

DOCTORAL PSYCHOLOGY INTERNSHIP PROGRAM 2019-2020



Dayton VA Medical Center

Doctoral Psychology Internship Program

Mental Health (17P)
4100 West Third Street
Dayton, Ohio 45428



Match Number

General Psychology Internship 151211
Pre Post Doc Neuropsychology 151212

Application Due Date

November 1, 2018

Start Date

July 22, 2019

Table of Contents

Overview of the Dayton VA Medical Center	5
Internship Training Program	6
Welcome Letter.....	6
Philosophy	7
Title.....	7
Model.....	7
Mission	7
Approach to Training	8
Aim	9
Profession Wide Competencies.....	9
Completion	13
Program Requirements for Successful Completion of the Internship	13
Comprehensive Assessment Requirement for Interns	15
Evaluation	17
Rotation Format and Assignment.....	17
Rotation Descriptions	18
Family Services Program.....	18
Geropsychology.....	18
Mental Health Clinic.....	19
Neuropsychology	19
Posttraumatic Stress Disorder Clinical Team	20
Primary Care Mental Health Integration.....	21
Psychosocial Rehabilitation	22
Substance Abuse Treatment Program.....	22
Additional Training Experiences and Support	23
Training Seminars.....	23
Group Supervision	23
Testing Materials	23
Library.....	24
Medical Media	24
Liability Protection for Trainees	24
Professional Development.....	24
Physical Setting and Support	25
Application.....	26
Appointment and Benefits.....	26
Admission Requirements.....	26
National VA Eligibility Requirements.....	26
Application Procedures	30
Match Day	31
Interview Dates and Rotation Preferences	32
Directions to the Dayton VA Medical Center	33

Psychology Training Committee.....	34
APPENDIX A.....	39
Internship Admissions, Support, and Initial Placement Data	39
Internship Program Tables	39
APPENDIX B.....	42
Conceptualization Statements of Training Supervisors	42
Andrea M. Bischoff, Psy.D.	42
Justin Bunn, Psy.D.....	42
Belinda Chaffins, Psy.D.	43
Massimo DeMarchis, Psy.D.	44
Deborah L. Downey, Psy.D.....	44
David Drake, Ph.D.	45
Kenneth L. Farr, Ph.D.	45
Yolanda T. Garmon, Psy.D.	45
Joshua H. Gootzeit, Ph.D.....	46
Monica Jackson, Ph.D.	47
Jeremy T. Johnson, Ph.D.....	47
Karen Lenhoff, Ph.D.....	48
Lyndsey N. Miller, Psy.D., MSCP	48
Monica Malcein, Ph.D.	50
Kelly Obert, Psy.D.....	50
Patricia A. Perry, Psy.D.....	50
Justine Ray, Ph.D.	51
Rahema Rodgers, Psy.D., ABPP (Clinical Psychology)	52
Kristin Rodzinka, Ph.D., ABPP (Clinical Psychology).....	52
Mary Schwendener-Holt, Ph.D., MDiv.....	53
Ramon Verdaguer, Ph.D., ABPP	54

Inquiries should be addressed to:

Director of Training
Psychology Internship Program (17P)
VA Medical Center
4100 West Third Street
Dayton, Ohio 45428

Phone: (937) 268-6511, Ext. 1079

FAX: (937) 267-5385

Email: 552internship@va.gov

Note: All application materials must be submitted electronically as part of the Online APPI. For more information go to: www.appic.org/Match/About-The-APPIC-Match/Application.

National Matching Service Program Code

151211 General Psychology Internship

151212 Pre Post Doc Neuropsychology

Accredited by the American Psychological Association
Commission on Accreditation
Office of Program Consultation and Accreditation
750 First Street, NE
Washington, DC 20002-4242
Phone: (202) 336-5979

Member of the Association of Psychology and Postdoctoral Internship Centers
10 "G" Street, NE Suite 440
Washington, DC 20002
Phone: (202) 589-0600

Overview of the Dayton VA Medical Center

The Veterans Health Administration (VHA) is part of the Department of Veterans Affairs, which is a cabinet level organization. The VA Medical Center, Dayton, Ohio offers a full time, one year, funded doctoral internship to doctoral students enrolled in clinical or counseling psychology programs that are accredited by the American Psychological Association (APA). Our psychology internship program is accredited by the APA. We were awarded seven year accreditation in 2016. Our next regularly scheduled site visit will be during 2023.

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 pleasant atmosphere for relaxation and rehabilitation. A large farm provided much of the produce used by the Veterans. 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 382 acres co-located with the Dayton National Cemetery. The Medical Center provides a broad spectrum of programs in primary, secondary, and most levels of tertiary care. The medical center serves 16 counties in central and western Ohio along with one county in Indiana with a total patient population of about 166,000. There are approximately 6,500 inpatient stays and close to 500,000 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 Veterans Affairs Medical Center is a well-established multicultural setting that employs about 1,900 full-time employees who reflect considerable diversity.

Internship Training Program

Welcome Letter

Dear Prospective Applicant,

Thank you for expressing an interest in the APA Accredited, Doctoral Psychology Internship Program at the Dayton VA Medical Center. The internship year can be one of the most exhilarating, challenging and significant experiences in your development as a professional psychologist. We are excited about the opportunity to participate in this process, and hope that this brochure will provide you with an understanding of the experiences offered in our program. In addition to describing the clinical rotations, training requirements, and application procedure, these materials are meant to depict the overall aim and philosophies of our program and give some sense of the training experience at the Dayton VA Medical Center.

We are excited about your interest in our Doctoral Psychology Internship Program and look forward to reviewing your application. Please feel free to contact us with questions about the program or the application process.

Sincerely,

Dayton VA Medical Center

Philosophy

We believe the internship 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. Interns 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.

Title

We use the title of Psychology Intern.

Model

The Dayton VAMC Psychology Internship Program philosophy is consistent with the Practitioner- Scholar model (Vail model) of academic training and practice as summarized by Rodolfa et al. (2005). This model emphasizes the "mutuality of science and practice" and the practical application of scholarly knowledge. Psychological science is viewed as a human practice, and psychological practice is construed as a human science, with the two informing each other. The model emphasizes the development of reflective skills and multiple ways of knowing in the practice of psychology. It stresses clinical practice and the importance of theory and the use of research to inform practice. Students are trained to be psychologists who think critically and engage in disciplined inquiry focused on the individual and who gain clinical experience rather than conducting laboratory science. Consistent with the ACCTA definition of practitioner scholar programs, it is also our philosophy to "include empirically supported treatments, a value on the psychologist as a consumer of research, recognition of the importance of generating knowledge through practice, and an expectation that interns participate in scholarly activities." Our pedagogical approach to the application of this model is that of a developmental/apprenticeship process that "nurtures people in making the transition from trainee to competent autonomous professional, thus helping them to integrate their personal and professional selves; places a high value on respecting the diversity and uniqueness of every individual; and underscores the importance of supervisory relationship and the mentoring process."

The Practitioner-Scholar Model is consistent with the mission of the VHA which includes patient care, education/training, and research.

Mission

We take pride in our profession and in the training of interns to become psychologists. We recognize the special responsibilities associated with the training of interns. The

mission of the Psychology Internship Program is to establish and maintain an environment that maximizes the potential for professional development for each psychology intern.

Approach to Training

There are various forms of supervision. Within the Internship 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. It is important that all parties concerned recognize, and are sensitive to, the multiple levels.
- Supervision for the purpose of training has four components.
 - Formal knowledge
 - Skills/experience
 - Attitudes/beliefs
 - Ensure safety of consumers
- Supervision for the purpose of training has a developmental quality.

We utilize a programmatic approach to training. Within a programmatic approach, each intern 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 intern and the tasks being learned.

We have adopted situational management theory as our conceptual basis. The role of a training supervisor evolves as an intern 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 Internship.

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 intern. There is a proactive dialogue among all relevant parties that begins before, and continues throughout, the Internship year.

Our general approach is to behave in a manner consistent with American Psychological Association (APA) guidelines and Department of Veterans Affairs Policies regarding the disclosure of personal information and to routinely maintain good boundaries in that regard. 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 Psychology Internship Program was developed to assure high quality training. We have developed a specific, competency based approach. The competencies notion is applied to all aspects of the training program. Within the context of this competency based structure, both positive and constructive feedback have heuristic value. Each serves to inform how well an element or process is functioning.

The Lead Psychologist and the Co-Directors of Training are administratively responsible for the Psychology Internship Program, while the Psychology Training Committee (PTC) is the governing body. Regular meetings are held and the minutes are distributed to all staff and interns. Interns are members of the training committee. Training supervisors who are actively providing intern supervision are required to attend PTC meetings or report on progress prior to meetings. While training supervisors who are not actively supervising interns are not necessarily required to be at all meetings, all psychologists involved in training are welcome to attend. Although the members of the training committee work toward consensus when making decisions, a simple majority vote is all that is required.

Aim

To train psychology interns who will become independently licensed, culturally competent, recovery oriented, evidence based practitioners of psychology.

Profession Wide Competencies

Our overall goal is for each intern 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 profession wide competencies identified in APA's Standards of Accreditation (see also IR C-8 I) are evaluated across rotations. The competencies are documented on formal competency evaluation forms. What follows are broad statements regarding the areas evaluated and examples of some of the behavioral anchors assessed.

Research

Understanding of research, research methodology, techniques of data collection and analysis, biological bases of behavior, cognitive-affective bases of behavior, and development across the lifespan. Respect for scientifically derived knowledge. Understanding of current body of research relevant to practice in area of rotation placement.

- Displays scientific critical thinking
- Independently applies knowledge and understanding of scientific foundations to practice

Ethical and legal standards

Application of ethical concepts and awareness of legal issues regarding professional activities with individuals, groups, and organizations.

- Recognize ethical dilemmas as they arise, and apply ethical decision-making processes in order to resolve the dilemmas.
- Conduct self in an ethical manner in all professional activities.

Individual and cultural diversity

Awareness, sensitivity and skills in working professionally with diverse individuals, groups and communities who represent various cultural and personal background and characteristics defined broadly and consistent with APA policy.

- Demonstrates an understanding of how their own personal/cultural history, attitudes, and biases may affect how they understand and interact with people different from themselves
- Demonstrates the ability to independently apply their knowledge and approach in working effectively with the range of diverse individuals and groups encountered during internship

Professional values, attitudes, and behaviors

Behavior and comportment that reflects the values and attitudes of psychology. Practice conducted with personal and professional self-awareness and reflection and engagement in appropriate self-care.

- Behaves in ways that reflect the values and attitudes of psychology, including integrity, deportment, professional identity, accountability, lifelong learning, and concern for the welfare of others
- Engages in self-reflection regarding one's personal and professional functioning; engages in activities to maintain and improve performance, well-being, and professional effectiveness
- Actively seeks and demonstrates openness and responsiveness to feedback and supervision

Communication and interpersonal skills

Relate effectively and meaningfully with individuals, groups, and/or communities both verbally and in writing.

- Develops and maintains effective relationships with a wide range of individuals, including colleagues, communities, organizations, supervisors, supervisees, and those receiving professional services
- Demonstrates effective interpersonal skills and the ability to manage difficult communication well

Assessment

Assessment and diagnosis of problems, capabilities and issues associated with individuals, groups, and/or organizations.

- Independently selects and applies assessment methods that draw from the best available empirical literature and that reflect the science of measurement and psychometrics; collects relevant data using multiple sources and methods appropriate to the identified goals and questions of the assessment as well as relevant diversity characteristics of the service recipient
- Interprets assessment results, following current research and professional standards and guidelines, to inform case conceptualization, classification, and recommendations, while guarding against decision-making biases, distinguishing the aspects of assessment that are subjective from those that are objective
- Communicates orally and in written documents the findings and implications of the assessment in an accurate and effective manner sensitive to a range of audiences

Intervention

Interventions designed to alleviate suffering and to promote health and well-being of individuals, groups, and/or organizations.

- Demonstrates the ability to establish and maintain effective relationships with the recipients of psychological services
- Develops evidence-based intervention plans specific to the service delivery goals
- Implements interventions informed by the current scientific literature, assessment findings, diversity characteristics, and contextual variables
- Independently evaluates intervention effectiveness, and adapts intervention goals and methods consistent with ongoing evaluation

Supervision

Supervision and training in the professional knowledge base of enhancing and monitoring the professional functioning of others.

- Understands ethical, legal, and contextual issues of the supervisor role to include evaluation, power, responsibility/liability, and imperative
- Applies knowledge of supervision in direct or simulated practice with psychology trainees, or other health professionals. Examples of direct or simulated practice

examples of supervision include, but are not limited to, role-played supervision with others, and peer supervision with other trainees

Consultation and interprofessional/interdisciplinary skills

Provides expert guidance or professional assistance in response to a client/program's needs or goals. Demonstrates knowledge of key issues and concepts in related disciplines. Identifies and interacts with professionals in multiple disciplines.

- Applies knowledge of consultation in direct or simulated consultation with individuals and their families, other health care professionals, interprofessional groups, or systems related to health and behavior.
- Demonstrates knowledge and respect for the roles and perspectives of other professions

Completion

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

Interns are rated from Level 0 – Level 5 across each competency area and then given an overall score for each rotation. Level 3 reflects an intermediate level of functioning - “many skills in this area have been acquired and intern works with moderate supervision.” Level 4 reflects “most skills in this area have been acquired and intern works with minimal supervision.” Level 5 reflects an advanced level of skills appropriate for independent functioning.

For successful completion of the internship, an intern must have on all rotations, a Final Rotation score at or above Level 3. Additionally, prior to successful completion an intern must demonstrate a minimum level of achievement at Level 3 or above on all rated competencies.

Two of the four rotations must have an overall competency score of “Level 4” or greater. If an intern takes a 6-month special emphasis rotation, an overall score of “Level 4” or greater must be obtained for that rotation.

At the beginning of each rotation, the assigned supervisor(s) will review the competency assessment with the intern and clarify critical domains for that professional experience. Overall rotation scores should flow naturally from the scores assigned, however, specific domains may have greater or lesser weight from one rotation to another (i.e., neuropsychology – assessment skills; MHC – intervention skills).

Throughout the internship year, the intern will receive ongoing evaluation. If, at any point, the supervisor evaluates the intern to be performing at a substandard level this will prompt a remediation plan to go into effect. This written remediation plan will be developed by the intern's primary supervisor with the intern's input. The plan will be tailored to meet the specific needs of the intern in order to enhance the areas of substandard performance and to support the intern in meeting the minimum required standards.

If the intern does not respond to remediation (i.e. continues to perform at substandard level), due process procedures will be implemented.

Program Requirements for Successful Completion of the Internship

1. *Diversity special emphasis including completion of:*
 - a. Diversity Pre-Assessment: Complete a self-assessment regarding individual and cultural diversity during orientation

- b. Diversity Project: Place yourself in an environment where you are the minority. Situations might include a religious ceremony that is different from your own, a particular social event that you are not used to being a part of. Think about diversity in terms of: ethnicity, SES, religion, sexual orientation, education, disability, age. Write a reaction paper based on this experience. This is to be completed by the end of January and will be discussed in the diversity seminar.
 - c. Family Origin Rules & Expectations: Investigate the cultural influences of your development. How does your family's ethnic, religious, SES, sexual orientation, etc., help form your sense about what is acceptable and not acceptable. Discuss this topic with at least one parent or grandparent to seek clues to particular cultural influences. To be completed and discussed ongoing within the context of supervision. Submit a summary about what you have learned by the end of April and process with your MHC supervisor.
 - d. Diversity Seminar: Every other month we will process diversity issues in a group format—This will be scheduled as part of two diversity related journal presentations, one intern discussion of the diversity project, and three diversity related case presentations (each intern will present one diversity case, and participate in discussion of the others) during the group supervision meetings.
2. *Case conceptualization and presentation*
 - a. Present two case studies in a didactic presentation, which employs your theoretical orientation including evidence based treatment. Explain your conceptualization of patient's symptoms and diagnosis based on your orientation. You are to include audio or video-taped parts of sessions.
 3. *Maintain a caseload sufficient to ensure a minimum of 500 hours of face-to-face, direct patient service is provided.*
 - a. During the year services must be provided to a minimum of 5 Veterans with serious mental illness.
 - b. Within the first month of internship, students are encouraged to contact their respective licensing board to ascertain if this requirement will fulfill their state licensing requirement.
 4. *12 comprehensive assessments that respond to the referral question and integrate appropriate data to provide diagnostic and/or treatment recommendations.*
 - a. This would include neuropsych, transplant, mental health, PTSD, substance abuse. Specific requirements are listed below.
 5. *Lead or Co-lead at least 2 psychotherapy (either psycho-educational or process-oriented) groups with a minimum of 6 sessions each.*
 6. *Video or audio-tape sessions or be involved in "live" supervision.*
 - a. A sampling of assessment and/or therapy sessions at the beginning of the rotation will be observed by the rotation supervisor either via means of audio/video recording or through live observation. Recording or live observation throughout the duration of the rotation will be left up to the discretion of the rotation supervisor who will base their decision on intern needs, interest, and

- time availability/practical logistics. All formal evaluations will be based on direct observation by the supervisor in addition to other methods of assessment.
- b. Have tape ready for supervision
 - c. Provide information for case conceptualization (see #2)
7. *Attend all intern didactics, including one on consultation and supervision unless on Leave Status*
 8. *Complete Training Log and Patient Log*
 - a. Intern is expected to track clinical and supervision hours. Intern must submit a monthly summary to current supervisors and the Co-Director of Training.
 9. *Attend 1 Grand-Round, either medical or psychiatric, per month, which is to be tracked by the intern and submitted to a Training Director as requested and at the end of the year*
 10. *Be prepared for and attend 4 hours of supervision per week.*
 - a. Intern supervision is regularly scheduled and sufficient relative to the intern's professional responsibility assuring at a minimum that a full-time intern will receive 4 hours of supervision per week, at least 3 hours of which will include individual supervision.
 11. *Participate in Umbrella Supervision of Practicum Students, based on student availability and supervisor involvement in practicum training.*
 12. *Complete a Theory of Change paper.*
 - a. Write a brief paper (2-5 pages) identifying your conceptualization of the Process of Change in Psychotherapy. This will be turned in by the end of May to your MHC supervisor, processed, and then shared in group supervision with your intern class.

Comprehensive Assessment Requirement for Interns

- A. A comprehensive assessment is an assessment that includes: 1) multiple data sources (e.g., thorough chart review, interview with staff/treatment team members, interview with pt's family/friends/etc, interview with pt, mental status, behavioral observations); 2) at least one standardized test/screening instrument/inventory or a specialty interview which tests the patient's psychological or cognitive status in some way (e.g., decisional capacity) and does not merely collect background information/history/symptoms/presenting problem as in a traditional clinical interview; and 3) integrates all this data into one coherent psychological report, which includes sections such as the following (as a general guideline): reason for referral, relevant background information, mental status, interview with patient, interview with collateral sources, test results/interpretation, diagnostic impression, recommendations/plan. (The specific style of the report may vary depending on service area and supervisor.)
- B. Each intern will be required to complete 12 comprehensive assessments over the course of the internship year. Half of these assessments (i.e., 6) must each include a

minimum of 3 standardized instruments/surveys/screens, at least one of which must be an objective personality measure (e.g., MMPI, PAI, MCMI). It is anticipated that all or most of these six assessments will be obtained in the MHC while performing intake evaluations. It is permissible, however, for some or all of these six assessments to be completed on other rotations if the opportunity arises, and the above requirements can be met.

- C. The Assessment Coordinator will provide training, monitor, consult, and at times supervise interns for the purpose of meeting assessment requirements. The intern's primary supervisor is responsible for identifying and supervising appropriate assessment cases unless special arrangements have been made in advance with the Assessment Coordinator.
- D. The other six comprehensive assessments, will be rotation-specific, and need only to meet the general requirements as outlined in Section A. The goal of these assessments is to give the intern "real world" training with regard to how a psychologist working with a specific population in a specific setting will competently assess patients (e.g., substance abuse; PTSD; medically ill inpatients; cognitively impaired, seriously mentally ill, or elderly patients who cannot tolerate lengthy testing). An intern will be required to complete at least one of these assessments for every two months on a rotation (i.e., a 2-month rotation = 1 assessment; a 4-month rotation = 2 assessments; a 6-month rotation = 3 assessments).
- E. Of the 12 comprehensive assessments that will be completed, the following is required:
- All assessments will include a section (narrative, not template) devoted to the patient's mental status and behavioral observations.
 - A minimum of 6 objective personality measures (i.e., MMPI, PAI, MCMI)
 - A minimum of 3 cognitive screens (e.g., Cognistat, RBANS, MOCA, SLUMS, DRS) or neuropsychological instruments
 - A minimum of 3 symptom inventories (e.g., BDI, BAI, STAI, GDS, PCLC, DAES, PHQ9)

(***All neuropsychological testing - this does not include cognitive screens - must be supervised by a staff psychologist with specialty privileges in neuropsychology***)

- F. The intern is responsible: to keep a record of the number and type of assessments completed (on a log sheet that will be provided to them), to have their supervisor initial off on the log, to ensure that they are making steady progress throughout the year, and that they have fulfilled the requirement by the end of the year. The Assessment Coordinator and Co-DoTs will ensure that the interns' progress towards completion of this requirement will be placed on the agenda and reviewed at PTC meetings every two months. A supplemental form will be attached to all mid- and end-rotation evaluations which will address whether the intern is meeting the comprehensive assessment requirement. (Both the intern and rotation supervisor will sign off on this form.)

Evaluation

Evaluations are an integral component of the internship training process and occur throughout the internship year. At the beginning of each rotation there is a general assessment of an intern's professional skills. There is a formal assessment of competencies about half way through a rotation and a formal assessment at the end of each rotation with feedback provided. At the end of each rotation, the intern also completes an evaluation form on the supervisor and rotation. At the end of the internship year each intern completes formal evaluations of the program.

Rotation Format and Assignment

Training plans will be collaboratively developed between the intern and training program. Intern preferences are given the highest level of consideration when assigning rotations. Additionally, feedback from the graduate program, previous clinical experience, and results of the initial competency assessment will be used to inform each individualized training plan. The Co-Director of Training engages in ongoing discussion with each intern to include Match Day, internship orientation, and prior to rotation changes. Our goal is to always have a tentative rotation structure in place prior to the beginning of the internship year that is consistent with the intern's needs and expectations.

There are two major rotation plans from which an intern can choose. Specifically, the intern may choose to have three 4-month rotations (4-4-4). Alternatively, an intern can choose to spend 6-months on two rotations. The second option is often preferred by interns who desire to implement a professional developmental plan that includes particular clinical emphases or specializations. Please note, while this internship program anticipates being able to meet most of these requests, any particular intern's rotation structure is decided upon on a case-by-case basis consistent with training needs.

Each major rotation is three days per week, regardless of whether the intern is completing a 4- or 6-month rotation. For the duration of internship, a fourth day is spent on a minor rotation (often a general mental health rotation such as the Mental Health Clinic), and a fifth day is utilized for training purposes (i.e., didactics, group supervision, Grand Rounds, dissertation, etc.). All interns will be required to complete a minimum of three different rotations during their internship year.

We do recognize that, after arrival and familiarization with the setting, an intern may wish to change a rotation and/or the sequence of rotations. Also, we recognize that professional development plans can, and do, change. Our preference is for such changes to take place early on during the internship year in order to best accommodate both the intern and supervisors.

Weekly Schedule

Monday	Tuesday	Wednesday	Thursday	Friday
8-12 Professional development 1-2 Group supervision 2-4 Didactic	Minor Rotation (min 1hr ind sup)	Major Rotation (min 2 hrs ind sup)		

Rotation Descriptions

Family Services Program

Supervisor: Rahema Rodgers, Psy.D., ABPP (Clinical Psychology)

The Family Services rotation provides the opportunity to engage in family focused evidenced-based practice for the treatment of couples and families. This rotation includes opportunities to provide a variety of services to meet the needs of families of the seriously mentally ill to promote improved management of the mental illness and overall family functioning. It is grounded in the Behavioral Family Therapy (BFT) model (Mueser & Glynn, 1999). Interventions include family crisis management, family consultation (education about mental illness, accessing care, obtaining support, goal setting, safety planning for what to do in a crisis), Support And Family Education (SAFE) programming for loved ones, short- and long-term psycho education based family therapy, inpatient groups, and educational workshops. This rotation also consists of opportunities in working with couples to improve their satisfaction with marital or conjugal-like relationships, as well as treatment of PTSD using a couples' modality. Interventions include Cognitive Behavioral Conjoint Therapy for Posttraumatic Stress Disorder (CBCT for PTSD) developed by Monson & Fredman (2008), and Integrative Behavioral Couples Therapy (IBCT) developed by Jacobson & Christensen (1996). Skills emphasized will be engagement and assessment with the identified patient and family members, providing education to the family about mental illness, improving communication skills in the family, teaching effective problem-solving strategies, treatment of trauma, and improving quality of marital or conjugal-like relationships.

In addition to regular supervision on site, this rotation includes the opportunity to interface with multiple interdisciplinary treatment providers from various programs to facilitate improved treatment planning and patient compliance. Specific intern activities will be determined by intern-supervisor goals, the intern's interests, and prior level of experience, as well as rotation competency requirements. Previous couples or family therapy experience is not required for the rotation. The rotation provides a unique opportunity for the intern to acquire skills in treatment of relationships as well as an appreciation of family systems issues that directly impact the successful management of a mental illness. The acquisition of this knowledge can come from multiple sources including didactics with the rotation supervisor, VHA medical center sponsored seminars, readings, interactions with experienced interdisciplinary team members, and clinical work. In addition to clinical duties, the intern is required to complete assigned readings and attend regularly scheduled supervision meetings.

Geropsychology

Supervisors: Linda DeShetler, Ph.D. and Patricia A. Perry, Psy.D.

The Dayton VA Medical Center Geropsychology Service welcomes interns who have a desire to serve the older Veteran; previous geropsychology and neuropsychology experience is not a prerequisite for this rotation. This service affords the intern an experience in geropsychological services across a continuum of care. Services are provided within a variety of settings: the inpatient rehabilitation unit, skilled nursing home units, at Veterans' homes, and/or at the VA hospice/palliative care unit. These settings potentially allow an intern to follow older adults between different levels of care as their needs change with the aging process.

The rotation provides a unique opportunity for the intern to acquire an appreciation of issues impacting an aging population, such as: dementia, delirium, cognitive changes, spirituality, adjustment/emotional reactions to functional decline, loss, psychiatric conditions, death/dying, and ethical issues. The intern is required to complete assigned readings pertinent to these topics, to be prepared and attend regularly scheduled supervision meetings.

Referrals to geropsychology are based on consultative need, often with a request for an assessment, testing, decisional capacity evaluation, intervention, and/or psychotherapy treatment for the Veteran and/or for the Veteran's family member(s). The intern will work with the geropsychologist to form a conceptualization, diagnostic impression, recommendations, and provide feedback to the Veteran and the interdisciplinary team. Throughout this process, special consideration is given to the Veteran's background, culture, military history, education, family dynamics, values/beliefs, medical and psychiatric diagnoses and comorbidities.

The intern will work with the rotation supervisor(s) to respond to consultation requests and to provide pertinent oral and written feedback in therapy settings (individual, group, family), in treatment team meetings, and in consultation with physicians and allied health providers.

Specific intern activities will be determined by intern-supervisor goals and prior level of experience and interest. Rotation proficiency requirements will be incorporated from APA's "Guidelines for Psychological Practice With Older Adults" and from the Council of Professional Geropsychology Training Programs/Pikes Peak Model.

Mental Health Clinic

Supervisors: Variable

The Mental Health Clinic (MHC) provides opportunities to engage in a variety of traditional psychotherapy as well as evidence based individual and group treatment. Participation is possible in a variety of outpatient groups. The Mental Health Clinic rotation will afford additional opportunities to build competence in personality assessment and treatment planning.

We believe that core competencies in assessment and treatment of a general mental health population may be obtained through the one-day/week experience. It is our goal to offer experiences that will facilitate more advanced competencies and skills mastery, particularly in assessment and evidence based practice, for those choosing MHC for a major rotation.

While there is not a current inpatient psychiatry rotation, the Dayton VA does have a psychiatric inpatient unit and interested interns may have the opportunity to observe and provide acute services.

Neuropsychology

Supervisors: Monica Malcein, Ph.D.

Consultations to the VAMC Neuropsychology service are received from disciplines across the spectrum of patient care providers with an equally diverse range of consult requests. The diverse array of neuropathological conditions and consultation concerns for which individuals are referred is a significant benefit of training in a VA medical center setting. Evaluations are performed using either a comprehensive selection of tests and procedures, or with the use of briefer protocols, depending on the reason(s) for referral and the patient's clinical history.

Our neuropsychological training proceeds, primarily, through a single track. The major training emphasis is completed within a 6-month rotation offered for those who wish to specialize in the field, and are planning to apply for post-doctoral training. There is also a possible 4-month rotation. This option has been offered to interns who are not seeking post-doctoral specialization, but who wish to acquire or increase a basic knowledge of the specialty practice by gaining neuropsychological screening experience. (This 4-month rotation, however, is provided when staffing circumstances allow, and may not be consistently available on a yearly basis).

Interns assigned to the Neuropsychology service will gain experience selecting, administering, scoring, and interpreting a wide variety of neuropsychological measures using a flexible battery approach. The majority of the assessments will be completed with veterans referred to the service on an outpatient basis, although there will be additional opportunities for assessment of veterans on inpatient services (i.e., psychiatry, rehabilitation) and in the primary care setting. Emphasis will be placed on concise report-writing skills. Face-to-face feedback regarding assessment findings and recommendations with veterans and family members is viewed as an important component of the assessment process. Additionally, there are opportunities, depending on the intern's interest, to provide cognitive rehabilitation or short-term neuropsychological intervention with veterans. Finally, the neuropsychological service typically has a year-long practicum position for students in their final year of doctoral training which provides the opportunity for the neuropsychology intern to gain experience in supervision of other trainees.

Throughout the 6-month neuropsychology rotation, book chapters and journal articles are provided on various topics (e.g., norm selection, neuropsychological correlates of CNS disease processes, clinical syndromes, neuroanatomy, neuroimaging, TBI, ethics, and other related topics). Flexible supervision time is readily provided over the course of the rotation. Supervision follows an apprenticeship model where the intern is expected to progress from close regular supervision to supervision that is more consultative in nature. Explicit rotation competency requirements are provided at the outset of the rotation.

Supplementary learning experiences in the 6-month rotation may be obtained through interactions with Neurology Clinic staff, section meetings and through attending the Mental Health Service's lecture series. There are weekly didactic presentations available to all interns from a variety of clinical disciplines on various clinical topics throughout the internship year.

Posttraumatic Stress Disorder Clinical Team

Supervisors: Deborah L. Downey, Psy.D., Joshua Gootzeit, Ph.D., Justine Ray, Ph.D., and Kristin Rodzinka, Ph.D., ABPP (Clinical Psychology).

The Dayton Post-Traumatic Stress Disorder Clinical Team (PCT) offers both outpatient and residential treatment for PTSD related to military trauma. The mission of the program is to empower Veterans by providing evidence-based, trauma-focused treatments for PTSD to

promote recovery from the harmful impact of trauma. This program offers evidence-based treatments as the first-line treatment for PTSD. The goal of the program is to assist Veterans with PTSD in achieving the fullest possible degree of psychosocial functioning and quality of life of which they are capable, provided in the least restrictive setting. Evidence-based treatments are those treatments that have been well-researched and shown to be effective for treating PTSD. These are time-limited treatments, which are highly structured and involve completing work outside of the session.

The primary treatment modalities offered are Cognitive Processing Therapy (CPT) and Prolonged Exposure (PE). Additional interventions which may also be offered include:

- 1) Adaptive Disclosure Treatment
- 2) Narrative Exposure Therapy
- 3) Written Exposure Therapy
- 4) Anger Management for PTSD
- 5) Skills Training in Affective and Interpersonal Regulation (STAIR): focuses on learning how to manage emotions and improve interpersonal functioning
- 6) Dual diagnosis treatment (for veterans with PTSD and substance abuse problems: focuses on both PTSD and substance abuse issues)
- 7) Cognitive Behavioral Therapy for Insomnia: focuses on treating sleep problems
- 8) Nightmare Therapy: focuses on reducing trauma-related nightmares
- 9) Cognitive-Behavioral Conjoint Therapy for PTSD: couples therapy that focuses on PTSD
- 10) Complimentary and integrative health (CIH) services (e.g., mindfulness, yoga) consistent with a Whole Health model of care

The Residential Treatment team provides services to Veterans with more severe symptoms who reside in the Mental Health Residential Rehabilitation Treatment Program (MHR RTP). The program has the capacity for up to 15 Veterans, enrolling in an 7-week program that offers individual therapy, group therapy, recreation therapy, chaplain services, psychoeducational groups, and medication management. The residential program accommodates Veterans dually diagnosed with substance use and personality disorders.

Primary Care Mental Health Integration

Supervisors: Andrea M. Bischoff, Psy.D., Lyndsey Miller, Psy. D., Kelly Obert, Psy.D., and Ramon Verdaguer, Ph.D., ABPP (Clinical Health Psychology)

The rotation in Primary Care Mental Health Integration (PCMHI) emphasizes the provision of psychological services in the medical primary care clinics 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 intern will become involved with the primary care team that consists of physicians, nurses, a psychologist, a psychiatrist, physician assistants, dieticians, a social worker, a pharmacist, and administrative associates.

Psychologists assigned to PCMHI provide a range of other services. Such services include programs for chronic pain management, weight management, smoking cessation, and patient adherence issues. Consultation services are provided to specialty clinics and inpatient wards: cardiology, infectious disease, neurology, oncology, surgery, and rehabilitation. An additional

important role in health psychology is responsibility for conducting evaluations of patients who are candidates for an organ transplant, bariatric surgery, and spinal cord stimulators.

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 an intern's specific professional interests and needs. One of the explicit competencies in all rotations is the provision of consistent messages to patients. An intern can anticipate an exploration of their personal behavior patterns (e.g., use of nicotine products) relative to behavior patterns that maximize good health and quality of life.

Additional opportunities may be available in Consultation and Liaison to include specialty medical pre-evaluations and medical inpatient consultation.

Psychosocial Rehabilitation

Supervisors: Justin Bunn, Psy.D. and Yolanda T. Garmon, Psy.D.

Psychosocial Rehabilitation (PSR) at the Dayton VA has rapidly expanded within the past several years and provides a continuum of care for Veterans with serious mental illness.

The Psychosocial Rehabilitation and Recovery Center (PRRC), also known as the "Building Bridges" Program, is an outpatient recovery center that provides daily-recovery focused services to Veterans who are diagnosed with serious mental illness and experience severe functional impairments in one or more areas.

The mission of the "Building Bridges" Program is to provide Veterans with services that will help them to take back their lives and take part in their communities. "Building Bridges" staff members fulfill this mission by providing Veterans with hope, focusing on their strengths, and teaching life skills that will help them reach their self-chosen goals.

Interns on this rotation will have the opportunity to learn how to deliver recovery-oriented services to a population with serious mental illness. Interns will learn the basics of psychiatric rehabilitation that focus on helping Veterans achieve self-identified goals for recovery, better psychosocial functioning, and greater integration into the communities of their choosing. Interns will have opportunities to conduct bio psychosocial assessments that focus on helping Veterans identify recovery goals; to provide individual recovery coaching sessions to help Veterans problem-solve towards goal achievement; and to facilitate psycho educational and skills-based groups, such as Social Skills Training, Illness Management & Recovery, and Wellness Recovery Action Planning.

Interns involved in the Psychosocial Rehabilitation rotation may also choose to participate in a Family Services supplementary experience.

Substance Abuse Treatment Program

Supervisors: David Baum, Psy. D., and Karen Lenhoff, Ph.D.

The SUD Programs (residential and outpatient) consist of interdisciplinary teams including psychologists, social workers, psychiatrists, and addiction therapists. The psychology intern will function as a member of the team, providing individual therapy, group therapy, and assessments. Measurement-based care is utilized in the programs. Interested interns may have the opportunity to assist in program evaluation.

Substance Use Disorder treatment at the Dayton VA has expanded significantly over the past few years. Programming includes Medication Assisted Treatment (MAT), outpatient SUD treatment, residential SUD treatment, Dual Diagnosis treatment, and Aftercare.

Interns on this rotation will have the opportunity to learn how to deliver recovery-oriented services to a population with substance use disorders in addition to a wide range of co-occurring mental health and medical issues. Interns will be expected to utilize evidence-based treatments for substance use disorders, including the basics of motivational interviewing, use of a stages of change model, and cognitive behavioral therapy (CBT for SUD). Interns will have the opportunity to co-facilitate and facilitate SUD recovery groups in addition to individual psychotherapy work.

Additional Training Experiences and Support

Training Seminars

There is an ongoing didactic series throughout the internship year. The meeting time is each Monday, 2:00pm – 4:00pm. The topics and presenters are quite varied. Intern attendance is mandatory. We also participate in a collaboration with Wright State University's School of Professional Psychology, Wright Patterson Air Force Base, and the University of Dayton's internship programs. Several times each year we coordinate shared didactics taking advantage of the strengths and unique aspects of each program and provide opportunities to spend time with interns from other local programs.

Group Supervision

Each Monday, 1:00pm – 2:00pm, is group supervision. The general approach is to augment supervision taking place in other settings and to provide a venue in which interns can support their mutual professional development. Both interns and training supervisors present cases for consultation providing a venue to discuss, in greater depth, diverse and complex cases. Interns are expected to participate as consultants to the presenter to help develop case conceptualization and supervisory skills. Specific subjects are quite varied: case presentations, diversity discussions, evidence based psychotherapy discussions, concepts/theories, etc. Interns are encouraged to identify goals and to practice competency based supervision skills during this time. Intern attendance is mandatory.

Testing Materials

Medical records are fully computerized including access to a wide variety of personality inventories, self-rating forms, etc. We also maintain and regularly update an extensive selection of noncomputerized psychological tests and neuropsychological instruments. (See also the Assessment Requirements listed above.)

Library

The Health Sciences Library provides access to professional books and professional journals. Immediate access to a wide variety of online electronic resources is available.

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 is quite helpful with teaching and the development of presentations.

Liability Protection for Trainees

When providing professional services at a VA healthcare facility, VA sponsored trainees acting within the scope of their educational programs are protected from personal liability under the Federal Employees Liability Reform and Tort Compensation Act 28, U.S.C.2679 (b)-(d).

Professional Development

An intern will be given up to 24 total hours of authorized absence during the training year. This time can be used to attend professional presentations, conferences, workshops, and organizational meetings that are consistent with professional development plans. This time can also be applied in support of dissertation related activities such as trips to the university, oral defense, etc. In addition, interns are provided with a four hour block of time each week for the purpose of dissertation work or other approved scholarly work. Finally, each intern is encouraged to make use of the many educational presentations within the medical center and the surrounding academic community.

Physical Setting and Support

Primary intern offices are located in Building 302 where the majority of outpatient Mental Health services are offered. Each intern has an individual office equipped for a clinical staff member (to include computer, telephone, therapy space). Many psychologists are co-located to include the Co-Director of Training. A conference room and several group rooms are available as well. Rotations located away from the outpatient Mental Health Building have additional office space, including computer access, for any intern to enable seeing patients and completing paperwork in that work area.

Medical records are electronic and almost all of the professional activities are accomplished through use of various computer programs. The first two weeks of the academic year are devoted almost entirely to orientation and training. Within a few days of arriving, each intern has full computer access and is able to engage in the full range of psychological services.

Application

Appointment and Benefits

Each intern receives a temporary appointment per Department of Veterans Affairs regulations. The type of appointment allows us to provide the same benefits offered to any regular employee including health insurance.¹

The internship year will begin on **Monday, July 22, 2019**. The total number of hours is 2,080 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 at the completion of internship. Sick leave can be accrued and maintained “on the books” indefinitely and may be used if one becomes a federal employee at some time in the future. For the purpose of state licensure, our procedure is to verify a 2,080 hour internship. The pay is \$26,787 for the year to be paid in equal installments over 26 biweekly pay periods.

Prior to the actual appointment, a matched applicant must complete the appropriate paperwork and complete a physical examination that certifies they are capable of the duties required. As a federal employee, drug screens and background checks are routine (see a complete list of eligibility requirements below). It is possible to coordinate with Human Resources to arrange for these appointments at your nearest VA. 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 informs us that they have a disability.

Additional information about VA training may be reviewed at:
<https://www.psychologytraining.va.gov/index.asp>

Admission Requirements

The official appointment as a Psychology Intern is contingent upon successful completion of practica and academic requirements (other than dissertation) along with continued professional conduct consistent with quality practice of psychology. In addition to psychotherapy experience, all applicants are expected to have psychological assessment and testing experience including the administration and interpretation of Objective Personality Assessments and standard IQ measures.

National VA Eligibility Requirements

www.psychologytraining.va.gov/eligibility.asp

¹ Note: On June 26, 2013, the Supreme Court ruled that Section 3 of the Defense of Marriage Act (DOMA) is unconstitutional. As a result of this decision, the Office of Personnel Management (OPM) has now extended benefits to employees and annuitants who have legally married a spouse of the same sex.

The Department of Veterans Affairs (VA) adheres to all Equal Employment Opportunity and Affirmative Action policies. As a Veterans Health Administration (VHA) Health Professions Trainee (HPT), you will receive a Federal appointment, and the following requirements will apply prior to that appointment

1. **U.S. Citizenship.** HPTs who receive a direct stipend (pay) must be U.S. citizens. Trainees who are not VA paid (without compensation-WOC) who are not U.S. citizens may be appointed and must provide current immigrant, non-immigrant or exchange visitor documents.
2. **U.S. Social Security Number.** All VA appointees must have a U.S. social security number (SSN) prior to beginning the pre-employment, on-boarding process at the VA.
3. **Selective Service Registration.** Male applicants born after 12/31/1959 must have registered for the Selective Service by age 26 to be eligible for U.S. government employment, including selection as a paid or WOC VA trainee. For additional information about the Selective Service System, and to register or to check your registration status visit <https://www.sss.gov/>. Anyone who was required to register but did not register before the age of 26 will need to apply for a Status Information Letter (SIL) and request a waiver. Waivers are rare and requests will be reviewed on a case by case basis by the VA Office of Human Resources Management. This process can take up to six months for a verdict.
4. **Fingerprint Screening and Background Investigation.** All HPTs will be fingerprinted and undergo screenings and background investigations. Additional details about the required background checks can be found at the following website: <http://www.archives.gov/federal-register/codification/executive-order/10450.html>.
5. **Drug Testing.** Per Executive Order 12564, the VA strives to be a Drug-Free Workplace. HPTs are not drug-tested prior to appointment, however are subject to random drug testing throughout the entire VA appointment period. You will be asked to sign an acknowledgement form stating you are aware of this practice. See item 8 below.
6. **Affiliation Agreement.** To ensure shared responsibility between an academic program and the VA there must be a current and fully executed Academic Affiliation Agreement on file with the VHA Office of Academic Affiliations (OAA). The affiliation agreement delineates the duties of VA and the affiliated institution. Most APA-accredited doctoral programs have an agreement on file. More information about this document can be found at <https://www.va.gov/oa/agreements.asp> (see section on psychology internships). Post-degree programs typically will not have an affiliation agreement, as the HPT is no longer enrolled in an academic program and the program is VA sponsored.

7. **TQCVL.** To streamline on-boarding of HPTs, VHA Office of Academic Affiliations requires completion of a Trainee Qualifications and Credentials Verification Letter (TQCVL). An Educational Official at the Affiliate must complete and sign this letter. For post-graduate programs where an affiliate is not the program sponsor, this process must be completed by the VA Training Director. Your VA appointment cannot happen until the TQCVL is submitted and signed by senior leadership from the VA facility. For more information about this document, please visit <https://www.va.gov/OAA/TQCVL.asp>
 - a. **Health Requirements.** Among other things, the TQCVL confirms that you, the trainee, are fit to perform the essential functions (physical and mental) of the training program and immunized following current Center for Disease Control (CDC) guidelines and VHA policy. This protects you, other employees and patients while working in a healthcare facility. Required are annual tuberculosis screening, Hepatitis B vaccine as well as annual influenza vaccine. *Declinations are EXTREMELY rare.* If you decline the flu vaccine you will be required to wear a mask while in patient care areas of the VA.
 - b. **Primary source verification of all prior education and training** is certified via the TQCVL. Training and Program Directors will be contacting the appropriate institutions to ensure you have the appropriate qualifications and credentials as required by the admission criteria of the training program in which you are enrolled.
8. **Additional On-boarding Forms.** Additional pre-employment forms include the Application for Health Professions Trainees (VA 10-2850D) and the Declaration for Federal Employment (OF 306). These documents and others are available online for review at <https://www.va.gov/oaa/app-forms.asp>. Falsifying any answer on these required Federal documents will result in the inability to appoint or immediate dismissal from the training program.
9. **Proof of Identity per VA.** VA on-boarding requires presentation of two source documents (IDs). Documents must be unexpired and names on both documents must match. For more information visit: <https://www.oit.va.gov/programs/piv/media/docs/IDMatrix.pdf>

Additional information regarding eligibility requirements

- Trainees receive term employee appointments and must meet eligibility requirements for appointment as outlined in VA Handbook 5005 Staffing, Part II, Section B. Appointment Requirements and Determinations. https://www.va.gov/vapubs/viewPublication.asp?Pub_ID=646&FTYPE=2
- Selective Service website where the requirements, benefits and penalties of registering vs. not registering are outlined: <https://www.sss.gov/Registration/Why-Register/Benefits-and-Penalties>

Additional information specific suitability information from Title 5 (referenced in VHA Handbook 5005):

(b) *Specific factors.* In determining whether a person is suitable for Federal employment, only the following factors will be considered a basis for finding a person unsuitable and taking a suitability action:

- (1)** Misconduct or negligence in employment;
- (2)** Criminal or dishonest conduct;
- (3)** Material, intentional false statement, or deception or fraud in examination or appointment;
- (4)** Refusal to furnish testimony as required by § 5.4 of this chapter;
- (5)** Alcohol abuse, without evidence of substantial rehabilitation, of a nature and duration that suggests that the applicant or appointee would be prevented from performing the duties of the position in question, or would constitute a direct threat to the property or safety of the applicant or appointee or others;
- (6)** Illegal use of narcotics, drugs, or other controlled substances without evidence of substantial rehabilitation;
- (7)** Knowing and willful engagement in acts or activities designed to overthrow the U.S. Government by force; and
- (8)** Any statutory or regulatory bar which prevents the lawful employment of the person involved in the position in question.

(c) *Additional considerations.* OPM and agencies must consider any of the following additional considerations to the extent OPM or the relevant agency, in its sole discretion, deems any of them pertinent to the individual case:

- (1)** The nature of the position for which the person is applying or in which the person is employed;
- (2)** The nature and seriousness of the conduct;
- (3)** The circumstances surrounding the conduct;
- (4)** The recency of the conduct;
- (5)** The age of the person involved at the time of the conduct;
- (6)** Contributing societal conditions; and
- (7)** The absence or presence of rehabilitation or efforts toward rehabilitation.

Application Procedures

Our primary source of information is the AAPI. We additionally require all applicants to include an Interview Dates and Rotation Preference paragraph in the cover letter to facilitate our interview process. This additional information is included at the end of this brochure and can be cut and pasted into your cover letter. Applicants who wish to be ranked for the Neuropsych track must also include a sanitized copy of a Neuropsych testing report. We adhere to the Association of Psychology Postdoctoral and Internship Centers (APPIC) guidelines for the recruitment and selection of psychology interns 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.

To apply you must complete:

- APPIC Uniform Application (AAPI), available at www.appic.org.
- Interview Dates and Rotation Preferences paragraph (unique to our site). This should be included in your cover letter.
- All applicants interested in the Neuropsych track must also upload a sanitized copy of a Neuropsych testing report. (General track applicants require no supplemental documents.)
- The deadline for receipt of application materials is **Thursday, November 1, 2018**. Please follow APPIC instructions and guidelines for completing and submitting the AAPI.

Our procedure is to review each qualified application in detail and invite 25-28 applicants for interviews. The customary agenda is for the applicants to meet with the Lead Psychologist and Directors of Training as a group. Each applicant then meets with three different supervisors who, as much as possible, are chosen based upon rotation preferences. Applicants meet with current interns as a group in a non-evaluative information sharing meeting. Finally, there is a general meeting among all applicants, supervisors, and current interns. We encourage applicants to become familiar with our staff and setting to assist in their decision making process. We try to schedule no more than seven applicants per interview day. Our practice is to rank those applicants who attend interviews for the purpose of the match. Only in rare circumstances would an applicant who is interviewed not also be ranked. Applicants who are invited for interviews but do not attend will not be ranked for the match.

If you are unable to be present for your scheduled interview date, we may be able to accommodate some adjustments in scheduling (although this is not guaranteed). We do not provide phone interviews.

Scheduled interview dates are:

- Tuesday, January 8, 2019; 12:00pm – 4:15pm
- Thursday, January 10, 2019; 12:00pm – 4:15pm
- Tuesday, January 15, 2019; 8:00am – 12:15pm
- Wednesday, January 16, 2019; 8:00am – 12:15pm

Match Day

The official dates for the 2019 – 2020 academic year is posted by APPIC at:
<http://www.appic.org/Match/About-The-APPIC-Match/APPIC-Match-Dates>

Phase I:

- February 6, 2019: Deadline for submission of Rank Order Lists.
- February 22, 2019: APPIC Phase I Match Day.

Immediately after learning the names of applicants with whom we have been matched, a Co-Director of Training will make contact through email and/or telephone. They will also be mailed two signed copies of a letter confirming the match. Each applicant is to return one signed copy of the letter confirming their agreement with the internship placement.

Interview Dates and Rotation Preferences

***This information MUST be included in your cover letter.**

The following worksheet is to help you organize the information we will need included in your application cover letter. Please rank all four interview dates and a minimum of three rotations. Our interns participate in three or four rotations during their internship year (including the MHC).

Interview Dates

Please **rank** in order your preferences for interview dates. We will contact you to arrange an interview.

	Morning	Afternoon
Tuesday, January 8, 2019		_____
Thursday, January 10, 2019		_____
Tuesday, January 15, 2019	_____	
Wednesday, January 16, 2019	_____	

Rotation Preferences

Please rank order your three rotation preferences to include both major and minor rotations of interest. Please note if you prefer two six month rotations (if available).

Family Services Program	_____
Geropsychology	_____
Mental Health Clinic	_____
Neuropsychology	_____
Primary Care Mental Health Integration	_____
PTSD Outpatient/Residential Program	_____
Psychosocial Rehabilitation	_____
Substance Abuse Treatment Program	_____

Sample paragraphs*:

My preference for interview dates are as follows: 1) Tuesday, 1/8, 2) Tuesday, 1/15, 3) Thursday, 1/10, 4) Wednesday, 1/16. To best meet my training goals my rotation preferences are 1) Neuropsychology (6 month), 2) Health Psychology, 3) Geropsychology.

My preference for interview dates are as follows: 1) Wednesday, 1/16, 2) Tuesday, 1/15, 3) Thursday, 1/10, 4) Tuesday, 1/8. To best meet my training goals my rotation preferences are 1) Substance Abuse, 2) PTSD, 3) Mental Health Clinic.

Directions to the Dayton VA Medical Center

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 I-75 / US 35 interchange. Take US 35 west to Liscum Drive (second traffic light). The medical center is on the right. Building 302 (Outpatient Mental Health) is on the south side of the campus with parking in the rear of the building. If you need further directions, lodging information, or have other questions, please feel free to contact us by telephone or email. Also, a map can be obtained on the Dayton VHA Medical Center Web Site at https://www.dayton.va.gov/visitors/campus.asp#campus_map.

Note: It is our experience that electronic devices have not been reliable with providing good driving directions on the VA campus. We encourage you to look at a map as the campus is large and it can be easy to get misdirected if you come in by the National Cemetery.

Psychology Training Committee

Baum, David

Psy.D. Clinical, 20016, Xavier University
Staff Psychologist, SUDS, DBT
At Dayton VA Medical Center since 2017
Licensed Psychologist, State of Ohio
Licensed Independent Chemical Dependency Counselor, State of Ohio
Professional Organizations: OPA, APA
Research Interests: Substance Use Disorders, Trauma-Related Disorders
Professional Interests: DBT, Program Development, SUD and Trauma-Related Disorders
Theoretical Orientation: Behavioral, Cognitive-Behavioral

Bischoff, Andrea

Psy.D. Clinical Psychology, 2008, Wright State University School of Professional Psychology
Co-Director of Training
Team Lead, Primary Care – Mental Health Integration
At Dayton VA Medical Center since 2012
Licensed Psychologist, State of Ohio
Professional Organizations: Ohio Psychological Association, Dayton Area Psychological Association
Clinical Interests: Health Psychology, Integrated healthcare, positive psychology, women's issues
Theoretical Orientation: Cognitive-Behavioral, Integrative

Bunn, Justin

Psy.D., Clinical Psychology, 2009, University of Indianapolis
Staff Psychologist, Building Bridges PRRC
At Dayton VA Medical Center since 2009
Licensed Psychologist, State of Ohio
Professional Organizations: Association of Veterans Affairs Psychology Leaders (AVAPL), Dayton Area Psychological Association (DAPA), APA Division 36 (Religion and Psychology)
Research Interests: Religion/Spirituality and Psychotherapy
Clinical Interests: Evidence-based practice with SMI populations, recovery-focused interventions, connecting Veterans back to their communities
Theoretical Orientation: Cognitive-Behavioral, Interpersonal, Integrative

Chaffins, Belinda

Psy.D., Clinical Psychology, 2003, Wright State University School of Professional Psychology
Clinical Psychologist in Mental Health
At Dayton VA Medical Center since 2010
Licensed Psychologist, State of Ohio
Clinical Interests: Sexual Health, Couples, Health and Wellness, Alzheimer's
Theoretical Orientation: Cognitive-Behavioral and Humanistic

De Marchis, Massimo

Psy.D. Clinical Psychology, 1987, Wright State University School of Professional Psychology
Local Evidence Based Practice Coordinator
At Dayton VA since November 2009
Licensed Psychologist, State of Ohio
Licensed Independent Chemical Dependency Counselor (LICDC)
APA Certificate of Proficiency in the treatment of Substance Use Disorders
Fellow, American Board of Sleep Medicine
Clinical Interests: General mental health, forensic psychology, addictions, sleep disorders
Theoretical orientation: Cognitive-Behavioral and ACT

DeShetler, Linda

Ph.D. Clinical, 2005, Fielding Graduate University
Clinical Psychologist/Geropsychologist, serve in the Department of Physical Medicine and Rehabilitation and in the Community Living Center
At Dayton VA 2007-2012 and 2013-present
Licensed Psychologist, State of Ohio
Professional Organizations: Dayton Area Psychological Association, Ohio Psychological Association (OPA), Dayton Area Psychological Association (DAPA).
Clinical Interests: Health Psychology, Primary Care Integration, Geropsychology, Disability, Terminal illness/End of life, Grief/Loss/Faith, and Resilience.
Research Interests: Neurobehavioral Disorders, Delirium, Decisional Capacity, Psychoneuroimmunology,
Theoretical Orientations: Cognitive Behavioral and Biopsychosocial

Diehl, Jane A.

Ph.D., Clinical, 1984, University of Toledo
Staff Psychologist, Substance Abuse Treatment Program
At Dayton VA Medical Center since July 2009
Licensed Psychologist, State of Ohio
Professional Organizations: Dayton Area Psychological Association, Ohio Psychological Association, American Psychological Association, APA divisions 18, 39, and 42, founding member Caring Connections (association of Dayton women private practice psychologists), International Society for the Psychological Treatment of the Schizophrenias and Other Psychoses
Clinical and Research Interests: Psychotherapy of schizophrenia and related disorders; other psychoses; dissociative disorders; borderline and other personality disorders; trauma, PTSD; adult children of physical, sexual, and emotional abuse and addictions
Theoretical Orientations: Psychodynamic, Interpersonal, Cognitive, Eclectic

Downey, Deborah L.

Psy.D., Clinical, 2002, Wright State University
Staff Psychologist, Post Traumatic Stress Disorder Program, Residential
At Dayton VA Medical Center since 2009
Licensed Psychologist, State of Ohio
Professional Organizations: APA, OPA, ABCT
Clinical Interests: PTSD; couples and families; values and identity formation
Theoretical Orientation: Eclectic with a foundation in CBT

Drake, David

Ph.D., Clinical, 1992, University of North Texas
Staff Psychologist, Mental Health Clinic
At Dayton VA Medical Center since 2010
Licensed Psychologist, State of Ohio and Kentucky
Professional Organizations: APA
Clinical Interests: Treatment of depression and anxiety disorders
Theoretical orientation: Psychodynamic

Farr, Kenneth L.

Ph.D., Clinical Psychology
Staff Psychologist, Mental Health Clinic
At Dayton VA Medical Center since 2016
Clinical Interests: PTSD
Theoretical Orientation: Cognitive-behavioral, Psychodynamic

Feiner, Adam J.

Staff Psychologist, Mental Health Residential Rehabilitation Treatment Program
At Dayton VA Medical Center since 2016

Garmon, Yolanda T.

Psy.D., Clinical, 2003, Wright State University
Staff Psychologist, Psychosocial Rehabilitation and Recovery Center
At Dayton VA Medical Center since 2009
Licensed Psychologist, State of Ohio
Clinical Interests: serious mental illness; women's issues; domestic violence issues; substance abuse; family/couple therapy; group therapy; geriatric issues
Theoretical Orientation: cognitive-behavioral

Gootzeit, Joshua

Ph.D. Clinical Psychology, 2014, University of Iowa
Staff Psychologist, Posttraumatic Stress Disorder Program
At Dayton VA Medical Center since 2015
Licensed Psychologist, State of Ohio
Clinical Interests: Assessment and treatment of PTSD, EBPs for PTSD, behaviorism, acceptance-based treatments
Theoretical Orientation: Cognitive-Behavioral

Jackson, Monica

Ph.D., Clinical, 1993, University of Cincinnati
Staff Psychologist, Chief Mental Health Residential Rehabilitation Treatment Program
At Dayton VA Medical Center since 2009
Professional Organizations: Ohio Psychological Association
Licensed Psychologist, State of Ohio
Clinical Interests: Chronic mental illness, substance dependence, women's issues, cultural issues, trauma, sexual health
Theoretical Orientation: Cognitive-Behavioral, Psychodynamic

Johnson, Jeremy T.

Ph.D. Clinical Psychology, 2012, Sam Houston State University
Clinical Psychologist, Consultation and Liaison
At Dayton VA Medical Center since 2014
Licensed Psychologist, State of Alabama
Clinical Interests: Differential diagnosis, cognitive assessment, neurocognitive disorders, forensic psychology, risk management
Theoretical Orientation: Cognitive-Behavioral, Interpersonal

Lenhoff, Karen

Ph.D. Counseling Psychology
Lead Psychologist
At Dayton VA Medical Center since 2014
Clinical Interests: psychological trauma, PTSD, health psychology, substance abuse, Evidence-Based Psychotherapy Coordinator, program development and evaluation, measurement-based care.

Malcein, Monica

Ph.D Clinical Psychology/Neuropsychology Specialty, 2000, University of Kentucky
Postdoctoral Fellowship, 2000-2002, Duke University Medical Center
Clinical Neuropsychologist, Mental Health Service
At Dayton VA Medical Center since 2014
Licensed Psychologist, State of Colorado
Professional Organizations: National Academy of Neuropsychology, APA Division 40

Clinical Interests: Neuropsychology, Aging/Dementia, TBI
Theoretical Orientation: Cognitive-Behavioral

Miller, Lyndsey

Psy.D. Clinical Psychology, 2010, Wright State University School of Professional Psychology
MSCP Clinical Psychopharmacology, 2015, University of Hawaii, Hilo
Staff Psychologist, Primary Care-Mental Health Integration
At Dayton VA Medical Center since 2016
Licensed Psychologist, State of New Mexico
Clinical Interests: Integrated Care, Health Psychology, brief evidence-based interventions, differential diagnosis, psychological evaluations, psychopharmacology, research, forensic psychology
Theoretical Orientation: Cognitive-Behavioral, Interpersonal, Integrative

Obert, Kelly

Psy.D. Clinical, 2017, Wright State University School of Professional Psychology
Staff Psychologist- Primary Care Mental Health Integration and Women's Health Clinic
At Dayton VA Medical Center since 2017
Licensed Psychologist, State of Ohio
Professional Organizations: OPA, DAPA, Division 38
Clinical Interests: Behavioral Medicine
Research Interests: Health Psychology, Program Evaluation
Theoretical Orientation: Cognitive-Behavioral

Perry, Patricia A.

Psy. D. Clinical, 1996, Wright State University, Dayton, Ohio.
Staff Psychologist, Community Living Center
At Dayton VA Medical Center since 2008
Licensed Psychologist, State of Ohio (Indiana – inactive)
Professional Organizations: APA
Clinical Interests: Psychodiagnosis, psychopharmacology, resident adjustment to long term care and family caregiver stress, sexual abuse survivor treatment, termination issues in therapy, the development of the therapist over time, managing compassion fatigue, and interdisciplinary collaboration
Research Interests: Evaluating the effective use of supervision, determining competence / proficiency in interviewing, and meeting the needs of an aging population in long-term care settings
Theoretical Orientation: Interpersonal or dynamic case conceptualization with eclectic and integrative interventions

Rankins, J. LeBron

Ph.D. Clinical Psychology, Kent State University
Clinical Psychologist with Home Based Primary Care
At Dayton VA Medical Center since 2013
Licensed Psychologist, State of New York
Clinical Interests: Suicide prevention, men's issues, depression and anxiety
Theoretical Orientation: Cognitive-Behavioral and Client Centered

Ray, Justine

Ph.D., Clinical Psychology, 2016, Bowling Green State University
Staff Psychologist, PTSD Program, LGBT Veteran Care Coordinator
At Dayton VA Medical Center since 2014
Clinical Interests: Evidence-based trauma treatment, mindfulness- and acceptance-based interventions, clinical needs of Transgender Veterans
Research Interests: LGBT Veterans, resiliency in LGBT individuals, trauma-related nightmares, the intersectionality of identity variables and its impact on psychosocial well-being
Theoretical Orientation: Cognitive-Behavioral, Interpersonal, Client Centered

Rodgers, Rahema

Psy.D. Clinical Psychology, 2006, Wright State University School of Professional Psychology
ABPP 2013, Clinical Psychology
Clinical Psychologist with Family Services Program
At Dayton VA Medical Center since 2010
Licensed Psychologist State of Ohio
Professional Organizations: Dayton Area Psychological Association, Association of Veteran Affairs
Psychology Leaders, Ohio Psychological Association
Research Interests: Multicultural & Family Issues
Clinical Interests: Marriage and Family, Assessment
Theoretical Orientation: Cognitive-Behavioral

Rodzinka, Kristin J.P.

Ph.D. Clinical, 2005, University of Arkansas
ABPP 2013, Clinical Psychology
Co-Director of Training, PTSD Programs Manager
At Dayton VA Medical Center since 2007
Licensed Psychologist, State of Ohio (Indiana – inactive)
Professional Organizations: DAPA, AVAPL, VAPTC
Research Interests: Sexual Trauma; PTSD; Psychology Training; Competency Based Supervision
Clinical Interests: evidence-based treatment for anxiety, depression, personality disorders, and serious mental illness; group psychotherapy; supervision
Theoretical Orientation: Mindfulness Based Cognitive-Behavioral

Schwendener-Holt, Mary J.

PhD. Counseling Psyc, 1995, Southern Illinois University – Carbondale
Staff Psychologist, Home Based Primary Care
At Dayton VA Medical Center since 2012
Licensed Psychologist, State of Indiana
Licensed Clinical Addictions Counselor, State of Indiana
Professional Organizations: Indiana Psychological Association (IPA)
Clinical Interests: general psychotherapy, women's issues, trauma, addictions, dual diagnosis, personality disorders, adult children of dysfunctional families, mindfulness
Theoretical Orientations: Mindfulness/Acceptance based tx, interpersonal, psychodynamic, cognitive behavioral, and systems.

Toliver, Janine

Verdaguer, Ramon

Ph.D. Clinical, 1990, Loyola University of Chicago
ABPP 2004, Clinical Health Psychology
Acting Lead Psychologist/Health Behavior Coordinator
At Dayton VA Medical Center since 1996
Licensed Psychologist, State of Ohio and Illinois (inactive)
Professional Organizations: Div. 38, APA.
Research Interests: Positive psychology
Clinical Interests: Wellness and health promotion, pre-surgical psychological evaluations
Theoretical Orientation: Cognitive-Behavioral

APPENDIX A

Internship Admissions, Support, and Initial Placement Data

Internship Program Tables

Date Program Tables are updated: August 2018

Internship Program Admissions:

Briefly describe in narrative form important information to assist potential applicants in assessing their likely fit with your program. This description must be consistent with the program's policies on intern selection and practicum and academic preparation requirements:

Applicants must meet the following prerequisites to be considered for our program:

1. Doctoral student in an accredited clinical or counseling psychology program
2. Approval for internship status by graduate program training director
3. U.S. citizenship
4. Male applicants born after 12/31/1959 must have registered for the draft by age 26
5. Matched interns are subject to fingerprinting, background checks, and urine drug screens. Match result and selection decisions are contingent on passing these screens. (For complete information about eligibility for VA appointment see Eligibility section above on page 26.)

Dayton VA Selection Process

Applicants must have completed all required graduate coursework and have successfully completed appropriate practica. Applicants will be selected based on the quality of their essays, relevant intervention and assessment experience, and letters of recommendation. Applicants who have experience working with complex adult patient populations and advanced assessment skills will receive higher ratings. Although this program reviews applications holistically and has chosen not to identify firm minimum numbers of hours, we look for evidence of adequate direct patient contact such that our interns will be prepared for the nature of VA work. Applicants without adult intervention experience or basic assessment skills to include the WAIS-IV and objective personality assessment will not be considered for interview and ranking.

Top rated applicants will be invited for interviews taking place in January 2019.

Does the program require that applicants have received a minimum number of hours of the following at time of application? If Yes, indicate how many:

Total Direct Contact Intervention Hours	X	No	Yes	(400+ preferred)
Total Direct Contact Assessment Hours	X	No	Yes	(100+ preferred)

Describe any other required minimum criteria used to screen applicants: Must have experience administering and scoring the WAIS-IV and objective personality measures.

Financial and Other Benefit Support for Upcoming Training Year*

Annual Stipend/Salary for Full-time Interns	\$26,787	
Annual Stipend/Salary for Half-time Interns	NA	
Program provides access to medical insurance for intern?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
If access to medical insurance is provided:		
Trainee contribution to cost required?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Coverage of family member(s) available?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Coverage of legally married partner available?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Coverage of domestic partner available?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Hours of Annual Paid Personal Time Off (PTO and/or Vacation)	4hrs accrued/2 week pay period (104 hours)	
Hours of Annual Paid Sick Leave	4hrs accrued/2 week pay period (104 hours)	
In the event of medical conditions and/or family needs that require extended leave, does the program allow reasonable unpaid leave to interns/residents in excess of personal time off and sick leave?	<input checked="" type="checkbox"/> Yes – to be determined on a case by case basis	<input type="checkbox"/> No
Other Benefits (please describe): Authorized Absence for training/dissertation defense; 10 annual federal holidays (paid); liability protection		

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

Initial Post-Internship Positions

(Provide an Aggregated Tally for the Preceding 3 Cohorts)

	2015-2018	
Total # of interns who were in the 3 cohorts	12	
Total # of interns who did not seek employment because they returned to their doctoral program/are completing doctoral degree	0	
	PD	EP
Community mental health center	0	1
Federally qualified health center	0	0
Independent primary care facility/clinic	0	0
University counseling center	0	0
Veterans Affairs medical center	4	1
Military health center	0	0
Academic health center	0	0
Other medical center or hospital	0	0
Psychiatric hospital	0	0
Academic university/department	3	0
Community college or other teaching setting	0	0
Independent research institution	0	0
Correctional facility	0	0
School district/system	0	0
Independent practice setting	1	2
Not currently employed	0	0
Changed to another field	0	0
Other	0	0
Unknown	0	0

*Note: "PD" = Post-doctoral residency position; "EP" = Employed Position. Each individual represented in this table should be counted only one time. For former trainees working in more than one setting, select the setting that represents the primary position.

APPENDIX B

Conceptualization Statements of Training Supervisors

Training supervisors are psychologists whose responsibilities include the provision of supervision for the purpose of training. The statements are intended to be 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.

Andrea M. Bischoff, Psy.D.

Clinical Health Psychology

I have been trained as a generalist and have practiced in a variety of settings, including community mental health, private practice, and federally qualified health center. It was during my internship year at Cherokee Health Systems, one of the pioneering sites in primary care integration, I learned that I loved the fast pace and variety of issues, both medical and psychological, that comes with working in a primary care setting.

By being present in the primary care clinic and available to see patients in “real time”, I am able to provide services to patients who may otherwise be unwilling to utilize mental health services. Seeing the patients in the medical office also allows me the opportunity to assist in prevention of illness or help the medical team identify maladaptive patterns before further issues develop. Using a biopsychosocial approach with the medical team, I can assist the patient in learning skills to prevent or manage health problems. I also help the medical team in identify psychosocial issues present in the patient’s life that might otherwise go unnoticed. To assist a patient and medical team in the overall goal of prevention and management, I gravitate towards brief interventions that blend a variety of techniques pulled from cognitive behavioral therapy, such as behavioral activation, MI, and acceptance and commitment therapy.

Dr. Bischoff serves as a Co-Director of Training in Psychology managing the post-doctoral fellowship program.

Justin Bunn, Psy.D.

Psychosocial Rehabilitation

Over the years I have come to a fuller understanding of how powerful the recovery model is in practice, and has led to my belief that if given the opportunity, resources, and support, any person can work toward and achieve their self-chosen goals. I believe this begins with the therapeutic relationship, which research has thoroughly shown to be one of the primary avenues for change in any client who presents for treatment. Within the therapeutic alliance, I tend to be guided by a cognitive-behavioral, interpersonal, and client-centered perspective with a focus on collaboratively developing an understanding of presenting problems within the context of understanding the individual from a biopsychosocial framework.

My training has taken an interesting path through a variety of settings, populations, and experiences. I've worked with at risk children and adolescents at a state-funded residential school, a Christian-based private practice, a neuropsychological program within a larger private hospital, and programs across the VA both as a practicum student at the Dayton VA, and a doctoral intern at the North Chicago VA (now the James A. Lovell Federal Medical Center). All of these experiences have been vital in my development both professionally and personally. In particular, my training as a doctoral intern significantly shaped my professional identity and

continues to guide me through the art and science of psychological practice. Working with both outpatient and residential PTSD, neuropsychology, and the Domiciliary/Homeless program I began to understand that while I may have certain theories and psychological perspectives, every individual is different, which requires a certain amount of flexibility in my conceptualization. My training has focused specifically on Cognitive-Behavioral (CBT), Cognitive-Processing (CPT), Interpersonal (IPT), Dialectical Behavior (DBT), Rational-Emotive Behavioral Therapy (REBT). More recently, I have also trained as a national consultant for the Interpersonal Therapy for Depression (IPT-D) and I have been training VA providers to become certified in IPT-D for the past two years.

My current role at the Dayton VA is focused on providing evidence-based treatment to individuals with a severe mental illness (SMI) through the Building Bridges Psychosocial Rehabilitation and Recovery Center (PRRC), while also coordinating our Psychology Practicum Program. Our goal is to provide a supportive setting for individuals who struggle with sometimes debilitating symptoms to begin creating and pursuing goals they may have never imagined for themselves. Our program offers opportunities for individual and group psychotherapy, as well access to evidence-based treatments such as cognitive-behavioral therapy, interpersonal therapy, and social skills training to work toward symptom reduction, greater community involvement, socialization, along with fewer, if any, psychiatric admissions. The recovery model something I have grown to cherish over the past 10 years of working within the VA and is very close to my heart because of my experiences both inside and outside the psychology world. Specifically, one of my passions is working on the mission field, something my wife and I have been a part of for the past 12 years. Through these experiences, both local and abroad, I've learned how important it is for our field to truly understand the impact culture and diversity have on the individuals we serve. The world we know is not necessarily the same experience of those around us. I found this to be an important and ongoing area of growth as I continue to develop as a psychologist and a person.

Belinda Chaffins, Psy.D.

Mental Health Clinic

My experience includes working in community mental health clinics, a state hospital, college counseling centers, private practice and at the VA. I have a great deal of assessment experience including instruments that measure cognitive processes, personality, achievement and memory. I was trained as a generalist at Wright State University and have developed expertise in the area of Sexual Dysfunctions/Sexual Health working with both individuals and couples. Other interests include women's issues, cultural issues, health and Alzheimer's disease and Caregivers. My orientation is based on Cognitive Behavioral as well as Humanistic principles. I have been trained in Integrative Couple Therapy developed by Neil Jacobson and Andrew Christensen.

Massimo DeMarchis, Psy.D.

Inpatient Psychiatry

My background is varied, as I have 13 years of experience working in a State Hospital with mostly chronic patients, typically court ordered, extensive experience performing Forensic evaluations, working with substance abuse, with sleep disorders and with general mental health issues, both in a private practice setting and in a State agency setting.

My orientation has typically been based on Cognitive Behavioral principles, and more recently has encompassed Acceptance and Commitment Therapy principles.

Deborah L. Downey, Psy.D.

Posttraumatic Stress Disorder Clinical Team

Traumatic experiences can have a shattering effect on clients' sense of self, their emotional stability, and worldview. Because trauma can negatively impact all aspects of our clients' identity and ways of relating to others and their environment, I approach clients in the PTSD residential treatment program in a holistic way.

Of course, good treatment begins with a thorough evaluation, and a variety of assessment instruments (e.g., semi-structured interview, PTSD instruments, other psychiatric screening instruments) are utilized. My basic case conceptualization and treatment approach is based in cognitive-behavioral theory with special attention to individual client characteristics such as gender, race, age, sexual orientation and the like. Additionally, I am familiar with and incorporate elements of humanistic, existential, Adlerian and other individual and systemic therapies into treatment as dictated by client need. Treatment is provided individually and in group formats.

My treatment approach is also team-based, out of necessity but also by preference. PTSD residential staff works closely with Mental Health Clinic, substance abuse, psychiatric and domiciliary staff, as well as others throughout the medical complex. Our mental health team and other VA service providers are a mix of professionals with unique personalities and professional strengths, and we all collaborate to serve our veteran clients. A collegial attitude, compassion for others' suffering, willingness to be flexible, moral and ethical practice principles, and sense of humor help facilitate the day-to-day give and take of a busy, demanding service schedule.

Our goals in PTSD residential are to measurably decrease patient suffering and distress, and to increase clients' level of functioning upon return to the community. Basic beliefs in the fundamental worth and dignity of each individual we serve are imperative. A nonjudgmental attitude, willingness to challenge dysfunctional beliefs, and teaching, leading, and coaching clients toward psychological health are key to our success in obtaining treatment goals.

Finally, I want to say that in keeping with a holistic approach to treatment I believe that we as mental health specialists need to take care of ourselves. We need to actively maintain balance in our own lives – psychologically, physically, socially, and spiritually. We need to continue learning and growing professionally and personally so we can nurture and inspire those with whom we work.

David Drake, Ph.D.
Mental Health Clinic

My work history includes experience in crisis triage, outpatient mental health assessment and psychotherapy, nursing home consultation, bariatric pre-surgical psychological assessments, and conducting disability evaluations for the Ohio Bureau of Worker's Compensation. I have worked in settings ranging from an outpatient division of a large metropolitan hospital, a university counseling center, and for 13 years I maintained a private practice. My training includes experience in both CBT and psychoanalytically-oriented psychotherapy. While I consider myself primarily psychodynamic in my clinical orientation and approach to case conceptualization, this theoretical orientation informs rather than dictates the specific interventions that I utilize in the course of any particular individual's treatment. One of the things that I love about the practice of psychology is the never-ending opportunity to grow both personally and professionally in the service of pursuing a calling to help others, and that includes a mindset of openness to the views of diverse treatment models (e.g., CBT; ACT Therapy; Interpersonal Psychotherapy).

Kenneth L. Farr, Ph.D.
Compensation and Pension

My education in Clinical Psychology gave me the opportunity to train in a wide variety of settings and with diverse populations including a state psychiatric hospital, a county juvenile detention facility, a public school system special education program, a private rehabilitation hospital, a public university health center, a private-practice style outpatient psychotherapy clinic, and a psychiatric emergency room at a large county hospital. In terms of orientation, I would describe my training as eclectic with a strong emphasis on psychodynamic theory.

Following completion of my doctorate, I worked in college mental health for eleven years, including five years as Director of Counseling Services at a large public university. I also taught the Abnormal Psychology course for nine years. I enjoyed my time in the university setting, and found it very rewarding, especially the multiple opportunities I had to supervise graduate psychology students at various levels of training. Following my time in college and university mental health, I entered the VA system where I have now worked for twelve years. While my psychodynamic training continues to inform my clinical work, I have adopted a more cognitive-behavioral clinical stance over time. A great deal of my work with the VA has been with people experiencing posttraumatic stress disorder. Prior to coming to Dayton in early 2016, I was the OEF/OIF (Operation Enduring Freedom/Operation Iraqi Freedom) specialist at a large VA Community Based Outpatient Clinic. I am certified by the VA in Cognitive Processing Therapy, Prolonged Exposure Therapy, and Motivational Interviewing. I also have extensive experience in the application of Imagery Rehearsal Therapy for nightmares.

Currently, I am assigned to the Compensation and Pension Clinic where my work involves providing disability examinations for veterans seeking service connection and/or compensation for mental disorders. I look forward to the opportunity to work with our trainees here at the Dayton VA Medical Center.

Yolanda T. Garmon, Psy.D.
Psychosocial Rehabilitation

In my professional career, I have worked with adults, senior adults, adolescents, and children. I have provided services in the areas of domestic violence, geriatric mental health, chemical dependency, and community mental health. I currently serve as the Program Manager for the Dayton VAMC Family Services Program and the Psychosocial Rehabilitation and Recovery

Center (PRRC - which is also known as the “Building Bridges” Program). Most of the Veterans that I serve have serious mental illness and severe functional impairments.

I have found that regardless of my practice setting, most individuals respond well to respect, empowerment, and collaborative treatment planning. It has always been my belief that everyone is capable of learning and growing, and that treatment should be based on a person’s strengths, so it was quite refreshing to learn that the VA aligns with the recovery model for treatment services. Many of the Veterans we serve struggle with stigma and have received direct or indirect messages that the most they should hope for is to manage symptoms in order to avoid hospitalization. Part of the work we do in “Building Bridges” is deconstructing former notions about treatment. We choose to focus on wellness, and not illness. We believe that everyone can live meaningful lives, and we work to instill hope and build skills that will help Veterans to overcome obstacles in order to assist them in reaching their self-chosen goals for recovery.

Implementation of the recovery model includes the use of evidenced-based practices. I often utilize cognitive-behavioral interventions in my practice. I believe that a person’s difficulties can often be traced back to maladaptive beliefs. In treatment, individuals can learn to identify, challenge, and modify these beliefs—leading to growth-promoting change. Engaging in the examination and behavioral testing of potentially irrational beliefs empowers an individual to take control of his or her own emotions and behaviors. It is my opinion that this also fosters hope, which is essential to the recovery process.

In working with individuals with serious mental illness (SMI), my team and I have also witnessed positive outcomes following the implementation of Social Skills Training, which is an evidenced-based practice for working with the SMI population. This approach uses modeling, feedback, and positive social reinforcement to increase effective use of appropriate social skills, including assertiveness, conversational, and conflict management skills. In our program, we have witnessed Veterans implementing these learned skills not only with other Veterans, but also while on outings beyond the VA campus, which reflects the goal of our program: to help Veterans integrate into the community.

Joshua H. Gootzeit, Ph.D.

Posttraumatic Stress Disorder Clinical Team

I am a staff psychologist in the Dayton VA PTSD Clinical Team (PCT). My interest in PTSD and trauma began as a graduate student at the University of Iowa, when I conducted research on the diagnostic structure of PTSD and trauma-related symptoms, leading to a strong interest in accurate and scientific assessment of the disorder. During that time, I was also becoming more interested in behaviorist and acceptance-based interventions with my clients. An early practicum in a VA PTSD clinic allowed me to combine these interests and to begin to learn how to integrate empirically-based psychological principles with evidence based treatments for PTSD. I have continued to gain experience treating PTSD in several settings since that time, and have continued to refine my approach to assessing and treating the disorder.

Much of the treatment I provide includes offering Evidence Based Treatments (EBPs) for PTSD, including Cognitive Processing Therapy for PTSD (CPT) and Prolonged Exposure for PTSD (PE). My current treatment approach is also greatly influenced by principles of Acceptance and Commitment Therapy (ACT). I have found that it is possible to balance fidelity to an EBP approach to treatment while also seeing each person as an individual with unique needs and flexibly applying appropriate psychological principles.

I strongly believe in a recovery model of treatment, where "recovery" means not only a remission of symptoms but a re-engagement with a valued, meaningful life. By introducing and eliciting a vision for

positive life change, and by offering tools to overcome barriers to change, I have found that individuals are able to rise to the occasion and to use positive coping skills to build better, more active, and more meaningful lives.

Monica Jackson, Ph.D.

Mental Health Residential Rehabilitation Treatment Program

My journey in psychology began as an undergraduate. Initially a political science major, I decided to switch to psychology for the same reason so many of us have...to learn more about why people do what they do. I found human behavior and emotions to be fascinating and intriguing. My beliefs about how people work is quite simple. People want to be happy. People sometimes don't know what that means for them. People sometimes don't know how to become happy. People sometimes don't want others to be happy. I have found that for the most part, we all want what we want, when we want it. We would prefer not to have rules and we would prefer that everybody like us and applaud everything we do. Now, the more mature of us, recognize that is not realistic and we go on to learn how to live out the Serenity Prayer. For some of us, that is not the case. We fight and fight against ourselves, others, and the reality of the situation we find ourselves in. The battle is fought via depression, anger, anxiety, guilt, grief, and so on and so forth. As a psychologist, my job is to assist people in untangling themselves from the battle, getting out of their own way, so that they can let "happiness" find them. I have found cognitive behavioral theories and psychodynamic theories to very useful in my practice. I find cognitive behavioral practices to be most in line with what I believe about people. Change the way you think and behave. How you think about a situation is half the battle. How you choose to respond to that situation is the other half.

Jeremy T. Johnson, Ph.D.

Consultation and Liaison Mental Health

My clinical experiences have included the provision of consultative, therapeutic, and assessment services for a wide variety of diverse patients in both clinical and forensic settings. Diagnostic presentations range from sub-acute adjustment-related and dysthymic complaints to serious and persistent mental illness (schizophrenia-spectrum disorders, severe bipolar disorder, major depressive disorder, and post-traumatic stress disorder).

Consultative services include: differential diagnosis and diagnostic refinement; interdisciplinary care planning; health behavior change; non-pharmacologic pain management; psychoeducation and training for staff and caregivers; education and supportive intervention for veteran's families; improving communication within and between interdisciplinary team members, veterans, and their families; synthesizing and conceptualizing complex medical and mental health presentations to inform treatment and care.

Therapeutic, evidenced-based services include: CBT for depression, chronic illness, and palliative care; IPT for depression, loss, and role-adjustment; ACT and other mindfulness-based approaches for managing anxiety; biofeedback, progressive muscle relaxation, deep-breathing, guided imagery, and other physiologically-based interventions for managing anxiety and reducing stress; supportive intervention for end-of-life issues and adjustment to polytrauma; behavioral/environmental intervention for managing challenging dementia-related behavior (STAR-VA) and management of disruptive behavior; social skills training for serious mental illness populations; and the Cancer 2 Health biobehavioral intervention for those undergoing oncologic treatment.

Assessment services include: psychodiagnostic evaluation and consultation; cognitive and mood evaluation for differentiating amongst and between neurocognitive disorders, delirium, and depression; monitoring of mental status and psychiatric/behavioral stability; suicide and homicide risk assessment; mental health assessment for pre-surgery and pre-transplant candidacy, and assessment of independent living and decision-making capacity. Statements of expert evaluation, to be used during formal guardianship hearings, are frequently completed to assist the court.

Karen Lenhoff, Ph.D.

Lead Psychologist/Evidence-Based Psychotherapy Coordinator

Throughout my career, I have worked in multiple settings, including inpatient, private practice, residential, and various outpatient settings. I have always been interested in the impact of psychological trauma, including how trauma affects physical well-being. While in graduate school, I completed a certificate program in Medical Behavioral Science through the University of Kentucky College of Medicine. I completed my internship at the New Orleans VAMC, with rotations in PTSD and health psychology. During my VA career, I have primarily worked in PTSD and substance abuse programs, most recently as the PTSD Coordinator at the Dayton VA. While at the Lexington VA, I was the SUD/PTSD Psychologist, as well as the Evidence-Based Psychotherapy Coordinator. I additionally served as the VISN 9 PTSD Mentor, and VISN 9 EBP Lead. I am an advocate of providing the best available treatments to help facilitate recovery. In my current role doing program development and evaluation, I am working on expanding the treatments we have available at the Dayton VA, as well as advocating for the usage of measurement-based care. Related to that, we have developed a Dialectical Behavior Therapy team at this VA. I also chair the Mental Health Quality Council.

I think self-awareness is critical for psychologists. As a supervisor, I try to focus on helping trainees become more aware of how their own beliefs and behaviors can impact how they interact with a particular client, as well as how they interact with colleagues. Related to this is the need to maintain a good work-life balance.

Lyndsey N. Miller, Psy.D., MSCP

Primary Care-Mental Health Integration

My career thus far has taught me that being a generalist with multiple tools in my toolbox is essential in being an effective psychologist. This ensures broad flexibility to tailor interventions and evaluations to the patient rather than fitting patients into predetermined approaches. As such, I tend to conceptualize cases through a social constructivist perspective and a biopsychosocial lens that incorporates diversity factors. My approach, flexible as it is, tends to be integrative with a strong cognitive-behavioral foundation in the context of a genuine therapeutic relationship. I tend to pull from evidenced based treatments, such as dialectical behavior therapy, acceptance and commitment therapy, and motivational interviewing as well as interpersonal strategies. I also have experience in evidence based treatments for specific diagnoses, such as Cognitive Processing Therapy, Prolonged Exposure, and Seeking Safety for PTSD and Illness Management and Recovery and Social Skills Training for severe and persistent mental illness. This evolution of my approach and skills has been influenced by the plethora of clinical experiences I have been fortunate enough to participate in thus far.

I have wanted to be a psychologist since high school. I always found the human mind fascinating and wanted to learn more about it. In undergraduate at Ohio State University, I not only obtained experience in human research, but I also began working with children with Autism Spectrum Disorders. I continued in this work while earning my Bachelor's degree.

Because I was not particularly fond of research, I sought out PsyD programs, which emphasized clinical practice rather than research. Subsequently, I was accepted to Wright State University School of Professional Psychology.

While in graduate school, I developed an interest in PTSD and completed a practicum at the Cincinnati VA's Trauma Recovery Center. Not only did I learn and implement evidenced based treatments for PTSD in an outpatient setting, but I also implemented these in residential settings for both men and women. My dissertation was focused on evaluating newly proposed criteria for PTSD in DSM-5. Although I had a strong interest in trauma, I obtained invaluable clinical practicum experience in general mental health settings as well. This is where I was first introduced to brief interventions, mindfulness, motivational interviewing, cognitive behavioral therapies, and interpersonal strategies.

In 2010, I completed my internship at the Bay Pines VAMC in St. Petersburg, Florida. There my rotations included Inpatient Psychology, Neuropsychology, Substance Abuse, Primary Care-Mental Health Integration, and outpatient and residential combat PTSD programs. I also made a strong effort to focus on developing psychological assessment skills and was able to conduct a variety of evaluations, including pre-surgical and transplant evaluations, differential diagnosis, neuropsychological evaluations, and neurocognitive screenings. Although I had planned to become a VA Psychologist specializing in PTSD after graduating, the universe had other plans.

Instead of joining the VA, my husband and I moved half way across the world to the Pacific island and U.S. Territory of Guam. My first postdoctoral job was at the Guam Behavioral Health and Wellness Center – the island's only community mental health center. In this position, I gained extensive experience in treating those with severe and persistent mental illness from a wide variety of cultural backgrounds different from my own. Our approach was recovery-oriented and client-centered. I worked in outpatient, residential, and inpatient settings as well as facilitating some groups within the substance abuse program. Crisis intervention was an integral and daily part of my job. Additionally, I had many community experiences as well, especially with the court system by acting as a liaison, conducting forensic psychological evaluations, and testifying in involuntary commitment hearings. Eventually, I opened a part-time private practice focusing on vocational rehabilitation evaluations and brief therapy. While in Guam, I also returned to school at the University of Hawaii at Hilo and graduated with my Masters in Clinical Psychopharmacology (MSCP) in August 2015. My experiences in Guam are too many to list here; however, I can say that this was not only the most professionally valuable, but also the most personally salient experience I've had in my life. A part of my heart will always be in Guam.

In 2016, we returned home to Ohio to be closer to family. It was at this time that I joined the Dayton VAMC in Primary-Care Mental Health Integration. In this position, I have found that not only has my generalist training, broad range of experience, and flexibility helped me in the fast-paced, never-know-what's-coming-through-your-door environment of Primary Care, but also my training in clinical psychopharmacology. I thoroughly enjoy working in an integrated setting utilizing a team-based approach. Every day is different and every day I learn something new. In my experience of working at three different VA's, I've found this one to be the most welcoming and supportive. I think you will too!

Monica Malcein, Ph.D.

Neuropsychology

I was trained in a clinical psychology program and began specializing in neuropsychology during graduate training. My experience and skills were further refined as I completed an internship and two-year postdoctoral fellowship with specialized training in clinical neuropsychology at a large academic medical center. Prior work experiences have included inpatient neuropsychological assessment, comprehensive outpatient neuropsychological assessment, work in an interdisciplinary outpatient neurorehabilitation center and neuropsychological services with a military population in an interdisciplinary traumatic brain injury (TBI) clinic. My assessment approach is flexible in nature and relies on psychological, neurological, cognitive, and behavioral assessment to evaluate neurocognitive strengths and weaknesses in relationship to normal and abnormal central nervous system functioning. In addition, I place significant importance on the providing patients with feedback of evaluation results and on providing practical recommendations.

Kelly Obert, Psy.D.

Primary Care-Mental Health Integration

I am a staff psychologist working in Primary Care Mental Health Integration (PCMHI). I was fortunate enough to match with the Dayton VAMC for my psychology internship and completed rotations in PCMHI, Geropsychology, and the Mental Health Clinic. I not only grew as a psychologist during my internship year, but also enjoyed the experience immensely! As a result, I happily accepted a position with the PCMHI team upon completion of my internship.

My journey to becoming a psychologist has been somewhat non-traditional. Following the completion of my undergraduate degree in psychology, I worked as a case manager with the Seriously Mentally Ill (SMI) population and then with children diagnosed with a chronic medical illness. These experiences motivated me to pursue a Master's degree in clinical social work. I then returned to working as a therapist with the SMI population. After working as a therapist for a few years, I was promoted to the Clinical Supervisor position for the therapy team which required me to consider the business aspects of providing mental health care. My education and training provided me with a good clinical foundation, but did not fully prepare me to lead a department. Therefore, I decided to pursue a doctorate in psychology.

Based on my past professional experiences and doctoral training, I have developed an integrative approach to working with veterans that includes a strong emphasis on cognitive behavioral principles. I incorporate a biopsychosocial framework with cognitive behavioral theories and strategies while considering a veteran's stage of change, diversity variables, and social justice principles to establish my clinical orientation.

Patricia A. Perry, Psy.D.

Geropsychology

The main areas of clinical practice that I have worked in have been community mental health and geropsychology. These areas have influenced my theoretical orientation, choice of intervention tools, and my view of self as a member of an interdisciplinary health care team. In community mental health I have worked in a day treatment program, and in outpatient clinics (e.g. sexual abuse recovery, vocational counseling). I have worked within all levels of long term care, from independent living on a retirement campus, to assisted living and the nursing home. My work has most often been with the lower socioeconomic status, underserved clients in the community.

As a psychologist, I would describe my theoretical orientation, i.e., how I conceptualize a client's problems / circumstances, as interpersonal or dynamic. My intervention strategies are eclectic and integrative, depending on a client's needs and ability to learn and change. I value a comprehensive assessment, i.e., a bio-psycho-social-spiritual evaluation, to provide a firm foundation for establishing all diagnoses. Furthermore, I want to ensure that each treatment plan addresses all diagnoses, and is collaboratively discussed with clients in an understandable and straightforward manner. Lastly, I believe in and regularly seek consultation with members of the interdisciplinary team for their contributions to problem solving.

In general, I want to educate a client to better understand his / her problems in functioning, to empower so that they can be a more active member of the health care team, to increase awareness of how his / her interpersonal functioning informs coping, and to promote use of existing skills and strengths as well as acquisition of new, positive behaviors.

In long term care settings, I see three therapeutic roles for the psychologist: 1) to assist the client both in the initial transition from community living to long term care campus life, and within levels of care (independent living to assisted living to the nursing home); 2) to help the client understand his / her health issues including functional losses / adaptations; and 3) to encourage the client to maintain the highest quality of life, especially in regard to relationships with family, friends, other residents, and God. As individuals experience the multiple losses of this stage of life (e.g., driving, home ownership, loss of partner / spouse, decisional capacity), the psychologist can be a skilled professional presence and a powerful ally in processing change.

In conclusion, geropsychology is especially exciting to me for several reasons. It is one of the growth areas of psychology, as the population continues to age. In a zeitgeist of brief therapy, this specialty offers a unique opportunity to form a trusting therapeutic relationship, potentially lasting many years, that promotes ongoing development and adaptation. (The average length of stay in nursing homes nationally is 7 years.) This specialty has allowed me to learn one-on-one from the previous generation about changes in culture, life, and values, as well as our place in time. It is both ironic and fitting that working in this specialty has enriched and informed my work with clients of every age.

Justine Ray, Ph.D.

Posttraumatic Stress Disorder Clinical Team

I'm a staff psychologist in the PTSD Clinic and I'm the Lesbian, Gay, Bisexual, and Transgender (LGBT) Veteran Care Coordinator. I began working at the Dayton VAMC in 2014 as a pre-doctoral intern, and they haven't been able to get rid of me since! In the PTSD Clinic I engage veterans in assessment and evidence-based trauma-focused treatments including Cognitive Processing Therapy and Adaptive Disclosure. As the LGBT Veteran Care Coordinator, I serve as an advocate for LGBT veterans and their families and work to create an environment at the Dayton VAMC that embraces our LGBT veterans.

My theory of change begins with a strong, genuine therapeutic relationship, which is a necessary but not sufficient component of successful psychotherapy. With a strong relationship as a foundation, providers can engage patients in comprehensive assessment to determine, as accurately as possible, a clear diagnostic picture. Good assessment allows the provider to make good treatment recommendations, and have a collaborative, open dialogue with a patient about their treatment plan. My theoretical orientation currently draws from Rogerian psychotherapy, cognitive-behavioral models, and mindfulness-based interventions. I actively work to not be too

convinced that any path is the correct one, because I value the ability to change and grow along with my patients.

Rahema Rodgers, Psy.D., ABPP (Clinical Psychology)
Family Services Program

I first discovered my love for psychology in the spring of my junior year of undergrad. I took an introduction to psychology class simply to fulfill a general requirement. I loved the class so much I decided to take another, then another, until I finally changed my major. I knew that as a psychology major I could continue pursuing my lifelong goal (declared at the age of 3) to become a medical doctor. I loved the thought that I could learn about something I was passionate about in the mean time. When it came time to apply for medical school, I went through all the steps. However, going through the motions helped me realize it was no longer my heart's desire to attend medical school. I prayed, searched my heart, researched my options, and determined I would pursue a PsyD.

Upon entering my doctoral training, I assumed I would gravitate toward a psychodynamic approach, and was excited when I started the intervention series. I also took cognitive behavioral, again to fulfill a requirement. Much to my surprise, cognitive behavioral was the therapy approach that I felt worked the best when helping a person make lasting changes to benefit their mental health. Reluctant to dismiss psychodynamic too quickly, I sought out an opportunity for focused supervision with a supervisor who identified as psychodynamic. I believe this experience further solidified my preference for CBT in treatment, while also enhancing my respect for what psychodynamic offered regarding client conceptualization. At that point, I began to form a conceptualization style in which I looked at the factors from the client's background that have contributed to their current dysfunction. I was very interested in family of origin, childhood experiences, attachment, and relationships with people who played a key role during the developmental years. I felt the CBT approach helped to "dig into" a person's psyche and uncover the underlying issues.

As my training continued, I was exposed to brief solution focused therapy, and crisis intervention. Again these approaches influenced my style of therapy, in that I learned how to identify and isolate issues that were of higher priority to a person's current functioning. This helped me let go of the idea that a therapist must address each and every problem they uncovered before the client could be considered "finished" with a course of treatment. I learned that effective treatment could be time limited and focused on the most distressing issue, and saw that clients could make significant progress on that particular issue in a short time span.

Next I pursued my special interest in family therapy, and was exposed to family systems. This was the final piece of my conceptualization puzzle; it reinforced a belief I already held that the people in the client's household were important influences on the progress of clients, especially with children, but even for adults. The dysfunction was not isolated to the identified client. The family, neighborhood, and greater community were also part of the picture and were also impacted by changes the client made through therapy.

I use my training and expertise to help people with severe mental disability on their path to recovery. I see myself as but an instrument for God to use. I believe my time in the clients lives, be it long or short, is for a purpose.

Kristin Rodzinka, Ph.D., ABPP (Clinical Psychology)
Posttraumatic Stress Disorder Clinical Team

I am the PTSD Programs Manager and Co-Director of Psychology Training. I absolutely love the mission of VA and the opportunities this large system has to offer. I am actively involved in the national VA Psychology Training Council, to include being an elected member of the Executive Council and Chair for the Clinical Advisory Committee. I am also Chair for the APPIC Membership Review Committee and am a member of the VISN 10 PTSD Experts workgroup. I have previously served on the Board of Trustees of the Dayton Area Psychological Association (DAPA).

My job provides me with a variety of administrative and supervisory responsibilities as well as the opportunity to work with individuals with a wide range of functioning levels, diagnoses, and mental health needs. My work has included caring for Veterans who have experienced complex trauma related to military sexual trauma, combat trauma, and non-military trauma. I have experience treating PTSD, psychotic disorders, mood disorders, anxiety disorders, traumatic brain injury, personality disorders, substance abuse and other medical health issues.

I believe in a recovery based approach and evidence based practice. I have worked in and managed PTSD, Military Sexual Trauma, Family Services, and Dialectical Behavior Therapy programs. I believe that training in Empirically Supported Treatments is necessary but alone is not sufficient. I have a strong Cognitive-Behavioral theoretical orientation that influences my case conceptualization and treatment interventions. That stated, I have found ESTs to be most effective when there is a good fit and the veteran has adequate skills and readiness to engage in them. Particularly when working with individuals with extensive trauma histories and complicated mental and medical health issues, comprehensive and ongoing case conceptualization (to include measurement based care) and multifaceted treatment approaches are a necessity.

I believe that change requires motivation, skills, and support. I use an interpersonal approach and value nurturing positive therapeutic relationships to create opportunities for implementing effective interventions.

I work to maintain a mindfulness-oriented approach to psychotherapy as well as life in general. I use a biopsychosocial model to inform my case conceptualization. I believe in striking a therapeutic balance between acceptance and change oriented interventions. I am committed to offering evidence based treatments, however, one size does not fit all and creativity and flexibility are necessary to meet patients where they are at. I believe strong case consultation and supervision (both formal and informal) are essential for developing good clinical skills. This is a process I greatly enjoy.

In my role as a Training Director I have provided mentorship, developed national level training, and created tools to assist with the dissemination and implementation of a competency based supervision approach within psychology training programs.

Dr. Rodzinka serves as a Co-Director of Training in Psychology managing the internship program.

Mary Schwendener-Holt, Ph.D., MDiv
Home Based Primary Care

I am a staff psychologist in the Home Base Primary Care (HBPC) program. I implement therapy and assessment in our veterans' homes. While this is an unusual setting for a psychologist, home visits provide a richness not found in a clinical therapy room. My government car is my office. In addition to my veterans, I meet partners, family members and pets. One encounters

unique situations in a home visit that can't be observed in a consulting room. My clinics are in/around Richmond, Lima, and Middletown.

I arrived at the VA after a long and zigzagging path. In my career, I have been a police/fire psychologist, tenured college professor, and state hospital psychologist. I have maintained a private practice since 2002. Over my career, clients have included; first responders, college students, addicts, and middle aged women. My VA clients are mostly male and elderly.

My theoretical orientation is eclectic. For me, the therapeutic relationship (Rogers) is foundational. Without a supportive relationship, no healing can occur. Additionally, trauma focused therapy underlies everything I do. Because I work with elderly veterans, developmental psychology is also important. Life review – with all of its' joys and grief is a common theme. As an M.Div., I am open to clients' spiritual questions. Another basic technique I practice in my daily living and work with clients is living in the present moment without judgement (Mindfulness). I find CBT to be helpful and employ CPT techniques, Problem Solving Therapy, and EMDR. At the same time, I believe that our childhood/early experiences influence our lives (psychodynamic). Finally, understanding the family/systems/cultural context which surrounds and influences clients is essential. My theoretical orientation matches theory and technique to the issues and personal style of each veteran.

Ramon Verdaquer, Ph.D., ABPP **Clinical Health Psychology**

As Health Behavior Coordinator one of my responsibilities is to help develop processes that support adoption of healthy behaviors through education of, and consultation with healthcare delivery teams, and through direct patient contact.

We understand that treatment of chronic illness, such as coronary artery disease, diabetes, and hypertension is a major burden on VA Healthcare and on the Nation as a whole. We also know that often these illnesses could be prevented or ameliorated through adoption of healthy behaviors. As a result VA is re- emphasizing the importance of illness and disease prevention, in particular through primary care programs and primary care based interventions. The development of our Primary Care Patient Aligned Care Teams (PACT) is a major shift in the delivery of healthcare which emphasizes patient centeredness and illness prevention. For example, counseling about the health risks of smoking, and alcohol use as well as the benefits of exercise 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, and demographic or sociological variables. Clearly, the nature and severity of the illness can also impact on a 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 clinician'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.