from Dr. Barbara Cubic, Eastern Virginia Medical School, in the form of six three-hour seminars, and 12 one-hour individual consultation sessions. The work day starts at 0730 and extends beyond 1630 Monday through Friday, though the fellow will spend Wednesdays on minor rotations. The fellow will not see patients after 1600 during the week, on weekends, or any time when there is no credentialed psychologist in the clinic.

Dr. _____, who assumes clinical responsibility for the patients seen by the fellow, will monitor supervision hours and ensure that the minimum number, per APA accreditation standards, is routinely met. At a minimum, Dr. _____ will provide one hour of scheduled, face to face, individual supervision each week, plus additional individual and/or group supervision in sufficient amounts to ensure sound guidance of the fellow's clinical work and adherence to APA's supervision requirements. Dr. _____ and the fellow will submit by close of business each Friday a weekly supervision form (see Program Manual).

The fellow may expect the following as part of the supervisory process:

- A sharing of supervisors' background and clinical competencies germane to the provision of mental health services to persons with depressive disorders.
- Specific instructions regarding clinic procedures and clinical documentation guidelines that are peculiar to the outpatient clinic.
- A training/supervision experience composed of, but not limited to the following elements:

Opportunity to observe supervisor and/or other staff members conducting diagnostic interviews and/or treatment.

Opportunity to review patient notes containing initial evaluations, progress notes, and termination notes.

Observation by supervisor of diagnostic interviews and treatment services provided by the fellow in sufficient numbers to support satisfactory completion of this rotation.

Review of and feedback regarding written diagnostic reports, treatment plans, and progress notes entered into the electronic medical record

- Respect for cultural, diversity, and power differences within the supervisor-supervisee-patient triad.
- A relationship characterized by:
 - Open communication and two-way feedback.
 - The expectation that the fellow will voice disagreements and differences of opinion.
 - Attention to personal factors, such as values, beliefs, biases, and predisposition.
- **The availability of the supervisor for any and all emergency situations above and beyond scheduled supervision times.**
- Timely completion of supervision-related administrative procedures.
- Communication of coverage assignments for supervision when the primary supervisor is away from the work setting.

Supervisor may expect from _____ the following:

- Adherence to outpatient clinic policies, and ethical and legal codes.
- Use of standard outpatient clinical evaluation and report templates.
- Completion of all clinical documentation on the day of service delivery.
- Prompt notification of high risk status in any patient.
- Provision of audio or video taped sessions when requested by the supervisor.
- Openness and receptivity to feedback.
- Adherence to the requirement that all patients be provided with name and contact information of the primary supervisor.

- Proper preparation for all supervision sessions and prompt attendance.
- An understanding that the supervisor bears liability in supervision and thus it is essential that the fellow share complete information regarding patients and abide by the supervisor’s final decisions, as the welfare of the patient is tantamount.
- Reading of the following:
- **An understanding that the primary supervisor must be notified promptly in the case of an emergency and independent of scheduled supervision times, whenever patient safety is in jeopardy.**

Performance Objectives

Specific competencies expected over the course of this rotation, outlined in the table below, reflect the 7 Foundational and 8 Functional competency domains that inform this training program. These competencies are further divided into Primary (i.e., all Foundational competencies and Assessment, Intervention, and Consultation of the Functional competencies) and Secondary (i.e., the Functional competencies of Research/Evaluation, Supervision, Teaching, Management-Administration, and Advocacy) competencies. All Foundational competencies must be addressed in the table below plus a minimum of 2 of the 3 Primary Functional competencies and a minimum of 2 of 5 of the Secondary Functional competencies. It is incumbent on the fellow to assure that all 15 competencies are adequately addressed over the course of the training year. Targeted and minimally acceptable competency levels applicable to this training experience are negotiated between the fellow and the supervisor, as are the bases for making competency ratings. This must be done with the overall program requirements for graduation kept in mind (i.e., if the fellow targets low levels of competency in all supervision contracts it is unlikely that he/she will be able to demonstrate the required competency levels at the end of the training year). Additionally, the targeted competency levels should be appropriate for the primary versus secondary designation of specific competencies and the time of the training year during which training takes place. Elaborating on this latter point, early in the training year targeted and minimally acceptable levels should be lower than in the middle or near the end of the year—development over the course of the training year is expected. All competency ratings are based on the scale provided in the training manual and the Competency Benchmarks for Professional Practice, which have been made available to the fellow.

The following table outlines the targeted (i.e., fully satisfactory) and minimally acceptable competency levels expected of the fellow by the end of the rotation plus the means by which the supervisor will evaluate each competency domain. These two columns are completed at the beginning of the rotation and the last two, which provide the fellow’s self ratings plus those of the supervisor, are completed at the termination of this training experience.

Competency Domain	Targeted Rating/Minimally Acceptable Rating	Basis for Supervisor Rating	End of Rotation Fellow Self-Rating	End of Rotation Supervisor Rating
Professionalism				

Reflective practice/Self-Assessment/Self-Care				
Scientific Knowledge and Methods				
Relationships				
Individual and Cultural Diversity				
Ethical Legal Standards and Policy				
Interdisciplinary Systems				
Assessment				
Intervention				
Consultation				
Research/Evaluation*				
Supervision*				
Teaching*				
Management—Administration*				
Advocacy*				

*Secondary Competency

Signatures at the initiation of this Supervision Contract

Supervisor

Psychology Postdoctoral Fellow

End of Rotation Evaluation

In light of the above constellation of supervisor-rated competency levels, the fellow's overall performance in this training objective is judged to be:

- Unacceptable for demonstrating advanced practice
- Marginally Acceptable for demonstrating advanced practice
- Acceptable for demonstrating advanced practice

Signatures at the completion of this training objective [Date: _____]

Supervisor

Psychology Postdoctoral Fellow

APPENDIX B

Clinical Work Samples Rating Form

Naval Medical Center Portsmouth Postdoctoral Training Program

Clinical Work Samples Rating Form

Fellow: _____ **Rater:** _____ **Date:** _____

For each rating requested below use the following numerical scale. The referent for the “Good” classification is the average psychologist who is ready to enter practice. By the end of the training year, fellows would be expected to consistently obtain ratings of “4” and “5” on this form. Raters are encouraged to write comments in the margins and/or at the end of this form.

- 5 Outstanding
- 4 Good
- 3 Satisfactory
- 2 Needs Improvement
- 1 Deficient

Written Diagnostic Interview Report

Case # _____

Informed consent documented Yes No

Voluntary nature of interview documented Yes No

Demographic information documented Yes No

1.) History of Presenting Issues (HPI):

- _____ 5 HPI section provides an unusually thorough description of patient’s symptoms, including precipitant, onset, frequency, and duration of symptoms, and the impact of these symptoms on patient’s social and occupational functioning. Diagnostic criteria are presented in great detail to fully support the differential diagnostic process. The HPI is clearly written, concise, and well organized. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is exceptionally high.
- _____ 4 HPI section describes patient’s symptoms, including precipitant, onset, frequency, and duration of symptoms, and the impact of these symptoms on patient’s social and occupational functioning. Diagnostic criteria are presented to support the diagnosis. HPI section is clear, concise, and organized. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is high.
- _____ 3 HPI section describes patient’s symptoms, including precipitant, onset, frequency, and duration of symptoms, to support the diagnosis, but is in need of better organization and a more logical flow of information. Some information required for differential diagnosis

may be inferred but not specifically stated. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is adequate.

- _____ 2 HPI section attempts to describe patient's symptoms and functioning, but may leave out some aspects of either or both. Rationale for diagnosis is not clearly spelled out and some information required for differential diagnosis is neither inferred nor provided. If an audio/video recording of the encounter was submitted, there is evidence of mild incongruence between the written report and the recording.
- _____ 1 HPI section documents why patient is being seen, but does not include sufficient information about current symptoms or functioning to support a clear diagnostic picture. If an audio/video recording of the encounter was submitted, there is evidence of marked incongruence between the written report and the recording.

2.) Substance Use:

- _____ 5 Reflects thorough assessment of current and history of substance use; i.e., assessment that reflects knowledge of diagnostic criteria for substance use disorders. If standard screening tools are referenced (e.g., AUDIT or CAGE), the report reflects a thorough and accurate understanding of scores/cutoffs. Clear documentation supporting or refuting a substance use disorder is provided. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is exceptionally high.
- _____ 4 Reflects assessment of current and history of substance use in sufficient detail to rule-in or rule-out a substance use disorder. If standard screening tools are referenced (e.g., AUDIT or CAGE), the report reflects an accurate understanding of scores/cutoffs. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is high.
- _____ 3 Provides basic documentation of current and history of substance use or may reference and correctly interpret findings from a standard screening tool (e.g., AUDIT or CAGE). If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is adequate.
- _____ 2 Reflects minimal documentation of current substance use and has no substance use history. If standard screening tools are referenced (e.g., AUDIT or CAGE), the report provides findings but does not interpret them (e.g., reports an AUDIT score of 9). If an audio/video recording of the encounter was submitted, there is evidence of mild incongruence between the written report and the recording.
- _____ 1 Current substance use is either not documented or is done so very superficially. If an audio/video recording of the encounter was submitted, there is evidence of marked incongruence between the written report and the recording.

3.) Psychiatric (self and family)/Medical History:

- _____ 5 Patient's psychiatric, medical, and family psychiatric history is thoroughly and clearly documented. Information is integrated uncommonly well with current symptoms to clarify the diagnostic picture. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is exceptionally high.
- _____ 4 Patient's psychiatric, medical, and family psychiatric history is thoroughly and clearly documented. Information is integrated with current symptoms to clarify the diagnostic picture. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is high.
- _____ 3 Patient's psychiatric, medical, and family psychiatric history is documented but not in great detail. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is adequate.
- _____ 2 Patient's psychiatric, medical, and family psychiatric history is documented with some information omitted or presented in an unclear manner. If an audio/video recording of the encounter was submitted, there is evidence of mild incongruence between the written report and the recording.
- _____ 1 Patient's psychiatric, medical, and family psychiatric history is not documented or is done so in an extremely cursory manner. If an audio/video recording of the encounter was submitted, there is evidence of marked incongruence between the written report and the recording.

4.) Psychosocial History:

- _____ 5 Patient's psychosocial history is clearly and thoroughly documented. The information is integrated uncommonly well into the biopsychosocial formulation of the case. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is exceptionally high.
- _____ 4 Patient's psychosocial history is clearly and thoroughly documented. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is high.
- _____ 3 Patient's psychosocial history is adequately documented. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is adequate.
- _____ 2 Patient's psychosocial history is documented with some information omitted. Some information may need to be clarified. If an audio/video recording of the encounter was submitted, there is evidence of mild incongruence between the written report and the recording.
- _____ 1 Psychosocial history is not documented or is done so in an extremely cursory manner. If an audio/video recording of the encounter was submitted, there is evidence of marked incongruence between the written report and the recording.

5.) Mental Status Exam:

- _____ 5 Fellow's documentation reflects unusually thorough knowledge of mental status examination. The mental status section is clearly written and is fully congruent with the overall diagnostic impression. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is exceptionally high.
- _____ 4 Fellow demonstrates good skills recording features of the mental status examination. Mental status section is clearly written. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is high.
- _____ 3 Fellow demonstrates adequate skills recording features of the mental status examination. Documentation is not specific enough in some areas. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is adequate.
- _____ 2 Fellow requires training to adequately document a mental status exam. Report may omit key components of the patient's mental status. If an audio/video recording of the encounter was submitted, there is evidence of mild incongruence between the written report and the recording.
- _____ 1 Mental Status is not documented or is done so in an extremely cursory manner. If an audio/video recording of the encounter was submitted, there is evidence of marked incongruence between the written report and the recording.

6.) Assessment of Risk to Harm Self or Others:

- _____ 5 Report reflects thorough assessment of risk to harm self or others, and is written in a manner that demonstrates strong knowledge of research literature on risk and protective factors for suicide and homicide. A fully adequate crisis plan is documented, if indicated. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is exceptionally high.
- _____ 4 Report reflects adequate assessment of risk to harm self or others, and reflects good knowledge of research literature on risk and protective factors for suicide and homicide. A crisis plan is documented, if indicated. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is high.
- _____ 3 Report reflects meaningful assessment of risk to harm self or others, and reflects basic knowledge of research literature on risk and protective factors for suicide and homicide. Crisis plans is documented, if indicated, but may need to be refined or expanded. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is adequate.
- _____ 2 Report reflects superficial assessment of risk to harm self or others. Risk and protective factors are not addressed and a necessary crisis plan may be absent. If an audio/video recording of the encounter was submitted, there is evidence of mild incongruence between the written report and the recording.

- _____ 1 Risk assessment is absent in the report or is done so in an extremely cursory manner. If an audio/video recording of the encounter was submitted, there is evidence of marked incongruence between the written report and the recording.

7.) Diagnosis:

- _____ 5 Fellow's report reflects an unusually strong knowledge of mental health classification and provides DSM-IV multi-axial diagnoses that are fully supported by the description of the presenting problem, history, and mental status findings. The basis for ruling out competing diagnoses is clearly evident in the report. All relevant diagnoses are included on all axes.
- _____ 4 Fellow's report reflects a strong knowledge of mental health classification and provides DSM-IV multi-axial diagnoses that are supported by the description of the presenting problem, history, and mental status findings. The basis for ruling out competing diagnoses is either explicit or strongly inferred from the manner in which the report is written. All relevant diagnoses are included on all axes.
- _____ 3 Report reflects an understanding of diagnostic nomenclature and the DSM-IV multi-axial system. Information needed to rule-in and rule-out diagnoses is adequate. All relevant diagnoses are included on all axes.
- _____ 2 Report reflects a theoretical knowledge and understanding of basic diagnostic nomenclature, but does not provide sufficient information to fully rule-in or rule-out specific diagnoses. One or more relevant diagnoses may be absent.
- _____ 1 Report reflects significant deficits in understanding of the mental health classification system and/or ability to use DSM-IV criteria to develop a diagnostic conceptualization.

8.) Recommendations and Disposition

- _____ 5 Recommendations are formulated and take into account patient's needs, military demands, and available resources outside of the Psychology Department, if applicable. The recommendations reflect solid knowledge of evidence based practice and specifies goals of treatment, patient strengths and limitations, treatment modality and expected length of treatment, if applicable. Presence or absence of occupational limitations is clearly noted.
- _____ 4 Recommendations are formulated and take into account patient's needs, military demands, and available resources outside of the Psychology Department, if applicable. Recommendations reflect knowledge of evidence based practice and specifies goals of treatment and treatment modality, if applicable. Presence or absence of occupational limitations is noted.
- _____ 3 Fellow formulates recommendations that include appropriate treatment goals and treatment modality. Recommendations may lack specificity or may fail to take into

account available community/military resources. Presence or absence of occupational limitations is implied.

- _____ 2 Fellow is unable to identify intervention strategies that are appropriate for the case and needs supervision to make appropriate recommendations to the patient and command. Fitness for duty may be absent or inaccurate.
- _____ 1 Fellow does not provide recommendations for psychological treatment or available resources/future contacts. Or fellow creates recommendations that are clearly inappropriate.

9.) Sensitivity to Diversity Issues:

- _____ 5 Report reflects strong awareness of cultural issues relevant to the particular patient, including how these issues may influence the patient’s psychosocial history, current symptoms, and focus of treatment (if applicable). When appropriate, attention is given to how cultural differences between the fellow and the patient could have affected the patient’s clinical presentation in the interview.
- _____ 4 Report reflects awareness of cultural issues relevant to the particular patient, including how these issues may influence reported the patient’s psychosocial history, current symptoms, and focus of treatment (if applicable).
- _____ 3 Fellow demonstrates basic knowledge of cultural issues relevant to the patient and makes an attempt to incorporate these issues into the report.
- _____ 2 The report acknowledges the patient’s particular cultural background but does not comment meaningfully on it.
- _____ 1 The report omits any mention of the person’s cultural background.
- _____ N/A- No relevant diversity issues in need of attention in this report are noted by rater.

10.) Overall Written Communication Skills

- _____ 5 Report is clear and thorough, follows a coherent outline, and is an effective summary of major relevant issues. Recommendations are useful and clearly address referral questions.
- _____ 4 Report is clear and summarizes major relevant issues. Recommendations are useful and related to the referral question.
- _____ 3 Report covers essential points without serious error but needs polish in cohesiveness and organization. Recommendations are useful and relevant. Grammatical/spelling errors are absent.

- _____ 2 Report covers most essential points, but fails to summarize patient information into a cohesive report. Report reflects difficulty in formulating recommendations to appropriately answer referral questions. The report may have minor grammatical/spelling errors.
- _____ 1 Report has incomplete information, lack of structure or confusing organization, poor grammar or spelling, or inconsistent information. Report may contain material that does not apply to current patient.

Therapy Progress Notes: Ratings are based on review of at least 3 consecutive progress notes from the same patient. In instances of differing quality of documentation, the most recent work sample receive the heaviest weighting.

Case # _____

11.) Subjective:

- _____ 5 Documentation addresses current issues/status within the context of initial presentation and prior sessions. Note is concise and reflects judicious selection of information that addresses important clinical issues without unduly divulging personally sensitive information. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is exceptionally high.
- _____ 4 Documentation addresses current issues/status within the context of initial presentation and prior sessions. Note is concise and free of extraneous information. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is high.
- _____ 3 Documentation addresses current issues/status within the context of initial presentation and prior sessions. Note is either not concise or contains some extraneous information. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is adequate.
- _____ 2 Documentation addresses current issues/status independently of the context of initial presentation and prior sessions. Note is either inappropriately brief or contains clearly extraneous information. If an audio/video recording of the encounter was submitted, there is evidence of mild incongruence between the written report and the recording.
- _____ 1 Note does not provide information regarding patient’s current concerns or does so in a manner that shows no continuity with previous sessions and/or is not clearly written. If an audio/video recording of the encounter was submitted, there is evidence of marked incongruence between the written report and the recording.

12.) Objective: Observed Features

- _____ 5 Fellow documents objective status of the patient in a manner that reflects an uncommonly thorough understanding of features of the mental status examination and in a manner that reflects session to session variability in the patient’s presentation. If an audio/video

recording of the encounter was submitted, congruence between the written report and the recording is exceptionally high.

- _____ 4 Fellow documents objective status of the patient in a manner that reflects a solid understanding of features of the mental status examination and in a manner that reflects some session to session variability in the patient's presentation. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is high.
- _____ 3 Notes reflect the recording of objective features of the patient's status at each session in a manner that reflects an understanding of the mental status examination. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is adequate.
- _____ 2 Fellow's notes contain fragments of a mental status examination in reporting objective features of the patient's status in each session. If an audio/video recording of the encounter was submitted, there is evidence of mild incongruence between the written report and the recording.
- _____ 1 One or more note does not reflect objective features of the patient's status at time of therapy session. If an audio/video recording of the encounter was submitted, there is evidence of marked incongruence between the written report and the recording.

13.) Objective: Measurements

- _____ 5 Progress notes include data from one or more objective tests/instruments designed to evaluate session by session patient status/outcomes. Notes provide accurate and appropriate interpretation of these data relative to treatment goals and prior test scores.
- _____ 4 Progress notes include data from at least one objective test/instrument designed to evaluate session by session patient status/outcome. Notes provide a basic interpretation of these data relative to treatment goals and prior test scores.
- _____ 3 Progress notes include data from at least one objective test/instrument designed to evaluate session by session patient status/outcome. Notes do not provide an interpretation of the finding relative to treatment goals and/or prior test scores.
- _____ 2 At least one note contains data from an objective test/instrument designed to evaluate session by session patient status/outcome, but does not contain an interpretation of the findings or provides an incorrect interpretation of the finding.
- _____ 1 None of the progress notes contains data from an objective test/instrument.

14.) Assessment of Suicide and Homicide Risks:

- _____ 5 For at risk patients, notes reflect an unusually thorough session by session assessment of risk to harm self or others, and are written in a manner that demonstrates strong knowledge of research literature on risk and protective factors for suicide and homicide. A fully adequate crisis plan is documented in each progress note. If an audio/video

recording of the encounter was submitted, congruence between the written report and the recording is exceptionally high.

- _____ 4 For at risk patients, notes reflect a thorough session by session assessment of risk to harm self or others, and reflect good knowledge of research literature on risk and protective factors for suicide and homicide. A crisis plan is documented. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is high.
- _____ 3 Notes reflect meaningful assessment of risk to harm self or others, and reflect basic knowledge of research literature on risk and protective factors for suicide and homicide. A basic crisis plan is documented but may need to be refined or expanded. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is adequate.
- _____ 2 Notes reflects superficial or inconsistent assessment of risk to harm self or others. Applicable risk and protective factors are not addressed, and a necessary crisis plan may be absent. If an audio/video recording of the encounter was submitted, there is evidence of mild incongruence between the written report and the recording.
- _____ 1 Risk assessment is absent in one or more of the progress notes. If an audio/video recording of the encounter was submitted, there is evidence of marked incongruence between the written report and the recording.

15.) Treatment Plan

- _____ 5 Progress notes include a treatment plan that is consistent with patient's needs, military demands, and ethical practice guidelines. The plan reflects solid knowledge of evidence based practice and specifies goals of treatment, treatment modality and expected length of treatment. The treatment plan indicates the patient's progress toward goals. Indications for changes in the treatment plan are clear in the body of progress notes. Consultations with other members of the treatment team are referenced, as are efforts to advocate on behalf of the patient, if applicable.
- _____ 4 Progress notes include a treatment plan that is consistent with patient's needs, military demands, and ethical practice guidelines. The plan reflects awareness of evidence based practice and specifies goals of treatment, treatment modality and expected length of treatment. The treatment plan indicates the patient's progress toward goals. Indications for changes in the treatment plan are reported. Some consultations with other members of the treatment team are referenced.
- _____ 3 Progress notes include a basic treatment plan that is appropriate for the patient but one that is not highly reflective of unique patient needs or military demands.
- _____ 2 Progress notes include a basic treatment plan that is appropriate for the patient but is lacking in detail and is not reflective of unique patient needs or military demands.
- _____ 1 Notes provide no treatment plan or one that appears to be either completely generic or inappropriate.

16.) Sensitivity to Diversity Issues:

- _____ 5 The progress notes reflect exceptionally strong awareness of cultural diversity issues relevant to the particular patient, including how these issues may influence the patient's current symptoms and response to treatment.
- _____ 4 The progress notes reflect awareness of cultural diversity issues relevant to the particular patient, including how these issues may influence the patient's current symptoms and response to treatment.
- _____ 3 The progress notes reflect basic knowledge re cultural issues relevant to the particular patient. The fellow documents when these issues are addressed.
- _____ 2 The progress notes acknowledge cultural diversity issues relevant to the patient but do not comment meaningfully on them.
- _____ 1 The notes reflect a fundamental lack of understanding of cultural diversity issues.
- _____ N/A- No relevant diversity issues in need of attention in this report are noted by rater.

Evaluation of Recorded Diagnostic Interview

Fellow status explained/informed consent obtained	Yes	No	
Boxer law and voluntary nature of the interview addressed	Yes	No	N/A
If involuntary, Boxer procedure followed appropriately	Yes	No	N/A

17.) Diagnostic Assessment:

- _____ 5 Assesses the referral question in an uncommonly thorough manner. Inquires about patient's symptoms, including precipitants, onset, frequency, and duration of symptoms and assesses the impact of these symptoms on patient's social and occupational functioning. Asks clarifying questions to support differential diagnosis with an unusual level of skills. Assesses all major psychiatric/psychological symptoms, including those that are not spontaneously presented by the patient.
- _____ 4 Assesses the referral question thoroughly. Inquires about patient's symptoms, including precipitants, onset, frequency, and duration of symptoms and assesses the impact of these symptoms on patient's social and occupational functioning. Asks clarifying questions to support differential diagnosis.
- _____ 3 Assesses the referral question adequately. Inquires about patient's symptoms, including precipitants, onset, frequency, and duration of symptoms and assesses the impact of these symptoms on patient's social and occupational functioning.

- _____ 2 Assesses the referral question by inquiring about patient's symptoms, however, the assessment is incomplete. May leave out precipitant, onset, duration or frequency of symptoms, or fails to assess the impact of these symptoms.
- _____ 1 Unable to generate appropriate questions to address the referral question. Symptoms are collected in a random fashion as reported by the patient.

18.) History Taking:

- _____ 5 Assesses patient's psychiatric history, medical history, family psychiatric history, developmental/educational history, psychosocial history and substance use history in an unusually thorough manner. Interview style is indicative of fellow's ability to form questions that relate historic data to current symptoms and possible diagnoses. Asks appropriate follow up questions that fully clarify the historical picture.
- _____ 4 Assesses patient's psychiatric history, medical history, family psychiatric history, developmental/educational history, psychosocial history and substance use history thoroughly. Asks appropriate follow up questions.
- _____ 3 Collects adequate historic and relevant information. May fail to ask important follow up questions at times during the interview.
- _____ 2 Struggles to gather relevant historical data and frequently fails to ask important follow up questions and/or leaves out important information in the interview.
- _____ 1 Clearly fails to gather significant parts of the patient's psychiatric history, medical history, family psychiatric history, developmental/educational history, psychosocial history and/or substance use history.

19.) Mental Status Exam:

- _____ 5 Fellow inquires thoroughly and skillfully about every component of mental status that cannot be directly observed, including assessment of thought content, thought process, perception, and cognition.
- _____ 4 Fellow inquires about every component of mental status that cannot be directly observed, including assessment of thought content, thought process, perception, and cognition.
- _____ 3 Fellow inquires about most components of mental status that cannot be directly observed, such as assessment of thought content, thought process, perception, and cognition.
- _____ 2 Fellow inquires about some components of mental status that cannot be directly observed, such as assessment of thought content, thought process, perception, and cognition. However, fellow neglects more than one important component.
- _____ 1 Fellow neglects most or all components of a mental status evaluation that cannot be directly observed.

20.) Assessment of Suicide and Homicide Risks:

- _____ 5 Fellow assesses suicide and homicide risks at a level appropriate to the risk factors of the patient. Interview style reflects strong knowledge of research literature on risk and protective factors for suicide and homicide. If indicated, fellow discusses a well thought-out crisis plan with the patient in a clear and appropriate manner.
- _____ 4 Fellow assesses suicide and homicide risks thoroughly. Interview style reflects good working knowledge of risk factors literature. If indicated, fellow discusses a crisis plan with the patient in a clear and appropriate manner.
- _____ 3 Fellow assesses suicide and homicide risks adequately. Interview style reflects rudimentary knowledge of research on risk factors. If indicated, fellow discusses a basic crisis plan with the patient.
- _____ 2 Fellow assesses suicide and homicide risks superficially. May fail to ask appropriate probing questions about risk factors, fail to assess protective factors, and/or fail to discuss with the patient, if indicated, a crisis plan.
- _____ 1 Fellow fails to recognize safety issues and does not ask questions about suicidal/homicidal ideations, intent or plan.

21.) Professionalism:

- _____ 5 Fellow conducts the interview with a remarkable level of professionalism. Fellow expertly maintains the structure of the interview while remaining sensitive to the individual experience and needs of the patient. Fellow clearly demonstrates respect for the beliefs and values of the patient.
- _____ 4 Fellow conducts the interview with a high level of professionalism. Fellow is able to maintain the structure of the interview while remaining sensitive to the individual experience and needs of the patient. Fellow demonstrates respect for the beliefs and values of the patient.
- _____ 3 Fellow conducts the interview with an adequate level of professionalism, although may appear hesitant or unsure at times. In general the interview is organized but flexible to accommodate the needs of the patient. The fellow is not disrespectful to the beliefs and values of the patient.
- _____ 2 The interview may not be well-organized or may follow a rigid set of questions without taking into account the need for flexibility. The fellow may have lapses in professional demeanor, such as unwarranted self-disclosure or use of language inappropriate to the patient or situation.
- _____ 1 Fellow fails to maintain a professional demeanor.

22.) Relationship Skills:

- _____ 5 Fellow establishes a strong therapeutic alliance with the patient. Fellow provides warmth and empathy and is unusually sensitive to the patient's emotional state. The fellow communicates exceptionally clearly and effectively with the patient. The fellow is able to resolve difficult situations, if present, in a manner that minimizes the potential for conflict.

- _____ 4 Fellow establishes a therapeutic alliance with the patient. Fellow provides warmth and empathy and is sensitive to the patient's emotional state. The fellow communicates clearly and effectively with the patient. The fellow is able to resolve difficult situations, if present, in a manner that minimizes the potential for conflict.
- _____ 3 Fellow is able to establish a positive working relationship with the patient. The fellow is usually able to convey warmth, empathy, and sensitivity to the patient's emotional state. Information is conveyed adequately. If difficult situations arise, the fellow may at first appear anxious or defensive but is able to resolve them satisfactorily.
- _____ 2 The fellow struggles to establish a therapeutic alliance. The fellow does not appear sensitive to the patient's emotional state and may seem dismissive or disinterested. If difficult situations arise, the fellow has difficulty resolving them.
- _____ 1 The fellow alienates the patient and shows a marked deficiency in relationship skills.

23.) Feedback/Follow up plan:

- _____ 5 Fellow provides appropriate feedback to the patient regarding the diagnosis if there is one, provides psychoeducation about the diagnosis if appropriate, provides an overview of the treatment to be offered, and instills a sense of hope in the patient for recovery. Makes an appropriate follow up plan with the patient and may initiate homework for the next session if appropriate.
- _____ 4 Fellow provides appropriate feedback to the patient regarding diagnosis if there is one, and provides information about the diagnosis and available treatment. Fellow makes an appropriate follow up plan with the patient.
- _____ 3 Fellow ends the interview with a sufficient summary of the intake session and schedules a follow up appointment with the patient for further assessment or treatment, or reviews other recommendations (e.g., referral to another professional).
- _____ 2 Fellow provides only limited feedback to the patient at the end of the interview and the follow-up plan is vague.
- _____ 1 Fellow ends the interview without reviewing findings with patient and offers no plan for future treatment or referral.

24.) Sensitivity to Diversity Issues:

- _____ 5 Fellow takes the initiative to discuss individual differences in terms of race, ethnicity, culture, and other individual difference variables comfortably and sensitively with patient when appropriate. Recognizes when more information is needed regarding the impact of patient's cultural background on current or past experiences and seeks such information during the assessment. If the patient is from a distinct minority group, it is apparent that the fellow has an understanding of how that culture may influence mental health issues.

- _____ 4 Fellow take the initiative to discuss individual differences in terms of race, ethnicity, culture, and other individual difference variables with patient when appropriate. Recognizes when more information is needed regarding the impact of patient’s cultural background on current or past experiences and seeks such information during the session.
- _____ 3 Fellow shows adequate ability to discuss differences that exist between self and patient in terms of race, ethnicity, culture and other individual difference variables. Fellow does not initiate discussion with patient about these differences unless brought up by patient. Fellow is open to patient discussing experiences related to cultural background but does not specifically ask about these experiences.
- _____ 2 Fellow may acknowledge some individual cultural identity variables but appears uncomfortable discussing them. Fellow misses clear opportunities to inquire about the impact of the patient’s cultural background on current or past experiences.
- _____ 1 The fellow demonstrates a fundamental lack of understanding of cultural/diversity issues, such as labeling behaviors appropriate in a specific minority culture as mental health symptoms or dismissing patient’s concerns about individual difference variables.
- _____ N/A –No relevant diversity issues in need of attention during session are noted by rater.

Evaluation of Recorded Therapy Session

25.) Professionalism:

- _____ 5 Fellow conducts the session with a remarkable level of professionalism. Fellow clearly demonstrates respect for the beliefs and values of the patient.
- _____ 4 Fellow conducts the interview with a high level of professionalism. Fellow demonstrates respect for the beliefs and values of the patient.
- _____ 3 Fellow conducts the session with an adequate level of professionalism, although may appear hesitant or unsure at times. The fellow is not disrespectful to the beliefs and values of the patient.
- _____ 2 The fellow may have lapses in professional demeanor, such as unwarranted self-disclosure or use of language inappropriate to the patient or situation.
- _____ 1 Fellow fails to maintain a professional demeanor.

26.) Relationship skills:

- _____ 5 Fellow establishes a strong therapeutic alliance with the patient. Fellow provides warmth and empathy and is unusually sensitive to the patient’s emotional state. The fellow communicates exceptionally clearly and effectively with the patient. The fellow acknowledges and works skillfully to resolve any therapeutic impasses.

- _____ 4 Fellow establishes a therapeutic alliance with the patient. Fellow provides warmth and empathy and is sensitive to the patient's emotional state. The fellow communicates clearly and effectively with the patient. The fellow acknowledges and works to resolve any therapeutic impasses.
- _____ 3 Fellow is able to establish a positive working relationship with the patient. The fellow is usually able to convey warmth, empathy, and sensitivity to the patient's emotional state. Information is conveyed adequately. If a therapeutic impasse arises, the fellow may at first appear anxious or defensive but works to resolve it.
- _____ 2 The fellow struggles to establish a therapeutic alliance. The fellow does not appear sensitive to the patient's emotional state and may seem dismissive or disinterested. The fellow has difficulty resolving any therapeutic impasses that arise.
- _____ 1 The fellow alienates the patient and shows a marked deficiency in relationship skills.

27.) Intervention (CPT or PE):

- _____ 5 Fellow follows the protocol closely and skillfully. Fellow appears exceptionally comfortable and familiar with the protocol and does not appear to be reading from a script. Fellow adapts explanations to suit the patient's level of education and psychological-mindedness. Fellow redirects the patient to stay on protocol in a way that allows patient to feel supported regarding current stressors or distress.
- _____ 4 Fellow follows the protocol closely. Fellow appears comfortable and familiar with the protocol and does not appear to be reading from a script. Fellow adapts explanations to suit the patient's level of education and psychological-mindedness.
- _____ 3 Fellow follows the protocol closely with only minor deviations. Fellow appears comfortable with the protocol. Fellow checks with patient to ensure understanding and provides further explanation if needed.
- _____ 2 Fellow has difficulty staying on track with the protocol. Fellow may have difficulty allotting time to session components and fails to finish the session. Or fellow may follow the timeline rigidly even when the patient clearly does not understand or accept the intervention.
- _____ 1 The session does not appear to follow either CPT or PE protocol.

28.) Intervention (CBT, IPT, DBT, Short-Term Psychodynamic, Crisis Management):

- _____ 5 Interventions are well-timed, effective and consistent with empirically supported treatment protocol. Reflect strong knowledge of current literature on evidence based treatments. Fellow tracks or reflects patient statements in session with a high level of skill, and maintains patient's motivation to work. Fellow balances tracking functions with guiding functions unusually well.
- _____ 4 Most interventions and interpretations facilitate patient acceptance and change. Reflect good knowledge of current literature on evidence based treatments. Fellow tracks or

reflects patient statements in session, and maintains patient's motivation to work. Fellow balances tracking functions with guiding functions.

- _____ 3 Many interventions and interpretations are delivered and timed well. Some interventions need to be clarified and adjusted to patient's needs. Demonstrates basic knowledge of current literature on evidence based treatments. Fellow tracks or reflects patient statements in session most of the time, but at times seems to follow own agenda. Fellow tries to maintain patient's motivation by periodically checking-in with patient.
- _____ 2 Some interventions are accepted by the patient while many others are rejected by patient. Fellow sometimes has difficulty targeting the interventions to patient's level of understanding and motivation. Fellow may follow own agenda in the session but responds to patient's needs when patient explicitly voices them. Alternatively, fellow's agenda may be unclear, and the session may lack structure.
- _____ 1 Most interventions and interpretations are rejected by patient. Fellow has frequent difficulty targeting interventions to patient's level of understanding and motivation. Demonstrates no knowledge of evidence based treatments. Or fellow provides an intervention that is clearly inappropriate.

29.) Sensitivity to Diversity Issues:

- _____ 5 Fellow takes the initiative to discuss individual differences in terms of race, ethnicity, culture, and other individual difference variables comfortably and sensitively with patient when appropriate. Recognizes when more information is needed regarding the impact of patient's cultural background on current or past experiences and seeks such information during the session. If the patient is from a distinct minority group, it is apparent that the fellow has an understanding of how that culture may influence mental health issues.
- _____ 4 Fellow take the initiative to discuss individual differences in terms of race, ethnicity, culture, and other individual difference variables with patient when appropriate. Recognizes when more information is needed regarding the impact of patient's cultural background on current or past experiences and seeks such information during the session.
- _____ 3 Fellow shows adequate ability to discuss differences that exist between self and patient in terms of race, ethnicity, culture and other individual difference variables. Fellow does not initiate discussion with patient about these differences unless brought up by patient. Fellow is open to patient discussing experiences related to cultural background but does not specifically ask about these experiences.
- _____ 2 Fellow may acknowledge some individual cultural identity variables but appears uncomfortable discussing them. Fellow misses clear opportunities to inquire about the impact of the patient's cultural background on current or past experiences.
- _____ 1 The fellow demonstrates a fundamental lack of understanding of cultural/diversity issues, such as prescribing interventions contrary to a cultural norm or dismissing patient's concerns about individual difference variables.
- _____ N/A –No relevant diversity issues in need of attention during session are noted by rater.

Comments: _____

APPENDIX C

Case Presentation Rating Form

Naval Medical Center Portsmouth Fellowship Training Program

Case Presentation Rating Form

Fellow: _____ **Presentation Date:** _____ **Rater:** _____

For each rating requested below use the following numerical scale. The referent for the “Good” classification is the average psychologist who is ready to enter practice. By the end of the training year, fellows would be expected to consistently obtain ratings of “4” and “5” on this form. Raters are encouraged to write comments in the margins and/or at the end of this form.

- 5 Outstanding
- 4 Good
- 3 Satisfactory
- 2 Needs Improvement
- 1 Deficient

1.) Case Material:

- _____ 5 Fellow presented the patient’s current symptoms, history of present illness, psychiatric history, medical history, family psychiatric history, developmental/educational history, psychosocial history and substance use history in an unusually thorough and well organized fashion. Fellow was able to skillfully integrate historic information with current symptoms to clarify the clinical picture.
- _____ 4 Fellow presented the patient’s current symptoms, history of present illness, psychiatric history, medical history, family psychiatric history, developmental/educational history, psychosocial history and substance use history thoroughly and in an organized fashion. There was evidence of integration of historic information with current symptoms.
- _____ 3 Fellow presented most relevant patient information, such as current symptoms, history of present illness, psychiatric history, medical history, family psychiatric history, developmental/educational history, psychosocial history and substance use history, but either neglected to collect some potentially valuable clinical data or provided less than fully clear symptom/data descriptions. There was only basic evidence of ability to integrate historic information with current symptoms.
- _____ 2 Fellow presented most relevant patient information, but left out some key clinical/historical facts or provided vague descriptions of such. There was little evidence of fellow’s ability to integrate historic information with current symptoms.
- _____ 1 Fellow presented patient information in a disjointed fashion and/or either provided vague descriptions of clinical/historical facts or failed to present major symptom clusters or clinical/historical facts.

2.) Assessment of Suicide and Homicide Risks:

- _____ 5 Fellow presented an unusually thorough suicide and homicide risk assessment. Presentation reflected strong knowledge of research literature on risk and protective factors for suicide and homicide. Fellow formulated an exceptional crisis plan, if indicated, and appropriate protective actions were taken if necessary.
- _____ 4 Fellow presented a thorough suicide and homicide risk assessment. Presentation reflected good working knowledge of the risk factors literature. Fellow formulated an adequate crisis plan, if indicated, and appropriate protective actions were taken if necessary.
- _____ 3 Fellow presented a basic suicide and homicide risk assessment. Presentation reflected rudimentary knowledge of research on risk factors. Fellow formulated a crisis plan, if needed, but it was in need of some refinement. Appropriate protective actions were taken if necessary.
- _____ 2 Fellow assessed suicide and homicide risks superficially. May have failed to ask appropriate probing questions about risk factors or failed to assess protective factors. Fellow recognized the need for protective actions if indicated but may have failed to initiate the appropriate actions.
- _____ 1 Fellow failed to recognize safety issues and did not assess suicidal/homicidal ideations, intent or plan.

3.) Diagnosis:

- _____ 5 Fellow demonstrated an unusually thorough knowledge of mental health classification, including multi-axial diagnoses and relevant DSM-IV diagnostic criteria, in supporting his/her diagnostic formulation. Fellow was unusually thorough in consideration of relevant patient data and accurately ruled out different diagnoses.
- _____ 4 Fellow demonstrated thorough knowledge of mental health classification, including multi-axial diagnoses and relevant DSM-IV diagnostic criteria, in supporting his/her diagnostic formulation. Fellow considered relevant patient data to rule out different diagnoses.
- _____ 3 Fellow demonstrated basic knowledge of diagnostic nomenclature and the DSM-IV, and his/her diagnostic formulation appeared adequate, though symptom descriptions were not sufficiently detailed to provide overwhelming support for the diagnoses and/or facts needed to rule out other diagnoses were not presented in a thorough manner.
- _____ 2 Fellow demonstrated only a rudimentary theoretical knowledge and understanding of basic diagnostic nomenclature and the DSM-IV. Fellows omitted a number of patient facts needed to support his/her diagnostic formulation and/or to rule out different diagnoses.
- _____ 1 Fellow demonstrated significant deficits in understanding of the mental health classification system and/or ability to use DSM-IV criteria to develop a diagnostic conceptualization. Fellow gave the patient wrong diagnoses based on inaccurate interpretation of the DSM-IV and/or inadequate data collection.

4.) Case Conceptualization:

- _____ 5 Fellow produced an unusually strong case conceptualization within own preferred theoretical orientation, and was able to draw multiple insights from other orientations. Case formulation demonstrated strong knowledge of current literature regarding preferred orientation and evidence based treatments.
- _____ 4 Fellow produced a good case conceptualization within own preferred theoretical orientation, and was able to draw some insights from other orientations. Case formulation demonstrated knowledge of current literature regarding preferred orientation and evidence based treatments.
- _____ 3 Fellow produced an adequate case conceptualization within own preferred theoretical orientation. Case formulation demonstrated basic knowledge of current literature regarding preferred orientation and evidence based treatments.
- _____ 2 Fellow's case conceptualization reflected some limitations in theoretical understanding of the fellow's chosen orientation, and demonstrated a limited appreciation of the current literature regarding preferred orientation and evidence based treatments.
- _____ 1 Fellow failed to reach a coherent case conceptualization from any orientation and was only able to report symptoms of the patient.

5.) Intervention:

- _____ 5 Fellow provided a description of psychotherapy interventions that reflects a sophisticated understanding of psychological treatment. Outcome data were presented that strongly support fellow's description of therapeutic effectiveness and illustrate fellow's sophistication in understanding and using outcome measures.
- _____ 4 Fellow provided a description of psychotherapy interventions that reflects a solid understanding of psychological treatment. Outcome data were presented that substantiate fellow's description of therapeutic effectiveness and illustrate fellow's awareness of the value of outcome measures.
- _____ 3 Fellow provided a description of psychotherapy interventions that reflects a basic understanding of psychological treatment. Some outcome data were presented that support fellow's description of therapeutic effectiveness and illustrate fellow's basic awareness of the value of outcome measures.
- _____ 2 Fellow provided a description of psychotherapy interventions that reflects only a very rudimentary understanding of psychological treatment. Outcome data are either not presented or are presented in a manner that does not support fellow's description of therapeutic progress.
- _____ 1 Fellow provides a description of psychotherapy interventions that are inappropriate for the given case, reflect poor understanding of psychological treatment issues, or do not take into consideration outcome data.

6.) **Military Issues:** (Not applicable if case is not an active duty service member)

- _____ 5 Fellow demonstrated an unusually thorough understanding of how demands of military service and military life impact patient's functioning and treatment options. Fellow identified operational needs and military issues present in the case, and, if indicated, illustrated how he/she addressed them proactively with the patient and/or the command.
- _____ 4 Fellow demonstrated good understanding of how demands of military service and military life impact patient's functioning and treatment options. Fellow identified some operational needs and military issues present in the case, and illustrated how he/she addressed them at some point in the treatment process with the patient and/or the command
- _____ 3 Fellow demonstrated some understanding of military issues and operational demands present in the case, but may have failed to take them into full consideration when making recommendations regarding the case.
- _____ 2 Fellow demonstrated limited awareness of important military issues and demands present in the case
- _____ 1 Fellow demonstrated no awareness of important military issues and demands present in the case.
- _____ N/A

7.) **Interdisciplinary Functioning:** (Applicable only if interdisciplinary issues are apparent for the case)

- _____ 5 Fellow identified indications for consultation with other professional services and exhibited an unusually keen awareness of the value of interdisciplinary approaches to treatment.
- _____ 4 Fellow identified need for consultation and initiated requests for such in a manner reflective of solid awareness of the value of interdisciplinary approaches to treatment.
- _____ 3 Fellow identified need for consultation and initiated requests for such in a manner reflective of some understanding of and appreciation for the value of interdisciplinary approaches to treatment.
- _____ 2 Fellow appeared to have a limited awareness of the need for consultation to other professional services, and appeared to have limited insight regarding the value of interdisciplinary approaches to treatment.
- _____ 1 Fellow appeared to have no awareness of the need for consultation to other professional services, and appeared to have no understanding of the value of interdisciplinary approaches to treatment.
- _____ N/A

8.) Recommendations:

- _____ 5 Recommendations for a treatment case took into account multiple patient needs and military demands, and took into consideration cultural diversity issues. Intervention strategies recommended were evidence based and an unusually thorough treatment plan was outlined in which measureable treatment goals were specified, patient strengths and limitations were delineated, a treatment modality was identified, and estimated length of treatment was provided.

- _____ 4 Recommendations for a treatment case took into account various patient needs and military demands, and took into consideration at least one cultural diversity issue. Intervention strategies recommended were evidence based and a thorough treatment plan was outlined in which treatment goals were specified, patient strengths and limitations were delineated, a treatment modality was identified, and estimated length of treatment was provided.

- _____ 3 Recommendations for a treatment case took into account patient needs and one or more military demands and/or cultural diversity issue. Intervention strategies recommended were evidence based and a treatment plan was outlined in which treatment goals were specified and a treatment modality was identified.

- _____ 2 Recommendations for a treatment case only superficially took into account patient's needs, military demands and/or cultural diversity issues. Intervention strategies recommended were not evidence based and/or a rudimentary treatment plan was outlined in which treatment goals and treatment modalities were vaguely specified.

- _____ 1 For a treatment case, inappropriate recommendations were made to the patient, his/her command, and/or referral sources. Either a treatment plan was not offered or it was clearly inadequate (e.g., recommended an inappropriate intervention for the presenting problem).

9.) Scholarly Review of the Literature:

- _____ 5 Fellow conducted a thorough literature review on a topic directly related to the case and succinctly summarized information gained from the review into a coherent report. Fellow used the knowledge gained to inform treatment or to positively impact assessment conclusions in an unusually skillful manner.
- _____ 4 Fellow conducted a literature review on a topic directly related to the case and was able to use the knowledge gained to inform treatment or to clarify assessment conclusions.
- _____ 3 Fellow conducted a literature review on a topic directly related to the case but did not appear confident or skillful in translating knowledge gained from the review into practice.
- _____ 2 Fellow conducted a limited literature review or conducted a literature review on a topic not directly related to the case and was not able to demonstrate ability to link insights gained from the literature to treatment/assessment of this case.
- _____ 1 Fellow did not conduct a literature review on a topic appropriate to the case or provided a very limited or inadequate one.

10.) Ethical and Legal Issues:

- _____ 5 Fellow demonstrated unusually strong knowledge of the ethical principles and military laws and regulations pertinent to the case. Fellow demonstrated unusually strong judgment regarding actions to take to resolve or address ethical issues, if such were identified.
- _____ 4 Fellow demonstrated full understanding of the ethical principles, and military laws and regulations pertinent to the case. Fellow was able to specify an appropriate means to resolve ethical issues in this case, if such were identified.
- _____ 3 Fellow demonstrated some understanding of the ethical principles, and military laws and regulations pertinent to the case. If such were identified, fellow offered only a vague prescription for resolving ethical issues or indicated only the need to consult with a supervisor.
- _____ 2 Fellow demonstrated only superficial awareness of potentially important ethical and legal issues present in the case, and did not discuss viable approaches to resolving ethical concerns, if any were identified.
- _____ 1 Fellow did not address ethical or legal concerns pertinent to this case.

11.) Diversity Issues:

- _____ 5 Fellow demonstrated strong acknowledgement and respect for differences between self and the patient in terms of race, ethnicity, culture and other individual/cultural variables. Recognized when more information was needed regarding patient differences and described highly skillful processes for securing this information. If the patient is from a

distinct minority group, the fellow knowledgably discusses how that culture may influence mental health issues.

- _____ 4 Fellow recognized individual differences with the patient, and demonstrated respect for differences between self and the patient in terms of race, ethnicity, culture and other individual/cultural variables. Case presentation demonstrated awareness of own limits in expertise and efforts to take diversity issues into consideration in case conceptualization/assessment and treatment planning.
- _____ 3 Fellow recognized individual differences with the patient, and was respectful of differences between self and the patient in terms of race, ethnicity, culture and other individual/cultural variables. Fellow made some efforts to take diversity issues into consideration in case conceptualization/assessment and/or treatment planning.
- _____ 2 Fellow demonstrated some recognition of individual differences between self and the patient but was unable to take diversity issues into full consideration when reaching case conceptualization/assessment and/or during treatment planning.
- _____ 1 Fellow did not address individual/cultural differences between self and the patient during the case presentation.

12.) Reflective Practice /Self-Care

- _____ 5 Fellow insightfully reflects on strengths and limitations in terms of working with this particular patient. Fellow demonstrates strong awareness of factors such as counter-transference and secondary traumatization. In difficult cases, fellow demonstrates a strong ability to self-monitor own reactions to patient and intervenes independently to care for own emotional needs in order to not impact patient care.
- _____ 4 Fellow reflects on strengths and limitations in terms of working with this particular patient. Fellow demonstrates awareness of factors such as counter-transference and secondary traumatization. In difficult cases, fellow self-monitors own reactions to patient and proactively seeks guidance to care for own emotional needs in order to not impact patient care.
- _____ 3 Fellow makes a good effort to reflect on strengths and limitations in terms of working with this particular patient. Fellow has a developing awareness of factors such as counter-transference and secondary traumatization. Fellow may not initially be aware of own reactions to patient but accepts guidance and recommendations when raised by supervisor or peers.
- _____ 2 Fellow has difficulty reflecting on strengths and limitations but shows an ability to seek supervision and guidance on issues regarding reflective practice. Fellow has deficits in knowledge of counter-transference and secondary traumatization but is open to discussion of the impact of own reactions on patient care.
- _____ 1 Fellow has difficulty reflecting on strengths and limitations and is unwilling or unable to accept feedback. Major countertransference issues may be observed by others but denied or minimized by fellow. Fellow's response to patient appears to have significantly impacted patient care.

13.) Consultation Issues:

- _____ 5 Fellow demonstrated a high degree of skill as per his/her descriptions of interactions with referral sources and/or military commands. Fellow described processes for providing feedback to referral sources, commands and/or others involved in the treatment of the case that reflect an unusually high level of consultative skill development.
- _____ 4 Fellow's description of interactions with referral sources, military commands, and/or others involved in the treatment of the case reflect appropriate ability to communicate recommendations.
- _____ 3 Fellow's description of interactions with referral sources, military commands, and/or others involved in the treatment of the case reflect acceptable ability to communicate recommendations.
- _____ 2 Fellow demonstrated only a rudimentary knowledge of consultative processes and his/her description of interactions with referral sources, military commands, and/or others involved in the treatment of the case reflect difficulties communicating recommendations clearly.
- _____ 1 Fellow was either unable to communicate recommendations clearly to the patient's referral source, command, or others involved with the treatment or did not appear to appreciate the need to consult with others involved in the care of the patient when the need for such is apparent from the description of the case.

14.) Advocacy Issues:

- _____ 5 Fellow intervened with others on behalf of the patient to promote changes positively impacting the patient's functioning and/or well being. Fellow's actions fostered self-advocacy on the part of the patient and also reflected fellow's awareness of the need to develop alliances with relevant individuals/groups and/or to engage groups with differing viewpoints around the issue to promote change.
- _____ 4 Fellow intervened with patient to promote actions on factors impacting the patient's functioning, promoted patient's self-advocacy, and/or assessed implementation and outcome of patient's self-advocacy plans.
- _____ 3 Fellow identified specific barriers to patient improvement (e.g., lack of transportation to mental health appointments), and assisted patient in the development of self advocacy plans. Fellow demonstrated understanding of appropriate boundaries and times to advocate on behalf of patients.
- _____ 2 Fellow demonstrated some awareness of social, political, economic and cultural factors that may impact on human development and functioning. Case presentation illustrated fellow's knowledge of therapist as change agent outside of direct patient contact but did not detail specific advocacy actions.

_____ 1 Fellow did not address advocacy issues.

15.) Program Development/Evaluation Project

_____ 5 Fellow's project demonstrates strong knowledge of and adherence to the program development/evaluation literature; reflects the fellow's ability to accurately interpret data and explain the basis for the selection of metrics; addresses a meaningful problem based on a sophisticated and empirically-based needs assessment; and highlights the fellows ability to engage in high-level critical thinking.

_____ 4 Fellow's project demonstrates clear awareness of the program development/evaluation literature; reflects the fellow's ability to explain how data are to be interpreted; addresses a meaningful problem in a manner reflecting the fellows ability to engage in critical thinking; and is described/presented in a manner that is easy for the audience to understand. The project description may or may not include the collection of data but must reflect the fellows understanding of how data from the project could be meaningfully addressed to meet the identified problem.

_____ 3 Fellow's project reflects a basic awareness of the program development/evaluation literature; reflects the fellow's ability to provide a basic explanation of how data are to be analyzed; and reflects the fellow's ability to engage in low-level critical thinking.

_____ 2 Fellow demonstrates only a very rudimentary awareness of the program development/evaluation literature; the project reflects only a vague description of the reasons supporting the choice of problem(s); the fellow's ability to explain how data are to be interpreted is very basic.

_____ 1 Fellow fails to demonstrate awareness of the program development/evaluation literature; is unable to explain how data are to be interpreted; does not present the material in a manner reflecting ability to engage in critical thinking.

16) Teaching Ability:

_____ 5 Fellow's presentation suggested advanced ability to function in a teaching role; i.e., fellow communicated with a high degree of effectiveness, articulated concepts in an unusually clear manner, and addressed questions in an uncommonly effective manner.

_____ 4 Fellow's presentation suggested solid ability to function in a teaching role; i.e., fellow communicated effectively, articulated concepts in a clear manner, and was receptive to questions.

_____ 3 Fellow's presentation suggested basic ability to function in a teaching role; i.e., fellow communicated adequately, articulated concepts in an acceptable manner, and was able to provide reasonable answers to questions.

- _____ 2 Fellow's presentation suggested limited ability to function in a teaching role; i.e., fellow communicated with difficulty, struggled to articulate concepts to be presented, and was only marginally effective in answering questions.
- _____ 1 Information presented during the presentation was difficult to follow and major points were poorly articulated. Responses to questions were not handled in a manner that promoted learning.

17.) Peer Consultation:

- _____ 5 Fellow's comments to peers following their presentations illustrated an unusually strong ability to suggest alternative approaches to conceptualizing case material. Fellow's verbal input reflected his/her high degree of awareness of the differing role functions one assumes as a consultant.
- _____ 4 Fellow's comments to peers following their presentations provided a clear indication of ability to suggest alternative approaches to conceptualizing case material. Fellow's verbal input reflected his/her awareness of the differing role functions one assumes as a consultant.
- _____ 3 Fellow's comments to peers following their presentations provided some indication of ability to suggest alternative approaches to conceptualizing case material. Fellow's verbal input reflected his/her basic awareness of the differing role functions one assumes as a consultant.
- _____ 2 Fellow's comments to peers following their presentations provided only limited indications of ability to suggest alternative approaches to conceptualizing case material. Fellow's verbal input reflected his/her limited awareness of the differing role functions one assumes as a consultant.
- _____ 1 Fellow's comments to peers following their presentations provided no solid indication of ability to suggest alternative approaches to conceptualizing case material. Fellow's verbal input did not reflect his/her awareness of the differing role functions one assumes as a consultant.

Comments: _____

APPENDIX D

Competency Self-Assessment

Naval Medical Center Portsmouth Clinical Psychology Postdoctoral
Fellowship
Competency Self-Assessment

Name: _____

Please rate yourself, using the following scale and the Competency Benchmarks, for each of 15 competency domains in the tables provided below.

Dates of Completion: Entry To Training Program: _____
Mid Year Evaluation _____
End of Year Evaluation _____

Competency Rating Scale

- 1.00 Meets criteria for Readiness for Practicum
- 1.25 Mildly exceeds some criteria for Readiness for Practicum
- 1.50 Mid-way between Readiness for Practicum and Readiness for Internship
- 1.75 Approaches or meets some criteria for Readiness for Internship
- 2.0 Meets criteria for Readiness for Internship
- 2.25 Mildly exceeds some criteria for Readiness for Internship
- 2.50 Mid-way between Readiness for Internship and Readiness for Entry to Practice
- 2.75 Approaches or meets some criteria for Readiness for Entry to Practice
- 3.00 Meets criteria for Readiness for Entry to Practice
- 3.25 Mildly exceeds some criteria for Readiness for Entry to Practice
- 3.50 Mid-way between Readiness for Entry to Practice and Readiness for Entry to Fully Autonomous Practice
- 3.75 Approaches or meets some criteria for Readiness for Entry to Fully Autonomous Practice
- 4.00 Meets criteria for Readiness for Fully Autonomous Practice
- 4.25 Mildly exceeds some criteria for Readiness for Fully Autonomous Practice
- 4.50 Mid-way between Readiness for Fully Autonomous Practice and Readiness for Life-long Learning
- 4.75 Approaches or meets some criteria for Readiness for Entry to Life-long Learning
- 5.00 Meets criteria for Entry to Life-long Learning

Professionalism

	Entry To Training Program	Mid Year Evaluation	End of Year Evaluation
Rating			
Basis for Rating			

Reflective Practice/Self-Assessment/Self-Care

	Entry To Training Program	Mid Year Evaluation	End of Year Evaluation
Rating			
Basis for Rating			

Scientific Knowledge and Methods

	Entry To Training Program	Mid Year Evaluation	End of Year Evaluation
Rating			
Basis for Rating			

Relationships

	Entry To Training Program	Mid Year Evaluation	End of Year Evaluation
Rating			
Basis for Rating			

Individual and Cultural Diversity

	Entry To Training Program	Mid Year Evaluation	End of Year Evaluation
Rating			
Basis for Rating			

Ethical Legal Standards and Policy

	Entry To Training Program	Mid Year Evaluation	End of Year Evaluation
Rating			
Basis for Rating			

Interdisciplinary Systems

	Entry To Training Program	Mid Year Evaluation	End of Year Evaluation
Rating			
Basis for Rating			

Assessment

	Entry To Training Program	Mid Year Evaluation	End of Year Evaluation
Rating			
Basis for Rating			

Intervention

	Entry To Training Program	Mid Year Evaluation	End of Year Evaluation
Rating			
Basis for Rating			

Consultation

	Entry To Training Program	Mid Year Evaluation	End of Year Evaluation
Rating			
Basis for Rating			

Research/Evaluation

	Entry To Training Program	Mid Year Evaluation	End of Year Evaluation
Rating			
Basis for Rating			

Supervision

	Entry To Training Program	Mid Year Evaluation	End of Year Evaluation
Rating			
Basis for Rating			

Teaching

	Entry To Training Program	Mid Year Evaluation	End of Year Evaluation
Rating			
Basis for Rating			

Management-Administration

	Entry To Training Program	Mid Year Evaluation	End of Year Evaluation
Rating			
Basis for Rating			

Advocacy

	Entry To Training Program	Mid Year Evaluation	End of Year Evaluation
Rating			
Basis for Rating			

APPENDIX E

Patient Perception Survey

(Supervisor and Training Administrative Assistant Versions)

Naval Medical Center Portsmouth Postdoctoral Fellowship Program

Patient Perception Survey—Supervisor Version

Date: _____ Supervisor: _____ Fellow: _____

Patient Initials: _____ Patient's Age _____ Gender: _____ Ethnicity: _____

Duty Status (e.g., Active Duty, retiree, family member): _____ Rank: _____ Service: _____

Rotation (circle one): Inpatient Outpatient I Outpatient II Assessment

Rotation Sequence (circle one): 1st Rotation 2nd Rotation 3rd Rotation 4th rotation

I am Dr. _____. I am _____ (the fellow)'s clinical supervisor. I would like to ask you about your impressions of _____ and the service(s) he/she has provided to you. Your responses will help me evaluate his/her performance in our program. Please be candid and truthful in your answers. Your responses will be shared with _____ but will not be linked to your identity. Your responses will also be shared with our Training Committee.

I would like you to respond to each of the following statements using a 5-point scale where: 1--means you strongly disagree; 2--means you disagree; 3--means you neither agree nor disagree; 4--means you agree; and 5--means you strongly agree.

_____ 1.) _____ (the fellow) made it clear to you that he/she is in a training program and is under my supervision.

_____ 2.) Today (Or at your last appointment) you were seen within 15 minutes of your scheduled appointment time unless you arrived late.

_____ 3.) _____ conducted him/her self in a professional manner.

_____ 4.) It was clear to you that _____ understood you as an individual and understood your unique needs and issues.

_____ 5.) _____ fully and clearly explained recommendations for your care.

_____ 6.) _____ asked you if you had any questions about your care and if so was able to answer them to your satisfaction.

_____ 7.) _____ appeared interested and concerned about protecting your private personal information.

_____ 8.) You feel comfortable working with _____.

_____ 9.) Treatment or evaluation services provided to you by _____ have been helpful in addressing your needs.

If a patient gives a 1 or 2 for any of the above items, query them as to the reasons for these ratings and record below:

Naval Medical Center Portsmouth Postdoctoral Fellowship Program

Patient Perception Survey—Training Administrative Assistant Version

Date: _____ Administrative Assistant: _____ Fellow: _____

Patient Initials: _____ Patient's Age _____ Gender: _____ Ethnicity: _____

Duty Status (e.g., Active Duty, retiree, family member): _____ Rank: _____ Service: _____

Rotation (circle one): Inpatient Outpatient I Outpatient II Assessment

Rotation Sequence (circle one): 1st Rotation 2nd Rotation 3rd Rotation 4th rotation

I am Mr./Ms. _____]. I am the Administrative Assistant for the Psychology Training Programs. I would like to ask you about your impressions of _____ (the fellow) and the service(s) he/she has provided to you. Your responses will help evaluate his/her performance in our program. Please be candid and truthful in your answers. Your responses will be shared with _____(fellow) but will not be linked to your identity. Your responses will also be shared with our Training Committee.

I would like you to respond to each of the following statements using a 5-point scale where: 1--means you strongly disagree; 2--means you disagree; 3--means you neither agree nor disagree; 4--means you agree; and 5--means you strongly agree.

_____ 1.) _____ (the fellow) made it clear to you that he/she is in a training program and is under _____ (fellow's rotation supervisor) supervision.

_____ 2.) Today (Or at your last appointment) you were seen within 15 minutes of your scheduled appointment time unless you arrived late.

_____ 3.) _____ conducted him/her self in a professional manner.

_____ 4.) It was clear to you that _____ understood you as an individual and understood your unique needs and issues.

_____ 5.) _____ fully and clearly explained recommendations for your care.

_____ 6.) _____ asked you if you had any questions about your care and if so was able to answer them to your satisfaction.

_____ 7.) _____ appeared interested and concerned about protecting your private personal information.

_____ 8.) You feel comfortable working with _____.

_____ 9.) Treatment or evaluation services provided to you by _____ have been helpful in addressing your needs.

If patient gives a 1 or 2 for any of the above items, query them as to the reasons for these ratings and record below:

APPENDIX F

Interdisciplinary Team Member Survey

(Supervisor and Training Administrative Assistant Versions)

Naval Medical Center Portsmouth Postdoctoral Fellowship

Interdisciplinary Team Member Survey: Supervisor Version

Date: _____ Supervisor: _____ Fellow: _____

Evaluation: ___ Mid-Year ___ End of Training

Initials of Team Member: _____ Profession: _____

I would like to ask you a few questions about one of our postdoctoral fellows, _____, who is currently working under my supervision and has had interactions with you as part of the _____ treatment team. Your responses will be shared with the fellow but will not be linked to your identity. Your responses will also be shared with our Training Committee. Please be candid and truthful in your answers.

I would like you to respond to each of the following statements using a 5-point scale where: 1--means you strongly disagree; 2--means you disagree; 3--means you neither agree nor disagree; 4--means you agree; and 5--means you strongly agree.

- _____ 1.) _____ (the fellow) made it clear to you that he/she is in a training program and is under my supervision.
- _____ 2.) _____ clearly defined what a psychology postdoctoral fellow is and his/her role on the treatment team.
- _____ 3.) _____ conducted him/her self in a professional manner.
- _____ 4.) _____ appears to understand your role and contribution to the treatment team.
- _____ 5.) _____ demonstrates respect for the contributions of other disciplines to the functioning of the treatment team.
- _____ 6.) _____ has made a significant contribution to the functioning of the treatment team.

If respondent gives a 1 or 2 for any of the above items, query them as to the reasons for these ratings and record below:

Naval Medical Center Portsmouth Postdoctoral Fellowship

Interdisciplinary Team Member Survey: Administrative Assistant Version

Date: _____ Administrative Assistant: _____ Fellow: _____

Evaluation: ___ Mid-Year ___ End of Training

Initials of Team Member: _____ Profession: _____

I would like to ask you a few questions about one of our fellows, _____, who is currently working under the supervision of Dr. _____, and has had interactions with you as part of the _____ treatment team. Your responses will be shared with the fellow but will not be linked to your identity. Your responses will also be shared with our Training Committee. Please be candid and truthful in your answers.

I would like you to respond to each of the following statements using a 5-point scale where: 1--means you strongly disagree; 2--means you disagree; 3--means you neither agree nor disagree; 4--means you agree; and 5--means you strongly agree.

- _____ 1.) _____ (the fellow) made it clear to you that he/she is in a training program and is under Dr. _____'s supervision.
- _____ 2.) _____ clearly defined what a psychology postdoctoral fellow is and his/her role on the treatment team.
- _____ 3.) _____ conducted him/her self in a professional manner.
- _____ 4.) _____ appears to understand your role and contribution to the treatment team.
- _____ 5.) _____ demonstrates respect for the contributions of other disciplines to the functioning of the treatment team.
- _____ 6.) _____ has made a significant contribution to the functioning of the treatment team.

If respondent gives a 1 or 2 for any of the above items, query them as to the reasons for these ratings and record below:

APPENDIX G

Consultation Services Survey

(Supervisor and Training Administrative Assistant Versions)

Naval Medical Center Portsmouth Postdoctoral Fellowship

Consultation Services Survey—Supervisor Version

Date: _____ Supervisor: _____ Fellow: _____

Patient Initials: _____ Patient's Age _____ Gender: _____ Ethnicity: _____

Duty Status (e.g., Active Duty, retiree, family member): _____ Rank: _____ Service: _____

Evaluation: Mid-Year End of Training Initials of referral source: _____

Source of Referral (circle one): Command Medical Officer Navy Primary Care

Manager—Physician Navy Primary Care Manager—non-Physician Specialty Clinic

Command Directed Referral Another Mental Health Provider Other: _____

I am Dr. _____. I am _____'s clinical supervisor. I would like to ask you about your impressions of the consultation services he/she recently provided for you regarding _____ (patient's name). Your responses will help me evaluate _____'s performance in our program. Please be candid and truthful in your answers. Your responses will be shared with _____ but will not be linked to your identity. Your responses will also be shared with our Training Committee.

I would like you to respond to each of the following statements using a 5-point scale where: 1—means you strongly disagree; 2—means you disagree; 3—means you neither agree nor disagree; 4—means you agree; and 5--means you strongly agree.

_____ 1.) _____ made it clear to you that he/she is in a training program and is under my supervision.

_____ 2.) _____ conducted him/her self in a professional manner.

_____ 3.) _____ provided feedback about this case in a timely manner.

_____ 4.) The feedback provided by _____ was helpful.

_____ 5.) You would feel comfortable referring patients in the future to _____.

If referral source gives a 1 or 2 for any of the above items, query them as to the reasons for these ratings and record below:

Naval Medical Center Portsmouth Postdoctoral Fellowship

Consultation Services Survey—Administrative Assistant Version

Date: _____ Administrative Assistant: _____ Fellow: _____

Patient Initials: _____ Patient's Age _____ Gender: _____ Ethnicity: _____

Duty Status (e.g., Active Duty, retiree, family member): _____ Rank: _____ Service: _____

Evaluation: Mid-Year End of Training Initials of referral source: _____

Source of Referral (circle one): Command Medical Officer Navy Primary Care

Manager—Physician Navy Primary Care Manager—nonPhysician Specialty Clinic

Command Directed Referral Another Mental Health Provider Other: _____

I am Mr./Ms._____. I am the Administrative Assistant for the Psychology Postdoctoral Fellowship Program. I would like to ask you about your impressions of the consultation services you recently received from one of our postdoctoral fellows, _____(fellow's name) regarding _____ (patient's name). Your responses will help evaluate _____'s (fellow's name) performance in our program. Please be candid and truthful in your answers. Your responses will be shared with _____ (the fellow) but will not be linked to your identity. Your responses will also be shared with our Training Committee.

I would like you to respond to each of the following statements using a 5-point scale where: 1—means you strongly disagree; 2—means you disagree; 3—means you neither agree nor disagree; 4—means you agree; and 5--means you strongly agree.

_____ 1.) _____ (the fellow) made it clear to you that he/she is in a training program and is under _____'s (supervisor's name) supervision.

_____ 2.) _____ conducted him/her self in a professional manner.

_____ 3). _____ provided feedback about this case in a timely manner.

_____ 4). The feedback provided by _____ was helpful.

_____ 5.) You would feel comfortable referring patients in the future to _____.

If referral source gives a 1 or 2 for any of the above items, query them as to the reasons for these ratings and record below:

APPENDIX H

Support Staff Survey

(Supervisor and Training Administrative Assistant Versions)

Naval Medical Center Portsmouth Postdoctoral Fellowship

Support Staff Survey: Supervisor Version

Date: _____ Supervisor: _____ Fellow: _____

Evaluation: ___ Mid-Year ___ End of Training Initials of support staff: _____

Support role (circle): Administrative support Psychiatric Technician Other: _____

I would like to ask you about your impressions of _____ (fellow), who is currently working under my supervision in our Postdoctoral Fellowship Training Program. Your responses will be shared with the fellow but not your identity. Your responses will also be shared with our Training Committee. Please be candid and truthful in your answers.

I would like you to respond to each of the following statements using a 5-point scale where: 1--means you strongly disagree; 2--means you disagree; 3--means you neither agree nor disagree; 4--means you agree; and 5--means you strongly agree.

- _____ 1.) _____ (the fellow) treats you with dignity and respect.
- _____ 2.) _____ behaves in a professional manner.
- _____ 3.) _____ understands your role within the organization.
- _____ 4.) _____ utilizes your services appropriately.

If respondent gives a 1 or 2 for any of the above items, query them as to the reasons for these ratings and record below:

Naval Medical Center Portsmouth Postdoctoral Fellowship

Support Staff Survey: Administrative Assistant Version

Date: _____ Administrative Assistant: _____ Fellow: _____

Evaluation: ___ Mid-Year ___ End of Training Initials of support staff: _____

Support role (circle): Administrative support Psychiatric Technician Other: _____

I would like to ask you about your impressions of _____ (fellow), who is currently working under _____ (supervisor's name) supervision in our Postdoctoral Fellowship Training Program. Your responses will be shared with the fellow but not your identity. Your responses will also be shared with our Training Committee. Please be candid and truthful in your answers.

I would like you to respond to each of the following statements using a 5-point scale where: 1--means you strongly disagree; 2--means you disagree; 3--means you neither agree nor disagree; 4--means you agree; and 5--means you strongly agree.

- _____ 1.) _____ (the fellow) treats you with dignity and respect.
- _____ 2.) _____ behaves in a professional manner.
- _____ 3.) _____ understands your role within the organization.
- _____ 4.) _____ utilizes your services appropriately.

If respondent gives a 1 or 2 for any of the above items, query them as to the reasons for these ratings and record below:

APPENDIX I

Clinical Supervision Rating Form

Naval Medical Center Portsmouth Postdoctoral Fellowship Program

Clinical Supervision Rating Form

Date: _____ Supervisee: _____ Rater: _____

Please indicate whether you are:

Supervisee: _____ Supervisor _____ Training/Asst Training Director: _____

Please rate the quality of clinical supervision by responding to each of the following statements using a 5-point scale where: 1--means you strongly disagree; 2--means you disagree; 3--means you neither agree nor disagree; 4--means you agree; and 5--means you strongly agree.

- _____ 1.) Supervisor provided a sense of acceptance and support.
- _____ 2.) Supervisor established clear boundaries.
- _____ 3.) Supervisor provided both positive and corrective feedback to the supervisee.
- _____ 4.) Supervisor helped the supervisee conceptualize the case.
- _____ 5.) Supervisor raised cultural and diversity issues relevant to the case.
- _____ 6.) Supervisor offered practical and useful case-centered suggestions.
- _____ 7.) Supervisor assisted the supervisee in integrating different techniques.
- _____ 8.) Supervisor conveyed active interest in helping supervisee grow professionally.
- _____ 9.) Peer Supervisor maintained appropriate and useful level of focus in supervision.
- _____ 10.) Supervisor was respectful of differences in culture, ethnicity or other individual diversity between supervisor and supervisee.

If any of the above items is given a 1 or 2, please explain the reasons for these ratings below:

APPENDIX J

Mid-Year and End-of-Year Competency Assessment Rating Scale

Mid-Year and End-of-Year Competency Assessment Rating Scale

Naval Medical Center Portsmouth Psychology Postdoctoral Fellowship Training Program Competency Assessment Rating Scale

Fellow: _____ Raters: _____

Consensus Rating: includes input from primary supervisor, training director, and another training faculty member.

_____MID-YEAR _____END-OF-YEAR

This form is intended to be used in conjunction with the Fellowship Training Program's Competency Benchmarks document to assign competency ratings for each of 7 Foundational and 8 Functional competency domains at the end of the rotation noted above. Ratings are provided by rotation supervisors, transrotational supervisors, and by the fellow's Competency Committee, as discussed in the program manual. Ratings are based on the following developmental scale anchored by the benchmarks for each competency domain:

- 1.00 Meets criteria for Readiness for Practicum
- 1.25 Mildly exceeds some criteria for Readiness for Practicum
- 1.50 Mid-way between Readiness for Practicum and Readiness for Fellowship
- 1.75 Approaches or meets some criteria for Readiness for Fellowship
- 2.00 Meets criteria for Readiness for Fellowship
- 2.25 Mildly exceeds some criteria for Readiness for Fellowship
- 2.50 Mid-way between Readiness for Fellowship and Readiness for Entry to Practice
- 2.75 Approaches or meets some criteria for Readiness for Entry to Practice
- 3.00 Meets criteria for Readiness for Entry to Practice
- 3.25 Mildly exceeds some criteria for Readiness for Entry to Practice
- 3.50 Mid-way between Readiness for Entry to Practice and Readiness for Entry to Fully Autonomous Practice
- 3.75 Approaches or meets some criteria for Readiness for Entry to Fully Autonomous Practice
- 4.00 Meets criteria for Readiness for Fully Autonomous Practice
- 4.25 Mildly exceeds some criteria for Readiness for Fully Autonomous Practice
- 4.50 Mid-way between Readiness for Fully Autonomous Practice and Readiness for Life-long Learning
- 4.75 Approaches or meets some criteria for Readiness for Entry to Life-long Learning
- 5.00 Meets criteria for Entry to Life-long Learning/Master Clinician

Expected* and minimally acceptable ratings are provided in the table below:

	Mid-Year	End-of-Year
Primary Competencies	3.5 (3.0**, 3.25)	4.0 (3.5, 3.75)
Secondary Competencies	2.75 (2.25, 2.5)	3.00 (2.5, 2.75)

* Ratings are based on consensus judgments made by the fellow’s competency committee

** The first number in parentheses specifies the lowest acceptable rating for an individual competency domain and the second number specifies the lowest acceptable average rating across all the primary or secondary domains, respectively.

In addition to the above expected/minimally acceptable competency ratings, fellows are required to pass both major rotations (i.e., PTSD and Depression) and have no more than two minor rotation supervisor ratings of “Marginally Acceptable for demonstrating advanced practice” at the end of the training year.

Foundational Competencies

1. Professionalism

Assessment Methods: Direct supervisor observation and discussion during supervision sessions; Review of fellow’s self study; Work Samples Rating Form items 21 & 25; Patient Perception Rating Form items 1-3; Interdisciplinary Team Member Survey items 1-3; Consultation Services Survey items 1-3; Support Staff Survey item 2.

Essential Components:

- ___ A: Integrity, Honesty, personal responsibility and adherence to professional values
- ___ B: Department
- ___ C: Accountability
- ___ D: Concern for the welfare of others
- ___ E: Professional Identity

___ **Final Rating**

2. Reflective Practice/Self-Assessment/Self-Care

Assessment Methods: Direct supervisor observation and discussion during supervision sessions; Review of fellow’s self study; Case Presentation Rating Form item 12.

Essential Components:

___ A: Reflective Practice

___ B: Self-Assessment

___ C: Self-Care (attention to personal health and well-being to assure effective professional functioning)

___ **Final Rating**

3. Scientific Knowledge and Methods

Assessment Methods: Direct supervisor observation and discussion during supervision sessions; Review of fellow's self study; Work Samples Rating Form items 9 & 15.

Essential Components:

___ A: Scientific Mindedness

___ B: Knowledge

___ C: Scientific Foundations

___ **Final Rating**

4. Relationships

Assessment Methods: Direct supervisor observation and discussion during supervision sessions; Review of fellow's self study; Work Samples Rating Form items 22 & 26; Patient Perception Rating Form item 8; Support Staff Survey item 1; Clinical Supervision Rating Form item 1.

Essential Components:

___ A: Interpersonal Relationships

___ B: Affective Skills

___ C: Expressive Skills

___ **Final Rating**

5. Individual and Cultural Diversity

Assessment Methods: Direct supervisor observation and discussion during supervision sessions and participation in Brown Bag Discussion ; Review of fellow's self study; Work Samples Rating Form items 9, 16, 24, & 29; Case Presentation Rating Forms items 6 & 11; Patient Perception Rating Form item 4; Clinical Supervision Rating Form items 5 & 10.

Essential Components:

- ___ A: Self as shaped by individual and cultural diversity
- ___ B: Others as shaped by individual and cultural diversity
- ___ C: Interactions of self and others as shaped by individual and cultural diversity
- ___ D: Applications based on individual and cultural context

___ **Final Rating**

6. Ethical Legal Standards and Policy

Assessment Methods: Direct supervisor observation and discussion during supervision sessions; Participation in Brown Bag Discussions; Review of fellow's self study; Case Presentation Rating Form item 10; Patient Perception Rating Form item 7.

Essential Components:

- ___ A: Knowledge of ethical, legal and professional standards and guidelines
- ___ B: Awareness and Application of Ethical Decision Making
- ___ C: Ethical Conduct

___ **Final Rating**

7. Interdisciplinary Systems

Assessment Methods: Direct supervisor observation and discussion during supervision sessions; Review of fellow's self study; Case Presentation Rating Form item 7; Interdisciplinary Team Member Survey items 4-6.

Essential Components:

- ___ A: Knowledge of the shared and distinctive contributions of other professions
- ___ B: Functioning in multidisciplinary and interdisciplinary contexts
- ___ C: Understands how participation in interdisciplinary collaboration/consultation enhances outcomes
- ___ D: Respectful and productive relationships with individuals from other professions

___ **Final Rating**

Functional Competencies

8. Assessment

Assessment Methods: Direct supervisor observation and discussion during supervision sessions; Review of fellow's self study; Work Samples Rating Form items 1-8, 10-14; 17-20; Case Presentation Rating Forms items 4 & 8; Clinical Supervision Rating Form item 4.

Essential Components:

- ___ A: Measurement and Psychometrics
- ___ B: Evaluation Methods
- ___ C: Application of Methods
- ___ D: Diagnosis
- ___ E: Conceptualization and Recommendations
- ___ F: Communication of Findings

___ **Final Rating**

9. Intervention

Assessment Methods: Direct supervisor observation and discussion during supervision sessions; Review of fellow's self study; Work Samples Rating Form items 8, 15, 23, 27, 28 ; Case Presentation Rating Form items 5; Patient Perception Rating Form item 9; Clinical Supervision Rating Form items 6&7.

Essential Components:

- ___ A: Knowledge of Interventions
- ___ B: Intervention Planning
- ___ C: Skills
- ___ D: Intervention Implementation
- ___ E: Progress Evaluation

___ **Final Rating**

10. Consultation

Assessment Methods: Direct supervisor observation and discussion during supervision sessions; Review of fellow's self study; Work Samples Rating Form item 8; Case Presentation Rating Form item 13& 17; Consultation Services Survey items 3-5;

Essential Components:

- ___ A: Role of Consultant
- ___ B: Addressing Referral Question
- ___ C: Communication of Findings
- ___ D: Application of Methods

___ **Final Rating**

11. Research/Evaluation (Secondary Competency)

Assessment Methods: Direct supervisor observation and discussion during supervision sessions; Review of fellow's self study; Work Samples Rating Form item 13; Case Presentation Rating Form item 9 & 14.

Essential Components:

- ___ A: Scientific Approach to Knowledge Generation
- ___ B: Application of Scientific Method to Practice

___ **Final Rating**

12. Supervision (Secondary Competency)

Assessment Methods: Direct supervisor observation and discussion during supervision sessions; Review of fellow's self study; Clinical Supervision Rating Form items 1-10.

Essential Components:

- ___ A: Expectation and Roles
- ___ B: Process and Procedures
- ___ C: Skills Development
- ___ D: Awareness of factors affecting quality
- ___ E: Participation in Supervision Process
- ___ F: Ethical and Legal Issues

___ **Final Rating**

13. Teaching (Secondary Competency)

Assessment Methods: Direct supervisor observation and discussion during supervision sessions; Review of fellow's self study; Case Presentation Rating Form item 16.

Essential Components:

___ A: Knowledge

___ B: Skills

___ **Final Rating**

14. Management-Administration (Secondary Competency)

Assessment Methods: Direct supervisor observation and discussion during supervision sessions; Review of fellow's self study; Support Staff Survey items 3&4.

Essential Components:

___ A: Management

___ B: Administration

___ C: Leadership

___ D: Evaluation of Management and Leadership

___ **Final Rating**

15. Advocacy (Secondary Competency)

Assessment Methods: Direct supervisor observation and discussion during supervision sessions; Review of fellow's self study; Case Presentation Rating Form item 14.

Essential Components:

___ A: Empowerment

___ B: System Change

___ **Final Rating**

Summary of Ratings:

Foundational Competencies

- ___ Professionalism
- ___ Reflective Practice/Self-Assessment/Self-Care
- ___ Scientific Knowledge and Methods
- ___ Relationships
- ___ Individual and Cultural Diversity
- ___ Ethical Legal Standards and Policy
- ___ Interdisciplinary Systems

Functional Competencies

- ___ Assessment
- ___ Intervention
- ___ Consultation
- ___ Research/Evaluation*
- ___ Supervision*
- ___ Teaching*
- ___ Management-Administration*
- ___ Advocacy*

*Denotes secondary competencies

- ___ Average rating of all Primary Competencies
- ___ Average rating of all Secondary Competencies

Clinical Supervisor Summary Evaluations Per Training Rotation:

Posttraumatic Stress Disorder—Major Rotation:

- ___ Either not completed at time of rating or training has yet to be initiated
- ___ Completed with the rating assigned indicated below
 - ___ Unacceptable for demonstrating advanced practice
 - ___ Marginally Acceptable for demonstrating advanced practice
 - ___ Acceptable for demonstrating advanced practice

Depression—Major Rotation:

- ___ Either not completed at time of rating or training has yet to be initiated
- ___ Completed with the rating assigned indicated below
 - ___ Unacceptable for demonstrating advanced practice
 - ___ Marginally Acceptable for demonstrating advanced practice
 - ___ Acceptable for demonstrating advanced practice

Severe Psychiatric Disorders—Minor Rotation:

- ___ Either not completed at time of rating or training has yet to be initiated
- ___ Completed with the rating assigned indicated below
 - ___ Unacceptable for demonstrating advanced practice
 - ___ Marginally Acceptable for demonstrating advanced practice
 - ___ Acceptable for demonstrating advanced practice

Chronic Pain—Minor Rotation:

- ___ Either not completed at time of rating or training has yet to be initiated
- ___ Completed with the rating assigned indicated below
 - ___ Unacceptable for demonstrating advanced practice
 - ___ Marginally Acceptable for demonstrating advanced practice

___ Acceptable for demonstrating advanced practice

Mild Traumatic Brain Injury—Minor Rotation:

- ___ Either not completed at time of rating or training has yet to be initiated
- ___ Completed with the supervisor rating indicated below
 - ___ Unacceptable for demonstrating advanced practice
 - ___ Marginally Acceptable for demonstrating advanced practice
 - ___ Acceptable for demonstrating advanced practice

Family Issues—Minor Rotation:

- ___ Either not completed at time of rating or training has yet to be initiated
- ___ Completed with the supervisor rating indicated below
 - ___ Unacceptable for demonstrating advanced practice
 - ___ Marginally Acceptable for demonstrating advanced practice
 - ___ Acceptable for demonstrating advanced practice

Substance/Alcohol Abuse—Minor Rotation:

- ___ Either not completed at time of rating or training has yet to be initiated
- ___ Completed with the supervisor rating indicated below
 - ___ Unacceptable for demonstrating advanced practice
 - ___ Marginally Acceptable for demonstrating advanced practice
 - ___ Acceptable for demonstrating advanced practice

Summative Findings

For Mid-Year Assessment:

The above competency ratings and supervisor evaluations indicate that _____
is/is not making satisfactory progress in this training program.

For End-of-Year Assessment:

The above competency ratings and supervisor evaluations indicate that _____
has/has not successfully completed all training requirements of this training program.

Comments: _____

Date: _____

Fellow

Competency Committee Members

APPENDIX K

Weekly Supervision Form

Postdoc Weekly Supervision Summary Form

Training Objective: _____
 Dates of Scheduled Supervision: _____
 Duration of Scheduled Individual Supervision: _____
 Duration of Scheduled Group Supervision: _____
 Supervisor: _____ Fellow: _____

<i>Unscheduled Supervision</i>		
<i>Day of Week</i>	Face to Face Individual Hours	Face to Face Group Hours
Monday	_____	_____
Tuesday	_____	_____
Wednesday	_____	_____
Thursday	_____	_____
Friday	_____	_____

CONTENT SOURCE: (Check all that apply for the entire week, including unscheduled supervision activities)

- | | |
|----------------------------------------------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Fellow description of case | <input type="checkbox"/> Outcome data reviewed |
| <input type="checkbox"/> Supervisor's observation of assessment/ therapy session | <input type="checkbox"/> Audio Available |
| <input type="checkbox"/> Supervisor's observation of team/referral source consultation | <input type="checkbox"/> Audio Reviewed |
| <input type="checkbox"/> Observation of Supervisor by fellow | <input type="checkbox"/> Video Available |
| <input type="checkbox"/> Observation of Adjunct Supervisor by fellow | <input type="checkbox"/> Video Reviewed |
| <input type="checkbox"/> Discussion of scholarly material relevant to case | <input type="checkbox"/> Other: _____ |

MEDICAL RECORD DOCUMENTATION REVIEWED THIS WEEK:

Yes No

COMPETENCIES ADDRESSED DURING WEEK'S SCHEDULED AND UNSCHEDULED SUPERVISION (Percent of total Supervision time with no units smaller than 5%)

- | | |
|-------------------------------------------------------------------|--------------------------------------------|
| 1) _____ <i>Professionalism</i> | 9) _____ <i>Intervention</i> |
| 2) _____ <i>Reflective practice/Self-Assessment
Self-Care</i> | 10) _____ <i>Consultation</i> |
| 3) _____ <i>Scientific Knowledge and/Methods</i> | 11) _____ <i>Research/Evaluation</i> |
| 4) _____ <i>Relationships</i> | 12) _____ <i>Supervision</i> |
| 5) _____ <i>Individual and Cultural Diversity</i> | 13) _____ <i>Teaching</i> |
| 6) _____ <i>Ethical Legal Standards and Policy</i> | 14) _____ <i>Management-Administration</i> |
| 7) _____ <i>Interdisciplinary Systems</i> | 15) _____ <i>Advocacy</i> |
| 8) _____ <i>Assessment</i> | Total: _____ (100%) |

POSITIVE FEEDBACK PROVIDED TO FELLOW:

No Yes, as follows: _____

CORRECTIVE FEEDBACK PROVIDED TO FELLOW:

No Yes, as follows: _____

ISSUES PERTAINING TO THE SUPERVISORY RELATIONSHIP DISCUSSED:

No Yes, as follows: _____

Supervisor _____ Fellow: _____

APPENDIX L

Fellow's Evaluation of Rotation Supervisor Form

Fellow's Evaluation of Supervisor for the _____ Rotation

Fellow: _____

Supervisor: _____

Date: _____

NOTE: Please rate your supervisor on the following criteria.

1. Supervisor was available at scheduled time for weekly supervision
1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

2. The availability of my supervisor for unscheduled, non-emergency supervision was fully adequate
1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

3. In an emergency, my supervisor was, or I feel would have been, available
1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

4. My supervisor treated me with appropriate courtesy and respect
1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

5. An appreciation of personal and cultural difference (i.e., opinions and ideas) was demonstrated by my supervisor
1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

6. Supervisor's supervisory style positively supported my acquisition of professional competencies
1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

7. Adequate feedback and direction was given by my supervisor (where needed)
1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

8. Supervisor allowed me to demonstrate an appropriate level of independence
1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

9. Supervisor fulfilled all supervisor responsibilities as designated in the supervision contract
1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

10. I feel comfortable in the professional relationship that was established between me and my supervisor
1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

Now, please rate the supervisor's ability to provide training as per the 7 Foundational and 8 Functional Competencies used to inform all of our training objectives.

- Use the following rating scale:
- 1 = Poor
 - 2 = Marginal
 - 3 = Adequate
 - 4 = Good
 - 5 = Excellent

**Foundational
Competency Domains**

- ___ Professionalism
- ___ Reflective practice/Self-assessment
- ___ Scientific knowledge and Methods
- ___ Relationships
- ___ Individual and Cultural Diversity
- ___ Ethical Legal standards and Policy
- ___ Interdisciplinary systems

**Functional
Competency Domains**

- ___ Assessment
- ___ Intervention
- ___ Consultation
- ___ Research/Evaluation
- ___ Supervision
- ___ Teaching
- ___ Management—
Administration
- ___ Advocacy

Additional Comments:

Fellow

Supervisor

APPENDIX M

Fellow's Mid-year Evaluation of Program Form

Mid-year Program Evaluation

Fellow: _____

Date: _____

Please provide your views of various experiences you have had up to this point in the training year. Circle the appropriate number, 1-5, as provided below.

1. Spending one month on inpatient psychiatry at the beginning of the training year was very help.
1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree
2. The quality of the supervision I received on inpatient psychiatry was very good.
1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree
3. The Organizational Development Seminar has been very informative.
1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree
4. Participation in the Organizational Development Seminar has given me practical skills.
1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree
5. I see a clear value to the program's Clinical Leadership training objectives.
1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree
6. I believe the training staff does a good job of treating me with dignity and respect.
1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree
7. An appreciation of personal and cultural difference (i.e., opinions and ideas) is demonstrated by training staff.
1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree
8. I consistently know who is covering for my supervisors if they are absent from the work space.
1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree
9. Overall, I am satisfied with this postdoctoral training program.
1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

Please list the best didactics you have attended:

Please list the least helpful didactics you have attended:

Additional Comments:

As the final component of this mid-year evaluation, please rate the training program, as a whole, in terms of its adequacy in addressing each of the 15 competency domains that serve as the basis for structuring this program.

- Use the following rating scale:
- 1 = Poor
 - 2 = Marginal
 - 3 = Adequate
 - 4 = Good
 - 5 = Excellent

**Foundational
Competency Domains**

**Functional
Competency Domains**

- | | |
|-----------------------------------------|-----------------------------------|
| ___ Professionalism | ___ Assessment |
| ___ Reflective practice/Self-assessment | ___ Intervention |
| ___ Scientific knowledge and Methods | ___ Consultation |
| ___ Relationships | ___ Research/Evaluation |
| ___ Individual and Cultural Diversity | ___ Supervision |
| ___ Ethical Legal standards and Policy | ___ Teaching |
| ___ Interdisciplinary systems | ___ Management—
Administration |
| | ___ Advocacy |

Additional Comments:

Signature
Signature

Date

APPENDIX N

Fellow's End-of-Year Evaluation of Program Form

End of Year Training Program Evaluation

Fellow: _____

Date: _____

Please provide feedback regarding the quality of each component of our training program. Your input is essential to our process improvement efforts on behalf of this program. Specifically, if a program element was particularly good, please let us know. On the other hand, if a program element was poorly executed or did not substantially enhance the training mission, please communicate this to us as well. Use additional pages if needed.

The application process for this program: _____

Orientation procedures over the first week of the program: _____

Severe Psychiatric Disorders Rotation: _____

Substance/Alcohol Abuse Rotation: _____

PTSD Rotation: _____

Depression Rotation: _____

TBI Rotation: _____

Chronic Pain Rotation: _____

Family Issues Rotation: _____

Clinical Leadership
Training: _____

Operational experience on Aircraft Carrier: _____

Operational experience with Marines/SEALS: _____

Organizational Development Seminar: _____

Psychiatry Grand Rounds: _____

Prolonged Exposure Treatment Workshop: _____

Cognitive Processing Therapy Workshop: _____

Center for Deployment Psychology 8-day Training: _____

Didactic Presentations: _____

The contributions to diversity training provided by Drs. Malloy and Dobbins: _____

Dr. Barbara Cubic's contributions to CBT training: _____

What were the best aspects of this training program? _____

Where is improvement needed? _____

As the final component of this end of year evaluation, please rate the training program, as a whole, in terms of its adequacy in addressing each of the 15 competency domains that serve as the basis for structuring this program.

- Use the following rating scale:
- 1 = Poor
 - 2 = Marginal
 - 3 = Adequate
 - 4 = Good
 - 5 = Excellent

**Foundational
Competency Domains**

**Functional
Competency Domains**

- | | |
|-----------------------------------------|-----------------------------------|
| ___ Professionalism | ___ Assessment |
| ___ Reflective practice/Self-assessment | ___ Intervention |
| ___ Scientific knowledge and Methods | ___ Consultation |
| ___ Relationships | ___ Research/Evaluation |
| ___ Individual and Cultural Diversity | ___ Supervision |
| ___ Ethical Legal standards and Policy | ___ Teaching |
| ___ Interdisciplinary systems | ___ Management—
Administration |
| | ___ Advocacy |

Overall, you would rate this training program as (please circle your response):

- 1 = Poor 2 = Marginal 3 = Adequate 4 = Good 5 = Excellent

Additional Comments:

Signature

Date

Appendix O
Program Outcomes Assessment and Monitoring Questionnaire

Clinical Psychology Postdoctoral Fellowship
Psychology Department (128Y00A)
Naval Medical Center
620 John Paul Jones Circle
Portsmouth, VA 23708-2197

Program Outcomes Assessment and Monitoring Questionnaire

Name: _____

Date: _____

Year and month you completed training at NMCP: Year: _____ Month: _____

Are you currently employed on a full-time basis as a clinical psychologist?

Yes

No

If yes, what is your current job title and where do you work. _____

If no, please describe your current employment status. _____

Are you currently licensed as a clinical psychologist? Yes No

If yes, in what state(s) and when were you granted licensure (year/month)? _____

If no, why are you not licensed? _____

Are you currently listed in the National Register? Yes No

If yes, when? _____

If no, are you planning to be listed? Yes No

Are you a member of APA? Yes No

If yes, to which divisions do you belong? _____

If no, are you planning to become a member? Yes No

Do you belong to other professional organizations? Yes No

If yes, which ones? _____

If no, are you planning to become a member of a professional organization?
 Yes No

Have you achieved ABPP status? Yes No

If yes, in what area? _____

If no, are you currently in the process of seeking ABPP status? Yes No

Have you had a manuscript accepted for publication in a peer-reviewed journal over the past _____ year?
Yes No

If yes, how many manuscripts and in what journals? _____

If no, do you plan to submit a manuscript within the next year for publication?
 Yes No

Have you given a presentation at a regional, national or international professional conference over the past year? Yes No

If yes, how many paper presentations and what conferences? _____

If no, do you plan to present a paper at a professional meeting within the next year?
 Yes No

Have you engaged in clinical supervision of an unlicensed or junior colleague over the past year?
 Yes No

If yes, how many total hours of direct supervision have you provided over the past year?

If no, do you anticipate functioning as a clinical supervisor at some point over the coming year?

Yes No

Have you engaged in teaching activities (e.g., given lectures, presented at Grand Rounds, etc.) over the past year? Yes No

If yes, briefly describe your teaching activities. _____

If no, do you anticipate engaging in teaching activities over the coming year?

Yes No

Have you been responsible for administrative tasks linked to your role as a clinical psychologist over the past year? Yes No

If yes, briefly describe your administrative duties. _____

If no, do you anticipate having administrative duties over the coming year?

Yes No

How many hours have you spent over the past year attending continuing education (CE) programs/activities?

Please list the topics covered in the CE offerings you have attended.

Have you been presented any awards or received special recognition for your work as a psychologist over the past year?

Yes No

If yes, please describe: _____

Below you will find a list of the 15 training objectives established for your fellowship program. These objectives correspond to the 7 Foundational and 8 Functional competencies around which our training program is designed. Please rate your current self-assessed competencies in these training objectives relative to your competency levels at the end of fellowship training. Also rate the relevance of these competencies to your

current professional practice and to your appraisal of their likely relevance to your professional practice in the future. The scales for these ratings are presented below.

Current Competency competency level at end of training year	Relevance of training to current professional practice	Anticipated relevance relative to to future professional practice
1 = greatly diminished	1 = not at all relevant	1 = not at all relevant
2 = diminished	2 = minimally relevant	2 = minimally relevant
3 = unchanged	3 = relevant	3 = relevant
4 = improved	4 = very relevant	4 = very relevant
5 = greatly improved	5 = highly relevant	5 = highly relevant

Training Objective	Current Competency	Relevance to Current Practice	Anticipated Relevance to to Future Practice
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1. Professionalism — The fellow will: 1.) Habitually monitor and resolve situations that challenge professional values and integrity; 2.) Be viewed by colleagues as highly professional; 3.) Be recognized as a role model for independently and consistently demonstrating personal responsibility; 4.) Demonstrate forward thinking with regard to problems; keeping the ability to safeguard the welfare of others as the foremost priority; and 5.) Exhibit full consolidation of identity as a psychologist; be broadly knowledgeable about issues central to the field; and consistently integrate science and practice.	Please circle the appropriate rating	Please circle the appropriate rating	Please circle the appropriate rating
	1	1	1
	2	2	2
	3	3	3
	4	4	4
	5	5	5
2. Reflective Practice/Self-Assessment/Self-Care — The fellow will: 1.) Consistently exhibit reflectivity in context of professional practice (reflection-in-action); habitually act upon reflections and use self as a therapeutic tool; 2.) Exhibit unusually accurate self-assessment of competence in all competency domains; habitually integrates self-assessment in practice; and 3.) Reliably self-monitor issues related to self-care and execute prompt interventions when disruptions occur	1	1	1
	2	2	2
	3	3	3
	4	4	4
	5	5	5

<p>3. Scientific Knowledge and Methods— The fellow will: 1.) Independently and consistently apply scientific methods to practice; 2.) Articulate advanced knowledge of core science; and 3.) Know and understand scientific foundations, and consistently and independently apply this knowledge to practice in a flexible manner</p>	<p>1 2 3 4 5</p>	<p>1 2 3 4 5</p>	<p>1 2 3 4 5</p>
<p>4. Relationships— The fellow will: 1.) Develop and maintain highly effective relationships with a wide range of clients, colleagues, organizations and communities; 2.) Manage unusually difficult communication; possess clearly advanced interpersonal skills; and 3.) Exhibit unusually articulate and eloquent command of language and ideas.</p>	<p>1 2 3 4 5</p>	<p>1 2 3 4 5</p>	<p>1 2 3 4 5</p>
<p>5. Individual and Cultural Diversity— The fellow will: 1.) Independently and consistently monitor and apply knowledge of self as a cultural being in assessment, treatment, and consultation; 2.) Independently and consistently monitor and apply knowledge of others as cultural beings in assessment, treatment, and consultation. 3.) Independently and consistently monitor and apply knowledge of diversity in the others as cultural beings in assessment, treatment, and consultation; and 4.) Skillfully apply knowledge, skills, and attitudes regarding intersecting and complex dimensions of diversity; for example, the relationship between one's own dimensions of diversity and one's own attitudes towards diverse others to professional work</p>	<p>1 2 3 4 5</p>	<p>1 2 3 4 5</p>	<p>1 2 3 4 5</p>
<p>6. Ethical Legal Standards and Policy— The fellow will: 1.) Habitually utilize and apply the APA Ethical Principles and Code of Conduct and other relevant ethical, legal and professional standards and guidelines of the profession; 2.) Apply an ethical decision making model in integrating ethics</p>	<p>1 2 3 4</p>	<p>1 2 3 4</p>	<p>1 2 3 4</p>

knowledge into professional work; and 3.) Proactively model and teach the integration of ethical/legal standards policy with all foundational and functional competencies.	5	5	5
7. Interdisciplinary Systems — The fellow will: 1.) Exhibit in depth knowledge of multiple and differing worldviews, professional standards, and contexts and systems plus advanced level knowledge of common and distinctive roles of other professionals; 2.) Show comprehensive knowledge of and ability to display skills that support effective interdisciplinary team functioning, including communicating information in a clear and professional manner, assisting the team in resolving disagreements in diagnosis and treatment goals, and eliciting and using perspectives of other team members; 3.) Demonstrate advanced level ability to recognize and engage in opportunities for effective collaboration with other professionals toward shared goals; and 4.) Evidence ability to develop, support, and advance collaborative relationships across time with differing disciplines.	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
8. Assessment — The fellow will: 1.) Verbalize a technical rationale for selecting and implementing differing methods and means of evaluation in ways that are responsive to and respectful of diverse individuals, couples, families and groups and context; 2.) Advanced knowledge of administration and scoring of traditional assessment measures, models and techniques, including clinical interviewing and mental status exam; 3.) Independently and skillfully administer a variety of assessment tools and integrate results to accurately evaluate presenting question appropriate to the practice site and broad area of practice; 4.) Utilize case formulation and diagnosis for advanced intervention planning in the context of stages of human development	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

<p>and diversity; 5.) Exhibit advanced skills in using assessment data to form case conceptualizations and recommendations; and 6.) Demonstrate ability to communicate results in written and verbal form with a high degree of both clarity and accuracy, and in a conceptually appropriate manner.</p>			
<p>9. Intervention— The fellow will: 1.) Apply advanced knowledge of evidence-based practice, including empirical bases of intervention strategies, clinical expertise, and client preferences; 2.) Evidence usually strong understanding of the relationship between case conceptualization and intervention planning; 3.) Exhibit advanced helping skills; 4.) Implement interventions with both strong fidelity to empirical models and a high degree of flexibility to adapt where appropriate; 5.) Incorporate strong understanding of outcome measurement and tailor outcome measures to the needs of the case; Provide conceptually appropriate treatment goals even in the absence of an established outcome measure; Evaluate treatment progress and modify planning as indicated, even in the absence of empirically validated outcome measures.</p>	<p>1 2 3 4 5</p>	<p>1 2 3 4 5</p>	<p>1 2 3 4 5</p>
<p>10. Consultation— The fellow will: 1.) Skillfully determine situations that require different role functions and adeptly shift roles accordingly; 2.) Exhibit advanced knowledge and consistent ability to select appropriate and contextually sensitive means of assessment/data gathering that answers the consultation referral question; 3.) Skillfully, promptly, and effectively provide assessment feedback that demonstrates advanced knowledge and leads to highly appropriate recommendations; and 4.) Apply literature to provide effective consultative services (assessment and intervention) in all routine and most complex cases.</p>	<p>1 2 3 4 5</p>	<p>1 2 3 4 5</p>	<p>1 2 3 4 5</p>

<p>11. Research/Evaluation (Secondary Competency)— The fellow will: 1.) Exhibit an understanding of the generation of knowledge; and 2.) Exhibit ability to evaluate outcomes.</p>	<p>1 2 3 4 5</p>	<p>1 2 3 4 5</p>	<p>1 2 3 4 5</p>
<p>12. Supervision (Secondary Competency)— The fellow will: 1.) Understand complexity of the supervisory role including ethical, legal and contextual issues; 2.) Express knowledge of procedures and practices of supervision; 3.) Engage in professional reflection about one’s clinical relationships with supervisees, as well as supervisees' relationships with their clients; 4.) Understand other individuals and groups and intersection dimensions of diversity in the context of supervision practice; able to engage in reflection on the role of one’s self on therapy and in supervision; 5.) Provide supervision independently to others in routine cases; and 6.) Exhibits knowledge of outcome assessment of teaching effectiveness relevant to ethical, legal, and professional standards and guidelines pertaining to supervision.</p>	<p>1 2 3 4 5</p>	<p>1 2 3 4 5</p>	<p>1 2 3 4 5</p>
<p>13. Teaching (Secondary Competency)— The fellow will: 1.) Demonstrate knowledge of outcome assessment of teaching effectiveness; and 2.) Evaluate effectiveness of learning/teaching strategies addressing key skill sets.</p>	<p>1 2 3 4 5</p>	<p>1 2 3 4 5</p>	<p>1 2 3 4 5</p>
<p>14. Management-Administration (Secondary Competency)— The fellow will: 1.) Manage direct delivery of professional services; exhibit awareness of basic principles of resource allocation and oversight; 2.) Demonstrate</p>	<p>1 2 3</p>	<p>1 2 3</p>	<p>1 2 3</p>

awareness of principles of policy and procedures manual for organizations, programs, or agencies; exhibit awareness of basic business, financial and fiscal management issues; 3.) Develop mission, goal-setting, implementing systems to accomplish goals and objectives; Demonstrate team-building and motivational skills; and 4.) Develops own plans for how best to manage and lead an organization	4	4	4
	5	5	5
15. Advocacy (Secondary Competency)— The fellow will: 1.) Intervene with client to promote action on factors impacting development and functioning; 2.) Promote change at the level of institutions, community, or society	1	1	1
	2	2	2
	3	3	3
	4	4	4
	5	5	5

Please indicate the value of each rotation experience to which you were exposed over the course of the training year. Use the 5-point scale, provided below, to rate the rotations in terms of their relevance to your current and anticipated future professional practice.

- 1 = not at all relevant
- 2 = minimally relevant
- 3 = relevant
- 4 = very relevant
- 5 = highly relevant

Rotation	Relevance to Current Practice	Anticipated Relevance to Future Practice
-----------------	-------------------------------	------------------------------------------

	Please circle or underline the appropriate rating	Please circle or underline the appropriate rating
PTSD (Major Rotation)	1 2 3 4 5	1 2 3 4 5
Depression (Major Rotation)	1 2 3 4 5	1 2 3 4 5
Mild TBI (Minor Rotation)	1 2 3 4 5	1 2 3 4 5

Chronic Pain (Minor Rotation)	1 2 3 4 5	1 2 3 4 5
Family Issues (Minor Rotation)	1 2 3 4 5	1 2 3 4 5
Severe Psychiatric Disorders/Inpatient Psychiatry (Minor Rotation)	1 2 3 4 5	1 2 3 4 5
Substance/Alcohol Abuse (Minor Rotation)	1 2 3 4 5	1 2 3 4 5
Clinical Leadership (Non-clinical Training Experience)	1 2 3 4 5	1 2 3 4 5

An over-arching goal of our training program was to inculcate a desire to engage in professional activities that foster lifelong learning and ongoing development of professional competencies. Please indicate the extent to which you have engaged in activities over the past year that demonstrates your life-long learning initiatives according to the foundational and functional competencies around which we structured your training year. Please check the statement that most accurately reflects your activities over the past year.

Foundational Competencies

- Professionalism:** I have not engaged in new activities in this competency domain this year
 My engagement in new activities in this competency domain this year has been limited
 I have engaged in several new activities in this competency domain this year
 I have engaged in multiple new activities in this competency domain this year
 I have been quite active this year engaging in activities linked to this competency domain.

Please list several activities in which you have engaged this year that reflect a commitment to lifelong learning in this competency domain.

**Reflective Practice/
Self-Assessment/**

Self-Care

- I have not engaged in new activities in this competency domain this year
- My engagement in new activities in this competency domain this year has been limited
- I have engaged in several new activities in this competency domain this year
- I have engaged in multiple new activities in this competency domain this year
- I have been quite active this year engaging in activities linked to this competency domain.

Please list several activities in which you have engaged this year that reflect a commitment to lifelong learning in this competency domain.

Scientific Knowledge and Methods

- I have not engaged in new activities in this competency domain this year
- My engagement in new activities in this competency domain this year has been limited
- I have engaged in several new activities in this competency domain this year
- I have engaged in multiple new activities in this competency domain this year
- I have been quite active this year engaging in activities linked to this competency domain.

Please list several activities in which you have engaged this year that reflect a commitment to lifelong learning in this competency domain.

Relationships

- I have not engaged in new activities in this competency domain this year
- My engagement in new activities in this competency domain this year has been limited
- I have engaged in several new activities in this competency domain this year
- I have engaged in multiple new activities in this competency domain this year
- I have been quite active this year engaging in activities linked to this competency domain.

Please list several activities in which you have engaged this year that reflect a commitment to lifelong learning in this competency domain.

Individual and Cultural Diversity

- I have not engaged in new activities in this competency domain this year
- My engagement in new activities in this competency domain this year has been limited
- I have engaged in several new activities in this competency domain this year
- I have engaged in multiple new activities in this competency domain this year
- I have been quite active this year engaging in activities linked to this competency domain.

Please list several activities in which you have engaged this year that reflect a commitment to lifelong learning in this competency domain.

Ethical Legal Standards and Policy

- I have not engaged in new activities in this competency domain this year
- My engagement in new activities in this competency domain this year has been limited
- I have engaged in several new activities in this competency domain this year
- I have engaged in multiple new activities in this competency domain this year
- I have been quite active this year engaging in activities linked to this competency domain.

Please list several activities in which you have engaged this year that reflect a commitment to lifelong learning in this competency domain.

Interdisciplinary Systems

- I have not engaged in new activities in this competency domain this year
- My engagement in new activities in this competency domain this year has been limited
- I have engaged in several new activities in this competency domain this year
- I have engaged in multiple new activities in this competency domain this year

I have been quite active this year engaging in activities linked to this competency domain.

Please list several activities in which you have engaged this year that reflect a commitment to lifelong learning in this competency domain.

Functional Competencies

- Assessment**
- I have not engaged in new activities in this competency domain this year
- My engagement in new activities in this competency domain this year has been limited
- I have engaged in several new activities in this competency domain this year
- I have engaged in multiple new activities in this competency domain this year
- I have been quite active this year engaging in activities linked to this competency domain.

Please list several activities in which you have engaged this year that reflect a commitment to lifelong learning in this competency domain.

- Intervention**
- I have not engaged in new activities in this competency domain this year
- My engagement in new activities in this competency domain this year has been limited
- I have engaged in several new activities in this competency domain this year
- I have engaged in multiple new activities in this competency domain this year
- I have been quite active this year engaging in activities linked to this competency domain.

Please list several activities in which you have engaged this year that reflect a commitment to lifelong learning in this competency domain.

- Consultation**
- I have not engaged in new activities in this competency domain this year
- My engagement in new activities in this competency domain this year has been limited

- I have engaged in several new activities in this competency domain this year
- I have engaged in multiple new activities in this competency domain this year
- I have been quite active this year engaging in activities linked to this competency domain.

Please list several activities in which you have engaged this year that reflect a commitment to lifelong learning in this competency domain.

**Research/
Evaluation**

- I have not engaged in new activities in this competency domain this year
- My engagement in new activities in this competency domain this year has been limited
- I have engaged in several new activities in this competency domain this year
- I have engaged in multiple new activities in this competency domain this year
- I have been quite active this year engaging in activities linked to this competency domain.

Please list several activities in which you have engaged this year that reflect a commitment to lifelong learning in this competency domain.

Supervision

- I have not engaged in new activities in this competency domain this year
- My engagement in new activities in this competency domain this year has been limited
- I have engaged in several new activities in this competency domain this year
- I have engaged in multiple new activities in this competency domain this year
- I have been quite active this year engaging in activities linked to this competency domain.

Please list several activities in which you have engaged this year that reflect a commitment to lifelong learning in this competency domain.

Teaching

- I have not engaged in new activities in this competency domain this year
- My engagement in new activities in this competency domain this year has been limited
- I have engaged in several new activities in this competency domain this year
- I have engaged in multiple new activities in this competency domain this year
- I have been quite active this year engaging in activities linked to this competency domain.

Please list several activities in which you have engaged this year that reflect a commitment to lifelong learning in this competency domain.

Management-Administration

- I have not engaged in new activities in this competency domain this year
- My engagement in new activities in this competency domain this year has been limited
- I have engaged in several new activities in this competency domain this year
- I have engaged in multiple new activities in this competency domain this year
- I have been quite active this year engaging in activities linked to this competency domain.

Please list several activities in which you have engaged this year that reflect a commitment to lifelong learning in this competency domain.

Advocacy

- I have not engaged in new activities in this competency domain this year
- My engagement in new activities in this competency domain this year has been limited
- I have engaged in several new activities in this competency domain this year
- I have engaged in multiple new activities in this competency domain this year
- I have been quite active this year engaging in activities linked to this competency domain.

Please list several activities in which you have engaged this year that reflect a commitment to lifelong learning in this competency domain.

Overall, how satisfied are you with the training you received at Naval Medical Center Portsmouth in regard to its value in preparing you for continued professional growth and development over the course of your career?

- Extremely Satisfied
- Very Satisfied
- Satisfied
- Neither Satisfied nor Dissatisfied
- Dissatisfied
- Very Dissatisfied
- Extremely Dissatisfied

Overall, how satisfied are you with the training you received at Naval Medical Center Portsmouth in regard to its value in preparing you to meet emerging issues and changes in the practice of professional psychology?

- Extremely Satisfied
- Very Satisfied
- Satisfied
- Neither Satisfied nor Dissatisfied
- Dissatisfied
- Very Dissatisfied
- Extremely Dissatisfied

Thank you for completing this questionnaire