

Predoctoral Psychology
Residency Program

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Veterans Health Administration
Medical Center
Dayton, Ohio

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OVERVIEW

The Veterans Health Administration (VHA) is part of the Department of Veterans Affairs which is a cabinet level organization. The VHA Medical Center, Dayton, Ohio offers a full time, one year, funded predoctoral residency to doctoral students enrolled in clinical or counseling psychology programs that are accredited by the American Psychological Association (APA). Our psychology residency program is accredited by the APA. The next regularly scheduled site visit will be during 2006.

The origin of the Dayton VHA Medical Center dates back to March 3, 1865, when President Abraham Lincoln signed into law an act of congress establishing the National Home for Disabled Volunteer Soldiers to care for disabled veterans of the Union Army. Dayton, Ohio was one of three original sites selected. Originally, the grounds consisted of 355 acres west of the city of Dayton. Lakes, surrounded by scenic trails, provided a relaxing atmosphere for relaxation and rehabilitation. A large farm provided much of the produce used by the residents. By the turn of the 19th to the 20th century, Dayton was the largest facility in the National Soldier's Home System. During 1930, when the Veterans Administration was formed, the National Soldier's Home System was discontinued and incorporated into the new organization. During 1989, the Veterans Administration was made a cabinet level organization and the title was changed to the Department of Veterans Affairs.

The medical center is located at the west edge of Dayton, Ohio. Much of the pastoral setting was preserved while establishing a modern, state of the art comprehensive medical facility. The current complex consists of approximately 60 buildings on about 240 acres. The medical center provides a broad spectrum of programs in primary, secondary, and most levels of tertiary care. The medical center serves 29 counties in central and western Ohio along with one county in Indiana with a total patient population of about 380,000. There are approximately 6500 inpatient stays and 200,000 outpatient visits each year. The medical center is a teaching facility that has numerous affiliation agreements with colleges, medical centers, medical schools, universities, and training programs throughout the area along with sharing agreements with other medical centers in the area and the Department of Defense. The medical center has excellent research facilities along with administrative and clinical support of such activities. The Dayton Department of Veterans Affairs Medical Center is a well established multicultural setting that employs about 1600 full-time employees who reflect considerable diversity.

RESIDENCY TRAINING PROGRAM

Philosophy

We believe the residency year is crucial in the transition of the individual from student to professional. We encourage the development of professional knowledge, skills, and beliefs/attitudes that form the basis for a solid professional identity along with the

competent practice of psychology. We encourage individual professional responsibility while recognizing the importance of communicating and sharing responsibility with other professionals. Residents are encouraged to be innovative and creative with their professional development while using well established principles, techniques, and procedures as a basis for professional activities. In the perennial balance of medical center and training needs, we recognize that a high quality training program must be designed for the needs of the residents.

Title

We use the title of Psychology Resident in order to be consistent with the titles used in this medical center. Also, two other accredited programs in the immediate area use the same title. The title is equivalent to the more frequently used title of Psychology Intern.

Model

The Psychology Residency Program is based on the Vail (Practitioner-Scholar) Model. Within the context of the practice of psychology, the mutually interdependent roles of science and practice are recognized and applied within a public service setting. The Practitioner-Scholar Model is consistent with the tripartite mission of the VHA: patient care, education/training, and research.

Mission

We take pride in our profession and in the training of residents to become psychologists. We recognize the special responsibilities associated with the training of residents. The mission of the Psychology Residency Program is to establish and maintain an environment that maximizes the potential for professional development for each psychology resident.

Approach to Training

There are various forms of supervision. Within the residency program, we define supervision by using the term "Supervision for the Purpose of Training."

- Inherent in supervision for the purpose of training is a complex social relationship that is operated on a number of levels simultaneously. We recognize, and are sensitive to, the multiple levels.
- Supervision for the purpose of training has four components.
 - Formal knowledge
 - Skills/experience
 - Attitudes/beliefs
 - Insure safety of patients
- Supervision for the purpose of training has a developmental quality.

We utilize a programmatic approach to training. Within a programmatic approach, each resident enters an ongoing patient care system and performs the duties of a psychologist. Within the context of programmatic approach, the apprenticeship approach is utilized to varying degrees. Variation is due to the specific needs of each resident and the tasks being learned.

We have adopted situational leadership theory as our conceptual basis. The role of a training supervisor evolves as a resident develops competence in a given task: direct, coach, consult, independence. The theory is elegant in its simplicity and incorporates well the developmental nature of a psychology residency.

Within the various guidelines, rules, regulations, laws, standards of care, and models that govern our professional behavior, training is individualized in order to meet the professional needs of each resident. There is a proactive dialogue among all relevant parties that begins before, and continues throughout, the residency year.

Our general approach is to behave in a manner consistent with American Psychological Association guidelines and Department of Veterans Affairs Policies regarding the disclosure of personal information and to routinely maintain good boundaries in that regard. Legitimate training supervision activities include, but are not limited to, the exploration of professional and personal values, the exploration of personal experiences along with their impact on the practice of psychology, the development of understandings regarding emotional reactions to events that occur during the course of professional activities, and the exploration of consistencies/inconsistencies between one's personal behavior patterns and behavior patterns that are consistent/inconsistent with good health and quality of life.

The general design of the Psychology Residency Program is quality assurance. We are in the process of developing a rather specific, competence based approach. The competencies notion is applied to all aspects of the training program. Within the context of a quality assurance structure, both positive and negative feedback have equal value. Each serves to inform how well an element or process is functioning.

The Psychology Training Committee is the governing body for the Psychology Residency Program. The CoDirectors of Training are responsible for its daily operation. Regular meetings are held and the minutes are distributed to all staff and residents. Residents are members of the training committee. A training supervisor who is actively supervising is required to attend all meetings. A training supervisor who is not actively supervising a resident is not necessarily required to be at all meetings, but attendance is recommended. Although the members of the training committee work toward consensus when making decisions, a simple majority vote is all that is required.

Goals

We designed the residency program to provide a broad predoctoral training experience that forms a sound basis for a professional career. The focus is on the acquisition

and/or development of formal knowledge, professional skills, and attitudes/beliefs that make for a solid professional identity. The expectation is that, by the end of the training year, a resident will be able to function competently (i.e., entry level or better) in five core areas: Ethical/Professional Issues, Assessment, Intervention, Diversity/Multicultural, and Science and Practice. We emphasize general skills. However, within the context of sound professional growth, we support actively the development of specialist skills.

Objectives/Competencies

Our overall goal is for each resident to be fully prepared for entry level practice. Entry level practice is defined as being fully prepared to begin the required period of supervision prior to licensure. It is the equivalent to a GS-11 psychologist in the Department of Veterans Affairs.

The core areas of Ethical/Professional Issues and Diversity/Multicultural are the same for all rotations. Each rotation has some unique competencies in the core areas of Assessment, Intervention, and Science and Practice. The competencies are documented in the form of competency grids. Currently, two rotations have completed the grids and the others are in process. What follows are generic statements that provide a reasonable guideline for the purpose of communication through a brochure.

Ethical/Professional Issues

Ethical/Professional Issues is a collective term that includes the many behaviors inherent in the many roles of a professional psychologist. Many do not fit easily into well defined categories.

- Observance of the American Psychological Association (APA) Ethical Principles of Psychologists and Code of Conduct, and Department of Veterans Affairs rules, regulations, and laws as well as other documents that govern our professional behavior.
- Ability to engage effectively in the various processes involved in a residency.
- Dependable professional demeanor consistent with the practice of psychology.
- The ability to monitor one's professional behavior along with the provision of unimpaired psychological services.
- Ability to understand the nature of his or her behavior within the context of each rotation.
- Knowledge of one's personal and professional strengths and limitations along with the recognition of the need to seek assistance or refer.
- Ability to recognize and deal with personal and professional issues in a constructive manner: e.g., use of supervision.
- Awareness of the nature of the impact of one's professional behavior.
- Appreciation for the power inherent in one's position relative to others.
- Management of time.

Assessment

Assessments are a unique role for psychologists. We perform a variety of assessments and each resident is required to demonstrate competence with the types of assessments involved in a given rotation. The expectation is that by the end of the residency year, each resident will have completed a wide variety and large number of assessments. At the beginning of the residency year, it is important to plan experiences so that there is variety in the nature and content of the assessments.

- All assessments involve a referral question (i.e., purpose). Each resident is required to demonstrate proficiency in understanding and explaining the nature of each referral question. If the nature of the referral question is not clear, the resident must clarify it with the referral source.
- Procedures
 - Selection of Procedures: For any given referral question, a variety of assessment procedures are possible. It is important to select the types and numbers of procedures that provide meaningful information. Each resident is required to become familiar with the concept of incremental validity and be able to apply it to actual situations.
 - Record Review: In most cases, medical records will be available. Each resident is required to be familiar with medical records along with usual and customary medical terminology.
 - Interview: Each resident is required to demonstrate competence in interviewing techniques: Mental status, open ended questions, content related to the referral question, etc.
 - Test Administration and Scoring: Actual test procedures utilized will depend upon the nature of the referral question and the rotation. Each resident is required to demonstrate proficiency in administration and scoring of tests.
- Interpretation of the Data
 - Each resident is required to demonstrate competence in interpreting data in a reasonable manner relative to the referral question.
- Written Report
 - All assessments require written documentation designed to meet the needs of the person - sometimes multiple persons. Each resident is required to demonstrate proficiency in writing clear, cogent reports that involve the integration of data in a coherent manner.
- Feedback
 - The provision of feedback in a manner that a patient can understand is a necessary professional skill. Also, in many cases, feedback to the referral sources is indicated as well. Each resident is required to demonstrate proficiency.

Intervention

Intervention occurs within the context of a special socially sanctioned relationship designed to maximize change in one party. Interventions are literature based and utilize

well established psychological knowledge and principles. Psychologists perform a variety of interventions. Each resident is required to demonstrate competence with the types of interventions required for a given rotation. At the beginning of the residency year, it is important to plan well to insure some variety in the types of therapy and patients treated.

- **Conceptualization/Theoretical Orientation:** A wide variety of conceptualizations and/or theoretical orientations are considered acceptable in the practice of psychology. Each resident is required to articulate a theory and/or conceptualization for each intervention.
- **Modality:** A fairly wide variety of treatment modalities are recognized in the practice of psychology. Each resident is required to demonstrate competence in the selection of a treatment modality that is appropriate to a given case. Emphasis is placed on intervention strategies that have a degree of verified effectiveness.
- **Treatment Planning:** The development of specific, attainable goals is important in interventions. Each resident is expected to be able to identify functional, measurable goals for each intervention.
- **Process:** Interventions are complex interpersonal processes. Each resident is expected to demonstrate competence with those processes relative to each rotation. Some examples are:
 - Personal and professional knowledge of self along with an awareness of one's impact on the therapeutic process.
 - The establishment and maintenance of feedback mechanisms utilized during the therapeutic process.
 - Identifying and processing one's own emotions as part of the therapeutic process.
 - Awareness of cause and effect relationships between one's behavior and change in a patient.
 - Ability to predict the consequences of one's specific intervention, comment, or behavior.
 - Timing of a specific intervention, comment, or behavior.
 - Awareness of boundaries with a given patient.
 - The presentation of clear and consistent messages to a given patient along with the avoidance of mixed or inconsistent messages.
 - Recognition when therapy has been completed or has become counterproductive.
 - Awareness of and ability to articulate when and how a relationship is therapeutic or not therapeutic in nature.
- **Termination.** There are various, acceptable reasons for termination of a case. Each resident is required to demonstrate the ability to terminate cases appropriately.

Diversity/Multicultural

Each resident is required to demonstrate competence in providing psychological services to individuals from diverse backgrounds: different ethnic histories, gender issues, sexual orientation issues, disabilities, unique experiences of veterans, etc.

Science and Practice

We are a rather fast paced patient care oriented setting. Consequently, our residency program has a practice focus. However, research influences practice and practice influences science. The use of relevant literature is an integral part of each rotation. As part of a given rotation, each resident is required to demonstrate an ability to use a quality literature base and apply it to professional practice through one or more of the following.

- Completion of a literature search on a specific subject and applying the knowledge during the rotation.
- Reading current literature on a subject related to the rotation and applying the knowledge.
- Participation in ongoing research.

Completion

Completion of the residency program is conditional upon a resident meeting the stated objectives along with professional behavior that meets or exceeds competencies. No partial credit is granted regarding the residency. Successful completion of the residency is an all-or-none decision.

Evaluation

Evaluations are an integral component of the residency training process and occur throughout the residency year. At the beginning of each rotation there is a general assessment of a resident's professional skills. There is a more formal assessment of competencies about half way through a rotation and at the end of each rotation. At the end of each rotation, the resident completes a competency form on the supervisor. Also, at the end of the residency year each resident completes formal evaluations of the program.

ROTATION FORMAT AND ASSIGNMENT

The basic rotation structure is three four month rotations with each resident spending one day per week in the Mental Health Clinic for the entire residency year. Any group of three rotations plus the one day per week in the Mental Health Clinic is consistent with our objectives/competencies. The one day per week in the Mental Health Clinic does not preclude a four month rotation in Mental Health. In other words, one may do both. However, based upon feedback from prior residents, we have learned that the one day per week in the Mental Health Clinic is sufficient for training purposes. Residents who

desire a full rotation in Mental Health are assigned to the Inpatient Mental Health/Emergency Room.

Consistent with the updated guidelines and principles of accreditation, there will be contact between the training committee and a resident's graduate program prior to the onset of the residency year. Also, there will be interactions between the residency program and the residents. The goal is to have rotation structure in place prior to the beginning of the residency year.

We recognize that after arrival and familiarization with the setting, a resident may wish to change a rotation and/or the sequence of rotations. Also, professional development plans can, and do, change. Our preference is for such changes to take place early during the residency year (the first couple months) in order to maximize predictability for all parties concerned.

Based upon feedback from prior residents, the Psychology Training Committee decided to adopt a 6-2-4 structure for individuals who have a well organized professional development plan that includes emphasis or specialization. The decision is made on a case by case basis and we anticipate meeting such requests.

ROTATIONS AND CONCEPTUALIZATION STATEMENTS OF TRAINING SUPERVISORS

Training supervisors are psychologist whose responsibilities include the provision of supervision for the purpose of training. The statements are similar to the conceptualization statements written by applicants with an orientation toward the setting in which the supervisor engages in the practice and training of professional psychology.

Geropsychology

Description

The geropsychology rotation incorporates a variety of clinical work with an inpatient elderly population. Geropsychological services are provided to multiple units on the medical center campus: the Hospice/Palliative Care Unit, the Nursing Home Care Units, and the secured Geriatric/Dementia Unit. The rotation offers the resident a wide variety of assessment, intervention, and consultative experiences involving the care and treatment of geriatric patients within the context of an interdisciplinary team approach. Specific resident activities will be determined by resident-supervisor goals, the resident's interests, and prior level of training as well as rotation competency requirements. Previous geropsychology and neuropsychology experience are not prerequisites for the rotation. Examples of professional psychology activities include: individual, family, and group therapy; psychological/emotional and cognitive assessments; behavior management assessment, planning, and implementation; and attendance at family meetings with the treatment team. In addition to providing such

clinical services, a resident will respond to consultation requests and provide pertinent oral and written feedback to staff as well each patients and families. The rotation provides a unique opportunity for the resident to acquire an appreciation of issues impacting on an aging population such as dementia, delirium, cognitive assessments, death and dying, psychology and spirituality, adjustment to physical and mental decline, and psychiatric conditions in the elderly. The acquisition of this knowledge can come from multiple sources including weekly didactics with the rotation supervisor, VHA medical center sponsored seminars, readings, interactions with experienced interdisciplinary team members, and clinical work. In addition to the clinical duties, each resident is required to complete a rotation “project” (read three books on death and dying provided by the supervisor, keep a journal reflecting on hospice experience, and turn in a brief paper at the end of the rotation), complete assigned readings, and attend regularly scheduled supervision meetings. Supervisor: Dr. Nicole Best.

Conceptualization Statement

Nicole A. Best, Psy.D.

Although true with clients of any age, culture, gender, or health status, it is especially important when working with geriatric and medically ill individuals that a biopsychosocial model be the foundation of any theoretical conceptualization. We are all spiritual, physical, mental, and social beings who are constantly and simultaneously functioning at each of these levels. When only a few years ago it was on the “cutting edge” to talk about the mind-body connection, today researchers are accepting the notion of a “Bodymind” – one entity, with thoughts and feelings causing physical changes; and cellular activity, hormonal secretions, and peptides transmitting messages back to the brain in a never-ending cycle.

The field of Psychoneuroimmunology has led the way in revealing the significant impact that relaxation, exercise, laughter, prayer, positive thinking, and emotional expression can have on physical health. Just as medications have been shown to alter brain chemistry, so too have lifestyle factors such as activity level, thought patterns, behaviors, and diet. Not only are neurotransmitters being studied, but so too are the consequences that prolonged stress and mood disturbances may have on actual brain structures. We are truly embarking upon discoveries that will lead us to unexplored areas of intervention.

Over and above a biopsychosocial basis, an appreciation for the roles of grief and spirituality become essential when working with a geriatric population. Whether terminally ill, residing in a nursing home, or continuing to function in the community, aging brings multiple losses and raises core existential questions. It is a time when many individuals have a need to review the story of their life, and to find meaning in past trials and triumphs, as well as in current illnesses and suffering. It is for some, the first and last time they will contemplate their place in the universe, a relationship with a Higher Power, their life’s mission, and whether they believe they have reached a satisfactory conclusion.

Working with individuals at this stage of their life's journey necessitates a solid common factors approach, grief work, and an ability to be flexible (eclectic) in interventions (e.g. existential, cognitive behavioral) based on the client's presenting issues, personality, belief system, cultural background, cognitive abilities, and readiness for change.

Although continually evolving, much of my inspiration at this point in my own professional development comes from: the works of countless psychologists and physicians who are dedicated to the exploration of the mind-body connection, spirituality, and healing (e.g. Bernie Siegel, Harold Koenig, Joan Borysenko, J.K. Kiecolt-Glaser and R. Glaser); neuropsychology; the Death and Dying and Near-Death Experience literature (e.g. Elizabeth Kubler-Ross, Therese Rando, J. W. Worden); and the Hospice philosophy, as well as my own faith and lessons learned from the best teachers of all – dying patients whom I have had the privilege to know.

Health Psychology

Description

The rotation in health psychology emphasizes the provision of psychological services in the four medical primary care firms at the medical center. Such services include: assessment of patients referred for a variety of issues – most commonly depression, anxiety, substance abuse, nonadherence to indicated treatment regimens, adjustment to medical conditions/disabilities, psychological factors impacting presentation of medical symptoms, and stress management. Interventions offered to primary care patients typically include brief, time limited treatments as well as psychoeducational activities such as health education groups. Each resident will become involved with a primary care team that consists of physicians, nurses, a psychologist, a dietician, a social worker, a pharmacist, and administrative associates.

Psychologists assigned to health psychology provide a range of other services. Such services include programs for chronic pain management, weight management, smoking cessation, and problems in sexual health. Consultation services are provided to specialty clinics and inpatient wards: cardiology, infectious disease, neurology, oncology, surgery, and rehabilitation. Also, health psychology is responsible for conducting evaluations of patients who are candidates for an organ transplant.

While many of the training activities and professional responsibilities are established as part of the routine program, the rotation is designed with an orientation toward flexibility to meet a resident's specific professional interests and needs. One of the explicit competencies in all rotations is the provision of consistent messages to patients. A resident can anticipate an exploration of his/her personal behavior patterns (e.g., use of nicotine products) relative to behavior patterns that maximize good health and quality of life. Supervisors: Dr. Frederick Peterson, and Dr. Ramon Verdaguer.

Conceptualization Statement

Frederick Peterson, Psy.D.

My conceptualization statement addresses two overlapping areas of my clinical activity within the field of health psychology, sex therapy and tobacco use treatment. When assisting people in need, I find it impossible to exclude the numerous influences on the formation of my professional perspective on human nature and the practice of psychology. Certainly the teachings of James, Maslow, Rogers, Adler, Albee, Ellis, and Perls come to mind.

The three most influential people in my professional life happen to be my former supervisors. I've been fortunate to have studied with three people I consider leaders of their field, if not pioneers. They are Dr. Ron Fox, past president of APA; Dr. William Masters, pioneer sex researcher and co-founder of the Masters and Johnson Institute, and Dr. Judy Seifer, past president of the American Association of Sex Educators, Counselors and Therapists (ASSECT).

As founding dean of the School of Professional Psychology at Wright State University, Dr. Fox taught me the importance of getting psychology "out of the box" of just having people coming to me in my office and doing traditional talk therapies. I see my calling in psychology, especially health psychology, as integrating psychologically sound principles and practices into all slices of normative life, such as child birthing, the transition into parenthood and becoming a family. Psychology should not be restricted and conceptually segregated from everyday life, just "on call" for those experiencing crisis in their life. When I am doing talk therapies, I find myself being as much of a health educator as I am a psychologist. Also, I tend to use what works in therapy with a particular client (eclectic pragmatism), whether that involves movement, trying to solve a riddle or singing.

My theoretical emphasis on the teachings of George Albee and Ron Fox lead me to be active in teaching and prevention work. Much of that is done outside the Department of Veteran Affairs, particularly at Wright State University, University of Dayton and other hospitals. At the VA, my interest in prevention led me to start the smoking cessation education classes seventeen years ago. Today, smoking is widely accepted as the number one preventable cause of death in the country and smoking cessation is considered the "gold standard" of cost/benefit ratios within all of medicine and healthcare. Ironically, applied psychology as a whole has little involvement with smoking cessation relative to other healthcare professions.

For two years, I chaired a group a statewide group of smoking cessation specialists which developed a "best practice model" within the Department of Veteran Affairs. The interventions within the best practice model are based upon a strong theoretical foundation of three interlocking models. The first is the Nicotine Addiction Model, developed by many but championed by Alan Leshner (the former Director of National Institutes of Health), which basically perceives nicotine dependence as a brain disease

within a social context. Secondly, Prochaska and DiClemente's Transtheoretical Model of Change is emphasized and applied to smoking cessation, as it has been applied to about every other form of human behavior. Finally, a Three-Factor Model developed by Gary DeNelsky at the Cleveland Clinic was incorporated into the best practice model. This Three-Factor Model addresses nicotine addiction, behavioral associations or "linkages" to smoking and a special set of "psychological meanings" tobacco use has for the smoker.

My work with Drs. Seifer and Masters occurred during my increasing observations about how sexual concerns so often occurred in therapy yet there where so few means of competently addressing these concerns within the teachings of traditional psychology. In my opinion, this state of affairs continues today as reflected by the divisional organization of APA, which has nearly sixty professional divisions but not one committed to sexual health.

The term "Sexual Health" is defined as the integration of the physical, emotional, intellectual and social aspects of sexual being, in ways that are positively enriching and enhance personality, communication and love (World Health Organization, 1992). The concept of sexual health developed from the writings of the sexosophers of the 19th century (such as Freud, Ellis, Van de Velde) and the sexologists of the 20th century (especially Kinsey, Masters and Johnson, Kaplan, Bancroft and Money). This collective body of writing provided the theoretical foundation to the development of an entirely new health profession - sexual health.

Sexual health is a multidisciplinary field that includes sex education and sex therapy. It conceptualizes sexual functioning as a natural state and disruptions to sexual functioning as typically multicausal and needing intervention on multiple levels for optimal treatment outcome. The field of sexual health and sex therapy is regulated through a code of ethics developed by a professional body called the American Association of Sex Educators, Counselors and Therapists (AASECT).

Contingent upon this theoretical foundation, the Sexual Health Clinic at the VA Medical Center addresses the concerns of male and female veterans and their partners, which include, but are not limited to, sexual dysfunction, sexual trauma, sexual compulsiveness, gender dysphoria disorders and issues of sexual orientation.

Ramon Verdaguer, Ph.D.

It is now well understood that many chronic medical illnesses such as coronary artery disease, diabetes, and hypertension, whose causes include strong behavioral components, are readily preventable. As a result we are gradually experiencing a shift in focus from treatment of disease to illness prevention. This is especially so in the VA Healthcare system where much attention is given to primary care programs and primary care based interventions. Counseling about the health risks of smoking, and alcohol use as well as the benefits of exercise, seat belt use, and a healthy diet, is now commonly integrated into routine primary care visits.

One of the roles of a psychologist in the primary care setting is to facilitate change in people who have identified the implementation of healthy behaviors as an effective mean to prevent and/or manage chronic illness and are prepared to embark in such a change. The Transtheoretical Model (Prochaska & DiClemente), a process theory of change, is a useful construct in determining who may be ready to embark in that change and to which interventions they may be more receptive.

Although skill acquisition and enlargement is an objective, the underlying goal is to assist in the development of a self-regulatory mechanism that can maintain and drive those positive behaviors on a long-term basis in the face of occasional lapses, frustrations, and lack of concrete positive feedback and reinforcement. The concept of *integration*, as defined by Deci et al. (1994) in the Self-Determination Theory perspective, in which a behavior is “volitional” and “emanates from oneself” and results in self-determined behavior seems to capture the essence of this aim. A combination of psycho-educational strategies, client-centered and cognitive-behavioral therapeutic interventions are useful in enabling individuals to attain this level of integration.

Yet, we also know that availability of information and education about the consequences of high-risk behaviors and the availability of alternative health behaviors does not always translate into positive behavior change. In that light, another role of the psychologist is to promote behavior change with those people who may not be necessarily ready or prepared to undertake such a change. In this case, it is important to acknowledge that people may not be ready to change for a variety of reasons. Some of these reasons may be the result of intrapersonal issues such as perceived susceptibility, low self-efficacy, ability, and outcome expectations. Environmental issues can also impact the decision to change and may include situational barriers or lack of resources (Health Action Process Approach), and demographic or sociological variables (Health Belief Model). Clearly, the nature and severity of the illness can also impact on decision to change. The biopsychosocial model is, therefore, a useful umbrella framework through which to conceptualize the individual and the factors influencing readiness to change. It lays out an outline for inquiry that can lead to an actionable roadmap for intervention.

In general, the orienting principle of my work is to assist people to act in ways that are consistent with their life values and goals. As such, I conceptualize my work as involving 2 phases. The first phase moves forward the process of value elucidation, goal determination, and choice clarification. Cognitive, emotive, and experiential strategies tend to be most effective in this phase. This process leads to the second phase, which involves facilitating decision making and actions that are consistent with attainment of the goals. Behavioral strategies tend to have a good response during this phase.

This process implicitly accepts that some people’s values and goals are not necessarily congruent with the majority’s values and that not everyone can, will, or should change. This may at times be incongruent with the institutional goals but its acceptance is crucial

if one is to respect the individual and if one is to remain vitally committed to good patient care without losing oneself in the process.

Mental Health

Description

The program is structured such that, regardless of rotation setting, each resident spends one day per week in the Mental Health Clinic setting for the entire residency year. The arrangement is intended to provide residents with the opportunity to follow patients for the purpose of therapy on a more long term basis. Our experience has been that one day per week in this setting is sufficient for the purpose of learning. For the purpose of the setting, it is defined to include the Mental Health Clinic, the outpatient Post Traumatic Stress Disorder team, and the Residential Psychosocial Rehabilitation Program. Supervisors for the Mental Health Clinic setting: Dr. Peggy Arnott (PTSD focus), Dr. Bruce Harrison (general outpatient setting and Residential Psychosocial Rehabilitation Program), and Dr. Dennis Johnson (Mental Health Clinic).

A resident who selects a four month rotation in mental health is assigned to Inpatient Mental Health/Emergency Room. With Inpatient Mental Health emphasis is on assessment, rapid stabilization, and planning for followup treatment. The Emergency Room experience involves providing mental health consultation to that setting for the purposes of rapid assessment and disposition. Supervisor for the inpatient setting: Dr. Rebecca Graham.

Conceptualization Statements

Peggy Cisneros Arnott, Ph.D.
(See Post Traumatic Stress Disorder Section)

Rebecca Graham, Ph.D.

My role within the Mental Health Care line is a psychological consultant to the Emergency Room and to the Acute Inpatient Mental Health Unit. In this role I deal primarily with patients who have had a recent change in mental status and/or a decline in their behavioral functioning. I see human behavior as being multidetermined, with assessment and interventions needing to be multidimensional. Because of this, I especially appreciate the luxury of working within the context a multidisciplinary treatment team. Of course, being a psychologist, my individual work tends to focus more on intrapsychic factors and social/environmental factors than on physiological ones, but I view it as very important to understand and take into account the contributing physiological factors.

In the Emergency Room, my task is rapid assessment of mental status and/or acute behavioral changes and formulation of disposition recommendations. I rely heavily upon the physicians to first rule-out any acute medical condition that could be causing

the change. Once this is accomplished, I examine psychological and environmental factors contributing to the changes, formulate impressions, and make my recommendations for disposition.

The goal of acute inpatient mental health treatment is to return the patient to baseline behavior and functioning as rapidly as possible. Because of that, on our unit there is a heavy reliance upon biological treatments but psychological and environmental interventions are not neglected. As a psychologist, I use primarily interpersonal and cognitive-behavioral perspectives to guide me in designing and implementing circumscribed psychological interventions. Essentially, I ask myself, "What needs to change psychologically or environmentally to help this patient return to her or his pre-hospitalization level of functioning?" Sometimes this involves helping the patient negotiate a difficult life transition. Sometimes it involves teaching skills to cope better with one's own emotions or situations. Sometimes, it involves a marital or family intervention. I find the work of Marsha Linehan to be particularly relevant to patients I treat. Whether they have a diagnosis of Borderline Personality or not, most patients I see have difficulty with emotion regulation, interpersonal relationships, and distress tolerance. Since the latter two problems are not particularly responsive to biological interventions, I'm often asked by other treatment team members to intervene here.

Bruce Harrison, Ph.D.

My approach to case conceptualization refers to a way of understanding how patients have developed into persons who are less than optimally functional and basically dissatisfied with their lives, and also of understanding how they may be able to modify their lives in accordance with what they would see as a more optimal pattern of functioning with which they would be basically more satisfied. This understanding relies largely on existential concepts such as actual decision making which occurs only through taking implementing actions vs. fantasy decision making which occurs when decisions are never implemented in actions that foreclose the possibility of taking other actions. Another major concept would be blame vs. responsibility where blame is viewed as condemning oneself or others for past actions that had significant negative consequences, and typically results in disabling feelings of guilt or anger, respectively. Responsibility is viewed as maintaining awareness of how the actions and reactions of both you and others can increase the probability of the negative consequences occurring. The taking of responsibility, as contrast to relying on blame of self or others, can result in a reduction of guilt and/or anger and facilitate the learning of how to better manage problematic and frustrating life situations.

The mode of change in therapy is through cognitive restructuring. Conflicting attitudes, assumptions and beliefs are examined as a way of energizing the patient to resolve the contradictions which may be resulting in passiveness and indecisiveness or impulsive actions. These approaches may feel good or relieve stress and tension in the short run, but which can readily result in a deterioration in functioning and/or relationships in the long run. There is also a focus on helping the patients understand in a non-esoteric fashion how they probably developed their dysfunctional pattern in part through past

tragedies they may have experienced, whether through experiencing acute episodes of mental illness or experiencing other serious negative life events.

Dennis Johnson, Ph.D.

I would describe myself as eclectic in working with patients. Patients are individuals who are in some way troubled and seeking relief of distress or assistance in functioning more effectively in their lives. It is important to have various diagnostic and conceptual frameworks to provide a basis for our work with people. I see our work as professional therapists as being selective and creative, rather than simply a matter of applying a protocol or a set of techniques to dealing with an individual patient. The straightforward application of techniques is a matter for technicians and paraprofessionals. I believe that a psychotherapist must also be able to see what is unique in a given individual and life situation and find levels to work that address the unique needs and motivations of the individual coming to us for assistance in improving his or her life.

I see our work with adult patients as being contractual in nature, but I also see that as an ideal because we are dealing with individuals whose needs and wants are constantly changing and who may have considerable difficulty expressing them clearly. And our limits and shortcomings come into play as well. But I see it as an ethical and professional challenge to work with individuals in ways that respect their integrity and their right to go in directions that we would not choose ourselves. If we find that we are in a situation where we are finding it difficult to do that we should consider withdrawing from a case.

It has been my experience that residents come in with a basic understanding of how to do therapy and how they want to work with people. I don't attempt to teach them another way to do therapy. I see it as my role to assist them in gaining experience to allow them to more fully develop their own way of doing things. In doing so I may however offer other ways of looking at cases and situations with the expectation that they may then have a rich set of options in terms of frameworks or approaches to individuals with whom they work. I recognize that supervision includes an evaluative function that obligates a supervisor to assist in resolving any deficit that is identified. If a deficit is identified, a somewhat more didactic or authoritarian approach may be needed to assure that the individual that we certify as having completed an internship is in fact ready to practice independently.

Neuropsychology

Description

The purpose of clinical neuropsychology is the assessment of brain-behavior relationships. The relationships are examined through a variety of measures utilizing a flexible procedure approach. Each examination assists in identifying the etiology, brain region, and extent of impaired functions along with well preserved abilities. Assessments are requested from disciplines across the full spectrum of patient care

providers for an equally full range of purposes. The nature of a given assessment can range from a brief interview to a very involved series of tests and procedures. Throughout the rotation there is a series of readings on various topics (mental status, neurology, attention, executive functions, etc.) along with regular supervision meetings to discuss them. Additional learning experiences are obtained through contact with Radiology, brain cuttings, Neurology Clinics, quarterly peer review meetings, and state neuropsychology meetings.

Within the overall programmatic structure of the residency program, there is a strong apprenticeship approach with the neuropsychology rotation. The general structure is for the supervisor to begin with a directive style and move toward a consultant, or even independent, role relative to a given professional skill as a resident demonstrates competence consistently in that particular skill. Initially, direct observation of the supervisor is the modal style. Almost simultaneously, there is training in the various tests and procedures used customarily in a neuropsychological assessment. The nature of the relationship evolves to the supervisor observing the resident administer tests along with a careful review of all protocols. Usually, report writing begins with the administration of one's first series of tests. There is considerable structure so the process is more of a "filling in the blanks." Eventually, the resident brings in a completed protocol and report for review. Rather quickly the number of assessments by a resident becomes a minimum of two per week. The usual schedule is face to face testing during the morning and writeup during the afternoon. Such a structure serves to maximize the experiential learning component. During the initial learning phases, the supervisor will adopt a directive role in report writing in order to insure timely completion of documentation. Although there is a large amount of structure on which to base the learning process, the development of individual style is encouraged and supported once a resident has demonstrated competence in the basic processes of an assessment.

Progress through the rotation is measured both quantitatively and qualitatively: more assessments, more complex assessments, less direct supervision, more independence with the process, faster completion of full reports, more sophisticated tests/procedures, etc.

Although the basic training structure remains the same, training is oriented to two different tracks. One is for a resident who wishes a workable knowledge of neuropsychology within the context of a well rounded residency experience. Any resident is considered qualified for the track. The other is for a resident who has aspirations of becoming a clinical neuropsychologist through a two year post doctoral training experience. Customarily, the latter opts for a 6-2-4 structure – though it is not required. Competency levels have higher thresholds since a superlative letter of recommendation from the supervisor is required and the supervisor prefers to adhere to Division 40 Guidelines. Acceptance into the track is not automatic and is at the discretion of the supervisor. If you have aspirations for a post doctoral position in clinical neuropsychology, be sure to make such intentions clear as part of your application. Supervisor: Dr. R. L. Stegman.

Conceptualization Statement

R. L. Stegman, Ph.D.

Virtually all of the sciences in our culture can trace their origins back through recorded history to the philosophers of Greece. The evolutions of modern day psychology are noticeable in the writings of the philosophers of the eighteenth and nineteenth centuries. In the search for absolute reality or truth, the British Empiricists emphasized the learning process (i.e., tabula rasa or “blank slate”) while the German Nativist school emphasized the innate features of the organism. Eventually, the Constructivist school was developed with the observation that reality or absolute truth is an ephemeral concept. That is, reality or truth changes depending upon various factors and within various contexts. In discussing case conceptualization, it is wise to remember such history for, as Albert Einstein stated so well, “Concepts which have proved useful for ordering things easily assume so great an authority over us that we forget their terrestrial origins and accept them as unalterable facts.” As a discipline, we have made the errors of forgetting our sometimes humble origins and accepting current conceptualizations as absolute fact. We forget that our self defined sophistication is a function of our attempts to make sense out of a complex world and not some inherent design of the universe.

The process of creating or making a conceptualization has equal, if not slightly greater, importance relative to the conceptualization. The notion of insanity and its many variants is a fairly open concept. Rules of inclusion and exclusion are reasonable guidelines at best. Hence, it is incumbent upon a professional to select carefully the concepts s/he will use in daily practice. Leon Levy (1965) wrote a book entitled *Conceptions of Personality*. He defined personality as an “interpersonal percept” that gives the appearance of origin with the organism. He was not denying the existence of the phenomenon of personality. Rather, he stated the nature of its existence. With all its various modifiers, the existence of personality (normal or abnormal) is that of an interpersonal event. A number of authors have written well on how the label of abnormal is not inherent in the behavior. Rather, the label is a function of the observer as a member of a given society. The important point is that we tend to forget that we are engaging in primarily an interpersonal event that we tend to misconceptualize wholly as a medical event. We must remember that we are engaging in interpersonal, primarily culturally based value judgments. In addition, Thomas Szasz (1961) made a revealing analogy between witchhunters, who practiced centuries ago, and the current practice of psychiatry. Witchhunters had to label people as witches in order to exist as a profession. Mental health professional must label people with diagnoses in order to exist as a profession. In other words, it is important that we remain aware of our vested interests in the process.

The fundamental premise of my conceptual approach comes from Ullmann & Krasner (1975). They wrote that abnormal behavior is no different from any other behavior in its acquisition, maintenance, and change. The same principles apply equally to behavior that we label as normal and abnormal. Behavior is behavior. They add that abnormal behavior can, and does, arise from fundamentally diverse sources. The statement,

though elegant in its simplicity, is exceeding complex in practical application. Multiple interacting factors have potential for etiological significance and impact on meaningful behavior change. With the exception of occasional teratogenic influences, the physical features of an individual is a function of genetics. However, the phenomenological experiences of individuals regarding one's physical features vary widely. An individual who has features that are valued by are society will have a remarkably different experience from an individual who has features not valued by our society. A person who is defined as a minority will have experiences remarkably different from those who are members of a dominant culture. An individual who suffers a right hemisphere cerebrovascular accident is likely to display behaviors remarkably consistent with the diagnostic features of a bipolar disorder. A person who seeks absolute assurance that an event will not occur is very likely to experience chronic anxiety. Marital discord may mask the effects of a traumatic brain injury. Behavior that is maladaptive in a general sense may well be quite functional in the setting that elicited it. There is overlap with the concepts of attention, executive functions, and working memory – or a deficit may well be a psychological event unrelated to neurological integrity. What appears to be a deficit in executive functions may actually be an obsession pattern. What appears to be a memory deficit may well be a deficit in complex attentional processes. There are inevitable existential issues secondary to a traumatic brain injury. To further complicate matters, the relative valence of any given influence may well change over time. Hence, it is important to reassess frequently one's conceptualizations regarding a given set of data and, as indicated, revise accordingly and/or collect more data. Currently there is no one comprehensive, coherent, unified theory or conceptualization that encompasses such a pluralistic approach. One must be well versed in the basic biological, psychological, and sociocultural aspects of behavior as well as possess knowledge of a wide variety of notions, concepts, and theories. Equally important, a clinician must monitor his/her professional processes, be self reflective, be flexible in one's thinking, and value ongoing professional development. Relative to the Neuropsychology Rotation, the conceptualization statement emphasizes the need for us to be clinicians first and neuropsychologists second. The core values of unconditional positive regard and the establishment of a meaningful relationship are germane to our professional behavior. In summary, it is important to be aware of, and identify as indicated, the multiple influences on behavior, apply conceptualizations as indicated, and to reassess one's thinking frequently.

Post Traumatic Stress Disorder Day Hospital Program PTSD Clinical Team

Description

The Posttraumatic Stress Disorder Day Hospital Program is a day hospital program for up to 15 patients under the direction of a psychologist. All of the patients live in the domiciliary and are expected to attend the daily routine of mostly group treatment. The program provides state of the art treatments including virtual reality and Eye Movement Desensitization Routine to veterans. Treatment for Post Traumatic Stress Disorder (PTSD) is not limited to war zone related stress. Patients are expected to attend a

trauma processing group, a life span group, an anger management group, a sleep hygiene group, a stress relaxation group, and a psychoeducational group. The patients are also involved in a community government and are expected to be in individual therapy. Residents function as a member of the treatment team. This program usually employs a practicum student from a nearby university and the resident is expected to supervise the student as part of their responsibility.

The PTSD Clinical Team offers outpatient treatment to patients with PTSD. Patients are offered a menu of different treatment formats that include individual and group therapies.

Supervisors: Dr. Arthur Aaronson and Dr. Peggy Arnott.

Conceptualization Statements

Arthur Aaronson, Psy.D.

As coordinator of the PTSD Clinical Team (PCT – Outpatient) and the PTSD Day Hospital Program, a residential program, I get the opportunity to do therapy as well as administration, training, and supervision. My training consisted of a combination of behavioral and dynamic orientations. Today, I consider myself more dynamically oriented. I do not consider myself a behaviorist; however, both conceptualizations would suggest exposure therapy as a therapy of choice.

I see patients as normal persons who have been exposed to one or more traumatic events are no longer able to see the world as a safe place. They spend the remainder of their lives learning how to live in a world that is hostile and unsafe. They constantly remind themselves how unsafe the world is by re-experiencing the trauma through a variety of symptoms. PTSD is the normal response for people that have been traumatized.

I also believe that a person's background and history "color" their ability to cope with the trauma and its aftermath. I rarely see patients that have only PTSD, but they come with a complex set of symptoms and circumstances that suggest background factors make their coping even more difficult. For example, I often see patients who have "escaped" the horrors of an abusive family by going into the military, only to discover the horror of war.

I see therapy for these people as a way of making them see themselves as survivors rather than victims. In therapy, I take patients back to the trauma and help them relieve it in a "safe" environment. By re-experiencing the cognitive and emotional aspects of the trauma without the danger, helps make the trauma, an historical event---a marker of the past and not an event to be anticipated in the future.

Peggy Cisneros Arnott, Ph.D.

Working with veterans with Post-Traumatic Stress Disorder affords me the opportunity to work with a complex population and use a variety of approaches largely driven by “where the veteran is at.” The majority of the veterans I see in therapy are combat veterans. Although the majority are Vietnam War era veterans, I also provide services to WWII, Korea, and Persian Gulf veterans. My responsibilities include conducting diagnostic assessments, treatment planning and conducting individual and group psychotherapy.

A person can be seen as not only a sum of his/her experiences, but also how those experiences are interpreted and internalized. I attempt to see my patients in a holistic fashion. Trained with a developmental background, I find it extremely important to know about any past trauma history and what s/he was like before they were exposed to trauma. Understanding post-trauma lifestyle is also essential as I try to “paint” the picture of this veteran, including his/her strengths. I consider myself as having an integrative theoretical orientation, mostly humanistic, interpersonal, and cognitive-behavioral. For assessment purposes I rely mostly on clinical interviewing, although on occasion I will use objective personality measures to help with my conceptualization of the veteran. I also believe in forming a collaborative alliance with the veterans, giving them responsibility for the pace and topics to be discussed in treatment.

My understanding of trauma is that it is an event(s) that impacts our biology, social functioning, emotional integrity and calls into question the very core of our existence. Issues of guilt and spirituality are commonplace as veterans explore how they survived their traumas. My multifaceted view of how trauma impacts the self is manifested in my practice as I espouse eclectic pragmatism. With an overall interpersonal approach, I use a variety of therapeutic techniques and schools of thought to understand and assist the veterans I work with. This includes cognitive-behavioral techniques to teach relaxation training, stress management and mastery over triggers, or more existential therapies as veteran’s struggle with the “why’s” that trauma seems to generate. The roles of unresolved grief, limited emotional expressiveness and spirituality become essential when working with many trauma survivors. All the while, reflective and empathic listening are used in order to provide a safe environment where the veteran can chose to experience some very intense emotions. With certain veterans, trauma processing can be very beneficial as we “go back” to the trauma in order to understand this experience’s bearing on their life today.

I see myself as an educator, helping veterans understand the effects of trauma. I find it valuable to spend time helping them understand PTSD and its effects on their lives. At the outset of therapy, many veterans state that they feel like they are “going crazy.” Spending time helping them understand PTSD helps them feel more “normal” providing much needed validation as well. I teach them about mind-body interactions by helping them identify and master their triggers as they attempt to gain some control back of their bodies and thoughts. The purpose is to empower the veteran, since one of the main diagnostic criteria of PTSD is having feelings of helplessness and powerlessness during the trauma.

What we hope to achieve is that a veteran that we work with feels good enough about his understanding of and mastery of PTSD symptoms that s/he can function independently without our help. We are not always likely to see remission of all symptoms, but we hope to help them gain some mastery over symptoms by taking a proactive approach to dealing with symptoms. We encourage healthy behaviors and refer to many hospital clinics to help the veteran take care of his overall health which, as we know, impacts his/her outlook on life and mood.

Substance Abuse Treatment and Rehabilitation Program

Description

The Substance Abuse Treatment and Rehabilitation Program (SATRP) is a residential and outpatient multidisciplinary approach to polysubstance abuse and dependence that includes a dual diagnosis approach. A variety of disciplines are integrated into the treatment process: psychiatry, psychology, social work, substance abuse counseling, nursing, chaplain services, vocational rehabilitation, dietetics, and recreation. The program is structured to encourage participation and cooperation among the patient and the staff to encourage the processes of recovery. The psychologist serves as an integral member of the dual diagnosis team. Psychological assessments to assist in the development of individualized treatment are routine along with the provision of consultation services. In addition, a major role of the psychologist is to provide individual and group interventions. Supervisor: Dr. Sundra Shorter.

Conceptualization Statement

Sundra Shorter, Psy.D.

Within the context of the Substance Abuse Treatment Program (SATP) I adopt primarily a cognitive behavioral orientation. The focus is on maladaptive cognitions and behaviors that contribute to self defeating substance abuse patterns.

The maladaptive cognitions and behaviors arise from diverse sources. A person may use substances to numb unwanted feelings secondary to trauma and other forms of stress. The words guilt and shame are used frequently by the veterans in our treatment program. An individual uses drugs and/or alcohol to avoid dealing with the reservoir of unprocessed, repressed emotions. A pattern care providers refer to as self medication. Even though illegal and/or frowned upon, substances are endemic in our culture. Each of us receives conflicting messages regarding use. Several decades ago Consumer's Reports in its classic book entitled *Licit and Illicit Drugs* noted that despite our societal condemnation of substances, we in effect encourage their use. Through various media people are encouraged to consume alcohol. Some people simply enjoy the alternate state provided by various substances and are not deterred by the inevitable negative consequences. With others, it is a gradual process – perhaps facilitated by poor oversight and/or role modeling. Social pressures are an important element regarding alcohol and/or drug abuse. Advertising media creates positive, but incorrect

expectations regarding the consumption of alcohol. With such a basis, we can view individuals who have a problem with substance and/or alcohol abuse as cognitively and behaviorally impaired.

Treatment is multifocused. There is a need to identify the maladaptive cognitions and behaviors. I accomplish such through assessment, individual work, group work, and education classes. Concurrently for all practical purposes I encourage and support the development of functional, adaptive cognitions and behaviors. With such an approach the probability of recidivism is reduced.

ADDITIONAL TRAINING EXPERIENCES AND SUPPORT

Training Seminars

There is an ongoing didactic series throughout the residency year. The meeting time is each Wednesday, 1000 – 1200. The subjects and presenters are quite varied. Attendance is mandatory. A copy of last year's schedule is part of this document.

Group Supervision

Each Wednesday, 0900 – 1000, is group supervision. The general approach is to augment supervision taking place in other settings and to provide a venue in which residents can support their mutual professional development. Specific subjects are quite varied: case presentations, mandatory medical center training, practice oral defense of dissertation, administration of residency program, concepts/theories, etc. Attendance is mandatory.

Testing Laboratory

Medical records are totally computerized – to include a wide variety of personality inventories, self rating forms, etc. We maintain and update regularly an extensive selection of noncomputerized psychological tests and neuropsychological instruments.

Library

The Health Sciences Library houses many volumes of professional books and subscribes to over 300 professional journals. Staff are experts in completing literature searches and obtaining copies of articles and borrowing books from other institutions. Also, the library has an extensive collection of audio, video, and microfilm holdings.

Medical Media

Medical Media is available to assist the hospital staff with a variety of services including photographs, graphic art, and video production. The staff are quite helpful with teaching and the development of presentations.

Professional Development

A resident will be given a reasonable amount of authorized absence to attend professional presentations, conferences, workshops, and organizational meetings that are consistent with professional development plans. We support strongly the completion of the dissertation and allow a maximum of six days of authorized absence for trips to the university, oral defense, etc. Also, if appropriate, a resident may select a four hour block of time each week for the purpose of dissertation work. Finally, each resident is encouraged to make use of the many educational presentations within the medical center and the surrounding academic community.

PHYSICAL SETTING AND SUPPORT

Primary resident offices are located in 9D-132 of Building 330 (the Patient Tower). Each resident has an individual office along with a workstation (computer connected to the mainframe) along with a telephone that has voice mail. One of the codirectors of training is located in the suite as well. Two conference/multipurpose rooms are part of the suite as well. There is an office, along with a workstation, in Mental Health Clinic (Building 302) for the residents to be used on the one day per week in that area. The Post Traumatic Stress Disorder Residential Rehabilitation Program and Substance Abuse Treatment Program each as an office, along with workstation, for a resident.

Medical records are electronic and almost all of the professional activities are accomplished through use of various computer programs. The first week of the academic year is devoted almost entirely to training in the various computer programs so that within a few days each resident has access to all the computer programs and is, therefore, able to engage in the full range of psychological services. The standard programs are the Computerized Patient Record System (CPRS) which exists in a dual form (Graphic User Interface and List Serve – the latter is a more DOS based system which is being phased out), psychological tests, Microsoft Outlook, Microsoft Word, Microsoft Windows 2000, Excel, Power Point, and Internet.

APPLICATION

Eligibility

An applicant must be a U.S. citizen who is enrolled in a clinical or counseling psychology graduate program that is accredited by the American Psychological Association. We require that all academic requirements, other than dissertation, be completed prior to the beginning of the residency year. We strongly desire that a

prospective applicant be sufficiently advanced with the dissertation so that completion can be anticipated by the end of the residency year.

The VHA Medical Center, Dayton, Ohio maintains a policy of equal employment opportunity in resident recruitment and retention. All recruitment processes are consistent with existing federal laws, guidelines, and policies.

Appointment and Benefits

Technically, each resident receives a one to three year temporary appointment per Department of Veterans Affairs regulations. The type of appointment translates to an actual one year plus one day appointment. There is a specific reason for such technicalities. The arrangement allows us to provide the benefits provided to any regular employee such as health insurance.

The residency year will begin on or shortly before August 21, 2005. The total number of hours is 2,088 to include established holiday leave, annual leave, and sick leave. Annual leave and sick leave are accrued at a rate of four hours per pay period. We are not authorized funds to purchase unused annual leave. Sick leave can be accrued and maintained "on the books" indefinitely and used if one should become a federal employee at some time in the future. For the purpose of state licensure, our procedure is to verify the usual and customary 2,000 hour internship/residency. The pay is \$18,500 for the year to be paid in equal installments over 26 biweekly pay periods.

As a federal employee, drug screens and background checks are routine. Prior to the actual appointment, a matched applicant must complete the appropriate paperwork and complete a physical examination that certifies s/he is capable of the duties required. The Department of Veterans Affairs, and consequently this medical center, adheres to the Americans With Disabilities Act and will provide reasonable accommodations for an individual who has a disability.

The official appointment as a Psychology Resident is contingent upon successful completion of practica and academic requirements (other than dissertation) along with continued professional conduct consistent with the practice of psychology. Decisions on our part regarding an applicant are based upon the fundamental assumption of a full and factually accurate application. Such an approach is inherent in the federal laws and regulations regarding employment and serves the training process very well. Subsequent acquisition of knowledge that there were one or more apparent and significant acts of omission and/or commission that misled us in the decision making process may be considered by the training committee justification to reevaluate the status of the resident regardless of source and/or intent.

Application Procedures

We use the uniform application and add a sheet unique to our residency program. The additional sheet is included with this brochure. We adhere to the Association of

Psychology Postdoctoral and Internship Centers (APPIC) guidelines for the recruitment and selection of psychology residents including the policy that no person at this training facility will solicit, accept, or use any ranking related information from any applicant prior to Uniform Notification Day.

We need the following documents

APPIC Uniform Application: available on the Internet at www.appic.org

A resume or curriculum vita.

Official transcripts of graduate work. The transcripts should cover all post baccalaureate course work.

Three letters of recommendation from professionals who are familiar with your academic and professional competencies.

Completed Interview Dates / Rotation Preference Form (unique to our site).

The deadline for receipt of application materials is December 1, 2003. Our preference is that all the materials be included in a single, large envelope. However, we do not require it. Please insure that letters of recommendation, the verification form, and transcripts are enclosed in appropriately sealed envelopes.

Our procedure is to review each application in detail and invite 28 applicants for interviews. The customary agenda is for the applicants to meet with the Professional Chief and Directors of Training as a group. Each applicant meets with three different supervisors who are chosen based upon rotation preferences. Applicants meet with current residents as a group in a totally nonevaluative information sharing meeting. Finally, there is a general meeting among all applicants, supervisors, and current residents. We encourage applicants to become familiar with our staff and setting to assist in the decision making process. We try to schedule seven applicants per interview day. We do not schedule more than eight on a given day as a greater number overtaxes our resources. Our practice is to make the 28 applicants, who are invited for interviews, our pool for the purpose of match day. That is, further reductions in the pool of applicants are unlikely.

If you are unable to be present for a scheduled interview date, we can arrange a conference call telephone interview. On site interviews on other than the specified dates will be less formal and be accommodated to the extent that they do not interfere with patient care duties.

Scheduled interview dates are:

Friday, January 7, 2005, 0800 – 1215

Monday, January 10, 2005, 0800 – 1215

Thursday, January 13, 2005, 1200 – 0415

Tuesday, January 18, 2005, 1200 - 0415

DIRECTIONS TO THE VHA MEDICAL CENTER, DAYTON, OHIO

Interstate Road 70 runs east-west a few miles north of Dayton. Interstate road 75 bisects Dayton in a north-south direction and US 35 bisects Dayton in an east-west direction. The VHA Medical Center is on the west side of Dayton. Visitors are advised to use US 35 west from the Interstate Road 75 / US 35 interchange. Take US 35 west to Liscum Drive (second traffic light). The medical center is on the right. The Patient Tower is the only nine story building in the area. If you need further directions, lodging information, or have other questions, please feel free to contact use using telephone or email. Also, a map is part of the Dayton VHA Medical Center Web Site at www.dayton.med.va.gov

Our main offices are located on the 9th Floor, Room 9D-132 of the Patient Tower (Building 330). Parking is free throughout the medical center and ample parking is available on the south and west sides of the Patient Tower – though please be prepared to walk a distance.

MATCH DAY

The official dates for the 2004 – 2005 academic year are as follows:

- Wednesday, February 9, 2005: Deadline for submission of Rank Order Lists.
- Friday, February 25, 2005: Applicants informed as to whether or not they were matched.
- Monday, February 28, 2005: APPIC Match Day.

Immediately after learning the names of applicants with whom we have been matched, a CoDirector of Training will contact each through email and/or telephone. Also, s/he will mail two signed copies of a letter confirming the match. Each applicant is to return one copy of the letter after signing it.

PSYCHOLOGY TRAINING COMMITTEE

Aaronson, Arthur L.

Psy.D., clinical, 1988, Wright State University School of Professional Psychology.

Staff Psychologist, PTSD Residential Rehabilitation Program.

At VHAMC-Dayton since 1988.

Licensed Psychologist, State of Ohio.

Professional Organizations: American Psychological Association (APA), Divisions 12-Clinical Psychology, 18-Psychologists in Public Service, 41-American Psychology-Law Society.

Research Interests: MMPI/MMPI-2 and using assessment instruments to predict outcome success.

Clinical Interests: assessment, psychopharmacology.

Arnott, Margaret I.C.

Ph.D., counseling, 2000, The Ohio State University

Staff Psychologist, PTSD Clinical Team

At VHAMC-Dayton since 2000

Licensed Psychologist

Professional Organizations: American Psychologist Association (APA)

Research Interests: Quality of life issues in PTSD

Clinical Interests: group psychotherapy, assessment, marital therapy

Theoretical Orientation: Integrated

Best, Nicole

Psy.D. clinical, 1997, Wright State University School of Professional Psychology

Staff Psychologist, Geriatric Extended Care Line

At VHAMC-Dayton since 1999

Licensed Psychologist, State of Ohio

Professional Organizations: American Psychological Association (APA), Ohio Psychological Association.

Research Interests: psychoneuroimmunology, cancer, psychology and spirituality, sports psychology and performance enhancement

Clinical Interests: geropsychology, psychological interventions with terminally ill patients, grief work, end of life issues, neuropsychology, health psychology, psycho-education, narrative therapy.

Theoretical Orientation: eclectic (common factors, cognitive-behavioral, existential, and psychodynamic conceptualizations)

Byrd, Anthony

Psy.D. clinical, 1989, Wright State University School of Professional Psychology

Staff Psychologist, Primary Care Line.

At VHAMC-Dayton since 1992.

Licensed Psychologist, State of Ohio & Arizona

Professional Organizations: American Psychological Association (APA), Division 40, National Academy of Neuropsychology.

Clinical Interests: neuropsychology, dementia, psychopharmacology.

Theoretical Orientation: Eclectic

Graham, Rebecca L.

Ph.D., clinical, 1991, University of Louisville.

Staff Psychologist, Inpatient Mental Health/Emergency.

At VHAMC-Dayton since 1991.

Licensed Psychologist, State of Ohio.

Professional Organizations: Society for Personality Assessment.

Clinical Interests: personality assessment; brief psychodynamic psychotherapy; group therapy.

Theoretical Orientation: interpersonal/psychodynamic.

Harrison, Bruce E.

Ph.D., clinical, 1979, University of Houston.

Staff Psychologist, Mental Health Primary Care.

At VHAMC-Dayton since 1979.

Licensed Psychologist, State of Ohio.

Professional Organizations: American Psychological Association (APA), Society for Personality Assessment.

Research Interests: individual differences and prediction from psychological tests.

Clinical Interests: personality functioning; vocational rehabilitation.

Theoretical Orientation: cognitive-existential.

Johnson, Dennis L.

Ph.D., clinical, 1975, University of North Dakota.

Staff Psychologist, Mental Health Primary Care.

At VHAMC-Dayton since 1975.

Licensed Psychologist, State of Ohio.

Professional Organizations: American Psychological Association (APA); Dayton Area Psychological Association; Association of Humanistic Psychologists; National Register of Health Service Providers in Psychology; National Organization of VA Psychologists (NOVA Psi).

Research Interests: treatment methods and processes.

Clinical Interests: a range of psychotherapeutic processes including life changing, growth enhancing and long term therapies; psychological treatment and management of severe and chronic mental disorders; psychological impact of medical illness; adult development.

Theoretical Orientation: eclectic within a framework that is primarily existential/Gestalt/humanistic, but also utilizes concepts that are cognitive, Eriksonian, and psychodynamic.

O'Brien, William F.

Ph.D., counseling, 1975, Ohio State University.

Professional Chief, Psychology Service.

At VHAMC-Dayton since 1984.

Licensed Psychologist, State of Michigan.

Professional Organizations: American Psychological Association (APA), Division 18-Psychologists in Public Service (officer); Association of VA Chiefs of Psychology (officer).

Research Interests: substance abuse; PTSD.

Clinical Interests: substance abuse; PTSD.

Theoretical Orientation: eclectic - client centered.

Papadakis, Emanuel A.

Psy.D., clinical, 1987, Wright State University School of Professional Psychology.

Staff Psychologist, Mental Health Primary Care.

At VHAMC-Dayton since 1992.

Licensed Psychologist, States of Ohio and Indiana.

Professional Organizations: American Psychological Association (APA).

Research Interests: chronic illness; primary prevention.

Theoretical Orientation: biopsychosocial model; systems theory; solutions orientation.

Peterson, Frederick L. Jr.

Psy.D., clinical, 1985, Wright State University School of Professional Psychology.

Staff Psychologist, Primary Care / Health Psychology.

At VHAMC-Dayton since 1985

Licensed Psychologist, State of Ohio.

Professional Organizations: AIDS Foundation of Miami Valley, American Association of Sex Educators, Counselors, and Therapists, American Board of Sexology, American Psychological Association (Div 51), American Lung Association.

Research Interests: Smoking cessation, organizational assessment and consultation, gender and management, HIV and volunteerism, sex education and therapy, sexual trauma, men's studies.

Clinical Interests: clinical sexuality, smoking cessation, health psychology, primary prevention in psychology, getting psychology out of the box.

Theoretical Orientation: psychological pragmatism.

Reinhard, Teresa A.

Psy.D., clinical, 1984, Wright State University School of Professional Psychology.

Staff Psychologist, Employee Assistance.

At VHAMC-Dayton since 1984.

Licensed Psychologist, State of Ohio.

Professional Organizations: American Psychological Association (APA); Ohio Psychological Association; National Association of Neuro Linguistic Programming.

Research Interests: belief system change.

Clinical Interests: belief systems, organizational behavior.

Theoretical Orientation: cognitive behavioral.

Shorter, Sundra G.

Psy.D., clinical, 1990, Wright State University School of Professional Psychology.

Staff Psychologist, Polysubstance Rehabilitation Program.

At VHAMC-Dayton since 1991.

Licensed Psychologist, State of Ohio.

Professional Organizations: American Psychological Association (APA); Ohio Psychological Association; Black Psychologists of Cincinnati.

Research Interests: minority issues, particularly African-Americans.

Clinical Interests: minority issues.

Theoretical Orientation: generalist.

Stegman, Robert L.

Ph.D., clinical, 1980, University of Missouri-Columbia.

Director of Training, Neuropsychologist

At VHAMC-Dayton since 1987.

Licensed Psychologist, State of Ohio and Kansas.

Professional Organizations: American Psychological Association (APA), International Neuropsychological Society (INS), National Academy of Neuropsychology (NAN), American Academy of Forensic Examiners (AFCE).

Research Interests: neuropsychology, clinical prediction.

Clinical Interests: integrated approaches to assessment and treatment.

Theoretical Orientation: social learning theory with primarily a cognitive behavioral focus.

Verdaguer, Ramon

Ph.D., clinical, 1990, Loyola University of Chicago.

Staff Psychologist, Primary Care / Health Psychology.

At VHAMC-Dayton since 1996.

Licensed Psychologist, State of Ohio and Illinois.

Professional Organizations: International Neuropsychological Society (INS), National Academy of Neuropsychology (NAN).

Research Interests: chronic pain and memory functions, malingering in neuropsychological assessment.

Clinical Interests: chronic pain, wellness and health promotion, neuropsychological assessment.

Theoretical Orientation: Cognitive-Behavioral

INTERVIEW DATES AND ROTATION PREFERENCES

Interview Dates

Please rank your preferred interview dates. We will contact you to arrange an interview.

	Morning	Afternoon
Friday, January 7, 2005	_____	
Monday, January 10, 2005	_____	
Thursday, January 13, 2005		_____
Tuesday, January 18, 2005		_____

Rotation Preferences

Please rank order your three rotation preferences. Remember that, regardless of rotation, each resident spends one day per week in the Mental Health Clinic setting.

Geropsychology	_____
Health Psychology	_____
Mental Health Inpatient/Emergency Room	_____
Neuropsychology	_____
PTSD Residential Rehabilitation Program	_____
Substance Abuse Treatment Program	_____

If you wish a six month rotation, please note it below.

(name)

APPIC APPLICATION SUPPLEMENT
VHA MEDICAL CENTER
DAYTON, OHIO