VA Central Western Massachusetts
Postdoctoral Residency in Clinical Neuropsychology
2025-2027

Application Deadline: **Monday, December 2, 2024**

Start Date: Monday, July 28, 2025

Overview: VA Central Western Massachusetts is recruiting for one (1) position in its two-year postdoctoral residency in clinical neuropsychology. The program is accredited by the American Psychological Association (APA) and adheres to a scientist-practitioner model and to the guidelines set forth by the Houston Conference on Specialty Education and Training in Clinical Neuropsychology. Training is specifically designed to ensure eligibility for specialty board certification in clinical neuropsychology at the end of the program. This residency position is primarily housed at the Worcester VA Health Clinic in Worcester, Massachusetts, the second-largest city in New England. The Neuropsychology Resident engages in clinical, didactic, and research activities.

Accreditation Status:

The Postdoctoral Residency in Clinical Neuropsychology at VA Central Western Massachusetts is accredited by the Commission on Accreditation of the American Psychological Association. APA conducted an initial site visit in 2022, and the program was granted accreditation on contingency. 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 1st Street, NE, Washington, DC 20002
Phone: (202) 336-5979 / Email: apaaccred@apa.org
Web: www.apa.org/ed/accreditation

Stipend:

The residency currently has a stipend of $60,091 for year 1 and $63,338 for year 2, plus benefits.

How to Apply:

To be eligible for this residency position, applicants must:

(1) Be US citizens;
(2) Be graduates of doctoral programs in clinical psychology or neuropsychology that have been accredited by the American Psychological Association (APA), Canadian Psychological Association (CPA), or Psychological Clinical Science Accreditation System (PCSAS);
(3) Have completed dissertation and earned their doctorate *prior to* the start of residency;
(4) Have completed an APA-approved predoctoral internship (brand-new not-yet-accredited programs are exempt from this requirement);
(5) Have significant prior experience in clinical neuropsychology and have demonstrated a strong interest in practicing clinical neuropsychology as a profession.

Applications should include (preferably as separate document files):

- Cover letter of intent, outlining career goals and goodness of fit
- Current curriculum vitae
- Two (2) de-identified sample reports
- Three (3) letters of recommendation *sent directly by the letter-writers*. At least one must be from an internship supervisor.

Interested candidates should send application materials by e-mail to Lee.Ashendorf@va.gov.

The deadline for application is **Monday, December 2, 2024**. Interviews will all be conducted **virtually**, and we intend for selection to be completed in January. Please note that we are *not* participants in the APPCN postdoc match.

Clinical Training:

General Neuropsychology Service: The resident will obtain broad training experiences evaluating outpatient Veterans across the age spectrum. Consult questions are varied but most often include differential diagnosis of dementia, assessment of civil capacities, and evaluations of remote head injury, neuropsychiatric disorders, substance/alcohol abuse, and medical/neurological disorders. While we currently primarily provide in-person services, telehealth (video) evaluations will likely remain a smaller component of our normal operations going forward.

Cognitive Rehabilitation: The second-year resident runs our cognitive rehabilitation services. There is a PTSD/TBI/ADHD group for younger adults with memory and attention concerns, and a Memory & Aging group for older adults with memory concerns. We also offer individual rehabilitation services for individuals who need specialized intervention or for whom neither group provides a good fit.

Polytrauma/TBI Clinic: The Polytrauma/Traumatic Brain Injury (TBI) Clinic is a multidisciplinary team clinic. This team specializes in the evaluation and treatment of returning OEF/OIF/OND veterans with suspected traumatic brain injuries, and typically comorbid PTSD. The resident performs neuropsychological evaluations of Veterans referred from this clinic, helps to guide treatment planning, actively participates in team meetings, and provides consultative assistance to the clinic's team leadership.

Consultative Services: The year 1 resident participates in interdisciplinary consultation services that includes observation and service provision to neurology or inpatient teams.

Psychological Intervention: The resident participates in a minor rotation (4 hours/week) each year: health psychology during year 1, and psychotherapy with neuropsychological populations during year 2.

Supervision: Advanced residents will gain experience providing direct tiered supervision to the neuropsychology practicum student. This will entail direct training on the assessment, scoring, interpretation, and report-writing components of neuropsychological evaluations. Support for this experience will be provided via a "supervision of supervision" peer group with the neuropsychology faculty.

In the second year, residents are allotted increased independence and work together with their supervisors to arrange a training plan based on individualized training needs, while maintaining engagement in direct clinical, didactic, and research activities on a weekly basis.

Didactics:

Our didactic seminars include two weekly neuropsychology seminars:

(1) The Worcester Neuropsychology Postdoctoral Seminar is operated in conjunction with the training program at the University of Massachusetts (UMass) Chan Medical School. This is a lecture-format series that is operated by faculty from the VA, UMass, and the local community of neuropsychologists and allied health professionals. Select seminar dates are also set aside for fact-finding activities and journal clubs.

(2) The Multi-site VTC Clinical Neuropsychology Fellowship Training Didactic is a two-hour, two-year-long course conducted via video conference with other VA residency programs. The first hour of each seminar is devoted to case presentations and fact-finding case conferences, and the second hour consists of a lecture-format presentation of an assigned topic relevant to VA residents and neuropsychology residents in general.

Trainees have the additional opportunity to attend Grand Rounds at UMass, and virtual Neurology meetings at the Boston VA, including brain cuttings. We also distribute alerts about virtual didactic seminars and conferences and strongly encourage attendance at these.

Research:

Neuropsychology residents are allotted up to 10% time to engage in a range of research activities. Research projects with VA investigators are available within our service and via the New England Mental Illness Research, Education, & Clinical Center (MIRECC). Research project collaborations with colleagues at other local institutions are welcome as well. Research activities conducted within the residency are expected to yield at least one conference presentation and/or manuscript submitted to a professional journal.

Supervision:

Residents receive 3 hours of individual supervision per week to discuss clinical and research topics as well as professional development objectives. In addition, supervisors are routinely available for impromptu consultation on an as-needed basis.

Facilities:

The VA Central Western Massachusetts Healthcare System provides primary, specialty, and mental health care to a population of more than 120,000 Veterans in central and western Massachusetts. The System includes the Northampton VA Medical Center, a 5-star facility with many inpatient and outpatient services, as well as five community-based outpatient clinics in Worcester, Springfield, Fitchburg, Greenfield, and Pittsfield. VA CWM has an academic affiliation and partnership with the University of Massachusetts Chan Medical School.

About Worcester:

The neuropsychology residency is primarily located at the Community Based Outpatient Clinic in Worcester (pronounced 'wuss/ter', or, if you want to sound like a native, 'wuss/tə'), New England's second largest city, centrally located within 60-90 minutes' drive or train ride to Boston, Amherst, Northampton, and Providence. Worcester balances rich cultural and community life with relative affordability. Worcester enjoys an abundance of intercultural diversity, with many ethnic festivals, markets, and food purveyors catering to its diverse population. Worcester also has an excellent and accessible food scene, including the Worcester Public Market. The immediate area boasts eleven colleges and universities, including: UMass Chan Medical School, Clark University, the College of the Holy Cross, Worcester State University, Worcester Polytechnic Institute, Assumption College, Becker College, Anna Maria College, Massachusetts College of Pharmacy, Cummings School of Veterinary Medicine at Tufts University, and Quinsigamond Community College. The Worcester Art Museum, Tower Hill Botanic Gardens, and the Worcester Center for Crafts are among the city's treasured cultural institutions. A burgeoning LGBT community offers an annual Pride Celebration that is uniquely integrated within Worcester's historic Canal District neighborhood. The area offers excellent nearby hiking, skiing, fishing and other New England outdoor activities, including proximity to the Appalachian Trail and New Hampshire's White Mountains. Rural agricultural towns rich with orchards and world-famous antiques venues surround the city. Sports lovers can

watch the Woo Sox, the Triple-A minor league affiliate of the Red Sox, play at the brand-new Polar Park Stadium, located in the Canal District. With a vibrant arts and music scene, world-class performance spaces, such as the Hanover Theater and Mechanics Hall—known for its excellent acoustics, many small music venues across the city, and several annual music festivals, such as the nearby Lowell Folk Festival (the oldest free music festival in the US) there is, maybe, too much to do in one's leisure time. For some quiet time, the Insight Meditation Society (IMS) in Barre, MA, 30 minutes from Worcester, hosts internationally renowned Buddhism and mindfulness instructors, offering talks and meditation retreats of any length.

Transportation

Air transportation by all major airlines is provided from Logan International Airport, located in Boston, Massachusetts. Interstate highway Route 90 connects Boston to Worcester, a drive of approximately 50 miles.

Technology:

Each resident is provided with a VA laptop. Residents at this time are allotted one day per week to telework, provided that they have wi-fi access in a private location at their home and have the ability to connect through the secure VPN used here. All client data are stored on the VA network or in a locked file cabinet in the resident's office.

Neuropsychology Residency Training Staff:

Lee Ashendorf, Ph.D., ABPP-CN, Board-Certified Neuropsychologist, Training Director, Worcester

Dr. Ashendorf earned his Ph.D. in 2005 from the University at Albany, State University of New York, completing his internship training in neuropsychology with a minor in health psychology at the VA Connecticut Healthcare System's West Haven campus. He completed a 2-year postdoctoral fellowship in neuropsychology at the VA Bedford Healthcare System. He worked there as a clinical neuropsychologist and co-director of neuropsychology training for several years, until 2016, when he joined the Worcester Outpatient Clinic in the VA Central Western Massachusetts (VACWM) Healthcare System. He functions as a clinical neuropsychologist and oversees neuropsychology referrals to this clinic.

He is also a member of the VACWM TBI/Polytrauma teams and the Research & Development Committee. He holds a faculty appointment as Assistant Professor of Psychiatry in the University of Massachusetts Medical School. He was the lead editor of the book, *The Boston Process Approach to Neuropsychological Assessment*, and has presented locally and nationally on this topic. He was elected a Fellow of the National Academy of Neuropsychology in 2014 and was the 2015 recipient of the Massachusetts Neuropsychological Society's Edith Kaplan Award. He has over 30 publications and has served as Associate Editor of the *Archives of Clinical Neuropsychology*, *Developmental Neuropsychology,* and (currently) *The Clinical Neuropsychologist*. His research interests include psychometric applications of the Boston Process Approach and implementation of forensic neuropsychological tools in Veteran populations.

Sarah Ward, Ph.D., ABPP-CN, Board-Certified Neuropsychologist, Worcester

Dr. Ward earned her doctorate in clinical psychology at the University of Minnesota-Twin Cities in Minneapolis, where she focused on neuropsychological assessment and research in behavioral genetics. She interned at the Massachusetts Medical Center/Beth Israel Deaconess Medical Center/Harvard Medical School, in the neuropsychology track, and with an additional focus on outpatient therapy to individuals with serious mental illness. She completed a two-year clinical neuropsychology post-doctoral fellowship at Beth Israel Deaconess Medical Center/Harvard Medical School, with rotations in outpatient psychiatry, outpatient neurology, Department of Mental Health, and Boston HealthCare for the Homeless. She works as an assessment psychologist at the Worcester clinic of VACWM. She spends part of her time conducting clinical neuropsychological and psychological evaluations for Veterans as part of the Worcester Mental Health Clinic and the TBI/Polytrauma team. She also completes mental health compensation and pension evaluations for the Veterans Benefits Administration. She provides clinical supervision in neuropsychological and psychological assessment.

Christopher Catalfamo, PsyD, PCMHI Psychologist, Worcester

Dr. Catalfamo earned his PsyD in Clinical Psychology from Marywood University in 2020 after completing his internship at the Lebanon VA Medical Center. His research centered on examining different healthcare providers' practices for assessing mild cognitive impairment. Following internship, Dr. Catalfamo completed a postdoctoral residency at the Edith Nourse Rogers VA Medical Center during which he focused on interdisciplinary education and program

development. While there, he co-led a Motivational Interviewing practice group for clinicians and trainees. He then provided individual and group psychotherapy to a general adult population while working as a psychologist with the UMass Memorial Medical Group Outpatient Psychiatry Department where he utilized training and experience in Cognitive Processing Therapy, Dialectical Behavior Therapy, and Acceptance and Commitment Therapy. He subsequently joined VA Central Western Massachusetts as a staff psychologist in PCMHI.

Teresa H. Malinofsky, Ph.D., Neuropsychologist, Northampton

Dr. Malinofsky started her professional career as a music therapist, then became clinical psychologist and neuropsychologist. As music therapist at the Creative Arts Rehabilitation Center, in NYC, she worked with children and adolescents with severe autism and adults with psychiatric and neurologic conditions. At the same time, she took courses in physiological psychology at NYU and laboratory experience at Rockefeller University before moving to the University of Cincinnati where she obtained her PhD in clinical psychology. Her PhD dissertation topic was Changes in Object Representation in Hypnosis as Manifested on the Rorschach Test. She interned at Cambridge Hospital (now the Cambridge Alliance) in clinical psychology, and obtained postdoctoral-level training and work experience in neuropsychology for a few years at Harvard-affiliated hospitals, including Massachusetts General Hospital. Her training and this early experience in neuropsychology was with geriatric and psychiatric populations. Then in Western Massachusetts, she first worked at the Weldon Center for Rehabilitation, Mercy Hospital, where she was Director of Neuropsychology and Chief Psychologist for the Inpatient Brain Injury Unit. At the same time, she co-edited a book, The Psychotherapist's Guide to Neuropsychiatry: Diagnostic and Treatment Issues (1994), along with co-editors James Ellison, MD, and Cheryl Weinstein, PhD. The book was well-received and has been translated into Korean. Dr. Malinofsky also contributed a chapter on a neuropsychological perspective on personality disorders. When her brother contracted HIV-AIDS and she was his primary family member and support, she moved from hospital-based work to consultation for the Statewide Head Injury Program (SHIP/Massachusetts Rehabilitation Commission), which allowed her the freedom and time to travel, both to help her brother, as well as provide consultation throughout Western Massachusetts, to agencies and schools, serving the severely traumatically brain injured and their families. Following her brother's death, and the birth of her second child, she started her private practice in neuropsychology and also taught at the Antioch New England Graduate School, courses in neuropsychology and biological foundations of clinical psychology. In 2003-2009, she worked three

days per week as neuropsychology consultant to the Geropsychiatry team at Baystate Franklin Medical Center. Following that, she returned to full-time private practice in neuropsychology with associated work in cognitive rehabilitation and psychotherapy, and also supervised practicum students from Antioch New England Graduate School. Now at the Boland VAMC, Dr. Malinofsky does neuropsychological assessments, some psychotherapy, and a weekly C&P exam, and serves as Assessment rotation supervisor and Case Conference facilitator for the internship program. She has developed a new interest in dissociation, a not uncommon symptom of PTSD.

Neuropsychology Residency Alumni:

	Graduate Program	Job
2018-20	Palo Alto University	psychologist Portland VA Medical Center
2019-21	University of Colorado-Denver	neuropsychologist Pittsburgh VA Medical Center
2020-22	William James College	neuropsychologist LifeStance Health
2021-23	Fairleigh Dickinson University	neuropsychologist NYU Langone Rusk Rehabilitation
2022-24	University of Tulsa	neuropsychologist Lehigh Valley Hospital

Evaluation Procedures:

Evaluation takes place three times during each training year. Successful completion of the program requires the equivalent of two full years of full-time training and achievement of advanced skill on all field- and program-specific competencies. These competencies represent professional skills, knowledge, and behaviors that must be demonstrated in order to graduate from the residency program.

At the beginning of the training cycle, the resident is asked to set learning goals/objectives for the residency. They also complete an initial fact-finding pre-test to identify any potential weaknesses that need further development. From this and their own goals and objectives, a formal, individualized training plan will be established. At least six times during the 24 months of training, the supervisors are asked to formally evaluate the resident's progress in training as well as progress towards the specified training objectives. If a supervisor rates functioning as "below resident level" in important practice areas on the core competencies, a meeting will occur between the resident, the supervisor, and the Training Director to develop a remediation plan. The **MINIMAL GRADUATION REQUIREMENT** is that all supervisor ratings on all core competencies are at a rating of "5" ("meets expectations for advanced specialized practice") by the end of your residency.

The resident will also be asked to evaluate their overall residency experience, anonymously, at the end of the training experience. There are several specific areas that they are asked to address. This feedback will be used to plan and make programmatic improvements going forward.

Due Process

Mechanisms for Addressing Impaired or Deficient Performance:
The purpose of this section of the handbook is to describe processes in place for responding to and correcting deficient and/or problematic behavior exhibited by residents and the grievance policy procedures afforded to all trainees. Potential domains of problematic resident behavior include two general areas: 1) Professional skills, competence and functioning, and 2) Adherence to professional ethics.
Relatively minor problems identified at formal evaluations may result in the modification of training experiences. Such modifications are the responsibility of the primary supervisor but may be based on consultation with the Training Director and/or the Training Committee. Minor problems identified at the end of a quarter will be communicated to relevant supervisors of that resident and/or the Training Committee. Problems deemed to be sufficiently serious to pose a potential threat to the resident's successful completion of the program will be referred to the Training Committee for consideration. Such problems may be identified at any time. In case of a serious breach of ethical principles, the Training Committee may recommend to the Mental Health Service Line that the resident be terminated immediately. In most cases, though, the Training Committee will develop a written remediation plan to help the resident achieve an acceptable level of performance. The remediation plan specifies the skills and/or behaviors to be changed and stipulates a date for remediation completion. The remediation plan may include a revision of the resident's training schedule. A copy of this plan will be given the resident. Within one week of the stipulated date for the completion of remediation, the Training Committee will make a determination of progress. The Training Committee will consider input from supervisor(s) and the resident. All Training Committee decisions will be by majority vote and communicated in writing to the resident. Three determinations by the Training Committee are possible, each followed by a different course of action:

(1) If a determination of satisfactory progress is made, the remediation plan will be terminated.

(2) If the Training Committee determines that sufficient progress is being made so that it seems possible the resident will successfully complete the residency but that further remediation is necessary, a revised remediation plan with completion date will be developed.

(3) If a determination of unsatisfactory progress is made, the Training Committee will conduct a formal hearing with the resident within one week of the meeting in which it is determined that unsatisfactory progress has been made. The resident will receive a minimum 3 days' notice to prepare for this hearing. Issue(s) of concern will be addressed to the resident by the Training Committee and any other staff electing to attend. The resident will be afforded an opportunity to respond and may invite anyone of his/her choice to attend the hearing to provide additional information. (However, trainees are not covered under union representation so this is not an option). Within one week of the hearing, the

Training Committee will either develop a revised remediation plan or will recommend termination of the residency to the Chief of Mental Health, Training Director, and ACOS of Education. Proceedings of the hearing will be documented in a summary transcript.

At any time prior to termination from the residency program, a resident may be permitted to resign his/her residency.

DUE PROCESS IN ACTION: THE IDENTIFICATION AND MANAGEMENT OF RESIDENT PROBLEMS/CONCERNS

This section provides residents and staff a definition of impairment, a listing of possible sanctions and an explicit discussion of the due process procedures. Also included are important considerations in the remediation of problems or impairment.

Definition of Problematic Behavior

Problematic behavior is defined broadly as an interference in professional functioning which is reflected in one or more of the following ways: 1) an inability and/or unwillingness to acquire and integrate professional standards into one's repertoire of professional behavior; 2) an inability to acquire professional skills in order to reach an acceptable level of competency; 3) an inability to control personal stress, strong emotional reactions, and/or psychological dysfunction which interferes with professional functioning; and 4) violation of the American Psychological Association Ethical Principles of Psychologists and Code of Conduct (2002, with 2010 Amendments), or of laws governing the practice of psychology established by the Commonwealth of Massachusetts.

It is a professional judgment as to when a resident's behavior becomes problematic, rather than merely of concern. Trainees may exhibit behaviors, attitudes or characteristics, which, while of concern and requiring remediation, are not unexpected or excessive for professionals in training. Problems typically become identified as impairments when they include one or more of the following characteristics: the resident does not acknowledge, understand, or address the problem when it is identified; the problem is not merely a reflection of a skill deficit, which can be rectified by academic or didactic training; the quality of services delivered by the resident is sufficiently negatively affected; the problem is not restricted to one area of professional functioning; a disproportionate amount of attention by training personnel is required; and/or the resident's behavior does not change as a function of feedback, remediation efforts, and/or time.

Identification of Problematic Behavior

Problematic behavior on the part of a resident may be identified through a number of channels. For example, a resident may receive an “unacceptable” rating from any of the evaluation sources in any of the major categories of evaluation. Alternatively another staff member may report concerns about a resident's behavior (ethical or legal violations, professional incompetence).

If the staff member who observes concerning behavior is not the resident’s primary supervisor, the staff member will consult with the Director of Training. Director of Training will discuss the concern with the resident's primary supervisor. The Director of Training may also consult with the full Training Committee or a subset of the Training Committee. If the Director of Training, primary supervisor, and /or Training Committee determine that the alleged behavior in the complaint, if proven, would constitute a serious violation, the Director of Training will inform the staff member who initially raised the concern, and remediation steps will be initiated, as outlined below. If the alleged behavior is not considered a serious violation, informal feedback, or a verbal warning may be deemed sufficient to address the behavior (Step 1 below).

Remediation and Sanction Alternatives

It is important to have meaningful ways to address problematic behavior once it has been identified. In implementing remediation or sanction interventions, the training staff must be mindful and balance the needs of the resident, the clients involved, members of the resident training group, the training staff, and other agency personnel. The following describes the graduated stages of intervention in the case of problematic behavior or impairment on the part of a resident:

- Step 1 - Verbal warning to the resident emphasizes the need to discontinue the inappropriate behavior under discussion. No record of this action is kept. Typically this feedback is given in the context of supervision with a direct supervisor, or in a face-to-face meeting with the Training Director. The resident will have the opportunity to respond to the feedback in the context of these face-to-face meetings. If Step 1 is insufficient to address the behavior, then we proceed to Step 2.

- Step 2 - Written acknowledgment to the resident formally documents that the Director of Training are aware of and concerned with a performance rating on the resident’s evaluation; that the concern has been brought to the attention of the resident; that the Director of Training will work with the resident to rectify the problem or skill deficits; and that the behaviors associated with the rating are not significant enough to warrant more serious action. The resident is given the opportunity for a meeting or “hearing” with the Training Director, during which the problematic behavior is discussed, and the resident has an opportunity to respond. The written acknowledgment may be removed

from the resident's file when the resident adequately addresses the behavior and successfully completes the residency. Alternatively the document may remain in the resident's file if they do not adequately address the problematic behavior. If Step 2 is insufficient to address the behavior, then we proceed to Step 3.

- Step 3 - Competency Remediation Plan:

    - Notification: the resident will be formally notified of the need to discontinue an inappropriate action or behavior. The written notification letter will contain: a clear description of the resident's unsatisfactory performance or problematic behavior; expectations for acceptable performance; actions needed by the resident, and responsibilities of the supervisor or training committee, to correct the unsatisfactory behavior; a brief specified timeline for correcting the problem; assessment methods to verify successful correction of the problem; the date of the evaluation to determine if successful remediation has been achieved; and consequences if the problem is not corrected. This written notification may follow the format of the Competency Remediation Plan recommended in the APA Competency Assessment Toolkit for Professional Psychology (http://www.apa.org/ed/graduate/competency.aspx).

    - Hearing: There will be a meeting in which staff will articulate to the resident the specific nature of the problematic behavior, and the resident will have an opportunity to respond. This meeting will include the resident and the Training Director, and if appropriate, the supervisor or staff member who noticed/evaluated the problematic behavior. The notification process will provide for the resident to respond to the assessment of problematic behavior and remediation plan.

    - Appeal: The resident may request that a higher ranking psychologist review the assessment and remediation plan. The resident also has the right to appeal the final decisions and actions taken by the training program by requesting review by a higher ranking psychologist.

    - Documentation: A copy of the notification will be kept in the resident's file. Documentation will contain the position statements of the parties involved and the Competency Remediation Plan. When the remediation is complete and all benchmarks are met, this will be clearly documented on the Remediation Plan which will remain in the resident's file. If remediation is not completed, further steps may be undertaken, including another remediation plan, schedule modification, probation, suspension, administrative leave, or dismissal from residency (see below for discussion of Further Options).

- Communication: This process will in most cases include communication with the Director of Clinical Training at the resident's academic program. Consultation with the APPIC Informal Problem Consultation service may also be initiated.

- Maintaining performance: During remediation, the resident is expected to maintain minimally acceptable levels of performance in other competency areas.

- Step 4 - Further Options: If successful remediation is not achieved through Steps 1-3, further options may include:
  - Schedule Modification is a time-limited, remediation-oriented, closely supervised period of training designed to return the resident to a more fully functioning state. Modifying a resident's schedule is an accommodation made to assist the resident in responding to situations such as personal reactions to environmental stress, with the full expectation that the resident will complete the residency. This period will include more closely scrutinized supervision, conducted by the regular supervisor in consultation with the Director of Training. Several possible and perhaps concurrent courses of action may be included in modifying a schedule. These include:
    - increasing the amount of supervision, either with the same or other supervisors;

    - changing the format, emphasis, and/or focus of supervision;

    - recommending self-care interventions outside of the training program such as medical or mental health care (the resident can use his/her health insurance to pay for this, if they so desire);

    - reducing the resident's clinical or other workload; requiring specific academic coursework.

  - The length of a schedule modification period will be determined by the Director of Training, in consultation with the primary supervisor and an advisory subset of the Training Committee. The termination of the schedule modification period will be determined, after discussions with the resident, by the Director of Training in consultation with the primary supervisor and an advisory subset of the Training Committee.

  - Probation is also a time-limited, remediation-oriented, more closely supervised training period. Its purpose is to assess the ability of the resident to complete the residency and to return the resident to a more fully functioning level of performance. Probation defines a circumstance in which the Director of Training systematically monitor for a specific length of time the degree to which the resident

addresses, changes, and/or otherwise improves the behavior associated with the inadequate rating. The resident is informed of the probation in a written statement, which includes: the specific behaviors associated with the unacceptable rating; the recommendations for rectifying the problem; the time frame for the probation during which the problem is expected to be ameliorated; and, the procedures to ascertain whether the problem has been appropriately rectified. If the Director of Training determine that there has not been sufficient improvement in the resident's behavior to remove the probation or modified schedule, then the Director of Training will discuss with the primary supervisor and the Training Committee other possible courses of action to be taken. The Director of Training will communicate in writing to the resident that the conditions for revoking the probation or modified schedule have not been met. This notice will include the course of action the Director of Training and Training Committee have decided to implement. These may include continuation of the remediation efforts for a specified time period or implementation of another alternative. Additionally, the Director of Training will communicate to the Academic Director of Training from the resident's school, that if the resident's problematic behavior is not adequately rectified, the resident will not successfully complete the residency.

- Suspension of Direct Service Activities requires a determination that the welfare of the resident's patient(s) or consultee(s) has been jeopardized. Therefore, direct service activities will be suspended for a specified period as determined by the Director of Training in consultation with the Training Committee. Again, the Director of Training will communicate with the Academic Director of Training from the resident's school regarding the suspension. At the end of the suspension period, the resident's supervisor, in consultation with the Director of Training and Training Committee, will assess the resident's capacity for effective functioning and determine when direct service can be resumed.

- Administrative Leave involves the temporary withdrawal of all responsibilities and privileges in the agency. If the Probation Period, Suspension of Direct Service Activities, or Administrative Leave interferes with the successful attainment of training hours needed for completion of the residency, this will be noted in the resident's file and the resident's Academic Director of Training will be informed. The Director of Training will inform the resident of the effects the Administrative Leave will have on the resident's stipend and accrual of benefits.

- Dismissal from the Residency involves a permanent withdrawal of all agency responsibilities and privileges. When specific interventions do not, after a reasonable time period, rectify the impairment and the resident seems unwilling or unable to alter his/her behavior, the Director of Training will discuss with the Academic Director of Training from the resident's school the possibility of

termination from the training program or dismissal from the agency. Either administrative leave or dismissal would be invoked in cases of severe violations of the APA Code of Ethics, or when imminent physical or psychological harm to a patient is a major factor, or the resident is unable to complete the residency due to physical, mental or emotional illness. When a resident has been dismissed, the Director of Training will communicate to the resident's academic department that the resident has not successfully completed the residency.

Due Process - Summary

Whenever a formal decision has to be made by the Director of Training about a change in the resident's training program (i.e. Step 3 above), or status in the agency (i.e., Step 4 above), the Director of Training will: (a) inform the resident in writing and (b) meet with the resident to review the decision, and hear the resident's response to the assessment, plan, and decision. This meeting may include the resident's primary supervisor. Any formal action taken by the Training Program may be communicated in writing to the resident's academic department. This notification includes the nature of the concern and the specific alternatives implemented to address the concern. Finally, the resident may choose to accept the conditions and decisions, or may choose to challenge or appeal the action. The procedures for challenging the action are presented below under "Grievance Procedures".

Due Process - General Guidelines

Due Process guidelines provide a framework to respond, act, or dispute, when the program has concerns about a resident's performance. Due Process ensures that decisions about residents are not arbitrary or personally based. It requires that the Training Program identify specific evaluative procedures, which are applied to all trainees, and provide appropriate appeal procedures available to the resident. All steps need to be appropriately documented and implemented. General due process guidelines include: presenting to the residents, in writing during the orientation period, the program's expectations related to professional functioning, and discussing these expectations in both group and individual settings; stipulating the procedures for evaluation, including when and how evaluations will be conducted; articulating the various procedures and actions involved in making decisions regarding impairment; communicating, early and often, with graduate programs about any suspected difficulties with residents and when necessary, seeking input from these academic programs about how to address such difficulties; instituting, when appropriate, a remediation plan for identified inadequacies, including a time frame for expected remediation and consequences of not rectifying the inadequacies; providing a written procedure to the resident, which describes how the resident may appeal the program's action; ensuring that residents have sufficient time to respond to any action taken by the program; using input from multiple professional sources when making decisions or recommendations regarding the resident's performance; and

documenting, in writing and to all relevant parties, the actions taken by the program and its rationale.

GRIEVANCE PROCEDURES: IF A RESIDENT HAS CONCERNS ABOUT THE PROGRAM

Purpose of Grievance Procedures

While Due Process delineates steps to follow in case of the training program's concern about a resident, Grievance Procedures outline the steps a trainee would undertake if they had a complaint about a supervisor, a remediation plan or decision, or about the training program.

Grievance Procedure

In the event a resident encounters any difficulties or problems (e.g., poor supervision, unavailability of supervisor, evaluations perceived as unfair, workload issues, personality clashes, other conflict) during his/her training experiences, he/she is encouraged first to seek informal resolution and, if this does not resolve the issue, to then consider formal resolution. (Likewise, if a training staff member has a specific concern about a resident, the staff member is also encouraged to attempt informal resolution first.)

- Step 1- Informal Resolution: The resident will first attempt to discuss the issue with the staff member involved. If the issue cannot be resolved informally between the two parties, the resident (or staff member) should discuss the concern with the Director of Training. If the Director of Training cannot resolve the issue, the resident can move into a formal grievance process and challenge any action or decision taken by the Director of Training, the supervisor, or any member of the Training Committee by following the formal grievance procedure below.

- Step 2 - Formal Grievance Process: The resident should file a formal complaint, in writing with all supporting documents with the Director of Training. The formal complaint consists of a detailed description of the behavior(s) of concern. The resident's Formal Complaint will be shared with the staff member to whom the complaint pertains, as well as with the Training Committee, if needed to consult and assist in crafting a resolution. If the resident is challenging a formal evaluation, the resident must do so within five workdays of receipt of the evaluation.

Within five workdays of a formal complaint, the Director of Training must consult with the Training Committee Review Panel via the procedures described below.

- Step 3 - Training Committee Review and Process: When needed, a Training Committee Review Panel will be convened by the Director. The panel will consist of at least five members of the supervisory staff. Within five workdays of being convened, (i.e., within

10 workdays of the formal complaint) the Review Panel will meet with the resident who filed the Formal Grievance, to review the matter. The Review Panel will determine if further meetings with the other parties involved are required for fair evaluation of the situation. The resident will have the right to hear all facts, or to dispute or explain the behavior of concern, if the resident's grievance is in response to an evaluation of the resident. After having met with the resident, the Review Panel will determine a recommended course of action, which will be made by majority vote. Within three workdays of the completion of the review, the Director of Training will write a report, including the Review Panel's recommendations for further action. The Director of Training will inform the resident of the recommendations and any action to be taken.

If the resident disputes the recommendations of the Training Committee Review Panel, the resident has the right to contact the Mental Health Service Line Manager, who will either accept the Review Panel's recommendations or reject them and offer an alternative. The decision of the Mental Health Service Line Manager is final. Should the Mental Health Service Line Manager recommend further remediation, the Training Committee will develop a plan in accordance with the remediation and sanction guidelines specified above.

Other Resources and References:

- APA Competency Assessment Toolkit for Professional Psychology is available for building remediation plans: http://www.apa.org/ed/graduate/competency.aspx

- APA Commission on Accreditation, Office of Program Consultation and Accreditation is available for resident and program consultation: http://www.apa.org/ed/accreditation/

- APA Ethics Office is available for resident and program consultation: http://www.apa.org/ethics/

- Residents (and/or the training program) may avail themselves of the APPIC Informal Problem Consultation service: http://appic.org/Problem-Consultation

- If informal resolution is unsatisfactory, residents may file a formal complaint with the APPIC Standards and Review Committee: https://www.appic.org/About-APPIC/APPIC-Policies/ASARC

[1]These policies are pending review by Human Resources.

Appendix 1: Neuropsychology Postdoctoral Residency Competency Evaluation Form

Please use the chart below to guide your ratings for each competency domain.

1	2	3	4	5
Notable deficiency in at least one part of the competency area; triggers need for performance improvement plan	Operating at an intern level; relatively mild deficiency requiring close supervision	Operating as an entry level fellow; no glaring deficiencies, but needs some supervision to improve and refine skills	Operating at a satisfactory level; still needs some supervision, but has generally sound skills, professional behavior, instincts	Operating as a highly functioning fellow; has a solid repertoire of clinical skills, refined diagnostic skills; consultation only expected on atypically challenging clinical topics; meets expectations for advanced specialized practice

Expectations: Reviews 1 & 2: -Each supervisor's mean rating across competencies should be 3.0 or higher
-No individual ratings less than 2

Review 3: -Each supervisor's mean rating across competencies should be 3.5 or higher
-No individual ratings less than 3

Review 4: -Each supervisor's mean rating across competencies should be 4.0 or higher
-No individual ratings less than 3

Review 5: -Each supervisor's mean rating across competencies should be 4.5 or higher
-No individual ratings less than 4

Final Review: -All competencies should be rated at 5. Any lower ratings trigger training committee review

1. **INTEGRATION OF SCIENCE AND PRACTICE**
Understanding of influence of science on practice and practice on science

- Able to apply scientific knowledge to daily practice
- Routinely accesses scientific literature to inform clinical work
- Displays knowledge of functional neuroanatomy
- Actively participates in seminars

2. **INDIVIDUAL AND CULTURAL DIVERSITY**

A. Self/Other as Shaped by Individual and Cultural Diversity (e.g. cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status) and by Context

- Demonstrates and applies knowledge, awareness, and understanding of self as a cultural being in clinical contexts
- Demonstrates knowledge, awareness, and understanding of how cultural/diversity factors shape others' behaviors and how they inform clinical practice
- Adapts professional behavior, treatment approach, and communication in a manner that is sensitive, nuanced, and appropriate to the needs of diverse others
- Seeks appropriate supervision or consultation when uncertain about clinically relevant diversity matters

B. *Applications based on Individual and Cultural Context*

- Demonstrates ability to identify and apply culturally appropriate assessment and intervention procedures
- Reads and remains current on relevant literature that updates one's understanding of cultural/diversity topics

3. **ETHICAL & LEGAL STANDARDS**

A. Knowledge of ethical, legal, and professional standards and guidelines

- Demonstrates awareness and knowledge of the APA Ethical Principles and Code of Conduct and other relevant legal and professional standards and guidelines
- Appropriately consults or seeks supervision regarding ethical dilemmas as they arise

B. Ethical Conduct

- Able to integrate ethical standards into own practice and professional conduct
- Takes responsibility for continuing professional development
- Recognizes and addresses intersection of personal and professional ethical and moral issues

4. PROFESSIONAL VALUES, ATTITUDES, AND BEHAVIORS

A. Integrity: Honesty, personal responsibility and adherence to professional values

- Demonstrates a nuanced, contextualized understanding of, and careful adherence to, professional values and standards.
- Conscientiously and independently resolves situations that challenge professional values and integrity in a skilled manner consistent with applicable personal and professional standards

B. Accountability: Consistently reliable and accepting of responsibility for own actions

- Takes responsibility to complete documentation in a timely and professional fashion

- Accepts responsibility for, and meets, deadlines
- Demonstrates developmentally appropriate initiative

C. Deportment: Understands how to conduct oneself in a professional manner

- Behaves in ways that reflect the values and attitudes of the field(s) of psychology and clinical neuropsychology, including integrity, deportment, professional identity, accountability, lifelong learning, and concern for the welfare of others
- Engages in self-reflection regarding one's personal and professional functioning; engage in activities to maintain and improve performance, well-being, and professional effectiveness
- Actively seeks and demonstrates openness and responsiveness to feedback and supervision
- Responds professionally in increasingly complex situations with a greater degree of independence
- Demonstrates an emerging professional identity consistent with the clinical neuropsychology specialty

5. CONSULTATION AND INTERPROFESSIONAL/INTERDISCIPLINARY SKILLS

A. Communication of Consultation Findings

- Appropriately and directly addresses referral question in written reports and in feedback
- Effectively translates complex biopsychosocial issues to other professionals
- Provides appropriate and intelligible explanations and characterization of evaluation results to other professionals

B. Multidisciplinary Systems

- Demonstrates knowledge and respect for the roles and perspectives of other professions such as effective communication, appropriate referrals, and integration of their perspectives into case conceptualizations
- Functions effectively in consulting roles across settings (e.g., clinical, legal, public policy, research), clarifying referral questions, applying knowledge appropriate to each setting, and communicating results to referral sources both verbally and in writing

6. COMMUNICATION AND INTERPERSONAL SKILLS

- Develops and maintains effective relationships with a wide range of individuals, including colleagues, communities, organizations, supervisors, supervisees, and those receiving professional services
- Produces and comprehend oral, nonverbal, and written communications that are informative and well-integrated
- Demonstrates a thorough grasp of professional language and concepts
- Demonstrates effective interpersonal skills and the ability to manage difficult communication well

7. ASSESSMENT

A. Knowledge and application of neuropsychological assessment methods

- Demonstrates the ability to accurately discern and clarify assessment questions, the recipients of the assessment results, and how assessment results will be utilized
- Addresses issues related to specific patient populations by referring to providers with specialized competence when appropriate, obtaining consultation, utilizing appropriate normative data, and describing limitations in assessment interpretation.
- Demonstrates knowledge of theories and methods of measurement and psychometrics relevant to brain-behavior relationships, cognitive abilities, social and emotional functioning, performance/symptom validity, test development, reliability validity, and reliable change
- Demonstrates knowledge of the scientific basis of assessment, including test selection, use of appropriate normative standards, and test limitations

B. Differential Diagnosis, Case Conceptualization and Assessment-Informed Recommendations

- Utilize clinical interviews, behavioral observations, record review, and selection, administration, and scoring of neuropsychological tests to answer the assessment question
- interpret assessment results to produce integrated conceptualizations, accurate diagnostic classifications, and useful recommendations informed by functional aspects of everyday living, quality of life, and educational/working/social/living environments
- Demonstrates knowledge of patterns of a) behavioral, cognitive, and emotional impairments associated with neurological, psychiatric, and general medical conditions that affect brain structure and functioning and b) incidence, prevalence (i.e., base-rate), natural course, and key signs/symptoms of disease processes for conditions of interest in neuropsychology
- Communicates both orally and in written reports the results and conclusions of assessments in an accurate, helpful, and understandable manner, sensitive to a range of audiences

8. INTERVENTION AND FEEDBACK: Ability to provide intervention, feedback, and recommendations in a way that is designed to promote health and well-being of individuals, groups, and/or organizations

A. *Feedback:*

- Able to provide feedback to patients and families regarding the results of cognitive assessments, including appropriate and well thought out recommendations
- Demonstrates the use of assessment and provision of feedback for therapeutic benefit

B. *Intervention planning and implementation:*

- Demonstrates an understanding of evidence-based interventions to address cognitive and behavioral problems common to recipients of neuropsychological services
- Demonstrates an understanding of how complex neurobehavioral disorders and sociocultural factors can affect the applicability of interventions
- Demonstrates the ability to plan and implement interventions with fidelity to empirical models and flexibility to adapt where appropriate

C. Intervention Skills

- Develops rapport and collaborative working alliance with both cooperative and difficult clients, or clients with complicated presenting problems
- Provides effective psychoeducation to patients, caregivers, and/or families
- Demonstrates proficiency with a range of clinical skills and assists clients with implementing meaningful change, when appropriate

9. SUPERVISION / TEACHING: Supervision and training in the professional knowledge base of enhancing and monitoring the professional functioning of others

A. Participation in Supervision Process

- Presents work to supervisor in a timely fashion
- Incorporates and appropriately responds to supervisory feedback
- Appropriately seeks supervision around unfamiliar clinical or professional topics

B. Teaching and providing supervision

- Demonstrates knowledge of supervision models and practices related to clinical neuropsychology
- Teaches, supervises, and mentors others by accurately, effectively, and appropriately presenting information related to clinical neuropsychology

10. RESEARCH

- Accurately and effectively performs neuropsychological research activities, monitor progress, evaluate outcome, and communicate research findings
- Applies knowledge of existing neuropsychological literature and the scientific method to generate appropriate research questions and determine effective research design and appropriate analysis

Appendix 2: Postdoctoral Residency Admissions, Support, and Initial Placement Data

Date Program Tables are updated: 7/11/2024

Program Disclosures

Does the program or institution require students, trainees, and/or staff (faculty) to comply with specific policies or practices related to the institution's affiliation or purpose? Such policies or practices may include, but are not limited to, admissions, hiring, retention policies, and/or requirements for completion that express mission and values?	_____ **Yes** __X___ **No**
If yes, provide website link (or content from brochure) where this specific information is presented:	
N/A	

Appendix 3: Postdoctoral Program Admissions

Date Program Tables are updated: 7/11/2024

Briefly describe in narrative form important information to assist potential applicants in assessing their likely fit with your program. This description must be consistent with the program's policies on intern selection and practicum and academic preparation requirements:
Our program seeks qualified applicants from doctoral training programs in clinical psychology, with prior training and experience in neuropsychology and a clearly demonstrated intent to pursue a career as a neuropsychologist. Applicants must have completed all requirements for their doctoral degree, which includes the successful defense of their dissertation, prior to starting the postdoctoral residency. In order for the program to make an offer to an applicant who has not yet completed their defense, a letter from the dissertation chair attesting that the dissertation will be completed prior to the start of the residency is required. Residents are selected based on academic excellence, clinical experience, research experience, recommendations of professors / supervisors, interview, and interests. Consideration is given to aspects of life experience, particularly the ability to understand human diversity. The program typically interviews selected applicants from December to early January. All interviews will be offered remotely to increase accessibility to applicants. If applicants are interested, we are happy to arrange an in-person interview experience so that they may be able to assess the local area and resources of the VA. However, the decision on whether to interview remotely or in-person will NOT be considered in candidate selection. Offers are generally made in early-to-mid January. The neuropsychology postdoctoral residency program does not participate in the APPCN Match system. Please note, by accepting a postdoctoral training position at our agency, the applicant is agreeing to complete two full years of residency training. It is fully expected that once an applicant accepts a position at our site, they will cease to pursue other postdoctoral or staff positions and will plan to complete the full training program at this facility. If an applicant has any reason to believe that they may not complete the residency program, they should not apply nor accept an offer for training at this site.

Describe any other required minimum criteria used to screen applicants:
To be eligible for this residency position, applicants must: (1) Be US citizens; (2) Be graduates of doctoral programs in clinical psychology or neuropsychology that have been accredited by the American Psychological Association (APA), Canadian Psychological Association (CPA), or Psychological Clinical Science Accreditation System (PCSAS); (3) Have completed dissertation and earned their doctorate *prior to* the start of residency; (4) Have completed an APA-approved predoctoral internship (brand-new not-yet-accredited programs are exempt from this requirement); (5) Have significant prior experience in clinical neuropsychology and have demonstrated a strong interest in practicing clinical neuropsychology as a profession.

Applications should include (preferably as separate document files):

- Cover letter of intent, outlining career goals and goodness of fit
- Current curriculum vitae
- Two (2) de-identified sample reports
- Graduate school transcript (scanned unofficial copies preferred)
- Three (3) letters of recommendation *sent directly by the letter-writers*. At least one must be from an internship supervisor.

Appendix 4: Financial and Other Benefit Support for Upcoming Training Year*****

Annual Stipend/Salary for Full-time Residents	$60,091 Y1 $63,338 Y2
Annual Stipend/Salary for Half-time Residents	N/A
Program provides access to medical insurance for resident?	Yes
If access to medical insurance is provided:	
Trainee contribution to cost required?	Yes
Coverage of family member(s) available?	Yes
Coverage of legally married partner available?	Yes
Coverage of domestic partner available?	No
Hours of Annual Paid Personal Time Off (PTO and/or Vacation)	104 accrued
Hours of Annual Paid Sick Leave	104 accrued
In the event of medical conditions and/or family needs that require extended leave, does the program allow reasonable unpaid leave to interns/residents in excess of personal time off and sick leave?	Yes
Other Benefits (please describe): Residencies are for 2080 hours per year, to be completed over a twelve month period. Residents accrue a total of thirteen days of personal leave as well as sick leave over the course of the year. In addition, residents are granted up to ten days for educational leave and/or professional development (such as attending training events, professional conferences, or job interviews) across the two-year program (five days per year). The training manual of the residency outlines specific policies regarding grievance options and procedures, due process with regard to resident performance or professional functioning, and other relevant policies related to the medical center and the training program specifically.	

Appendix 5: Initial Post-Residency Positions

(Aggregate of three cohorts)	**2021-2024**	
Total # of residents who were in the 3 cohorts	3	
Total # of residents who remain in training in the residency program	0	
	PD	**EP**
Academic teaching		
Community mental health center		
Consortium		
University Counseling Center		
Hospital/Medical Center		2
Veterans Affairs Health Care System		
Psychiatric facility		
Correctional facility		
Health maintenance organization		
School district/system		
Independent practice setting		1
Other		

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