James Haley Veterans' Hospital and Clinics Tampa

Neuropsychology Residency Program

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Welcome!

Hello and thank you for your interest in the Tampa VA! We are a large and diverse program which has been APA-accredited since 2003 and is based at one of the VA system's flagship medical centers. Our program has a strong reputation for training in neurorehabilitation, differential diagnosis of complex syndromes, brain injury research, and development of world-class neuropsychology professionals. We are also proud to be part of the dynamic Tampa Bay area, one of the country's fastest-growing metropolitan areas and a region known for its world-class beaches, amazing cuisine, and temperate Florida living (and #ChampaBay). Take a moment to review our materials, and please feel free to contact Dr. Kamper with any questions (Joel.Kamper@va.gov). Our team of 14 core program faculty look forward to meeting you!

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Program Facts At-A-Glance

Program TD
Joel E. Kamper, Ph.D., ABPP-CN
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Applications Due
December 15th

APPCN Match Number
9381

Memberships
APA-Accredited (next visit in 2028)
APPCN Member

Stipend and Benefits
$52,005 1st year and $54,816 2nd year
-Health insurance coverage available
-11 paid federal holidays
-13 vacation days and 13 sick days
-5 days of authorized absence for professional activities
-Free onsite parking
-Individual private office space
- 5 ABPP-CN rotation supervisors among our 12 core training faculty
-Great weather, world-class beaches, and a thriving restaurant scene

How to Apply
Applications are online through the APPA-CAS (APPA CAS Postdoc Online Application (appic.org)

Program Websites
https://www.appic.org/Postdocs/Universal-Psychology-Postdoctoral-Directory-UPPD/Detail/id/2247

https://appcn.org/member-programs/entry/728/?pagenum=3

Psychology Training - Internship & Residency Programs | VA Tampa Health Care | Veterans Affairs

Accreditation Status

The two-year Neuropsychology Postdoctoral Residency at the **James A. Haley Veterans' Hospital, Tampa** is accredited by the Commission on Accreditation of the American Psychological Association. The next site visit will be in **2028**.

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 / E-mail: apaaccred@apa.org
Web: www.apa.org/ed/accreditation

NMS APPCN Match

The APA-accredited Neuropsychology Residency is an APPCN member and participates in the APPCN match. Our Match Number is 9381. This residency site agrees to abide by the APPCN policy that no person at this facility will solicit, accept, or use any ranking-related information from any residency applicant.

Application & Selection Procedures

Applications due: December 15

QUALIFICATIONS

1. United States citizenship.
2. Obtained a doctoral degree from an APA or CPA accredited graduate program in Clinical, Counseling, or Combined Clinical-School/Counseling-School Psychology or PCSAS accredited Clinical Science program. Persons with a doctorate in another area of psychology who meet the APA or CPA criteria for respecialization training in Clinical, Counseling, or Combined Clinical-School/Counseling-School Psychology are also eligible.
3. Completed an APA -accredited psychology internship or a VA-sponsored internship.
4. For males -- have registered with the Selective Service System before age 26.
5. Residents are subject to fingerprinting and background checks.
6. Residents must meet physical and health requirements as part of the onboarding process. This information is treated as confidential and can be verified via source documentation or a statement from a healthcare professional attesting that the resident meets the health requirements for VA training (: Trainee Qualifications and Credentials Verification Letter (TQCVL) - Office of Academic Affiliations (va.gov)). Residents are also subject to random drug screening (VA Drug-Free Workplace Program Guide for Veterans Health Administration Health Professions Trainees).

Health Professions Trainees (HPTs) are appointed as temporary employees of the Department of Veterans Affairs. As such, HPTs are subject to laws, policies, and guidelines posted for VA staff members. There are infrequent times in which this guidance can change during a training year which may create new requirements or responsibilities for HPTs. If employment requirements change during the course of a training year, HPTs will be notified of the change and impact as soon as possible and options provided. The VA Training Director for your profession will provide you with the information you need to understand the requirement and reasons for the requirement in timely manner.

HPTs directly paid by VA are appointed under authority 38 USC 7405 subsection (a)(1) for a temporary period, not to exceed one year (2080 hours or less). All direct VA-paid HPTs, to include interns, residents, fellows, externs trainees, and students, shall be appointed in one-year intervals, renewable on an annual basis for no more than three years. Refer to the Paid AH and Nursing HPT Appointment Schedule Guidelines for updates.

a. *A Trainee Qualifications and Credentials Letter (TQCVL) is required prior to all initial and subsequent HPT appointments.*
b. *HPTs appointed for 90 days or more and who participate in training a minimum of 130 hours per month mee the eligibility requirements for Federal Employee Health Benefits (FEHB). HPTs can enroll in FEHB on their first day at VA and be covered by the first pay period. If there are additional questions, please contact your local HR staff.*
   Resources for Health Professions Trainees Coming to VA | Eligibility and Forms - Office of Academic Affiliations

See https://www.psychologytraining.va.gov/docs/Trainee-Eligibility.pdf for a full description of eligibility criteria (Am I Eligible? Checklist for VA HPTs).

The Department of Veterans Affairs is an Equal Opportunity Employer. Women and minority applicants are particularly encouraged to apply.

Application Packet

1. A Vita;
2. A letter of interest outlining training goals for the postdoctoral residency year and detailing future professional goals;
3. A letter from the Internship Training Director describing the clinical experiences and overall performance of the applicant during the internship year. (Successful completion of an APA, CPA accredited internship – or VA sponsored internship -- prior to the post-doc is required, and this letter should state if successful completion is expected.);
4. Some demonstration that the doctoral degree has been obtained from an APA accredited doctoral program or that the applicant will graduate prior to the beginning of the residency year (if all doctoral requirements are completed prior to the beginning of the post-doc, and the applicant will be awarded the doctoral degree within 4 months of the beginning of the post-doc, and the Graduate Training Director documents this in writing, then the applicant will be considered to have met this requirement); completion of the standard APPCN doctoral verification satisfies this requirement.
5. Three or more other letters of recommendation, one of which must be from an internship supervisor; and
6. A brief (one paragraph minimum) statement detailing your experiences with and/or commitment to diversity.

Applications packets and letters of recommendation must be submitted electronically via the APPIC site: https://appicpostdoc.liaisoncas.com/applicant-ux/#/login

Questions to:

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Mental Health and Behavioral Sciences (116A)
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Phone: (813) 972-2000 x 6650
Email: Joel.Kamper@va.gov

Application packets must be complete by December 15. Earlier submissions are preferred.

SELECTION PROCEDURES

We have four postdoctoral residents and two openings per year. Each resident completes two full years. Application materials will be reviewed for completion. A selection committee composed of post-doctoral rotation supervisors and current residents will review and rank order all completed applications. Offers will extended via email to top candidates to participate in **virtual interviews**. The structured interviews are conducted by two faculty members and one current resident, and typically last 30-45 minutes. During the interview, applicants are asked to respond to general questions related to their prior experience, training, diversity, and career goals. In addition, applicants are asked to respond to 1-2 performance-based interview questions. All interviews will be completed ahead of the INS February meeting. Due to COVID-19, we cannot accommodate requests for on-site visits for the 2021-2022 application cycle. While not conducting formal interviews at INS, staff are available for 1:1 meetings if desired by an applicant, and our postdocs typically host a program Q&A which is available but not mandatory.

We know that finding the right fit is important, both for us as a program but also for you as an applicant. We also believe that participation in the APPCN Match is the fairest way for you as an applicant to consider your fit with potential programs. As APPCN members, we agree to abide by the rules of the match. However, we strongly encourage interested applicants who receive preemptive offers outside of the match to contact Dr. Kamper for information on their standing, including up to the possibility of a guaranteed match.

Please note that the residency program is available only to U.S. citizens who have graduated from a APA-, CPA-, or PCSAS-accredited graduate psychology program and completed an APA- or CPA-accredited, or VA-sponsored internship program. We strongly encourage applications from candidates from underrepresented groups. The Federal Government is an Equal Opportunity Employer. The United States Government does not discriminate in employment on the basis of race, color, religion, sex (including pregnancy and gender identity), national origin, political affiliation, sexual orientation, marital status, disability, genetic information, age, membership in an employee organization, retaliation, parental status, military service, or other non-merit factor.

Our program has a strong commitment to, and interest in, diversity issues. Our diversity training has several arms: 1) a bi-weekly diversity seminar that follows a format of a 'lunch and learn' focused on

discussion/experiential process of diversity issues, which is overseen by a diversity planning committee; 2) integration of diversity topics on rotations with a focus on discussion of diversity topics/research within that area of practice; and 3) a focus on recruitment and retention of diverse trainees and staff. In addition, the MH&BSS has a multidisciplinary Diversity and Inclusion Committee that provides diversity training, peer consultation & support, hiring/retention consultation, and dissemination of diversity-related information to the Service. As part of our selection process, we also evaluate each candidate's provided response regarding their experiences with diverse populations and commitment to diversity/inclusion.

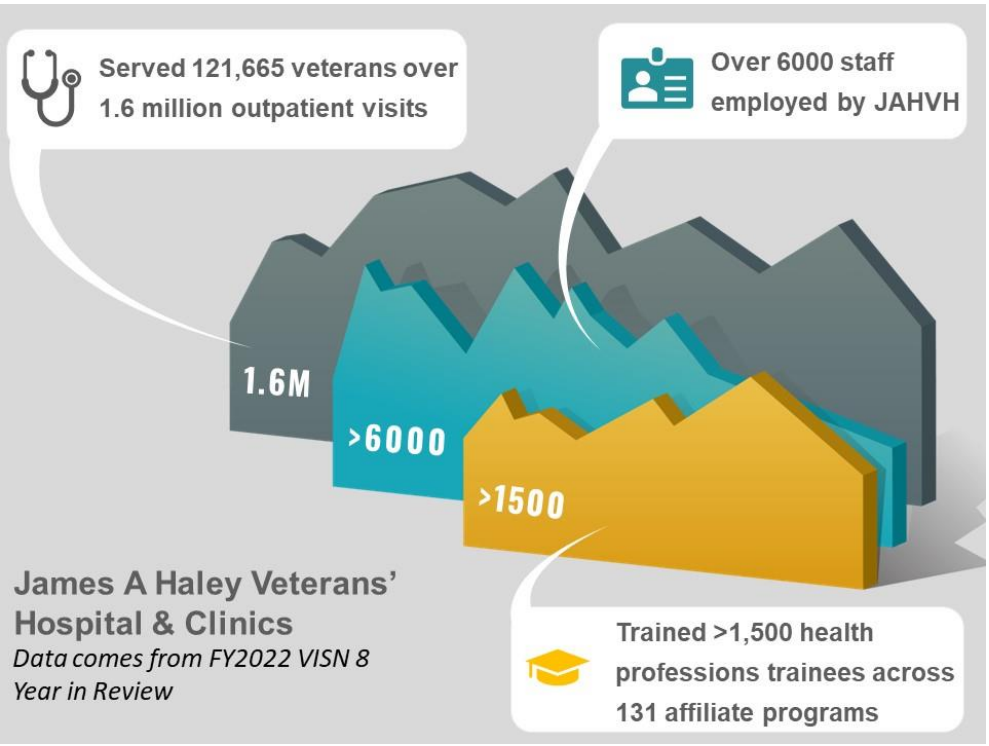
Program Setting

JAMES A. HALEY VETERNS HOSPITAL

The James A. Haley Veterans' Hospital (Tampa VAMC), a JCAHO accredited hospital, is a 415 bed Level 1a facility that provides comprehensive inpatient, primary, secondary, and tertiary care in medical, surgical, neurological, rehabilitation, and short-term psychiatric modalities; primary and specialized ambulatory care; and rehabilitation nursing home care through its 118 bed nursing home care unit.

Specialized programs are offered in treatment of chemical dependency, post-traumatic stress, comprehensive rehabilitation, and women's health. The hospital is one of five VA Polytrauma centers. The Tampa VAMC also has an established Clinical Center of Excellence in Spinal Cord Injury/Disease, ALS, and MS. In addition, the medical center has six outpatient clinics that are located in New Port Richey, Brooksville, Lecanto, Zephyrhills, Lakeland, and Riverview. Our medical center provides healthcare services to Veterans and TRI-CARE patients in central Florida. The medical center is one of the busiest in the VA healthcare system of 150+ hospitals, treating 10,534 inpatients and providing 450,187 outpatient visits.

The facility has a national reputation for excellence. In 1997, the hospital was awarded the Robert W. Carey Award for quality as well as the National Partnership Award for staff/leadership relationships. In 1998, we received a Merit Achievement for the President's Quality Award. These are the highest awards bestowed upon a VAMC.



The medical center is affiliated with the University of South Florida (USF) and its College of Medicine. The university is the 16th largest educational center in the nation and provides all facilities and resources typical of a large metropolitan university. The medical center's dynamic and progressively expanding postgraduate teaching program encompasses most of the healthcare specialties. Approved programs are conducted in Audiology and Speech Pathology, General Surgery, Internal Medicine, Neurology, Nursing, Ophthalmology, Orthopedics, Otolaryngology, Psychiatry, Psychology, Radiology, Pathology, Social Work, and Urology.

PSYCHOLOGY SERVICE

The Psychology Service is comprised of over 120 doctoral level psychology staff representing a variety of theoretical orientations and specializations. Psychologists have major leadership roles within hospital clinical and research programs and have recognized national expertise and leadership within VHA as well as state and national psychology organizations. Many staff hold faculty appointments at the nearby University of South Florida. Staff psychologists have authored textbooks, written numerous professional articles, and developed or helped develop prominent psychological tests. In addition, psychologists have served on national VHA Work Groups, Polytrauma Task Forces, and QUERIs.

Seventeen doctoral level psychologists are involved in the neuropsychology residency, of these 14 are potential primary or secondary rotation supervisors, 6 have a diplomate in clinical neuropsychology (ABPP-CN), and 1 has a diplomate in rehabilitation psychology (ABPP-RP).

In addition to our American Psychological Association (APA) accredited two-year neuropsychology postdoctoral residency program (four residents), we also have an APA accredited psychology internship program (eight interns), a two-year Rehabilitation Psychology Postdoctoral Residency (2 residents) and a Clinical Psychology Postdoctoral Residency with emphases on pain/psycho-oncology (2 residents), health (2 residents), trauma (2 residents), and community-based (2 residents) psychology.

TRAINING MODEL AND PROGRAM PHILOSOPHY

Our philosophy is that sound clinical practice is based on scientific research and empirical support. Our training model is the Scientist-Practitioner Model of Training – research and scholarly activities inform and direct clinical practice, and clinical practice directs research questions and activities.

PROGRAM GOALS AND OBJECTIVES

The primary goal of the program is to train residents who will become licensed psychologists prepared to assume positions in public sector medical center settings serving specialized patient populations with neurological conditions. Residents completing the program should have solid foundational preparation to initiate ABPP certification in Clinical Neuropsychology. The neuropsychology program is designed to be consistent with recommendations of the 1997 Houston Conference for Training in Clinical Neuropsychology. These overall training goals are consistent with our program's and the VA's mission to provide training and research opportunities which further the quality clinical care of veterans with these important needs.

Our expectation is that our residents will become licensed psychologists. In pursuit of its primary goal, the training program is designed such that ten primary practice competencies are pursued. Specifically, residents are expected to achieve competency in: 1) Integration of Science and Practice; 2) Ethical and Legal Standards/Policy; 3) Individual and Cultural Diversity; 4) Professional Identity & Relationships/Self-Reflective Practice; 5) Interdisciplinary Systems/Consultation; 6) Assessment; 7) Intervention; 8) Research; 9) Teaching/Supervision/Mentoring; and 10) Management/Administration.

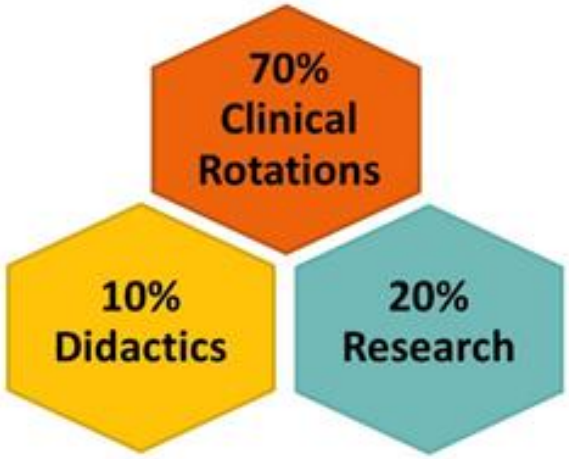
The Psychology Service plays an integral role in the hospital's training function. The hospital and the Psychology Service are pleased to have the opportunity to contribute to the professional development of interns and residents. Their presence stimulates and enhances our services to the thousands of patients who are entrusted to us for effective and caring treatment. In return, we believe that the rich training experience at our hospital, and at our affiliated institutions, will make a vital contribution to your professional growth and development.

The psychology staff regards the training of new psychologists as a serious responsibility, and this is demonstrated by a commensurate investment of staff time and energy in all facets of the training program. The didactic and clinical experiences of this program are designed to facilitate the professional attitudes, competencies, and personal resources essential to the provision of high quality patient care in contemporary psychology service settings. As mentors, psychology staff members demonstrate, and encourage resident participation in, the professional roles of clinician, consultant, team member, supervisor, evaluator, and researcher. The professional growth and development of residents is enhanced by consistent supervision, varied clinical responsibilities with diverse patient populations, and ongoing didactic training.

Program Structure

TRAINING PLAN

An orientation period serves to familiarize residents with the Medical Center, the various treatment units, and the staff psychologists and their various roles. During this time, residents attend VA required New Employee Orientation sessions and also visit potential rotation sites and supervisors. Following the orientation period, the resident is requested to prepare his/her own training program proposal. The proposal indicates the rotations desired, research ideas and projects, didactic activities desired (above and beyond the required didactics), etc. The Director of Training and/or Assistant Training Director reviews the proposal with the resident, taking into account the resident's prior experience and professional goals. When mutual agreement is achieved concerning the plan, it is reviewed with the Neuropsychology Postdoctoral Training Committee for approval. Residents may request training plan changes at any point during the program through the Director of Training. In order to offer each resident maximal exposure to a variety of patients and settings, training plans may allow rotations through a variety of service and training areas.



There are four major components to the training program:

(a) clinical rotations
(b) didactic seminars
(c) training in supervision
(d) ongoing research activities

The clinical rotations allow practical application of past skills, current and prior didactic instruction, and ongoing competency development in assessment, intervention, and consultation, and the impact of ethics, law and human diversity issues on these professional activities. The didactic seminars are designed to provide an advanced level of training in neuropsychological and psychological assessment, interventions, advanced multivariate statistics, ethics, law, and human diversity issues. Postdoctoral residents also play an active role in providing first line supervision and training to psychology interns, under the overall supervision of their clinical rotation supervisor(s). This allows hands-on professional development in the areas of supervision and teaching, and furthers their professional development and sensitivity to ethical, legal, and human diversity issues. In addition, neuropsychology postdoctoral residents are responsible for co-teaching portions of a neuropsychology seminar in which they provide didactics well as arrange for others to present on selected topics. Again, this helps further their professional development in the area of supervision/teaching. Finally, research and scholarly activities are developed through required participation in a variety of research studies and involve critical literature reviews, statistical and methodological sophistication, and scholarly manuscript preparation.

ROTATIONS

During the two-years of training, residents complete four 6-month clinical rotations. In addition to the clinical rotations, residents attend training seminars and participate in research activities.

The Neuropsychology Residency requires that the resident complete 1) the Inpatient Clinical Neuropsychology (Acquired Brain Injury) rotation and 2) the Memory Disorder Clinic / General Outpatient Neuropsychology rotation. The third and fourth rotations may be selected from other rotation offerings, but must be approved by the Neuropsychology Postdoctoral Training Committee according to the resident's training needs and goals. Residents may complete one off site (non-VA) rotation among the available rotations.

Availability & Timing of Rotations

Residents normally complete their required 6-month rotations during the first year. The sequence for their remaining rotations will be mutually determined by them and the Neuropsychology Postdoctoral Training Committee on the basis of availability during a given rotation period.

DIDACTIC SEMINARS

The development of clinical skills requires not only day-to-day patient contact but also ongoing didactic training. To accomplish this, the neuropsychology postdoctoral training program includes seminars which focus on theoretical as well as applied aspects of clinical work. Regular attendance at two year-long seminars is required for all residents: Neuropsychology Postdoctoral Seminar and Professional Development Seminar. Participation in Diversity seminar is strongly encouraged. Residents are also welcome to participate in the seminar series offered to the psychology interns which include a Fundamentals of Neuropsychology Seminar (required for residents who have not completed it previously) and a general Assessment Seminar. Dementia Boards, USF Medical School Psychiatry Grand Rounds, USF Department of Psychology Seminar series, brain cuttings, and additional didactic opportunities are also available.

RESEARCH

A number of Psychology Service staff maintain active involvement in clinical research, provide research consultation to other services within the VA and at the University of South Florida, serve on VA and USF research committees, provide reviews for a wide variety of professional journals, and serve on journal editorial boards and grant application review committees.

Residents are required to demonstrate competence in methods of scholarly inquiry by conducting and/or participating in a research project(s) within their special focus area. Residents are expected to participate in at least one research project. At a minimum, residents submit a scientific presentation to some annual professional meeting such as ACRM, APA, INS, NAN, AACN, American Pain Society, ASCIP, etc. Typically, these are then submitted to a journal for possible publication. Development of a grant proposal and submitting it for funding would also meet the research requirement. Residents wishing to do more are encouraged to do so. Several staff members are actively involved in funded research projects providing role models, research opportunities, supervision, and training for residents. Residents receive ongoing didactic seminars that integrate the scientific literature with their clinical case material and receive regular feedback on their developing competencies in critically reviewing, utilizing, and conducting scientific research.

Participation in research is an expected part of the postdoctoral years. Protected research time is available, with most residents having a 10% carve out. However, the amount of time approved is contingent on the needs of the active project, and requests for up to 20% protected research time will be considered.

DIVERSITY EXPERIENCES

In order to be responsive to our diverse patient population, we need to be fully responsive to and inclusive of diverse and capable staff and trainees. The James A Haley Veterans' Hospital Psychology Training Programs affirm our welcome of staff and trainees along the full spectrum of individual differences. We are committed to engaging individuals of historically under-represented backgrounds within our program. We have a diversity seminar planning committee within the psychology service that provides information and "lunch and learn" activities to trainees and staff alike on various topics related to diversity. The Diversity "Lunch & Learn" Seminar, hosted by the Psychology Diversity Planning Committee, provides an opportunity for trainees to learn about diversity issues that may not be commonly experienced in clinical rotations or seminars. Lunch & Learn topics have included mental health issue in Latinx individuals, mental health needs and barriers to treatment in transgendered individuals, and privilege and its effect on care delivery. We demonstrate respect and understanding of diversity via training we provide, including covering diversity issues in individual supervision, journal readings, etc.

Within the MH&BS Service, a Diversity and Inclusion Committee has been formed with multiple foci: addressing ongoing training needs of staff in the areas of diversity, equity, and inclusion; providing a safe space to have difficult discussions around diversity, equity, and inclusion; improving hiring and retention of diverse staff, dissemination of diversity-related information, and improving diversity-sensitive care for veterans. We have several staff members who have specific interest in mentoring multicultural, ethnic/racial and/or LGBT trainees. We also have staff who have clinical caseloads consisting of primarily Hispanic patients (Spanish speaking), LGBTQ patients, and transgender patients. Several staff also offer training opportunities related to working with individuals with physical disability. We have staff who belong to the hospital's LGBTQSA committee. Here is information on our hospital's LGBTQSA Emphasis Program: https://www.tampa.va.gov/services/lgbtqveterans.asp. Its mission is to identify and address barriers, stereotypes, and other related issues in the workplace, foster allies, increase awareness of health care issues, and advocate for a caring, respectful and welcoming environment for our LGBT Veterans, family members and employees. We have staff who have completed specialized training to work with transgender patients (SCAN-ECHO).

The James A Haley Veterans' Hospital similarly values diversity in trainees and has several programs/initiatives to honor the diversity of our hospital staff. To this end, the hospital has established policy on promoting and honoring diversity and has developed a Diversity Inclusion & Advisory Council comprised of a Chair, Vice Chair (Hospital Associate Director); the EEO Manager, Cultural Competency Coordinator and the following Special Emphasis Program Managers: Federal Women's; Asian American/Pacific Islander Program; Hispanic Employment, African American Employment, Native American Employment, Persons with Disability Employment Program and the Lesbian, Gay, Bi-Sexual, Transgender, Queer, Straight Ally Program (LGBTQSA). The Council reviews and evaluates proposals and planned Special Emphasis Program Observances activities. The Diversity Inclusion & Advisory Council ensures that the specific planning events and activities are addressed as well as to include EEO & Diversity Inclusion training. Observance events include the African American/Black History Month (February 1-29), Women's History Month (March 1-31), National Disability Employment Awareness Month (October 1-31), Asian Pacific Heritage month (May), Native American Heritage Month (November)

and LGBT Pride (June). Participation in the SEP observances benefits employees through increasing their personal awareness and developing cultural competencies throughout the year. The goal is to sustain a productive, diverse, and engaged workforce through our commitment to enhance employment, training and career advancement opportunities; allowing us to provide outstanding service to Nation's Veterans and their families. The JAHVH is also proudly one of 96 VA facilities to achieve the Human Rights Campaign's Healthcare Equality Index Leader status since 2013, proving that it promotes an equitable and inclusive care environment for LGBT patients, their families, and employees.

SUPERVISION RECEIVED

In helping residents acquire proficiency in the core competency areas, learning objectives are accomplished primarily through experiential clinical learning under the supervision and mentoring of licensed psychologists. All work performed by residents during the year must be under the supervision of a licensed psychologist. Essentially, residents are involved in the day-to-day demands of a large psychology service. Residents work with and are supervised by psychologists who serve as consultants to medical staff members or who serve as members of multidisciplinary teams in treatment units or programs. As a consultant or team member under supervision, the resident's core competencies are developed and the resident learns to gradually accept increasing professional responsibility. The residency is primarily learning-oriented, and training considerations take precedence over service delivery. Because residents enter the program with varying levels of experience and knowledge, training experiences are tailored so that a resident does not start out at too basic or too advanced a level.

Residents receive a minimum of two hours of supervision each week; however, typical supervision includes 2-3 hours on their rotations and 1-2 hours from other activities (e.g., group supervision, supervision of research). Rotation supervision is dyadic supervision of a clinical nature and includes discussion and development of core competency areas. Complementing basic supervision, through the process of working closely with a number of different Psychology Service supervisors, residents are also exposed to role modeling and mentoring on an ongoing basis. In addition to the above supervision, residents also receive didactic seminar presentations on topics related to their training.

TIME COMMITMENTS

The postdoctoral residency is a minimum of 40 hour per week. Typically, residents have 3-4 hours of supervision as part of their rotation, research, and group supervision. If they pick up therapy cases in addition to their rotational responsibilities, they will typically have an additional hour of weekly supervision.

Training Experiences

ROTATION DESCRIPTIONS

The following is a description of each major rotation available to residents. Other training experiences can be structured specific to the particular interests of a resident depending on availability at the clinical site, availability of adequate supervision, and approval by the Neuropsychology Postdoctoral Training Subcommittee and the Training Committee.

First Year Rotations (both are required)

Inpatient Rehabilitation Neuropsychology (Acquired Brain Injury)
Memory Disorder Clinic / General Outpatient Neuropsychology

Second Year Rotations (choose 2)

Vulnerable Populations & Applied Ethics
Medical Neuropsychology
Polytrauma Transitional Rehabilitation (PTRP) Neuropsychology
Spinal Cord Injury/Disorders Rehabilitation (including ALS and MS)
USF Neuropsychology / Epilepsy and Forensics

INPATIENT REHABILITATION NEUROPSYCHOLOGY – Acquired Brain Injury

Supervising Psychologists: Tracy Kretzmer, Ph.D., ABPP-CN & Thomas M. Oswald, Psy.D.

This inpatient rotation involves participating in an interdisciplinary approach to assessment and rehabilitation of individuals with a history of acquired brain injury, including TBI, stroke, and anoxia. Two units will be covered:
POLYTRAUMA UNIT: This 18-bed, locked unit provides rehabilitation services to veterans as well as active-duty service members who have recently acquired significant brain injuries, typically moderate to severe TBI (including disorders of consciousness), stroke, or anoxic injury. The unit also provides services to individuals with significant polytrauma injuries with or without a comorbid head injury. Individuals are occasionally admitted to the unit while recovering from brain tumor resection, viral encephalopathy, and seizures. Cases on this unit are typically more acute and/or more severe in nature resulting in longer lengths of stay compared to general rehabilitation units. Tampa VAMC is one of the five primary TBI and Polytrauma rehabilitation centers within the VA Polytrauma System of Care, which results in admissions from throughout the southeast in addition to service members from Walter Reed National Military Medical Center, Tripler Army Medical Center, and military hospitals abroad. These primary sites are also involved in a Department of Defense funded TBI program (TBICoE; see website at Traumatic Brain Injury Center of Excellence | Health.mil) and with TBI Model Systems (research).

GENERAL REHAB UNIT: This is an 18-bed unit that admits a wide variety of medical populations for needed rehabilitation due to functional limitations as a result of cardiac conditions, amputations, orthopedic injuries, or other medical conditions that have left them debilitated/deconditioned (e.g., COVID-19). While medical diagnoses are diverse, the majority of patients are male veterans ranging in age from 50-80 years old. Average length of stay is 3 weeks.

General clinical referrals on these units typically result in an assessment of cognitive and behavioral deficits resulting from brain dysfunction, the residual cognitive strengths for rehabilitation and vocational planning purposes, and personality and emotional adjustment issues that may impact treatment participation. Interview and assessment ranges from 1- 5 hours, and varies depending on the patient's injury severity and time since injury. Assessments can range from a brief assessment of orientation (serially tracking delirium/PTCS) to comprehensive neuropsychological evaluations. Team neuropsychologists are also asked to complete capacity evaluations. Commonly employed test measures include: selected WAIS-IV subtests, O-LOG, COG-LOG, California Verbal Learning Test-III, Brief Visuospatial Memory Test – Revised, subtests from the Delis-Kaplan Executive Function System, Rey-Osterrieth Complex Figure, Trail Making Tests, RBANS, NAB modules, and Behavioral Neurology tasks. Trainees are challenged to utilize creative ways to assess cognitive functioning, given many patients have significant motor and sensory limitations that prevent them from completing many standardized measures. Cognitive and behavioral assessments that include both qualitative and quantitative data ("process") are key to inpatient evaluations and case conceptualizations. Residents will routinely conduct

capacity assessments, often in areas of medical decision making to help team, patient and family members with safe discharge planning.

Residents are expected to complete one to three evaluations each week while also maintaining a limited caseload of patients needing psychological support/intervention. This involves reviewing the chart for relevant history, conducting a careful clinical interview, noting relevant behavioral observations, choosing appropriate testing measures, conducting the neuropsychological evaluation, scoring using age-and-education-adjusted norms, interpreting results, incorporating functional neuroanatomy, and writing integrated reports with appropriate recommendations to help improve the patient's ability to succeed during his/her inpatient stay and upon return home. Report styles vary from comprehensive to more succinct, especially given the notable change patients often demonstrate during the acute recovery phase. Turn-around time for evaluations and reports is typically expected within 48-72 hours.

As patients may also struggle with mood disorders or difficulties with adjusting to their injuries, providing support and psychological interventions are also a part of the resident's professional role on these units. Co-leading weekly group therapy, providing individual intervention, and attending unit recreational outings will also be part of the resident's responsibilities. Rehab neuropsychologists are also asked to provide assistance with behavioral management, as patients may struggle with agitation, apathy, anosognosia, confusion, and/or disinhibition that can negatively impact rehab care. As with an interdisciplinary team, interacting with colleagues in other rehab disciplines, including ensuring open communication, developing appropriate treatment plans, and assisting with improved treatment engagement is integral to this rotation. Additional responsibilities and skill development include: 1) Providing feedback and psychoeducation to patients and family members, 2) Attend and lead Inpatient Rehab Journal Club, 3) Attend weekly interdisciplinary treatment team meetings, 4) Supervise interns, 5) Co-treatment with rehab providers to help facilitate participation, and 5) Program Development.

Training objectives: By the end of the rotation the resident will be able to:

1. State the rationale underlying the selection of various neuropsychological tests and other assessment methods for use with individuals with ABI.
2. Perform neuropsychological evaluations utilizing standardized instruments in a flexible-adjusted, clinically-guided approach, and incorporate "process" observations into the interpretive endeavor.
3. Produce a journeyman's quality written, integrated neuropsychological report that provides functional and practical information to the rehabilitation team and includes appropriate recommendations.
4. Understand the course of recovery from ABI and be able to identify factors that can negatively or positively impact that course. Identify and grade TBI severity using commonly utilized measures and track recovery milestones (i.e. recovery from PTA, Rancho Scale, GCS, TBI severity).
5. Identify and describe common neurobehavioral syndromes or clinical problems that occur in individuals with ABI.
6. Cite the major literature on common cognitive, behavioral, emotional, personality, and psychosocial issues related to ABI.
7. Function effectively as a consultant to other health care providers in relation to cognitive, behavioral, social, and emotional issues associated with ABI.

MEMORY DISORDER CLINIC / GENERAL OUTPATIENT NEUROPSYCHOLOGY

Supervisory Psychologists: Jessica Vassallo, Ph.D., ABPP-CN & Erin Bailey, Ph.D., ABPP-CN

The role of the neuropsychologist and post-doctoral resident in this rotation is to provide a variety of assessment and consultation services. The neuropsychologist and postdoctoral resident attempt to determine the cognitive and behavioral deficits resulting from cerebral dysfunction secondary to disease or injury. An assessment is also made of cognitive strengths so that such information can be utilized in rehabilitation and future vocational or placement planning. This is accomplished by the rational, selective use of a variety of neuropsychological evaluation procedures (see below) as well as test instruments for personality assessment (e.g., Beck, MMPI, Geriatric Depression Scale). The general purpose of such evaluation is to determine potential disruption of general cognitive and behavioral function secondary to neurologic disease; identification of specific neurobehavioral deficits, and identification of critical areas of dysfunction which relate to rehabilitation potential. Specific questions addressed in consultation requests include (but are not restricted to) the following:

1. Documentation of symptoms in diagnosed neurological disease.
2. Issues of competency.
3. Delineation of vocational disabilities.
4. Differentiation of neurobehavioral and psychiatric disorders.
5. Differential diagnosis of dementia and pseudodementia.
6. Rehabilitation/treatment planning.

The key training emphasis on this rotation is on a process-oriented, flexible/adjustive approach to neuropsychology in contrast to the fixed battery approaches. In this approach test instruments are selected to provide cognitive ability data relevant to the specific hypotheses formulated for the individual case. Commonly employed procedures include selected WAIS-IV subtests, tests of language ability, learning and memory tests, tests of visual-spatial competency, executive functioning tests, and other selected procedures and tests as indicated. Residents are expected to complete or supervise an average of 4-6 evaluations and reports each week. These will include comprehensive evaluations; however, residents may also supplement with memory screening evaluations. Residents will also attend clinic case conference, weekly journal club and other presentations pertinent to neuropsychology services.

Rotation Learning Objectives: By the end of the rotation the neuropsychology resident will have:

1. Demonstrated a thorough knowledge of standardized neuropsychological evaluation procedures by stating rationale for selection of measures of intelligence, concept formation, language/aphasia, learning and memory (verbal, visual, and remote), visual-perceptual-spatial ability, executive functioning, and sensorimotor ability. The emphasis is on a core evaluation with flexible-adjustive exploration of specific neurobehavioral syndromes.
2. Demonstrated the ability to identify and describe common neurological disorders, provide brief screening evaluation procedures, and navigate the interface of psychiatric/neurologic disease by producing clinically sound conceptualizations and interpretive statements that take into account potential rule-out conditions.
3. Developed knowledge and experience in serving as consultant to various services and departments within the healthcare settings by consistently producing concise, integrated neuropsychological reports that include diagnostic impressions, prognostic indicators, and recommendations for treatment and follow-up.
4. Developed knowledge and experience relevant for maintaining a high-volume neuropsychology consultation clinic well-suited to the VA system of care through executing day-to-day administrative tasks of the clinic.

5. Developed supervisory skills by providing one-on-one supervision throughout the rotation, as available.
6. Demonstrated the interpersonal skills necessary for collaborative endeavors in both clinical and research settings.

VULNERABLE POPULATIONS AND APPLIED ETHICS
Supervisory Psychologists: Erin K. Bailey, PhD, ABPP-CN & Bethan Roberts, PhD

The high benchmark for ethical practice in provision of mental health care, as well as our cognitive and psychological expertise, renders neuropsychologists an invaluable part of the healthcare community. For this reason, neuropsychologists across many practice settings are often asked to speak to cognitive vulnerability and decision-making capacity or weigh in as part of interdisciplinary consultation in ethically ambiguous situations. As such, it is our belief that every resident should emerge from their fellowship with these competences.

This advanced 2nd year rotation requires residents to expand their current skill set to include populations where clinical complexity requires a higher degree of case management. Ethical and legal parameters are discussed in depth with specific emphasis on assessment of decisional capacity and evaluation of vulnerable adult populations. Practical application of ethical principles and patient advocacy will also be discussed relating to broader healthcare contexts, such as healthcare disparities, health literacy, and other socioeconomic and diversity issues. By the completion of this rotation, the resident will have an advanced ability to critically think "outside the box" when faced with clinically or ethically complex situations. Residents will gain practice crafting specialized, patient-centric reports which include necessary elements and verbiage to defend or support conclusions to a wide audience and/or in formal proceedings, if necessary.

Although specifically applicable in medical center and other consultative settings, these transferable skills will elevate trainees' existing clinical repertoire and yield well-rounded future colleagues poised to pursue a vast arrays of employment opportunity in a competitive job market.

Training Model: Training is conducted under a "junior colleague model" where residents are encouraged to be autonomous in advanced decision-making using supervisors as consultants, while still providing occasional opportunities for co-assessment, if desired. Residents will gain experience working with at-risk patients with any combination of cognitive, physical, emotional, or psychosocial vulnerabilities. Cases often include assessment of cognitively vulnerable adults in the context of poor self-care, exploitation, neglect, and/or low health literacy. Due to the unique nature of these patients, this rotation is designed to develop advanced critical thinking skills necessary to assess cognitive functioning in circumstances where traditional neuropsychological measures or norms are not wholly appropriate or available.

Emphasis is placed on the role of neuropsychologists as clinical consultants across inpatient and outpatient settings. As such, this rotation will also provide opportunities for interdisciplinary treatment planning and consultation with related disciplines (i.e., Geriatric Psychiatry, Social Work, Geriatric Medicine, Inpatient Hospitalists). Opportunities to consult to government agencies, such as community circuit courts and Adult Protective Services are available, though case dependent. Lastly, residents will gain experience navigating complex psychosocial systems impacting functional outcomes, such as differing treatment preferences of family members or weighing patient autonomy and confidentiality with family-based decision-making. Residents may engage with family members by providing education,

fostering collaboration and open communication with the medical teams, or consulting in family planning meetings.

Neuropsychological Assessment: The fellow will develop decision-making skills for complex differential diagnosis and application of relevant recommendations to optimize cognition and quality of life for vulnerable populations. Evaluations will frequently address elements of capacity and decision-making across various cognitive/medical/lifestyle domains – often in ethically complex, or ambiguous situations. Typical referral questions include differential diagnosis of dementia, severity and staging of impairment for neurodegenerative and other cognitive disorders, comprehension of medical treatment and compliance issues, functional prognosis and recommendations for long-term care/placement, ability to live independently, financial exploitation, abuse/neglect, etiology of behavioral disturbance, and other modifiable factors affecting cognition (e.g., delirium/encephalopathy, polypharmacy, mental health diagnoses, sleep issues, etc.). Testing batteries are tailored to each patient and, in cases where appropriate norms are insufficient, emphasis is placed on elucidating clinically meaningful information from interviews, behavioral observations, and other collateral sources. To this end, the advanced resident serves as an "investigator" of cognitive and functional status, as opposed to merely an evaluator.

Intervention: The role of intervention in this rotation is flexible and will depend upon the trainee's needs and interests. Fellows have the unique opportunity to work alongside an interdisciplinary treatment team consisting of Geriatric Psychiatry and Psychology staff and medical residents. Patients residing in the Community Living Center (CLC) tend to be medically compromised, often with psychiatric and/or cognitively comorbidities. Therapeutic intervention opportunities may include brief therapy with patients and families and treatment planning meetings.

Interventions will focus on a variety of presenting problems regarding behavioral medicine, health, and psychological intervention, including using neuropsychological assessment to inform psychological treatment, as well as environmental supports during and after discharge. These may include insomnia treatment, psychiatric disturbance (e.g., depression, anxiety, adjustment difficulties), end of life issues, implementation of strategies to improve cognition and daily functioning, etc.

Clinical Settings: As this is an advanced rotation designed to promote independent practice, the selection of patient populations of interest and types of evaluations will be flexible, diverse, and determined by the interests of the trainee. The resident will take on an autonomous role in covering all clinical needs (e.g., selecting the types of cases, scheduling patients, collaborating with referral sources, feedback to patients and families).

Residents can expect a clinical caseload equaling that of an independent licensed provider, averaging ~24-30 hours of clinical time (~12-15 hours F2F) per week across both outpatient and inpatient settings. These include:

- Medical Inpatient Consultation-Liaison Neuropsychology service
- Outpatient Neuropsychology/Memory Disorders Clinic (MDC)
- Community Living Center (CLC) & Geropsychology
- Consultation to Geriatric Medicine, Geriatric Psychiatry, and Inpatient Hospital teams
- Acute Recovery Center (ARC)
- Liaison to Social Work and other government agencies (e.g., APS) when necessary

Mandatory Rotation Activities: In addition to clinical care and programmatic requirements:

- Residents will spend a minimum 2 hours per week in specialized didactics on a broad range of topics including diversity factors in patient care, patient advocacy roles, issues surrounding resource allocation and healthcare access, and the interplay of moral judgements and clinical constraints. Literature on decision-making capacity, relevant legal statutes (e.g., guardianship, power of attorney), clinical ethics, or assessment of vulnerable adults will be discussed. Cases are often used to supplement journal club readings and illustrate application of ethics and advanced assessment skills.

    ❖ Rotation VP Journal Club (Mandatory): Mondays 10am
    - Topics may include: psychosis and other behavioral disturbance in dementia, considerations for report writing, addressing questions of decision-making capacity, assessing risk for exploitation, diversity factors in healthcare systems

    ❖ Rotation Ethics Rounds (Mandatory): Every other Friday 11am
    - Weekly discussion may include: Case vignettes, relevant federal or state legislature, clinical ethical dilemmas, morality in healthcare practice, health disparities, and public policy

- Residents are required to attend care planning meetings on the CLC. Additionally, family meetings for CLC patients are scheduled on an as-needed basis, but are also considered mandatory for residents in order to provide comprehensive patient care.

    ❖ CLC Sitting Rounds (Mandatory): Weekly, Wednesdays 9:30am-10:15am

- CLC Scheduled Family Meetings, as indicated on a case-by-case basis

Optional Didactics: As time allows, residents are invited to attend other programmatic and departmental didactics, including those listed below.

- CLC Walking Rounds: Weekly, Wednesdays 8:30am-9:30am
- CLC Care Planning Meetings: Weekly, Wednesdays 10:15am-12pm
- Geriatric Grand Round Series: Weekly, Fridays @ 1:00pm
- Dementia Boards: Monthly, 2nd Friday @ 1:00pm
- Medical Neuropsychology Rotation Journal Club: Weekly, Wednesdays @ 11:00am.
- JAHVH Ethics Committee meetings, when available

Professional Development: In addition to refinement of the advanced resident's confidence in clinical and ethical decision-making, an emphasis will be placed on development of one's professional identity as a neuropsychologist and interdisciplinary provider. This rotation strives to provide a welcoming environment that encourages discussion of clinical and overarching professional issues. If desired, trainees can receive guidance and mentorship for EPPP, ABPP, and/or employment preparations, including job search, applications, interviews, and contract/salary negotiation.

Rotation Goals: To produce independent neuropsychologists who can:

1. Competently use neuropsychological theory and assessment to go beyond diagnostic utility and extrapolate real world application from testing data.

2. Develop consultation/liaison skills across inpatient and outpatient settings. Function as useful clinical consultants in complex cases and help guide referring providers, interdisciplinary teams, and families to patient-centered outcomes.
3. Conduct targeted clinical assessments of decisional capacity with consideration of appropriate legal and ethical statutes.
4. Expertly assess complex patients in ethically ambiguous situations to promote patient safety and quality of life.
5. Obtain targeted differential diagnosis and provide prognostic information to patient/families/medical teams in clinical situations where etiology is often multifactorial.
6. Extract meaningful data from alternate sources, in additional to traditional testing data, to provide more robust evaluations of cognitive and functional status.
7. Discuss contributors to behavioral disturbance, treatment non-compliance, and modifiable factors impacting cognition and be able to give useful recommendations for management of such.
8. Identify unique considerations when working with vulnerable populations.
9. Identify ethical dilemmas and apply ethical standards of care.
10. Develop advanced communication and consultation skills necessary when presenting neuropsychological findings/conclusions in interdisciplinary or medico-legal settings.
11. Develop advanced working knowledge of the current literature and specific topics of interest, e.g., decision-making capacity, vulnerable adults, etc.
12. Increase familiarity and applicability of APA Ethical Principles of Psychologists and Code of Conduct

MEDICAL NEUROPSYCHOLOGY

Supervisory Psychologist: Joel E. Kamper, Ph.D., ABPP-CN

The Medical Neuropsychology rotation is an advanced rotation designed to provide 2nd-year residents with greater ability and autonomy in working with medical populations and interfacing directly with physicians and other healthcare providers. The rotation encompasses both inpatient and outpatient components, which gives residents exposure to the breadth of settings likely encountered in a typical staff position. This rotation has 3 main foci: 1) Development of advanced clinical abilities, including interdisciplinary work in an inpatient medical setting; 2) Preparation for independent practice; and 3) Didactic and extra-clinical professional activities.

In contrast with 1st year rotations, clinical referrals on this rotation prioritize complex presentations, diagnostically challenging cases, and rare diseases. Through these cases, residents are expected to refine their ability to quickly integrate and conceptualize cases using all available data sources, build skill and clinical confidence liaising with other disciplines, honing feedback skills, and efficiently completing administrative tasks (e.g. report writing). When appropriate, direct communication with and delivery of results to referring providers and other healthcare professionals is encouraged. Given the aim of the rotation, development and incorporation of non-standardized assessments (e.g. neurobehavioral exams) into clinical practice is also encouraged.

Clinical experiences include:

1) Outpatient MDC referrals: Cases will be selected from the pool of outpatient referrals with focus/preference given for medically and/or neurologically complex cases. Typical referrals include individuals with complex medical comorbidities, those with overlapping/hard to decipher processes (e.g. dementia due to Alzheimer's disease vs. left TLE) and rare diseases (e.g. Stiff Person Syndrome, Fahr's Disease, etc.).

2) Consultation-Liaison service: Cases will also be selected from inpatient referrals from the medical floors of the hospital and the Acute Recovery Center (ARC, our inpatient psychiatric unit), with preference given to complex or difficult-to-diagnose evaluative questions. Given the fast pace of the medical inpatient setting, training is focused on making clinical decisions/conclusions without the wealth of test data typically available in outpatient settings. Typical referral questions for inpatient cases include: Dementias vs. delirium, decision-making capacity to pursue a desired medical intervention, cognitive ability to live independently, and differential diagnosis or characterization of emergent or rare presentations (e.g. paraneoplastic encephalitis, non-convulsive status epilepticus, antiphospholipid syndrome, etc.). Residents will work closely with C&L Psychiatry on many inpatient cases, including rounding with psychiatry residents and attendings, and doing co-evaluations when appropriate. In all cases, residents are expected to consider the full spectrum of medical/neurological history in their conceptual understanding to gain a richer appreciation for possible etiological considerations (e.g. would past Guillain-Barré syndrome affect cognition?).

A second focus of this rotation is preparation for entry-level specialty practice. To that end, advanced residents are viewed as junior colleagues, and are afforded reasonable flexibility and autonomy in how they arrange their day-to-day activities and manage their work and caseload, with a goal of averaging 28 hours of clinical time per week. This will not only give residents the opportunity to move towards greater independence within the bounds of a supportive training environment, but will also allow for the ability to further refine their individualized approach to neuropsychological practice. Given the complex/atypical nature of many referrals, the rotation is designed to offer a collaborative relationship with the supervisor (e.g. doing co-evaluations for complex inpatients).

A third component of this rotation is didactic and extra-clinical professional activities, including the following:

1) Weekly didactic discussions with the supervisor contingent on the needs and interests of the resident and/or recently seen cases. Available topics include advanced discussion of medical and neurological conditions that impact cognition, professional practice issues, or other topics of the resident's choosing.
2) Learning the nuances of commonly and rare medical comorbidities to improve competence and communication with other providers, with the goal of making the neuropsychology resident a more effective member of the medical team (e.g. learning which chemotherapy agents can cross the blood-brain barrier so as to better collaborate with oncology).
3) Encouragement of autonomy to work directly with medical staff for inpatient referrals with the goal of improving competency as a neuropsychologist embedded in a medical setting.
4) The resident is given reasonable latitude to pursue or schedule other educational opportunities (e.g. special lectures through USF, neurology rounds, observation of TMS or other outpatient procedures) at their discretion.
5) Protected time will also be given for involvement in brain cuttings as they are available, and the resident is encouraged to coordinate directly with the pathology residents and fellows.

6) Other opportunities (e.g. further development of supervision skills, clinical research) may also be available.

By the end of the rotation the advanced neuropsychology resident will have:

1. Developed the ability to quickly and effectively conceptualize cases, as evidenced by provision of an average of ~28 hours of clinical care per week, timely completion of administrative tasks (e.g. report writing), and comfort working in inpatient medical and other fast-paced settings.
2. Demonstrated the ability to integrate and work with physicians and other health care professionals by developing comfort with medical terminology and concepts and providing concise and tailored feedback both in person and in writing.
3. Developed the comfort and flexibility required for an independent neuropsychologist in expert practice, as evidenced by the ability to successfully manage their own time and workload, complete consultation requests in a timely manner, interact with other staff neuropsychologists, and manage administrative demands.
4. Gained exposure to brain cuttings and other educational opportunities to enhance knowledge of brain-behavior relationships.
5. Demonstrated the comfort and ability to collegially interact with neurology and psychiatry residents, as well as other professional colleagues.
6. Demonstrated a working knowledge of behavioral neurology and functional neuroanatomy, and advanced knowledge of neurocognitive and neurobehavioral syndromes through clinical cases and professional activities.

POLYTRAUMA TRANSITIONAL REHABILITATION (PRTP) NEUROPSYCHOLOGY

Supervisory Psychologist: Jennifer Duchnick, PhD, ABPP-RP

This rotation will provide an opportunity for postdoctoral neuropsychology residents to gain: 1) enhanced clinical skills related to assessment and intervention with post-acute polytrauma/brain injury patients; 2) experience with the multiple roles of rehabilitation neuropsychologists, such as team consultation, therapy provision, cognitive rehabilitation, assessment of family needs & provision of feedback regarding cognitive and behavioral functioning to patients and families; and 3) exposure to a holistic model of interdisciplinary treatment. This rotation occurs within the context of the Polytrauma Transitional Rehabilitation Program (PTRP) which is housed in the Physical Medicine & Rehabilitation Service. PTRP is a CARF-accredited interdisciplinary rehabilitation program for Veterans and Active Duty Military who have sustained brain injury. It consists of both outpatient day treatment and a residential program. The day treatment program has been offered exclusively via telehealth (VVC) since 2020. Moderate to severe traumatic brain injury is the most common injury, with many program participants also having sustained orthopedic trauma and/or amputation . Other patients may present with acquired brain injury secondary to stroke, anoxia, disease process, or other causes. Many were exposed to trauma and have related psychological disorders. Patients may also present with comorbid anxiety, depression, substance use, or issues related to adjustment to disability. Primary transitional program goals are to aid participants': 1) return to community living with maximum independence; and 2) return to productive community roles, with an emphasis on work, volunteer, or education programs. Psychoeducation and supportive services are offered to participants' family members.

The PTRP residential treatment is a 10-bed residential unit and treatment space on the hospital campus. This building includes patient residences, treatment clinics, and common areas for patient use. Therapeutic activities are scheduled 5 to 7 days per week, including group and individual therapeutic activities for patients and families. Areas targeted include cognitive skills, functional living skills, home

management skills, community reintegration skills, and management of emotional and behavioral symptoms post brain injury. Therapeutic work/volunteer activities may be available and educational guidance is provided through vocational rehabilitation. The outpatient day program provides virtual activities similar to those of the residential component, with coordinated treatment from multiple disciplines focused on assisting the patient to engage in productive community life with maximum independence. Transitional program psychologists function as members of the interdisciplinary treatment team and provide a full range of psychological and neuropsychological rehabilitation services within both component programs. Participants are typically in their 20s to 50s with acquired brain injuries resulting is significant impairment. Length of time since injury ranges from a few months to multiple years. The mean length of stay is 3-4 months.

At program admission, the psychologists conduct evaluations to help the team conceptualize the nature of cognitive, emotional, personality, and psychosocial issues that may affect the individual's progress in continuing rehabilitation, adjustment to injury, and quality of life issues. The resident will be involved in a mix of general psychological assessment, neuropsychological assessment, and intervention. Neuropsychology evaluations may occur at program admission, discharge, or at periods during the program where updated evaluation of cognitive functioning is useful to inform treatment planning. On average, 3-5 opportunities for neuropsychological evaluation occur per month. These evaluations tend to be brief in nature (typically 3-4 testing hours). Evaluation instruments are selected based on clinical questions and on consideration of the individual's current behavioral repertoire. Recommendations are typically generated to address areas such as: ability to engage in work or volunteer activities, ability to participate in educational activities, capacity for independence with IADLs, or readiness for return to motor vehicle operation. Trainees will gain skill in providing therapeutic feedback to the patient and the family (if applicable), as well as to the rehabilitation treatment team. Psychological evaluations are conducted at admission for every patient, and typically include interview and questionnaire measures. Instruments assessing emotional state and personality/ psychopathology may also be included.

The postdoctoral resident is expected to learn and utilize multiple treatment formats directed toward cognitive rehabilitation, behavioral functioning improvement and psychological adjustment, including individual and group interventions. Intervention with families may also occur. The trainee will be expected to lead or co-lead at least one of the weekly interdisciplinary groups and carry an individual caseload of 2-3 patients. Individual case load will vary depending upon the complexity of the patient/family needs and the time demands of assessment and group involvement. The trainee will lead 1-2 presentations in the Healthy Lifestyles psychoeducational group over the course of the rotation. Involvement in at least one team in-service presentation over the course of the rotation is expected. Opportunities also exist for involvement in co-treatment with other disciplines and for development of programming. At times, opportunities are also available for involvement in supervision of intern trainees.

The resident will learn to function at an increasingly independent level with regards to provision of consultation to other disciplines, coordination of interdisciplinary interventions, and education of rehabilitation staff. Various components of a holistic treatment model will be utilized for case conceptualization, including the focus on the adjustment process and compensatory management of TBI-related cognitive deficits. Pertinent readings will be assigned to further develop the postdoctoral trainee's knowledge regarding neuropsychological and psychological issues associated with the specific patient population served. Participation in monthly journal club is also expected.

By the end of rotation the neuropsychology resident will have:

1. Obtained advanced knowledge of common cognitive, behavioral, emotional, and psychosocial issues related to brain injury and polytrauma, with an increased appreciation of common behavioral manifestations of brain injury symptoms.
2. Demonstrated sound clinical rationale for assessment methods and intervention techniques in postacute brain injury rehabilitation. The trainee will have developed clinical intervention skills specific to the patient population and will have provided interventions with increased independence.
3. Developed familiarity with the multiple roles of a neuropsychologist in a rehabilitation setting.
4. Demonstrated ability to produce integrative written reports of neuropsychological and psychological test findings, with recommendations. The resident will have achieved high-level assessment skills, including test selection, administration, and integration of information from patient report, collateral sources, and the medical record.
5. Demonstrated ability to share findings and recommendations with relevant stakeholders, including patients, family members, and treatment team members.
6. Demonstrated advanced ability in providing consultation to interdisciplinary treatment team members regarding the implications and/or management of cognitive, behavioral, or emotional status of patient.

SPINAL CORD INJURY/DISORDERS REHABILITATION

Supervisory Psychologist: Julie Cessna Palas, Ph.D.

This rotation occurs within the context of the Spinal Cord Injury/Disorders (SCI/D) Service. The SCI/D Service provides clinical care to individuals who have sustained spinal cord injuries or who suffer from other causes of spinal cord dysfunction, such as multiple sclerosis or spinal stenosis. The service is located in a newly constructed wing dedicated to the care of individuals with SCI/D. The inpatient component is comprised of 100 beds, including 10 beds for individuals weaning off ventilators and 30 long-term care beds (10 of which are for individuals dependent on ventilators). The SCI/D Inpatient Rehabilitation Program is CARF-accredited. Annually, it provides acute and sustaining care to more than 500 individuals through a multidisciplinary team model of health care delivery. Patient characteristics vary considerably from the older WWII and Korean War veteran to young active duty individuals injured in the Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn.

SCI/D neuropsychologists and residents function as members of the multidisciplinary teams and provide a full range of psychological rehabilitation services. The resident may work with veterans and active-duty individuals through both the inpatient and outpatient components of the SCI/D Service but the primary experience will be with the inpatient Acute Rehabilitation Team. The SCI/D neuropsychologist helps to identify and conceptualize the nature of cognitive, personality, and psychosocial issues that may affect the individual's progress in rehabilitation, adjustment to SCI/D, and quality of life. Common findings include cognitive impairment from concomitant head injury, hypoxia, or premorbid neurological disorder; mood and adjustment disorders; substance abuse/dependence. Personality disorders/characteristics, grief and loss, and changes in primary relationships are common areas of focus. Psychotherapeutic interventions may include relatively brief series of problem-focused interactions, longer-term treatment of adjustment to disability, education/interventions with treatment staff, and couples or family therapy. Residents will be involved in co-facilitating supportive group therapy and/or a psychoeducational group. Residents may conduct cognitive rehabilitation under the aegis of our

Speech and Language Pathology Service. Close involvement and consultation with the treatment team, including attendance at weekly team meetings and team rounds, is expected.

Opportunities for involvement in outpatient referrals are diverse. The J. A. Haley SCI/D program is part of the VA Multiple Sclerosis Centers of Excellence and actively treats individuals with MS. In addition, the SCI/D program provides treatment to a large cohort of individuals with amyotrophic lateral sclerosis (ALS). The resident will conduct neuropsychological evaluations for those individuals requiring baseline evaluations and evaluations following MS exacerbations. The resident will provide feedback and education regarding neuropsychological status and the behavioral expression of those deficits. Outpatient evaluations can also include participation in conducting the psychosocial needs assessment, which is part of the Comprehensive Annual Medical Examination.

A clinically-oriented, flexible/adaptive approach is used for conducting cognitive and psychological evaluations. Evaluations involve chart review for relevant history, clinical interview, collateral interview (when available), administration and scoring of appropriate tests, interpretation of test performance, and the production of a written report of the findings and recommendations. Evaluation instruments are selected based on clinical questions and on consideration of the individual's current behavioral repertoire. Regardless of the specific instruments selected, evaluations typically include assessment of intellectual ability, learning and memory abilities, visuospatial abilities, reasoning/concept formation ability, attentional control and other executive functions, and emotional state and personality/psychopathology.

Participation in the weekly meeting of the SCI/D psychologists and the monthly SCI/D Psychology journal club is also expected. Experience in supervision of psychology interns who are completing the SCI/D internship rotation is possible.

By the end of the rotation, the resident will demonstrate:

1. A sound knowledge of the etiology and physical sequelae of SCI/D.
2. An advanced knowledge of the cognitive and psychosocial sequelae of SCI/D.
3. Sound clinical rationale for test selection and administration of cognitive and psychological assessment instruments with this specialized population.
4. A journeyman's ability to produce integrative written reports of psychological test findings with recommendations for treatment and rehabilitation.
5. Advanced ability in providing psychotherapeutic interventions that address the broad range of psychological and psychosocial sequelae of SCI/D.
6. The interpersonal skills necessary for consultative and collaborative endeavors in both clinical and research settings.

USF NEUROPSYCHOLOGY / EPILEPSY & FORENSICS

Supervisory Psychologist: Michael Schoenberg, Ph.D., ABPP-CN

This rotation will involve working closely with attending neuropsychologists completing both outpatient and inpatient neuropsychological assessments with children and adults at either the downtown Tampa outpatient center (STC building) or at USF Affiliated Hospital, including Tampa General Hospital and FL Hospital-Tampa. Residents will work with a broad number of neuropsychological and psychological measures. Focused experiences are provided in the neuropsychology of epilepsy, bedside

neurobehavioral assessment on an inpatient rehab and neurological care unit as well as forensic neuropsychology.

Epilepsy/Neurosurgical Neuropsychology: Experiences in the neurosurgical neuropsychology focus on epilepsy surgery as well as surgical evaluation for DBS and normal pressure hydrocephalus. Residents will be exposed to outpatient neuropsychological evaluations, intracarotid methahexital (Wada's) testing, and assessments completed during long-term video monitoring on an inpatient consult service. Additional experiences, including observing aspects of neurological surgery including resection and stereotaxic surgical procedures as well as electrocorticography (ECoG) can be negotiated. Residents will be provided with hands on training in conducting Wada's testing with attending neuropsychologist as well as neurology and interventional radiology faculty. Residents will be expected to attend and participate in weekly Epilepsy case conferences. Residents will review neuropsychology, neurology, and neurosurgical literature in epilepsy to provide a framework for consulting with neurology and neurosurgery faculty on providing input to guiding surgical decision-making process. Opportunities for research in the neuropsychology of epilepsy and/or pseudo nonepileptic seizures/attacks is also available to motivated residents. Goals of the rotation include continued development of assessment skills, diagnosis, and recommendations. Functional neuroanatomy is discussed in depth. Training will emphasize gaining competence to identify neuropsychological features that, when combined with neurological and/or radiological data, have implications for predicting surgical outcome, and consulting in multidisciplinary treatment teams to provide input for neuropsychological indications and contra-indications for surgical treatment. Evidence-based neuropsychology practice is emphasized. Residents will also participate in didactic neuropsychology programmatic activities within the USF Health, Dept. of Neurosurgery and Brain Repair as well.

Forensic Neuropsychology: Experiences in forensic neuropsychology practice will include exposure to civil case neuropsychology services. Cases will include personal injury, independent neuropsychological (medical) evaluations (IME), worker's compensation cases, and long-term disability cases. Residents will obtain experience in civil aspects of forensic neuropsychology practice (allowed by parties involved), including record review, neuropsychological assessment, interviewing skills, and developing integrative reports to answer referral questions. Additional experiences, including observing depositions and court testimony of neuropsychology attending may also be possible. Residents will review relevant literature for particular cases to provide input to guiding the assessment and interpretation process. Opportunities for research are available to motivated residents. Goals of the rotation include continued development of assessment skills, diagnosis, and means to practice neuropsychology in a medicolegal arena. Evidenced-based neuropsychology research and practice is emphasized. Residents will also participate in didactic experiences as detailed above for the epilepsy neuropsychology service.

Training expectations:

1. Perform a minimum of 4-8 evaluations each month in either epilepsy and/or forensic neuropsychology. Forensic neuropsychology caseloads vary and Residents may be allowed to participate depending upon agreement from parties involved; however, every effort will be made to assure Resident’s involvement in at least 1 forensic case each rotation. Residents may be involved in testing patients/claimants, scoring data, and assisting in conceptualization and decision making.
2. Review medical/legal records and integrate into report.
3. Write/complete full reports within 1 week of the completed assessment.
4. Participate in weekly division meetings.
5. Participate in bi-monthly readings and didactics focused on these specific populations.
6. Participate in weekly Epilepsy case conference meetings

7. Participate in weekly (or more) scheduled supervision.
8. Attend Neurosurgery Grand Rounds, Neurology Grand Rounds and Radiology Grand Rounds as may be possible.

Training objectives:

By the end of the rotation the post-doctoral trainees will be able to

1. State the rationale underlying the selection of various neuropsychological tests and other assessment methods for use with individuals in specific populations.
2. Perform neuropsychological evaluations utilizing standardized instruments in a flexible-battery, clinically-guided approach.
3. Perform the neuropsychological or cognitive portion of the Intracarotid methahexital (Wada's) tests independently.
4. Produce a written, integrated neuropsychological report that provides diagnostic and interpretive summary to address referral question.
5. Identify and describe common neuropsychological and psychological syndromes (e.g., TBI, poor effort/malingering, PTSD) or clinical problems specific to these populations.
6. Cite the major literature on common cognitive, behavioral, emotional, personality, and psychosocial issues related to these populations.
7. Demonstrate improved differential diagnostic skills.
8. Demonstrate ability to consult with neurologists and neurological surgeons on pre-surgical planning for patients with medication refractory epilepsy using evidence-based neuropsychology.

Residency Requirements for Completion

To successfully complete the postdoctoral residency, Residents are expected to:

(1) Competence: Demonstrate an appropriate level of professional psychological skill and competency; all elements across competency domains evaluated at the end of the program must be rated at least a 5 (see "**Evaluation Procedures**").

(2) Didactic Training: Residents are expected to attend the Fundamentals of Neuropsychology Seminar (first years), Neuropsychology Seminar, and the Professional Development Seminar. Other seminars may include the Rehabilitation Psychology Seminar, Clinical Psychology Seminar, Diversity Seminar, conferences or various seminars/lectures/ colloquia offered through the USF medical school (e.g., Psychiatry Grand Rounds, Neurology Rounds), Tampa General Hospital, Moffitt Cancer center, or other USF Departments such as Psychology, Gerontology, or Aging and Mental Health.

(3) Research/Scholarly Work: Submit for review a poster (final poster product must also be developed), platform presentation, or article based on the research they have been conducting as part of this postdoctoral residency.

(4) 4160 Hours over 2 years: The postdoctoral training program requires two years of full-time training to be completed in no less than 24 months (4160 hour appointment). On duty requirements include absences from the use of annual leave, holidays, authorized absence, and sick leave (residents must be on-duty and involved in training for at least 90% of their appointment).

(5) Patient Contact: Average 17 patient contact/care activity hours per week (i.e., "face-to-face" contact with patients or families for any type of group or individual therapy, psychological testing, consultation, assessment activities, including record review or report writing, or patient education). This experience meets Florida psychology licensing requirements (i.e., a minimum of 900 hours of patient contact/care activity hours per year).

EVALUATION PROCEDURES

Competency-Based Evaluation System: It is our intention that evaluation of postdoctoral residents' progress be open, fair, and part of the learning process. Residents are involved in all phases of evaluation from the initial concurrence with training goals through the final evaluation. Ongoing feedback during supervisory sessions is presumed and residents should request clarification from supervisors if there is uncertainty about progress.

To assist in our postdoctoral training and evaluation process, and to document the attainment of basic core competencies and outcomes, competency evaluations are conducted for the resident's clinical activities. The program utilizes a behaviorally-based model of evaluation with ratings based on the amount of supervision required for the resident to perform the task competently. In general, this rating scale (described below) is intended to reflect the developmental progression toward becoming an independent psychologist. Expectations for Postdoctoral Residents are as follows:

Goal for post-doctoral evaluations done at 12 months (completion of 1st year): 80% of all elements across competency areas will be rated at goal (3), including critical items. No elements will be less than 2 pts. below goal (described below):

Specialty competency in routine cases is on-level developmentally, concomitant with the expectations of a VA Staff Psychologist in independent generalist practice. Specialty competency in non-routine cases is emerging. Supervision resembles peer consultation in routine cases, but is prescriptive or in-depth as needed.

Goal for post-doctoral evaluations done at 24 months (completion of residency): All elements across competency areas will be rated at goal (5).

Specialty competency, even in non-routine cases, is demonstrated at an early-career specialist level concomitant with the expectations of a VA Staff Psychologist in independent specialty practice. While licensed, supervision is maintained due to trainee status. Supervision is devoted primarily to advanced, expert topics, and trainee maintains competency and autonomy in all but exceptional circumstances.

At the end of each rotation, in the judgment of his/her supervisor and the Postdoctoral Training Subcommittee, the resident is evaluated in each of the core competency areas and their components, with an expectation of satisfactorily progressing. The core competency areas are: 1) Integration of Science and Practice; 2) Ethical and Legal Standards/Policy; 3) Individual and Cultural Diversity; 4) Professional Identity & Relationships/Self-Reflective Practice; 5) Interdisciplinary Systems/Consultation; 6) Assessment; 7) Intervention; 8) Research; 9) Teaching/Supervision/Mentoring; and 10) Management/Administration. To successfully complete the residency, all elements across competency areas will be rated at goal (5). Competency based ratings are as follows:

6. Advanced specialty competency is demonstrated, with skills comparable to a board-certified specialty practitioner. This is a rare rating that reflects collegial level of autonomy and competency at the expert level despite maintenance of required trainee role and expectations.

5. Specialty competency, even in non-routine cases, is demonstrated at an early-career specialist level concomitant with the expectations of a VA Staff Psychologist in independent specialty practice. While licensed, supervision is maintained due to trainee status. Supervision is devoted primarily to advanced, expert topics, and trainee maintains competency and autonomy in all but exceptional circumstances.
(GOAL FOR END OF 24 MONTHS – COMPLETION OF RESIDENCY)

4. Specialty competency in routine cases is demonstrated at an early-career specialist level. Competency in non-routine cases or new populations is developmentally appropriate but without full autonomy. While potentially licensed, supervision is maintained due to trainee status. Supervision is largely consultative, and is only occasionally prescriptive or in-depth.

3. Specialty competency in routine cases is on-level developmentally, concomitant with the expectations of a VA Staff Psychologist in independent generalist practice. Specialty competency in non-routine cases is emerging. Supervision resembles peer consultation in routine cases, but is prescriptive or in-depth as needed.
(GOAL FOR END OF 12 MONTHS – COMPLETION OF 1ST YEAR).

2. Specialty competency is emerging. Generalist skills are implemented with ease, and specialty skills are developing with assistance. Supervision is generally routine and prescriptive, with occasional consultative supervision in clearly routine cases.

1. Competency attainment is below the expected developmental level. Remediation is indicated to accelerate specialty competency attainment (formal remediation plan may or may not be implemented).

Residents receive a formal evaluation (electronically completed and stored) from their rotation supervisor at the end of each rotation, as well as an intermediary evaluation at the mid-point of each rotation. The rotation mid-point evaluations are intended to be a progress report for residents to ensure they are aware of their supervisor's perceptions and to help them focus on specific goals and areas of work for the second part of the rotation. Final rotation evaluations will also provide specific feedback and serve to help the resident develop as a professional. Residents also provide a written evaluation of each rotation and supervisor upon completion of the rotation. This and the supervisor's evaluation of the resident are discussed by the resident and supervisor to facilitate mutual understanding and growth.

Upon completion of each rotation, copies of the resident's and the supervisor's final rotation evaluations are stored electronically.

Training Staff

All members of the Psychology training staff have clinical responsibilities. In addition, they all serve in a variety of other professional roles: as faculty members in the College of Medicine and other university departments, as office holders in professional organizations, in administrative roles within the hospital, and as researchers. In the following pages, we provide a brief description of potential primary and/or secondary supervisors. They are listed alphabetically with information regarding their doctoral training program, primary clinical responsibility, faculty appointments, and clinical interests.

Erin K. Bailey – Ph.D., ABPP-CN, Alliant International University – CSPP-San Francisco, 2014
Clinical Neuropsychologist, Outpatient Neuropsychology, Vulnerable Populations
Assistant Professor, College of Medicine, University of South Florida
Clinical/Research Interests: Dementias, Neurobehavioral Syndromes, Geriatric Neuropsychology, Decision-Making Capacity, Epilepsy, COVID-19

Joe Boscarino – Psy.D., William James College, 2021
Clinical Neuropsychologist, Outpatient Neuropsychology
Clinical/Research Interests: Atypical Dementias, Reliable Change, Pre/Post Surgical Evaluations; Substance Use Disorders

Julie Cessna Palas – Ph.D., University of South Florida, 2017
Clinical Neuropsychologist, SCI/D Rehabilitation Program
Clinical Interests: Neurobehavioral syndromes, SCI Rehabilitation

Jennifer J. Duchnick – Ph.D., ABPP-RP, Auburn University, 2001
Assistant Training Director, Rehabilitation Psychology Postdoctoral Program
Rehabilitation Neuropsychologist, Polytrauma Transitional Rehabilitation Program
Clinical Interests: Neuropsychology, Rehabilitation Psychology, TBI, SCI, Clinical Intervention, Adjustment to Injury, Trauma

Amanda Garcia – Ph.D., University of Florida, 2017
Clinical Neuropsychologist, Polytrauma Rehabilitation Program
Clinical Interests: mTBI, Language disorders,

Danielle Herring – Ph.D., University of Central Florida, 2019
Clinical Neuropsychologist, Polytrauma Rehabilitation Program, Post-COVID Rehabilitation Program
Clinical Interests: Neuropsychology, Rehabilitation Psychology, TBI, Stroke, COVID-19, Cognitive Rehabilitation

Joel E. Kamper – Ph.D., ABPP-CN, Loma Linda University, 2013
Assistant Training Director, Neuropsychology Postdoctoral Residency Program
Clinical Neuropsychologist, Outpatient Neuropsychology & Medical C&L Neuropsychology
Clinical/Research Interests: Rare Diseases, Paraneoplastic Syndromes, Neurobehavioral Syndromes, Epilepsy, Presurgical Evaluations

Tracy S. Kretzmer – Ph.D., ABPP-CN, University at Alabama, Birmingham 2006
Rehabilitation Neuropsychologist, Polytrauma Rehabilitation Program
Assistant Professor, USF Department of Psychology
Clinical Interests: Acquired Brain Injury, Concussion, post-TBI challenging behaviors

Risa Nakase-Richardson – Ph.D., West Virginia University, 1999
Clinical Neuropsychologist, Polytrauma Rehabilitation Program
Associate Professor, USF Department of Medicine, Pulmonary & Sleep Medicine Division
Clinical Interests: Acquired Brain Injury, Emerging Consciousness, Rehabilitation, Sleep

Thomas M. Oswald – Psy.D., Nova Southeastern University, 2015
Rehabilitation Neuropsychologist, Polytrauma Rehabilitation Program
Clinical Interests: TBI, Stroke, Adjustment to Disability, Team Dynamics, Functional Neurologic Symptom Disorder, Burnout

Bethan Roberts – Ph.D., University of Kentucky, 2017
Psychologist, Geropsychology, Community Living Center
Clinical Interests: Aging, Adjustment to Disability & Life transitions, Dementia Care, Cognitive Assessment

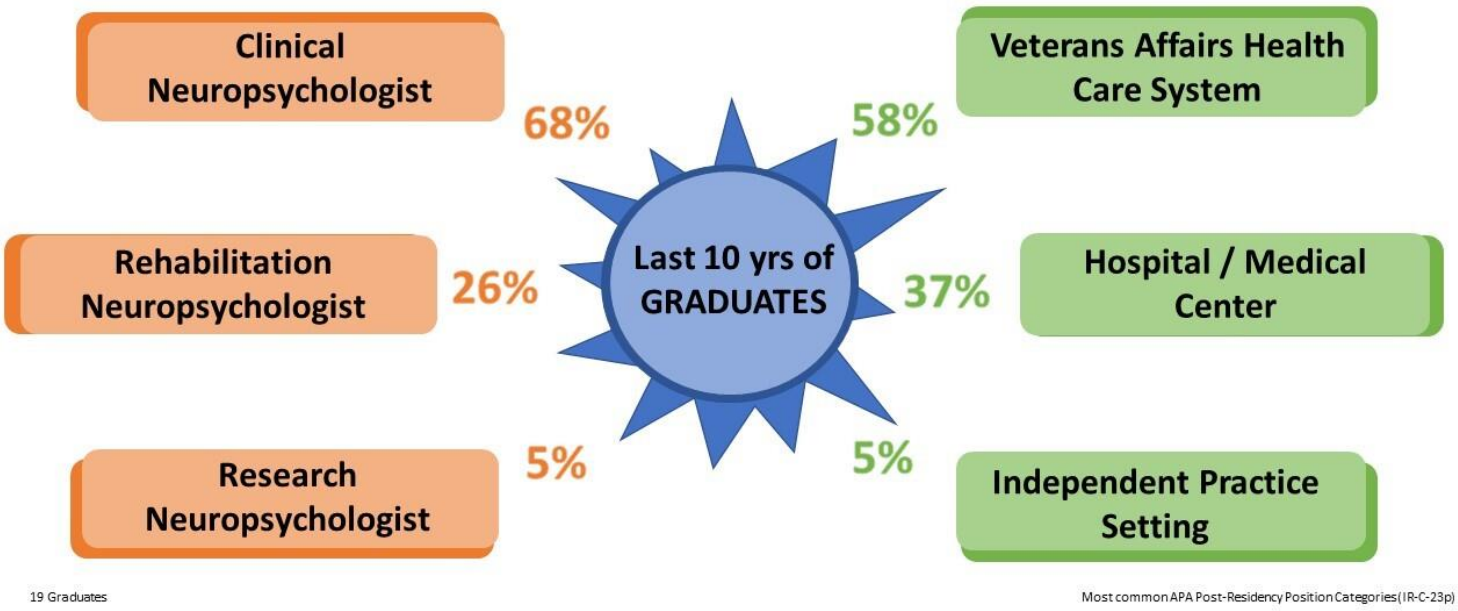
Mike R. Schoenberg – Ph.D., ABPP-CN, Wichita State University, 2001
Chief, Neuropsychology Division, USF Dept of Neurosurgery
Associate Professor, Depts. of Psychiatry and Neurosciences, Neurology, and Neurosurgery, USF
Clinical Interests: Epilepsy, TBI, Mild Cognitive Impairment, Neuroanatomic Organization of Language and Memory, Forensic Assessment

Marc A. Silva – Ph.D., Marquette University, 2011
Clinical Neuropsychologist, Polytrauma Rehabilitation Program
Assistant Professor, College of Medicine, University of South Florida
Courtesy Faculty, Department of Psychology University of South Florida
Clinical/Research Interests: Assessment, Brain Injury, Sleep

Emily N. Vanderbleek – Ph.D., University of Notre Dame, 2020
Clinical Neuropsychologist, Outpatient Neuropsychology
Clinical/Research Interests: Dementias, Rehabilitation, Psychometrics, Personality Disorders

Jessica L. Vassallo – Ph.D., ABBP-CN, Fairleigh Dickinson University, 2004
Director, Psychology Training Programs
Clinical Neuropsychologist, Outpatient Neuropsychology
Clinical Interests: Dementia, Capacity, Epilepsy, Neuropsychological Interventions, Healthy Aging

Postdoctoral Residency Admissions, Support, and Initial Placement Data



TRAINEES

Past Residents are listed below by year of beginning the program, graduate school, type of graduate program, degree earned, and prior internship site.

Year	Graduate University	Area of Prof	Degree	Internship Site
2010	Univ of Florida	Clinical	Ph.D.	Tampa VA
2011	Marquette University	Counseling	Ph.D.	Tampa VA
2011	Florida Institute of Technology	Clinical	Psy.D.	Brooke Army Medical
2012	Univ of IL - Urbana-Champaign	Counseling	Ph.D.	Tampa VA
2013	Wayne State University	Clinical	Ph.D.	Univ of Alabama
2013	Loma Linda University	Clinical	Ph.D.	Detroit VA
2014	George Washington University	Clinical	Ph.D.	Tampa VA
2014	California School of Prof. Psych.	Clinical	Ph.D.	Gainesville VA
2015	Roosevelt University	Clinical	Psy.D.	Tampa VA
2015	Univ of Houston	Clinical	Ph.D.	UAB
2016	Roosevelt University	Clinical	Psy.D.	Tampa VA
2016	Wayne State University	Clinical	Ph.D.	Tampa VA
2017	Kent State University	Clinical	Ph.D.	Tampa VA
2017	University of Florida	Clinical	Ph.D.	Emory University
2018	University of WI-Milwaukee	Clinical	Ph.D.	Tampa VA
2018	Palo Alto University	Clinical	Ph.D.	Pittsburgh VA
2019	Wayne State University	Clinical	Ph.D.	Tampa VA
2019	University of South Florida	Clinical	Ph.D.	UAB

2020	University of Notre Dame	Clinical	Ph.D.	Milwaukee VA
2020	Univ of Alabama - Birmingham	Clinical	Ph.D.	Tampa VA
2021	Georgia State University	Clinical	Ph.D.	Minneapolis VA
2021	Marquette University	Clinical	Ph.D.	Baylor CoM
2022	Louisiana State	Clinical	Ph.D.	Houston VA
2022	Univ of Houston	Clinical	Ph.D.	Tampa VA
2023	Univ of Florida	Clinical	Ph.D.	Tampa VA
2023	Rosalind Franklin Univ	Clinical	Ph.D.	Minneapolis VA

PROGRAM TABLES – ADMISSIONS, SUPPORT, AND PLACEMENT DATA

Date Program Tables are updated: 9/1/2023

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?	No
If yes, provide website link (or content from brochure) where this specific information is presented: N/A	

Postdoctoral Residency Program Admissions

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

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

1. Obtained a doctoral degree from an APA or CPA accredited graduate program in Clinical, Counseling, or Combined Clinical-School/Counseling-School Psychology or PCSAS accredited Clinical Science program. Persons with a doctorate in another area of psychology who meet the APA or CPA criteria for respecialization training in Clinical, Counseling, or Combined Clinical-School/Counseling-School Psychology are also eligible.
2. Completed an APA -accredited psychology internship or a VA-sponsored internship.
3. U.S. citizenship
4. For males -- have registered with the Selective Service System before age 26.
5. Matched interns are subject to fingerprinting, background checks, physical/health requirements and urine drug screens. Match results and selection decisions are contingent on passing these screens.

We seek individuals with sound clinical and scientific knowledge base from their academic program, strong foundational skills in assessment and intervention, and who are interested in learning and motivated to develop further professionally during the residency year. Our selection criteria are based on a "goodness–of–fit" with our scientist-practitioner model, and we look for residents whose training goals match the training that we offer. The aim of the program is to promote advanced competencies in our residents such that graduates are eligible for employment in public sector medical center settings serving specialized patient populations with neurological conditions. Residents completing the program should have solid foundational preparation to initiate ABPP certification in Clinical Neuropsychology. We review applicants to our program using the following criteria: clinical experience, research experience, letters of recommendation, motivation/professional development, writing ability, commitment to and/or experience/interest in diversity, and interview/match with our program. Ideally, we are looking for individuals committed to the scientist-practitioner model and who are committed to pursuing board certification in clinical neuropsychology. The James A Haley Veterans' Hospital in which our training program resides is an Equal Opportunity Employer; we are committed to ensuring a range of diversity among our training classes, and we select candidates representing different kinds of programs and theoretical orientations, geographic areas, ages, racial and ethnic backgrounds, sexual orientations, disabilities, and life experiences. All things being equal, consideration is given to applicants who identify themselves as veterans; as members of historically underrepresented groups on the basis of racial or ethnic status; as representing diversity on the basis of sexual orientation; or as representing diversity on the basis of disability status.

Describe any other required minimum criteria used to screen applicants:

The qualifications listed above in this brochure (see "Qualifications") are required of all applicants; applicants not meeting these qualifications will not be considered.

Financial and Other Benefit Support for Upcoming Training Year

Annual Stipend/Salary for Full-time Residents	**$52,005 (1st Year), $54,816 (2nd Year)**
Annual Stipend/Salary for Half-time Residents	N/A
Program provides access to medical insurance for residents?	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)	PTO/Vacation leave accrues at the rate of 4 hours every two weeks, amounting to 13 vacation days
Hours of Annual Paid Sick Leave	Sick leave accrues at the rate of 4 hours every two

	weeks, amounting to 13 sick days
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): All Federal Holidays off; 5 days authorized absence for approved professional activities (e.g., conferences, workshops, etc.).	

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

Initial Post-Residency Positions

(Provide an Aggregated Tally for the Preceding 3 Cohorts)

Graduating Years	**2020-2022**
Total # of interns who were in the 3 cohorts	6
Total # of interns who did not seek employment because they returned to their doctoral program/are completing doctoral degree	0
Academic teaching	PD=0, ED=0
Community mental health center	PD=0, ED=0
Consortium	PD=0, ED=0
University Counseling Center	PD=0, ED=0
Hospital/Medical Center	PD=0, ED=3
Veterans Affairs Health Care System	PD=0, ED=3
Psychiatric facility	PD=0, ED=0
Correctional facility	PD=0, ED=0
Health maintenance organization	PD=0, ED=0
School district/system	PD=0, ED=0
Independent practice setting	PD=0, ED=0
Other	PD=0, ED=0

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

Facility and Training Resources

Residents share one large office in which there are individual workstations with computers, but are assigned individual office for patient care activities. The offices are all equipped with networked computers that allow access to the computerized medical record system, productivity software, internet/intranet and email. Administrative assistance for clinical activities such as scheduling initial or return outpatient appointments is provided by the Hospital Administrative Service (HAS) clerks assigned to the various mental health clinics and inpatient units. Administrative tasks such as requesting a change in work hours, days off, and so forth are facilitated by the MH&BS timekeeper, other MH&BS administrative staff, and the Training Director and Assistant Training Director.

The Medical Library is open 24/7 for staff and trainees. It has 12 computers, and is conveniently located near the cafeteria and auditorium of the main hospital. The hospital maintains its own professional library listing of books and journals, although the majority of professional literature is available online. Our hospital library provides access to more than 7,000 print and electronic journals, as well as access to MEDLINE, PSYCHLIT, and other databases. The main library at the University of South Florida houses over 1,500,000 volumes including 4,900 journal subscriptions. In addition, the USF College of Medicine library, which is directly across the street from the VA medical center, maintains over 88,000 books including over 1,400 journal subscriptions. Literature searches and complete bibliographies with abstracts are available upon request.

Commonly used psychological tests are available from rotation supervisors and from within the Mental Health Assistant option in the Computerized Patient Record System. Among these are numerous specialized psychological and neuropsychological tests and surveys in the areas of chronic pain, trauma, family and interpersonal functioning, coping, stress, adjustment to disability, language/verbal abilities, learning and memory, executive functioning, attention, mental control, visuoperceptual/sensorimotor functioning, and abstract problem solving.

THE TAMPA ENVIRONMENT

The James A. Haley Veterans' Hospital is located in Tampa, Florida. Tampa is a growing metropolitan area which serves as the county seat of Hillsborough County and is the second most populous city in the state. The city is situated on the west coast of Central Florida, 266 miles northwest of Miami and 197 miles southwest of Jacksonville. With a population of almost 3.2 million based on 2020 census, Tampa Bay is composed of several residential, industrial, and agricultural communities which are interspersed with orange groves and cattle ranches. The climate is generally mild with an average annual temperature of 73 degrees. Freezing temperatures are rare, as are those of more than 95 degrees.

Because of its climate, opportunities for outdoor recreation activities abound. The coastal waters of the Gulf of Mexico and Tampa Bay offer a broad spectrum of water sports – water skiing, swimming, deep-sea fishing, power boating, sailing, board sailing, and scuba diving. Freshwater fishing is also available in the numerous local lakes. Residents enjoy facilities and activities year-round because there is little change in the seasons. Golf is very popular locally and many public and private courses are available. Bike trails are numerous throughout the Hillsborough, Pinellas, and Pasco counties.

Cultural Environment and Activities

A variety of arts and cultural activities can be found in the Tampa Bay area. Because of Florida's early history in the exploration of the "New World," Tampa has a very large population of Hispanic and Latinx residents (23.1% of the population). The African-American population is also well represented (26.2% of the population). Events celebrating the heritage and contribution of various ethnic cultures to the area occur throughout the year. For example, the Tampa Bay Black Heritage Festival, Festival del Sabor, Asia Fest, Tampa Pride Parade, and the Tampa International Gay & Lesbian Film Festival are all popular annual events that highlight the region's diversity.

The University of South Florida, located just across the street from the hospital, has an active and acclaimed drama and fine arts program. Film, dance, stage productions, and repertory companies are regular offerings of the Tampa Theatre and Tampa Bay Performing Arts Center (both located in downtown Tampa) and the world-famous Asolo Theater (located approximately 50 miles south of Tampa, in Sarasota). Tampa has also become a popular stop for touring musicians. The Amphitheater, Amalie Arena, Raymond James Stadium, and the USF Sundome are popular venues for contemporary music and have hosted top artists. Across Tampa Bay, St. Petersburg is home to the Dale Chihuly glass museum, the Salvador Dali museum, which is the only exclusive museum of this artist's works in the world, and the Mahaffey Theater. See http://cltampa.com/ for current cultural events in the Tampa/St. Pete area. For sports fans, there are seven major league baseball spring training camps within 20 miles of Tampa. The Tampa Bay area is also home to several professional sport franchises, including the Buccaneers, the Rays, and the Lightning. The Tampa Bay Rowdies are a professional soccer team that plays in neighboring St Petersburg.

Well known tourist attractions also lie in close proximity to Tampa. Busch Gardens and Adventure Island Water Park are only 3 miles from the hospital. The various Disney World theme parks and Universal Studios are 75 miles east of Tampa in Orlando, and the Ringling Brothers Museum is located in Sarasota. Tampa itself is home to a world-class aquarium (the Florida Aquarium) in downtown Tampa harbor and an award-winning zoo, Lowry Park Zoo.

The Tampa Bay area has numerous quality educational institutions including the University of South Florida with an enrollment of over 49,000 students and colleges in Architecture, Arts and Letters, Business Administration, Education, Engineering, Fine Arts, Medicine, Natural Sciences, Nursing, and Social and Behavioral Sciences. The University of Tampa, located in downtown Tampa, has an enrollment of about 8,000 students. Both Hillsborough County and neighboring Pinellas County have well-regarded community colleges. In addition to the higher educational facilities, there are excellent public, parochial, and technical school systems.

Administrative Policies and Procedures

ANNUAL AND SICK LEAVE

Accumulated according to standard VA policy: 4 hours of sick leave and 4 hours of vacation leave are earned every two-week pay period. Residents are allowed up to 5 days authorized absence for professional and educational activities each year. Residents must not exceed 10% of their appointed time with accrued leave during the year.

COLLECTION OF PERSONAL INFORMATION & MAINTENANCE OF RECORDS

We collect no personal information from you when you visit our website. If you are accepted as a resident, some demographic descriptive information is collected and sent to the American Psychological Association as part of our annual reports for accreditation. This information is treated as confidential by APA and used for accreditation purposes only. Contact the Commission on Accreditation for more information (apaaccred@apa.org). Residents must meet physical and health requirements as part of the onboarding process (TQCVL). This information is treated as confidential and can be verified via source documentation or a statement from a healthcare professional attesting that the intern meets the health requirements for VA training (see https://www.psychologytraining.va.gov/docs/Trainee-Eligibility.pdf for a full description of eligibility criteria). Training files will be stored and retained for a duration of 50 years.

UNSATISFACTORY OR DELAYED PROGRESS

Most issues of clinical or professional concern are relatively minor and can be addressed in open and ongoing assessment of skills by the intern and immediate supervisor. However, the following procedures are designed to advise and assist interns performing below the program's expected level of competence when ongoing supervisory input has failed to rectify the issue (Reference: Psychology SOP 116ak-02):

A. Definition of Problematic Performance: Problem behaviors are said to be present when supervisors perceive that a trainee's competence, behavior, attitude, or other characteristics significantly disrupt the quality of his or her clinical services; his or her relationship with peers, supervisors, or other staff; or his or her ability to comply with appropriate standards of professional behavior. It is a matter of professional judgment as to when such behaviors are serious enough to constitute "problematic performance."

    1. Definition of Illegal, Unethical, or Inappropriate Behavior: Behaviors which reflect poor professional conduct, disregard for policies and procedures of the Service and the Hospital, and/or ethical or legal misconduct will be taken seriously and addressed immediately. It is a matter of professional judgment as to when such behaviors are serious enough to constitute unethical or inappropriate behavior.

B. Informal Process for Remediation of a Serious Skill and/or Knowledge Deficit: Clinical supervisors/staff who determine that a trainee is not performing at a satisfactory level of competence are expected to discuss this with the trainee and initiate procedures to informally remediate the skill/knowledge deficit. This may include providing additional supervisory guidance and directing the trainee to additional resources (e.g., didactics, additional clinical experiences). No formal communication with the Training Director(s) is required at this point. Occasionally, the problem identified may persist and/or be of sufficient seriousness that the trainee may not achieve the minimum level of competency to receive credit for completion of

the program unless that problem is remediated. As soon as this is identified as the case, the problem must be brought to the attention of the Training Director(s), and the clinical supervisor should note in writing the concerns that led to the identification of the skill/knowledge deficit and the remedial steps that were attempted. At this point, a formal remediation plan will be initiated, following the procedures outlined below.

C. Informal Staff or Trainee Complaints or Grievance Process: Clinical supervisors/staff and/or trainees are encouraged to seek informal redress of minor grievances or complaints directly with the other party, or by using a mentor, other clinical supervisor, the Assistant Training Director, or the Training Director as go-betweens. Such informal efforts at resolution may involve the Psychology Service Chief as the final arbiter. Failure to resolve issues in this manner may eventuate in a formal performance/behavior complaint or trainee grievance as the case may be, following the procedures outlined below. Should the matter be unresolved and become a formal issue, the trainee is encouraged to utilize the designated mentor, or in the case of conflict of interest, another clinical supervisor or senior staff member, as a consultant on matriculating the formal process.

Procedures for Responding to Problematic Performance: When it is identified that a trainee's skills, professionalism, or personal functioning are problematic, the Training Committee, with input from other relevant supervisory staff, initiates the following procedures:

A. As soon as problematic performance is identified, the problem must be brought to the attention of the Training Director(s), and the clinical supervisor should note in writing the concerns that led to the identification of the problematic performance and the remedial steps that were attempted. Trainee evaluation(s) will be reviewed with discussion from the Training Committee and other supervisors, and a determination made as to what action needs to be taken to address the problems identified.

B. After reviewing all available information, the Training Committee may adopt one or more of the following steps, or take other appropriate action:

1. The Training Committee may elect to take no further action.
2. The Training Committee may direct the supervisor(s) to provide constructive feedback and methods for addressing the identified problem areas. If such efforts are not successful, the issue will be revisited by the Training Committee.
3. For interns, the trainee's graduate program Director of Clinical Training may be consulted on the matter, depending on the seriousness of the issue(s).
4. Where the Training Committee deems that *informal remedial* action is required, the identified problematic performance or behavior must be addressed. Possible remedial steps may include (but are not limited to) the following:
    i. Increased supervision, either with the same or other supervisors.
    ii. Change in the format, emphasis, and/or focus of clinical work and supervision.
    iii. Change in rotation or adjunctive training experiences.
5. Alternatively, depending upon the gravity of the matter at hand, the Training Committee may issue a *formal Remediation Plan notice* which specifies that the Committee, through the supervisors and Training Director(s), will actively and systematically monitor for a specific length of time, the degree to which the trainee addresses, changes, and/or otherwise improves the problem performance or behaviors. The *Remediation Plan* is a written statement to the trainee that includes the following items:

- A description of the problematic performance behavior.
- Specific recommendations for rectifying the problems.
- A time frame for remediation during which the problem is expected to be ameliorated.
- Remediation plans will be tied directly to the program's identified competencies.

For interns, the trainee's graduate program Director of Clinical Training is not notified of the problem during the rotation when the problem is first identified in order to allow time for improvement, unless the problem identified is judged to be a major problem that is likely to result in the intern's failure or dismissal from the internship. If deficiencies persist into the next rotation, written communication to the intern's graduate program will occur outlining the identified problem(s), the plan for remedial actions, and the implications of improvement or lack thereof. Copies of this written communication and subsequent progress reports to the intern's graduate program will also be provided to the intern.

For behavior that involves significant illegal or unethical behavior, or gross violation of the training program's or the host facility's policies, immediate termination may be warranted. In such cases, no remediation will be provided. See Section on *Illegal, Unethical, or Inappropriate Behavior*.

6. Following the delivery of *a formal Remediation Plan notice*, the supervisor(s) and Training Director(s) will meet with the trainee to review the required remedial steps. The trainee will have the opportunity to have an advocate of their choice at said meeting. The trainee may elect to accept the conditions or may grieve/appeal the Training Committee's actions as outlined below. In either case, if this involves a doctoral intern, the Training Director(s) will inform the intern's graduate program Director of Clinical Training, and indicate the nature of the inadequacy and the steps taken by the Training Committee.

Monitoring of subsequent progress will occur through the Rotation Supervisor(s), Psychotherapy Supervisor(s), and Training Director(s). If performance improves such that the training goals for that rotation are subsequently met, the trainee will proceed with subsequent rotation(s) as planned. Once the Training Committee has issued an acknowledgement notice of the Remediation Plan, the problem's status will be reviewed within the time frame indicated on the Remediation Plan, or the next formal evaluation, whichever comes first. The trainee may be removed from probationary status with demonstration of acceptable performance (achievement of expected level of competency at that timepoint in the program) at the next marking period; however, the Remediation Plan will continue throughout the timeframe indicated on the written plan. If, at any time, the trainee disagrees with the evaluation of progress, he/she may appeal by following the grievance procedures outlined (informal and formal grievance processes) to resolve the disagreement.

Failure to Correct Problems: When the defined intervention does not rectify the problematic performance within the defined time frame, or when the trainee seems unable or unwilling to alter his or her behavior, the Training Committee may need to take further formal action. If the trainee has either not demonstrated improvement or demonstrated some improvement but at a rate that precludes satisfactory completion of a rotation, the trainee (and for interns, the graduate program Director of Clinical Training), will be notified and the trainee will be placed on probationary status. The trainee's progress will be closely monitored by the Training Committee and Training Director(s). Further review and recommendations will be made at mid-rotation and end-of-rotation evaluations, including consideration of options below as necessary:

A. Continue the Remediation Plan for a specified period, with modifications if necessary.

B. If correction of the problem is possible with additional months of training beyond the normal training year or by adding additional diverse training experiences (including alteration in rotation sequence), such may be recommended. The trainee may be placed in a non-pay status (without compensation) for the duration of the extension. If this involves a doctoral intern, the intern's graduate program's Director of Clinical Training will be informed.

C. If the problem is severe enough that it cannot be remediated in a timely manner, termination may result. The trainee will be informed that the Training Committee is recommending to the Psychology Service Chief that the trainee be terminated from the training program. If this involves a doctoral intern, the intern's graduate program's Director of Clinical Training will be informed.

1. Termination: If a trainee on probation has not improved sufficiently under the conditions specified in the Remediation Plan, termination will be discussed by consultation with the full Training Committee, VA OAA, and the facility DEO (or designee), and in the case of an intern with the graduate program Director of Clinical Training and APPIC. A trainee may choose to withdraw from the program rather than being terminated. The final decision regarding the trainee's passing is made by the Director of Psychology Training and the Psychology Service Chief, based on the input of the Committee and other governing bodies, and all written evaluations and other documentation. This determination will occur no later than the May Training Committee meeting. If it is decided to terminate the trainee, he/she will be informed in writing by the Director of Psychology Training that he/she will not successfully complete the program. The trainee, and if an intern, his/her graduate program, will be informed of the decision in writing no later than May 15th.

D. At any stage of the process, the trainee may request assistance and/or consultation; please see section below on grievances. Trainees may also request assistance and/or consultation outside of the program. Resources for outside consultation include:

VA Office of Resolution Management (ORM) Department of Veterans Affairs Office of Resolution Management (08) 810 Vermont Avenue, NW, Washington, DC 20420 1-202-501-2800 or Toll Free 1-888- 737-3361 http://www4.va.gov/orm/	This department within the VA has responsibility for providing a variety of services and programs to prevent, resolve, and process workplace disputes in a timely and high-quality manner.
Association of Psychology Postdoctoral and Internship Centers (APPIC) Informal Problem Consultation (IPC) – Dr. Jeff Baker (via IPC online form) http://appic.org/Problem-Consultation Formal Complaints – Dr. Ellen Teng, Chair, APPIC Standards and Review Committee ETeng@BCM.edu	APPIC has established both an Informal Problem Consultation process and a Formal Complaint process in order to address issues and concerns that may arise during the internship training year.

APA Office of Program Consultation and Accreditation: 750 First Street, NE Washington, DC 20002-4242 (202) 336-5979 http://www.apa.org/ed/accreditation
Independent legal counsel
Please note that union representation is not available to trainees as they are not union members under conditions of their VA term-appointment.

DUE PROCESS/GRIEVANCE

Trainee Grievance Procedures: Although infrequent, differences may arise between a trainee and a supervisor or another staff member. Should this occur, the following procedures will be followed:

1) The trainee should request a meeting with the supervisor or staff member to attempt to work out the problem/disagreement. The supervisor will set a meeting within 2 working days of the request. It is expected that the majority of problems can be resolved at this level. However, if that fails:

2) The trainee should request to meet with the Training Director(s) of the program. A meeting will be arranged within 2 working days to work out the difficulty. In cases involving disagreement with the Assistant Training Director, the trainee may address their case directly to the Director of Psychology Training. In cases involving disagreement with the Director of Psychology Training, the trainee may address their case directly to the Psychology Service Chief for appropriate action. If that fails:

3) The Director of Psychology Training, Assistant Training Director, trainee, and supervisor or staff member meet within 2 working days of Step 2. If a consensual solution is not possible:

4) The trainee, Psychology Service Chief, Director of Psychology Training, Assistant Training Director, and the trainee's supervisor or staff member meet to resolve the problem within 5 working days of Step 3. If that fails:

5) The issue will be brought before the Affiliations Subcommittee of the Continuing and Hospital Education Committee for resolution. This is the final step of the appeal process.

6) In unusual and confidential instances, the trainee may address their case directly to the Psychology Service Chief and, if this fails, the trainee may proceed to Step 5.

Trainees who receive a *notice* of a Remediation Plan, or who otherwise disagree with any Training Committee decision regarding their status in the program, are entitled to challenge the Committee's actions by initiating a grievance or appeal procedure. Should this occur, the following procedures will be followed:

a) Within 5 working days of receipt of the Training Committee's notice or other decision, the trainee must inform the Training Director(s) in writing that he/she disagrees with the Committee's action

and to provide the Training Director(s) with information as to why the trainee believes the Training Committee's action is unwarranted. Failure to provide such information will constitute an irrevocable withdrawal of the challenge. Following receipt of the trainee's grievance, the grievance process (described above) will begin at Step 2.

Storage of Trainee Grievance Due Process Documents:

A. All documentation of active grievances will be stored electronically in a secure folder and/or in a locked filing cabinet by the Director of Psychology Training.
B. All documentation of resolved grievances will be stored electronically in a secure folder and/or in a locked filing cabinet by the Director of Psychology Training and/or training programs' support specialist.

Illegal, Unethical or Inappropriate Behavior: Psychology training programs are bound by the Ethical Principles of Psychologists and Code of Conduct set forth by the American Psychological Association (APA, 2002, 2010, 2017) and the James A Haley Veterans' Hospital's Code of Conduct for Employees and Trainees (HPM 00-46). Rarely, instances arise which reflect poor professional conduct, disregard for policies and procedures of the Service and the Hospital, and/or possible ethical or legal misconduct. Any person who observes such behavior, whether staff or trainee, has the responsibility to report the incident. Should this occur by a trainee, the following procedures apply:

A. Illegal, unethical, or professionally inappropriate conduct by a trainee must be brought to the attention of the Training Director(s) in writing. Any person who observes such behavior, whether staff or trainee, has the responsibility to report the incident.

    1. Infractions of a very minor nature may be dealt with among the Training Director(s), the supervisor, and the trainee. A written record of the complaint and the action taken become a temporary part of the trainee's file.

    2. Any significant infraction or repeated minor infractions or issues of gross incompetence must be reviewed by the Training Committee, after the written complaint is submitted to a Training Director(s). After review of the case, the Training Committee will recommend either starting a formal Remediation Plan or termination of the trainee's appointment. In the case of an intern, the Training Director(s), with concurrence of the Psychology Service Chief, will determine if the behavior warrants notifying the graduate program's Director of Clinical Training at the outset of a Remediation Plan (prior to the trainee being placed in a probationary status).

    3. The Psychology Service Chief receives the recommendations of the Training Committee, decides on final deposition including recommendation for termination of the trainee's appointment.
        i. Should a trainee's conduct be particularly egregious, immediate intervention may be deemed necessary (e.g., suspension with pay) and review by the Affiliations Subcommittee of the Continuing and Hospital Education Committee requested for recommendations (which may include termination of the program without completion). A trainee may choose to withdraw from the program rather than being terminated.

B. Patient Abuse: Trainees witnessing or becoming aware of incidents of patient abuse will inform their supervisor or other Psychology training staff who will assist them in filing the required incident report and in following out the procedures outlined in VAMC memoranda.

Recent Staff and Resident Peer-Reviewed Publications (2018-present)

Trainee and Staff names are **bolded**

Babicz, M. A., Matchanova, A., & Woods, S. P. (2023). Apathy among persons living with HIV is associated with lower self-efficacy for healthcare provider interactions. Journal of the Association of Nurses in AIDS Care, 34(4), 389-397.

Babicz, M. A., Matchanova, A., Broomfield, R., DesRuisseaux, L.A., Gereau, M. M., Brothers, S. L…Woods S. P. (2023). Was the COVID-19 pandemic associated with gender disparities in authorship of manuscripts submitted to clinical neuropsychology journals?. Journal of the International Neuropsychological Society, 29(1), 105-109.

Bailey, E., Steward, K., VandenBussche Jantz, A., Kamper, J., Mahoney, E., & Duchnick, J. (2021). Neuropsychology of COVID-19: Anticipated Cognitive and Mental Health Outcomes. Neuropsychology, 35(4), 335-351.

Brown, R.M., Tang, X., Dreer, L.E., Driver, S., Pugh, M.J., Martin, A.M., **McKenzie-Hartman, T**., Shea, T., **Silva, M. A**., & **Nakase-Richardson, R**. (2018). Change in body mass index within the first year post-injury: A VA Traumatic Brain Injury (TBI) Model Systems study. Brain Injury, 32(8), 986-993. doi: 10.1080/02699052.2018.1468575

Brown-Taylor, L., Jaramillo, C., Eapen, BC; Kretzmer, T., Gavin, LP, Cooper, T., Pugh, MJ. (2020). Accumulation of good intentions: how individual practice guidelines lead to polypharmacy in the treatment of patients with polytrauma. PM&R Journal, 9.2020 http://dx.doi.org/10.1002/pmrj.12526

Cotner BA, **Nakase-Richardson R**, O'Connor DR, **Silva MA,** Hammond FM, Carlozzi NE, Finn JA, Chung J, Hoffman JM. (2023). Barriers and facilitators to accessing rehabilitation healthcare: A Veterans Affairs Traumatic Brain Injury Model Systems qualitative study. Archives of Physical Medicine & Rehabilitation, 104(3), 380-389. doi: 10.1016/j.apmr.2022.09.020

Dillahunt-Aspillaga, C., Pugh, M.J., Cotner, B., **Silva, M. A**., Haskin, A., Tang, X., Saylors, M.E., & Nakase-Richardson, R., (2018). Employment stability in veterans and service members with traumatic brain injury: A VA Traumatic Brain Injury Model Systems study. Archives of Physical Medicine and Rehabilitation, 99(2), S23-S32. doi: 10.1016/j.apmr.2017.05.012

Dismuke-Greer C, Almeida E, **Silva MA**, Dams-O'Connor K, Rocek G, Phillips L, Walker WC, **Nakase-Richardson R**. (2023). Effect of post-traumatic amnesia duration on traumatic brain injury (TBI) first year hospital costs: A Veterans Affairs TBI Model Systems study. Archives of Physical Medicine & Rehabilitation, 104(7), 1007-1015. doi: 10.1016/j.apmr.2023.03.023

Dreer LE, Tang X, **Nakase-Richardson R**, Pugh MJ, Cox MK**, Bailey EK**, Finn J, Zafonte R, Brenner LA. Suicide and traumatic brain injury: a review by clinical researchers from the National Institute for Disability and Independent Living Rehabilitation Research (NIDILRR) and Veterans Health

Administration Traumatic Brain Injury Model Systems. *Current Opinion in Psychology*, 2017: 22C (2018); 73-78. doi:10.1016/j.copsyc.2017.08.030 PMID 28963946.

Eapen, BC, Bowles, AO, Sall, J., Lang, AE, Hoppes, CW, Stout, KC, Kretzmer, T., & Cifu, DX (2022): The management and rehabilitation of post-acute mild traumatic brain injury, Brain Injury, DOI: 10.1080/02699052.2022.2033848.

Garcia, A., **Kretzmer, T.** S., Dams-O'Connor, K., Miles, S. R., Bajor, L., Tang, X., Belanger, H. G., Merritt, B. P., Eapen, B. Mckenzie Hartman, T., & **Silva, M. A**. (2022). Health conditions among special operations forces versus conventional military service members: A VA TBI Model Systems study. Journal of Head Trauma Rehabilitation.

Garcia, A., **Kretzmer, T. S**., Dams-O'Connor, K., **Miles, S. R**., Bajor, L., Tang, X., Belanger, H. G., Merritt, B. P., Eapen, B. Mckenzie Hartman, T., & **Silva, M. A**. (2022). Health conditions among special operations forces versus conventional military service members: A VA TBI Model Systems study. Journal of Head Trauma Rehabilitation, 37(4), E292-298. doi: 10.1097/HTR.0000000000000737.

Garcia, A., Miles, S. R., Reljic, T., **Silva, M. A.,** Dams-O'Connor, K., Belanger, H. G., Bajor, L., & **Nakase-Richardson, R.** (2021). Neurobehavioral symptoms in U.S. Special Operations Forces in rehabilitation after traumatic brain injury: A TBI Model Systems study. Military Medicine, usab347, Advance online publication. doi: 10.1093/milmed/usab347

Jiang, S., Brownell K.C., **Kamper, J.E**., & Stewart, J.T. (2020). Clonazepam for catatonia incompletely responsive to lorazepam. Psychosomatics, S0033-3182(20)30258-9.

Jiang, S., Brownell, K. C., **Kamper, J. E.,** & Stewart, J. T. (2021). Clonazepam for Catatonia Incompletely Responsive to Lorazepam. Journal of the Academy of Consultation-Liaison Psychiatry, 62(1), 97–101.

Kanser, R., O'Rourke, J., & **Silva, M. A**. (2022). Performance validity testing via telehealth and failure rate in veterans with moderate-to-severe TBI: A VA TBI Model Systems study. NeuroRehabilitation, 49, 169-177. doi: 10.3233/NRE-218019.

Kanser, R. J., Logan, P. M., Steward, K. A., Vanderbleek, E. N., & Kamper, J. E. (2022). Specificity of Embedded Performance Validity Tests in Elderly Veterans with Mild and Major Neurocognitive Disorder. Archives of clinical neuropsychology : the official journal of the National Academy of Neuropsychologists, acac106. Advance online publication. https://doi.org/10.1093/arclin/acac106

Kanser, R. J., VandenBussche Jantz, A. B., Logan, P. M., Bailey, E. K., & Kamper, J. E. (2022). Comparing Detection of Alzheimer's and Vascular Disease-Related Cognitive Impairment With Brief Cognitive Screens. The Journal of neuropsychiatry and clinical neurosciences, 34(4), 361–366. https://doi.org/10.1176/appi.neuropsych.21040091

Keelan, R. E., **Mahoney, E. J**., Sherer, M., Hart, T., Giacino, J., Bodien, Y. G., **Nakase-Richardson, R**., Dams-O'Connor, K., Novack, T.A., & **Vanderploeg, R. D.** (2019). Neuropsychological Characteristics of the Confusional State Following Traumatic Brain Injury. Journal of the International Neuropsychological Society, 25(3), 302-313.

Kumar, R. G., Ketchum, J. M., Hammond, F. M., Novack, T. A., O'Neil-Pirozzi, T. M., **Silva, M. A.,** & Dams O'Connor, K. (2022). Health and cognition among adults with and without TBI: A matched case control study. Brain Injury. 36(3), 415-423. doi: 10.1080/02699052.2022.2034190

Lequerica, A. H., Watson, E., Dijkers, M. P., Goldin, Y., Hoffman, J. M., Niemeier, J. P., **Silva, M. A.,** Rabinowitz, A., & Chiaravalloti, N. D. (2022). The utility of the Patient Health Questionnaire (PHQ-9) sleep disturbance item as a screener for insomnia in individuals with traumatic brain injury. Journal of Head Trauma Rehabilitation, 37(5), 383-E389. doi: 10.1097/HTR.0000000000000746

Matchanova, A., Woods, S. P., Neighbors, C., Medina, L. D., Podell, K., Beltran-Najera, I., Alex, C., **Babicz, M. A.,** & Thompson, J. L. (in press). Are accuracy discernment and sharing of COVID-19 misinformation associated with older age and lower neurocognitive functioning? Current Psychology.

Mahoney, E. J., **Silva, M. A**., Reljic, T., Dams-O'Connor, K., Hammond, F. M., Monden, K. R., Chung, J. S., Dillahunt-Aspillaga, C., & **Nakase-Richardson, R.** (2021). Rehabilitation needs at five-years post-TBI: A VA TBI Model Systems study. Journal of Head Trauma Rehabilitation, 36(3), 175-185

Miles, S. R. Hammond, F. M., Neumann, D., **Silva, M. A**., Tang, X., Kajankova, M., Dillahunt-Aspillaga, C., & **Nakase-Richardson, R**. (2021). Evolution of irritability, anger, and aggression after traumatic brain injury: Identifying and predicting subgroups. Journal of Neurotrauma, 38(12), 1827-1833.

Miles, S. R., **Silva, M. A**., Hoffman, J., Venkatesan, U., Sevigny, M., & **Nakase-Richardson, R.** (2021). Sleep apnea and posttraumatic stress after TBI: A TBIMS study. Rehabilitation Psychology, 66(4), 450-460. doi: 10.1037/rep0000389.

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Miles, S. R., **Silva, M. A**., Neumann, D., Dillahunt-Aspillaga, C., Corrigan, J. D., Tang, X., Eapen, B. C., **Nakase-Richardson, R**. (2021). Demographic and mental health predictors of arrests 1-10 years post-TBI: A Veterans Affairs TBI Model Systems study. Journal of Head Trauma Rehabilitation, 36(4), E240-E248.

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Nakase-Richardson, R., Dahdah, M. N., Almeida, E., Ricketti, P., **Silva, M. A**., Calero, K., Magalang, U., & Schwartz, D. (2020). Concordance between current AASM and CMS scoring criteria for obstructive sleep apnea in hospitalized persons with TBI: A VA TBI Model System study. Journal of Clinical Sleep Medicine, 16(6), 879-888. doi: 10.5664/jcsm.8352

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Noyes, E. T., Tang, X., Sanders, A. M., **Silva, M. A**., Walker, W. C., Finn, J. A., Cooper, D. B., & **Nakase-Richardson, R**. (2021). Relationship of medical comorbidities to psychological health at 2- and 5-years following TBI. Rehabilitation Psychology, 66(2), 1074-117. doi: 10.1037/rep0000366

Reale-Caldwell, A., Osborn, K.E., Soble, J.R., **Kamper, J.E**., Rum, R., & **Schoenberg, M.** (2019). Comparing the North American Adult Reading Test (NAART) and the Test of Premorbid Functioning (TOPF) to estimate premorbid Wechsler Adult Intelligence Scale – 4th edition FSIQ in a clinical sample with epilepsy. Applied Neuropsychology: Adult.

Ropacki S, **Nakase-Richardson R**, Farrell-Carnahan L, Lamberty GJ, Tang X. Descriptive findings of the VA Polytrauma Rehabilitation Centers TBI Model Systems National Database. *Archives of Physical Medicine and Rehabilitation 2018; 99:952-9.* doi: 10.1016/j.apmr.2017.12.035 PMID 29425697

Saloner, R., Casaletto, K.B., Dutt, S., Wynn, J., **Vanden Bussche, A.B.,** Fox, E., & Kramer, J.H. (2018). Performance on a 1-week delayed recall task is associated with medial temporal lobe structures in neurologically normal older adults. *The Clinical Neuropsychologist.* 32(3), 456-467. doi:10.1080/13854046.2017.1370134.

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Silva, M. A., Arriola, N. B., Radwan, C. K., Womble, B. M., **Healey, E. A.,** Lee, J. M., Aloia, M. S., & **Nakase-Richardson, R.** (in press). Improving sleep apnea treatment adherence following traumatic brain injury: A nonrandomized feasibility study. Rehabilitation Psychology, 66(4), 461-473. doi: 10.1037/rep0000473

Silva, M. A., **Belanger, H. G**., Dams-O'Connor, K., Tang, X**., McKenzie-Hartman, T**., & **Nakase-Richardson, R.** (2018). Prevalence and predictors of tobacco smoking in veterans and service members with traumatic brain injury: A TBI Model Systems study. Brain Injury, 32(8), 994-999. doi: 10.1080/02699052.2018.1468576

Silva, M. A., Brennan, E. M., **Calvo, D**., Reljic, T., Drasher-Phillips, L., Schwartz, D. J., Kumar, A., Cotner, B., & **Nakase-Richardson, R**. (2020). Incidence and predictors of adherence to sleep apnea treatment in rehabilitation inpatients with acquired brain injury. Sleep Medicine, 69, 159-167. doi: 10.1016/j.sleep.2020.01.016

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Silva, M. A., Finn, J. A., Dillahunt-Aspillaga, C., Cotner, B. A., Stevens, L. F., & **Nakase-Richardson, R**. (2022). Development of the traumatic brain injury rehabilitation needs survey: A VA TBI Model Systems study. Disability and Rehabilitation, 14(16), 4474-4484. . doi: 10.1080/09638288.2021.1900930

Silva MA, Gonzalez AV, Tang X, Carnahan ND, Klyce DW, Liou-Johnson V, **Martin AM**, Moberg JM, Dreer LE. (2023).
Examining the relationship between sleep apnea diagnosis and suicide risk in Veterans with traumatic brain injury: A VA TBI Model Systems study. Journal of Head Trauma Rehabilitation. Advance online publication. doi: 10.1097/HTR.0000000000000856

Silva, M. A., Lee, J. M., **Garcia, A.,** Dams O'Connor, K., & **Nakase-Richardson, R**. (2022). Impact of obstructive sleep apnea disease duration on neuropsychological functioning after traumatic brain injury: A Veterans Affairs TBI Model Systems study. Journal of Head Trauma Rehabilitation. Advance online publication. doi: 10.1097/HTR.0000000000000797

Silva, MA, **Miles, SR**, O'Neil-Pirozzi, TM, Arciniegas, DB, Klocksieben, F, Dismuke-Greer, CE, Walker, WC, **Nakase-Richardson, R**. (2023). Alternative structure models of the traumatic brain injury Rehabilitation Needs Survey: A Veterans Affairs TBI Model System study. Archives of Physical Medicine & Rehabiltation, 104(7), 1062-1071. 10.1016/j.apmr.2023.01.004

Silva, M. A., Schwartz, D. J., **Nakase-Richardson, R**. (2019). Functional improvement after severe brain injury with disorder of consciousness paralleling treatment for comorbid obstructive sleep apnea: A case report. International Journal of Rehabilitation Research, 42(3), 285–288. doi: 10.1097/MRR.0000000000000364.

Silva, M. A., **VandenBussche Jantz, A. B**., Klocksieben, F., Monden, K. R., Rabinowitz, A. R., Cotner, B. A., Dillahunt-Aspillaga, C., & **Nakase-Richardson, R.** (2021). Unmet rehabilitation needs indirectly influence life satisfaction 5 years after traumatic brain injury: A VA TBI Model Systems study. Archives of Physical Medicine and Rehabilitation, 102(1), 58-67.

Snow JC, Tang X, **Nakase-Richardson R**, Adams RS, Wortman KM, Dillahunt-Aspillaga C, Miles SM. The relationship between PTSD symptoms and social participation in veterans with TBI: A VA TBIMS study. J Appl Rehabil Counsel, 50(1); 2019: 41-56. doi: 10.1891/0047-2220.50.1.41

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Sunderaraman, P., Dunn, C. B., **Kamper, J. E**., DeDios-Stern, S., Azar, M., Feigon, M., Cooper, S., & Gooding, A. (2023). Characteristics of and Professional Issues Experienced by Early Career Neuropsychologists in the United States - Findings from a Survey Study. Archives of clinical neuropsychology : the official

journal of the National Academy of Neuropsychologists, acad020. Advance online publication. https://doi.org/10.1093/arclin/acad020

Thompson, J. L., Matchanova, A., Beltran-Najera, I., Ridgely, N., Mustafa, A., **Babicz, M. A**., Hasbun, R., Giordano, T. P., & Woods, S. P. (2023). Preliminary validity of a telephone-based neuropsychological battery in a consecutive series of persons with HIV disease referred for clinical evaluation. Archives of Clinical Neuropsychology, 38(4), 570-585.

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RECENT STAFF AND TRAINEE SYMPOSIA, ORAL PRESENTATIONS, AND BOOK CHAPTERS (2018-PRESENT)

Trainee and Staff names are **bolded**

Bailey, E.K., Kamper, J.E., and Gius, B. (2022). Anticipated long-term neurobehavioral outcomes following COVID-19. In Frontiers of COVID-19. Springer.

Brennan, E. M., Noyes, E., Ching, D., Royer, A. C., **Nakase-Richardson, R**., & **Silva, M. A**. (2019, November). Sleep apnea prevalence differs by TBI severity in veterans and service members: A VA TBIMS study. Archives of Physical Medicine and Rehabilitation 100(10), e28. Oral presentation presented at the 96th Annual Conference of the American Congress of Rehabilitation Medicine, Chicago, IL

Corrigan J, Kumar R**, Nakase-Richardson R**. Bogner J, Ketchum J. Dams O'Conner K. Understanding the Impact of Co-morbid Conditions on Outcomes from TBI. Symposium accepted to the 95th annual meeting of the American Congress of Rehabilitation Medicine; September 2018; Dallas, TX.

DeDios-Stern, S. & **Kamper, J.E.** (2020, August). Tweeting in the name of science: Using social media to disseminate your research and to attract attention. Symposium given at the annual meeting of the American Psychological Association, Washington, D.C.

Furst A, Gehrman PR, **Nakase-Richardson R**, **Silva M.** Sleep-Wake Disturbances after Traumatic Brain Injury. Symposium at the 4th Federal Inter-Agency Conference on Traumatic Brain Injury, June 2018, Washington, DC.

Garcia, A. M., Reljic, T., **Silva, M. A.,** Miles, S., **Kretzmer, T**., Belanger, H., Dams-O'Connor, K., & **Nakase-Richardson, R.** (2020). Predictors of neurobehavioral symptoms after TBI for Special Operations Forces (SOF) vs. non-SOF service members/veterans: A VA TBI Model Systems study. Archives of Physical Medicine & Rehabilitation, 101(11), e8-e9. Oral presentation at the 97th annual meeting of the American Congress of Rehabilitation Medicine, Atlanta, GA [virtual conference].

Gonzalez, A. V., **Silva, M. A**., Liou-Johnson, V., Klyce, D. W., Carnahan, N. D., **Martin, A. M**., Dreer, L., Moberg, J. M., & **Nakase-Richardson, R.** (2022, September 12-15). Differential impact of sleep disturbances on suicidal ideation in veterans with traumatic brain injury: A VA TBI Model Systems study [Oral presentation]. Military Health System Research Symposium, Kissimmee, FL.

Gootam, P. K., **Kretzmer, T. S**., **McKenzie Hartman, T**., **Nakase-Richardson, R**., **Silva, M. A**., & Bajor, L.A. (2020). Assessment and treatment of sleep in mild traumatic brain injury. In Eapen, B., & Cifu, D. (Eds.), Concussion: Assessment, Management, and Rehabilitation (pp. 77-88). Philadelphia, PA: Elsevier.

Kamper, J.E. (2018, March). Mindfulness and TBI. CE Workshop presented through the University of South Florida Department of Psychology, Tampa, FL.

Kamper, J.E., DeDios-Stern, S., & Block, C. (2021, August). Tweeting in the name of science: Using social media to disseminate your research & attract attention. Symposium given at the annual meeting of the American Psychological Association, Held Virtually.

Kamper, J.E. (2022, March). Advanced Capacity Assessment for the Psychiatrist: Clinical decision-making in complex cases. Oral Presentation given at the annual meeting of the American Academy of Geriatric Psychiatry, Orlando, FL.

Kretzmer, T., Kieffer, K., Kaplan, JM, Darkangelo, BJ, Garrison, B, Humayun, F, & Belanger, HG. (2018). Community Reintegration. In Cifu & Eapen (Eds.), *Rehabilitation after Traumatic Brain Injury.* Elseiver. pp 255-270. https://www.elsevier.com/books/rehabilitation-after-traumatic-brain-injury/eapen/978-0-323-54457-3

McCarthy, M. & **Silva, M. A.** (2018). VA TBI Model System program. In J.S. Kreutzer, J. DeLuca, & B. Caplan (Eds.), Encyclopedia of Clinical Neuropsychology (2nd ed.) (pp. 3547-3548). Springer. doi: 10.1007/978-3-319-57111-9_9236

Merritt, B., ***Kretzmer, T.***, Hartman-McKenzie, T., & Gootam, K. (2019). Neurobehavioral Management of Polytrauma Veterans. In Eapen & Cifu (Eds.), *Polytrauma Rehabilitation.* Elsiver.

Miles, S., **Silva, M**., Martindale, S., Troyanskaya, M., & **Nakase-Richardson, R**. (2020). Putting the pieces together to understand anger: PTSD, sleep apnea, TBI, and pain as contributors. Archives of Physical Medicine & Rehabilitation, 101(11), e13. Oral presentation at the 97th Annual Meeting of the American Congress of Rehabilitation Medicine, Atlanta, GA [virtual meeting].

Nakase-Richardson, R., Bell, K., & **Silva, M. A.** (Moderator). (March 4-9, 2020). Screening and diagnosis of sleep apnea in acute TBI. Symposium conducted at the accepted at the International Society of Physical Medicine & Rehabilitation Medicine World Congress & Association of Academic Physiatrists annual meeting, Orlando, FL.

Nakase-Richardson R, **Silva MA, Garcia A.** Sleep Apnea and Outcome After Military TBI. Symposium accepted to the 95th annual meeting of the American Congress of Rehabilitation Medicine; September 2018; Dallas, TX.

Nakase-Richardson R. & Bell K. Advancing Sleep Research: Two Multi-Center Studies within the TBI Model System Program. Symposium at the 4th Federal Inter-Agency Conference on Traumatic Brain Injury, June 2018, Washington, DC.

Nakase-Richardson R, Hammond F, Kowalski R. Extending our Knowledge of Long-Term Outcomes After Severe TBI: Three DOC TBI Model System Studies. Symposium at the 4th Federal Inter-Agency Conference on Traumatic Brain Injury, June 2018, Washington, DC.

Nakase-Richardson R, Bell KR, Lequerica AH, Coulter J, Coulter J. Advancing sleep research in moderate to severe TBI: Three multicenter studies within the TBI Model System program of research. Symposium at SLEEP 2018, the 32st Annual Meeting of the Associated Professional Sleep Societies, June 2018; Baltimore, MD.

Nakase-Richardson, R., Bell, K., & **Silva, M. A**. (Moderator). (March 4-9, 2020). Screening and diagnosis of sleep apnea in acute TBI. Symposium conducted at the accepted at the International Society of Physical Medicine & Rehabilitation Medicine World Congress & Association of Academic Physiatrists annual meeting, Orlando, FL.

Nakase-Richardson, R., Humayun, F., McCarthy, M. (Moderator), & **Silva, M. A**. (March 4-9, 2020). Actigraphy in acute TBI polytrauma: The James A. Haley VA experience. Symposium conducted at the accepted at the International Society of Physical Medicine & Rehabilitation Medicine World Congress & Association of Academic Physiatrists annual meeting, Orlando, FL.

Nakase-Richardson, R., Schwartz, D.J., Bell, K., **Silva, M.A**., & Bogner, J. (2019, March). Managing Sleep Disorder Comorbidities to Enhance Brain Injury Outcome. Invited talk at the International Brain Injury Association's 13th World Congress on Brain Injury, Toronto, Canada.

Nakase-Richardson, R., **Silva, M. A**., **Garcia, A**., & Wattine. L. (2022). Sleep management after traumatic brain injury. In Zasler, N. D., Katz, D. I., & Zafonte, R. D. (Eds.), Brain injury medicine (3rd ed.). demosMEDICAL/Springer.

Nakase-Richardson, R., **Silva, M. A**., **Garcia, A**., & Wattine. L. (2021). Sleep management after traumatic brain injury. In Zasler, N. D., Katz, D. I., & Zafonte, R. D. (Eds.), Brain injury medicine (3rd ed.) (pp 625-634). demosMEDICAL/Springer.

Ricketti P, Schwartz D, Kalero C, Anderson W, Diaz-Sien C, Drasher-Phillips L, O'Connor D, Rechkemmer MB, Bell K, Dahdah M, **Nakase-Richardson R**. American Academy of Sleep Medicine versus CMS criteria for obstructive sleep apnea in TBI. Oral presentation to the 4th Federal Inter-Agency Conference on Traumatic Brain Injury, June 2018, Washington, DC.

Royer, A.C., **Silva, M.A**., Finn, J., Cotner, B., and **Nakase-Richardson, R.** (2018). Rehabilitation Needs in Veterans and Service Members 1-Year after Traumatic Brain Injury [Abstract]. Archives of Physical Medicine and Rehabilitation 99(11), e174. Poster presented at the Federal Interagency Conference on TBI, Washington DC.

Silva, M. A. (2022). Psychomotor vigilance test. In, Kushida C. (Ed.), Encyclopedia of sleep and circadian rhythm disorders, (2nd ed.). Elsevier/Academic Press.

Silva, M. A. (2021). Psychomotor vigilance test. Reference Module in Neuroscience and Biobehavioral Psychology. Elsevier. doi: 10.1016/B978-0-12-822963-7.00046-3.

Silva, M. A. (2018). Neurobehavioral Symptom Inventory. In J.S. Kreutzer, J. DeLuca, & B. Caplan (Eds.), Encyclopedia of Clinical Neuropsychology (2nd ed.) (pp. 2387-2839). Springer. doi: 10.1007/978-3-319-57111-9_9234

Silva, M. A. (2018). PCL-C (PTSD Checklist). In J.S. Kreutzer, J. DeLuca, & B. Caplan (Eds.), Encyclopedia of Clinical Neuropsychology (2nd ed.) (pp. 2605-2608). Springer. doi: 10.1007/978-3-319-57111-9_9235

Silva, M. A. (2020). A readable introduction and overview of the neuropsychology of sports-related concussion. [Review of the book Neuropsychology of sports-related concussion by P. A. Arnett (Ed.)]. Archives of Clinical Neuropsychology, 35(3), 342-344. doi: 10.1093/arclin/acz050

Silva, M. A. (2021). [Review of the test of Memory and Learning-Senior Edition]. In J. F. Carlson, K. F. Geisinger, & J. L. Jonson (Eds.), The twenty first mental measurements yearbook (pp 784-789). Lincoln, NE: Buros Center for Testing, University of Nebraska-Lincoln.

Silva, M. A. (2018, October). Sleep apnea treatment adherence is poor among rehabilitation inpatients with acquired brain injury. In, R. Nakase-Richardson (Chair), Sleep Apnea and outcome after brain injury. Symposium conducted at the American Congress of Rehabilitation Medicine, Dallas, TX.

Silva, M. A. (2018, June). Sleep-Wake Disturbance after TBI During Inpatient Rehabilitation and Sleep Monitoring with Actigraphy. In Ansgar Furst (Chair), Sleep-Wake Disturbances after Traumatic Brain Injury. Symposium conducted at the Federal Interagency Conference on TBI, Washington DC.

Silva, M.A. (2019). Incidence and predictors of sleep apnea treatment adherence after acquired brain injury [Abstract]. Brain Injury, 33(suppl_1), 61. Paper presented at the International Brain Injury Association's 13th World Congress on Brain Injury, Toronto, Canada.

Silva, M. A. (2021). Development of an intervention with cognitive adaptations to enhance sleep apnea treatment adherence among persons with traumatic brain injury. Archives of Physical Medicine & Rehabilitation, 102(4), e2. Presented at the 97th annual meeting of the American Congress of Rehabilitation Medicine, Atlanta, GA [virtual conference, 2020, October 21-24

Silva, M. A., **Belanger, H. G**., Tang, X., Dams-O'Connor, K., **McKenzie Hartman, T**., & **Nakase-Richardson, R.** (2018). Prevalence and Predictors of Tobacco Smoking 1-2 years after Rehabilitation for Traumatic Brain Injury [Abstract]. Archives of Physical Medicine and Rehabilitation 99(11), e173-e174. Poster presented at the Federal Interagency Conference on TBI, Washington DC.

Silva, M. A. & Brennan, E. M. (2022). [Review of the test of Premorbid Function]. The twenty first mental measurements yearbook. Lincoln, NE: Buros Center for Testing, University of Nebraska-Lincoln.

Silva, M. A., & Lee, J. M. (2021). Neurocognitive testing. Reference Module in Neuroscience and Biobehavioral Psychology. Elsevier. doi: 10.1016/B978-0-12-822963-7.00047-5.

Silva, M. A., & **Lee, J. M.** (2021). Neurocognitive testing. Reference Module in Neuroscience and Biobehavioral Psychology. Elsevier**.** doi: 10.1016/B978-0-12-822963-7.00047-5.

Sullivan, G., Iannuzzi, G., & **Kamper, J.E**. (2022, March). The Capacity to be an Expert: Considerations of decision-making assessment for geriatric psychiatrists. Symposium given at the annual meeting of the American Academy of Geriatric Psychiatry, Orlando, FL.

Turkel, M. L., Miles, S. R., **Nakase-Richardson, R., Silva, M. A**., Martindale, S. L., & Troyanskala, M. (2020, November 5-7). Obstructive Sleep Apnea Risk, TBI, and PTSD Increase Anger in Veterans. Presented at the 36th Annual Meeting of the International Society for Traumatic Stress Studies, Atlanta, GA (Virtual Meeting)

RECENT TRAINEE POSTER PRESENTATIONS (2020-PRESENT)

Trainee names are **bolded**

Fox ME, Silva MA, Hoffman J, Tran J, Klocksieben F, Nakase-Richardson R. Cross-sectional analysis of rehospitalization following discharge from inpatient rehabilitation in veterans with traumatic brain injury up to 10 years postinjury. Poster presented at: 51st Annual Meeting of the International Neuropsychological Society, February 1-4, 2023, San Diego, CA.

Logan, P.M. & Kamper, J.E. (2021). When there's a WMS there's a way: Investigating the differential utility of the WMS-IV Logical Memory I Adult versus Older Adult versions in a mixed clinical sample of 65-69 year-old veterans. Poster presented at the Annual Meeting of the International Neuropsychological Society, San Diego, CA.

Loyo K, Wittine L, Silva MA, Ketchum JM, Hammond, FM, Chung JS, Kretzmer T, Nakase-Richardson R. Causes of mortality among veterans previously hospitalized after traumatic brain injury. Poster presented at: 99th annual meeting of the American Congress of Rehabilitation Medicine, November 8-11, 2022; Chicago, IL. Published abstract: Arch Phys Med Rehabil. 2022; 103(12), e128. doi: 10.1016/j.apmr.2022.08.772

O'Rourke, J. J. F., **Kanser, R. J**., & Silva, M. A. (2021, November 10-13). Performance validity testing in telehealth research: A VA Traumatic Brain Injury Model Systems study [Poster presentation]. 2021 National Academy of Neuropsychology Annual Conference: Neuropsychology and Neurorehabilitation: Future of Clinical Practice.

Silva, M. A., **Kanser, R. J**., & O'Rourke, J. J. F. (2022, February 2-5). Performance validity testing via telehealth and failure rate after mild versus moderate-to-severe traumatic brain injury: A Veterans Affairs TBI Model Systems study [Poster presentation]. 50th Annual meeting of the International Neuropsychological Society, New Orleans, LA.

Silva, M. A., **Kanser, R. J**., & O'Rourke, J. J. F. (2021, August 23-26). Performance validity testing in a telehealth modality and failure rate after mild versus moderate-to-severe traumatic brain injury: A Veterans Affairs TBI Model Systems study [Poster presentation]. 2021 Military Health System Research Symposium, Kissimmee, FL.

Steward, K., Tang, X., Wittine, L., Dams O'Connor, K., Silva, M. A., Maduri, P., Nakase-Richardson, R. (2022, February 2-5). The relationship between obstructive sleep apnea severity and cognitive performance in acute moderate/severe TBI Poster presentation]. 50th Annual meeting of the International Neuropsychological Society, New Orleans, LA.

Vanden Bussche Jantz, A.B., Mahoney, E.J., Bailey, E.K., Vassallo, J.L., & Kamper, J.E. (2020, February) The Modified Mini-Mental State (3MS) Examination and MMSE: Comparing Two Common Screeners' Ability to Predict Executive Functioning. Poster session to be presented at the *International Neuropsychology Society (INS) Annual Meeting*, Denver, CO.

Vanden Bussche Jantz, A.B., Nakase-Richardson, R., Rabinowitz, A.R., Flores-Stevens, L., Monden, K.R., Cotner, B.A., Dillahunt-Aspillaga, C., Giacino, J.T., & Silva, M.A. (2020, Feb). The Impact of Rehabilitation Needs on Satisfaction with Life: A VA TBI Model Systems Study. Poster session presented at the *International Neuropsychology Society (INS) Annual Meeting*, Denver, CO.

Vanden Bussche Jantz, A. B., Nakase-Richardson, R., Rabinowitz, A., Stevens, L. F., Monden, K. R., Cotner, B., Dillahunt-Aspillaga, C., Giacino, J. T., & Silva, M. A. (February 5-8, 2020). The impact of rehabilitation needs on satisfaction with life: A VA TBIMS study. Poster presented at the 48th annual meeting of the of the International Neuropsychological Society: Neuropsychology in the Era of Precision Medicine, Denver, CO.

Weitzner, D.S., Miller, B.I., & Webber, T.A. *The Impact of Performance and Symptom Invalidity on Relationships Between Subjective and Objective Cognitive Functioning.* Poster presented at the International Neuropsychological Society Annual Meeting, San Diego, CA, February 2023.