Naval Medical Center San Diego

Mental Health Service

CLINICAL PSYCHOLOGY INTERNSHIP TRAINING PROGRAM

TRAINING MANUAL

Commanding Officer
Captain Elizabeth Adriano, M.D.
Medical Corps, United States Navy

Director of Mental Health
Commander Nathan Hydes, Ph.D., ABPP
Medical Service Corps, United States Navy
(619) 532-8551

Chair of Psychology
Director of Psychology Training
W. Michael Hunt, Ph.D., ABPP
(619) 532-6209

June 1, 2025
Naval Medical Center San Diego
Directorate for Mental Health
34800 Bob Wilson Drive
San Diego, CA, 92134-5000

TABLE OF CONTENTS

PREFACE

The following manual describes in detail one of three Navy Clinical Psychology Internships. The other Navy Internship sites are at the Walter Reed National Military Medical Center, Bethesda, MD, and the Naval Medical Center Portsmouth, VA.

These sites do not function as a formal *Consortium*, as defined by the American Psychological Association. However, the programs are similar, and they work in general cooperation with one another, given that all three internships train psychologists who will work as Navy psychologists for at least three years after internship.

Any application for a Navy Clinical Psychology Internship, which MUST be submitted through the APPIC Match and simultaneously through the applicant's local Navy Medical Programs Recruiter (see Appendix A), is considered by a single Selection Board made up of representatives from the three Navy Internship sites. Any resulting APPIC Match with a Navy internship will be with the specific internship site, and applicants are asked to rank order their site preferences during the APPIC Match process. Therefore, it benefits applicants to acquire sufficient information about the sites so that informed rank orderings can be made.

The three Navy sites will make a reasonable effort to share contact information for potential applicants requesting information from any particular site. However, it remains the ultimate responsibility of the applicants to seek out the information they need to make their choices and decisions.

Additional Navy Internship Contacts and Addresses of Interest:

Richard Bergthold, Ph.D., Training Director
Department of Psychology
Walter Reed National Military Medical Center
Bethesda, MD 20889-5600

(301) 319-2997

CAPT Michael Franks, Ph.D.
Psychology Training Director
Naval Medical Center
Portsmouth, VA, 23708

(757) 953-5714

OVERVIEW – June 2025

The APA-accredited* internship program in clinical psychology offered by the Directorate of Mental Health at the Naval Medical Center, San Diego is an intensive twelve-month period of clinical and didactic experiences designed to meet two broad aims. We are committed to meeting the overall requirements for continued accreditation, as established by the American Psychological Association in its various Commission on Accreditation publications.

The first aim of the internship program is to train psychologists who are competent with the knowledge and skills required for entry level practice of Health Service Psychology, as defined by the American Psychological Association. Included within this aim is preparation of interns for clinical practice, including readiness for independent licensure, particularly given the increasing number of states permitting licensure upon doctoral degree completion, as opposed to after an additional year of postdoctoral supervised practice. There are a number of ways in which these generalist professional skills can be operationally described. However, a useful model, which we have attempted to follow, is to target our training toward acquiring or enhancing the Profession Wide Competencies set forth in the APA Standards on Accreditation. All target competencies and evaluative criteria throughout the internship reflect one or more of these Profession Wide Competencies.

The second aim of the internship is to equip graduates with additional specific clinical knowledge and competencies in personnel evaluation, military-specific cultural and industrial-organizational factors, and community psychology approaches, all essential to the practice of clinical psychology within a military health care system. This second aim is quite important, as graduates of the internship are required to serve for three years as active duty Navy psychologists after completing the internship.

We have learned via feedback from former interns that the follow on, obligated service assignments for graduates of a Navy internship typically demand a higher level of independent responsibility and professionalism than is typical in early career civilian practice. Therefore, our teaching faculty has identified, and continues to develop, learning experiences aimed at imparting the skills necessary for effective professional performance at the next Navy duty station. Specifically, the internship's clinical experiences reflect the major areas in which military clinical psychologists may provide clinical services: Inpatient, Outpatient, Health Psychology, and Psychological Assessment. In addition, the internship offers out-of-hospital training trips of varying length that reflect professional activities, customer populations, and service environments consistent with the industrial organizational and community psychology aspects of Navy psychologists' work. Interns also engage in a Transrotation experience offering longer-term assessment and intervention practice which otherwise might be lost in a very busy 12 month internship with a highly mobile population and a contemporary American healthcare delivery culture in which extended Mental Health Services are in declining availability.

From a longer professional perspective, the internship is one of a series of supervised experiences which continue beyond the internship until the psychologists-in-training obtain the doctorate, complete postdoctoral supervised experience if required, are awarded a license in some state, and are credentialed as Independent Providers by the commanding officer of the Navy medical facility to which they are assigned. Please note that all internship graduates are expected by the Navy to achieve state licensure within 18 months of internship completion. Ultimately, we encourage our graduates to earn Board Certification from the American Board of Professional Psychology. To further reward this process of professional development, the Navy may pay all the fees of the Board Examination, once passed, and an annual salary bonus to its Board Certified Psychologists.

The Department of Defense operates within a comprehensive Medical Staff privileging system that is in many ways more comprehensive than some systems in the civilian sector. For military psychologists, central to this system is completion of APA-accredited doctoral programs in clinical or counseling psychology, completion of

APA-accredited internships, and mandatory state licensure as conditions for awarding of staff clinical privileges. Coupled with these fundamental requirements is a stringent hospital staff credentialing and re-credentialing process (by the military health care system), which follows the health care providers wherever they go within the worldwide military health care system. Our continual development of learning experiences, attuned to particular psychological service delivery tasks our Internship graduates will face, "fits" well with this over-all credentialing and quality-assurance process, as well as with the psychological needs of the community our graduates will be serving for at least the next three years after graduation. Anecdotal feedback from dozens of now-civilian but former Navy psychologists over the past twenty years also confirms how valuable they have felt their Navy training and experiences were to their subsequent work in the civilian sector following their active duty service.

Before starting internship, selected applicants are commissioned as Lieutenants in the Navy's Medical Service Corps. During the internship (and subsequent service as active duty Navy psychologists), interns receive full pay and benefits as Navy officers. For calendar year 2025, a new Navy Lieutenant in San Diego receives annual pay of $118,768.56 if single, and $122,008.56 with spouse and/or dependent children. The increased amount for interns with spouses and/or children reflects a larger Variable Housing Allowance, which is based on typical housing costs for Navy Lieutenants in the San Diego area. Interns with prior active military service will be paid at a slightly higher rate, based on prior years of military service. Salary amounts are set, and annual pay raises occur on January 1, as determined by the U.S. Congress for all military officers.

The report of the APA Commission on Accreditation (CoA) in 2022 gave the NMCSD Internship high praise and recommended that it be reaccredited for a full ten year period. The internship is fully APA accredited*, and the CoA's schedule calls for a re-evaluation visit in 2032.

*Questions related to the program's accredited status should be directed to the Commission on Accreditation:

Office of Program Consultation and Accreditation
American Psychological Association
750 First Street, N.E.
Washington, D.C., 20002-4242
(202) 336-5979 E-mail: apaaccred@apa.org Web: www.apa.org/ed/accreditation

APPIC Special Notice: This internship program has been a member of the Association of Psychology Postdoctoral and Internships Centers (APPIC) since the program's beginning in 1990 and conducts intern selection in accordance with the policies and procedures of APPIC. "This internship site agrees to abide by the APPIC Policy that no person at this training facility will solicit, accept or use any ranking-related information from any intern applicant prior to Uniform Notification Day."

PROGRAM DESCRIPTION
(GENERAL)

The internship program is organized around a **Practitioner-Scholar** training model. As such, day to day training emphasizes increasing skill in clinical practice but always with increasing familiarity with and careful reflection on research underpinnings for that practice. We recognize and emphasize that science and practice are interlocking skills forming the foundation of Health Service Psychology. The training faculty expects interns to learn to practice clinical psychology in a manner that is informed by psychological theory and research. Although active participation in research is not required as part of the internship, we expect interns to develop competence in evidence-based practice, including competence in a number of interventions that have been supported by research.

The training year is comprised of a brief orientation period followed by five clinical rotations each about 10 weeks long, an overarching Transrotation experience which is 12 months long, didactics, and out-of-hospital training trips of varying lengths. As noted above, these clinical experiences enhance intern competence related to the Profession Wide Competencies, both in terms of generalist psychological practice with adults and specific applications within military mental health.

Because Navy Medicine, including Navy psychologists, provides healthcare services and consultation for, primarily, the Navy and Marine Corps, the program offers specific training related to those two branches of the Department of Defense. Whenever possible, training trip experiences include approximately one week aboard a major Navy combat ship at sea, which gives the interns a firsthand overview of life at sea for crew members, of resilience and positive adaptation, and of clinical issues that arise in the Navy Fleet. A similar trip is scheduled to the Marine Corps Base Camp Pendleton to enhance intern understanding of the same factors but, in this case, specific to the Marine Corps. Both of the above experiences are intended to enhance intern understanding of the unique military cultural factors specific to the Navy and Marine Corps. Recent additions to the internship's training trips in military-specific clinical psychology have included tours of other Navy vessels (including submarines) and observation of psychological testing assessment for personnel selection for high stress and high responsibility positions, such as for Marine Corps drill instructors at the San Diego Marine Corps Recruit Depot and for Special Forces personnel at the Naval Base Coronado, also in San Diego.

In addition to clinical practice and the military "field trips", interns attend several full day or multi-day trainings in evidence-based psychotherapy interventions. Given the increased rates of Posttraumatic Stress Disorder among military personnel over the past 20 years, training in empirically supported trauma treatments (e.g., Prolonged Exposure and Cognitive Processing Therapy) is provided every internship year, along with supervised practice of these modalities after didactic training. Other extended trainings over the past few years have included Cognitive Behavioral Therapy for Insomnia, Dialectical Behavior Therapy, and Suicide Risk Identification and Mitigation.

Didactic training during the internship also includes timely lectures and seminars, planned not to repeat training the interns have already experienced in their graduate studies but to augment their clinical education or provide training in professional development as a military psychologist, Navy officership, and military cultural competence. Also important in developing didactics are emerging directions in the science of clinical psychology, including applications within military mental health practice. During all didactics, both regularly scheduled seminars/Grand Rounds and the extended full day or multi-day trainings, interns have no clinical responsibilities scheduled to ensure full attendance in the didactic aspects of the internship.

It should also be noted that, because few of our interns have had prior military experience, all attend a five week "Officer Development School" at Newport, Rhode Island and a one-week overview of military medicine prior to arrival at NMCSD for internship. These trainings include didactic presentations on the history, traditions,

organization and "sub-culture" of the Navy; psychosocial patterns and influences which are found in the military in general and the Navy and Marine Corps in particular; and an overview of active duty medicine. Once they arrive in San Diego, interns are paired with a more senior active duty psychologist who serves as their mentor for the year.

FACILITIES AND INTERN SUPPORT

Facilities

The Naval Medical Center San Diego (NMCSD) is a large tertiary care teaching hospital, providing a full range of inpatient and outpatient services for service members, military retirees, and their family members, both from the San Diego area and, for tertiary specialty care, throughout the Pacific Rim. In addition to the Psychology Internship, NMCSD hosts extensive Graduate Medical Education including well over a dozen physician residencies and fellowship programs. Also hosted are training programs for Physician Assistants, advanced practice pharmacy, and numerous other healthcare training programs. This wide diversity of healthcare training programs fosters a strong commitment to academic and training excellence at NMCSD. This greatly enhances the opportunities for psychology interns to develop competence as multidisciplinary team members and consultants and to develop an appreciation of the potential roles of psychologists in large healthcare delivery organizations.

The NMCSD Directorate for Mental Health is comprised of inpatient, outpatient, and residential program services both on the NMCSD main campus and at several of its San Diego area branch clinics. Interns have rotations in a number of those locations, further described below. On each of the 5 rotations, interns have fully furnished offices with computers and access to printers, copiers, and other standard office supplies. Offices are all in close proximity to those of immediate rotation supervisors, fostering ready availability of emergent or "on the fly" consultation and supervision whenever needed. In addition, the Medical Center's medical library includes a range of journals, books, and electronic search capabilities related to the practice of psychology, as well as staff assistance with on-line literature searches. Research and statistical consultation is available both within the Mental Health Directorate and the medical center's Clinical Investigations Department.

Administrative and Technical Support

Each clinic or ward where interns work has administrative staff members who assist both clinical staff and interns with administrative aspects of patient scheduling, administration of computerized psychological testing and outcome measures, plus some level of clerical assistance. A full time psychometrician provides administration and scoring of numerous psychological tests for both staff psychologists and interns. Office computers include full access to the military's electronic medical record system (Genesis), used for patient charting in all military medical facilities. Computers also provide access to Microsoft software products, email, and to the Internet for conducting on-line literature searches and other official government business. (Interns should note that access to a variety of websites is restricted on government computers, including many social media sites, YouTube, etc., to ensure security of the military electronic network system.) NMCSD has access to a large Information Technology department, providing interns the same level of IT support as for staff providers. IT support is available 24 hours a day, seven days a week.

Financial Support and Benefits

As noted earlier, interns are paid at the same level as all Lieutenants in the Navy; for 2025, $118,768.56 for interns who do not have spouses or children, and $122,008.56 for those with spouses and/or dependent children (based on increased housing allowance for military personnel with families). Interns (and spouses and children)

have full military healthcare and dental benefits, including access to inexpensive TRICARE insurance for family members, and healthcare at NMCSD and its branch clinics, as well as worldwide in any military healthcare treatment facility. As with all military personnel, interns have access to lower cost shopping in military commissaries (for groceries) and department stores (referred to as "Exchanges").

Military members including interns acquire 30 days a year in vacation time, referred to as "Annual Leave". Interns are generally not able to take that full amount of time, as this would prevent completion of the internship's required 2000 hours. However, they are able to carry over any unused annual leave balance to the following year at their next military duty stations.

The military currently offers service members who give birth 12 weeks of parental leave, following a period of convalescence, to care for the child. In addition, service members who are the non-birth parent will be authorized 12 weeks of parental leave. Parental leave is also authorized for parents adopting children. All of this time is fully paid and is in addition to the military member's Annual Leave balance. Interns would be entitled to parental leave, although this could necessitate extending the completion of the internship. Such an extension would remain fully paid, as the intern would remain on active duty for the duration. The "clock" for the additional years of obligated service as a Navy psychologist after internship completion would not start until the delayed date of completion.

PROGRAM DESCRIPTION (SPECIFIC)

The program described below is in place for the current internship year (2025-2026) and planned for the coming year (2026-2027). Our internship training plan is intended to be dynamic and will evolve as experience shows a better way and new opportunities present themselves.

I. Orientation

The orientation period includes approximately the first five days of the internship and, following hospital check-in, covers such topics as departmental structure, standard operating procedures, a tour of the hospital, rotational objectives, the importance of dissertation completion, seminar scheduling, office assignments, etc. As with every other newly reporting staff member, the intern will spend two to three additional days during the initial rotation in a hospital-wide, mandated, orientation seminar and will attend training on the hospital's electronic system for patient charting and e-mail.

II. Clinical Rotations

A. Adult Outpatient Mental Health Rotation: This rotation involves provision of outpatient assessment, therapy, and group therapy primarily to active duty military members but occasionally to military retirees and their families. Services provided include interview assessment and psychotherapy with general mental health outpatients and formal psychological testing in the Psychological Assessment program.

Referrals for this rotation typically arrive from primary care medical clinics throughout the medical center and its outlying clinics and from patients discharging from the mental health inpatient ward. The full spectrum of mental health problems is involved, and the intern has the opportunity to hone diagnostic and intervention skills with a wide variety of patients in terms of age, sex, socioeconomic status, ethnicity, and sexual orientation. Multidisciplinary mental health teamwork with psychiatrists and social workers is readily available and encouraged. Psychological services include both diagnostic assessment and brief individual therapy as well as

group psychotherapy. A licensed psychologist faculty member provides primary rotation supervision.

Over the course of the internship year, each intern conducts a number of psychological evaluations incorporating psychological testing. While these evaluations may be conducted during any of the five primary rotations, the bulk will occur during the rotation at Adult Outpatient Mental Health and on the Inpatient Rotation (see below). Interns are expected to become proficient in the administration, scoring, and interpretation of various mainstream psychological assessment instruments. Written reports are prepared under the clinical supervision of one of the licensed psychologist faculty members working within the Mental Health Directorate's Psychological Assessment Program within Adult Outpatient Mental Health or the licensed psychologist faculty member working in the Inpatient Division.

B. Health Psychology: During this rotation, interns respond to health psychology consults from other inpatient and outpatient services, including cardiology, neurology, oncology, and the pain clinic, among others. These consults usually request psychological evaluation, diagnosis, and treatment for referral problems including sleep disorders, chronic pain, poor adherence to prescribed medical regimens, functional neurological disorder, and anxiety disorders co-occurring with physical illnesses and injuries. Interns treat these problems with behavioral and health psychology interventions such as mindfulness, stress-management techniques, and cognitive behavioral strategies. Interns also will have opportunities to participate in interdisciplinary care meetings and structured group interventions for managing functional neurological disorder and for sleep problems. There may be additional opportunities for innovative, behavioral medicine interventions with outpatients at a number of the Medical Center's outpatient medical and surgical clinics, in close collaboration with clinic physicians of varied specialties. Supervision is provided by the hospital's licensed Health Psychologist.

C. Mental Health Operational Outreach Division: During this operational rotation the intern works at the Mental Health Operational Outreach Division (MHOOD) at the Naval Station San Diego. The MHOOD Clinic primarily serves active duty Navy personnel and provides psychology-related consultation with those sailors' military commands. Psychological services typically include interview assessment and brief psychotherapy. Much of the focus of this rotation is learning to assess mental health fitness and suitability for military duties and consulting with patients' military commands regarding those assessments, both key components of the day-to-day work of military psychologists. A unique opportunity is the chance to work directly with Navy psychiatrists who are embedded with Navy Fleet Surgical Teams; this gives interns the opportunity to learn a great deal about mental health issues on board Navy ships and about consultation with seagoing Navy commands. This clinic represents quite well the type of outpatient clinic associated with a Navy Fleet port, in which a Navy psychologist is likely to work in a first post-internship assignment. The rotation emphasizes development of competence in mental health consultation with Navy Fleet commands and is supervised by a licensed psychologist.

D. Marine Corps Mental Health: During this operational rotation the intern works at the Mental Health Clinic, Marine Corps Recruit Depot (MCRD) San Diego. This clinic primarily serves active duty Marine Corps service members. This rotation involves brief assessments of Marine Corps recruits experiencing psychological difficulty in adjusting to Marine Corps boot camp. It also involves a significant amount of assessment and treatment of Marine Corps members on staff at MCRD who are struggling with Post Traumatic Stress Disorder and other psychological issues subsequent to (often multiple) combat deployments. The rotation emphasizes development of competence in mental health consultation with Marine Corps commands.

In both of these operational rotations, the intern will learn or refine skills for rapid evaluation of patients referred from a large number of sources with a wide variety of presenting problems. The intern may follow patients in brief interventions, refer patients to appropriate military or civilian resources, or recommend active duty patients for discharge from the military. Part of the challenge of these operational rotations is learning to handle a steady case load, utilize available resources, and communicate and consult effectively with Navy and Marine Corps

units (the "organizational customer") without becoming overwhelmed by the clinical pace and competing demands on time. Interns also will engage in outpatient psychotherapy groups, and will be involved in crisis intervention. Multidisciplinary teamwork is available and encouraged. Licensed military and civilian faculty psychologists practicing in the Operational Mental Health Clinics provide direct supervision of interns.

E. Inpatient Mental Health/Emergency Mental Health Rotation: During this rotation, interns become competent with the admission, diagnosis, treatment and disposition of patients with severe mental health disorders of such severity as to require emergency evaluation and, often, hospitalization. Interns split their time between the Inpatient Service and the Emergency Mental Health Service. The intern is part of a multidisciplinary treatment team (comprised of staff psychiatrists and psychologists, psychiatric residents, nurses, social workers, social work fellows, and hospital corps staff) and is immediately responsible for patient care to the credentialed staff psychiatrists who head the Inpatient and Emergency Mental Health teams. The attending psychiatrists hold clinical privileges and final responsibility to make ultimate admission and discharge decisions for mental health patients. The staff psychiatrists leading the intern's treatment teams provide daily supervision of the intern's inpatient or emergency evaluation caseloads. The credentialed staff psychologist on the Inpatient and Emergency Mental Health Services provides administrative and oversight supervision, meeting directly with the intern for weekly supervision throughout the rotation.

Interns on this rotation may provide psychological testing for psychiatric inpatients, specific to consults from the Inpatient multidisciplinary treatment teams. Testing is supervised by the Inpatient staff psychologist. During this rotation (and twice following completion of the rotation), the intern will stand the weekend day in-house mental health watch, once every other week, with the psychiatry resident on call and the assigned medical students. During these watches, the intern will work with the resident in responding to psychiatric emergencies in the medical center's Emergency Department, on the inpatient psychiatric wards, and elsewhere in the hospital. Supervision of on-call responsibilities rests with the Mental Health Department psychiatrist on call.

This training experience involves close multidisciplinary collaboration with psychiatrists, psychiatry residents, social workers, and social work fellows, as well as extensive consultation to physicians and physicians-in-training from multiple disciplines outside Mental Health. It additionally may offer the interns opportunities to provide training and basic supervision to multidisciplinary trainees including psychiatry interns, physician assistant students, and students training to become Independent Duty Corpsmen.

This rotation is the most demanding of the intern's time and requires the learning and completion of many processes and much formal paperwork within short periods of time.

F. Transrotational Requirements: In addition to the five core clinical rotations, each intern is expected to carry three or at most four long-term outpatient cases during the year (long-term generally meaning 4 months or longer). Longer term cases fall into two categories. First are patients with Post Traumatic Stress Disorder being considered for treatment with an evidence-based trauma treatment (e.g., Cognitive Processing Therapy or Prolonged Exposure). Work with these patients is supervised (during group supervision) by one of the faculty psychologists with particular expertise in these evidence-based treatments, including their application with patients with complex co-occurring disorders. Other transrotation cases focus on longer term therapy for patients with more complex mood, anxiety, and personality issues. Within the first two internship months, the Director of Psychology Training will assist the interns and rotation supervisors in identifying long-term cases, which may come from various sources. In addition to offering longer term services to patients who may benefit from such treatment, Transrotation cases are specifically chosen to enhance the training of each intern, challenging interns with new learning, new clinical skills, or enhancement of competencies for dealing effectively with, for example, difficult psychotherapy alliances.

III. Formal Presentations

Interns deliver formal presentations to the faculty and each other twice during the year. The first presentation, early in the training year, involves a single case and includes both a written summary of the case as well as an oral discussion. This includes discussion of diagnostic considerations, transdiagnostic factors impacting therapy planning and delivery, individual and cultural factors, overall formulation and treatment planning, therapy delivered, and assessment of therapy outcome. Theoretical perspectives and empirical findings impacting conceptualization, treatment planning, and treatment delivery are included. There is no "scoring" of intern performance; rather, this is used by the intern and faculty as a method to help fine tune the intern's training in terms of integration/dissemination of science and practice, breadth of conceptualization, and grounding in evidence based practice.

At the end of the year, interns complete a capstone project where they demonstrate the clinical skills and military cultural competence they have acquired over the course of the internship. Similar to an oral examination for professional licensure, interns are given a prototypical case from one of their rotations and asked to discuss how they would approach the case with regard to clinical and safety risk assessment, case conceptualization (including cultural considerations), treatment planning, outcome monitoring, and military disposition. Additionally, interns are asked to highlight their approach to the integration of science and practice, professional ethics, and consultation in patient care. As with the initial case presentation, there is no "pass" or "fail" on the capstone project; rather, interns receive feedback regarding strengths and areas for growth in their performance.

In addition to the above, interns present twice to a wider audience of mental health professionals. The first is a challenging clinical case presented during Directors' Rounds to a multidisciplinary group comprised of faculty and trainees from the psychology internship program, the psychiatry residency program, and the social work fellowship program. The second is their dissertations presented during one of the Directorate's Grand Rounds. This provides an opportunity to demonstrate understanding of the science of psychology, to disseminate it to a wider audience of mental health professionals, and to receive targeted feedback on the presentation.

IV. Didactics

A program of regularly scheduled seminars and other workshop presentations accompanies the intensive direct supervision inherent in the five clinical rotations. These didactics are designed to expose the intern to contemporary information and training relevant to effective functioning as a psychologist, with special reference to the social, vocational and special risks of the Navy and Marine Corps subcultures. The faculty, the presenter, and the level of interest of the attendees determine the particular format for a topic and the amount of time devoted to it. The presenters of these didactic programs frequently are distinguished colleagues from the Navy and civilian clinical/academic communities. Didactics include weekly Intern Seminars, weekly Directors' Rounds case discussions, bi-weekly Mental Health Grand Rounds, bi-weekly Journal Club discussions, and periodic special training opportunities lasting a full day or longer.

Interns also participate in a Supervision of Supervision course intended to teach fundamentals of clinical supervision and to allow time for practicing the skill via guided role play. Additionally, over the course of the year, interns take on increasing responsibility for tiered supervision within their cohort or with behavioral health technicians working alongside them on the various rotations.

V. Operational Experiences

As noted previously, the operational experiences are essentially "field trips" where interns tour operational environments, shadow mental health professionals working in those environments, and interact with the Navy or Marine Corps staff those professionals serve. The goal of these field trips is for interns to gain a greater understanding of the clinical, professional, and cultural considerations that arise when working with Navy or Marine Corps personnel.

The primary operational experience is a working cruise, lasting approximately one week, aboard a major Navy combat ship. During this tour, the interns will experience actual shipboard living conditions and stresses, observe in the ship's Medical Department, and interact with and be educated by successfully adapted sailors about the industrial and psychological demands of their work. This cruise almost always is aboard a US Navy aircraft carrier, under the guidance and supervision of the Navy Psychologist stationed full time on board the ship. The primary emphasis for this cruise is developing familiarity with resilience among typical sailors who are succeeding and even thriving in the Fleet, as opposed to clinical work with sailors not doing well.

When possible, a second operational experience is scheduled with one of the Marine Divisions, the Marine Corps School of Infantry, or the Marine Special Operations Command, all at Camp Pendleton, CA. Particular emphasis is placed on gaining familiarity with the operational plans and stresses unique to the Marine Corps and on developing skills for effective consultation with Marine Corps Commands. As with the carrier cruise, the primary emphasis of the field portion of this trip is witnessing the resilience and success of typical Marines in infantry commands.

In recent years, interns have had the opportunity to meet with one of the psychologists working with the submariner community and then to tour a submarine. This had afforded them a similar opportunity to learn about occupational challenges associated with submarine duty and to observe service members thriving in this environment.

VI. Division Meetings

Each division within the Mental Health Directorate holds regular meetings for all staff and trainees where news is passed, discussions of current issues are held, and each division member is invited to contribute. Interns attend the division meetings applicable for their current training rotations.

VII. Additional Intern Functions and Roles

A. Medical Service Corps Membership: Psychology interns are members of the Allied Sciences Branch of the Medical Service Corps (MSC). Therefore, it is strongly encouraged that they interact professionally and socially with other MSC officers assigned to the hospital. Such interaction is important to the smooth and effective performance of the intern's job when it extends beyond the mental health clinic, it increases the intern's appreciation for other non-physician specialists in the Navy healthcare system, and it enhances others' awareness of the role psychologist play in the system. At San Diego, for example, there are several interest groups and annual celebratory functions such as the MSC Birthday Ball.

VIII. Supervision

Throughout the internship year, interns benefit from comprehensive supervision provided by the core training faculty, consisting of staff psychologists who oversee the five clinical rotations. Adjunct supervisors, specifically credentialed psychiatrists on the Inpatient Mental Health and Emergency Mental Health Rotations, also contribute to the supervisory experience. This rotational structure ensures that each intern is exposed to the expertise of most of the psychologists on faculty, as well as several psychiatry teaching faculty. Recognizing

the importance of ongoing support, the program strongly encourages interns to seek additional supervision and consultation beyond scheduled times, with resources readily available to meet those needs. (See Appendix C for Core Training Faculty bios.)

IX. Supervision Structure and Documentation

A. Individual Supervision: As previously noted, interns train in five clinical rotations within the Mental Health Directorate: Adult Outpatient, Health Psychology, Mental Health Operational Outreach, Marine Corps Mental Health, and Inpatient/Emergency Mental Health. On these rotations, each intern receives at least two hours of individual supervision weekly from their rotation supervisor (a credentialed staff psychologist from the Core Training Faculty). Supervisors are readily available for additional consultation as needed and maintain an open-door policy for spontaneous, ad hoc supervision.

B. Group Supervision: The entire intern group meets weekly for two hours of group supervision led by core psychology faculty serving as Transrotation Case supervisors. Group supervision allows for clinical supervision of transrotation cases, peer learning opportunities, and practice of clinical supervision skills. Over the course of the year, interns gradually take on more responsibility for leading discussions to demonstrate supervisory competency. As a supplement to the clinical supervisors, a consulting psychologist joins for 1.5 hours bi-weekly to provide specialized training and consultation in evidence-based trauma treatments. As with individual supervision, the faculty group supervisors maintain an open door policy and are available for additional consultation as needed.

This overall structure of individual and group supervision ensures interns receive at least four hours (often more) of consistently scheduled supervision each week.

C. Documentation Requirements: All supervisors retain final clinical responsibility for the patients seen by interns and co-sign related clinical documentation and administrative paperwork. On outpatient rotations, routine documentation must be completed and co-signed within 72 hours. On the inpatient/emergency mental health rotation, documentation must be completed and co-signed the same day in which the patient is seen. (It is important to note that high-risk patients on *any* rotation must be discussed with supervisors and notes written/co-signed, *before* the patient leaves the clinic or ward.)

X. Telesupervision

In accordance with the standards set forth by the American Psychological Association (APA), *telesupervision* is defined as the "supervision of psychological services through a synchronous audio and video format where the supervisor is not in the same physical location as the trainee."

The NMCSD internship program prioritizes high-quality in-person supervision and training experiences for all psychology interns. As such, telesupervision is only used under unusual or exceptional circumstances such as temporary illness, mandated quarantine, or other unanticipated absence from the physical work location by supervisors or trainees. During these limited instances, telesupervision is conducted using a secure, audio/video platform provided to all staff (including interns) by the Department of Defense. Please see Appendix B for the full Telesupervision Policy.

TRAINING AIMS AND COMPETENCIES

OVERALL TRAINING AIMS: As noted earlier, the internship has two overarching aims. The first is to train psychologists with intermediate to advanced competency for entry level, generalist practice in health service psychology. The second is to train psychologists who are competent with the knowledge and skills required to practice health service psychology effectively within the military.

COMPETENCIES: By the end of the internship year, interns are expected to demonstrate intermediate to advanced competency in the nine Profession Wide Competencies as outlined in APA's Standards on Accreditation. These include (1) Research, (2) Ethical and legal standards, (3) Individual and cultural diversity, (4) Professional values, attitudes, and behaviors, (5) Communication and interpersonal skills, (6) Assessment, (7) Intervention, (8) Supervision, and (9) Consultation and interprofessional/interdisciplinary skills. Training and assessment of competencies occurs through extensive, supervised clinical practice as well as didactic training related to numerous professional practice areas, including individual and group psychotherapy (both brief and longer term), psychological assessment by interview and by testing, conducting emergency evaluations, obtaining consultation from other healthcare providers, providing consultation to other healthcare providers, providing clinical consultation to active duty military patients' military commands, and participation in multidisciplinary treatment teams. Additionally, interns will demonstrate competence in application of knowledge of supervision models and practice and in evaluation of intervention efficacy through didactics and supervision experiences. Competence in each of these areas at an intermediate to advanced level is the expected minimum standard of achievement by the end of the internship. Interns will demonstrate that their work with each of these competencies is informed by the theoretical and research literature in psychology, by sensitivity to multicultural factors impacting all aspects of clinical practice, and by the ethics of our profession.

As can be seen from the earlier descriptions of the five internship rotations, day-to-day clinical duties and experiences of interns may vary substantially among rotations. However, all five rotations, and the assessment of competencies in evaluations conducted on all rotations, are structured around the two program Aims and nine Profession Wide Competencies. Thus, no matter where interns start the year within the five rotations, there is consistency in the goals and expectations for professional development, and the overall trajectory of competency growth and mastery carries across the full year.

GENERAL BEHAVIORAL CHARACTERISTICS EXPECTED OF INTERNS: Successful psychology interns not only demonstrate competence in the field of psychology but also embody a sense of professionalism and military bearing. As such, they demonstrate (1) Willingness to learn, self-reflection, receptivity to feedback, (2) Efficiency in work organization and completion, (3) Assumption of responsibility, increasing over the course of the year, (4) Professional/military bearing and appearance, and (5) An ability to solve problems creatively, being a self-starter.

INTERN EVALUATION

A. Weekly supervision: During each clinical rotation, interns receive weekly scheduled supervision, as well as unscheduled supervision as needed or requested. A key component of this supervision is reviewing the intern's progress toward their rotational learning goals (see section B below). At the midpoint of the rotation, the intern and supervisor participate in a formal session to assess progress on these learning goals. This mid-rotation review provides an opportunity to adjust the intern's focus in areas where they may be experiencing difficulties, ensuring they are well-prepared for the final evaluation at the end of the rotation.

B. Psychology Intern Performance Evaluation: Intern performance is assessed using a rating format

(Appendix B) directly aligned with training in eight of the nine Profession Wide Competencies. (Competence in application of knowledge of supervision models and practices is evaluated separately, and the Research competency is evaluated both at the rotation level and through intern presentations. However, these evaluations follow the same format.) This performance rating is used on all five rotations, although not every rotation includes every item on the form. This rating is prepared by the rotation supervisor, reviewed with and co-signed by the intern, and submitted to the Director of Psychology Training by the primary supervisor of the intern at the midpoint and at the end of each rotation. Discussions between the supervisor and the individual intern provide an opportunity to review progress, highlight strengths, and identify areas for growth. The Training Director can attend this meeting if desired by the intern or supervisor, but this is not required. End of rotation Performance Evaluations are the critical instruments in determining "passing" of rotations and successful internship completion.

As can be seen from the evaluation forms in Appendix B, interns are evaluated on the specific Profession Wide Competencies. Each competency assessed is rated on a 5 point scale, from "R" (remedial work required) through "P" (professional skill level). Competencies are identical for the 5 rotations. In order to pass a rotation, an intern must achieve an average rating of 3.0, or "I" (Intermediate), and no competency may be rated lower than 2, or "E" (entry level). If an intern has any competency rated "R" (remedial work required) at the end of a rotation, that rotation must be repeated and successfully completed before the internship can be passed. Further, for the 5th and final rotation (plus the supervision and research competencies assessed separately), interns must achieve an average rating of 3.0 (Intermediate), with no individual competency ratings lower than 3 (Intermediate). Thus, interns must demonstrate at least an Intermediate level of competency on all competencies evaluated at the end of the internship in order to successfully complete the program. Failure to achieve this level of competency will result in remediation and likely extension in training past the end of the internship year, until required competency is completed. In the quite unusual situation where an extension of the training year were required, interns would remain commissioned Navy Lieutenants and thus would still have full pay and benefits during the extended internship. The additional years of obligated active duty service would not begin until successful completion of the internship, however.

C. Competency in Supervising Others: Primary training in supervising others occurs through didactic seminars related to theories and methods of supervision and, following those seminars, through intern role plays, through participation in group supervision, and, as the opportunities arise, through tiered supervision of behavioral health technicians. The didactic series on supervision involves readings from the supervision literature and seminar and journal club discussions based on those readings. Interns are then expected to demonstrate growth in their supervisory skills utilizing knowledge learned in the didactic series. Please see the Supervision Competency Evaluation Form contained in Appendix B, following the rotation Evaluation Form.

D. Competency in critical evaluation and explanation of research in the field of health service psychology and the ability to discuss its application is assessed during the five clinical rotations. It is further assessed via the case presentation early in the year, and the dissertation presentation and capstone project toward the end of the internship year. Please see the Research Competency Evaluation form contained in Appendix B, following the Supervision Competency Evaluation Form.

E. Navy Fitness Report: All Navy officers receive annual Fitness Reports, an official evaluation by the NMCSD Command of their performance both in their areas of specialization and, more generally, regarding their leadership abilities, teamwork, etc. These reports are prepared by the Training Director and then routed through the Director for Mental Health to the Medical Center Chain of Command. Ultimately, Fitness Reports are approved and signed by the Commanding Officer/Reporting Senior and then by the intern. Fitness Reports become a permanent part of the Officer Service Record.

PSYCHOLOGY INTERN DEFICIENT PERFORMANCE: A PROCEDURAL OUTLINE FOR DUE PROCESS MANAGEMENT

1. Acceptable levels of performance on each rotation are established, as discussed above in Psychology Intern Performance Evaluations.

2. Performance criteria will be provided to and discussed with each intern at the beginning of the Internship year via a copy of this Training Manual. That discussion during the indoctrination and orientation period also highlights discussion of these Due Process, Appeals, and Grievance policies.

3. For each rotation, the rotation's supervising psychologist will meet with the intern individually for at least two hours of individual supervision weekly. During formal supervision (and numerous informal supervision opportunities), the supervisor will provide verbal feedback outlining intern performance related to competency achievement criteria. The supervisor documents verbal feedback and any positive or negative changes in the intern's performance, as well as formal written feedback at the midpoint and end of each rotation.

4. After completion, midrotation and end of rotation evaluations are forwarded by the rotation supervisor to the Director of Psychology Training.

5. In order to meet internship requirements, all rotations must be satisfactorily completed. Failure to meet criteria satisfactorily for one rotation does not necessarily exclude the intern from the next rotation but may delay the scheduled graduation from the internship.

6. Remediation Status: If consistent unsatisfactory progress is determined by discussion of the rotation supervisor(s) with the Training Committee (the Psychology Faculty, chaired by the Training Director), the intern will be notified by the Training Director in writing of placement on Remediation Status. (Remediation status may continue while the intern is on another rotation.) The Training Director will outline in writing the deficiencies and suggest methods and objectives to regain satisfactory status. A Review will be held 30 days and then 60 days following the original notification of Remediation Status. If satisfactory standards are met within 60 days, remediation status will be removed, again in writing by the Training Director, and the intern will be in good standing within the internship. Remediation is intended for situations where the intern is not demonstrating reasonable progress during a rotation and where the deficit is considered serious enough that it may not be resolved through regular, ongoing training across rotations. This is an “interim” training status designed to highlight particular issues of concern but cannot lead directly to termination from the program. Notification of placement on remediation would be communicated to the intern’s doctoral university Training Director, and any information and/or recommendations from the university would be requested. The university Training Director would again be notified of successful remediation, or unsuccessful remediation leading to probation (see below).

7. Probation: If the intern fails to meet the criteria necessary for removal from remediation status, the issues are discussed by the Training Committee, which may determine that the intern will be placed on formal Probationary Status. The Training Director will notify the intern in writing, including the deficiencies, and suggest methods and objectives to regain satisfactory status and establish a "cautionary period" of time (not more than 60 days) during which the deficiencies must be brought up to acceptable levels. Because failure to correct problems of such severity as to require Probation could result in termination from the program, at this point the Training Director would also notify the Director of Mental Health and the Medical Center’s Director for Graduate Medical Education, as well as the intern’s doctoral program Director of Training. The process for resolving Probationary Status could require extension of the intern in training beyond the original scheduled completion date. As with other causes for extension of training previously discussed, the intern

would remain on Navy active duty and in full pay status during this extension of training. Assuming successful resolution of Probation and ultimate internship completion, the additional years of obligated active duty service would begin upon actual internship completion.

After the designated period of probation has been completed, if progress is satisfactory and required competency improvements have been achieved, the intern will be restored to good standing in the program by a letter from the Director of Psychology Training. This includes notation that the specific competency improvements have been achieved. The Director of Mental Health, Director for Graduate Medical Education, and the intern's doctoral program Director of Training are also notified.

If intern performance does not reach a satisfactory level of competency improvement, the Training Committee may decide in one of two ways. If the intern is demonstrating clear but not sufficient improvement, and it appears that at least Intermediate levels of competency can reasonably be achieved, the Probation Cautionary Period can be continued for a specified time. This extension will be by written letter from the Training Director, specifying improvements made, further improvements necessary, and a specific time period of extension. Notifications will be the same as for initial Probation.

If the Training Committee determines that improvement is not satisfactory and if it is determined that the intern cannot reasonably be expected to achieve at least Intermediate competency with a brief extension, the Committee will determine that the intern should be terminated from the internship. A letter is prepared by the Director of Psychology Training for the Director of Mental Health's signature requesting, via the Medical Center's Director for Graduate Education, that the intern be disenrolled from the training program, by reason of "failure to satisfactorily complete a training program." All relevant correspondence will be attached to the disenrollment letter and the intern's deficiencies specifically addressed. The Director of Mental Health, with the assistance of the Graduate Medical Education committee, will then convene a meeting of a Disenrollment Board also comprised of the Director of Psychology Training and the Command Legal Officer. The intern will be given the opportunity at that time to appeal to the Board personally and to justify their performance. If disenrollment of the intern is determined, the Director of Mental Health makes the notification to the Bureau of Navy Personnel via the Medical Center GME committee and subsequent appropriate Navy channels. The intern's doctoral program Director of Training is of course kept apprised throughout this process. As disenrollment from the internship would make it impossible for the intern to meet training requirements to serve as an active duty Navy Psychologist, the disenrolled intern would be separated from the Navy and would not have the additional years of obligated service.

8. In the event that an intern's performance for any reason requires it, the Director of Psychology Training may request extension of that intern's training period beyond the original intern year. Such request is transmitted to the Director of Mental Health.

9. Genuinely serious ethical or legal breaches may result in immediate recommendation for disenrollment through the same official procedures and channels, without remediation or probation. In such a situation, the intern would be immediately removed from all clinical responsibilities during processing of the disenrollment recommendation.

INTERN APPEALS PROCESS

Interns have the right to appeal any of the above potentially adverse decisions made by the Training Committee, including Remediation, Probation, and Termination. Appeals can be made at any or all of those stages.

Interns should make the appeal in writing to the Training Director, outlining the specific reasons for disagreement with the Training Committee's decision. This would typically include factual disagreements with evaluations leading to the negative decisions about the intern's competency achievement or about the intern's ability to reach sufficient competency in a reasonable period of time.

Immediately after receiving such an appeal, the Training Director will convene an Appeals Panel consisting of a faculty member who is not directly involved with the intern at the time, a second faculty member of the intern's choosing, and the Training Director. If the intern's appeal involves evaluations made by the Training Director, the Associate Training Director will replace the Training Director as the third member of the appeals panel. The panel will consider information presented both by the faculty and by the intern. The intern may request information from members of the NMCSD staff whom the intern believes can add useful information for the appeal. Both the intern and other staff members requested by the intern are welcome to appear in person at the Appeals Panel meeting, as are faculty members directly involved in identification of the issues leading to the potentially adverse decision being appealed. A panel decision will be provided to the intern in writing within one week of the Appeals Panel meeting. The Panel can, by majority vote, decide to uphold the decision leading to Remediation, Probation, or Termination, or to uphold the intern's appeal. In the latter case, the intern is restored to good standing in the program.

The intern may subsequently make a further appeal to the NMCSD Director for Graduate Medical Education. This step would involve specific processes and timelines specified by the NMCSD Directorate for Professional Education. The intern would be provided with the most current instructions regarding the Directorate for Professional Education appeal process to ensure the intern's appeal receives proper and fair hearing and determination within the Professional Education Directorate.

PROCEDURE FOR INTERN GRIEVANCES

If an intern has a grievance specific to the training program, based on apparently continuing events (as contrasted with one or two time disagreements), the recommended steps are as follows:

1. In accordance with conflict resolution research, the APA ethical code, and general principles of organizational personnel advice, the intern should first attempt to communicate the problem as clearly and specifically as possible to the party perceived as the source of the problem, either verbally or in writing. The intern and the other party are encouraged to seek an informal resolution of the issue.

2. If for any reason the intern feels unable to approach the perceived source directly or has already done so but the problem could not be resolved, the intern should then approach the Director of Psychology Training with a report of the problem. The intern is strongly encouraged, but not mandated, to put the report in writing in order to provide necessary clarity. The Training Director will work with the intern, and any other parties involved, to seek a satisfactory resolution. If the grievance is with the Director of Psychology Training, the intern should take the matter to the Director of Mental Health. If the perceived source is the Director of Mental Health, the intern may take the matter either to the Director of Psychology Training or to the Director of Graduate Medical Education.

3. If the matter is taken outside the Directorate for Mental Health to the Director of Graduate Medical Education level (which may require a written report of the problem), the procedures outlined by the Medical Center's Graduate Education Committee will become the governing process. The Naval Medical Center's Graduate Medical Education Policy on Resident Grievances provides guidance regarding trainee grievance

and fair process in Navy Medical Department education programs. This instruction is available on the Command's Graduate Medical Education intranet and also on the psychology internship sharepoint under Orientation Materials.

4. More general grievances of an Equal Employment Opportunity nature may be handled in accordance with the procedures outlined in Naval Medical Center Instruction 5354.2A, "Command Managed Equal Opportunity (CMEO) Program". This instruction is readily available on the command's intranet website in "Resources" and then "Command Instructions".

PROGRAM EVALUTION BY INTERNS

At the end of the internship year, each intern submits a written critique of the training program to the Director of Psychology Training. This report discusses several specific aspects of the program, with a focus on an overall assessment of the training program's success in preparing the intern for future work in psychology. The report format is included in Appendix B. Additionally, at the end of each rotation interns are requested to submit an evaluation that highlights strengths of the rotation and supervision along with suggestions for improving the rotation. Finally, in terms of formal intern feedback, interns have a retreat day near the end of the training year, during which they develop feedback and recommendations representative of the class as a whole. More informally, the Training Director invites and regularly seeks informal feedback from interns regarding the program, both "positives" and "negatives". These formal and informal sources of feedback are a critical part of the program's ongoing self-assessment and improvement process and have been the source of numerous program enhancements over the past several years.

Approximately one year after internship completion, graduates are contacted by the Training Director and asked to complete a survey tied to the program's success in achieving its aims and its success in training interns in the Profession Wide Competencies. This time frame allows graduates a reasonable period of time to see how well they believe they were trained, while also being recent enough for graduates to distinguish internship contributions to their training from post-internship training, supervision, consultation, continuing education, etc. Graduates are also asked to provide feedback on our recruiting efforts.

POLICY ON INTERNS' VACATION

The following guidelines have been developed to help staff evaluate requests by psychology interns for time away from the internship. Interns are required to plan their absences well in advance, except for emergent situations, and to submit their requests in a manner that will allow adequate review by rotation supervisors and the Training Director. Absences will be tracked for monitoring purposes to ensure that interns still accrue the internship's required 2000 hours of training

A. With rare exceptions under special circumstances, no more than five consecutive working days of planned absences, and no more than two weeks during the training year will be approved.

B. Two leave periods should not normally be requested during the same rotation. This implies that if a request for Temporary Additional Duty (see below) is going to be made during the last rotation, other requests should be planned in earlier training rotations, if possible.

C. All requests for absences are contingent upon the projected requirements of the intern's training assignments and upon the intern's progress in the internship. Above all, patient care responsibilities are

primary.

D. Time away for meeting academic requirements, such as meeting with dissertation committees, defending dissertations, participation in graduation ceremonies, and sitting for licensure exams (i.e., EPPP) is supported. Please work with rotation supervisors and the Director of Training on scheduling well in advance to avoid needing to cancel patients who are already scheduled.

Hospital policies, which are subject to change, determine whether time away for academic requirements is considered "official Navy business." Depending on the current policy, interns may be placed on permissive Temporary Additional Duty orders during these absences. "Permissive" signifies that while the internship program and NMCSD cannot cover travel expenses or per diem for these trips, the intern is not required to use personal leave (vacation time). Conversely, at other times, such travel may be funded or require the intern to utilize annual leave.

POLICY ON INTERNS' SICK LEAVE

Interns who unexpectedly become ill or have emergencies are encouraged to call out to foster an environment of health within the internship, reduce length of illness, reduce spread of illness, and reduce incidence of burnout. However, doing so does not free them from their responsibilities as interns, clinicians, and military officers. The general requirements for calling out sick follow.

1. On the FIRST day of a new rotation, interns should ensure they have contact information (phone/email) for their rotation supervisors, the Training Director, the Associate Training Director, and any colleagues on their team who may have agreed to provide back-up coverage (e.g., on the inpatient rotation). If there is a need to call out for any reason, those individuals should be notified immediately. In addition, it is the intern's responsibility to notify front desk staff who may facilitate notification and rescheduling of the intern's patients.

2. If interns are out for two consecutive business days, on day THREE they will need to provide an SIQ chit to their rotation supervisor and Training Director.

3. There is no penalty for taking sick days. However, absences will be tracked for monitoring purposes to ensure that interns still accrue the internship's required 2000 hours of training.

PSYCHOLOGY INTERNSHIP DIDACTIC PRESENTATION SERIES

The purpose of the didactic series is to provide psychology interns with training in areas relevant to the practice of psychology in the Navy, whether the particular presentation is called Grand Rounds, Directors' Rounds, or Seminar. Training will be given by a mental health professional with expertise in the subject area. In addition, journal article discussions are held twice monthly, focusing on Clinical Supervision and on Multicultural Competence with a particular emphasis on multicultural influences on military members and military psychology practice.

The following principles have been established for the various education series:

1. Each presentation is practice oriented.

2. The interns will be exempted from scheduled clinical responsibilities during planned didactics. Any exception must be cleared with the rotation supervisor, though clinical responsibilities should be scheduled so as not to be a reason for absence.

3. For interns, attendance is mandatory, unless leave, liberty, TAD, etc. has been approved in advance.

Examples of Recent Seminar, Grand Rounds, and Extended Training Topics:
Cognitive Processing Individual and Group Therapy (three-day course)
Prolonged Exposure Therapy (two-day course)
Cognitive Behavior Therapy for Insomnia (two-day course)
Acceptance and Commitment Therapy (two-day course)
Ethics and Professional Practice in Psychology
Ethics and Professional Practice in Navy Psychology
Licensure, Board Certification, and Other Credentials in Psychology
Co-Occurring PTSD and Traumatic Brain Injury
Navy Psychology Practice on Aircraft Carriers
Ethical and Effective Practice of Supervision
Supervision Training: Defining and Assessing Competencies
Special Operations/Special Warfare and Navy Psychology
Substance Use and Co-Occurring Disorders Assessment and Treatment
Suicide Risk Assessment and Intervention

ADJUNCTIVE TRAINING STAFF

To support the development of interns and enhance the overall educational experience, the internship program incorporates adjunctive training staff as a valuable component of its training model. Adjunctive training staff includes

- **Psychology Staff:** Licensed psychologists who are not part of the Core Faculty but are readily available to interns for additional supervision and consultation.
- **Psychiatry Staff:** Attending Psychiatrists on the Inpatient Service and Attending Psychiatrists on the Emergency Mental Health Service.
- **Outside Consultants:** Licensed psychologists who offer mentorship or didactic material and group consultation in areas that complement the expertise of the Medical Center staff.

PROGRAM RECORD KEEPING AND EXTERNAL COMMUNICATIONS

The Director of Psychology Training is responsible for assuring that the following record keeping and external communication requirements are met.

I. Training records are maintained in locked file cabinets in a locked office and/or on a secure server with access limited to the Training Director and Associate Training Director. Records include copies of (a) rotation evaluations completed by supervisors on intern competency and feedback from interns about both rotations and the program as a whole, (b) internship completion certificates, (c) communications with interns' graduate schools regarding initial Match, midyear progress, and program completion, (d) any training contracts and evaluations specifically required by graduate schools, (e) completion verifications and other communications with licensing boards, ABPP, and other professional bodies, (f) APPIC applications, and (g) Navy-specific materials such as Fitness Reports, credentials/privileges documentation, etc.

II. Any records generated related to intern complaints or grievances would also be stored in locked files, separate from interns' training files or on secure server.

III. The Training Director communicates directly with Matched interns on the day of the APPIC Match, with follow up e-mailed correspondence confirming the Match results to both the intern and the intern's doctoral program Director of Training. E-mailed progress review is sent to doctoral program DCTs at the internship midpoint, and confirmation of completion is e-mailed to DCTs at the end of the internship.

IV. The Training Director provides confirmation of internship completion and other necessary communications with state licensing boards and other external agencies, as requested by internship graduates and with their signed release for such communications.

Manual last revised June 2025, will be in effect for the 2025-2026 internship year and planned for the coming year (2026-2027).

W. Michael Hunt, Ph.D., ABPP
Director of Psychology Training
Mental Health Directorate
Naval Medical Center, San Diego, 92134

PHONE: (619) 532-6209
E-mail: William.m.hunt.civ@health.mil

APPENDIX A: APPLICATION TO THE INTERNSHIP

As with the other APPIC Member Navy internship in Bethesda, MD, application to the Naval Medical Center San Diego internship is handled through the Navy Recruiting Command (for Navy Officer commissioning clearance) and through the APPIC Match. The officer commissioning part of the application process is NOT made directly to the internship program. As applicants to the internship are also applying to become active duty Navy officers if matched to our program through the APPIC match, they must meet all age, security background check, and medical requirements for commissioning as Naval officers prior to being placed on the internship's APPIC match list. The Navy officer application process is quite familiar to the Navy recruiters and most easily and efficiently handled through them. Applicants do not already need to be in the military to apply, and, despite the extensive officer commissioning background process during the application, there is no military service obligation unless an applicant matches with the internship through the APPIC match.

Application packages will include the standard APPIC application (including graduate training director verification of readiness for internship), transcripts of all graduate school education, a curriculum vitae, and letters of reference from graduate school professors and practicum supervisors. Letters from professors and supervisors directly familiar with applicants' clinical work are most helpful in the application review process. Additionally, Navy Recruiting will include required Navy Officer recruiting paperwork, the physical exam, and the criminal/security background check in the application package.

Our internship and the Navy welcome and encourage applications from everyone, and we do not discriminate on the basis of sex, race, ethnicity, religion, or sexual preference. In accordance with United States law regarding military officers, applicants must be United States citizens. As noted above, applicants must also meet age, security background check, and medical qualification requirements for Navy officer commissioning prior to being placed on the internship's APPIC Match ranking list.

It is important to emphasize that the Navy accepts internship applicants only from APA-accredited doctoral programs in clinical and counseling psychology.

All written and/or oral comprehensive examinations required by the doctoral graduate program and approval of the dissertation proposal by the applicant's full dissertation committee must be successfully completed prior to the APPIC Match List submission deadline. Prior to starting the internship year, all doctoral degree requirements other than the internship and doctoral dissertation must be completed. This includes all required coursework and pre-internship practicum experiences. Whenever possible, the dissertation should be completed prior to internship, but this is not a requirement.

The Navy internships have not established a required minimum number of practicum hours or required types of practicum settings to be considered for our internships. However, given the predominantly adult focus of our internships, and of Navy Psychology in general, we specifically seek applicants with practicum experience in generalist clinical assessment and psychotherapy work with adults. Experience with adults with major psychopathology is preferred but not mandatory. Applicants with minimal experience with adults or with adult experience only in narrowly focused specialty areas such as neuropsychological assessment would be at a significant disadvantage in our review and APPIC ranking of applicants.

Graduate students interested in applying to the Navy internships in San Diego or Bethesda are advised to contact the Navy Recruiting Office in their local areas. This office can typically be found on line by searching Navy Recruiting. Applicants should specifically ask for Medical Programs Recruiting. Often, small recruiting offices will not have Medical Program Recruiters, but they can easily direct the applicant to the closest Medical Programs Recruiter. If you continue to have difficulty finding a recruiter, please contact us

at: usn.ncr.bumedfchva.list.msc-clinicalpsychology@health.mil

Since 2020, all interviews for the Navy internships' classes have been conducted virtually. In consideration of a desire to reduce the cost and complexity of the interview process for our applicants, we anticipate that this will be the case for interviews conducted in the future as well. That said, applicants who are invited for interviews during the APPIC Match process are welcome to tour the campuses of either or both of the San Diego and Bethesda internship sites during specially scheduled Open Houses if they are interested in doing so. However, we fully understand the time, travel, and financial burden of the APPIC Match process and want to make clear that whether an applicant chooses to visit in person will not be factored into the selection process. Applicants are strongly encouraged to contact the Director of Psychology Training with any questions or concerns.

APPENDIX B: INTERNSHIP FORMS AND POLICY

This appendix contains copies of the following internship documents:

(1) NMCSD Psychology Intern Performance Evaluation – Rotations
(2) NMCSD Psychology Intern Performance Evaluation - Supervision
(3) NMCSD Psychology Intern Performance Evaluation - Research
(4) Intern Evaluation of Rotation
(5) Intern End of Program Critique
(6) Telesupervision Policy

NMCSD PSYCHOLOGY INTERN PERFORMANCE EVALUATION

Intern Rank/Name	**Rotation Name:** **Rotation #:**
Supervisor Name(s)	**Date:**

Competency Ratings Descriptions
(Competencies are identical for all 5 Rotations)

P (5) Professional Skill Level: Skill level comparable to autonomous practice at an advanced post-doctoral or licensed staff psychologist job position. Rating descriptive of exceptional interns at completion of internship training.

H (4) Highly Developed/Advanced: Occasional supervision or consultation is needed. A frequent level of performance demonstrated by strong interns at the completion of a rotation or at the end of the internship. Competency attained in all but non-routine cases; supervisor provides overall mentoring of intern's activities. Depth of supervision or consultation may increase with highly complex cases. Rating descriptive of advanced competence at end of internship.

I (3) Intermediate: Generally solid skill levels, ready for entry level practice. Areas identified which would remain a focus in supervision, including postdoctoral supervision or, if licensed, consultation after internship. Common skill level during the course of a rotation, and at the end of rotations earlier in the internship. Passing rating for a competency at end of internship.

E (2) Entry Level: Skill level frequently seen at the commencement of internship or for new competencies for an intern at start of a rotation. Continued close, ongoing, and regular supervision is needed. Not a passing competency rating at end of internship; this rating at end of final rotation requires remedial work of intern.

R (1) Remedial Work Required: Requires remedial work of intern. Insufficient skill level and/or professionalism demonstrated. Not a passing competency rating on either individual rotation or at end of internship, remediation for competency required.

N/A Not applicable for this rotation/Not assessed during rotation.

To pass each rotation: To pass a rotation, an intern must achieve an average rating of 3.0 ("I" or Intermediate) across all items with no items rated lower than 2.0 ("E" or Entry Level) on the end-of-rotation evaluation. Regardless of their average rating across all items, if an intern has any items rated 1.0 ("R" or remedial work required) at the end of the rotation, that rotation must be repeated and successfully completed before the internship can be passed.

To pass internship: To complete internship successfully, an intern must successfully pass every rotation as noted above. In addition, for the 5th and final rotation, interns must achieve an average rating of 3.0 ("I" or Intermediate) across all items with no items rated lower than 3 ("I" or Intermediate). Thus, interns must demonstrate at least an Intermediate level of competency on all items for all competencies evaluated at the end of the internship (i.e., final rotation) in order to successfully complete internship. Failure to achieve this level of competency by the end of internship could require extension of the internship past one year in order to achieve successful completion.

Profession-Wide Competency: Research

Demonstrates knowledge of and/or use of empirical literature to guide selection and interpretation of appropriate assessment measures.		Mid	Final
P (5)	Detailed understanding/application of empirical literature as it relates to choosing and interpreting assessment measures for both broad categories of patients and as related to specific patients. Fully dedicated to expanding knowledge and skills, independently seeks out information to enhance clinical practice utilizing available databases, professional literature, seminars and training sessions, and other resources. Eager independent consumer of empirical research on clinical assessment.		
H (4)	Strong basic and detailed understanding/application of empirical literature as it relates to choosing and interpreting assessment measures for broad categories of patients. Identifies areas of needed knowledge with specific patients and initiates steps to enhance own learning.		
I (3)	Solid basic understanding/application of empirical literature in selecting and interpreting assessment measures. Relies solely on knowledge of supervisor to enhance new learning.		
E (2)	Demonstrates only a superficial understanding of empirical literature and/or does not apply it consistently during selection or interpretation of assessment measures.		
R (1)	Unwilling to acquire or incorporate empirical literature into practice. Resists suggestions to expand clinical perspective. Procrastinates on readings assigned by supervisor.		
N/A			

Demonstrates appropriate knowledge of, use of empirical literature to support therapeutic interventions and treatment plans, as well as in supervision discussion.		Mid	Final
P (5)	Detailed understanding/application of empirical literature as it relates to selection of appropriate interventions and development of treatment plans for both the most common mental health disorders and those less frequently seen. Fully dedicated to expanding knowledge and skills, independently seeks out information to enhance clinical practice utilizing available databases, professional literature, seminars and training sessions, and other resources. Eager independent consumer of empirical research on clinical intervention.		
H (4)	Strong basic and detailed understanding/application of empirical literature as it relates to selection of appropriate interventions and development of treatment plans for the most common mental health disorders. Identifies areas of needed knowledge with less common mental health disorders and initiates steps to enhance own learning.		
I (3)	Solid understanding and/or application of empirical literature in supporting basic therapeutic interventions and development of treatment plans. Relies solely on knowledge of supervisor to enhance new learning.		
E (2)	Demonstrates superficial understanding of empirical literature and/or does not apply it consistently during development of treatment plan or therapeutic intervention.		
R (1)	Unwilling to acquire or incorporate new information into practice. Resists suggestions to expand clinical perspective. Procrastinates on readings assigned by supervisor.		
N/A			

Research Competency Comments:

Profession-Wide Competency: Ethical and Legal Standards

Demonstrates good knowledge of the ethical principles and legal standards of general clinical practice. Consistently applies these appropriately, seeking consultation as needed.		Mid	Final
P (5)	Spontaneously and consistently identifies potential ethical/legal issues and addresses them proactively. Judgment is reliable about when consultation is needed.		
H (4)	Consistently recognizes potential ethical/legal issues, appropriately asks for supervisory input.		
I (3)	Generally recognizes situations where ethical/legal issues might be pertinent, is responsive to supervisory input.		
E (2)	Often unaware of important ethical/legal issues.		
R (1)	Ignores ethical/legal concerns or disregards supervisory input regarding professional standards.		
N/A			

Demonstrates good knowledge of the ethical principles as specifically applied to military practice situations, as well as military laws and regulations. Consistently applies these appropriately, seeking consultation as needed.		Mid	Final
P (5)	Spontaneously and consistently identifies ethical and legal issues impacting military clinical practice and addresses them proactively. Judgment is reliable about when consultation is needed.		
H (4)	Consistently recognizes ethical and legal issues impacting military clinical practice, appropriately asks for supervisory input.		
I (3)	Generally recognizes situations where ethical and legal issues might be pertinent to military clinical practice, is responsive to supervisory input.		
E (2)	Often unaware of important ethical and legal issues impacting military clinical practice.		
R (1)	Ignores ethical or legal concerns impacting military clinical practice or disregards supervisory input regarding ethics or law.		
N/A			

Ethical/Legal Standards Competency Comments:

Profession-Wide Competency: Individual and Cultural Diversity

Demonstrates knowledge of cultural and individual factors contributing to patient diversity. Committed to providing culturally sensitive services.		Mid	Final
P (5)	Discusses individual differences with patients when appropriate. Acknowledges and respects differences that exist between self and clients in terms of race, ethnicity, culture and other individual difference variables. Recognizes when more information is needed regarding patient differences and seeks out information autonomously. Aware of own limits to expertise. Actively seeks consultation/supervision on diversity. Strong knowledge of research literature on diversity factors in assessment and psychotherapy.		
H (4)	Acknowledges and respects differences that exist between self and clients in terms of race, ethnicity, culture, and other individual difference variables; utilizes supervision/consultation effectively in application with individual patients. Needs only occasional supervisory input to recognize when more information is needed regarding patient differences, and then seeks out information autonomously. Usually aware of own limits to expertise. Actively seeks consultation/supervision on diversity. Good working knowledge of research literature on diversity factors in assessment and psychotherapy.		
I (3)	May have lack of knowledge regarding some patient groups, but resolves such issues effectively through supervision and literature searches. Open to feedback regarding limits of competence with diversity issues, and takes steps to enhance competence. Makes positive use of supervision/consultation on diversity. Basic working knowledge of research literature on diversity factors in assessment and psychotherapy, responsive to supervisor suggestions to seek additional readings.		
E (2)	Is beginning to learn to recognize influence of personal beliefs and cultural influences, which limit effectiveness with patient populations. Discussions of diversity issues must usually be initiated by supervisor. Rudimentary working knowledge of research literature on diversity factors in assessment and psychotherapy, needs strong supervisor encouragement to seek additional readings.		
R (1)	Has been unable or unwilling to surmount own belief systems and/or cultural influences to deal effectively with diverse patients. Poor knowledge of research literature on factors in assessment and psychotherapy. Ignores or resists new readings, new learning.		
N/A			

Demonstrates understanding of impact of diverse military subcultures on mental health issues.		Mid	Final
P (5)	Independently demonstrates broad and nuanced understanding of military subcultures and the challenges they create for individual patient and their families. Minimal supervision needed to assess impact on patient functioning or to inform diagnoses and treatment options. Consults with other professionals and/or scientific literature as needed to refine understanding, treatment options, and interventions.		
H (4)	Has a strong, broad understanding of military subcultures and the challenges they create for individual patients and their families. Regularly uses this knowledge of diversity to inform diagnoses and treatment options. Infrequent supervision needed to clarify more subtle role of these diversity issues.		
I (3)	Working knowledge of broader issues related to military subcultures and the challenges they create for individual patients and their families. Uses this knowledge of diversity to inform diagnoses and treatment options. Needs regular supervision/consultation to clarify the more subtle impact of these diversity issues.		

E (2)	Some understanding of military subcultures and their impact on the patient's individual functioning, family, diagnoses, and treatment options. Needs frequent supervision to clarify the interaction and impact.		
R (1)	Does not have an understanding of military subcultures and their impact on family, individual functioning, diagnoses, and treatment options. Not able to incorporate into assessment and treatment plans even with supervision.		
N/A			

Individual and Cultural Diversity Competency Comments:

Profession-Wide Competency: Professional values, attitudes, and behaviors

Demonstrates positive coping strategies with personal, professional/military stressors and challenges. Maintains professional functioning and quality patient care.		Mid	Final
P (5)	Good awareness of personal and professional problems. Stressors have only mild impact on professional practice. Actively seeks supervision, consultation, and/or personal therapy to resolve issues. Demonstrates appropriate therapeutic, professional, and military boundaries.		
H (4)	Good insight into impact of stressors on professional functioning, seeks supervisory input, consultation, and/or personal therapy as indicated to minimize this impact. Demonstrates appropriate therapeutic, professional, and military boundaries.		
I (3)	Needs significant supervision time to minimize the effect of stressors on professional functioning. Accepts reassurance from supervisor well. Demonstrates appropriate therapeutic, professional, and military boundaries.		
E (2)	Personal problems can significantly disrupt professional functioning. Demonstrates questionable judgment with regard to therapeutic, professional, or military boundaries or behaviors.		
R (1)	Denies problems or otherwise does not allow them to be addressed effectively. Poor therapeutic, professional, or military boundaries.		
N/A			

Development of expertise in role as Naval officer and enhancing credibility as military mental health professional.		Mid	Final
P (5)	Exemplary military bearing and rarely requires corrective feedback. Immediately responsive to feedback if necessary. Strong example of military discipline and consistently assumes leadership role. Consistently demonstrates strong use of military officership as an enhancer of credibility as a military mental health professional.		
H (4)	Consistently good military bearing and responsive to corrective feedback when minor issues arise. Good example of military discipline and beginning to take on leadership role. With only occasional lapses, demonstrates strong use of military officership as an enhancer of credibility as a military mental health professional.		

I (3)	Beginning to display military bearing, seeks feedback to improve. Military discipline is satisfactory. Little assumption of leadership role. Utilizes reminders from supervisors and officer mentors to utilize military officership to enhance credibility as military mental health professional.		
E (2)	Inconsistent use of military bearing and minimal responsiveness to corrective feedback. Behavior minimally conducive to military discipline/no assumption of leadership role. Lackadaisical in officer skills and presentation, difficulty understanding importance in credibility as a military mental health professional.		
R (1)	Lack of military bearing, not responsive to corrective feedback. Behavior that is not conducive to military discipline/undermines leadership role. Resistant to developing appropriate officer skills, bearing, and credibility, despite guidance from supervisors and military mentors.		
N/A			

Professional values, attitudes, and behaviors Competency Comments:

Profession-Wide Competency: Communication and interpersonal skills

Demonstrates skill in utilizing and summarizing patient information from all relevant resources into a well-organized psychological report which meets professional standards of care and departmental peer review criteria.		Mid	Final
P (5)	Reports are clear and thorough, follow a coherent outline, and effectively summarize major relevant issues. When available, relevant psychological test results are woven into reports as supportive evidence. Recommendations are related to referral questions.		
H (4)	Reports cover essential points without serious error, may need polish in cohesiveness and organization. Readily completes assessments with minimal supervisory input, makes useful and relevant recommendations.		
I (3)	Able to develop useful draft reports. Uses supervision effectively for assistance in determining important points to highlight.		
E (2)	May fail to summarize patient information into a cohesive report and have difficulty formulating recommendations to appropriately answer referral question. Relies heavily on supervisor for guidance in determining important points and treatment recommendations.		
R (1)	Inaccurate conclusions or grammar interfere with communication. Reports are poorly organized and require major rewrites.		
N/A			

Demonstrates ability to establish and sustain rapport and effective communication with patients.		Mid	Final
P (5)	Establishes quality relationships with almost all patients, reliably identifies potentially challenging patients, addresses therapeutic alliance issues effectively and seeks supervision as needed. Consistently manages scheduling challenges to optimally meet treatment and situational needs of patients. Effectively explains assessment results and recommended treatments, and resolves questions raised by patients, in almost all cases.		

H (4)	Generally comfortable and relaxed with most patients, consults effectively, and handles anxiety-provoking or awkward situations so that they do not undermine therapeutic process. Generally manages scheduling challenges to optimally meet treatment and situational needs of patients. Generally explains assessment results and recommended treatments, and resolves questions raised by patients, in most cases, with direct assistance of supervisor in highly complex situations.		
I (3)	Actively develops skills with new populations. Relates well when has prior experience with the population. May need frequent supervisory input to manage scheduling challenges to optimally meet treatment and situational needs of patients. May need supervisory assistance to explain assessment results and recommended treatments, and to resolve questions raised by patients, in numerous cases.		
E (2)	Has difficulty establishing rapport. Even with frequent supervisory input, struggles to manage scheduling challenges to optimally meet treatment and situational needs of patients. Frequently needs direct supervisory involvement to explain assessment results and recommended treatments, and to resolve questions raised by patients.		
R (1)	Alienates patients or shows little ability to recognize problems. Frequently unable to explain to patients assessment results and treatment plans, or to resolve questions raised by patients. Frequently unable or unwilling to manage scheduling challenges to meet treatment and situational needs of patients.		
N/A			

Communication and interpersonal Competency Comments:

Profession-Wide Competency: Assessment

Demonstrates skill in synthesizing DSM-5/TR diagnoses based on relevant clinical, historical, and test data.		Mid	Final
P (5)	Demonstrates a thorough knowledge of mental health classification, including relevant biopsychosocial and other diagnostic criteria to develop an accurate diagnostic formulation autonomously. Consistently able to support diagnoses with both inclusionary and exclusionary data.		
H (4)	Has a good working knowledge of mental health diagnoses. Is thorough in consideration of relevant patient data, and diagnostic accuracy is typically good. Generally able to support diagnoses with both inclusionary and exclusionary data. Uses supervision well in more complicated cases involving multiple or more unusual diagnoses.		
I (3)	Understands basic diagnostic nomenclature and is able to accurately diagnose many mental health problems. With less complex cases usually able to support diagnoses with both inclusionary and exclusionary data; may miss relevant patient data when making a diagnosis. Requires supervisory input on more complex diagnostic decision-making.		
E (2)	Has a theoretical knowledge and understanding of basic diagnostic nomenclature, but lacks practical experience applying knowledge to actual cases. May miss both inclusionary and exclusionary data when making a diagnosis. Requires supervisory input on most diagnostic decision-making.		
R (1)	Has significant deficits in understanding of the mental health classification system and/or ability to use DSM-5 criteria to develop a diagnostic conceptualization. Often unable to support diagnoses with inclusionary and exclusionary data.		
N/A			

Demonstrates skill in effectively evaluating, managing and documenting patient risk by assessing immediate concerns such as suicide, homicide, and any other safety issues.		Mid	Final
P (5)	Assesses and documents all risk situations fully prior to leaving the clinic. Appropriate actions taken to manage patient risk situations (e.g., admitting the patient, liaison with patient's command) are initiated immediately, while seeking consultation and confirmation from supervisor. Strong knowledge of research literature on risk factors.		
H (4)	Aware of how to cope with safety issues, continues to need occasional reassurance in supervision. Asks for input regarding documentation of risk as needed. Sometimes can initiate appropriate actions to manage patient risk, sometimes needs input of supervisor first. Good working knowledge of risk factors literature.		
I (3)	Recognizes potentially problematic cases, but needs guidance regarding evaluation of patient risk. Supervision is needed to cope with safety issues; afterwards interns handle them well. Can be trusted to seek consultation immediately if needed, while patient is still on site. Needs to refine crisis plans in collaboration with supervisor. Needs input regarding documentation of risk. Rudimentary knowledge of research on risk factors.		
E (2)	Delays or forgets to ask about important safety issues. Does not document risk appropriately. Does not consistently inform other clinical team members about a patient's risk. Needs reminders in supervision regarding risk factors. Needs supervisor's reminders to seek out research literature on risk factors.		
R (1)	Makes inadequate assessment or plan, does not take measures to protect the patient. Does not seek immediate supervision in situations of elevated patient risk. Ignores, or unaware of, research regarding risk factors.		
N/A			

Demonstrates skill in selecting both appropriate psychological tests and self-report measures to assist with assessment.		Mid	Final
P (5)	Is confident in selection of assessment tools to address referral questions. Understands psychometric properties of tools as well as strengths and weaknesses of each measure. Is able to defend choice of test and why others were excluded. Seeks out experiences with new tests to broaden their capabilities.		
H (4)	With supervision is able to select appropriate measures to address the referral question. With prompting will be able to explain why alternate measures would not be as useful as the measures chosen. Knows the basic psychometric properties of each test and is willing to seek out information regarding limitations and strengths of measures.		
I (3)	Has some knowledge regarding the selection of testing materials. Is open to discussion regarding the strengths and weaknesses of measures and utilizes supervision to learn about new tests. Researches additional measures with prompting.		
E (2)	Is beginning to learn about basic test selection and development. Does not usually bring up strengths and weaknesses of a measure and relies on supervisor for guidance. Needs strong or repeated supervisor encouragement to seek additional readings.		
R (1)	Has been unable or unwilling to choose appropriate measures to address a referral question. Does not seek to expand knowledge base regarding testing instruments. Poor knowledge of research literature on assessment. Ignores or resists new readings, new learning.		
N/A			

Demonstrates skill in interpretation of psychological testing data.		Mid	Final
P (5)	Independently and thoroughly integrates testing data with the history of the patient. Explains discrepancies when possible. Will select additional measures to address discrepancies as able. Will recognize test construction or weakness of a measure as a possible reason for discrepancy.		
H (4)	With minimal supervision is able to explain outcome of assessment data and how data relate to the patient's history. With only routine prompting will be able to discuss and explain any discrepancies between patient's history and testing data. Generally recognizes that test construction is a possible explanation for discrepancies.		
I (3)	Has working knowledge regarding the interpretation of test data. Is able to recognize significant elevations on scales and, with routine supervision, can interpret testing data in the context of the patient's history and circumstances. Supervision often required in explaining any discrepancies between the data, the patient's history, including potential causes for discrepancies such as test construction factors.		
E (2)	Is beginning to learn about effective testing data interpretation. Struggles with integrating data with the history of the patient. Does not recognize significance of elevations of scales or does not recognize discrepancies between the patient's history and the data. Does not consistently recognize possible causes of discrepancies, such as test construction factors.		
R (1)	Unable to interpret testing data without extensive supervision. Does not exhibit a basic understanding of test construction. Does not seek to expand knowledge base regarding test interpretation. Ignores or resists new readings, new learning to expand knowledge base.		
N/A			

Assessment Competency Comments:

Profession-Wide Competency: Intervention

Demonstrates ability to formulate a useful case conceptualization that draws on theoretical and research knowledge. Collaborates with patient to form appropriate treatment goals, works toward goals systematically.		Mid	Final
P (5)	Independently produces good case conceptualizations within the chosen theoretical orientation, can also draw insights into cases from other orientations. Consistently sets, works toward realistic goals with patients. Strong knowledge of research literature regarding preferred orientation.		
H (4)	Reaches case conceptualization on own, recognizes improvements when pointed out by supervisor. Strong working knowledge of research literature regarding preferred orientation. Readily identifies emotional issues but occasionally needs supervision for clarification. Sets appropriate goals, works toward them with patients. With occasional prompting from supervisor, distinguishes realistic and unrealistic goals.		
I (3)	Reaches case conceptualization with occasional supervisory assistance. Aware of emotional issues when they are stated by the patient, sometimes needs supervision for development of awareness of underlying issues. Sometimes needs supervision or consultation to set realistic therapeutic goals with complex patients and to pursue those goals, aside from those presented by patient. Good basic knowledge of literature regarding preferred orientation.		

E (2)	Responses to patients need for enhanced theoretical understanding and case formulation. Often needs supervision to perceive important emotional issues in therapy. Without close supervision, may have difficulty setting or working toward appropriate treatment goals with patients. Acceptable knowledge of literature regarding preferred orientation, but frequently struggles in application of that literature in all but clearly routine cases.		
R (1)	Responses to patients indicate significant inadequacies in theoretical understanding and case formulation. Misses or misperceives important emotional issues. Unable to set or work toward appropriate treatment goals with patients. Rudimentary knowledge, at best, of literature regarding preferred orientation.		
N/A			

Demonstrates ability to evaluate efficacy of interventions.		Mid	Final
P (5)	Little to no supervision needed to regularly select and utilize appropriate outcome measures to monitor therapeutic progress, when such measures are applicable. Able to cogently discuss situations where empirically derived outcome measures may not represent actual patient progress, such as secondary gain. Demonstrates motivation to increase knowledge and expand range of evaluative measures through reading and consultation.		
H (4)	With reminders in supervision, often selects and utilizes appropriate outcome measures to monitor therapeutic progress when such measures are applicable. With inquiry, can recognize situations where empirically derived outcome measures may not represent actual patient progress, such as secondary gain. With occasional encouragement, seeks to increase knowledge and expand range of evaluative measures through reading and consultation.		
I (3)	With supervisory direction, able to select and utilize appropriate outcome measures to monitor therapeutic progress when such measures are applicable. Beginning to recognize situations where empirically derived outcome measures may not represent actual patient progress, such as secondary gain. Utilizes resources from supervisor to increase knowledge and expand range of evaluative measures through reading and consultation.		
E (2)	Periodic difficulty selecting and utilizing appropriate outcome measures to monitor therapeutic progress when such measures are applicable. Some difficulty recognizing situations where empirically derived outcome measures may not represent actual patient progress, such as secondary gain. Needs significant encouragement from supervisor to increase knowledge and expand range of evaluative measures through reading and consultation.		
R (1)	Frequent or consistent difficulty selecting and utilizing appropriate outcome measures to monitor therapeutic progress when such measures are applicable. Even with supervision, difficulty recognizing situations where empirically derived outcome measures may not represent actual patient progress, such as secondary gain. Needs frequent direction from supervisor to increase knowledge and expand range of evaluative measures through reading and consultation; may resist such application.		
N/A			

Demonstrates planning and delivery of interventions which are well-timed, effective, consistent with patients' treatment needs and, where relevant, consistent with empirically supported treatment protocols.		Mid	Final
P (5)	Interventions and discussions with patients facilitate patient acceptance and change. Consistently, effectively utilizes empirically supported therapies whenever indicated and appropriate. Demonstrates motivation to increase knowledge and expand range of interventions through regular reading plus consultation as needed. Consistently maintains non-judgmental perspective on patient challenges while therapeutically addressing challenges to therapeutic gains. Consistently refers for multidisciplinary consultation/ treatment when indicated.		

H (4)	Most interventions and discussions with patients facilitate patient acceptance and change. Supervisory assistance needed for timing and delivery of more difficult interventions with highly complex cases. Generally effectively utilizes empirically supported therapies whenever indicated and appropriate. Generally seeks new readings, additional consultation to assist with planning and delivery of interventions. Generally maintains non-judgmental perspective on patient challenges while therapeutically addressing challenges to therapeutic gains. Consistently refers for multidisciplinary consultation/ treatment when indicated.		
I (3)	Many interventions and interpretations are delivered and timed well. Needs supervision to plan interventions and clarify aim of intervention. With some supervisory direction required, effectively utilizes empirically supported therapies whenever indicated and appropriate. Collaborates with supervisors on use of literature, makes good use of supervisor-assigned readings and consultation. May need direct assistance with more challenging situations to maintain non-judgmental perspective on patient challenges while therapeutically addressing challenges to therapeutic gains.		
E (2)	Some interventions are accepted by the patient while some others are rejected by patient. Sometimes has difficulty targeting the interventions to patient's level of understanding and motivation. Needs strong encouragement to utilize empirically supported therapies, and to seek new readings or consultation. Has difficulty maintaining non-judgmental perspective on patient challenges, struggles with therapeutically confronting challenges to therapeutic gains. Often does not recognize need for multidisciplinary consultation/ treatment.		
R (1)	Most interventions and interpretations are rejected by patient. Has frequent difficulty targeting interventions to patients' level of understanding and motivation. Negligent or contraindicated use of intervention techniques. Lacks ability to formulate a case and develop/execute intervention. Resists or ignores opportunities for empirically supported treatments and/or recommended readings or consultations regarding intervention. Generally unable to maintain non-judgmental perspective. Fails to recognize need for multidisciplinary consultation/treatment in most cases.		
N/A			

Intervention Competency Comments:

Profession-Wide Competency: Consultation and interprofessional/interdisciplinary skills

Demonstrates assessment/psychological testing consultation skills.		Mid	Final
P (5)	Independently reviews consultation request to determine referral questions. Will contact referral source to clarify referral question and is confident in determining if testing will be useful to address referral question. Consistently provides thorough feedback to referral source in a timely and professional manner.		
H (4)	With minimal supervision is able to determine if testing is an appropriate way to address referral questions. Recognizes when testing may not be helpful. With only occasional prompting will contact referral source to clarify referral questions. Provides feedback to referral source with only rare need for reminders. Is able to summarize test findings in a succinct and appropriate manner. Includes all pertinent information in presentation.		

I (3)	Has reasonable knowledge regarding the appropriateness of testing to address a referral question. May need supervision to determine when to contact referral source to clarify question. Provides feedback to referral source but may require direct supervision in order for feedback to be thorough and effective. Is able to summarize test findings but sometimes needs closer supervision to do so in a succinct and professional manner.		
E (2)	Is beginning to seek out information regarding testing consults. Needs close supervision to recognize that testing may not be an appropriate way to address some referral questions. Needs frequent reminders to provide feedback, or feedback is often disjointed and poorly presented.		
R (1)	Does not seek further information regarding a testing consult even when recommended in supervision. Does not utilize supervision to question appropriateness of testing to address a referral question. Does not provide feedback to referral source without multiple reminders.		
N/A			

Demonstrates professional and appropriate interactions with multidisciplinary treatment teams, peers and supervisors.		Mid	Final
P (5)	Smooth working relationships, handles differences openly, tactfully, and effectively. Consistently strong leadership of multidisciplinary consultation and treatment teams. Actively seeks, utilizes collegial support.		
H (4)	Actively participates in team meetings. Appropriately seeks input from supervisors to cope with rare interpersonal concerns in professional relationships. Effective leadership of multidisciplinary consultation and treatment teams. Generally seeks, utilizes collegial support.		
I (3)	Progressing well on providing input in team meetings. Effectively seeks assistance to cope with interpersonal concerns in professional relationships. With supervisory encouragement, can provide effective leadership of multidisciplinary consultation and treatment teams. Often seeks, utilizes collegial support, but may need supervisory reminders to do so.		
E (2)	Ability to participate in team model is limited, but generally relates appropriately to peers and supervisors. Even with supervisory encouragement, may struggle to provide effective leadership of multidisciplinary consultation and treatment teams. May need frequent encouragement to seek and utilize collegial support.		
R (1)	May be withdrawn and/or non-contributory in team meetings, overly confrontational, insensitive or may have had hostile interactions with colleagues. Not able to provide effective leadership of multidisciplinary consultation and treatment teams.		
N/A			

Demonstrates understanding of appropriate military resources and channels in military-specific case dispositions, and skill in liaison with military referral sources and military commands.		Mid	Final
P (5)	Relates well to patients' commands and other appropriate agencies/professionals. Able to provide appropriate feedback and disposition recommendations to commands. Highly effective psychology consultant to military commands.		
H (4)	Requires occasional input regarding the manner of delivery or type of feedback given to commands. Generally strong, effective psychology consultant to military commands.		
I (3)	Requires some ongoing supervisory input regarding the feedback given to military commands. Has developed good working knowledge of military command psychological consultation.		
E (2)	Needs continued guidance and continued input regarding appropriate feedback and military disposition recommendations. Has difficulty consulting without intensive supervisory oversight.		

R (1)	Unable to establish rapport or communicate recommendations clearly. Ineffective consultant, may require supervisor to take over consultation with military commands.		
N/A			

Consultation and interprofessional/interdisciplinary Competency Comments:

The preceding evaluation was reviewed in detail with me.

_____

Intern's Signature

This evaluation was reviewed in detail with the intern. All rated competencies were directly observed at least once during this rotation. Method(s) of direct observation included:

_____ _____

Supervisor Signature
Secondary, if applicable

Supervisor Signature

Additional Comments:

NMCSD PSYCHOLOGY INTERN PERFORMANCE EVALUATION

SUPERVISION

Intern Rank/Name	
Evaluator Name	**Date** **Mid-year/ End-year (circle one)**

Competency Ratings Descriptions

P (5) Professional Skill Level:

Skill level comparable to autonomous practice at a post-doctoral or entry-level job position. Rating descriptive of exceptional interns at completion of internship training.

H (4) Highly Developed/Advanced:

Intermediate to advanced knowledge level regarding supervision. Competency attained at level required in all but quite complex supervisory situations; would successfully utilize consultation in such cases. Rating descriptive of more advanced competence in knowledge and delivery of supervision.

I (3) Intermediate:

Generally solid supervisory knowledge level, with some areas which would remain a focus of consultation as a new supervisor. Would require occasional consultation regarding supervisory practice. Passing rating for competency.

E (2) Entry Level:

Knowledge level frequently seen at the commencement of internship. Very frequent consultation with more experienced supervisors would be necessary for supervisory practice. Not a passing rating for internship completion.

R (1) Remedial Work Required:

Requires remedial work of intern. Insufficient knowledge level demonstrated. Not a passing competency rating, remediation for competency required.

LEARNING OBJECTIVES

Profession-Wide Competency: Supervision

Demonstrates the ability to apply knowledge of supervision as described by APA's CoA for HSP in direct or simulated practice with psychology trainees, or other health professionals. Examples of direct or simulated practice of supervision include, but are not limited to, role-played supervision with others and peer supervision with other trainees.

1. ***Applies the supervisory skill of observing in direct or simulated practice.***

P	Supervisory skill of observing is comparable to autonomous practice at a post-doctoral or entry-level psychologist job position.
H	Supervisory skill of observing is highly developed/advanced, requiring only minimal consultation or clarification from faculty or others.
I	Supervisory skill of observing is solid and acceptable for entry level practice in spite of requiring moderate level of consultation or clarification from faculty or others. Passing rating for a competency at end of internship.
E	Supervisory skills of observing is superficial and requires a significant level of consultation or clarification from faculty or others. Not a passing competency rating for internship completion.
R	Supervisory skill of observing is insufficient. Not a passing competency rating; remediation for competency required.

2. ***Applies the supervisory skill of evaluating in direct or simulated practice.***

P	Supervisory skill of evaluating is comparable to autonomous practice at a post-doctoral or entry-level psychologist job position.
H	Supervisory skill of evaluating is highly developed/advanced, requiring only minimal consultation or clarification from faculty or others.
I	Supervisory skill of evaluating is solid and acceptable for entry level practice in spite of requiring moderate level of consultation or clarification from faculty or others. Passing rating for a competency at end of internship.
E	Supervisory skills of evaluating is superficial and requires a significant level of consultation or clarification from faculty or others. Not a passing competency rating for internship completion.
R	Supervisory skill of evaluating is insufficient. Not a passing competency rating; remediation for competency required.

3. Applies the supervisory skill of giving guidance and feedback in direct or simulated practice.

P	Supervisory skill of giving guidance and feedback is comparable to autonomous practice at a post-doctoral or entry-level psychologist job position.
H	Supervisory skill of guidance and feedback is highly developed/advanced, requiring only minimal consultation or clarification from faculty or others.
I	Supervisory skill of guidance and feedback is solid and acceptable for entry level practice in spite of requiring moderate level of consultation or clarification from faculty or others. Passing rating for a competency at end of internship.
E	Supervisory skills of guidance and feedback is superficial and requires a significant level of consultation or clarification from faculty or others. Not a passing competency rating for internship completion.
R	Supervisory skill of guidance and feedback is insufficient. Not a passing competency rating; remediation for competency required.

Additional Comments:

This evaluation was reviewed in detail with the intern. All rated competencies were directly observed at least once during this rotation.
Method(s) of direct observation included: _____

_____ _____
Supervisor's Signature Intern's Signature
Rev 3/24

NMCSD PSYCHOLOGY INTERN PERFORMANCE EVALUATION

RESEARCH

Intern Rank/Name	Case Presentation/Dissertation/Capstone
Evaluator Name	Date

Competency Ratings Descriptions

P (5) Professional Skill Level:

Skill level comparable to autonomous practice at a post-doctoral or entry-level job position. Rating descriptive of exceptional interns at completion of internship training.

H (4) Highly Developed/Advanced:

Intermediate to advanced competence in evaluation and dissemination of research/scholarly activities.

I (3) Intermediate:

Generally solid competency level in the ability to evaluate and disseminate research/scholarly activities. Competency rating required for successful completion of internship.

E (2) Entry Level:

Knowledge level frequently seen at the commencement of internship. While a passing rating during the internship year, this is not a passing rating for internship completion.

R (1) Remedial Work Required:

Insufficient knowledge level demonstrated. Not a passing competency rating; remediation for competency required.

LEARNING OBJECTIVES

Profession-Wide Competency: Research

1. ***Demonstrates ability to critically evaluate research in the field of health service psychology (HSP) and to discuss its application.***

P	Demonstrates the ability to critically evaluate research in the field of health service psychology (HSP) and to discuss its application at the level of an advanced post-doctoral or licensed staff psychologist.
H	Demonstrates a highly developed/advanced ability to critically evaluate research in the field of health service psychology (HSP) and to discuss its application. Requires only minimal consultation or clarification from faculty or others.
I	Ability to critically evaluate research in the field of health service psychology (HSP) and to discuss its application is solid and acceptable for entry level practice in spite of requiring moderate level of consultation or clarification from faculty or others. Passing rating for a competency at end of internship.
E	Ability to critically evaluate research in the field of health service psychology (HSP) and to discuss its application is superficial and requires a significant level of consultation or clarification from faculty or others. Not a passing competency rating for internship completion.
R	Ability to critically evaluate research in the field of health service psychology (HSP) and to discuss its application is inaccurate and/or significantly insufficient to impart knowledge about the subject matter. Not a passing competency rating; remediation for competency required.
N/A	

2. ***Demonstrates ability to explain scientific research related to health service psychology (HSP).***

P	Presentation of research or scholarly activities is at the level of an advanced post-doctoral or licensed staff psychologist as evidenced by thorough and articulate discussion of relevant science including strengths and weaknesses of scientific methods/procedures/practices.
H	Presentation of research or scholarly activities is highly developed/advanced, requiring only minimal consultation or clarification from faculty or others.
I	Presentation of research or scholarly activities is solid and acceptable for entry level practice in spite of requiring moderate level of consultation or clarification from faculty or others. Passing rating for a competency at end of internship.
E	Presentation of research or scholarly activities is superficial and requires a significant level of consultation or clarification from faculty or others. Not a passing competency rating for internship completion.
R	Presentation of research or scholarly activities is inaccurate and/or significantly insufficient to impart knowledge about the subject matter. Not a passing competency rating; remediation for competency required.
N/A	

Additional Comments:

This evaluation was reviewed in detail with the intern. All rated competencies were directly observed at least once during this rotation.
Method(s) of direct observation included: _____

_____ _____
Supervisor's Signature Intern's Signature
Rev 3/24

CLINICAL PSYCHOLOGY INTERNSHIP
INTERN EVALUATION OF ROTATION

Intern: _____ Date: _____

Rotation: _____

This evaluation is designed for use by the faculty in assessing and, when indicated, modifying the internship rotations. We ask that you be thoughtful and straightforward in answering the questions. Then, please give your evaluation to your primary supervisor on the rotation, but NOT before receiving the final evaluation your supervisor has completed regarding your work on the rotation. Also, please give a copy to the Director of Training.

Our sincere thanks for completing this!

1. Briefly describe your goals for learning during this rotation.

2. How well were these goals met over the course of the rotation? Briefly discuss.

3. What were the most useful aspects of this rotation? Briefly discuss.

4. What aspects of the rotation could be improved, and how?

5. Briefly discuss how supervision (including telesupervision, if applicable) during the rotation was helpful to you.

6. How could supervision (including telesupervision, if applicable) have been improved to be more helpful?

7. Any additional comments, suggestions, etc., for this rotation?

NMCSD PSYCHOLOGY INTERNSHIP
SUPPLEMENTAL ROTATION EVAL

Location: ☐ MHOOD ☐MCRD/Miramar ☐AOP ☐Health ☐Inpatient/EPS ☐Transrotation

This was my: ☐1st rotation ☐ 2nd rotation ☐3rd rotation ☐4th rotation ☐5th rotation ☐Full year (transro only)

Structure/Overall experience	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
1. Orientation for this rotation was adequate and met my needs	◯	◯	◯	◯	◯
2. Supervision was regularly scheduled each week	◯	◯	◯	◯	◯
3. My supervisor was available for unscheduled consultation when needed	◯	◯	◯	◯	◯
4. Supervision was rescheduled or backup supervision was provided during supervisor absences	◯	◯	◯	◯	◯
5. My supervisor adjusted teaching model to skill level (e.g, less teaching/more intern autonomy over course of internship year and in keeping with skill level)	◯	◯	◯	◯	◯
6. Adequate templates and sample write-ups were provided for guidance with clinical notes, evaluations, ADSEP memos, and/or LIMDUs/MEB NARSUMs	◯	◯	◯	◯	◯
7. Notes and/or reports were reviewed and returned with feedback within 5 days of receipt	◯	◯	◯	◯	◯
8. Written feedback was consistent with verbal discussion and feedback	◯	◯	◯	◯	◯
9. My supervisor modelled and encouraged positive self-care.	◯	◯	◯	◯	◯
10. My supervisor helped me identify my training goals for this rotation	◯	◯	◯	◯	◯

Clinical Skills	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
1. This rotation helped me develop my case conceptualization skills	◯	◯	◯	◯	◯
2. My supervisor assisted me in developing concise case formulations including differential diagnoses	◯	◯	◯	◯	◯
3. This rotation allowed me to practice interventions from different theoretical models, including evidence-based treatment protocols.	◯	◯	◯	◯	◯
4. My supervisor directed me to scholarly or theoretical readings to further my knowledge of case conceptualization and/or treatment interventions.	◯	◯	◯	◯	◯
5. My supervisor helped me with decision-making for managing ethical dilemmas	◯	◯	◯	◯	◯
6. Supervision included discussion of diversity factors, individual differences, and multicultural competence	◯	◯	◯	◯	◯
7. My supervisor helped me manage high risk patients to ensure patient safety	◯	◯	◯	◯	◯
8.	◯	◯	◯	◯	◯
9.	◯	◯	◯	◯	◯
10.	◯	◯	◯	◯	◯

Command Consultation/Military Context	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
1. My supervisor helped my development as an officer in the United States Navy	◯	◯	◯	◯	◯
2. This rotation exposed me to operational and/or mission focused demands of military psychology	◯	◯	◯	◯	◯
3. My supervisor modeled effective command consultation and provided guidance for consulting with commands	◯	◯	◯	◯	◯
4.	◯	◯	◯	◯	◯
5.	◯	◯	◯	◯	◯

Supervisory Relationship	*Strongly Disagree*	*Disagree*	*Neither Agree nor Disagree*	*Agree*	*Strongly Agree*
1. My supervisor demonstrated genuine interest in and commitment to quality training	◯	◯	◯	◯	◯
2. My supervisor was knowledgeable of the areas being supervised	◯	◯	◯	◯	◯
3. My supervisor demonstrated respect for interns, patients, and colleagues	◯	◯	◯	◯	◯
4. My supervisor was open to feedback	◯	◯	◯	◯	◯
5. Personal issues that impact my role as a psychologist/therapist were addressed in a respectful supportive manner	◯	◯	◯	◯	◯
6. I received feedback on both strengths and weaknesses in a way that enabled me to grow.	◯	◯	◯	◯	◯
7. My supervisor maintained appropriate professional boundaries	◯	◯	◯	◯	◯
8. My supervisor gave regular, clear feedback on my progress and skill development	◯	◯	◯	◯	◯
9. If telesupervision was utilized during this rotation, the supervision experience was high quality and effective.	◯	◯	◯	◯	◯

Overall Rating (circle one):

0-Poor training experience/supervision relationship
1-Fair.
2- Adequate
3- Good
4-Strong, informative, and supportive
5-Consistently excellent overall

Trainee requests for change: _____

_____

_____

_____

Other comments: _____

_____

_____

_____

Signature:_____ Review Date:_____

CLINICAL PSYCHOLOGY INTERNSHIP END OF PROGRAM CRITIQUE

Name: _____

Inclusive Dates of Program: _____

This is your opportunity, at the completion of your internship, to provide your analysis of the internship - both positives and negatives - to assist the faculty in continuous assessment and strengthening of the program. We ask that you submit this prior to your final checkout from the internship.

Please submit a thorough assessment of the internship, considering the entire year, and submit to the Director of Training. It is especially helpful if you can specifically address the following areas:

1. Clinical training and rotations
2. Didactics – seminars, Grand Rounds, longer courses
3. Supervision
4. Operational Psychology orientation and familiarization
5. Anything else you'd like to address.

Again, we welcome and carefully consider both positive comments and constructive criticism. We greatly appreciate your thorough and frank assessment of our program!

NMCSD PSYCHOLOGY INTERNSHIP TELESUPERVISION POLICY

I. Policy Statement and Definition

In accordance with the standards set forth by the American Psychological Association (APA), *telesupervision* is defined as the "supervision of psychological services through a synchronous audio and video format where the supervisor is not in the same physical location as the trainee."

The NMCSD internship program is committed to ensuring high-quality supervision and training experiences for all psychology interns. The standard and preferred method of supervision is in-person, and telesupervision is only used under unusual or exceptional circumstances such as temporary illness, mandated quarantine, or other unanticipated absence from the physical work location by supervisors or trainees. During these limited instances, telesupervision is conducted using a secure, audio/video platform provided to all staff (including interns) by the Department of Defense. Patient confidentiality is rigorously protected by referring to patients using only initials during telesupervision and by conducting sessions in private, secure environments.

II. Rationale for Telesupervision

As previously noted, telesupervision is not routinely incorporated into the 4 hours of required weekly intern supervision. However, our program views it as allowing for continuity of training and clinical oversight during periods when in-person supervision is temporarily not possible; it ensures that training progress is not interrupted by short-term illness or workplace absence. This flexibility supports health, accessibility, and adherence to training timelines while maintaining clinical and ethical standards.

III. Alignment with Training Aims and Outcomes

Telesupervision is aligned with the program's training goals, including fostering professional development, acquisition of the profession-wide competencies, ethical practice, and adaptability to evolving technologies in healthcare. It reinforces interns' exposure to real-world adjustments in service delivery.

IV. Self-Assessment and Program Evaluation

The program engages in ongoing evaluation of telesupervision to ensure its quality and effectiveness. This includes collecting intern satisfaction data and qualitative feedback, supervisor evaluations of trainee competence, and monitoring for problems in the achievement of training milestones and outcomes during telesupervision compared to those during in-person supervision periods. Additionally, the program reviews any negative incidents that occur during periods of telesupervision to inform continuous improvement and ensure accountability.

V. Determination and Use of Telesupervision

Telesupervision is not the default in the internship's training model and is only utilized under specific circumstances. These include instances when in-person supervision is not possible due to short-term absence or illness of the supervisor (possibly necessitating supervision by a covering supervisor from off-site) or when telesupervision is explicitly approved by the Training Director in consultation with program leadership. In such cases, before telesupervision may begin, both supervisors and trainees must demonstrate

reliability and professionalism, as well as a clear understanding of patient confidentiality and the ethical use of technology, as outlined in "Technology and Competence" below.

VI. Supervisory Relationship

To ensure the strength of the supervisory alliance, all supervisory relationships begin in person. Rapport-building, contracting, and the establishment of mutual expectations occur prior to any use of telesupervision. Throughout the supervisory relationship, regular check-ins are used to monitor the quality of the connection between supervisor and trainee and to identify and address any ruptures that may occur.

VII. Supervisor Responsibilities

As with in-person supervision, supervisors engaging in telesupervision maintain full professional responsibility for all clinical cases. This includes ensuring their availability for supervision/consultation, reviewing and providing feedback of clinical documentation, monitoring the provision of quality service, and maintaining accountability for adverse events. In addition, they, a covering provider in their clinic, or a covering internship supervisor are available for non-scheduled consultation and crisis management during business hours. The hospital's Emergency Psychiatric Services program is available for clinical emergencies after hours.

VIII. Privacy and Confidentiality

To protect patient and trainee privacy and confidentiality, telesupervision is conducted in a private, secure environment and only using DoD-approved, secure technology. Patients are referred to only by initials during telesupervision, no session is recorded, and no identifiable patient data is shared.

IX. Technology and Competence

Hardware and software platforms used for telesupervision are provided and approved by the Department of Defense (DoD) and must support synchronous, secure video and audio communication (e.g., Microsoft Teams). Prior to engaging in telesupervision, both supervisors and interns receive annual training on the secure use of technology and best practices for maintaining confidentiality and HIPAA compliance. Supervisors are required to demonstrate competence in telesupervision through formal training or experience. This includes proficiency in technological literacy, ethical and legal considerations specific to remote supervision, effective virtual communication, crisis and emergency response protocols in a remote context, engagement and interpersonal skills, maintenance of professional boundaries in digital environments, assurance of continuity of care, and awareness of cultural, linguistic, and individual differences that may impact the quality and effectiveness of telesupervision.

X. Flexibility and Change of Modality

Telesupervision will be discontinued and in-person supervision resumed when the absence or illness precipitating the use of telesupervision resolves, when the Training Director deems it clinically or educationally necessary, or when any privacy concerns or technological failures occur. In cases where telesupervision is ended early, alternative plans for in-person supervision will be made.

XI. Diversity, Equity, Inclusion, and Accessibility

Telesupervision is conducted with awareness of cultural and individual differences in communication, privacy needs, and access to technology. Reasonable accommodations are made when telesupervision is necessitated by disability or other DEIA-related factors, and trainees are encouraged to voice any barriers or challenges to the successful use of telesupervision. Feedback is integrated into program evaluation and improvement.

APPENDIX C – BRIEF FACULTY BIOS

Program Leadership

W. Michael Hunt, Ph.D., ABPP, is Director of Psychology Training and Chair of Psychology at NMCSD. In addition to overall leadership of the internship, he provides supervision of transrotation cases and leads the group supervision and seminar courses. Dr. Hunt holds a Ph.D. in clinical psychology from the University of South Florida and completed his internship at the University of California San Diego/Veterans Affairs San Diego Healthcare System. He also completed a postdoctoral fellowship with the National Institute on Alcohol Abuse and Alcoholism. Dr. Hunt is Board Certified in Clinical Psychology by the American Board of Professional Psychology. He provides training and consultative supervision in several evidence-based therapies, with a particular focus on Cognitive Processing Therapy, and he is one of the primary investigators on a research project at NMCSD investigating combined CPT and Behavioral Activation Treatment for PTSD complicated by depression.

Heather M. Anson, Ph.D., ABPP, is the Associate Training Director for the NMCSD Psychology Internship Program. She holds a Ph.D. in clinical psychology from Eastern Michigan University and completed her internship at the Naval Medical Center San Diego. Following internship she served three additional years as an Active Duty Navy psychologist at NMCSD, before joining NMCSD's civilian psychology staff. She is Board Certified in Clinical Psychology by the American Board of Professional Psychology. Her primary clinical interests are in the areas of depressive, anxiety, and trauma- and stressor-related disorders.

Rotation Supervisors

Denise Boychuk, Psy.D., is the primary rotation supervisor for the Adult Outpatient and Psychological Assessment Rotation. Dr. Boychuk has extensive experience in military mental health practice, having worked as a staff psychologist at NMCSD since 2016 in generalist outpatient practice and, prior to that, at the Navy Consolidated Brig from 2008 – 2016 where she provided assessment and treatment services to military personnel convicted of sex offenses. She oversees NMCSD's Directorate for Mental Health clinical privileging program, ensuring all mental health providers sustain appropriate peer review, documentation of continued licensure, and other requirements for being awarded and maintaining clinical practice privileges. She holds a Psy.D. in clinical psychology with a forensics emphasis from Alliant International University/California School of Professional Psychology San Diego. She completed forensically related internships in San Diego at Professional Community Services treating adult domestic violence batterers and at Sharper Future treating adult sex offenders with chronic substance use disorders. She brings a uniquely valuable perspective on military cultural competence to the Core Faculty, having served several years as an enlisted member of the U.S. Marine Corps prior to completing her education.

Christian Carter, Ph.D, ABPP-CN, is the primary rotation supervisor for the Health Psychology rotation. He holds a Ph.D. in Clinical Psychology from The California School of Professional Psychology (San Diego), and he is board certified in Clinical Neuropsychology by the American Board of Professional Psychology. Dr. Carter completed his internship at the UCLA Semel Institute for Neuroscience and Human Behavior. Following internship, he completed a 2-year post-doctoral fellowship in clinical neuropsychology at the West Los Angeles VA Medical Center. He was then on staff at the Minneapolis VA Medical Center, specializing in neuropsychological assessment and

behavioral sleep medicine. Dr. Carter has been on staff at NMCSD since 2013. His current areas of specialty include cognitive and behavioral treatments for Insomnia, Chronic Pain, and Functional Neurological Disorders.

LT Veronica Crawford is the primary supervisor for the Mental Health Operational Outreach Division (MHOOD) rotation. She obtained her Ph.D. in Counseling Psychology from Auburn University. She completed her pre-doctoral internship at the Medical College of Georgia/Charlie Norwood VA Consortium in Augusta, Georgia where she received specialized training in trauma-focused treatment. LT Crawford became a commissioned officer in January 2017, completing her post-doctoral fellowship at Naval Medical Center Portsmouth (NMCP) in 2018. She was selected to serve in a hot-fill assignment at the Branch Health Clinic in Iwakuni, Japan from October 2018 - October 2020. She next served as the Ship's Psychologist on the USS RONALD REAGAN, homeport Yokosuka, Japan from October 2020 - January 2023, deploying in support of Freedom's Sentinel, Operation Countdown, and Allies Refuge. Her personal awards include the Navy and Marine Corps Commendation Medal, the Navy and Marine Corps Achievement Medal, and a host of unit awards. She is qualified as a Surface Warfare Medical Duty Officer. LT Crawford is licensed in the state of Virginia and board certified in Counseling Psychology. She has published three peer-reviewed articles focusing on counselor/psychology trainee development.

Tamer Mattar, Psy.D., is a rotation supervisor for MCRD. He holds a Bachelor's in Cognitive Psychology from the University of California, Irvine, and a Master's and Doctorate in Clinical Psychology from the California School of Professional Psychology (Los Angeles). His graduate study emphasized Multicultural and Community Psychology, family and couples counseling, and acculturation processes. Dr. Mattar completed certification in Adult Psychoanalytic Psychotherapy from the New Center for Psychoanalysis in Los Angeles, and he is a Teacher's Academy Fellow with the American Psychoanalytic Association. Dr. Mattar's clinical experience has emphasized Community Mental Health in underserved Communities, to include Downtown Los Angeles as well as a rural regional clinic in Cody, Wyoming. Prior to onboarding with NMCSD in 2024, Dr Mattar worked for almost ten years as a counseling psychologist aboard Camp Pendleton, and a Compensation and Pension Examiner for the VA MDE program. Dr. Mattar's areas of specialty include multicultural and community psychology, acculturative stress, severe and persistent mental illness, and psychoanalytic psychotherapy.

Kenneth Sekulic, Psy.D., is one of the rotation supervisors for the Mental Health Operational Outreach Division (MHOOD) Clinic rotation. He holds a Psy.D. in Clinical Psychology from Yeshiva University in NYC. Dr. Sekulic completed his internship at the Federal Medical Center-Devens MA, which is one of four hospital centers operated by the Federal Bureau of Prisons. Following internship, he completed his post-doctoral fellowship in clinical psychology with a concentration in substance abuse treatment at the Federal Correctional Institute in Danbury CT. Once licensed he served as a staff psychologist at both the Metropolitan Detention Center in Brooklyn NY and the Metropolitan Correctional Cetner in San Diego CA. He was then selected as the Chief Behavioral Health Officer, Western Region for the Immigration Health Service Corps where he was responsible for the delivery of mental health services at seven Immigration Detention Centers. CAPT Sekulic has been on staff at NMCSD since 2013. His current areas of specialty include crisis management/triage and substance abuse treatment.

Steven Snook, Ph.D. is the primary rotation supervisor for the Inpatient Mental Health/Emergency Mental Health rotation. He holds a Ph.D. in Clinical Psychology from the Fuller Graduate School of Psychology and is a licensed clinical psychologist. Dr. Snook completed his internship at Patton State

Hospital and then was commissioned as an officer in the United States Army. He completed a second internship at the Silas B. Hays Army Community Hospital, Fort Ord, CA and was then the Chief of the Human Factors Branch at the U.S. Army School of Aviation Medicine and clinical psychologist at the Lyster Army Aeromedical Center, Fort Rucker (now Fort Novosel), Alabama. Dr. Snook was in private practice in Atlanta, Georgia and consulting psychologist at Ridgeview Institute, Anchor Hospital, and the Talbott Recovery Campus. Dr. Snook served as the psychologist on a multidisciplinary committee that evaluated physicians, surgeons, and airline pilots with alcohol and substance use disorders. Dr. Snook then worked as a clinical psychologist at the Vilseck Army Health Clinic in Germany with the 2nd Cavalry Regiment before coming to NMCSD in 2024 as the Director of the Program of Care for the inpatient psychiatric unit.

Other Active Duty Mentoring Faculty

CDR Nathan Hydes, Ph.D., began his mental health career in 2008, working as a clinical psychologist for the Veterans Health Administration, first at the National Center for PTSD/Boston VA and then the North Little Rock Veterans Hospital in Arkansas. In 2011, he joined the Navy as a clinical psychologist. He started his career at Walter Reed National Military Medical Center but left the following year when he took orders to Branch Health Clinic Sasebo. For the next three years, he assumed the roles of sole mental health provider and Division Officer for Ancillary Services. In 2015, he transferred to the USS Nimitz (CVN-68) and served as the ship's "PsychO" for 24 months, assisting the crew during their yard period, the workup cycle, sea trials, INSURV, and a 6-month deployment to the Arabian Gulf in 2017. While on deployment, he earned his Surface Warfare Medical Department Officer (SWMDO) qualification and was selected for lieutenant commander. Upon completing deployment, he transferred to NMRTC Bremerton, where he served as the Mental Health Division Officer and was tasked with creating a new mental health billet for Marine Corps Security Forces Battalion (MCSFBn) Bangor while simultaneously embedded with Submarine Group 9 (COMSUBGRU NINE), going underway with the USS Pennsylvania (SSBN-735) in 2020. In addition to these duties, he served as the Division Officer for the Mental Health Department as well as acting Department Head. He transferred to NMRTC Sigonella in August 2020 and served as the Director of Medical Services (DMS) for two years (2021-2023). He was also a MEDIG Team Lead and the installation's SERE Psychologist, leading EUCOM's Phase II operations for Personnel Recovery. In August 2023, he transferred to NMRTC San Diego where he currently serves as the Associate Director for Mental Health (ADMH).

Additional career schooling includes Survival, Evasion, Resistance, and Escape (SERE) training and Joint Professional Military Education (JPME) Phase I. He is a Lean Six Sigma Green Belt. LCDR Hydes is board certified in clinical psychology and is a member of the American Psychological Association (APA) and the American Board of Clinical Psychologists (ABPP). His personal awards include the Navy and Marine Corps Commendation Medal (third award) and the Navy and Marine Corps Achievement Medal (second award). In his free time, LCDR Hydes enjoys traveling, coaching sports, reading, collecting vinyl records, and spending time with his wife Lisa and their four children.