Integrating Evidenced Based Practices into Psychology Internship and Postdoctoral Training

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Acknowledgments....

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- Dr. Charles Peterson
- Dr. Melissa Polusny
- Dr. Nina Sayer
- Dr. Linda Van Egeren
- Dr. Ann Wagner Mickle
- Dr. Brent Walden

Many of the staff that developed these training clinics have become national trainers for the VA system
Learning Objectives

- Participants will learn ...
  - how multiple EBP can be integrated into training at the internship and postdoctoral levels.
  - methods of evaluating intern and postdoc performance in EBP
  - how to navigate obstacles typically encountered when integrating training in EBP

Overview

- Definitions
- General discussion of EBP
- Training guidelines/requirements (CoA, APPIC)
- EBP – One program’s experience
  - Background
  - Structure of the program
  - Initial struggles/challenges
  - Review of specific EBP
- Conclusions/lessons learned
Definitions

- (EVT) Empirically Validated Treatments – developed by the American Psychiatric Association - largely biological based (Rx) approaches.
- (EST) Empirically Supported Treatment - psychologists adopted concept but focused on the idea that “validated” could be interpreted as “proven” - much disagreement about what could be included and/or that empirical support was needed.
- (EBP) Evidence Based Practices
  - Focuses more than on just intervention to include assessment
  - Practices based on the scientific literature but not rigidly adhering to research protocols
  - Practices that systematically assess effectiveness of an individual application

Evidence-Based Clinical Practice

- Synthesizer
  - Locate
  - Critically Appraise
  - Meta-analysis
- Evidence User
  - Locate
  - Appraise quality & relevance
  - Integrate
- Researcher
  - Design
  - Conduct
  - Analysis
  - Reporting
- Clinician
  - Communicate
  - Establish alliance
  - Deliver EST
- Patient
  - Understanding
  - Alternatives
  - Risks & Benefits
  - Preferences
  - Access
- Clinical Expertise
- Best Available Research Evidence
- Clinical Decision-Making
- Patient's Values, Characteristics, Preferences, Circumstances

Taken from Spring (2007)
Translating the Framework into Practice: EBP Skills

• Best Available Research Evidence
  • Ability to locate, critically appraise, and synthesize relevant research evidence
  • Ability to conduct clinically-relevant scientific research

• Clinical Expertise
  • Assessment, case formulation, and treatment planning
  • Clinical decision-making, treatment implementation, and monitoring of patient progress.
  • Interpersonal expertise

• Patient Characteristics, Culture and Preferences
  • Understands and is able to integrate knowledge of individual differences in treatment planning.
  • Is able to conceptualize and account for the impact of comorbidities on the course of treatment.

Why Implement EBP and ESTs?

• Pros:
  • Impetus to improve quality of health care services (Wennberg, Fisher, & Skinner, 2004)
  • Impact of policy and financial considerations on treatment
  • Provides lifelong learning opportunities
  • EBP allows us to apply treatments reliably and in accordance with the best science available

• Cons:
  • ESTs/manualized treatments remove clinical wisdom from the scientific practices
  • Most lists of ESTs exclude “difficult” to quantify treatments such as psychoanalytic approaches.
Why EBP on Internship/ or Postdoc?

- Some evidence that only the “research leg” is being addressed in doctoral programs (Spring, 2007).
  - Lack of clarity by doctoral students regarding what constitutes EBP
  - Perceived lack of EBP training on practica (Luebbe et al., 2007)
  - Lack of training in both didactic and experiential components of ESTs (Weissman et al., 2006).
- Doctoral students express interest and anticipate EBP impacting their clinical work in the future (Luebbe et al., 2007)
- Modeling EBP in practice can help dispel associated myths (Collins, Leffingwell & Belar, 2007).
- Creates academic environment with opportunities for transdisciplinary learning opportunities.

Perceived Advantages and Barriers to Training in EST and EBP

- Perceived Advantages
  - Easy to teach
  - Economical
  - Better patient care
  - Treatments targeted toward disorders

- Perceived Obstacles
  - Lack of trainee interest
  - Do not have qualified faculty
  - Too time-consuming
  - Too difficult to teach

Weissman et al., (2006)
CoA – G&P

- Domain B1(a) - Psychological practice is based on the science of psychology which, in turn, is influenced by the professional practice of psychology.
- Domain B4 - In achieving its objectives, the program requires that all interns demonstrate an intermediate to advanced level of professional psychological skills, abilities, proficiencies, competencies, and knowledge in the areas of:
  - (a) - Theories and methods of assessment and diagnosis and effective intervention (including empirically supported treatments).

CoA - Proposed IR

- Training in empirically supported procedures should focus on acquiring the attitudes, knowledge and skills to promote the integration of science and practice.
- Familiar with the research literature
- Students and interns are exposed to the literature regarding how evidence and science (which are distinguishable entities) should inform the practice of professional psychology.
- To evaluate effectiveness – experience of collecting outcome data on psychological services.
CoA – IR – Public Comment

- 30 out of 3 Significantly opposed
- Change empirically supported to evidence based
- Assessment and diagnoses
- Expectations are too restrictive

APPIC Guidelines

- Do not address training in the science of psychology or EBP
Integrating EBP: One Program’s Experience

- Minneapolis VA Medical Center Training Program
  - 8 Predoctoral interns- 6 standard clinical track, 2 Neuropsychology
  - 4 Postdoctoral residents – Emphases in Severe Mental Illness, Primary Care/Mental Health, Neuropsychology, and Polytrauma
    - Developing a 2 year specialty program in neuropsychology
    - 6-8 Practicum students

Background

- Historically, training focused on learning a range of interventions utilized by staff – not planned or structured
- The teaching of ESTs was not very structured and occurred mostly through clinical supervision and suggested readings.
- Training in ESTs occurred exclusively in our main rotations and was dependent on how much the supervisor chose to emphasize ESTs
Background

- 1996 - recognize the importance of assuring that all interns received training in evidence based practices (EBPs)
- 1997 – restructuring requiring interns to participate in adjunctive or specialty empirically-supported intervention and assessment techniques, in addition to core rotations.
  - Psychological Assessment Clinic
  - Anxiety Intervention Clinic
  - Dialectic Behavior Therapy
- Increased focus on EBP in our program and the VA nationally.

VA Uniform Mental Health Services Package 9/11/08

- Establishes minimum clinical requirements and essential components to be implemented nationally
- Evidence-based psychotherapies
  - PTSD - All veterans with PTSD must have access to CPT or PE
  - Depression and Anxiety - All veterans must have access to CBT, ACT, or Interpersonal Therapy
  - Combine Txs - When meds and therapy are superior
- Minneapolis VA – had already developed and had been training trainees and staff in many of these models (several VA National Trainers/Consultants)
EBP adjunctive training experiences has expanded to include...

- Psychological Assessment Training Clinic
- Dialectical Behavioral Therapy (DBT)
- Acceptance and Commitment Therapy (ACT)
- The Anxiety Interventions Clinic (AIC)
- Cognitive Behavioral Social Skills Training (CBSST)
- Motivational Interviewing (MI)
- Cognitive Processing Therapy (CPT)
- Prolonged Exposure (PE)
- Cognitive Behavioral Therapy (CBT)
- Family Therapy Training Clinic (FTTC)
- Time-Limited Dynamic Psychotherapy (TLDP)
- Psychoanalytic Therapy Clinic
- Research
- Administration

**Background**

**Program Structure**

- Core rotations (24 hrs per week)
- Choice to participate in three to four of these EBP practices over the course of the training year (some 12 months and some 6 months).

- Postdoctoral residents also participate in the EBP
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<thead>
<tr>
<th>Main Rotations</th>
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<tr>
<td>Standard Interns</td>
<td>Rotation 1</td>
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Adjunctive Experiences:
- DBT, Family Therapy, TLDP, MI, CPT, Admin., ACT, Extended Psychodynamic Therapy Clinic, Research, AIC (17.5 hrs per week)

- Adjunctive Exp. -- 4 hours per week
- Adjunctive Exp. -- 4 hours per week
- Assmt. Clinic -- 1.5 Hrs. per week
- Reading/misc. -- 2 Hrs per week
- Seminars -- 2 Hrs per week

Minneapolis VA Training Programs

Main Trimester Rotations
- Addictive Disorders
- Mental Health Urgent Care
- Geropsychology
- Primary Care/Health Psychology
- Women’s Clinic
- Home Based Primary Care
- Mood and Anxiety Disorders Team
- Neuropsychology
- Partial Psychiatric Hospitalization
- Post-Traumatic Stress Recovery (PTSR)
- Rehabilitation Psychology
- Polytrauma
- Serious and Persistent Mental Illness (SPMI)

*** account for approximately 55% of trainees’ time
Initial Struggles

- Not all staff placed the same value on training in EBP
- Revising the program's structure to ensure EBP training takes time from main rotations
- A major transformation in the culture and philosophy of the program and how supervisors approach training
  - Particularly challenging for more senior supervisors
- Challenges and resistance increased as we integrated more EST adjunctive rotations

Challenges

- Multiple rotations and EBP adjunctives results in a very complicated training program to administrate
- Limited slots in adjunctives
- Time conflicts with adjunctive and rotation meetings and clinics (requires a lot of flexibility)
- Very time consuming
  - Three or more supervisors at a time
  - Heavy in didactic instruction (learning new models)
  - More required reading (learning new models)
  - Still sufficient but less time in direct patient care (focus is on competence rather than hours)
Psychological Assessment Clinic

- Paul Arbisi, Ph.D., ABPP
  - Co-author of several MMPI-2 scales and the new MMPI RF Scales
  - Miscellaneous Psychology staff with assessment expertise

Assessment Clinic - Structure

- Forces trainees to acquire basic competence in assessment (many doc programs provided limited training)
- Year long (2 hrs, didactic and group supervision)
- Strong peer consultation supervision
- Formal supervision of a specific case may vary depending on the type of assessment
- Multilevel – interns, prac students, and postdocs
Assessment Clinic - Structure

- Heavy didactic training early in year
- Emphasis on empirical basis of assessment and exposure to a range of measure of psychometric soundness
- Cases assigned every 6-8 weeks (varied types of assessment)

Assessment Clinic - Evaluation

- Discussions in group supervision/consultation
- Individual verbal feedback from supervisors
- Mid-year and end-year Adjunctive Evaluation Form
Assessment Clinic - Challenges

- Some trainees lack experience with assessment
- Some resistance to learning formal assessment
- Fitting cases into their schedule when assigned
- Learning how to consult with referral sources
- Writing reports to the referral questions

Dialectic Behavior Therapy (DBT)

- Laura Meyers, Ph.D.
- Deadra Dahl, CNS
- Nina Sayer, Ph.D.
- Jennie Leskela Ph.D.
- Melissa Polusny, Ph.D.
- Marci Mylan, Ph.D.

Linehan (1994)
DBT - Structure

- Day long training on DBT model and skills
- Weekly readings from Linehan’s text (1994)
- 1 hour weekly didactic; 1 hour weekly group supervision (individual supervision as needed)
- 1 hour weekly individual patient
- 1.5 hours consultation team (i.e., with staff and trainees from multiple disciplines)
- 2nd and 3rd trimesters - phase out didactic and group supervision
- Each trainee co-leads a skills group for 1 trimester

DBT - Evaluation

- Video observation of individual sessions
- Discussions in group and individual supervision
- Mid-year and end-year Adjunctive Evaluation Form
DBT - Challenges

- Time consuming – 4+ hours a week (not including readings/documentation)
- Challenging model to teach/learn - working with suicidal patients
- Phone coaching
- Large pool of trainees to supervise
- Varied levels of previous DBT experience
- Trainees need a lot of reassuring/direction managing suicidal patients

DBT – Trainee Challenges

- Teaching validation strategies are easy; irreverence is tough (i.e., trainees tend to already be nice and supportive)
- Helpful to provide self-disclosure of own insecurities and history with learning the model
- Role plays are uncomfortable
- Normalize anxiety and self-doubt
- No manualized one right way to respond in every situation
Anxiety Interventions Clinic – (AIC)

- Douglas Olson, Ph.D., ABPP


AIC - Background

- 1994 needs assessment demonstrated underutilization of empirically supported cognitive behavioral approaches to anxiety disorders
- Regional expert/consultant with CBT and anxiety disorders
- AIC was given the Dept. of Veterans Affairs Under Secretary for Health's Innovations Award (AIC model replicated at other VAs)
AIC - Structure

- 6 month adjunctive therapy experience (2 cycles)
- Didactic training with readings on empirical supported literature on anxiety disorders
- Group supervision/consultation weekly (60 minutes)
- Individual supervision as needed
- Role playing, modeling, case presentations

- Average 3 to 5 intake assessments translating into 3 intervention cases.
- Referrals elicited primarily through various treatment team coordinators
- Training manual provided
AIC - Evaluation

- Weekly feedback in group and individual supervision
- Peer feedback
- Mid- and end-year Adjunctive Evaluation Form

Motivational Interviewing (MI)

- Carl Isenhart, PsyD., ABPP
  - International Motivational Interviewing Network of Trainers

MI - Structure

- Clinic runs 6 months
- Two day training
  - Experiential training on the spirit of MI, and MI goals and principles
  - Demonstration and practice of MI basics - managing resistance, and eliciting and responding to change talk and commitment language
- Weekly group or individual supervision
  - Review of audio taped sessions using MI-coding sheet
  - Providing feedback to trainings with ongoing instruction and practice
- Multilevel multidisciplinary training

MI - Evaluation

- Review MI session audiotape
  - Strive to meet listed “thresholds.”
  - Trainees focus on specific goals, for example:
    - More open than closed-ended questions
    - More reflections than questions
- Ongoing verbal feedback in supervision
- Mid and end of the year Adjunctive Evaluation form
MI - Challenges

- Not as easy as it looks
- Being directive and intentional in using MI techniques to “move” the client towards the intended target behavior.
- Adhering to the MI “spirit” that the goals, strategies, and time-frames for change are within the client and need to be evoked from within rather than “inserted” from the outside.
- Listening and responding to the client’s change talk and commitment language

MI – Trainee Challenges

- Realizing that they do not have to “fix” the client right away.
- Understanding they do not need the client’s full history to do MI
- Intentional and tactical use of MI techniques to move client towards change and not simply “following” the client and doing “client-centered reflective listening.”
Family Therapy Training Clinic - FTTC

- Jennie Leskela, Ph.D.
- Chris Erbes, Ph.D.

FTTC - Background

- Developed in 1997 due to unmet need of having enough couple and family therapy services
- Decided on a training clinic given the limited number of staff with expertise
- Multilevel multidisciplinary training
FTTC - Challenges

- Referrals - Getting staff to realize they can only refer while clinic is open
- Decision to add a community consultant - hard to find
- Collect ongoing data for patient outcome and staff and trainee satisfaction.
  - IRB too cumbersome for a ongoing project so decision to focus on staff and trainee satisfaction.
  - Some patient outcome at times but only for clinical purposes

FTTC - Structure

- 5 month training
- Trainees see one case at a time; sometimes more if the case is not seen weekly
- Group consultation/supervision format
- Frequent videotape utilization
- Formal didactic and reading list
  - Social construction family therapy (solution focused) and narrative therapy models
  - Some general overview of other models
  - Supervisors and consultants show own tapes
  - Role plays
FTTC - General comments

- Challenges learning a new treatment modality - solution focused is a more manualized approach to easier to learn
- Narrative therapy more difficult to learn
- Develop basic competence in both
- More anxiety with couples/families versus individuals due to more people in the room

FTTC – Effectiveness?

- Research limited in this area (some on solution focused)
- Difficult to assess effectiveness as hard to measure some of the concepts
- Narrative therapy only now adding research component and it is more qualitative
FTTC – Evaluating Trainees

- Decreased expectations than other trainings
- New model is so new for most and we expect they only have basic skill level after the 5 months
- Written Adjunctive Evaluation Form

Acceptance & Commitment Therapy (ACT)

- John Billig, Ph.D., ABPP
  - VA National ACT Consultant
- Lutz Hess, Ph.D.

ACT - Structure

- 2-Day experiential workshop focused on using participants own experiences to understand the ACT model and processes
- Second half of training year
- Weekly Seminar
  - 1 hour didactic
  - 1 hour group supervision
  - Readings from books, articles
- 1 hour weekly in individual therapy with a patient
- Individual supervision as needed

ACT - Evaluation

- Video observation of individual sessions
- Discussions in group and individual supervision
- End of year formal written evaluations - Adjunctive Evaluation Form
- One staff member is a consultant for the VA ACT National Roll Out
- Staff encouraged and supported in attending continuing education such as the ACT Summer Institutes
ACT - Challenges

- Teaching trainees a model that is different than the prevailing cognitive model
  - Challenging to convey understanding of the function of possible interventions rather than simply the form (“Just tell me what to do next”)
- Limited time to teach the theory/foundations of the model
- Varied levels of previous ACT or behavioral knowledge/experience from no knowledge to well versed in the ACT model

ACT – Trainee Challenges

- Difficult for trainees to sit with discomfort (their own and the patient’s) in session or in supervision
- Grasping some of the concepts is challenging; particularly the underlying theory (Relational Frame Theory)
- Roll plays and other experiential exercises are helpful but uncomfortable
- Normalize anxiety and self-doubt
  - Not manualized – no one right way to respond in every situation.
Cognitive Behavioral Social Skills Training (CBSST)

- Bridget Hegeman, Ph.D.
- Lisa Hoffman-Konn, Ph.D.

CBSST - Structure

- Integration of Cognitive Behavioral Therapy with Social Skills Training techniques
- Focus specifically on 4 modules
  - Changing your thinking
  - Problem solving
  - Asking for support and creating a safety plan
  - Communication skills

McQuaid, E. Granholm, et al. (2000)
CBSST - Structure

- 6-month adjunctive experience (can also be part of the 4-month SPMI team primary rotation)
- Components
  - Weekly 1-hour didactic meetings/group supervision (individual supervision as needed)
  - Readings and discussion of CBT interventions (general and for psychosis) and CBSST intervention specifically
  - Co-facilitation of one of the CBSST skills group
  - Individual therapy utilizing CBSST model with one veteran

CBSST – Training and Evaluation

- Audio observation of individual sessions
- Co-facilitation of groups with an experienced CBSST leader
- Use of CBSST group facilitators’ manual developed by several MVAMC staff
- Use of CTS-Psy Criteria (Cognitive Therapy Scale for Psychosis) to assess and give feedback on skills development
- Discussions in group and individual supervision
- Written Adjunctive Evaluation Form
CBSST - Challenges

- Time consuming – up to 4 hours a week
  - two 60-minute skills groups or one 90-minute graduates group
  - one 50-minute individual therapy session
  - one 60-minute didactic meeting
  - individual supervision as needed: at least one hour
- Learning to assess for and discuss psychotic symptoms in therapy sessions can be difficult
- Effectively challenge or distract the client from psychotic symptoms - easy to get caught in debating veracity of symptoms

CBSST – Challenges

- Adjust expectation and tx goals for population
- Severe Mental Illness (SMI) population may require additional support and contacts
- Clients not be able to tolerate a typical 50-minute weekly session
- Varying levels of previous experience working with SMI population (“yes, you can do CBT with clients with schizophrenia!”)
- Role plays (helpful but uncomfortable)
- Normalize anxiety and self-doubt as a therapist
Cognitive Processing Therapy (CPT)

- Karen Kattar, Psy.D.
  - National Trainer and local Minneapolis VA CPT Coordinator
- John Rodman, Ph.D.
- Linda Van Egeren, Ph.D
- Jenna Bemis, Ph.D.


CPT - Background

- Prior to national roll-out, the PTSD team decided to implement this protocol based on empirical evidence to support its use
- Pilot outcome data yielded robust positive results
- Trainees expressed interest in learning model
- Integrated within training programs
- National roll-out began to disseminate this model
- VA clinicians attended formal CPT training
CPT - Structure

- Full 2-day CPT workshop beginning of year
- Weekly didactic, consultation/supervision - 90’
- Individual supervision as needed
- Multilevel, multidisciplinary training
- Adjunctive experience or in PTSD rotation
- Group facilitator and/or individual therapist
- Training DVDs, tx manual, readings, misc. resources (all available hospital shared drive)
- Measures given pre-, mid-, post-treatment (BDI-II and Posttraumatic Checklist)

CPT - Challenges

- Comfort level of trainee for trauma-focused therapy (learn that affect is okay)
- Fidelity to the model (reverting to supportive therapy)
- Balancing adherence to the manual and allowing for therapist style and clinical wisdom (wiggle room to do what is clinically indicated)
- Time management of sessions (agenda-oriented protocol: staying on track from week to week)
- Provide therapist support for working with trauma population
CPT - Trainee Impressions

- Find that manualized treatment can still be an “intimate” and powerful experience for the client
- Appreciate the time-limited format and treatment plan to follow
- Enjoy case consultation since all our clients are moving through the protocol sequentially together
- Ease of documentation with templated notes
- Learn to incorporate measurement feedback as part of the intervention
- Realize that people can recover from trauma

Prolonged Exposure Therapy (PE)

- Melissa Polusny, Ph.D.
- Thad Strom, Ph.D.
- National consultants for VA’s Prolonged Exposure Training Initiative

Foa et al. (2005)
PE - Structure

- Offered as a part of the PTSR rotation or 2\textsuperscript{nd} or 3\textsuperscript{rd} trimesters.

  - 1\textsuperscript{st} trimester
    - Six week didactic series held in outpatient PTSD clinic.
    - Weekly readings addressing the following areas:
    - History, diagnosis, assessment, and treatment of PTSD.
    - Bi-monthly, multidisciplinary consultation group

  - 2\textsuperscript{nd} and 3\textsuperscript{rd} trimesters
    - Beginning of 2\textsuperscript{nd} trimester: 1.5 day PE training
    - Weekly 90 min appointments with 1-2 veterans
    - Bi-monthly consultation group
    - Weekly supervision

PE - Evaluation

- Audio/videotaped observation of individual sessions

- Discussions in individual supervision and bi-monthly consultation group

- Mid-year and end of year Adjunctive Evaluation Form
PE – Challenges

- Time consuming - Minimum of 2.5 contact hours a week (not including readings/documentation)
- Varied levels of experience with exposure-based treatments
- Infrequent referral stream
- Frequently need to confront myths associated with PE (e.g., role of supportive therapist undermined, “re-traumatization”)
- Consent for audio/videotaping
- Frequent administration of assessment measures often requires clerical support

PE – Challenges

- Teaching how to titrate emotional engagement can be difficult
- Tolerating trauma narratives can be difficult for novice therapists.
  - Helpful to provide review of research literature documenting treatment effectiveness to underscore importance of exposure
- Role plays are extremely helpful but uncomfortable
- Normalize anxiety and self-doubt
Time-Limited Dynamic Psychotherapy (TLDP)

- Ann Wagner-Mickle, Ph.D.


TLDP - Structure

- Weekly 2-hour group supervision meeting
- Readings from Levenson text and Strupp and Binder text are reviewed, usually a few chapters each week. Trainees take turns presenting the outlines of the chapters.
- Each trainee presents article of their choosing
- One patient for 12 to 20 sessions
- Multidisciplinary and multilevel
- As a group, assist each trainee in formulating the Case Conceptualization for the Cyclical Maladaptive Pattern and develop the blueprint for the course of therapy
TLDP - Evaluation

- Audiotaped sessions are reviewed in group supervision
- Discussions in group supervision
- Written Adjunctive Evaluation Form
- Completion of Vanderbilt Therapeutic Strategies Scale as a group for an early session and a later session for each therapy case. Trainee keeps the ratings as they are a learning tool.

TLDP - Challenges

- Sometimes so “wedded” to CBT model, hard to learn a different model. However, even the “resistant” trainees have reported benefit
Psychoanalytic Psychotherapy Clinic

- Charles Peterson, Ph.D.
- Brent Walden, Ph.D.

Psychoanalytic Clinic - Structure

- 1-2 hours weekly psychotherapy (1-2 patients)
- 2 hours group supervision weekly; individual supervision when indicated
- 1 hour weekly observation and discussion of "live" case by supervisors
- Readings as indicated
- Optional opportunities for pre-therapy assessment and role-induction procedures
- Optional participation in Psychoanalytic Study Group
- Multidisciplinary and multilevel
Psychoanalytic Clinic - Evaluation

- Group review of audio-taped sessions
- Discussions in group supervision
- Encouragement of a career-long practice of peer-supervision and consultation
- Mid-year and end-year Adjunctive Evaluation Form

Psychoanalytic Clinic - Challenges

- Hard to introduce psychoanalytic modality in culture dominated by CBT
- The “shame” of not being an “evidence-based” therapy
- Addressing counter-transference in supervision
- Being a non-manualized intervention
Adjunctive Research Experiences


Several different experiences offered.
- Interns and postdoctoral fellows are required to select at least one research experience
- Possible experiences include:
  - Dissertation work
  - Collaboration with senior research staff
  - Intern group research project
Intern Group Research Project

- Jennie Leskela, Ph.D.
- Thad Q. Strom, Ph.D.
- Paul Thuras, Ph.D.

- Structure
  - Bi-monthly meetings
  - Collaborative product-focused project
  - Statistics and methodology didactics

Evaluation of EBP

- Ongoing feedback in individual and group supervision (peer supervision)
- Audio and/or video tape
- 6 and 12 month periods
  - Core rotations on trimester basis

- Intervention or Assessment
- Professional Issues
- Ethics and Sensitivity to Diversity

- Feedback is integrated in meetings with TDs
### Ethics and Sensitivity to Diversity

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<th>Item</th>
<th>Rating</th>
<th>Notes or Comments</th>
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<td>2. General ability to think critically about ethical issues</td>
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<td>3. Overall behavior is consistent with ethical principles</td>
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<td>7. Related to scholarly inquiry</td>
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### Assessment

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<td>3. Completes treatment within a reasonable timeframe</td>
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<td>4. Selection of appropriate assessment approaches</td>
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<td>5. Administration/Interpreting of WAIS-III</td>
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<td>6. Administration of WMS-III</td>
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<td>7. Administration of neuropsychological tests</td>
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<td>8. Interpretation of neuropsychological tests</td>
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<td>9. Administration of HAM-D</td>
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<td>10. Administration of HAM-A</td>
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<tr>
<td>11. Administration of neurobehavioral impairment</td>
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<tr>
<td>12. Administration of neurobehavioral impairment</td>
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<tr>
<td>13. Administration of vocational assessment</td>
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<td>14. Reliability measures required with tools</td>
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<tr>
<td>15. Administration and adherence to IRB ethical guidelines and policies in assessments</td>
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<tr>
<td>16. Awareness and use of current literature, research, and practice in assessments</td>
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<tr>
<td>17. Sensitivity to issues of ethics, cultural, gender, or sexual diversity in assessments</td>
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</tbody>
</table>

### Supervision

- Supervisor: [Name]
- Date: [Date]

### Training

- Trainer: [Name]
- Date: [Date]

### Evaluation Date

- 3/15/2009

### Percentage of Focus noted as competent

- [Percentage]
Lessons Learned

- Can’t do it all!
- How much is too much? (breadth vs. depth)
- Add something, need to give up something
- Information overload early in the year – learning new models and acclimating to program and hospital
- Hard to learn multiple models simultaneously
- Trainee exit interview feedback (hard but wouldn’t change anything)
- Considering tracks of combined rotations and adjunctives

Lessons Learned

- Trainees do reading base before training year starts?
- Definition? What constitutes an EST?