Holcomb Behavioral Health Systems

Pre-doctoral Psychology Internship Manual

2017 – 2018

Training Director: Brian McManus, Ph.D.

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Holcomb Behavioral Health Systems 2017-2018 Internship Program

Holcomb welcomes the Pre-doctoral Internship cohort of 2017-2018. Although you will be completing your pre-doctoral psychology internship, Holcomb has elected to formally refer to your positions as Psychology Residents. Please use this reference in all written documentation and introductions. The use of "resident" has been chosen to avoid a broader use of the term "intern" that frequently has significantly less professional signification.

Overview of Pre-doctoral Internship

Holcomb's pre-doctoral internship program is APA-accredited and a participating member of APPIC. It is designed to provide students with the clinical opportunities that allow for a comprehensive training experience so that residents can assume the role of a professional psychologist. Each rotation, didactic and other training requirements are designed to expand and enrich the residents' existing clinical knowledge and experiences. The internship program utilizes multiple sites and services to accomplish this goal. Residents will be provided exposure to diverse clinical presentations, ages and cultural issues. Residents will be expected to work from an integrated theoretical approach. Schedules will be approximately 40 – 45 hours each week.

It is expected that each resident will achieve increasing levels of responsibility and autonomy as the year progresses. In the end, the internship year is seen as the culmination of the student's opportunities to practice the art of psychology, based on prior exposure to the science of psychology.

In our experience, residents take away from the internship program what they seek to gain from it. All residents are encouraged to embrace the clinical training year and to take on as many challenges and unique experiences as their time allows.

Goal of the Pre-doctoral Internship Program

Holcomb's Internship program is a post-practicum, pre-doctoral training program that is designed to provide a variety of educational and clinical experiences to prepare residents as generalist practitioners in the field of clinical psychology.

<u>Internship Training Goals</u>

1. To produce internship graduates who demonstrate competence with respect to individual and cultural diversity.
2. To produce internship graduates who demonstrate competence with respect to global clinical skills and professional attitudes represented within the field of psychology.
3. To produce internship graduates who demonstrate competence in assessment, diagnosis and case conceptualization.
4. To produce internship graduates who demonstrate competence in applied clinical ethics.
5. To produce internship graduates who demonstrate competence in evidence-based interventions, scientific knowledge and clinical application.

Internship Training Objectives

To prepare doctoral candidates to competently deliver treatment services for:

- Substance abuse, dependency, and co-occurring issues.
- Children/adolescents and family therapy.
- Specialized populations: Forensic clients and psychological/neuropsychological testing
- Individuals experiencing psychiatric and/or psychosocial crisis.
- Individuals requiring services from a community mental health setting.

Expectations of the Resident

- Holcomb's internship is based on a 12-month and 2000-hour program that runs from August 1st through July 31st.
- Residents are expected to provide a minimum of 500 hours of direct client service (25%).
- Residents will likely work 40 – 45 hours on-site each week. Minimally, two evenings per week are required based upon the rotation.
- Residents will complete three rotations and demonstrate competency in working with each population.
- Residents will demonstrate the ability to present cases and provide didactic training to various staff members.
- Residents will develop and implement a community outreach project.
- Residents will demonstrate competency in utilizing evidenced-based treatment.

Introduction to Holcomb Behavioral Health Systems

Holcomb Behavioral Health Systems is a private, non-profit corporation which was founded in 1978 to provide community-based services to individuals as an alternative to long-term institutionalization. Since then the agency has expanded in size, scope and vision to become a full range provider of behavioral health services throughout Southeastern Pennsylvania, the Lehigh Valley, and the states of Delaware, Maryland and New Jersey. During its existence, Holcomb's programs have focused on the goal of supporting individuals to live full, productive and self-empowered lives, avoiding long-term institutionalization, out-of-home placement and unnecessary reliance on inpatient care.

Holcomb is accredited by the Joint Commission, achieving its initial accreditation in November 2000. Holcomb's score of 93 was unusually high for an initial applicant, and the Commission's report noted**:** "Multiple services are tailored and altered to meet specific needs of their target population. Interviews with clients validated that they perceive that staff members partner with them so that they are able to meet or exceed their rehabilitation goals. The quality of services is exceptionally high." Holcomb is licensed by the Pennsylvania Department of Public Welfare as a provider of psychiatric outpatient treatment, psychiatric rehabilitation (clubhouse), community residential rehabilitation (CRR), mobile crisis intervention and crisis residential services, family-based mental health, personal care homes, intensive case management/resource coordination; and

community homes for individuals with Intellectual and Developmental Disabilities (IDD); and by the Pennsylvania Department of Health as a provider of substance abuse outpatient treatment.

Holcomb currently has 31 service locations located throughout Southeastern and Southcentral Pennsylvania, the Lehigh Valley, northeastern Maryland, Delaware and central New Jersey, with its corporate headquarters in Exton (Chester County) Pennsylvania. Its range of services include: Mental health and substance abuse outpatient therapy; psychiatric services; Psychiatric Rehabilitation (clubhouse); Behavioral Health Rehabilitation Services (BHRS); residential services for the mentally ill and developmentally disabled; ICM/RC; in-home life skills instruction and support for families affected by mental illness or developmental disability; evaluation of parenting skills in abuse and neglect cases; vocational rehabilitation for the mentally and developmentally disabled; mobile crisis intervention and crisis residential services; Family Based Mental Health Services; supported employment; intensive case management; and substance abuse prevention/education. Holcomb currently provides services to over 8,900 clients each fiscal year.

Holcomb Senior Management:

Roger Osmun, Ph.D. – Chief Operating Officer
Susan Berryman, Esq. – Chief Administrative Officer
Gail Corrado, M.D. – Medical Director
Nicole Brown, M.A., LPC – Senior Director of Operations
Natalie Bilynsky, Ph.D. – Clinical Director
Adrienne Pennell, M.Ed., BCBA – Regional Director, Chester County
Gerry Clark, LSW – Regional Director, Delaware/Philadelphia Counties
Henry Hor, M.A. – Regional Director, Lehigh Valley
Howard Isenberg, M.A. – Regional Director, State of Delaware / Maryland
Leslie Lipson, LCSW – Director of Crisis Services
Deborah Marsilio, M.A. – Regional Director, York County
Vance Hamill, LSW – Regional Director, Berks and Montgomery Counties
Aerielle Waters, MPH – Associate Director of Prevention Services
Patricia Poppert, RN – Director of Developmental Disability Services
Betsy Warner – Director of Clinical Support Services / QI

Internship Orientation

Residents will participate in a three-day orientation process during the first three days of the internship year. Residents will complete all requisite child abuse and criminal clearances, as well as all relevant human resource paperwork. Each resident must comply with requirements regarding completion and submission of mandatory HR documents. Failure to complete or return material in a timely manner may result in a temporary suspension of your privileges to work with clients, which could either delay or risk the completion of your internship year. Residents will meet with the Training Director and related faculty to review pragmatics of the internship year. Site administrative supervisors will be introduced to the residents and each resident will be provided time to ask questions of the agency and internship staff. If, upon the completion of clearances, it is determined that a resident does not meet the criteria for work at Holcomb or is

disqualified from interactions with clients, the resident will be formally notified and neither Holcomb or Holcomb's internship is liable for the resident's failure to meet mandatory standards.

Residents will be provided with reference material or will be directed to where various reference materials can be accessed. Residents will be provided with a network login so that they may access Holcomb's business software, intranet, internet and email.

Key policy and procedures will be reviewed during the orientation. Residents should become familiar with the agency Policy and Procedures Manual during the first two weeks of the internship year. The Policy and Procedures Manual will provide each resident with a structured framework regarding the overall functioning of the agency and how specific services must function within state regulatory guidelines.

Training Rotations

Holcomb's pre-doctoral program is comprised of three 4-month clinical rotations. Residents matched with Holcomb's internship program are asked to rank order their rotation preferences so that they may be placed in three of the four available rotations. The available rotations include: Child/Adolescence, Substance Abuse, Crisis Services and Special Populations. The internship faculty will consider resident preferences and past clinical experiences when determining what rotations will be assigned to each resident during the course of the year.

Child/Adolescence

During this rotation, residents will spend their time providing therapeutic support for children and adolescents who have been legally classified as truant or are at risk of such classification. Services include the provision of mobile individual and family therapy, conducted within the home and/or school. Based on the client/family's need, interventions may be either short- or long-term. Issues impacting the client attending school could vary from practical psychosocial issues (e.g., bullying, teen pregnancy) to overt behavioral health disorders (e.g., anxiety, depression or substance use). Each client has a case manager involved as part of the team, providing linkage to necessary systems. This program is meant to be relatively short-term, with a length of stay no longer than 6 months. Therefore, assertive engagement of the client and family in interventions is necessary to stabilize his/her school attendance and allow for a transfer of services to community-based providers. Residents will complete a clinical assessment of each client upon admission into the program and collaborate with the case manager in developing a comprehensive service plan. Behavioral consultation may also be necessary to establish a behavior management plan that will more fully support the client and his/her environment. Each resident must conduct a minimum of 200 hours of direct service. This averages to a minimum of 12 hours of direct service per week. Additional resident functions may include, but are not limited to: Integrated Clinical Assessments, psychological testing (if recommended), behavioral consultation, or functional behavioral assessments. Residents will attend at least one of the two weekly scheduled case review meetings.

Supervisor: Kathleen West, Ph.D.
Administrative Site Supervisor: Isabelle Gauthier, M.S., L.M.F.T.

Substance Abuse

During this rotation, residents will work in the Newark, Delaware office of Open Door, Inc., which is an affiliate of Holcomb Behavioral Health Systems. The focus of this rotation is to give residents the exposure to the provision of formal substance abuse treatment. Clients being seen out of this office may be attending outpatient counseling on an elective basis or may be court mandated, in particular as a result of a DUI conviction. Residents will provide individual and group therapy as clinically indicated. Substance Abuse assessments are another clinical service that will be provided by residents. Each resident must conduct a minimum of 200 hours of direct service during this rotation. Residents will conduct 3 hours of group therapy and approximately 7 hours of individual therapy per week. Residents will be scheduled for up to two 2-hour substance abuse assessments per week.

Residents will attend any site case reviews or site-specific in-services.

Rotation Supervisor: Jesse Matthews, Psy.D.
Administrative Site Supervisor: Eymorfia (Vicky) Mattoscio

Crisis Services

The crisis services rotation provides residents with the opportunity to work with clients who are experiencing significant psychological or psychosocial crisis. During this rotation, residents will have the opportunity to provide telephone, walk-in and mobile crisis interventions to residents of Chester County in the effort to support the client's ability to remain in the community and to better access community mental health resources for follow-up care. Additional opportunities are available for residents to provide group and individual counseling services to clients in Holcomb's crisis residential program. This availability is based on the need of individuals in the residential part of the program. Each resident will have hours dedicated weekly to crisis intervention that may include a varied mix of walk-in, telephone counseling, and outreach services.

Rotation Supervisor: Brian McManus, Ph.D.
Administrative Site Supervisors: Leslie Lipson, LCSW, Michelene Dziekonski

Special Populations

The special population rotation provides residents with the opportunity to work with a forensic population, as well as occasional opportunities to conduct psychological and neuropsychological assessments. During this rotation, residents will provide services out of the Exton office and the Chester County Prison. The forensic population allows residents the opportunity to conduct clinical assessments for individuals with legal infractions to determine treatment recommendations that will be used in the clients' court proceedings. Occasionally, residents will provide clinical assessment, including psychological and neuropsychological testing, when opportunities become available based on the referral process. There may also be opportunities to perform decision-making capacity evaluations to older adults in the community who are at risk of

needing guardianship. These evaluations can include neuropsychological testing as well as personality testing, depending upon the referral.

Each resident will conduct a minimum of 200 hours of direct service during this rotation, including report writing time. Specific hours dedicated to the different specialty populations may vary considerably from week to week based on referrals.

Rotation Supervisor: Andrea Parry, Psy.D. / Brian McManus, Ph.D.
Administrative Support: Rachel Barnes

Outpatient Caseload

Each resident will maintain an outpatient caseload throughout the internship year. Some discretion is available regarding the location of the office in which the outpatient therapy is provided and will be determined by the Internship Director prior to the beginning of the internship year. Sites include, but may not be limited to: Exton, Upper Darby and Kennett Square. Residents will be scheduled up to 10 therapy clients per week. Of those 10 hours, it is likely that 8 hours will be filled at any given time. Residents must conduct a minimum of 240 outpatient hours during the course of the year. This averages to a minimum of 5 contact hours per week. Cases will be assigned with the goal of providing each resident with diverse clinical issues, ages and cultural experiences. Therapy will include individual, family and group counseling. At times, residents will be assigned assessment cases. If these need to be scheduled during times that a resident is supposed to be doing rotation work, the resident must check with their site supervisor to approve the change in schedule prior to scheduling the appointment. Assessment cases that are not related to rotational work will be supervised by outpatient supervisors.

Outpatient Supervisors: Natalie Bilynsky, Ph.D.; Bethany Dudash, Psy.D.; Kathleen McDonald, Psy.D.

Site Administrative Supervisors: Bethany Dudash, Psy.D.; Jari Santana-Wynn, Ph.D. and Kevin Titze, Psy.D.

Supervision

Each resident will receive a minimum of 2 hours a week of individual supervision from a doctoral-level, licensed psychologist. One hour will be provided from their rotation supervisor (which will change as the resident moves through rotations). Each resident will be assigned a primary supervisor for the entire internship year to oversee all outpatient cases. In addition, group supervision will be provided through weekly two-hour case conferences (explained in more detail below) overseen by one or more of the agency's doctoral level, licensed psychologists. Case Conferences are held on Mondays 1-3pm.

Residents will have opportunity for informal supervision from other licensed/certified behavioral health professions (site supervisors) for their rotational work. However, the ultimate clinical responsibility for cases lies upon their identified psychologist supervisor.

To the extent possible, supervisory times will be pre-scheduled. When not possible, each resident will collaborate with their supervisor(s) to find a mutually agreeable supervision time.

Supervisors are accessible by phone or email when they are not in the office. Residents and supervisors routinely exchange mobile phone numbers to facilitate communication, when needed, outside of standard business hours. In any emergency, residents are instructed to consult with any identified agency supervisor if their internship supervisor is not readily available.

In addition to the aforementioned pre-established supervisory routines, each resident will meet informally with the Training Director on a bimonthly basis in order to provide opportunities for individual residents to discuss their perception of their progress in the program. Administrative and clinical feedback from the Training Director is to be expected as part of the process of growth facilitation.

Didactics

Residents are required to participate in weekly two-hour didactics. These didactics will cover various topics with key importance within the behavioral health field, in addition to topics specific to the practice of psychology. The majority of didactics will be presented by the agency's psychologist staff; however other topics may be covered by other agency professionals with more specialized experience in the particular topic. Successful completion of the didactics includes a passing grade of 80% or more on each post-test for the didactics. If a resident does not receive a passing grade on the post test, that resident will meet with the Training Director to develop a plan that will allow them to achieve a passing grade.

Absences from didactics are not permitted given that the topics include key areas of competence determined by the faculty for successful completion of the internship program. Therefore, if a resident must miss a didactic subsequent to unforeseeable events, the expectation remains that a passing grade is achieved on the post-test and that the required readings for the topic missed are completed in order to ensure that competence is gained in a particular area.

Each didactic has an abstract, learning objectives and required readings. Residents have access to a database which includes the readings required for didactics. Minimally, material is accessible on the network, but some reference material may be made available through hard copy or other digital means.

Regular didactics will be scheduled on Tuesday mornings from 9am -11am in the Exton office.

2017-2018 Internship Didactic Schedule
Tuesdays 9 AM – 11 AM

Date	Didactic Topic	Presenter	Primary Domain	Secondary Domain
08/08/17	Differential Diagnostic Considerations	McManus	AD	SI
08/15/17	Ethical Decision-Making in Clinical Practice	Osmun	SI	S
08/22/17	Substance Abuse Assessment	Matthews	AD	PE
08/29/17	Trauma Informed Therapy	Bilynsky	EI	CD
09/05/17	Motivational Interviewing / Stages of Change	McManus	EI	AD
09/12/17	Suicide Assessment / Crisis Intervention	Lipson, L.	AD	EI
09/19/17	Cultural Competency	Santana-Wynn	CD	SI
09/26/17	Client Feedback / Difficult Conversations with Clients	Dudash	EI	EI
10/03/17	Psychotherapy Theory and Practice: Anxiety Disorders	Bilynsky	EB	SI
10/10/17	Ethnic Minorities	Santana-Wynn	CD	SI
10/17/17	Dialectical Behavior Therapy	Dudash	EB	PE
10/24/17	Biological Bases of Chemical Dependency	McManus	SI	EI
10/31/17	Neuropsychological Assessment and Rehabilitation	Osmun	AD	EI
11/07/17	Guest Lecturer	TBD	EI	SI
11/14/17	Functional Behavioral Assessments	Pennell, A.	AD	PE
11/21/17	**Holiday Break**			
11/28/17	Psychotherapy Theory & Practice: Interpersonal	Santana-Wynn, J.	EI	SI
12/05/17	Psychiatric Rehabilitation and Recovery Principles	Filippone, C.	EI	PE
12/12/17	Veteran Cultural Awareness Training	Norris, T.	CD	EI
12/19/17	Clinical Supervision & Consultation	Bilynsky	S	C
12/26/17	**Holiday Break**			
01/02/18	Neuroimaging	Osmun	SI	C
01/09/18	**2017-2018 Internship Interviews**			
01/16/18	Domestic Violence	McManus	EI	CD
01/23/18	Psychological Evaluation for Children's Services	Dudash	AD	C
01/30/18	Treatment Termination	McManus	EI	S
02/06/18	Psychotropic Medications	McManus	EI	C
02/13/18	Physical & Sexual Abuse and Neglect of Children	McManus	EI	SI
02/20/18	Serving the LGBTQI Population	Santana-Wynn, J.	CD	SI
02/27/18	Recovery, Relapse Prevention and Harm Reduction	Matthews	EI	PE
03/06/18	Chronic Pain and Behavioral Health	McManus	EI	SI
03/13/18	Psychotherapy Theory & Practice: Humanistic	Bilynsky	EI	SI
03/20/18	Mindfulness Techniques	Windfelder	EI	EB
03/27/18	Compassion Fatigue: Care of the Clinician	Matthews	SI	PE
04/03/18	Exposure with Response Prevention for OCD	Ashenfelter	EB	EI
04/10/18	Legal Issues for Psychologists	Bilynsky	SI	EI
04/17/18	Licensure / Professional Issues	Osmun	S	C
04/24/18	Psychotherapy Theory & Practice: Personality Disorders	Matthews	SI	EI
05/01/18	Psychotherapy Theory & Practice: Attachment Issues	McManus	SI	EI
05/08/18	Clinical Outcome Measures	Osmun	PE	SI
05/15/18	Resident Presented Topic – Assessment & Diagnosis	Resident 1	AD	
05/22/18	Resident Presented Topic – Effective Interventions	Resident 2	EI	
05/29/18	**Holiday Break**			

06/05/18	Resident Presented Topic – Evidence Based Treatment	Resident 3	EB	
06/12/18	Resident Presented Topic – Consultation	Resident 4	C	
06/19/18	Resident Presented Topic – Supervision	Resident 5	S	
06/26/18	Resident Presented Topic – Cultural Diversity	Resident 6	CD	
07/03/18	**Holiday Break**			
07/10/18	Resident Presented Topic -	Resident 7		
07/17/18	Forensic Clients	Parry	CD	AD
07/24/18	**Internship Wrap-up**			

Dates, topics and presenters subject to change.

Curriculum Areas:

AD – Theories/Methods of Assessment and Diagnosis
EI – Theories/Methods of Effective Interventions
EB – Theories/Methods of Empirically-Based Treatment
C – Theories/Methods of Consultation
PE – Theories/Methods of Program Evaluation
S – Theories/Methods of Supervision
SI – Theories/Methods of Scholarly Inquiry
CD – Theories/Methods of Cultural and Individual Diversity

Dissertation and Research

The internship year is intended to be an intensive clinical training experience. Given the clinical emphasis of the program, there is essentially very limited time available for research or work on completing dissertations. Residents are welcome to participate with agency staff on active research projects or to initiate new projects. However, required clinical responsibilities remain the residents' primary responsibility. Work on dissertations, if not completed prior to the start of the internship year, must be completed on the resident's personal time or the resident must use their vacation time. Residents will be given one warning if internship time is observed being used for dissertation activity.

Residents have access to several university libraries in the area. Immaculata University and West Chester University are within 10 minutes of the Exton office and allow open access to the public for research.

Holcomb maintains a small library of books that can be signed out through the Clinical Director. A collection of journal articles relevant to the internship program is maintained through the agency's reference library on the corporate server. Residents should check this collection periodically for updates and should recommend inclusion of articles as they become aware of research that may be beneficial to the internship program.

Cases Conferences / In-service Presentations

Residents will participate in weekly two-hour case conferences. This provides students the opportunity to present and hear cases in a group, supervisory setting. Residents will be expected to periodically present cases from either their outpatient caseload or from work in their rotations. The intent of the case conference is to increase the resident's experience and comfort with presenting cases in a group setting and to receive both supervisor and peer feedback. Case conferences are designed to enhance the skill development of the residents on the work being performed, but not to replace the direction provided by their individual supervisor. Psychological and neuropsychological testing cases will be routinely reviewed in this setting or order to provide the entire cohort opportunity to learn from the process undertaken by other residents. Supervising psychologists and pre-approved post-doctoral graduates will lead case conferences.

Each resident is expected to present one 2-hour in-service to interested agency staff during the course of the year. Residents can present on topics of interest and/or expertise to them or topics for which they would like to explore further. Topics should be discussed with their outpatient supervisor during the first two months of the internship year, and approved by the Training Director by February, with the actual in-service presentation occurring between May and July. Topics will follow one of the curriculum domains. The resident must provide the Training Director with an outline of their proposed in-service presentation for approval and are expected to modify the structure or content of their presentation as needed in order to achieve the topic's training objectives. Similar to the learning objectives that the program develops for its didactics, residents will required to identify three learning objectives for their presentation in order to provide direction for the development of the presentation.

Community Outreach Project

Each resident is expected to participate in one community outreach project during the course of the year. Residents are expected to have their community outreach project completed by the end of the second rotation. Residents will typically review their outreach idea with the Training Director during the first rotation and conduct the outreach at some point during the second rotation. This project would ideally be coordinated with Holcomb's Prevention/Education program in either the Exton or Media office. This program actively works on educational outreach services. The goal of the community outreach project is to give residents the opportunity and experience with providing a presentation or intervention to the local community in a manner that highlights the agency's status within the community and the professionalism of the resident.

Compensation / Benefits

As approved by Holcomb's Quality Management Committee and the Board of Directors, residents will be compensated for their work through a stipend. The stipend is not contingent upon the work produced by the resident. The amount of the resident stipend is reviewed for each internship year and is competitive with surrounding local internship programs. Residents receiving a stipend are paid on a bi-weekly basis, consistent with the agency's payroll schedule. Stipends are based on a 40-hour work week, which is consistent with the agency's definition of a

salaried employee, despite that it is known that the hours required by the internship program are approximately 45 hours per week. Each resident must submit a time card on a weekly basis, due to the Training Director by Monday at 1pm to ensure timely payment. Each resident is responsible for documenting their worked days versus vacation days. Stipends are taxable based on applicable tax laws.

For the 2017-2018 year: $ 23,712 stipend

All residents are provided with an agency contribution towards health insurance, at a rate comparable to agency employees as determined by the Board of Directors. Holcomb attempts to maintain at least two health plans from which the residents may choose. At the start of the internship year, if not prior, residents will be requested to choose a plan and complete the requisite enrollment paperwork. Any resident not electing to enroll in a healthcare plan will not be provided additional compensation in lieu of the health plan.

Each resident is provided with **10 days of vacation** time during the internship year. Residents may take up to five days off in a row at a time. Residents should obtain prior written approval from the Internship Training Director of all time off unless within the context of an emergency or illness. It is agency policy that all employees submit leave requests at least one week in advance. It is the responsibility of the resident to provide a copy of the approved request form to the program(s) that are impacted on the dates they will not be in the office. The Training Director will routinely discuss requests for time off with respective programs through which clinical services are provided. In the case of illness or emergency, the Training Director should be notified at the beginning of the business day. ***It is the resident's responsibility to make the rotation site supervisor and clinical supervisor aware of absences from rotational work, whether these are planned absences or absences due to illness.*** Residents also have time off for the agency's seven recognized holidays.

Residents are also offered **3 floating holidays**, that can be used for any personal reason. Floating holidays may, at the discretion of management, be issued all at one time or be incrementally allocated in four-month periods. Additionally, the use of floating holidays may, at the discretion of management, be determined that they have to be used within the period in which they were accrued. If this applies, then residents will forfeit floating holidays after the applicable period expires.

Absences due to illness must be used through one of the above entitlement days. Please note that vacation days and floating holidays cannot be used during the last two weeks of the internship year. Also, please note that since the internship is a temporary employment position, residents do not accrue sick/personal time, nor are they eligible for bereavement leave or research/dissertation leave beyond the context of the 13 allowed days. All time must be recorded on time cards as Vacation, Holiday or Floating Holiday. Residents are expected to monitor their use of paid time off. Time in excess of the 13 days referenced above can only be taken within the context of significant medical considerations, which must be discussed with the Training Director in a timely fashion. Under that circumstance, the resident will be expected to ameliorate the missed time and learning experiences in order to officially complete their internship year. Residents are not permitted to make changes to their scheduled work days (i.e., working a Saturday instead of a weekday) in order to take additional time off. If a resident is going to be late for work he/she must

contact the Training Director as well as the site supervisor. Excessive absences and/or tardiness are not permitted and can be subject for grounds for dismissal from the internship program.

All residents are expected to adhere to the schedules that are provided for them. Schedules have been carefully developed to meet the needs of the programs with continuity across changes in staffing by a particular resident, as well as to provide opportunities to be involved in different aspects of the departments in which they work. Any requests for changes in schedules must be approved by the Training Director who will notify the appropriate supervisors of the change.

Travel Reimbursement Policy

Residents will be reimbursed for their mileage, at the agency established rate, when using their personal vehicle for agency business. This would include travel for the provision of any mobile service or traveling between agency sites. A mileage reimbursement form must be submitted along with time cards to the Training Director on a weekly basis. Reimbursement submissions more than one month old cannot be honored, as per company policy. Any other expenditure for which a resident wants reimbursement must be approved by the respective Regional Director and the Training Director prior to making the purchase. Items purchased without proper pre-approval will not be reimbursed.

Internship Statement regarding Concurrent Employment

The internship year is an intensive educational and experiential year and Holcomb expects residents to be committed to their work and the learning process. Holcomb does not support residents holding other employment concurrent with the internship year. If residents are engaged in other employment and there is any negative impact on the resident's work as it relates to his/her internship performance, the resident will be instructed to determine whether they want to continue their employment and withdraw from the internship program.

Due Process

Holcomb maintains a Due Process system to support residents that are demonstrating substandard achievement during their training year. Any area of substandard performance, clinical or administrative, will be first informally addressed with the resident via his/her primary supervisor and the internship Training Director. The internship director will discuss the means in which the resident can ameliorate the noted deficiencies and set an informal time table. If a resident continues to demonstrate difficulty within the internship program, a formal written corrective action plan will be developed. Any corrective action plan will document the noted area(s) of deficiency, expected changes on the part of the resident and the means in which the internship program will support the resident's efforts toward improvement. All deficiency areas will have a formal date of expected completion, with a minimum of 1 month to complete requirements unless deficient areas pose a client safety concern or any other concern that relates to client care. All deficiency areas must be rectified in order to remain in the program. Residents with an incomplete corrective action plan at the end of the standard internship year (i.e., July 31st) will be required to continue within the program until he/she has successfully met the corrective action plan requirements. If a resident is unable to successfully address all relevant correction action requirements, termination from the internship program is a realistic consequence.

Residents with a written corrective action plan will have the Director of Clinical Training of their respective academic program notified of the corrective action plan. At any time in the process, a resident has the right for a formal review of the corrective action plan and to appeal the decision of the internship program. Appeals will be reviewed and ruled on by the Clinical Director, Director of Compliance and the Director of Human Resources. The decision of this appeal committee is final.

Impaired Professional

Holcomb maintains an Impaired Professional Policy that ensures clients are safeguarded from staff impaired by substance use or significant psychological issues and to ensure that residents have sufficient opportunity to address personal problems without immediate risk to their internship placement. All residents have a responsibility for monitoring their individual competency and taking necessary action when behavioral health issues (including substance use or mental disorder) may impair or compromise their ability to function in a competent and professional manner. If a resident or another employee has concern about a resident's ability to perform his/her duties competently, this concern needs to be presented to the Internship Training Director and the Director of Human Resources. A resident has the right to rebut an allegation of impaired functioning consistent with the Impaired Professional policy. Rebuttal information will be reviewed in the context of any supporting documentation provided by staff making the report to determine if the resident sufficiently meets the criteria of an impaired professional. A resident designated as an impaired professional either by him/herself directly or through the review process will be assisted in the following manner: (1) The resident will be referred to the agency's EAP service for evaluation and further treatment recommendations or the resident may seek independent evaluation and treatment. (2) The resident will be placed on either unpaid administrative leave or modified work duties, whichever is most appropriate. All residents designated as impaired professionals will be afforded additional time, to the extent possible, to complete the internship requirements after consultation with their graduate program Director of Clinical Training.

Grievance Procedure

Holcomb maintains a formal grievance procedure to assist employees and residents with maintaining an effective and healthy work environment. Residents may file a grievance with respect to any work environment (discrimination; sexual harassment) or internship-related (supervision, case assignment) issue. Consistent with the agency policy, grievances should be submitted to the Director of Human Resources. Grievance issues that are specific to the internship program will be addressed directly with the Training Director, unless the grievance directly involves that person. In the latter case, the issue will be discussed with the Clinical Director. General grievances will be addressed exclusively within the HR department. Residents will be provided with feedback regarding resolution of their grievance within five business days. Residents have the right to appeal a proposed resolution if the resident does not feel that the issue is resolved. Any appealed grievance is directed to the attention of the Clinical Director for review and disposition. The Clinical Director may involve other members of the management time in the effort to resolve the grievance. Results of any grievance appeal will be communicated to the resident within 3 business days. Residents can appeal this decision in which the grievance appeal

will then be reviewed by a committee of at least three members of the management team for final resolution. Decisions by this committee are considered final. Residents are protected from retaliation when either a grievance is filed or an appeal is requested.

Resident Evaluations

Residents are provided with written feedback regarding their competencies and performance in the internship program at the end of each 4-month rotation by their respective outpatient therapy supervisor which also includes feedback from at least the resident's rotation supervisor and Training Director. The resident evaluations are inclusive of core competencies which are consistent with the overarching learning mission of the internship program. The evaluations are based on a 5-point Likert scale. The evaluation of competencies is based on a developmental perspective, with the understanding that scores are expected to increase to some degree during the course of the year. The resident will sign indicating the competency evaluation was reviewed with them and that they were afforded an opportunity to provide comments to their evaluation. The internship Training Director will review all evaluations and maintain them in the resident's file. A resident's final evaluation should document no single competency score below a 2 and all domains must average at least 3.0 or better for their respective competencies for successful completion of the internship program.

Residents will complete a self-appraisal regarding their perceived need for supervisor support for each internship-identified core competency. Self-appraisals will be completed at the beginning of internship (or immediately prior to the start of the year), at the mid-year point, and at the end of internship. The purpose of this data collection is to fully support the resident throughout their involvement in the program. This method of assessment which includes collecting data pertaining to self-perception is crucial to providing adequate and accurate supervisory support and also as a measure of progress.

A resident's graduate program will be provided with copies of all evaluations. These will be sent on three occasions, end of each rotation, to the resident's Director of Clinical Training. The internship program will not complete graduate program-specific evaluation forms due to the additional work required to meet these individual (and often lengthy) evaluations. To date, despite claims by some graduate programs that they must have their own evaluations completed, all programs have accepted Holcomb's APPIC-approved evaluations.

At the end of the internship, each resident will be asked to provide feedback of their internship experience by completing an online survey. Data will be collected regarding the internship's success toward achieving its training goals, supporting the development of residents' core competencies, and the residents' experiences with didactics, supervision and overall impression of how well the internship prepared them for the role as a professional psychologist. The residents will be requested to provide a personal email address in order for the internship program to contact them for collection of distal data regarding their experience over time.

Dress Code

It is important that each resident present themselves in a professional manner in both dress and interpersonal demeanor. Subsequently, it is expected that each resident will dress in a manner that is consistent with "smart business" attire. For men, this involves a dress shirt and tie (no jacket is required) for all office-based services. Short-sleeve dress shirts are acceptable as are sweaters over dress shirts. Dress shoes or loafers are appropriate. For women, dresses, skirts or pants are acceptable. Dress blouses or sweaters are acceptable. On most rotations, pants may be more practical and, in some cases, preferred (e.g., when conducting prison assessments). For community-based services (e.g., in-home sessions) attire can be less formal but should still be sufficiently professional. Therefore, khakis may be acceptable in lieu of dress slacks in those settings. At no time are the following items considered acceptable: shorts, jeans, t-shirts, tank tops, spaghetti straps, items exposing the midriff, sneakers or sandals. All residents are asked to consider how their attire represents their professional status to the public, regardless of the actual setting.

Residents should keep their agency ID on their person at all times, especially when providing community-based services. This identifies the resident as a member of the Holcomb organization and ensures clients are adequately informed of your role in their services.

Communication of Trainee Status

Ethical standards require that clients be informed of a resident's trainee status. The agency documents that clients are informed through the Notification of Therapist Trainee Status form. Pre-doctoral residents present all of their clients with the form, explaining the nature of the pre-doctoral internship, identifying their supervisor and how to contact that supervisor if the client chose to. This documentation must be kept in each client's chart.

Requirements for Completion of Internship Year

The internship year is a 12-month (minimum 2,000 hour) program. In accordance with APPIC standards, each resident must complete a **minimum** of 500 hours of direct service (i.e., 25% of the internship). Because of the nature of the internship, it cannot be completed on an accelerated basis. Each resident will submit on a monthly basis a tracking of his/her hours within their rotation and their outpatient work, following a format approved by the internship program. If direct service hours are not being accrued at a rate that will allow for a timely completion of the program, corrective action may be taken so that the required hours can be achieved. If the accuracy of direct service hours as presented by the resident is questioned, verification of hours will be conducted against the agency's computerized database. If discrepancies exist, the database will prevail unless the resident is able to sufficiently explain the discrepancy. All clinical documentation related to services performed during the year must be completed before the resident is considered having completed the internship.

In order to meet the 2,000 hours for the overall program, residents can not miss more time than allotted through their vacation, holiday and floating holiday time. If a resident needs to use more than the allocated entitlement time (e.g., serious medical illness), the resident must notify the

Training Director immediately. Time and experiential opportunities missed beyond the standard entitlement time must be made up within the internship year. Under this circumstance, the resident will be assigned additional responsibilities (i.e., experiential and/or scholarly inquiry work) to be completed on extended days or weekends. If missed time is excessive but justifiable due to illness, the resident may have to arrange for an extended internship year. Missed time in excess of the allocated entitlement time that is not due to serious medical illness will be considered unexcused and may jeopardize the resident's completion of the program.

A resident's graduate program will be notified of the resident's completion of the program as of August 1st after the completion of their training year. If a graduate program allows for a July graduation or conferring of degree, the internship Training Director can notify a graduate program of only the following: (a) whether or not the resident has met the required direct service hours as of the date of notification, (b) whether it is anticipated that the resident will be able to readily complete the required 2,000 hours by July 31st and (c) whether the resident's current status in the program is within good standing.

Post-Doctoral Opportunities

Many residents are interested in pursuing post-doctoral opportunities following the completion of the internship year. Although Holcomb does not have a formal post-doctoral fellowship program, the agency is able to accommodate a limited number of post-doctoral employment opportunities and to provide the requisite clinical and supervision hours for licensure in Pennsylvania. Residents interested in post-doctoral positions should express his/her interest to the Clinical Director during the month of April. Inquiries earlier than this cannot be considered. Residents interested in post-doctoral employment are encouraged to have specific employment position(s) in mind when inquiring. Many post-doctoral hires reflect a combination of functions/role within the agency. Residents may be required to accept a diversified role in order to be offered a post-doctoral position. It is likely that, despite an initial inquiry in April, it may not be possible to extend a formal offer until mid-summer (and at times July). However, you will be notified of all progress toward locating a position. Residents are encouraged to explore outside post-doctoral employment opportunities. Due to limited employment options and supervisory time, not all individuals interested can be accommodated within Holcomb. In fairness to all, consideration will <u>not</u> be made on a first-come, first-served basis. Instead, placements will be made, in consultation with the relevant Regional Director(s), based on the best mutual fit between the resident (and his/her skills, interests and competencies) and the needs of the agency in filling employment positions.

Email Access / IT Issues

Each resident will be issued an email account through the agency server. All business communication will be sent through this email address, not your personal account. All email transmitted through the Holcomb email system is secure, even when being sent between agency offices or if you access the email server from your home. Thus, as long as you use the agency email server and the end address is managed by Holcomb, there is no need to encrypt or password-protect confidential records. Residents will receive training on the use of the platform and how to access IT support.

It is important that you check your agency email at least twice a day. This will be one of the primary means of communicating with you between sites, across departments and by secondary supervisors.

You can gain remote access to your Holcomb email account from home or non-agency computers. To do so, go to the following URL:

https://mail.holcombbhs.org

Depending on the version of your computer's operating system, you may not be able to access the email server without making adjustments to your internet security settings. Holcomb assumes no responsibility for changes that you make to your computer or tablet in order to access email remotely.

You will be prompted for your email name and password. The layout of the login screen and the email list is slightly different than you will experience accessing email from the office. The screens may also take longer to refresh, especially when you delete an email or send an email.

Please note that as of August 2010, all thumb/flash drives have been disabled on agency computers. You cannot download information from the network to a thumb drive to work on material at home. This is due to security risks. Prior lost, unprotected thumb drives have necessitated this precaution. Until the IT department can identify a means of Holcomb issuing and securing thumb drives effectively and inexpensively, you cannot use thumb drives to transfer files. If you need to work on a report at home, you may send it to yourself via the Holcomb email. Again, by sending to yourself through the agency email server, there is no risk of intercept due to the use of a virtual private network.

Electronic Health Record

Holcomb Behavioral Health Systems utilizes an electronic health record (EHR) for all clinical documentation. Clinical support staff will provide an overview of access and key features to the software during the internship orientation. Residents may require additional support to become fully comfortable with the software. All clinical documentation, unless otherwise informed by a supervisor, must be recorded in the EHR. All office-based service documentation must be entered into the system the same day as the service. Community-based services may be entered within 24 hours, unless a mobile electronic method of data entry has been provided (e.g., an electronic tablet) by the agency whereby same-day entry is expected.

Given the accessibility of all client records from any agency location, residents are encouraged to remain abreast of the range of services provided to their clients by other professionals within the organization. The EHR affords all staff greater resources to provide quality coordinated care.

Faculty

Natalie Bilynsky, Ph.D. is Clinical Director at Holcomb Behavioral Health Systems. She provides clinical oversight for all Holcomb programs. Dr. Bilynsky received her doctoral degree in counseling psychology from Boston College. She is licensed as a psychologist in Pennsylvania. She has devoted her career to working in community mental health. She joined the Holcomb team in 2016 but has served as Clinical Director in several agencies in Philadelphia and Delaware County. Her clinical focus is on working with children, adolescents and families. She has specialized in the treatment of trauma.

Bethany Dudash, Psy.D. is a Clinical Coordinator at Holcomb in the Exton office. Dr. Dudash received her doctoral degree in clinical psychology from the American School of Professional Psychology at Argosy University/Washington, DC. She is licensed as a psychologist in Pennsylvania. Her areas of clinical interests and experiences include Family Systems (specifically the Ecosystemic Structural Family Systems model), children and adolescents, and community mental health. Other clinical interests include geriatrics and psychological assessment.

Jesse Matthews, Psy.D. is a licensed psychologist and a graduate of Immaculata University's clinical psychology PsyD program. He has been with Holcomb for the past four years, having completed his internship and postdoctoral training here. With Holcomb, Dr. Matthews works in the Kennett Square outpatient substance abuse program and providing substance abuse assessments in the Chester County Youth Center. Dr. Matthews also provides supervision in the internship program and assists with assessments for Mental Health Court and Behavioral Health Rehabilitative Services. Dr. Matthews has also been in private practice since 2012 and he is an adjunct faculty member at Immaculata University. His clinical interests include: substance abuse; mood disorders; ADHD; relationship issues; ethics; and stress and work/life balance.

Kathleen McDonald, Psy.D. is a licensed psychologist. Dr. McDonald received her doctoral degree in Clinical Psychology from Immaculata University. She works out of the Kennett Square Office and has been with Holcomb for more than 6 years. Her areas of clinical interest and experience include: mood disorders, substance abuse, psychotic disorders, anxiety, relationship issues, cultural diversity, trauma, Cognitive Behavior Therapy and Family Systems. Other areas of interest are couples, and grief counseling.

Brian McManus, Ph.D. is Holcomb's Internship Training Director. Dr. McManus is a licensed psychologist and graduate of the Clinical Psychology Program at DePaul University in Chicago. Training at DePaul emphasized delivery of services for youth and families living in urban settings, including services delivered in schools and community mental health centers. His area of specialization is in child/adolescence and family therapy. Dr. McManus has research and clinical experience focused on intimate partner violence and treatment of substance use disorders. Areas of clinical interest include: Family Systems, Developmental Psychopathology, Attachment, Cognitive Behavioral Therapy, Motivational Interviewing/Enhancement, Relapse Prevention, and Psychological Assessment.

Roger Osmun, Ph.D. is Holcomb's Chief Clinical Officer and served as the internship's Training Director during its initial 5 years. Dr. Osmun received his degree in clinical psychology from Temple University. He is licensed as a psychologist in Pennsylvania, Delaware and Maryland.

His area of specialization is in child/adolescence and family therapy. He is adjunct faculty at Immaculata University and Philadelphia College of Osteopathic Medicine. His clinical and research interests include: CBT, Humanistic Therapy, Object Relational Therapy, Structural Family Therapy; neuropsychological assessment; biological bases of addiction; cultural diversity; empirically-supported treatments and use of outcome measures to assess treatment efficacy.

Andrea Parry, Psy.D. received her degree in clinical psychology from Philadelphia College of Osteopathic Medicine (PCOM). She is licensed as a psychologist in Pennsylvania. Her areas of clinical interests and experiences include clinical supervision, Behavioral Health Rehabilitative Services, forensic assessment, and community mental health. Other clinical and research interests include Cognitive Behavioral Therapy (CBT) and psychological assessment.

Kathleen West, Ph.D. is a graduate of Temple University and began her career as a psychologist with the Devereux Foundation. She has maintained an independent practice since 1999 treating children, adolescents and families, and has specialized in the treatment of trauma, with emphasis on early attachment and development.

Anjun Irfan, M.D. received his medical degree from Nishtar Medical College. He completed his internship at Christina Hospital and his residency at the Medical College of Pennsylvania. Dr. Irfan is Chief of Psychiatry at Chester County Hospital. He also is an Assistant Clinical Professor at Philadelphia College of Osteopathic Medicine.

Additional clinical faculty may be assigned to participate in the internship program at any time during the year. All faculty are qualified by education, training and/or licensure/certification to provide clinical supervision, didactics or other support services.

AGENCY LOCATIONS

HBHS-Home Office 467 Creamery Way **Exton, PA** 19341 Ph: 610-363-1488 Fx: 610-363-8273 CSS Fx: 610-363-8848 Clinical Fx: 610-363-1222	**HBHS- Valley Creek Crisis** 469 Creamery Way **Exton, PA** 19341 Ph: 610-280-3270 Warm Line: 866-846-2722 Toll Free: 877-918-2100 Residential Ph: 610-594-1665 Consumer Ph: 610-594-1666 Chart room Fx: 610-594-1664 Residential Fx: 484-713-6711	**HBHS MR Division** **Aldan House** 6 Glenwood Circle **Aldan, PA** 19018 Ph: 610-622-4795 Fx: 610-622-5919	**HBHS MR Division** **Secane** 333 North Avenue Bldg., B, Apt. 19A **Secane, PA** 19018 Ph: 610-328-1851 Fx: 610-328-1599
HBHS 225 South 69th Street **Upper Darby, PA** 19082 Ph: 610-352-8943 Admin/upper Fx: 610-352-8880 Front Desk Fx: 610-352-3412 CSS/lower Fx: 610-352-5452	**Cornerstone Clubhouse** 224 Hall Street **Phoenixville, PA** 19460 Ph: 610-935-2290 Fx: 610-935-2393	**HBHS MR Division** **Lincoln Green** 400 Presidential Blvd., Apt. 1101 **Philadelphia, PA** 19131 Ph: 215-877-3675 Fx: 215-877-3918	**HBHS MR Division** **Radnor** 108 Hillside Circle **Villanova, PA** 19085 Ph: 610-687-3183 Fx: 610-867-3184
West Chester CRR 1308 West Chester Pike, B-3 **West Chester, PA** 19382 Ph: 610-692-1959 Fx: 610-692-0363	**HBHS** 920 E. Baltimore Pike, Suite 200 **Kennett Square, PA** 19348 Ph: 610-388-7400 Fx: 610-388-7407 **Chester County Substance Abuse** Main: 610-388-9225 Fax: 610-388-9224	**HBHS/MR Division Office** 126 E. Baltimore Pike Gayley Square **Media, PA** 19063 Ph: 484-444-0412 Fx: 484-444-0421	**HBHS MR Division** 205 Yale Ave. **Morton, PA** 19070 Phone : 610-544-4628 Fax - 610-544-4635
Upper Darby CRR 7200 Merion Terrace, C115 **Upper Darby, PA 19082** Ph: 610-352-8698 Fx: 610-352-8988	**Newlin House** 1 Indian Hollow Lane **Kennett Square, PA** 19348 Ph: 610-347-2048 Fx: 610-347-1805	**Burmont House** 115 Burmont Road-Apt. A **Drexel Hill, PA** 19026-2041 Ph: 610-394-6119 Fx: 610-394-6748	**Open Door, Inc.** 254 E. Main Street **Newark, DE** 19711 Ph: 302-731-1504 Fx: 302-731-2720 Toll Free: 877-860-6955
HBHS Rockland Professional Bldg., 1940 North 13th St., Suite 248 **Reading, PA** 19604 Ph: 610-939-9999 Fx: 610-939-9996	**Kirk Lane-MISA House** 290 Kirk Lane **Media, PA** 19063 Ph: 610-566-5412 Fx: 610-566-3924	**Aston House** 1021 Cherry Tree Road **Aston, PA** 19014 Ph: 610-364-9846 Fx: 610-364-9848	**Open Door, Inc.** 3301 Green Street **Claymont, DE** 19703 Ph: 302-798-9555 Fx: 302-798-9550
HBHS 1405 North Cedar Crest Blvd., Suite 105 **Allentown, PA** 18104-2308 Ph: 610-435-4151 Fx: 610-435-3044	**Family-Child Resources, Inc.** 3995 E. Market St. **York, PA** 17402 Phone: 717-757-1227 Fax: 717-757-1353	**HBHS** 400 Creekside Dr. **Pottstown, PA** 19464 Ph: 484-925-0990 Fx: 484-949-8597	**Open Door, Inc.** 884 B Walker Road **Dover, DE** 19904 Ph: 302-678-4911 Fx: 302-678-4948
HBHS 929 Northampton Street **Easton, PA** 18042 Ph: 610-330-9862 Front Desk Fx: 610-330-2854 Chartroom Fx: 610-330-2853	**New Jersey- SHIP Office** Heights of Collingswood 540 Colllings Avenue Apt. A-119 **Collingswood, NJ** 08107 Ph: 856-858-2616 Fx: 856-858-1289	**Open Door, Inc.** 107 Pennsylvania Ave. **Seaford, DE** 19973 Ph: 302-629-7900 Fx: 302-629-7954	**Open Door, Inc.** 2400 W. 4th Street **Wilmington, DE** 19805 Ph: 302-654-1816 Fx: 302-654-4130

Directions from Exton office

Newark Office: Approximate drive time: 50 minutes

- Take US 202 South	20 miles
- Merge onto I-95 South	9.7 miles
- Take Exit 3 (Route 273/Ogeltown Rd.) towards Newark	3.0 miles
- Route 273 becomes Main Street within Newark limits	0.5 miles

- Office is on the right across from Bing's Bakery

Parking in shopping center on right immediately past office. Obtain a parking placard from the office to avoid towing.

Kennett Square Office: Approximate drive time: 25 minutes

- Take US 202 South	6.9 miles
- Turn Right onto PA-926 (Street Rd)	5.5 miles
- Turn Left onto PA-52 (Lenape Rd)	0.5 miles
- Turn Right onto US-1 (E. Baltimore Pike)	0.4 miles

- Office is on left-hand side of road just past Dairy Queen (which is on the right side). Look for large blue Holcomb sign. MH services are on the upper floor (front of building) and D&A services are on the lower level in the back of the building.

Chester County Prison: Approximate drive time: 25 minutes

- Take US 202 South	6.9 miles
- Turn Right onto PA-926 (Street Rd)	5.5 miles
- Turn Right onto PA-52 (Lenape Rd)	0.8 miles
- Take a slight Left onto S. Wawaset Rd.	0.5 miles

- CCP and Juvenile Detention Center are on the right, CCP is further back toward the left of the juvenile detention center.

Upper Darby Office: Approximately drive time: 45 minutes

- Take US 202 South	7.0 miles
- Take Route 3 Exit toward Newtown Square	17.8 miles
- Turn Right onto 69th Stree	0.4 miles

- Office is on left-hand side of road. Look for large blue Holcomb sign on the side of the building. Limited parking is available in the parking lot. Ask staff where best to park to avoid metered parking.

Sample Resident Schedule – Child/Adolescent Rotation

Time	Monday	Tuesday	Wednesday	Thursday	Friday
8:00	X	X	X	X	X
9:00	Outpt. Sup. A, B, C & D	**Didactics**	Rotational Supervision 1	X	X
10:00	Outpt. Sup. E, F, G & H	↓	Rotational Supervision 2	Rotational Work	Outpatient Therapy
11:00	**Resident Networking**	*Travel*	Rotational Supervision	↓	↓
12:00	↓	Rotational Work	↓	↓	↓
1:00	**Case Conference**	↓	↓	↓	↓
2:00	↓	↓	↓	↓	↓
3:00	Travel Time	↓	↓	↓	↓
4:00	Outpatient Therapy	↓	↓	↓	
5:00	↓	↓	↓	↓	
6:00	↓	↓	↓	↓	
7:00	↓				
8:00					
	11 hrs.	10 hrs.	10 hrs.	9 hrs.	6 hrs.

- Family Assessments
- Family Therapy
- Individual Therapy

Sample Resident Schedule – Substance Abuse Rotation

Time	Monday	Tuesday	Wednesday	Thursday	Friday
8:00	X	X	X	X	X
9:00	Outpt. Sup. A, B, C & D	**Didactics**	Rotational Work	Rotational Work	X
10:00	Outpt. Sup. E, F, G & H	↓	↓	↓	Outpatient Therapy
11:00	**Resident Networking**	Rotational Supervision 1	↓	↓	↓
12:00	↓	Rotational Supervision 2	↓	↓	↓
1:00	**Case Conference**	*Travel*	↓	↓	↓
2:00	↓	Rotational Work	↓	↓	↓
3:00	Travel Time	↓	↓	↓	↓
4:00	Outpatient Therapy	↓	↓	↓	
5:00	↓	↓	↓	↓	
6:00	↓	↓			
7:00	↓	↓			
8:00					
	11 hrs.	10 hrs.	9 hrs.	9 hrs.	6 hrs.

- Chemical Dependency Assessments
- Individual Therapy
- Group Therapy

Sample Resident Schedule – Special Population Rotation

Time	Monday	Tuesday	Wednesday	Thursday	Friday
8:00	X	X	X	X	X
9:00	Outpt. Sup. A, B, C & D	**Didactics**	Rotational Supervision 1	Rotational Supervision 2	X
10:00	Outpt. Sup. E, F, G & H	↓	Rotational Work	↓	Outpatient Therapy
11:00	**Resident Networking**	Rotational Work	↓	↓	↓
12:00	↓	↓	↓	↓	↓
1:00	**Case Conference**	↓	↓	↓	↓
2:00	↓	↓	↓	↓	↓
3:00	Travel Time	↓	↓	↓	↓
4:00	Outpatient Therapy	↓	↓	↓	
5:00	↓	↓	↓	↓	
6:00	↓		↓	↓	
7:00	↓				
8:00					
	11 hrs.	9 hrs.	10 hrs.	10 hrs.	6 hrs.

- Mental Health Court Assessments
- Neuropsychological Screenings
- Neuropsychological Assessments
- Cognitive Rehabilitative Counseling

Sample Resident Schedule – Crisis Rotation

Time	Monday	Tuesday	Wednesday	Thursday	Friday
8:00	X	X	X	X	X
9:00	Outpt. Sup. A, B, C & D	**Didactics**	Rotational Work	X	X
10:00	Outpt. Sup. E, F, G & H	↓	↓	Rotational Work	Outpatient Therapy
11:00	**Resident Networking**	Rotational Work	↓	↓	↓
12:00	↓	Rotational Supervision 1	↓	↓	↓
1:00	**Case Conference**	Rotational Supervision 2	↓	↓	↓
2:00	↓	↓	↓	↓	↓
3:00	Travel Time	↓	↓	↓	↓
4:00	Outpatient Therapy	↓	↓	↓	
5:00	↓	↓	↓	↓	
6:00	↓	↓		↓	
7:00	↓			↓	
8:00					
	11 hrs.	10 hrs.	9 hrs.	10 hrs.	6 hrs.

- crisis evaluations
- telephone crisis intervention
- mobile crisis intervention
- recovery-oriented individual and group counseling
- consultation with multidisciplinary crisis team

Didactics: Abstracts, Learning Objectives and Readings

Ethical Decision-Making in Clinical Practice

Standard ethical principles utilized within decision making in psychological practice are reviewed so that residents can see their applicability in routine, daily decisions not just "crises". The didactic emphasizes the practical application of these principles utilizing scenarios in order to determine how both good and poor decisions can be made. Residents will apply these principles to situations in order to determine how to combine clinically effective interventions while maintaining the highest ethical standards.

1. Residents will be able to define basic ethical principle constructs and explain how these principles related to ethical decision making.
2. Residents will be able to apply the principles of ethical decision making to treatment contexts.
3. Residents will able to relate general ethical decision making principles with established professional codes of ethics.

Gottlieb, M. C., Handelsman, M. M., & Knapp, S. (2013). A model for integrated ethics consultation. *Professional Psychology: Research and Practice, 44*(5), 307-313. doi:10.1037/a0033541

Knapp, S., & VanderCreek, L. (2007). Balancing respect for autonomy with competing values with the use of principle-based ethics. *Psychotherapy: Theory, Research, Practice, Training, 44*(4), 397-404. doi:10.1037/0033-3204.44.4.397

Knapp, S., & VandeCreek, L. (2007). When values of different cultures conflict: Ethical decision making in a multicultural context. *Professional Psychology: Research and Practice, 38*(6), 660-666. doi:10.1037/0735-7028.38.6.660

Biological Bases of Chemical Dependency

The principles of substance abuse and dependency are reviewed with emphasis on the physiological mechanisms of tolerance and chemical dependency. These principles are referenced against the psychological elements of dependency in order to produce a more holistic understanding of the dependency process.

1. Residents will be able to identify the physiological mechanism of tolerance for at least two substances.
2. Residents will be able to identify the physiological mechanism of chemical dependency for at least two substances.
3. Residents will be able to identify the interrelationship between the physiological issues and the psychological issues present with chemical dependency.

Feldstein, Ewing, S. W., & Chung, T. (2013). Neuroimaging mechanisms of change in

psychotherapy for addictive behaviors: Emerging translational approaches that bridge biology and behavior. *Psychology of Addictive Behaviors, 27*(2), 329-335. doi:10.1037/a0031491

Mendelson, J., Flower, K., Pletcher, M. J., & Galloway, G. P. (2008). Addiction to prescription opioids: Characteristics of the emerging epidemic and treatment with Buprenorphine. *Experimental and Clinical Psychopharmacology, 16*(5), 435-441. doi:10.1037/a0013637

Sneider, J. T., Pope, H. G., Silveri, M. M., Simpson, N. S., Gruber, S. A., & Yurgelun-Todd, D. A. (2006). Altered regional blood volume in chronic cannabis smokers. *Experimental and Clinical Psychopharmacology, 14*(4), 422-428. doi:10.1037/1064-1297.14.4.422

Psychotherapy Theory and Practice: Anxiety Disorders

The various anxiety disorders are reviewed, with similarities and differences noted as it relates to the clinical presentation. Cognitive and behavioral interventions are discussed within the context of the specific clinical manifestation of each anxiety disorder. Model interventions and promising intervention strategies are reviewed.

1. Residents will be able to identify the primary commonalities of the various anxiety disorders as per DSM-IV and DSM-5.
2. Residents will be able to identify model interventions for the various anxiety disorders.
3. Residents will be able to apply a combination of interventions applicable to specific anxiety disorders.

Goldin, P. R., Ziv, M., Jazaieri, H., Werner, K., Kraemer, H., Heimberg, R. G., & Gross, J. J. (2012). Cognitive reappraisal self-efficacy mediates the effects of individual cognitive-behavioral therapy for social anxiety disorder. *Journal of Consulting and Clinical Psychology, 80*(6), 1034-1040. doi:10.1037/a0028555

Hofmann, S. G., Wu, J. Q., & Boettcher, H. (2014). Effects of cognitive-behavioral therapy for anxiety disorders on quality of life: A meta-analysis. *Journal of Consulting and Clinical Psychology, 82*(3), 375-391. doi:10.1037/a0035491

Podell, J. L., Kendall, P. C., Gosch, E. A., Compton, S. N., March, J. S., Albano, A.,...Piacentini, J. C. (2013). Therapist factors and outcomes in CBT for anxiety in youth. *Professional Psychology: Research and Practice, 44*(2), 89-98. doi:10.1037/a0031700

Differential Diagnostic Considerations

The DSM system is frequently seen as a simple list of signs and symptoms and as such diagnosing is often oversimplified in a manner that results in inaccurate diagnoses. The principles of differential diagnosing will be reviewed and specific disorders will be reviewed to illustrate these points.

1. Residents will be able to identify common differential diagnostic mistakes.
2. Residents will be able to identify core strategies to remain mindful of critical diagnostic considerations.
3. Residents will be able to apply these strategies to clinical vignettes that represent diagnostic challenges.

Schillaci, J., Yanasak, E., Adams, J. H., Dunn, N. J., & Rehm, L. P. (2009). Guidelines for differential diagnoses in a population with posttraumatic stress disorder. *Professional Psychology: Research and Practice, 40*(1), 39-45. doi:10.1037/a0013910

Neuropsychological Assessment and Rehabilitation

The principles of the most primary neuropsychological constructs will be reviewed, which includes but is not limited to: attention/concentration, memory, executive functioning, and language. The didactic emphasizes the methods of assessing these constructs and how a neuropsychological assessment protocol would be assembled based on the consultative question(s) and the results ongoing testing. An emphasis will exist on developing concrete recommendations and to develop creative rehabilitative interventions.

1. Residents will be able to identify how the various neuropsychological constructs are defined and typically assessed.
2. Residents will be able to identify the process in which neuropsychological protocols are developed based on referral questions and existing testing results.
3. Residents will be able to identify how to provide rehabilitative interventions based on neuropsychological deficits and strengths.

Brooks, B. L., Strauss, E., Sherman, E. M., & Iverson, G. L. (2009). Developments in neuropsychological assessment: Refining psychometric and clinical interpretive methods. *Canadian Psychology, 50*(3), 196-209. doi:10.1037/a0016066

Guilmette, T. J., Temple, R. O., & Kennedy, M. (2008). The relationships among rehabilitation staff members' reports of cognitive dysfunction and neuropsychological assessment in an acute rehabilitation population. *Rehabilitation Psychology, 53*(2), 238-242. doi:10.1037/0090-5550.53.2.238

Poreh, A. (2005). Analysis of mean learning of normal participants on the rey auditory-verbal learning test. *Psychological Assessment, 17*(2), 191-199. doi:10.1037/1040-3590.17.2.191

Neuroimaging

The use of neuroimaging through CTs or MRIs is more commonplace with clients where neuropsychological issues are suspected. The principles of how various neuroimaging methods work and their relative strengths and weaknesses will be reviewed. Brain structure as depicted via the primary neuroimaging methods will be discussed through the use of real images. Discussion will include the process of reviewing neuroimages and radiology reports to consider the relevance of findings to functional neuropsychological testing.

1. Residents will be able to differentiate between the three most common neuroimaging methods.
2. Residents will be able to identify core methods of approaching a review of neuroimaging from a non-physician perspective.
3. Residents will be able to apply clinical vignettes and actual brain images within the context of rounding out neuropsychological testing impressions.

Miller, G. A., Elbert, T., Sutton, B. P., & Heller, W. (2007). Innovative clinical assessment technologies: Challenges and opportunities in neuroimaging. *Psychological Assessment, 19*(1), 58-73. doi:10.1037/1040-3590.19.1.58

Clinical Supervision and Consultation

The principles of clinical supervision and case consultation are reviewed as it applies to behavioral health services. The roles of supervisor and supervisee will be broken down in order to better examine the requisite components of this relationship to support the highest quality supervision. Consultation questions will be reviewed to support how to form the most effective consultative requests of other professionals and how to provide the best response to the requests received from other professionals.

1. Residents will be able to identify the similarities and differences between clinical supervision and case consultation.
2. Residents will be able to identify the skills required by both the supervisor and supervisee to support quality clinical supervision.
3. Residents will be able to identify the core strategies to form quality consultation questions and how respond to the consultation requests of others.

Kaslow, N. J., Falender, C. A., & Grus, C. L. (2012). Valuing and practicing competency-based supervision: A transformational leadership perspective. *Training and Education in Professional Psychology*, *6*(1), 47-54. doi:10.1037/a0026704

Reiser, R. P., & Milne, D. L. (2014). A systematic review and reformulation of outcome evaluation in clinical supervision: Applying the fidelity framework. *Training and Education in Professional Psychology, 8*(3), 149-157. doi:10.1037/tep0000031

Rousmaniere, T. G., & Ellis, M. V. (2013). Developing the construct and measure of collaborative clinical supervision: the supervisee's perspective. *Training and Education in Professional Psychology, 7*(4), 300-308. doi:10.1037/a0033796

LGBTQI

Despite progressive strides in respect and equality, LGBTQI individuals continue to face misunderstanding and bias even from well-intended professionals. The didactic will address the unique experiences of individuals that identify as LGBTQI and how behavioral health professionals can more effectively meet their needs through affirmative interventions.

1. Residents will increase their familiarity with specific issues and barriers faced by LGBTQI individuals, especially those who are in need of behavioral health care services.
2. Residents will increase their awareness of how special needs of LGBTQI individuals may intersect with their mental health needs.
3. Residents will enhance their ability to offer sensitive, affirmative, culturally relevant, and effective treatment to LGBTQI individuals.

Fassinger, R. E., Shullman, S. L., & Stevenson, M. R. (2010, April). Toward an affirmative lesbian, gay, bisexual, and transgender leadership paradigm. *American Psychologist, 65*(3), 201-215. doi:10.1037/a0018597

Haldeman, D. C. (2010). Reflections of a gay male psychotherapist. *Psychotherapy: Theory, Research, Practice, Training, 47*(2), 177-185. doi:10.1037/a0019757

Israel, T., Gorcheva, R., Walther, W. A., Sulzner, J. M., & Cohen, J. (2008). Therapists' helpful and unhelpful situations with LGBT clients: An exploratory study. *Professional Psychology: Research and Practice, 39*(3), 361-368. doi:10.1037/0735-7028.39.3.361

Johnson, S. D. (2012). Gay affirmative psychotherapy with lesbian, gay, and bisexual individuals: Implications for contemporary psychotherapy research. *American Journal of Orthopsychiatry, 82*(4), 516-522. doi:10.1111/j.1939-0025.2012.01180.x

Psychotherapy Theory and Practice: Humanistic

The humanistic theoretical view of psychotherapy will be reviewed with emphasis on the elements of the theory that can be incorporated into therapy regardless of the clinician's overarching theoretical framework. In particular, James Bugental's work will be used to accentuate this integrative process. Application will be demonstrated through role play interactions within the didactic.

1. Residents will be able to identify the core components of a humanistic approach to psychotherapy, even if other theoretical constructs are more primary.
2. Residents will be able to identify the value of humanistic approaches to address complicated clinical issues.
3. Residents will be able to apply humanistic approaches through integration into role play scenarios.

Wampold, B. E. (2012). Humanism as a common factor in psychotherapy. *Psychotherapy, 49*(4), 445-449. doi:10.1037/a0027113

Legal Issues for Psychologists

The most common legal requirements faced by psychologists will be reviewed, with emphasis on the interface between ethical obligations and legal requirements. Strategies for remaining

mindful of legal obligations will be discussed. Key Pennsylvania laws applicable to psychologists and general behavioral health practice will be reviewed. Practical application will occur through discussion of vignettes.

1. Residents will be able to identify common legal obligations of psychologists.
2. Residents will be able to distinguish the role of ethical and legal obligations and reconcile the two.
3. Residents will increase their proficiency with reasoning through situations that may present legal dilemmas.

Herman, M., & Sharer, N. (2013). Trying to summarize state licensure laws for psychologists: Burial by grains of salt. *Training and Education in Professional Psychology, 7*(2), 123-133. doi:10.1037/a0031636

Knapp, S., Gottlieb, M., Berman, J., & Handelsman, M. M. (2007). When laws and ethics collide: What should psychologists do? *Professional Psychology: Research and Practice, 38*(1), 54-59. doi:10.1037/0735-7028.38.1.54

Clinical Outcome Measures

Clinical outcome measures have become ubiquitous but continue to be overlooked data available to most clinicians. The principles of selecting and utilizing outcome measures in order to achieve specific purposes will be reviewed. Critical psychometric properties will be discussed within the context of measure selection. The process of application of outcome measures will be reviewed from both a client and aggregate perspective.

1. Residents will be able to identify the process in which appropriate outcome measures would be selected to achieve the desired purpose.
2. Residents will be able to identify how to consider core psychometric properties salient for the measures intended purpose.
3. Residents will be able to identify how outcome measures can be used to evaluate individual client progress or programmatic success.

Joyce, A. S., Piper, W. E., & Ogrodniczuk, J. S. (2007). Therapeutic alliance and cohesion variables as predictors of outcome in short-term group psychotherapy. *International Journal of Group Psychotherapy, 57*(3), 269-296.

Licensure and Professional Issues

Psychology as a profession is discussed beginning with the commonalities across states with respect to professional licensure. Specifics will be reviewed as it relates to Pennsylvania and other regional states. Rights and responsibilities inherent to psychology licensure will be reviewed. Interdisciplinary relationships and understanding of the scope of other professional licenses is critical to collaborative work.

1. Residents will be able to identify the licensure requirements for at least one state.

2. Residents will be able to identify the scope of rights and responsibilities associated with licensure as a psychologist.
3. Residents will be able to identify the scope of responsibilities for at least one other behavioral health profession.

Baker, D. C., & Bufka, L. F. (2011). *Professional Psychology: Research and Practice, 42*(6), 405-411. doi:10.1037/a0025037

Reaves, R. P. (2006). The history of licensure of psychologists in the United States and Canada. In T. J. Vaughn (Ed.), *Psychology licensure and certification,* (1 ed. pp. 17-26). Washington, DC: American Psychological Association.

Sharpless, B. A., & Barber, J. P. (2009). The examination for professional practice in psychology (EPPP) in the era of evidenced-based practice. *Professional Psychology: Research and Practice, 40*(4), 333-340. doi:10.1037/a0013983

Motivational Interviewing / Stage of Change

The principles of Motivational Interviewing include consideration of an individual's Stage of Change regarding a problematic behavior. Clients present with varying degrees of willingness, ability, and readiness to implement behavioral change despite cognitive distress. Motivational Interviewing is a therapeutic strategy that harnesses a client's otherwise resistance to change by embracing the discrepancies between their desired outcomes and current status. Basic principles of Motivational Interviewing will be discussed and application of it will be implemented based upon case(s) presented in the didactic.

1. Residents will be able to identify Stages of Change and explain how corresponding stage relates to intervention strategy.
2. Residents will be able to identify critical concepts of Motivational Interviewing.
3. Residents will able to identify MI techniques.

B. (2014). The relationship in motivational interviewing. *Psychotherapy,* 51(3), 358-363.

Westra, H. A., & Aviram, A. (2013). Core skills in motivational interviewing. *Psychotherapy, 50*(3), 273-278. doi:10.1037/a0032409

Psychological Evaluation of Children

Children are brought for psychological evaluations for a range of reasons and there is incredible diversity in the presenting problem. This didactic explains core features essential in the clinical interview of a child and how to translate that to the page, namely, the intended reader. The presenter will discuss how to interweave quantitative and qualitative data into a sophisticated report that maintains strong emphasis on the least restrictive level of care for the child while providing explicit instruction to the clinical team to best serve the child and their family.

1. Residents will be able to identify core components of a psychological evaluation for

children.
2. Residents will be able to identify methods for determining level of care for a child.
3. Residents will be able to identify non-specific factors that influence a psychological evaluation of a child, including influence of referral source or parent, factors of the clinical team, and investment of maintaining the child as the identified patient in a system.

Tavernor, L., Barron, E., Rodgers, J., & McConachie, H. (2012). Finding out what matters: Validity of quality of life measurement in young people with ASD. *Child: Care, Health, and Development, 39*(4), 592-601. doi:10.1111/j.1365-2214.2012.01377.x

Psychotherapy and Practice: Psychotic Disorders

Approximately 1% of the population is estimated to experience a psychotic disorder. These disorders may feature delusional beliefs, hallucinatory experiences, disorganized speech and disorganized behavior and can have a significant impact on an individual's psychosocial functioning. While psychopharmacological interventions have played a large role in the treatment of people with psychotic disorders, a growing body of literature has developed which suggests that psychotherapy can play an important role as an adjunct-therapy to help people manage symptoms and develop adaptive coping skills. This didactic will help trainees increase competency with assessment of psychotic disorders, increase the awareness of evidence supported interventions, and increase trainees awareness of diverse theories pertaining to psychosocial/therapeutic interventions for individuals with psychotic disorders.

1. Residents will be able to identify methods for assessment of psychotic disorders.
2. Residents will be able to identify increased awareness of evidence-based interventions.
3. Residents will be able to identify awareness of diverse theories pertaining to psychosocial / therapeutic interventions for individuals with psychotic disorders.

Ethnic Minorities

The purpose of the "Counseling Ethnic Minorities" didactic is to increase knowledge about the relationship between culture and mental health in ethnic minority groups.

1. Residents will demonstrate increased cultural self-awareness.
2. Residents will be able to describe an understanding of the ecological perspective of human development.
3. Residents will demonstrate increased knowledge of best practices as it pertains to assessment and intervention with ethnic minority consumers.

Trierweiler, S. J., Muroff, J. R., Jackson, J. S., Neighbors, H. W., & Munday, C. (2005). Clinician race, situational attributions, and diagnoses of mood versus schizophrenia disorders. *Cultural Diversity and Ethnic Minority Psychology, 11*(4), 351-364. doi:10.1037/1099-9809.11.4.351

Trauma-informed Therapy

Trauma and Trauma-informed care will be reviewed and various issues related to client trauma will be discussed. A group discussion regarding the statistics and rates of trauma in treatment will be reviewed. Additionally, the presenter will open a dialogue about the perception of trauma within the lives of their clients. The impact of personal and/or professional bias regarding trauma will also be discussed to facilitate and increased understanding and acceptance of individual factors related to client trauma.

1. Residents will be able to identify the statistical impact of trauma in treatment.
2. Residents will identify main principles of Trauma-informed therapy.
3. Residents will demonstrate an increased awareness of the impact of bias in relationship to client treatment.

Functional Behavior Assessment

The purpose of this didactic is to review characteristics and selected use of functional behavior assessments. Behavioral principles will be discussed and core components of functional behavior assessments will be reviewed. A description of the purpose of the functional behavior assessment will be explained as well as essential characteristics of data collection and analysis. Discussion of reinforcement will occur in combination with direction on creation of interventions related to specific problem behaviors.

1. Residents will be able to identify core components related to behavioral principles.
2. Residents will be able to describe the steps involved with developing a functional behavior assessment.
3. Residents will be able to identify strategies for data collection and data analysis.

Gable, R. A., Lee Park, K., & Scott, T. M. (2014). Functional behavioral assessment and students at risk for or with emotional disabilities: Current issues and considerations. *Education and Treatment of Children, 37*(1), 111-135.

Kern, L., Gallagher, P., Starosta, K., Hickman, W., & George, M. (2006). Longitudinal outcomes of functional behavioral assessment-based intervention. *Journal of Positive Behavioral Interventions, 8*(2), 67-78.

Noell, G. H., & Gansle, K. A. (2009). Introduction to functional behavioral assessment. In K. A. Akin-Little, S. G. Little, M. A. Bray, & T. J. Kehle (Eds.), *Behavioral interventions in schools: Evidence-based positive strategies* (pp. 43-58). Washington, DC: American Psychological Association.

Shayne, R., & Miltenberger, R. G. (2013). Evaluation of behavioral skills training for teaching functional assessment and treatment selection skills to parents. *Behavioral Interventions, 28,* 4-21. doi:10.1002/bin.1350

Cultural Competency

This didactic addresses the rapid demographic shifts in the United States, pro-western bias in psychology, and mental health disparities among minority populations. Discussion will include that cultural competence can be applied to all individuals given that human interaction is anchored in a cultural context. Essential concepts will be explored including cultural encapsulation, the core components of cultural competence, and self-awareness of one's own blind spots in clinical work. Strategies for identifying and overcoming cultural biases through cultural self-assessment will be reviewed.

1. Residents will be able to define essential concepts related to cultural competency.
2. Residents will be able to identify factors related to mental health disparities across minority and under-represented populations.
3. Residents will be able to identify barriers to developing self-awareness and strategies for addressing the same.

Dialectical Behavior Therapy

Dialectical Behavior Therapy (DBT) is a method designed to assist clients with building skills to decrease emotional reactivity which is generally considered to be abnormal or disproportionate to the stimulus. This didactic will introduce the DBT model and structure, common target behaviors, and skills. Also to be reviewed will include an overview of Borderline Personality Disorder and the general literature regarding the effectiveness of DBT treatment for it.

1. Residents will be able to describe the population for whom DBT is designed as well as the structure of the program.
2. Residents will be able to identify the specific skills which are taught in the model.
3. Residents will be able to describe the role of homework in the DBT model.

Chronic Pain and Behavioral Health

Best practice standards centrally emphasize chronic pain management from a biopsychosocial standpoint. Chronic pain has historically been viewed as a nuisance medical problem whose symptom cluster has represented somatized psychopathology, substance dependence, or antisocial behavior in search of disability funding. Chronic pain is a complex phenomenon that can be viewed from several theoretical models and psychological treatment of which is best applied from a multidisciplinary perspective. There is emerging clinical evidence regarding the efficacy of assisting clients to not only identify and challenge maladaptive cognitions related to pain but to also modify metacognitions that maintain endorsements of high pain levels.

1. Residents will be able to identify and describe at least one model related to chronic pain.
2. Residents will be able to describe the impact of chronic pain from a biopsychosocial perspective.

3. Residents will be able to identify core features of a chronic pain psychological assessment and establish a client's perception of pain, etiology of their pain, impact on quality of life, and coping strategies.

Newton-John, T. R., Mason, C., & Hunter, M. (2014). The role of resilience in adjustment and coping with chronic pain. *Rehabilitation Psychology, 59*(3), 360-365. doi:10.1037/a0037023

Tennen, H., Affleck, G., & Zautra, A. (2006). Depression history and coping with chronic pain: A daily process analysis. *Health Psychology, 25*(3), 370-379. doi:10.1037/0278-6133.25.3.370

Psychotherapy Theory and Practice: Interpersonal

Interpersonal Therapy (IPT) is a time-limited therapeutic intervention and has been tested in a broad range of clinical populations. Discussion regarding the fundamental principles and application of IPT will be reviewed. Clinical conceptualization from an IPT perspective includes that individuals can experience relief from psychological symptoms by teaching clients how to improve their communication patterns as well as the manner in which they relate to other people.

1. Residents will develop an ability to translate behavioral health symptoms into the interpersonal context.
2. Residents will demonstrate increased knowledge of exploratory, directive, and supportive techniques that are used in IPT.
3. Residents will be able to identify the fundamental principles of IPT.

Poleshuck, E. L., Gamble, S. A., Cort, N., Hoffman-King, D., Cerrito, B., Rosario-McCabe, L. A., & Giles, D. E. (2010). Interpersonal psychotherapy for co-occurring depression and chronic pain. *Professional Psychology: Research and Practice, 41*(4), 312-318. doi:10.1037/a0019924

Recovery, Relapse Prevention and Harm Reduction

Covered in this didactic is information on both the abstinence and harm reduction movements in substance abuse treatment. Traditional, abstinence-based treatments focus on relapse prevention and dedicating one's efforts to avoiding use of any substances, as well as potentially triggering influences. Involvement in a 12-step program is often encouraged or required, being potentially integrated into a client's treatment. Treatments that utilize a harm reduction approach, including SMART Recovery, promote strategies to avoid further abuse of substances as well as knowledge of oneself and development of coping skills.

1. Residents will be able to describe substance abuse treatment both in the context of an abstinence-based model as well as from a harm reduction perspective.
2. Residents will be able to identify at least two strategies from a harm reduction approach.
3. Residents will be able to identify at least two factors that support development of effective coping strategies for individuals in recovery from substances.

Magill, M., Stout, R. L., & Apodaca, T. R. (2013). Therapist focus on ambivalence and commitment: A longitudinal analysis of motivational interviewing treatment ingredients. *Psychology of Addictive Behaviors, 27*(3), 754-762. doi:10.1037/a0029639

Compassion Fatigue: Care of the Clinician

The didactic includes discussion of the concept of compassion fatigue or burnout as it relates to the clinician. These and related terms will be addressed, in addition to potential sources of difficulty for clinicians and how to recognize when an issue begins to arise. Discussed will be the importance of supervision or consultation, continued education, and the development of an ongoing self-care plan. Self-care strategies for clinicians will be addressed as well as the ethical duty of clinicians to manage sources of difficulty before they begin to impact one's work or the clients served.

1. Residents will be able to describe how to recognize signs of compassion fatigue.
2. Residents will be able to identify at least two self-care strategies.
3. Residents will demonstrate an ability to describe ethical duty within the context of self-care principles.

Adams, R.E., Boscarino, J.A., & Figley, C.R. (2006). Compassion fatigue and psychological distress among social workers: A validation study. *American Journal of Orthopsychiatry, 78*(1), 103-108. doi: 10.1037/0002-9432.76.1.103

Figley, C.R. (2002). Compassion fatigue: Psychotherapists; chronic lack of self-care. *Journal of Clinical Psychology, 58*(11), 1433-1441.

Shapiro, S.L., Brown, K.W., & Beigel, G.M. (2007). Teaching self-care to caregivers: Effects of mindfulness-based stress reduction on the mental health of therapists in training. *Training and Education in Professional Psychology, 1*(2), 105-115.

Substance Abuse Assessment

This didactic covers substance use disorders, the continuum of use, and co-occurring disorders. A review of the range of disorders will provide participants with the necessary information to formulate an accurate diagnosis and to assist a client in accessing the appropriate level of care. Treatments goals are addressed, as well as the levels of care available, community resources, confidentiality, and other relevant issues. The Stages of Change, as discussed in Prochaska and DiClemente's Transtheoretical Model, are reviewed as well as motivational interviewing and other strategies for engaging clients in the assessment and treatment of substance use disorders.

1. Residents will be able to identify distinctions between disorders of substance use, misuse, abuse, and dependence.
2. Residents will be able to identify how to approach treatment with a client presenting with substance-based concerns and with respect to their stage of change.
3. Residents will be able to describe motivational interviewing strategies.

Davis, K. E., Devitt, T., O'Neill, S., Kaiser, S. M., & Mueser, K. T. (2014). Targeting consumers in the early stages of substance use treatment: A pilot study. *Psychiatric Rehabilitation Journal, 37*(1), 37-42. doi:10.1037/prj0000047

Psychotherapy Theory and Practice: Ecosystemic Family Therapy

The Ecosystemic Structural Family Therapy Model (ESFT) is based upon the work of Minuchin and includes assessment, goal setting, and treatment interventions were are rooted in four stages and four pillars. A basic premise of ESFT is that symptoms are viewed as a problem with the system that is being expressed through the children rather than the problem coming from within the child. A discussion regarding the role of attachment and parenting styles will also occur.

1. Residents will be able to describe the four stages and four pillars of the ESFT model.
2. Residents will demonstrate an ability to conceptualize a case from an ESFT perspective.
3. Residents will identify at least two techniques from the ESFT model.

Lindblad-Goldberg, M., Northey, W.F. (2013). Ecosystemic structural family therapy: Theoretical and clinical foundations. *Contemporary Family Therapy*, doi: 10.1007/s10591-012-9224-4

Domestic Violence

Intimate Partner Violence (IPV) impacts millions of families and the negative effects of it are known to partners, family members, courts, and social service agencies. IPV is known to be transmitted across generations of a family and there is strong evidence to suggest emotional regulation as a mediator in family systems characterized by violence. Multiple factors are hypothesized as mechanisms for the development and maintenance of violence in intimate partner relationships. Factors affecting the decision for clients to remain in an abusive relationship are discussed in addition to proposed treatment strategies in working with a client that is in an actively abusive relationship.

1. Residents will become knowledgeable of current statistics pertaining to domestic violence in the United States and identify at least one trend.
2. Residents will be able to describe at least three factors in a client's decision to remain in an abusive relationship with respect to the complexity of those factors and propose strategies on how to best address related concerns in the context of the therapy relationship.
3. Residents will identify culturally competent and responsive factors regarding development and implementation of treatment strategies specific to clients who have or are being impacted by intimate partner violence in a same-sex relationship.

O'Leary, K. D., Tintle, N., & Bromet, E. (2014). Risk factors for physical violence against partners in the U.S. *Psychology of Violence*, *4*(1), 65-77. doi:10.1037/a0034537

Oringher, J., & Samuelson, K. W. (2011). Intimate partner violence and the role of masculinity in

male same-sex relationships. *Traumatology, 17*(2), 68-74. doi: 10.1177/1534765610395620

Siegel, J. P. (2013). Breaking the links in intergenerational violence: An emotional regulation perspective. *Family Process, 52*(2), 163-178. doi:10.1111/famp.12023

Stover, C. S., Meadows, A. L., & Kaufman, J. (2009). Interventions for intimate partner violence: Review and implications for evidenced-based practice. *Professional Psychology: Research and Practice,40*(3), 223-233. doi:10.1037/a0012718

Suicide Assessment / Crisis Intervention

There are multiple known factors that are associated with individuals who are at high risk for suicide some of which include a history of previous attempts, age, gender, race, marital status, and cognitive correlates to name a few. This didactic will include a comprehensive discussion of leading risk factors for suicide and strategies effective for assessment of it. In particular will be discussion regarding how to determine the necessity of hospitalization, whether voluntarily nor not, and how to engage with local systems to facilitate it. Discussion regarding how to implement preventative and safety measures with a client who is at risk for suicide will also occur.

1. Residents will be able to identify major risk factors associated with suicide.
2. Residents will be able to conduct an assessment for the imminence of suicide risk.
3. Residents will demonstrate increased knowledge regarding local systems and how to effectively intervene if there is a client in suicidal crisis.

Cheng, A.T., Chen, T. H., Chen, C.C., & Jenkins, R. (2000). Psychosocial and psychiatric risk factors for suicide: Case-control psychological autopsy study. *British Journal of Psychiatry, 117,* 360-365.

Dumais, A., Lesage, A.D., Alda, M., Rouleau, G., Dumont, M. & Chawky, N., et al. (2005). Risk factors for suicide completion in major depression: A case-control study of impulsive and aggressive behaviors in men. *American Journal of Psychiatry, 162* (11), 2116-2124.

Psychotherapy Theory and Practice: Personality Disorders

Personality Disorders are marked by traits so rigidly entrenched that personal distress or significant impairment across life domains is impacted. A dimensional approach to the treatment of personality disorders involves the clinical application of a perspective that embraces such disorders as maladaptive variants of normal personality traits. This didactic will include a specific emphasis on discussion of Cluster B Personality Disorders, of which there are four, whose common core includes dramatic, overly emotional, and erratic clinical presentations. An overview of proposed disorder-specific treatment interventions will be included in this didactic. Proposed guidelines related to cognitive therapy with personality disorders will be included.

1. Residents will be able to describe guidelines associated with the provision of cognitive therapy with individuals that present with a personality disorder.

2. Residents will be able to identify at least one salient clinical treatment consideration related to
   each Cluster B Personality Disorder.
3. Residents will be able to identify skills deficits associated with each Cluster B disorder.

Kolden, G. G., Klein, M. H., Strauman, T. J., Chisholm-Stockard, S., Heerey, E., Schneider, K. L., & Smith, T. L. (2005). Early psychotherapy process and cluster B and C personality pathology: Similarities and differences in interactions with symptomatic and interpersonal distress. *Psychotherapy Research, 15*(3), 165-177. doi:10.1080/10503300512331387825

Miller, J. D., Gaughan, E. T., Pryor, L. R., & Kamen, C. (2009). The consequences of depressive affect on functioning in relation to cluster B personality disorder features. *Journal of Abnormal Psychology, 118*(2), 424-429. doi:10.1037/a0015684

Sheets, E., & Kraines, M. (2014). Personality disorder traits as a moderator of poor social problem-solving skills and depressive symptoms. *Journal of Individual Differences, 35*(2), 103-110. doi:10.1027/1614-0001/a000132

Forensic Clients

Approximately 5% of the United States population has a serious mental illness, however approximately 16% of an incarcerated population has a mental illness. Assessment of clients who present with primarily forensic-based concerns requires a nuanced approach and particularly with consideration to consistency within reports as well as how an assessor can account for discrepancies in a client's report. A discussion regarding motivating factors for a forensic population necessitates a discussion regarding malingering, feigning, denial and acknowledgement, defensiveness, social desirability, and impression management. Basic detection strategies of genuine cognitive impairment will also be discussed.

1. Residents will be able to identify at least three factors that distinguish a forensic-based assessment from other types of assessments.
2. Residents will be able to distinguish between different motivating factors which are more likely to be present in a forensic population, such as malingering versus feigning.
3. Residents will be able to identify at least one task that most individuals with cognitive impairment are able to perform successfully.

Christy, A., Poythress, N. G., Boothroyd, R. A., Petrila, J., & Mehra, S. (2005). Evaluating the efficiency and community safety goals of the Broward County mental health court. *Behavioral Sciences and the Law, 23*, 227-243. doi:10.1002/bls.647

Hughes, S., & Peak, T. (2012). Evaluating mental health courts as an ideal mental health intervention. *Best Practices in Mental Health, 8*(2), 20-37.

Karson, M., & Nadkarni, L. (2013). How to present your opinion. In *Principles of forensic report writing* (pp. 89-105). : American Psychological Association. doi:10.1037/14182-007

Mullen, P. E. (2010). The psychiatric expert witness in the criminal justice system. *Criminal*

Behavior and Mental Health, 20, 165-176. doi:10.1002/cbm.764

Neal, T. M., & Grisso, T. (2014). The cognitive underpinnings of bias in forensic mental health evaluations. *Psychology, Public Policy, and Law, 20*(2), 200-211. doi:10.1037/a0035824

Psychotropic Medications

Psychotropic medications are an important adjunct to the successful treatment of a variety of behavioral health problems. In fact, some cases medically require psychotropic medication management, such as with bipolar and attentional disorders, in order for behavioral health stability to occur. Being recommended to a trial of psychotropic medications can elicit varying thoughts and emotions in our clients and thus requires effective multidisciplinary action to fully support their mental health recovery. These aspects, as well as commonly prescribed medications, and the physiological actions of different classes of medications will be the main focus of this didactic.

1. Residents will be able to identify at least two commonly prescribed psychotropic medications from several different medication classes.
2. Residents will be able to identify neurotransmitters involved with major mental illnesses and commonly prescribed medications associated with them.
3. Residents will be able to describe short and long-term impact of medications including complicating factors, such as the kindling effect, in which certain medications will lose effectiveness over time.

Physical and Sexual Abuse and Neglect of Children

Child abuse has been linked to numerous problems and which have the potential to stem over the course of an individual's lifetime. Some concerns potentially include attachment problems, depression, and substance abuse, unemployment, and relationship difficulties to name a few. The majority of child abuse reports in Pennsylvania are disproportionately female whose alleged perpetrator is someone known to them. Child abuse is a faceless phenomenon and occurs across all socioeconomic backgrounds, races, and genders. Types of abuse, mandated reporting, and basic clinical principles for clinicians working with children that have a history of abuse are discussed.

1. Residents will be able to identify five different types of child abuse.
2. Residents will be able to describe mandated reporting and circumstances in which reporting is required.
3. Residents will be able to identify at least two types of therapeutic strategies specific to working with children that have a history of trauma.

Psychotherapy Theory and Practice: Attachment Issues

Stemming from research by Bolwby, attachment theory conceptualizes how individuals develop and use relational bonds whose foundation occurs in infancy and of which a dominant style is

established in adulthood. There are four basic attachment styles and individuals tend to seek relationships throughout life that are aligned with the level of security of that original bond. According to Bowlby, a client's ability to benefit from therapy is based on the client's ability to develop a secure attachment to the therapist.

1. Residents will be able to identify and define the four basic attachment styles.
2. Residents will demonstrate an ability to conceptualize a case from an attachment perspective and to develop treatment goals that are appropriate to the client's style of attachment.

Berry, K. & Danquah, A. (2015). Attachment-informed therapy for adults: Towards a unifying perspective on practice. *Psychology & Psychotherapy, 7*(14) doi: 10.111/papt. 12063

Marmarosh, C.L. (2015). Emphasizing the complexity of the relationship: the enxt decade of attachment-based psychotherapy research. *Psychotherapy 52*(1), 12-18.

Treatment Termination

Many clients enter treatment with a history of feeling abandoned or rejected by others or with a sense of reliance on others to manage their emotions. While development of rapport and a strong therapeutic alliance is assumed for an effective foundation of healing to occur, termination of treatment is a reality which must be discussed from the outset and continually worked toward rather than a topic to be avoided in the therapy relationship. This didactic will address how to proactively discuss treatment goals and discharge from the outset in a way that promotes appropriate autonomy from the therapist in the therapeutic relationship rather than fostering dependence and unnecessarily delaying treatment termination.

1. Residents will be able to identify at least three different types of treatment termination scenarios and appropriate clinical course for addressing it.
2. Residents will be able to describe at least one aftercare consideration for at least three different clinical concerns.

Martin, E.S. & Schurtman, R. (1985). Termination anxiety as it affects the therapist. *Psychotherapy: Theory, Research, Practice, Training, 22*(1), 92-96.

Vasquez, M.J., Bingham, R.P., & Barnett, J.E. (2008). Psychotherapy termination: Clinical and ethical responsibilities. *Journal of Clinical Psychology, 64*(5), 653-665.

Psychiatric Rehabilitation and Recovery Principles

Psychiatric rehabilitation promotes recovery, full community integration and improved quality of life for individuals diagnosed with behavioral health disorder that seriously impairs their functioning. While psychiatric rehabilitation services are not treatment, it is important for treatment professionals to be informed of the principle of psychiatric rehabilitation can have in supplementing treatment interventions. Concepts of Personal Medicine® as a specific model will be discussed.

1. Residents will be able to identify at least six core principles of psychiatric rehabilitation.
2. Residents will be able to describe how these principles complement standard treatment interventions for clients with serious mental illness.
3. Residents will be able to describe how Personal Medicine® principles can be used within treatment to provide clients with additional support.

MacDonald-Wilson, K. L., Deegan, P. E., Hutchison, S. L., Parrotta, N., & Schuster, J. M. (2013). Integrating personal medicine into service delivery: Empowering people in recovery. *Psychiatric Rehabilitation Journal, 36*(4), 258-263. doi:10.1037/prj0000027

Razzano, L. A., Jonikas, J. A., Goelitz, M. A., Hamilton, M. M., Marvin, R., Jones-Martinez, N., & Cook, J. A. (2010). The recovery education in the academy program: Transforming academic curricula with the principles of recovery and self-determination. *Psychiatric Rehabilitation Journal, 34*(2), 130-136. doi:10.2975/34.2.2010.130.136