Doctoral Internship in Clinical & Community Psychology

Handbook

2020 -2021
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Program Aims
The overarching aim of the Yale Doctoral Internship in Clinical and Community Psychology is to provide state-of-the-art training to the next generation of health service psychologists that:

1. Prepares them for entry-level practice in which they deliver high quality services within an increasingly integrated healthcare landscape
2. Fosters growth and development of psychology leaders and innovators who can effectively apply their knowledge and skills to ensure access, availability and affordability of psychological interventions to meet the needs of an increasingly diverse public
3. Fosters academic leadership and development, including scholarly contributions to the field
4. Promotes the career development of fellows by facilitating informed choices about their next steps professionally

Program Actions
To support attainment of program aims, the program utilizes the following actions:

Action 1
Provide a doctoral internship of exceptional quality that combines intensive and diverse professional experiences, supervision and mentoring from a skilled faculty, highly interactive seminars, and opportunities for scholarship.

Action 2
Foster the development among fellows of an intermediate level of competency in the program’s core competencies, which are as follows:

- **Competency 1:** Communication and interpersonal skills
- **Competency 2:** Individual and cultural diversity
- **Competency 3:** Professional values, attitudes and behaviors
- **Competency 4:** Ethical and legal standards
- **Competency 5:** Assessment
- **Competency 6:** Intervention
- **Competency 7:** Consultation, interprofessional/interdisciplinary and systems-based practice
- **Competency 8:** Supervision
- **Competency 9:** Research and scholarship

Action 3
Promote the career development of fellows, facilitating an informed choice about their next steps professionally.

- **Strategy A:** Increase the fellows’ awareness of career options and post-internship opportunities.
- **Strategy B:** Support fellows in searching for and securing post-internship positions
Doctoral Internship Policy & Procedures

Program Philosophy

Revised 01-03-20

The internship year is first and foremost a supervised, intensive, experiential learning opportunity focused on the delivery of psychological services. The program embraces a scientist-practitioner model in which theory and evidence routinely inform health service psychology (HSP) practice. As science is at the center core of HSP, each fellow has protected time to pursue a scholarly activity that can center on research, program evaluation, clinical care, or education.

Training is competency-based and relies on evidence-based teaching approaches. The internship is part of a nurturing professional community of psychologists that values and promotes diversity among the faculty, fellows, populations served, and the theoretical perspectives and interventions utilized.

All fellows in the internship program receive training in clinical psychology. Those fellows who elect a primary or secondary placement at The Consultation Center also receive training in community psychology.

A priority is placed on professional development, including assistance to doctoral fellows in securing opportunities after internship such as postdoctoral fellowships and employment. Each year, many graduating fellows remain at Yale to pursue postdoctoral training and research.

There are six explicit core elements to the philosophy that guide the Yale Department of Psychiatry Doctoral Internship in Clinical and Community Psychology. Each of these is described in detail below.

1. Scientist-Practitioner Model
   - The internship year is first and foremost an intensive, experiential learning opportunity focused on the delivery of psychological services.
   - The experience centers on a combination of activities that include clinical care, assessment, diagnosis, prevention, clinical intervention, consultation, and evaluation.
   - Throughout the internship, both theory and empirical evidence inform doctoral fellows’ practice.
   - Learning to search for and apply the best available evidence in the provision of psychological services is an inherent part of the learning experience.
   - Protected time is afforded to further develop skills as a scholar through a project that centers on research, evaluation, clinical care, and/or education.

2. Evidenced-Based Teaching Approaches
   - Learning is planned, sequenced, and graded in complexity over the course of the year.
   - Learning is competency-based with explicit articulation of the competencies to be developed and demonstration that those competencies are achieved during the training year.
   - An apprenticeship model is used in which fellows observe faculty psychologists modeling the competencies and faculty members observe fellows mastering the competencies.
• The internship experience is learner-driven with psychology fellows playing an active role in identifying, through self-assessment, their strengths, learning needs, and progress in mastering the competencies.
• In keeping with adult learning principles, learning is problem-oriented, focused on the challenges experienced by the fellows in the course of their internship responsibilities.
• Classroom learning is directly linked, to the extent possible, to site-based and community-based experiential learning opportunities.

3. Diversity
• Diversity is integral to the training experience and valued among faculty, fellows, and the individuals and families served with respect to gender, race, ethnicity, sexual orientation, socio-economic status, culture, geography, country of origin, and disability status.
• Diversity is valued among faculty and fellows with respect to professional interests, activities, and work setting.
• Diversity is valued with respect to theoretical perspectives and interventions used in caring for individuals and their families, and incorporated into the work of service systems.
• Diversity is valued with respect to the use of cultural and linguistic adaptations of evidence-based practices.

4. A Nurturing Professional Community
• Through professional and social group meetings and gatherings a community is formed that serves as the fellows' psychological and social home for the training year.
• A premium is placed on creating supportive relationships that help fellows excel professionally while maintaining a balance between the professional and the personal, and developing skills in self-care.

5. Professional Development
• The broad range of experiences that comprise the internship foster the development of fellows’ sense of professional identity.
• Ethical issues in psychological practice are examined and discussed throughout the internship.
• Intensive interactions with other disciplines and professions help fellows define the essential characteristics of psychology as a discipline and recognize those attributes that are shared in common with other healthcare professions. A competency in interdisciplinary and team-based practice is mastered.
• The unique life histories, diversity of professional and personal interests, and expertise among the fellows create a community of peers who learn from each other.
• Fellows receive many things during the internship year, but are simultaneously challenged to give back, making a constructive mark on their peer group and the clinical and consultation settings in which they work.
• A planned sequence of educational opportunities combined with individual mentoring helps each fellow explore and pursue their professional development and post-internship career opportunities.

6. Continuous Quality Improvement
• Comprehensive and periodic self-evaluation promotes constant improvements in the quality of the internship program and the fellows’ experience.
I. Communication and Interpersonal Skills

A. Communicates effectively
   1. Listens attentively to others
   2. Demonstrates a command of language, both written and verbal
   3. Identifies differences in communication needs across contexts and intended recipients and adjusts communications accordingly
   4. Demonstrates a thorough grasp of professional language and concepts and uses them appropriately and clearly in oral and written communications
   5. Produces and comprehends written work that is organized, comprehensive and well-integrated

B. Forms positive relationships with others
   1. Develops, maintains, and effectively terminates therapeutic relationships with individuals receiving professional services
   2. Develops and maintains productive working relationships with colleagues, communities, organizations, supervisors, and supervisees
   3. Interacts in a manner that is honest, straightforward, and flexible
   4. Expresses genuine interest in others, providing them support and encouragement
   5. Displays compassion and empathy toward others, including those dissimilar from oneself

C. Manages complex interpersonal situations
   1. Maintains appropriate boundaries (e.g., sharing of personal information, personal touch, dual relationships)
   2. Acknowledges and tolerates others’ feelings and attitudes, including those expressed toward them
   3. Allows and facilitates patients’ exploration of emotionally laden issues
   4. Maintains emotional equilibrium and judgment when faced with interpersonal conflict and patient distress
   5. Recognizes and uses problem solving strategies to address interpersonal conflicts
   6. Offers and accepts feedback constructively

D. Demonstrates self-awareness as a professional
   1. Identifies and monitors personal attitudes, values, beliefs, individual and cultural identities, and their typical role in groups
   2. Recognizes how others experience them and the impact of self on others
   3. Uses personal reactions to inform work with patients and other professionals
   4. Adjusts professional behavior based on awareness of self and awareness of impact on others
II. **Individual and Cultural Diversity**

A. **Demonstrates awareness of diversity and its influence**
   1. Identifies the various dimensions of individual and cultural diversity (e.g., age, race, ethnicity, national origin, language, socioeconomic status, gender, gender identity, sexual orientation, religion, spiritual beliefs, physical and mental ability)
   2. Recognizes and appreciates complexities inherent to individual and cultural diversity (e.g., intersectionality)
   3. Recognizes the potential influence of individual and cultural diversity on others and on the interactions between individuals, groups and systems of care
   4. Explores and monitors how they are influenced by individual and cultural characteristics and experiences
   5. Moves beyond recognition and identification toward an integrated and developed framework for working with populations that are diverse

B. **Develops effective relationships with culturally diverse individuals, families, and groups**
   1. Recognizes and respects differences between self and others
   2. Communicates in patient’s preferred language or uses interpreter services as needed
   3. Explores with patients their individual and cultural identities and the meaning of these identifications to them
   4. Recognizes and responds appropriately to the impact of individual and cultural diversity in clinical, consultative, and supervisory relationships

C. **Applies knowledge of individual and cultural diversity in practice**
   1. Selects assessment instruments, uses assessment tools, and interprets findings within the context of patients’ linguistic and cultural characteristics
   2. Considers individual and cultural characteristics in developing treatment plans and selecting, modifying, implementing, and monitoring interventions
   3. Is aware of and integrates knowledge of individual and cultural diversity across aspects of professional role (intervention, assessment, consultation, research, leadership, etc.)
   4. Connects patients to culturally responsive services and resources
   5. Recognizes, brings attention to, and/or addresses disparities in access to services, or other forms of discrimination

D. **Pursues professional development about individual and cultural diversity**
   1. Recognizes the limitations in their abilities to work with individuals from diverse backgrounds
   2. Reviews and applies relevant literature and practice guidelines on providing services to diverse populations
   3. Seeks supervision to enhance their abilities to work with individuals from diverse backgrounds
   4. Pursues continuing education and multicultural experiences to enhance their abilities to work with individuals from diverse backgrounds

III. **Professional Values, Attitudes and Behavior**

A. **Displays professional behavior**
   1. Maintains appropriate personal hygiene and professional attire
2. Utilizes appropriate language and non-verbal communications, including in difficult interactions
3. Demonstrates sound judgment in their responses to routine, complex and/or challenging situations
4. Responds professionally in increasingly complex situations with a level of independence that matches their professional role
5. Clarifies expectations and engages in behavior appropriate for their professional role and adjusts behavior to the setting and situation

B. Engages in self-assessment and self-reflection
1. Uses multiple methods to routinely assess professional strengths and areas for growth (e.g., supervision, peer supervision/consultation, audio/video recordings, patient feedback)
2. Is open, receptive and responsive to feedback around performance and professional functions
3. Recognizes and observes the limits of personal knowledge and skills
4. Recognizes changes in the field that require the development of new or enhanced competencies

C. Demonstrates accountability
1. Acts responsibly (e.g., organizes workload; completes assigned duties efficiently; keeps appointments; honors commitments; follows policies, procedures and administrative requirements)
2. Demonstrates reliability (e.g., arrives on time, completes work on time, documents in an accurate and timely manner)
3. Remains available and accessible as their role requires
4. Acknowledges and assumes responsibility for errors, lapses in judgment, and deviations from professional ethics and values

D. Demonstrates professional identity
1. Exhibits knowledge of the profession and awareness of issues central to the field
2. Reflects the professional value of life-long learning by pursuing continuing education
3. Articulates and pursues professional and career goals
4. Demonstrates emerging leadership skills

E. Engages in the self-care essential for functioning effectively as a psychologist
1. Uses self-care approaches to maintain health and wellness
2. Uses positive coping strategies to tolerate ambiguity and uncertainty and to manage stress
3. Recognizes personal challenges and addresses them so as to minimize their impact on professional performance

IV. Ethical and Legal Standards
A. Demonstrates awareness of ethical and legal standards applicable to Health Service Psychology practice, training, and research
1. Recognizes the ethical values and principles held by professional psychology and the institutions in which they work
2. Demonstrates awareness of relevant laws, regulations, rules and policies governing health service psychology practice at the organizational, local, state, regional, and federal levels
3. Demonstrates awareness of specific concepts that underlie the above laws, regulations and policies (e.g., informed consent, confidentiality, mandated reporting)
4. Articulates own ethical values and priorities

B. Recognizes and manages ethical and legal issues in Health Service Psychology practice, training, and research
1. Adheres to all ethical and legal standards in all professional activities
2. Recognizes and helps others recognize ethical and legal issues as they arise
3. Demonstrates a clear decision-making process in the development and implementation of plans to resolve ethical and legal issues
4. Takes appropriate action when others behave in an unethical or illegal manner
5. Seeks supervision or consultation on ethical and legal issues

C. Adheres to the APA Ethical Principles and Code of Conduct
1. Strives to benefit others and do no harm
2. Develops relationships of trust with others and accepts responsibility for their behavior
3. Maintains personal integrity
4. Promotes fairness and justice
5. Respects the dignity, worth, and rights of all people

V. Assessment
A. Conducts clinical interviews
1. Quickly establishes rapport with individuals being interviewed
2. Formulates relevant and culturally responsive interview questions
3. Conducts semi-structured interviews

B. Appropriately selects and applies evidence-based assessment methods
1. Screens referrals and identifies clear goals for assessments
2. Selects psychometrically sound assessment methods and tools that draw from the best empirical literature and that are relevant to assessment aims
3. Administers assessment methods and tools accurately and efficiently
4. Scores and interprets results

C. Collects and integrates data
1. Obtains and integrates multiple sources of information (e.g., observations, historical information, interview data, test results, information from collateral sources, and findings from the literature)
2. Demonstrates current knowledge of diagnostic classification systems and awareness of cultural (and other) limitations of such systems
3. Uses above systems to classify and differentiate functional and dysfunctional behaviors and as well as identify strengths and protective factors
4. Formulates case conceptualizations that demonstrate a clear understanding of behavior within its context (e.g., familial, societal, cultural, social, etc.)
5. Formulates treatment recommendations that arise from collected data
6. Uses alternative, non-diagnostic approaches to conceptualizing individuals and their environments, groups, and organizations
D. Summarizes and reports data
   1. Writes clear, accurate and timely integrated reports
   2. Communicates findings and recommendations clearly to patients and other providers
   3. Recognizes and reports the strengths and limitations of assessments and findings

VI. Intervention

A. Formulates case conceptualizations and treatment plans
   1. Collaborates with patients and families to identify goals and plans
   2. Links case conceptualizations and treatment plans to assessments
   3. Utilizes at least one theoretical orientation and theory of change
   4. Selects appropriate evidence-based interventions and best practices

B. Implements evidence-based interventions
   1. Displays clinical skills with a wide range of evidence-based interventions, patients and patient service needs
   2. Implements interventions with fidelity and adapts them to honor diversity characteristics and contextual factors as is appropriate
   3. Recognizes and manages problems and issues that arise with interventions
   4. Modifies and adapts evidence-based approaches effectively when a clear evidence-base is lacking

C. Monitors the impact of interventions
   1. Routinely evaluates progress toward service delivery goals
   2. Measures outcomes
   3. Modifies intervention methods and treatment goals based on evaluation findings
   4. Monitors and adapts own role and performance with the intervention

VII. Consultation, Interprofessional/Interdisciplinary and Systems-Based Practice

A. Provides consultation (e.g. case-based, group, organizational systems)
   1. Forms effective consultative relationships
   2. Clarifies and refines referral questions and consultation goals
   3. Develops and implements a consultation plan, recognizing the individual, group, organizational, and systems issues that may impact it
   4. Communicates consultation results and recommendations

B. Engages in interprofessional/interdisciplinary collaboration
   1. Demonstrates awareness and respect of the roles, beliefs, values, practices and contributions of other professionals, providers, patients, family, and community members
   2. Contributes psychological information while working flexibly with others to develop and implement a plan of care
   3. Represents their professional opinions, encourages others to express their opinions, and works to resolve differences of opinion or conflicts
   4. Integrates behavioral healthcare with other services (e.g., primary and specialty medical care; rehabilitative, recovery, vocational, residential and social services)
   5. Shares and receives information from others in a sensitive manner when authorized by the patient and permissible under applicable laws, regulations, policies, and ethical codes
C. Engages in systems-based practice
   1. Delivers care using knowledge of healthcare benefits, coverage limits, utilization management procedures, billing, and reimbursement
   2. Analyzes and understands problems within organizations and systems from individual, interpersonal, group, and intergroup perspectives
   3. Recognizes the potential influence of group memberships on the behavior of individuals in organizations and systems
   4. Responds appropriately to problems within organizations and systems given their role

VIII. Supervision

A. Seeks and uses supervision effectively
   1. Establishes strong working relationships with supervisors of diverse practice orientations
   2. Clarifies broad personal goals for supervision and specific agenda items for supervisory sessions
   3. Seeks supervision routinely and when specifically needed (e.g., complex cases; unfamiliar patients or services; ethical and legal issues; strong personal reactions to patients)
   4. Uses multiple methods to provide supervisors with timely, accurate information about their work and is open to being observed

B. Uses supervisory feedback to improve performance
   1. Accepts feedback without being overly defensive
   2. Acknowledges challenges and areas for professional growth
   3. Follows supervisors’ direction
   4. Adjusts professional behavior based on feedback

C. Facilitates peer supervision/consultation
   1. Leads peer supervision/consultation groups
   2. Structures the groups using an explicit method to guide discussions by peers of their work
   3. Maintains a constructive and supportive environment within the groups
   4. Gives constructive and supportive feedback to peers

D. Provides individual supervision (if applicable)
   1. Establishes supportive supervisory relationships with explicit roles and responsibilities for supervisor and supervisee (or does so by engaging in simulated practice of supervision)
   2. Uses multiple methods to monitor the quality of care provided and to assess supervisee level of development, strengths, and learning needs (e.g., observation; audio and video recording; case discussion and presentations; review of documentation; clinical measures; QA data; feedback from others)
   3. Uses an explicit model of supervision and multiple methods to ensure the quality of care being provided and to address supervisee learning needs (e.g., case discussion, feedback, instruction, modeling, coaching, providing publications)
   4. Provides feedback that is direct, clear, timely, behaviorally anchored, and mindful of the impact on the supervisee and supervisory relationship
   5. Maintains accurate and timely documentation of supervision and supervisee performance
   6. Requests and uses feedback from supervisees to improve the quality of supervision
IX. Research and Scholarship

A. Displays critical scientific thinking
   1. Demonstrates scholarly curiosity and routinely questions assumptions
   2. Understands and values evidence-based practice
   3. Formulates questions that can be addressed by the literature, research, and program evaluation
   4. Critically evaluates and shares ideas with others through teaching and scholarly writing

B. Uses the scientific literature
   1. Accesses, summarizes, and evaluates the literature related to their professional activities
   2. Discusses the relevant literature in case conferences, lectures, and/or professional presentations
   3. Applies the scientific literature to their work (e.g., clinical, consultation, research, program evaluation, quality assurance)

C. Implements scientific methods
   1. Selects and implements methods appropriate to the question, setting, and/or community
   2. Uses scientific methods to evaluate interventions and programs and to engage in continuous quality improvement
   3. Manages, analyzes, and interprets quantitative and qualitative data
   4. Collaborates with other professionals, persons in recovery, family members, and stakeholders in developing questions, implementing methods, and understanding results
   5. Contributes to the preparation of manuscripts, technical reports, case studies, or other scholarly work
1. **Total Hours**: The expectation of total internship hours is an average of 50 per week.

2. **Connecticut Mental Health Center**: For CMHC, total hours are allocated as follows: 30 for the primary placement, 15 for the secondary placement, and 5 hours for seminars (the core seminars plus placement-based seminars). A total of 4 hours for scholarly activity is included within the primary placement, though does not have to be allocated as a single time block.

3. **Yale-New Haven Hospital**: The fellows have the same allocation of time as CMHC fellows for seminars and scholarly activity, with the time for scholarly activity typically allocated as a single block. The remainder of the week is dedicated to the clinical placement, of which there is only one.

4. **Dissertations**: The internship program does not provide dedicated time for fellows to work on dissertations, as the APA Office of Accreditation considers dissertations a graduate school activity as opposed to an internship activity. Fellows may use their formal leave time to work on or defend dissertations.
Doctoral Internship Policy & Procedures

Psychological Assessment Policy

Revised 01-05-16

1. **Definition:** In this internship program, psychological assessment refers to the evaluation of individuals and families. It is broadly defined to include, but not be limited to: clinical interviews, semi-structured interviews, observation, behavioral assessment, screening, intellectual assessment, educational assessment, cognitive assessment, neuropsychological assessment, personality assessment, symptom assessment, risk assessment, and forensic assessment.

2. **Purpose:** Psychological assessment serves a number of functions including, but not limited to: informing case conceptualization, differential diagnosis, treatment planning, and clinical decision-making; and monitoring the severity of behavioral health conditions and treatment progress.

3. **An Essential Competency:** Psychological assessment is one of the core competencies of the internship program and it is a required competency under the internship accreditation standards of the American Psychological Association. Given the importance of this professional practice, it is essential that fellows in this internship receive organized training in psychological assessment and that their skills in assessment are evaluated.

4. **Didactic Instruction:** Psychological assessment is a substantive topic in sessions within the internship’s Core Seminar. All Placement-Based Seminars will include sessions relevant to the assessment of the populations served within the placement.

5. **Brief & Comprehensive Assessments:** Assessment is an integral part of providing clinical care to clients. The internship differentiates between “brief” and “comprehensive” assessments. While the specific nature and content of these assessments are defined within the placement sites, they have the following general characteristics:

   a. **Brief Assessments** are relatively short, routinely conducted evaluation approaches tailored to the common health issues faced by typical clients served in a particular setting. A brief assessment might include: (i.) a clinical interview; (ii.) a review of additional information (e.g., from a referral source, significant others, and/or a medical record); and (iii.) a minimum of one objective measure or test. Some brief assessments are re-administered on multiple occasions to monitor change over time in clinical or health status.

   b. **Comprehensive Assessments** tend to be thorough evaluations comprised of multiple assessment measures or strategies. These are conducted on a less frequent basis to assess complex diagnostic, clinical, treatment planning, or forensic issues.

6. **Responsibility of Placement Sites:** It is the responsibility of the faculty psychologists within each placement, working in concert with the Chief of Psychology for the institution, to ensure the availability of the following:
a. **Written description of the psychological assessment services offered** within the placement site or otherwise available to the clients being served. This document should be available to faculty, fellows, and clinicians within the site.

b. **Written description of the brief and comprehensive assessments** used within the site. This document should be available to fellows and faculty. There should be one or more brief assessments used in each site and each brief assessment should include a minimum of one objective measure or test. The use of measures to monitor change over time is encouraged.

c. **Qualified supervisors** available to supervise fellows in psychological assessment.

d. **Psychological assessment and testing supplies** that are up to date and in adequate supply within the placement site. Chiefs of Psychology in the institutions should survey faculty in the spring of each year regarding assessment resource needs and then work with the institution’s administration to address those needs. In general, borrowing supplies is not considered practical given the multiple sessions often required to complete assessments, the frequency of client no-shows for assessment sessions, and the time involved for fellows in traveling to pick up and drop off supplies.

e. **A process for identifying clients within the site** who could benefit from psychological assessment. This involves working with clinicians in the site regarding the indications for psychological assessment and teaching fellows to consult with clinicians on potential referrals.

f. **A timely orientation for fellows to psychological assessment in the placements.** This should cover: assessments offered, assessment materials, referral processes, supervision, and report formats.

g. **Time for fellows to complete assessments.** This should be factored into the 50 hour per week schedule. The process of assigning and scheduling assessments should be designed to minimize, to the extent possible, the disruption of fellows’ other responsibilities.

7. **Assessment Training Requirement:** The training experience for each doctoral fellow will be shaped by the clinical needs within the placement site and the clinical interests of the fellow. The experience will include the following:

   a. Each fellow will receive placement-based training and practical experience in consistently using one or more brief assessments in the natural flow of delivering services to clients. This will occur in all clinically oriented primary and secondary placements.

   b. Each fellow will complete a minimum of two comprehensive assessments during the course of the internship year. Preferably these will be conducted at the fellow’s placement site with clients from that site. However, at the Primary Advisor’s discretion, these can be conducted with clients from other sites and/or at locations other than the placement site. For fellows with a primary and secondary placement, the assumption is that the required comprehensive assessments will be conducted at the primary placement site unless the Primary Advisor takes the initiative to negotiate a different arrangement with the Secondary Advisor. Fellows with a placement at The Consultation Center will conduct all brief and comprehensive assessments at their other placement site, and that other site will provide the supervision of those assessments.
c. For fellows with a **primary** placement at The Consultation Center, the time to conduct the two comprehensive assessments will be allocated from their scheduled time at The Consultation Center. The requirements above do not apply to fellows in the CMHC Psychological and Neuropsychological Assessment Service, as the Service sets expectations for its fellows.

8. **Conveying Expectations to Fellows:** The internship’s approach to training fellows in psychological assessment is documented in this policy, the internship handbook, the internship brochure, and the general sections and the placement-specific sections of the program’s website. These expectations also will be reviewed during the Visit Days with prospective applicants and during the orientation of new fellows.
1. **Purpose:** Each placement should have at least one placement-based seminar throughout the year. The purpose of these seminars is to provide a learning experience that is tailored to the professional activities that are conducted within the placement.

2. **Goals & Objectives:** As required by APA Accreditation Guidelines, each seminar must have a written syllabus stating the overall goals of the seminar and identifying the specific learning objectives of individual sessions. Recurring case conferences do not require session specific learning objectives.

3. **Evaluation:** Using MedHub, fellows should complete an overall evaluation of each seminar at its conclusion. With the exception of case conferences, individual sessions within seminars should be evaluated using MedHub. Faculty leaders of the seminars should use the evaluation findings to continually improve the seminars.

4. **Content of the Seminars:** To the extent possible, the following should be considered in planning placement-based seminars:
   a. The content should address the internship core competencies.
   b. Duplication with the Core Seminar content should be avoided.
   c. Optimally, some sessions in the placement-based seminars will build on initial sessions in the Core Seminar, adding placement-relevant knowledge (e.g., psychopharmacology).
   d. All presenters should be asked to address the evidence-base for the topic being discussed.

5. **Diversity:**
   a. There should be considerable diversity among presenters in placement-based seminars.
   b. All presenters should be asked to address issues related to diversity as it pertains to their topic.
Doctoral Internship Policy & Procedures

Anti-Discrimination & Affirmative Action Policy

Revised 01-03-20

1. **Anti-Discrimination** - The Doctoral Internship in Clinical and Community Psychology adheres to the anti-discrimination policy of the Yale School of Medicine, which is as follows:

Yale University is committed to basing judgments concerning the admission, education, and employment of individuals upon their qualifications and abilities and affirmatively seeks to attract to its faculty, staff, and student body qualified persons of diverse backgrounds. In accordance with this policy and as delineated by federal and Connecticut law, Yale does not discriminate in admissions, educational programs, or employment against any individual on account of that individual’s sex, race, color, religion, age, handicap or national or ethnic origin; nor does Yale discriminate on the basis of sexual orientation.

2. **Americans with Disabilities Act (ADA) Compliance** - All program training and service provision activities in the Doctoral Internship in Clinical and Community Psychology are conducted within institutions (YSM, CMHC, and YNHH) who adhere stringently to the accommodations required by the ADA. Information regarding the adherence to ADA for each institution are located at their respective webpages: CMHC: [https://www.ct.gov/dmhas/cwp/view.asp?a=2902&q=600822](https://www.ct.gov/dmhas/cwp/view.asp?a=2902&q=600822), YNHH: [https://www.ynhh.org/ynhhs/policies.aspx](https://www.ynhh.org/ynhhs/policies.aspx) and Yale University: [https://equalopportunity.yale.edu/accommodations-program-faqs](https://equalopportunity.yale.edu/accommodations-program-faqs). Should an issue arise, each institution has compliance offices (Yale- Office of Institutional Equity and Access; YNHH- Office of Corporate Compliance and CMHC/DMHAS- DMHAS Office of the Commissioner, Client Rights and Grievance Offices) and representatives who can assist in resolving any issues related to adherence or compliance. Finally, Yale University also has Web Accessibility Policy ([https://your.yale.edu/policies-procedures/policies/1605-web-accessibility-policy](https://your.yale.edu/policies-procedures/policies/1605-web-accessibility-policy)) with ensures that people with disabilities are able to independently use a website or web application.

3. **Affirmative Action** - The Doctoral Internship in Clinical and Community Psychology adheres to the affirmative action policy of the Yale School of Medicine, which is as follows:

University policy is committed to affirmative action under law in employment of women, minority group members, handicapped individuals, special disabled veterans, and other veterans. Inquiries concerning these policies may be referred to the Chief Diversity Officer or the Director of the Office of Equal Opportunity Programs.

4. **Statement on Public Documents** – The following statement will appear on the program’s website and promotional materials:

*Yale University is an Equal Opportunity/Affirmative Action Employer* and does not discriminate based on an individual’s sex, race, color, religion, age, disability, veteran status, national or ethnic origin, sexual orientation, or gender identity or expression.
1. Requirements to Apply:
   a) Enrolled in an APA or CPA accredited doctoral program in clinical, counseling or clinical and community psychology*
   b) Minimum 450 face-to-face hours of assessment and intervention combined at time of application**
   c) At least three years of graduate training
   d) Passed the comprehensive or qualifying exam by the application deadline
   e) Approved dissertation proposal by the application deadline

*Neither the program nor the student may be on probation at the time of the application deadline
**Terminal masters hours count if the application indicates that these were verified by the doctoral program director of clinical training

2. Requirements for Acceptance: Practicum and academic preparation are evaluated through a thorough application review and interview process. During the application review, applicants are assessed on: (a) whether they meet the program’s admission requirements; (b) the congruence between their goals and the training offered in their preferred placement(s); (c) the congruence between their previous training and experience and the training offered in the placement(s); (d) prior education; (e) experience with diverse patients/consumers/participants; (f) quality and clarity of writing; (g) professional development and conduct; and (h) potential for leadership in the field. Information acquired through the interview process contributes to a decision about applicants’ preparation for the placement and internship, interpersonal skills, and overall fit for the placement and internship.

The program does not make exceptions to these criteria. Applications received from individuals who do not fully met each of the criteria will not be considered.
1. **Review of Applications:** The application review process is coordinated by the Student Coordinator under the supervision of the Director of Clinical Training and in collaboration with the Chiefs of Psychology at each facility. Applicants can apply to only one primary placement and the faculty involved in psychology training at that placement hold the primary responsibility for the review and screening of applications. A standardized “Application Review Form” is used by faculty to determine the potential fit of the applicant with the placement and overall program. Each reviewer rates the applicant on items related to program admission requirements, preparation for the placement, and the congruence between placement and the applicant’s goals and previous training. Once the match is complete, Application Review Forms are forwarded by faculty members to the Student Coordinator who scans and stores them electronically for a minimum of seven years (the maximum accreditation cycle). A copy of the Application Review Form for applicants who match is kept in the fellow’s file by the Primary Advisor.

2. **Invitations to Visit Days:** Decisions about extending invitations for Visit Days are made by the faculty at each placement and are communicated to the Student Coordinator. Applicants to be invited are contacted by a faculty member from the primary placement who schedules the visit. Three Visit Days are scheduled in January and it is expected that all visits will happen on those days. In rare circumstances, applicants may visit on a date other than the formal Visit Days, with faculty notification of such a visit to the Director of Clinical Training. Faculty members notify the Student Coordinator of the visit dates for applicants attending the Visit Days and also provide the names of applicants who will not be invited. The Student Coordinator provides email notifications to applicants who will not be invited. Such notifications occur by the deadline posted on the APPIC website.

3. **Interview Rating:** Each faculty interviewer from the primary placement evaluates the applicants he or she interviews using a standardized “Interview Rating Form”. This form is used to document the interviewer’s perception of the adequacy of the applicant’s preparation for the placement, interpersonal skills, and overall fit for the placement and internship. Other interviewers, if any, (e.g., program leadership, secondary placement faculty) are asked to complete these forms and provide them to the appropriate primary placement faculty member. Current fellows meet with applicants for the benefit of the applicants and are to provide no feedback to faculty members about the applicants either in written form or informally through casual conversation about the applicants, unless the fellow observes behavior of major concern. Once the match is complete, Interview Rating Forms are forwarded by faculty members to the Student Coordinator who scans and stores them electronically for a minimum of ten years (the maximum accreditation cycle). A copy of the Interview Rating Form for applicants who match with this program is kept in the fellow’s file by the Primary Advisor.

4. **The Ranking Process:** Each primary placement is responsible for constructing its rank list for the APPIC Match. The Chief of Psychology at each facility creates the internal procedure for establishing rankings and also approves the final rankings, which are then forwarded to the Student Coordinator. The Student Coordinator, under the supervision of the Director of Clinical Training, enters the rankings into the APPIC match system. A print out from APPIC of the confirmed match list is emailed to the primary placement supervisors for their verification and signature, attesting that the rankings are correct. Once verifications are received from all primary placement faculty members, the match list is declared final by the Director of Clinical Training. Applicants who are no longer under consideration and will not be ranked are not notified of this decision. In accordance with APPIC match rules, those applicants who will be ranked do not receive any ranking related information from the program and its faculty.
1. **Yale University:** Yale University requires that matched interns/fellows complete a background check prior to the start of the internship. This includes a criminal history check, a confirmation of previous employment, and a verification of educational background and social security number. With regard to the criminal history check, there are no automatic disqualifying convictions. Convictions for misdemeanor and felony crimes are reviewed, with attention paid to the severity of the crime and its relationship to the position the applicant will hold. The applicant is always afforded the opportunity to explain the circumstances of a conviction. However, depending on the circumstances, a misdemeanor or felony conviction could result in a disqualification and dismissal from the internship.

2. **Yale-New Haven Hospital:** Interns/fellows matched to a placement at Yale-New Haven Hospital complete a questionnaire as part of their credentialing application. The hospital does not conduct a background check unless the intern/fellow acknowledges on the questionnaire a history of issues such as: criminal convictions, addiction to drugs or alcohol, other health issues that impair ability to practice, disciplinary actions related to the delivery of health care, and malpractice claims against the individual. There are no issues that automatically disqualify a matched intern/fellow from an internship at YNHH. Each issue is reviewed, with attention paid to its severity and its relationship to the position the applicant will hold. The applicant is always afforded the opportunity to explain the circumstances surrounding the issue. However, depending upon the circumstances, any of these issues could result in a disqualification and dismissal from the internship.

3. **Connecticut Mental Health Center:** For interns/fellows matched to a placement at the Connecticut Mental Health Center, the Center does not conduct a separate background check, with just one exception. Fellows with a placement at the CMHC Child and Adolescent Service in West Haven must complete the following as a requirement of the Connecticut Department of Children and Families (DCF), which funds the Service: a criminal records check; a child welfare records check; and a health screen. Occurrence of the following during the past five years or during internship may preclude starting or completing this internship: conviction on offenses involving possession, use, or sale of a controlled substance; or substantiation of child abuse or neglect. The presence of a current health problem that poses a threat to the well being of children may also preclude starting the internship.
1. **Brief Informal Visits:** The faculty invite incoming fellows who have matched to the internship to visit with their Primary Advisor at the placement site if the fellows are in New Haven prior to the start of the internship. This might occur, for example, in the context of a trip to the New Haven area to search for housing. The opportunity is contingent on faculty availability at the time of the visit. Incoming fellows are asked to schedule these visits by contacting their Primary Advisor in advance.

2. **Pre-Internship Get Acquainted Visits:** All placements offer incoming fellows the opportunity to spend a maximum of one day at their placement site prior to the start of the formal internship. A typical visit of this nature involves a meeting with the Primary Advisor, some shadowing of the current fellow, and some introductions to other staff.

The Primary Advisor will typically issue the invitation and ensure, in addition, that at least one current fellow reaches out to each newly matched fellow to extend a welcome and offer to serve as a resource.

The purpose of these Pre-Internship visits is to ease fellows’ transitions to internship. The visits are not intended to formally orient incoming fellows. These visits are entirely voluntary. An incoming fellow may not wish to visit prior to the start of the internship year and may be unable to visit due to prior commitments in another city or the inability to access housing in New Haven until the formal start date of the internship. No incoming fellow will be penalized in any way for not participating in one of these visits. The faculty will provide a full orientation to every fellow beginning on the first day of internship.

Incoming fellows who decide to visit should contact their Primary Advisor well in advance to schedule the date.
1. **Stipend**: Doctoral psychology fellows receive a stipend from Yale University, which is paid in 12 equal installments at the end of each month beginning at the end of July. The Federal Internal Revenue Service and the Connecticut Department of Revenue Services consider the stipend taxable income.

2. **Health Insurance**: All fellows are required to have health insurance and most students enroll in a Yale University sponsored health insurance plan, taking advantage of the University Health Care Subsidy. Under this subsidy fellows receive fully paid coverage through Yale Health ([http://yalehealth.yale.edu/](http://yalehealth.yale.edu/)) for themselves, spouses, same sex partners joined through civil union, and children. There is the option to purchase coverage through a number of alternative private health insurance plans at an additional charge. **It is important to understand that the value of the subsidy, which is substantial, is also considered taxable income by the federal and state government.**

3. **Dental Coverage**: Dental coverage is optional for fellows and the cost is fully paid by fellows. Therefore, this benefit does not contribute to reported taxable income.

4. **Reported as Miscellaneous Income**: The value of the stipend and the health care subsidy will be reported to fellows as Miscellaneous Income using a federal 1099-MISC form. Since the Fellowship spans two calendar years, the income will be reported across those two years with 50% reported in each calendar year. Your 1099-MISC form will be mailed to you at the beginning of February. It will not be available online. If you do not receive it call the Employee Service Center to request a copy (203-432-5552).

5. **Current Values**: For the 2020-2021 academic year the value of the stipend is $35,700. For the 2019 calendar year the value of the health care subsidy is: $699/month for single coverage; $1,328/month for single plus child(ren) coverage; $1,467/month for single plus spouse coverage; and $2,096/month for family coverage. The health care subsidy values are adjusted on January 1st of each year and usually increase.

6. **Withholding**: **Yale University does not withhold taxes from doctoral fellows.** Fellows who believe that they will owe taxes have the option of making Estimated Tax Payments on a quarterly basis during the course of the year. IRS Form 1040ES is designed to assist the taxpayer in estimating and making those payments. Examples of completed 1040ES forms can be found at: [http://tax.yale.edu/individual-income-tax-returns](http://tax.yale.edu/individual-income-tax-returns).

7. **FICA**: While stipends are taxable they are not classified by the IRS as wages and thus are not subject to FICA taxes (Social Security and Medicare).
8. **Tax Liability**: The tax liability of a fellow is determined by a number of factors including income from other sources and spouse income, if any. Fellows should consult a tax professional for additional information and assistance in estimating and paying taxes. The program is unable to advise fellows on taxes or serve in a tax consultant role.

9. **Additional Work**: The internship is considered a full time commitment for fellows. Therefore, fellows are highly discouraged from engaging in additional compensated activities during the course of the internship year. Yale faculty and Yale institutions and programs are prohibited from offering and Yale fellows may not accept from them additional compensation for additional duties during the internship year.

10. **Filing Taxes**:

   a. **Examples**: Yale University provides examples of completed Federal and State tax returns at: [http://tax.yale.edu/individual-income-tax-returns](http://tax.yale.edu/individual-income-tax-returns). Choose the examples of “postdoctoral fellowship” or “postdoctoral fellowships and pdf funded healthcare”. Note that the stipend level is for a postdoctoral level (not your postgraduate level). The entries for items such as interest income and estimated tax payments are simply examples. Keep in mind that the examples are for fellows who have been employed at Yale for a full year. You will only be reporting a stipend from Yale for the latter half of the year as documented on the 1099-MISC form. To this you would add any income from other sources during the first half of the year.


   c. **Where to list your stipend**: Note that your stipend is listed on your returns on the “Wages, salaries, tips, etc.” line. The letters “SCH” and the amount of your stipend (or stipend plus healthcare) are to be typed on this line to the left of the far right column (see the examples at the link listed above). Your stipend should not be reported on a Schedule C. Note that programs such as Turbo Tax may automatically and incorrectly fill out a Schedule C for your 1099 income erroneously increasing the calculated amount of tax due.

   d. **Free tax preparation assistance**: Based on income level, you may qualify for free online or in person tax preparation sponsored by United Way New Haven: [http://www.uwgnh.org/our-work/income/find-tax-prep-site](http://www.uwgnh.org/our-work/income/find-tax-prep-site). The New Haven Public Library location has volunteers that may be the most familiar with preparing returns for Yale affiliated fellows.

   e. **You remain responsible**: All information provided above is believed to be accurate. However, you remain responsible for verifying this information and accurately completing and submitting your returns.
Doctoral Internship Policy & Procedures

Leave & Sick Time Policy
Revised 04.23.2020

1. **Leave Schedule**: Each fellow follows the leave schedule that is selected on the Leave Worksheet by his or her primary advisor.

2. **Personal Leave**: All fellows have a total of 20 personal leave days during the internship year. This is inclusive of, but not limited to, scheduled vacations, other personal activities, job interviews, dissertation work or defense, graduate school graduations, and attendance at conferences.

3. **Prior Approval of Leave**: Leave should be requested well in advance, with a minimum of 30 days prior to the requested leave. The primary advisor has final authority to approve or deny requested leaves. Fellows can facilitate the review of the leave request by discussing it in advance with the secondary placement advisor (if applicable). Primary advisors will make every effort to approve reasonable requests for leave.

4. **Avoiding June Leave**: Leave during the month of June is not permitted due to the need to ensure coverage of professional responsibilities and completion of work. In rare instances, and at the discretion of the primary advisor, exceptions can be granted for a limited number of days of leave during June for unavoidable conflicts or essential tasks (e.g., dissertation defense, graduation ceremonies, transition to a new city for a position that begins on July 1).

5. **Coverage**: The primary advisor and secondary advisor (if applicable) are responsible for ensuring that there are procedures and personnel available for providing coverage while the fellow is away. However, the fellow will usually be asked to help arrange coverage once the leave is approved and to ensure that reasonable preparations are made prior to the leave (e.g., alerting covering staff to emergent clinical issues).

6. **Sick time**: Fellows are entitled to three sick days. Personal leave days should be used after sick days are exhausted. Strategies for managing the impact of extended illnesses and absences from the internship will be devised through consultations between the fellow, primary and secondary advisors, Chief of Psychology for the facility, and the Director Training. For fellows who exhaust their sick days and leave days for illnesses that are not verified through documentation from a health professional, the Executive Training Committee has the prerogative to extend the fellows’ internship to cover the number of additional days missed or to reduce the value of the stipend in proportion to those additional days missed.

7. **Situations outside of this policy**: Issues not covered by this policy will be resolved through discussions between the fellow, primary advisor, and secondary advisor, with involvement as necessary by the Chief of Psychology from the facility and Director of Training.
Instructions: Primary Advisor indicates below the Leave Schedule to be followed and provides this form to the fellow during orientation in July.

Fellow:

Primary Advisor:

Primary/Secondary Placements:

Leave Schedule that this Fellow will Follow:

_____ YNHH  _____ CMHC  _____ YALE (check only one)

a) Personal Leave: There is no restriction on the purpose for which personal leave days can be used. Typical uses include, but are not limited to: vacations, other personal activities, job interviews, dissertation work or defense, or other professional activities ............ 20 20 20

b) Holidays: Follow the holiday schedule associated with the assigned Leave Schedule (YNHH, CMHC, or Yale) ........................................ 8 12 8

c) Professional Development: For activities such as: dissertation work or defense; conference or workshop attendance; research; etc.) ........ 0 2 0

d) Yale Recess Days: (see Notes below) .................................................................

Total Days 34 34 34

Notes:

a) All fellows receive the same total number of Leave days.

b) The number of days for each type of Leave varies among placements due to variation in the policies of the institutions in which fellows are being trained regarding vacation schedules, clinical coverage, and the Yale Recess.

c) Fellows who do not receive Yale Recess Days may take time off on these dates with the permission of their Primary and Secondary Placement Advisors by using Personal Leave or Professional Development Leave days. An effort will be made to ensure that fellows who do not receive Recess Days can take at least 50% of the Recess dates off in this manner should they desire to do so.

d) Fellows who do receive Yale Recess Days may be asked to work these dates to provide coverage, though an effort will be made to ensure that they will not be required to provide coverage on more than 50% of the Recess dates. For each Recess Day that a fellow who receives these days is required to work, he or she is given an additional Personal Leave day.

e) Primary advisors notify the fellow of specific Recess dates on which there will be a requirement to work as early as possible, but preferably at least 45 days in advance of those dates.
# Holiday & Recess Schedule 2020 - 2021

**CMHC, YNHH & Yale University**

<table>
<thead>
<tr>
<th>Holiday</th>
<th>Dates</th>
<th>CMHC</th>
<th>YNHH</th>
<th>Yale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independence Day</td>
<td>July 3, 2020</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Labor Day</td>
<td>Sept. 7, 2020</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Columbus Day</td>
<td>Oct. 12, 2020</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Veteran's Day</td>
<td>Nov. 11, 2020</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thanksgiving Day</td>
<td>Nov. 26, 2020</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Christmas Day</td>
<td>Dec. 25, 2020</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>New Year's Day</td>
<td>Jan. 1, 2021</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Martin Luther King Day</td>
<td>Jan. 18, 2021</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Lincoln's Birthday</td>
<td>Feb. 12, 2021</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Washington's Birthday/Presidents Day</td>
<td>Feb. 15, 2021</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Good Friday</td>
<td>April 2, 2021</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Memorial Day</td>
<td>May 31, 2021</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>12</strong></td>
<td><strong>8</strong></td>
<td><strong>8</strong></td>
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</tr>
</tbody>
</table>

**Recess Days**

- November 27, 2020
- December 24, 2020
- December 28, 2020
- December 29, 2020
- December 30, 2020
- December 31, 2020

**Total 6**
1. **Use of Personal Leave and Sick Time:** For illness and family-related issues that result in a fellow being absent from the internship, fellows must first use their 3 sick days. After the use of sick days, fellows are strongly encouraged, though not required, to use a minimum of 10 of their 20 personal leave days, assuming that these days have not been previously exhausted.

2. **Medical Documentation:** After seven consecutive days of absence from work for medical reasons, medical documentation from a health care provider is required to verify that the fellow is unable to return to work.

3. **Family & Medical Leave:** A fellow may request Family or Medical Leave anytime after the 3 sick days are exhausted and no later than the date on which all sick days and personal days are exhausted. Medical and Family Leave is unpaid. The federal Family and Medical Leave Act ("FMLA") provides fellows with up to 12 work weeks of unpaid, job-protected leave within a 12-month period, and requires health benefits to be maintained during the leave. State of Connecticut FMLA allows for 16 weeks of unpaid leave over a 24-month period. Both laws are applicable to fellows and run concurrently. Unpaid leave may be granted under FMLA in the following circumstances: serious illness of the appointee; birth, adoption or foster care placement of a child; care of a seriously ill child, stepchild, spouse, parent, parent-in-law, or civil union partner.

4. **Childbirth & Adoption:** Fellows who bear a child or adopt a child under the age of six or whose spouse or civil union partner bears a child or adopts a child under the age of six during the term of their appointment may be granted up to eight weeks of paid parental leave. To qualify for this leave the appointee must be a primary caregiver throughout the period of the leave: caring for the child during normal working hours, while the other parent, if any, is employed at least half time.

5. **Required Hours:** Fellows complete a full calendar year of internship working an average of 50 hours per week. As is customary with all Yale employees, the following do count towards the total work hour requirement during the calendar year: personal leave; sick time; and recess days. The total number of internship hours is 2600 (52 weeks at 50 week hours per week). Fellows are required to complete all hours unless absent on an approved/verified Family or Medical leave.

6. **Minimum Requirements:** With review and approval of the Executive Training Committee, a fellow who has been on an approved/verified Family or Medical leave can successfully graduate from the internship with a minimum of 2200 hours plus satisfactory ratings on all of the internship’s core competency categories.
7. **Extension of Internship:** If an individual (a) completes less than 2200 hours or (b) has between 2200 and 2600 hours but does not achieve satisfactory ratings on the core competency categories, he or she may be asked to extend the internship up to a maximum of 2600 hours or the achievement of satisfactory ratings on the core competency categories, whichever comes first.

8. **Maximum Internship Length:** While leaves may extend the total length of an internship, completion of the internship in terms of required hours and achievement of satisfactory ratings on the competencies must occur no later than 18 months from the start of the internship.

9. **Compensation:** Fellows who take an unpaid leave and complete less than the standard 2600 hours will receive a reduced annual stipend, which will be prorated based on the number of hours worked.
1. **Adherence to APA Standards and Regulations:** The internship program adheres to the supervision requirements issued by the APA Commission on Accreditation through its *Standards of Accreditation for Health Service Psychology* [Standard II.C.3.] and corresponding Implementing Regulation [C-14. I].

2. **Definition:** Supervision within the internship is defined in the following ways:

   a. The internship adheres to the APA/COA definition of supervision, which is as follows:
      
      “Supervision is characterized as an interactive educational experience between the intern and the supervisor. This relationship: a) is evaluative and hierarchical, b) extends over time, and c) has the simultaneous purposes of enhancing the professional functioning of the more junior person(s); monitoring the quality of professional services offered to the clients that she, he, or they see; and serving as a gatekeeper for those who are to enter the particular profession (Bernard and Goodyear, 2009).”

   b. In applying the above definition, the internship program will deem a professional relationship to be supervisory if: (a) the faculty member or other professional has authority over some aspect of the fellow’s work; and (b) that work is an essential element of the fellow’s internship experience.

3. **Exclusions:** Supervision is distinct from educational sessions, such as traditional seminars, and from administrative and management sessions such as clinical team meetings and staff meetings. From the perspective of the internship program, faculty members and other staff members may influence, consult to, and even direct the activities of a fellow without being in a formal supervisory role. For example, attending physicians, unit chiefs, or “medical back-ups” are generally not considered formal supervisors. Non-physician leaders of teams on which fellows are placed may or may not be designated as supervisors at the discretion of the chief psychologist (or designee). Similarly, individuals consulting to fellows on topics such as research may play a non-evaluative, non-supervisory, mentoring role or may function in an evaluative supervisory capacity.

4. **Resolving Questions About What Qualifies as Supervision:** Questions regarding whether an activity meets the APA/COA definition of supervision are resolved by the Primary Advisor through consultation with the Chief of Psychology at the facility and the Director of Training. The APA/COA definition of supervision, reprinted above, will be used as the basis for resolving such questions.

5. **Supervision Requirements:** The following requirements apply:

   a. Each fellow will receive a minimum average of four hours of supervision weekly and a minimum total of 176 hours for the year.

   b. *Two of the four hours weekly* must be individual supervision from doctoral-level psychologists licensed in the State of Connecticut who are involved in an ongoing supervisory relationship with the fellow and have primary professional clinical responsibility for the cases or other professional work that is being supervised. These supervisors, when on vacation or other leave, must designate a covering supervisor who will be available to the fellow.
c. The additional two hours of supervision can be provided by licensed psychologists or by professionals from other disciplines who are appropriately licensed or credentialed for their role in the program. The format for these additional hours can be group or individual. Coverage for these supervisors, when on vacation or other leave, is automatically provided by the individual supervisors described above.

d. Routine supervision sessions will not occur when either the supervisor or fellow are on vacation or other leave. Supervision sessions cancelled during weeks in which the supervisor and fellow are working must be rescheduled.

6. **Primary Advisor Oversight:** The Primary Advisor for each fellow, who is a doctoral-level psychologist licensed in the State of Connecticut and member of the employed faculty, maintains overall responsibility for all supervision, including oversight and integration of supervision provided by other mental health professionals.

7. **Supervisor Assignments:** At the beginning of the training year the chief psychologist at each facility (or designee) will provide the fellow with a written list of placement advisors and supervisors. All supervisors must meet the definition outlined above, which means that they have a hierarchical relationship with the fellow, responsibility for promoting and ensuring the fellow’s professional functioning, complete formal evaluations of the fellow, and meet regularly for individual or group supervision with the fellow, separate from clinical, team, or project meetings.

The chief psychologist (or designee) will inform all advisors and supervisors that they have been designated in a formal supervisory role, with the responsibilities and the authority outlined above. The chief psychologist (or designee) will notify the fellow and supervisors of any changes in supervisory assignments over the course of the year.

8. **Minimum Number of Supervisors:** Each fellow will have a minimum of three supervisors who they meet with routinely. The Primary Advisor determines the maximum number of supervisors per fellow. In general, the maximum number of supervisors per fellow is recommended as six. However, this number may be exceeded for various reasons, including: supervisory needs across both a primary and secondary placement; and the need for occasional supervision from a supervisor with specialized knowledge and skills. Primary Advisors are responsible for ensuring that all supervisory time, including the time involved in scheduling multiple supervisors and managing multiple supervisory relationships, fits within the 50 hour per week average allotted for all internship responsibilities.

9. **Supervision Tracking:** Fellows track the supervision they receive using the program’s Supervision Log. This form captures the supervisor’s name, date and length of supervision, and format (individual versus group). The completed log is submitted as an electronic copy monthly (by the 10th of the following month) to the program’s Student Coordinator. In submission of the log, the fellow necessarily includes the Primary Advisor in the communication (by email carbon copy) who also reviews the document. The Student Coordinator prepares aggregates the hours for each fellow and submits them to the Director of Training for monthly review. Any patterns of gaps or deficits are reviewed with the Primary Advisor and Fellow for resolution.

10. **Supervision Location:** All supervision must be provided at the placement site where the work being supervised is occurring. The only approved exceptions are as follows:

    a. A fellow with two placements may receive supervision for the work at one site while at the other site provided that this does not result in additional travel for the fellow.
    b. Supervision within the Long Term Care Clinic can occur offsite, typically in the private offices of voluntary faculty.
c. Fellows in the Substance Abuse Services rotation may receive supervision at the West Haven VA provided that it occurs immediately before or after the seminar that these fellows routinely attend at the VA.

Requests for exceptions to this policy must be approved by the Chief of Psychology at the training facility, the Director of Training, and the Executive Training Committee of the training program.

Fellows are not authorized to agree to offsite supervision arrangements that are not in the above list of approved exceptions.

11. Medical Record Documentation: The following requirements apply to medical record documentation as it relates to supervision:
   a. The legally responsible supervisor for clients served by a fellow shall be documented in each client’s medical record using procedures established by the institution in which the service is being delivered. Licensed psychologists should be supervising at least half of the fellow’s caseload.
   b. The documentation created by psychology fellows shall be reviewed and co-signed by the licensed professional supervising the care of the client using procedures established by the institution in which the service is being delivered.
Doctoral Internship Policy & Procedures

Telesupervision Policy

Revised 01-17-20

Rationale for Telesupervision: The Yale Doctoral Internship in Clinical and Community Psychology places a premium on clinical and professional supervision. Within the internship program, it is the expectation that fellows will receive supervision by way of in-person supervision. However, the program recognizes that certain special circumstances may arise that create the need to consider alternative routes to delivery of high quality supervision.

Because consistent access to and continuity of supervision is foundational to health service psychology training and practice, the program has adopted a Telesupervision Policy to guide provision of supervision under special circumstances.

Adherence to APA Standards and Regulations: The internship program adheres to the telesupervision requirements issued by the APA Commission on Accreditation (APA CoA) through its Standards of Accreditation for Health Service Psychology [Standard II.C.3.] and corresponding Implementing Regulation [C-15 I.]

Notably, this policy does not supersede, reduce or alter supervision requirements in the internship Supervision Policy.

APA CoA Definitions and Distinctions
1. Telesupervision: supervision (as defined in the supervision policy) of psychological services through a synchronous audio and video format where the supervisor is not in the same physical location as the trainee.
2. In-Person supervision: supervision of psychological services where the supervisor is physically in the same room as the trainee.

APA CoA Guidelines and limits: The internship program observes the guidelines and limits set forth by the APA CoA regarding Telesupervision which are as follows:
1. Telesupervision may not account for more than one hour (50%) of the minimum required (as defined in the SoA) two weekly hours of individual supervision, and two hours (50%) of the minimum required (as defined in the SoA) four total weekly hours of supervision.
2. Supervision beyond the minimum number of required hours may utilize methods are modalities that are deemed appropriate by the Yale Doctoral Internship program.
Criteria for Telesupervision Usage: Telesupervision is to be used only in those special circumstances in which a fellow's in-person access to an already established supervisor:
1. Is expected to be prolonged (e.g., 4 weeks or more),
2. Is expected to significantly interrupt/eliminate continuity of clinical supervision,
3. and/or where specialized clinical supervisory expertise is contingent upon using telesupervision and would otherwise be unavailable to the trainee.

Privacy and Compliance: Approved telesupervision of clinical services must be conducted using HIPAA compliant software. The Primary advisor of the fellow being supervised, should provide the name of the HIPAA compliant software to be used between the fellow and supervisor to the Director of Training and the Chief of Psychology at the training facility.

Primary Advisor Responsibility and Oversight: In keeping with the standards set forth in the internship supervision policy, in cases of approved telesupervision, the Primary Advisor for the fellow, who is a doctoral-level psychologist licensed in the State of Connecticut and member of the employed faculty, maintains overall responsibility for all supervision, including oversight of the telesupervision and integration of in person supervision provided by other mental health professionals.

Approval: Requests for approval for telesupervision should be submitted to the Chief of Psychology at the Training facility, and subsequently to the Director of Training using the Telesupervision Rationale and Request Form by the Fellow’s Primary Advisor.
Telesupervision Rationale and Request Form

01-17-20

Date: 
Fellow: 
Primary Advisor: 
Supervisor Conducting Telesupervision: 
Placement(s): 

Rationale for Telesupervision: 

Anticipated Dates of Telesupervision: 

HIPAA Compliant Software: 

SIGNATURES

Primary Advisor ________________________________  Date ________
Fellow ________________________________  Date ________
Chief of Psychology (Facility) ________________________________  Date ________
Director of Training ________________________________  Date ________
### Supervision and Time Log

**Yale Doctoral Internship in Clinical and Community Psychology**

**Fellow**

**Primary Advisor**

<table>
<thead>
<tr>
<th>Month</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>July</td>
<td>20xx - 20xx</td>
</tr>
</tbody>
</table>

**Supervisors (first 6 letters of last name)**

<table>
<thead>
<tr>
<th>Sup Name</th>
<th>Sup Format</th>
<th>Planned Min</th>
<th>Planned Freq</th>
</tr>
</thead>
</table>

| Date | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |

**Summary:**

| Hours | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
|-------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|

| All Hours | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Mean/Wk  | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |

Make all entries in MINUTES

Planned Min = planned minutes of supervision per session

Planned Freq = planned frequency of sessions: W=weekly; B=biweekly; 0 = other

Codes for Sessions Not Kept: F=fellow; S=supervisor; V=vacation; C=cancelled (eg. FC = Fellow Cancelled)
Supervision and Time Log
Yale Doctoral Internship in Clinical and Community Psychology

Average Hours Per Week (Check one answer below)
Were you able to complete your REQUIRED internship responsibilities in an AVERAGE of 50 hours per week THIS MONTH (Excluding dissertation hours and optional, non-required activities)?

Yes  No

FELLOW ATTESTATION
By inserting your name and date in the fields below and submitting the completed form you represent that this is an accurate accounting of the supervision received and time spent.

Fellow Name   insert name   Date   insert date

PRIMARY ADVISOR ATTESTATION
Did the supervision this fellow received this month meet the internship’s standards regarding amount and type?

Yes  No

Comments:

Primary Advisor should insert his or her name indicating that this report has been reviewed and accepted.

Faculty Name   insert name   Date   insert date

INSTRUCTIONS:

When First Using this Form:

1. Save this form to your desktop or laptop using the electronic file name: "your last name - supervision" (for example: Brown - supervision)

2. Click on the "Supervision" tab and insert the first name, last name, email address, and work supervised for each assigned supervisor.

3. In the "July tab" insert your name, your primary advisor's name, and the academic year on lines 1 & 2. This information will carry forward to future months.

4. Insert your supervisors’ last names (up to 6 letters) in the highlighted row. List the Primary Placement Advisor first; then the Secondary Placement Advisor (if applicable).

5. Insert the planned length (in minutes) and frequency of supervisory sessions using the codes listed under the table.

6. In future months do not delete any supervisors from this log, even if they stop providing supervision. If you add a new supervisor place their name in the next open column for the month during which they start providing supervision.

Throughout the Month:

1. Record the length of each supervision session by placing the number of MINUTES under the appropriate cell, based on the supervisor, date, and whether it was individual or group in format.

2. Indicate the reasons for session not kept by coding Fellow (F) or Supervisor (S) AND Vacation (V) or Cancelled (C.), which is used for all non-vacation reasons. Do not code a session as not kept if it is rescheduled in the same week.

At the End of Each Month:

1. Insert your name and date in the Attestation section above.

2. By the 5th day of the following month email the completed form to your Primary Advisor for review and acceptance. (For the last month of internship, forms are due on the last day of the internship).

3. By the 10th of each month Primary Advisors review completed forms, insert their name and date above indicating acceptance, and email to the Student Coordinator at psychsec.yale.edu.

4. Save the file as a new document by changing the "month" in the electronic file name. Click on the tab for the that month and begin tracking supervision for the month.

In You Have Questions: Email the Student Coordinator at psychsec@yale.edu
# Supervision and Time Log

**Yale Doctoral Internship in Clinical and Community Psychology**

<table>
<thead>
<tr>
<th>Fellow Primary Advisor</th>
<th>Month</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jane Doe</td>
<td>July</td>
<td>2015 - 2016</td>
</tr>
<tr>
<td>Brady Seacourt</td>
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## Supervisors (first 6 letters of last name)

<table>
<thead>
<tr>
<th>Sup Name</th>
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<th>Ponce</th>
<th>Baker</th>
<th>Sisto</th>
<th>Wetteman</th>
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<td>W</td>
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</tbody>
</table>

**Make all entries in MINUTES**

Planned Min = planned minutes of supervision per session
Planned Freq = planned frequency of sessions; W=weekly; B=biweekly; O = other
Codes for Sessions Not Kept: F=fellow; S=supervisor; V=vacation; C=canceled (eg. FC = Fellow Cancelled)

**Summary:**

<table>
<thead>
<tr>
<th>Hours</th>
<th>Month</th>
<th>Year</th>
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<td>19.0</td>
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<td>4.5</td>
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<tr>
<td>4.5</td>
<td>4.5</td>
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</tr>
</tbody>
</table>

**All Hours:**

| 4.0 | 4.0 | 3.0 | 4.0 | 4.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |

**Mean/Wh:**

| 1.0 | 1.0 | 0.7 | 1.0 | 1.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
Supervision and Time Log
Yale Doctoral Internship in Clinical and Community Psychology

TIME COMMITMENTS (Check one answer for each question) - Were you able to:
1. Complete REQUIRED internship responsibilities in AVERAGE of 50 hrs/wk THIS MONTH (Excluding dissertation hours and non-required activities)? Yes No X
2. Spend an AVERAGE of four hrs/wk on your scholarly project (Sept to May only)? Yes No X

FELLOW ATTESTATION
By inserting your name and date in the fields below and submitting the completed form you represent that this is an accurate accounting of the supervision received and time spent.

Fellow Name: Jane Doe  Date: 08/04/11

PRIMARY ADVISOR ATTESTATION
Did the supervision this fellow received this month meet the internship’s standards regarding amount and type?

Comments:

Primary Advisor should insert his or her name indicating that this report has been reviewed and accepted.

Faculty Name: Brady Seacourt  Date: 08/06/11

INSTRUCTIONS:
When First Using this Form:
1. Save this form to your desktop or laptop using the electronic file name: "your last name - supervision" (for example: Brown - supervision).
2. Click on the "Supervision" tab and insert the first name, last name, email address, and work supervised for each assigned supervisor.
3. In the "July tab" insert your name, your primary advisor's name, and the academic year on lines 1 & 2. This information will carry forward to future
4. Insert your supervisors' last names (up to 6 letters) in the highlighted row. List the Primary Placement Advisor first; then the Secondary Placement
5. Insert the planned length (in minutes) and frequency of supervisory sessions using the codes listed under the table.
6. In future months do not delete any supervisors from this log, even if they stop providing supervision. If you add a new supervisor place their name in the
   next open column for the month during which they start providing supervision.

Throughout the Month:
1. Record the length of each supervision session by placing the number of MINUTES under the appropriate cell, based on the supervisor, date, and
   whether it was individual or group in format.
2. Indicate the reasons for session not kept by coding Fellow (F) or Supervisor (S) AND Vacation (V) or Cancelled (C.), which is used for all non-vacation
   reasons. Do not code a session as not kept if it is rescheduled in the same week.

At the End of Each Month:
1. Answer the two Time Commitment questions.
2. Insert your name and date in the Attestation section above.
3. By the 5th day of the following month email the completed form to your Primary Advisor for review and acceptance. (For the last month of internship,
   forms are due on the last day of the internship).
4. By the 10th of each month Primary Advisors review completed forms, insert their name and date above indicating acceptance, and email to the Student
   Coordinator at psychsec.yale.edu.
5. Save the file as a new document by changing the "month" in the electronic file name. Click on the tab for the that month and begin tracking supervision
   for the month.

In You Have Questions: Email the Student Coordinator at psychsec@yale.edu

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1. Observation Encouraged: The internship program strongly encourages advisors and supervisors to observe the work of psychology fellows. This process enables advisors and supervisors to most accurately assess the performance of the fellows and to provide immediate and constructive feedback.

2. Audio and Visual Recordings: Audio and visual recordings tend to be the most frequently used method for advisor and supervisor observation of fellows’ work. Each placement site will have available at least one audio recording device for fellows to facilitate recording and review of their work. Fellows, advisors, and supervisors must comply with applicable recording policies and procedures of the institution in which they are placed. Those policies and procedures are contained in the Internship Handbook in hard copy and online. The use of recordings made for research purposes is controlled by the HIC/IRB approved protocol governing the research. Such recordings cannot be used for non-research supervisory purposes unless the protocol and the subject consent document specifically allow for such use.

3. Live Observation: Fellow and client interactions may be observed live by advisors and supervisors with the client’s verbal consent.

4. Providing Professional Services Jointly: Supervisors may observe fellows by jointly providing professional services with them provided that: (a) the supervisor is credentialed by the institution in which the fellow is delivering services, and (b) the Primary Advisor verbally approves this joint activity.
**CMHC Recording Policy**

Revised 03-31-15

<table>
<thead>
<tr>
<th>TITLE: PERMISSION FOR VIDEOTAPE/AUDIOTAPE/PHOTOGRAPH/OR INTERVIEW RECORDING FORM #7</th>
<th>MOST RECENT REVISION APPROVAL DATE: 8/11, 11/11</th>
<th>PAGE: POLICY &amp; PROCEDURE</th>
</tr>
</thead>
</table>

**CROSS REFERENCES AND RELATED POLICIES AND PROCEDURES:**

**POLICY:** It is the policy of the Connecticut Mental Health Center to obtain written authorization to video tape, audiotape, photograph and/or interview a client.

**DEFINITIONS:**

**PROCEDURES:**

A. The client will sign PERMISSION FOR AUDIO OR VISUAL RECORDING FORM (#7) before any audiotape, videotape, photograph, and/or interview, is conducted/recorded.

B. The permission form is filed in the client’s medical record in the legal section.

C. A written request is required to revoke this consent. The written request must be completed by the client and sent to the Health Information Management Department.

D. The Health Information Department will contact the appropriate person(s) within 7 days of receipt of the revocation and will forward a copy of the revocation.
CONSENT FOR MEDIA USAGE:

VIDEO TAPE / AUDIO TAPE / PHOTOGRAPH / INTERVIEW

Name:_________________________    MPI #:________________Date:

Street
City
State
Zip

I give my consent for Connecticut Mental Health Center, and /or their representatives or affiliates, to take and use photographs, videotape, audiotape of me and /or interview me for (check all that apply):

☐ education    ☐ publicity    ☐ fundraising    ☐ marketing    ☐ advertising

through

☐ internal publication    ☐ external publication    ☐ radio    ☐ television    ☐ video    ☐ internet

for the purpose of__________________________________________.

Such photographs, films and /or interview content will disclose the fact that I have been a client /subject of Connecticut Mental Health Center and may contain other information about me, including private health information, what I say in the interview, or facts that can be inferred from the photograph or film.

My name ☐ may / ☐ may not be used.

• I understand that I am not required to sign this form in order to receive treatment or payment for my care.

• I understand that information used or disclosed under this authorization may be reused by the recipient and may no longer be protected by privacy regulations.

• I understand that I may revoke this authorization at any time by notifying Connecticut Mental Health Center Health Information Management Department in writing, and the revocation will be effective 7 days from the date notified (except to the extent action has already been taken based on my earlier consent).

• I understand that this authorization will expire in 99 years, unless I have given written notification stating otherwise.

Date:_________________________    Time:________________

Signature of Client /Subject

Date:_________________________    Time:________________    Signature of

Legal Guardian /Authorized Legal Representative - if patient or subject is incapable of signing. A copy of the legal appointment must be attached, if applicable.

If legal representative, please print name and relationship to client: __________________________________________________________

Date:_________________________    Time:________________

Signature of Witness
Name of photographer: ________________________________ Phone #:  
Address: 

Name of interviewer: ________________________________ Phone #:  
Address: ___________________________________________

Name of CMHC staff member: __________________________ Phone #:  
_____________________________________________________

When completed, this form will be retained by the CMHC Health Information Management Department and other appropriate, authorized person.

CMHC/MR/Form # 7 Rev. 12/11
# CMHC Recording Log

**Revised 03-31-15**

**NAME OF FELLOW:**

<table>
<thead>
<tr>
<th>Client Initials</th>
<th>Device A or B?</th>
<th>ROI record in chart? Y/N</th>
<th>Date of Session</th>
<th>Date Destroyed</th>
<th>Supervisor verifying destruction (please initial)</th>
</tr>
</thead>
<tbody>
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**NAME OF FELLOW:**

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YALE-NEW HAVEN HOSPITAL
CLINICAL POLICY & PROCEDURE MANUAL

<table>
<thead>
<tr>
<th>Policy Title:</th>
<th>Photographing, Audio/Videotaping of Patients for training/research purposes</th>
<th>Manual Code:</th>
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</thead>
<tbody>
<tr>
<td>Reviewed:</td>
<td>July 20, 2012</td>
<td>Revised:</td>
</tr>
<tr>
<td>Supersedes</td>
<td>Suitable.</td>
<td>Dated:</td>
</tr>
<tr>
<td>Approved By:</td>
<td>William Sledge, MD, Ralph Hoffman, MD Sabina Lim, MD, MPH</td>
<td></td>
</tr>
</tbody>
</table>

I. Purpose: Establishing policies and procedures regarding taping patients for educational or research

II. Procedure:

Photographing, audio- and/or videotaping of patients at YNHH is permitted for educational and/or research purposes if an approved written consent form is signed by the patient and witnessed by a clinician. These recordings may be released to other individuals or facilities, if and only if, the patient explicitly consents to this further release in writing. These tapeings should not reveal the name of the patient. The consent form should reflect the fact that the recordings will be retained for a pre-specified period of time, after which time the recordings will be erased or destroyed. If digital, recordings will be stored at YNHH in a secure computer system accessible only by a limited access code. If by regular taping, recordings will be kept in locked, secured file cabinet. The consent form should reflect the fact that failing to consent to such taping will not negatively impact the care ordinarily provided by YNHH and that the patient may revoke his/her consent at any time, after which recording would cease and all prior recordings stored at YNHH would be immediately destroyed or erased.

STEPS FOR OBTAINING PATIENT CONSENT AND STORAGE OF RECORDED MATERIAL:

1. Prior approval to audio/videotape for training/research purposes is required from the hospital’s Director of Psychology.

2. Any YNHH staff, faculty and trainees who requests audio/videotaping will be given a copy of the hospital’s policy and procedures for audio/videotaping and will be required to sign an attestation acknowledging that they have read and understand the policy prior to obtaining patient’s signed permission to audio/videotape.

3. All requests to audio/videotape will be logged in a centralized file housed within YPH central administration. The purpose of the log will be to track the frequency, purpose, and location of taping. The log will record the following information:

   a. Name of hospital staff, faculty or trainee
   b. Name and MRUN of patient providing consent
   c. Location of taping
   d. Purpose of taping
   e. Date request made
   f. Date signed policy attestation received
   g. Date sign consent received
h. Date audio/videotape received  
i. Date audio/videotape destroyed

4. A separate file will be kept in YPH central administration to maintain copies of all signed patient consent forms and original signed staff, faculty and trainee attestations. Original signed release forms will be kept in the patient’s medical record.

5. All audio and video recordings will be created using a single laptop computer and will be stored within YPH central administration in a locked file cabinet.

6. Any audio/videotape that is created using traditional tape recording devices will be stored in a locked file cabinet within YPH central administration.

7. Hospital staff and faculty supervisors of trainees who are engaging in audio/videotaping are responsible for assuring that all audio/videotapes are submitted to YPH central administration for proper storage and/or disposal.

8. All audio/videotape recordings will be destroyed after one year (12 months) of original taping.
I hereby consent to be photographed, videotaped / audiotaped at Yale-New Haven Psychiatric Hospital (YNHPH) by YNHPH personnel or by faculty or trainees from Yale University who are working with YNHPH patients. Taping is for educational / research purposes. During the taping I may be asked to provide information about my symptoms, behavior, and other personal matters.

Check the one that applies:

______ I understand that my participation in individual psychotherapy over a maximum of _____ (fill in) sessions will be recorded.

______ I understand that my participation in group psychotherapy over a maximum of _____ (fill in) sessions will be recorded.

It is my understanding that the recordings will / will not (circle one) be released to other facilities or individuals outside of YNHPH.

Name of facility or individual, and reason for the release outside the facility, if applicable:
_____________________________________________________________________________________
_____________________________________________________
________________________________

It is also my understanding that my name or other identifying information such as place of residence will not be revealed to anyone outside of YNHPH or Yale University, and that the taping, if digital, will be stored at YNHH in a secure computer system accessible only by code. If by regular taping, recordings will be kept in locked, secure file cabinet. By signing this form I am permitting YNHPH to retain these recordings for a maximum of 1 year (or specify some shorter length of time _______) after which time they will be erased/disposed.

I have been informed that refusing to participate or refusing to sign this form will not in any way negatively impact or limit the care and treatment I ordinarily receive at YNHPH.

I also understand that I may revoke this consent at any time, and that any stored recordings at YNHH will be destroyed or erased immediately upon revocation of this release.

______________________________           ______________
Signature of patient        Date

____________________________       _______________
Name of patient (print)       Time

_____________________________________________________________________________________
Signature and printed name of witness
Doctoral Internship Policy & Procedures

Scholarly Project Policy
Revised 02-13-2020

1. **Purpose**: As an essential part of the internship learning experience, each fellow completes a scholarly project during the course of the internship year. The purpose of this project is to further develop competencies in research and/or scholarship. These comprise one of the core competency categories that are a focus during the internship.

2. **Content**: Projects may center on empirical research, theory or program evaluation, clinical care, training and education, or consultation. The project is intended to facilitate development of the scholarship/research profession-wide competency. However, this does not exclude practice-based or clinically oriented projects, so long as these projects involve the integration of scholarly work (i.e., there is scholarly evaluation of the work being conducted). Proposed projects should have relevance and utility for the behavioral health field, not just for the fellow. Fellows should consider developing projects that can result in submission of a proposal/abstract for a presentation or poster in a professional meeting, submission of a manuscript for publication, or presentation as a workshop or other professional training. This provision is encouraged, though not required. Fellows conducting research or program evaluation in the routine course of their placement can use these activities to fulfill the scholarly project requirement. Projects that involve human subjects and require IRB approval are generally discouraged because of the difficulties completing them in the time allotted (e.g., projects involving subject recruitment, interventions, and/or data collection). Fellows can easily join research in progress, in which IRB approvals have been obtained and data collection or analysis is ongoing. If a fellow pursues an IRB approval/exemption and data collection, the IRB application would optimally be submitted very early in the year, with data collection beginning shortly thereafter. Delays in IRB approval do not relieve fellows from the responsibility to complete a scholarly project.

3. **Project Selection**: Each fellow’s Primary Advisor is closely involved in consideration of the scholarly project and/or facilitates the fellow’s introduction to another faculty member who will serve as the Project Supervisor. Primary Advisors are asked to provide information to applicants about the types of scholarly projects conducted in the placements and the amount of choice provided to fellows. The fellow’s career interests are considered in the process of project selection.

4. **Feasibility**: In selecting a project, fellows and Primary Advisors should ensure the following: that fellows have or can develop the necessary skills to conduct their project; that they will have access to necessary resources and supports; and that the project or some major portion of the project can be completed during the course of the internship.

5. **Collaboration with Faculty**: Collaboration on the project between the fellow and his or her Primary Advisor is common. However, this relationship is not required and with the approval of the Primary Advisor, the fellow can have the scholarly project supervised by another faculty member or have another faculty member serve as a collaborator on the project. When this occurs, the Primary Advisor is responsible for orienting the project advisor about the requirements and timelines for the project and for periodically discussing and monitoring progress on the project with the fellow.
6. **Collaboration with peers:** Projects can be considered in which 2-3 fellows work together as a team. In such instances, the scope of the project should be extensive enough to justify a multi-person effort, and each fellow’s contribution must be clearly delineated prior to approval of the proposed project.

7. **Allocation of Time:** An average of four hours per week from the primary placement are allocated for each fellow to pursue their scholarly project. Fellows are encouraged to schedule time during their work week for the project in appropriate increments to complete the project.

8. **Deliverables:** Using the Scholarly Project Proposal Form, each fellow will submit a brief summary of the planned project, as approved by the Primary Advisor (and project supervisor/advisor, if different) to the Student Coordinator. At the conclusion of the project, each fellow will complete a brief written report of the project and submit this to their Primary Advisor and Project Advisor (if different) for review and feedback. Upon approval, this written report summarizing the work accomplished in the project, will be submitted to the Student Coordinator.

9. **Timelines:** Project proposals are to be submitted to the Student Coordinator by September 1st. Projects are to be completed and the summary Project Report is to be submitted to the Student Coordinator by June 1.

10. **Presentation of Projects:** A forum will be convened toward the end of the internship year, during which fellows will present their project to faculty and fellows. Primary Advisors and Project Advisors are asked to support fellows on their presentations, attend the presentations when possible, and give fellows feedback on the projects.
Doctoral Internship Policy & Procedures

Scholarly Project Proposal Form

Revised 02-13-2020

Please complete this form and submit to your Primary Advisor (and Project Supervisor, if different) for review and submission to the Student Coordinator at psychsec@yale.edu by September 1st.

Fellow Name:

Primary Placement Site:

Primary Placement Advisor:

Working Title of Project:

Project Advisor:

1. Project Overview (one paragraph):

2. Project Method(s) (one paragraph):

Does this project involve:

a. IRB approval or exemption? ___ Yes ___ No
b. Collection of data? ___ Yes ___ No
c. Participant recruitment? ___ Yes ___ No
d. An intervention? ___ Yes ___ No

3. Project Tasks and Timelines (Identify a timeline of project tasks from the inception to completion, with a target date for completion by April 30; completed projects are presented to fellows and faculty in mid-May. If an IRB application is required, please indicate the planned submission date):

4. Proposed Final Product (one paragraph):

5. Plan for Supervision of the Project (including frequency):
Doctoral Internship Policy & Procedures

Scholarly Project Report
Revised 02-13-2020

Instructions: Submit a 1.5 to 2 page report to psychsec@yale.edu in Microsoft Word (not a pdf) using Calibri 11 point font and single spacing. Use this form, keeping the header above, but deleting these instructions. Create a title in a format similar to a journal article. Note the planned dissemination of deliverables (e.g., presentations, publications, workshops). It is optional to use additional documents when presenting your projects to other fellows. An electronic copy of this document should be submitted to the Student Coordinator (psychsec@yale.edu) by June 1st.

Title of Project:
Fellow Name:
Institution / Primary Placement Site:

Project Advisor:

Purpose:

Method:

Results:

Discussion:

Planned Dissemination:
**Evaluation of Fellows Policy**

**Doctoral Internship Policies & Procedures**

**Procedure & Documentation**

1. **Orientation of Fellows**: Fellows are educated about this policy during an initial group orientation to the internship program by the Director of Training.

2. **Evaluation Frequency**: Fellows are evaluated using a standardized form three times yearly in October, February, and June.

3. **Use of a Standardized Evaluation Form**: All individuals formally designated as “advisors” or “supervisors” of a fellow will evaluate the fellow using a standardized competency evaluation form at each evaluation point and will review their feedback with the fellow. While all competency domains apply to all fellows, supervisors can use a rating of Not Applicable (NA) to designate that the competency was not observed or is not covered in the training experience being supervised. Each fellow typically receives evaluations from at least four supervisors, which provides a comprehensive and diverse set of perspectives on the fellow’s performance. If significant discrepancies in assessment of the Fellow’s competency are apparent in the supervisor evaluations, these discrepancies are discussed among the supervisors and Primary Advisor and a shared decision making occurs in provision of feedback to the fellow. Faculty involved in training also meet during each review period to discuss trainee competency development and performance, offering a strategic opportunity to resolve any potential discrepancies should they arise.

4. **Submission of Evaluations to the Primary Advisor**: All supervisor evaluation forms are forwarded to the fellow’s Primary Advisor. For fellows with a secondary placement, the Secondary Advisor completes an evaluation form and forwards it to the Primary Advisor as well.

5. **Primary Advisor Evaluations**: For each evaluation period, the Primary Advisor uses the evaluations received from other supervisors to create a composite evaluation for that period that is recording onto the Primary Advisor Evaluation Form. This serves as the formal evaluation for the fellow for each evaluation period. The Primary Advisor’s narrative summary, which is includes at the end of the form, is then sent to the fellow’s graduate program after each evaluation period.

**Competency Expectations**

1. **Adequate Progress**: For each evaluation period, the Primary Advisor will indicate on the evaluation form whether the fellow has made adequate progress toward achieving an intermediate level of proficiency for all competency categories and is on track for successful completion of the internship.
2. **Expected Proficiency Levels**: Program expectations regarding Primary Advisor ratings of the competency categories are:
   a. **October**: Each fellow will be at least at Level 2 (Basic Proficiency) for all competency categories.
   b. **February**: Each fellow will be at Level 3 (Developing Proficiency) for the majority of competency categories, with some fellows rated at Level 2 (Basic Proficiency) and/or Level 4 (Intermediate Proficiency) for some categories.
   c. **June**: All fellows will be at Level 4 for all categories with a few fellows achieving ratings at Level 5 (Advanced Proficiency) for some categories.

3. **Major Deficiencies**: Major deficiencies in the competencies that are judged at any time in the program to pose the potential of harm to others and/or serious breaches in professionalism may result in the fellow being placed on probation or terminated, as outlined in the Probation and Termination Policy. Since probation is reserved for these issues, it is possible for a fellow to not meet expected proficiencies and not successfully complete the internship without being placed on probation.

**Procedure to Address Concerns**

1. **Written Skill Development Plan**: If, at any time, a Primary Advisor evaluates a fellow as not making adequate progress, the Advisor, in collaboration with the fellow, will develop a written skill development plan (that is, a remediation plan) to address the identified concern. These plans will be reviewed and approved by the Chief of Psychology at the facility and the Director of Training. The plans are designed to ensure: (a) fellow and faculty awareness of the importance of raising the level of competence by year’s end, and (b) a clear and focused plan to achieve that level of competence. In accordance with the Graduate Program Communication Policy, the fellow’s graduate program DCT will be notified of the skill development plan and an opportunity for input will be provided. In addition, the Psychology Section Chief will be apprised of the plan and approval as necessary will be obtained.

2. **Frequent Feedback on Plans**: The Primary Advisors of fellows who have a skill development plan will provide verbal and written feedback to each fellow monthly regarding their progress, or lack thereof, in achieving the intermediate level of competence necessary to successfully complete the internship. In making these assessments, the Advisors will, as needed, gather and document verbal and written feedback from other supervisors. This monthly feedback must indicate in writing if, in the opinion of the Primary Advisor, the fellow is or is not making adequate progress toward completing the internship successfully. Copies of the written feedback will be provided to the Chief of Psychology at the facility, the Director of Training, and the Fellow’s graduate program DCT.

3. **Expedited Final Evaluation**: A fellow who is in jeopardy of not completing the internship successfully will have his or her final evaluation process expedited by the Primary Advisor. The fellow will receive final feedback by June 5th, including the Primary Advisor’s recommendation to the Director of Training as to whether the fellow has or has not met all criteria to successfully complete the internship.

4. **Criteria for Successful Completion**: For each fellow in the program, the year-end evaluation of the Primary Advisor must demonstrate an intermediate level of proficiency across all competency categories for the fellow to successfully complete the internship. Successful completion also requires that all other internship expectations (e.g., scholarly project) are met.
5. **Fellows Not Meeting Competency Expectations:** For fellows who do not meet all criteria for internship completion listed above, the Primary Advisor, in consultation with the fellow, can present to the Psychology Executive Training Committee no later than June 10th a corrective action plan focused on professional training and activities that will occur after the June 30th internship end date. Within two weeks of that date, the Executive Training Committee, at its discretion, can: (a) accept the plan and require its adequate completion before the fellow is designated as having successfully completed the internship; (b) accept the plan and designate the fellow as having successfully completed the internship, concluding that the competency deficit is sufficiently narrow and that an adequate post-internship plan is in place to supervise and promote skill development of the fellow; or (c) conclude that the fellow has permanently failed to complete the internship.

**Grievance & Due Process**

1. **Rights to Grievance & Due Process:** The Grievance and Due Process Policy of the internship program applies to all steps in this process, thus ensuring that fellows have the opportunity to question, challenge, and appeal supervisory ratings, skill development plans, corrective action plans, and decisions regarding successful completion of the internship.
# Evaluation of Fellows - Timelines

Revised 05-19-16

<table>
<thead>
<tr>
<th>All Evaluation Periods</th>
<th>Eval 1 Jul-Oct</th>
<th>Eval 2 Nov-Feb</th>
<th>Eval 3 Mar-Jun</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Coordinator releases instructions and Supervisor Evaluation Form to fellows and their Supervisors.</td>
<td>Sept 21</td>
<td>Jan 21</td>
<td>May 1</td>
</tr>
<tr>
<td>Each Supervisor completes and electronically signs a form, discusses it with the fellow, and emails it to the fellow. The fellow adds optional comments, electronically signs, and emails the form to the Primary Advisor with a copy to the Supervisor.</td>
<td>Oct 14</td>
<td>Feb 14</td>
<td>May 21</td>
</tr>
<tr>
<td>Primary Advisor completes and electronically signs a Primary Advisor Form, integrating feedback from all Supervisors, discusses the completed form with the fellow, and emails it to the fellow. The fellow adds optional comments, signs electronically, and emails the form to the Student Coordinator with a copy to the Primary Advisor.</td>
<td>Nov 1</td>
<td>Mar 1</td>
<td>Jun 7</td>
</tr>
<tr>
<td>Student Coordinator forwards Primary Advisor evaluation to fellow’s graduate program, copying the fellow.</td>
<td>Nov 15</td>
<td>Mar 15</td>
<td>June 15</td>
</tr>
</tbody>
</table>

### Additional Steps - Final Evaluation Period

| Student Coordinator releases instructions and template for the Year End Summary of Experience | May 1 |
| Fellow completes draft of the Year End Summary of Experience and emails this to the Primary Advisor. | May 15 |
| Primary Advisor edits the draft, reviews changes with the fellow, and forwards a fully signed final to Student Coordinator with a copy to the fellow. | Jun 7 |
| Student Coordinator forwards Year End Summary of Experience (and Primary Advisor June Evaluation) to Fellow’s graduate program, copying the fellow. | Jun 30 |
DOCTORAL INTERNSHIP IN CLINICAL & COMMUNITY PSYCHOLOGY

ADVISOR EVALUATION OF PSYCHOLOGY FELLOWS (Revised 2-11-20)

Fellow ___________________________ Advisor ___________________________

Facility & Placements ___________________________

**Instructions:**
For each fellow use one evaluation form for the entire year. The evaluations for each evaluation period (October, February & June) are added to a single form. Complete the form electronically using this MS Word template.

Place the cursor where you want to type. **Do Not Use the Tab Key to move through the document.**

For Advisors: For each evaluation period (October, February, and June):

a. Save the document electronically as follows: Eval of [fellow last name] by [your last name] Advisor [date].
b. Section A: Insert the date the evaluation was completed.
c. Section B: Indicate all methods you used to assess the competencies during the current evaluation period.
d. Section C: Review the Competency Rating Scale.
e. Section D: For the evaluation period, complete ONLY an overall numerical rating for each competency that integrates the numerical ratings from each supervisor. Advisors may also write an optional summary that integrates supervisor comments for each competency.
f. Section E: At the end of this form, write a summary that integrates the fellow’s progress for that period. This summary integrates all supervisor ratings and comments into a final narrative summary. **Advisors are reminded to include specific behavioral descriptors that highlight fellows’ demonstration of competencies in their narrative summary.** When done, type your name as your electronic signature and insert the date of signature; review the evaluation with the fellow; ask the fellow to insert comments (optional), sign electronically, and date the document. The fellow then returns the document electronically to you to forward to the Training Office.

For Fellows: For each evaluation period (October, February, and June):

a. Review and discuss with your advisor the completed evaluation.
b. Add optional comments at the end of the form, sign it electronically by typing your name, add the date, and forward the document electronically to your Primary Advisor.

**Section A: Date Evaluation Completed with Fellow** (Insert dates for each of the following):

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

**Section B: Methods Used to Assess Competencies** (place an X in the box for all that apply during this evaluation period):

<table>
<thead>
<tr>
<th>Oct</th>
<th>Feb</th>
<th>Jan</th>
<th>Oct</th>
<th>Feb</th>
<th>Jun</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Observation</td>
<td>Review of other written work</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Videotape</td>
<td>QA data or clinical measures</td>
<td></td>
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<tr>
<td>Audiotape</td>
<td>Feedback from staff &amp; supervisors</td>
<td></td>
<td></td>
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<tr>
<td>Case presentations</td>
<td>Feedback from peers</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Discussion of work</td>
<td>Feedback from patients &amp; families</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review of documentation</td>
<td>Other (specify):</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Section C: Competency Rating Scale

Expected Competency Level During Internship

<table>
<thead>
<tr>
<th>RATING ➔</th>
<th>1 Beginning proficiency</th>
<th>2 Basic proficiency</th>
<th>3 Developing proficiency</th>
<th>4 Intermediate proficiency</th>
<th>5 Advanced proficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Typical developmental level:</td>
<td>Early or mid-practicum</td>
<td>Internship entry</td>
<td>Internship mid-year</td>
<td>Internship completion</td>
<td>Post-internship</td>
</tr>
<tr>
<td>Skill level:</td>
<td>Learning basic skills</td>
<td>Has acquired basic skills</td>
<td>Developing more advanced skills</td>
<td>Flexibly integrating a range of skills</td>
<td>Competence at an advanced level</td>
</tr>
<tr>
<td>Supervision required:</td>
<td>Extensive with close supervision</td>
<td>Frequent</td>
<td>Routine</td>
<td>Minimal</td>
<td>Functions independently</td>
</tr>
<tr>
<td>Nature of supervision:</td>
<td>Supervisor sets agenda</td>
<td>Supervisor sets agenda with fellow input</td>
<td>Agenda set jointly by supervisor &amp; fellow</td>
<td>Fellow largely sets agenda with supervisor input</td>
<td>Seeks consultation on an as needed basis</td>
</tr>
<tr>
<td>Direction required:</td>
<td>Very frequent &amp; explicit</td>
<td>Frequent &amp; explicit</td>
<td>Moderate &amp; decreasing</td>
<td>Occasional</td>
<td>Infrequent</td>
</tr>
<tr>
<td>Structure required:</td>
<td>Very high</td>
<td>High</td>
<td>Moderate</td>
<td>Low</td>
<td>Very minimal</td>
</tr>
</tbody>
</table>

*Note: Ratings of NA (not applicable/not observed) are made if there are no supervisor ratings for that competency.

Advisors only complete an overall numerical rating for each competency that integrates the numerical ratings from all supervisors. They also may complete an optional comment for each competency.

Section D: Competency Ratings

Category I: Communication & Interpersonal Skills

Competencies & Their Elements

<table>
<thead>
<tr>
<th>Jul-Oct</th>
<th>Nov-Feb</th>
<th>Mar-Jun</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Communicates effectively</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Listens attentively to others</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Identifies differences in communication needs across contexts and intended recipients and adjusts communications accordingly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Demonstrates a thorough grasp of professional language and concepts and uses them appropriately and clearly in oral and written communications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Produces and comprehends written work that is organized, comprehensive and well-integrated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Forms positive relationships with others</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Develops, maintains, and effectively terminates therapeutic relationships with individuals receiving professional services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Develops and maintains productive working relationships with colleagues, communities, organizations, supervisors and supervisees</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Interacts in a manner that is honest, straightforward, and flexible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Expresses genuine interest in others, providing them support and encouragement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Displays compassion and empathy toward others, including those dissimilar from oneself</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Manages complex interpersonal situations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Maintains appropriate boundaries (e.g., sharing of personal information, personal touch, dual relationships)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2. Acknowledges and tolerates others’ feelings and attitudes, including those expressed toward them
3. Allows and facilitates patients’ exploration of emotionally laden issues
4. Maintains emotional equilibrium and judgment when faced with interpersonal conflict and patient distress
5. Recognizes and uses problem solving strategies to address interpersonal conflicts
6. Offers and accepts feedback constructively

D. **Demonstrates self-awareness as a professional**
1. Identifies and monitors personal attitudes, values, beliefs, individual and cultural identities, and their typical role in groups
2. Recognizes how others experience them and the impact of self on others
3. Uses personal reactions to inform work with patients and other professionals
4. Adjusts professional behavior based on awareness of self and awareness of impact on others

**Comments on Communication & Interpersonal Skills Competency:**
(Integrates supervisor comments for this competency. Optional - May be left blank.)

**Overall Rating for this Competency Category**
(This integrates all supervisor numerical ratings)

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<table>
<thead>
<tr>
<th>Category II: Individual and Cultural Diversity</th>
<th>Ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competencies &amp; Their Elements</td>
<td>July-Oct</td>
</tr>
<tr>
<td><strong>A. Demonstrates awareness of diversity and its influence</strong></td>
<td></td>
</tr>
<tr>
<td>1. Identifies the various dimensions of individual and cultural diversity (e.g., age, race, ethnicity, national origin, language, socioeconomic status, gender, gender identity, sexual orientation, religion, spiritual beliefs, physical and mental ability)</td>
<td></td>
</tr>
<tr>
<td>2. Recognizes and appreciates complexities inherent to individual and cultural diversity (e.g., intersectionality)</td>
<td></td>
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<tr>
<td>3. Recognizes the potential influence of individual and cultural diversity on others and on the interactions between individuals, groups and systems of care</td>
<td></td>
</tr>
<tr>
<td>4. Explores and monitors how s/he or they are influenced by individual and cultural characteristics and experiences</td>
<td></td>
</tr>
<tr>
<td>5. Moves beyond recognition and identification toward an integrated and developed framework for working with populations that are diverse</td>
<td></td>
</tr>
<tr>
<td><strong>B. Develops effective relationships with culturally diverse individuals, families, and groups</strong></td>
<td></td>
</tr>
<tr>
<td>1. Recognizes and respects differences between self and others</td>
<td></td>
</tr>
<tr>
<td>2. Communicates in patient’s preferred language or uses interpreter services as needed</td>
<td></td>
</tr>
<tr>
<td>3. Explores with patients their individual and cultural identities and the meaning of these identifications to them</td>
<td></td>
</tr>
<tr>
<td>4. Recognizes and responds appropriately to the impact of individual and cultural diversity in clinical, consultative, and supervisory relationships</td>
<td></td>
</tr>
<tr>
<td><strong>C. Applies knowledge of individual and cultural diversity in practice</strong></td>
<td></td>
</tr>
<tr>
<td>1. Selects assessment instruments, uses assessment tools, and interprets findings within the context of patients’ linguistic and cultural characteristics and identities</td>
<td></td>
</tr>
<tr>
<td>2. Considers individual and cultural characteristics and identities in developing treatment plans and selecting, modifying, implementing, and monitoring interventions</td>
<td></td>
</tr>
<tr>
<td>3. Is aware of and integrates knowledge of individual and cultural diversity across aspects of professional role (intervention, assessment, consultation, research, leadership, etc.)</td>
<td></td>
</tr>
<tr>
<td>4. Connects patients to culturally responsive services and resources</td>
<td></td>
</tr>
<tr>
<td>5. Recognizes, brings attention to, and/or addresses disparities in access to services or other forms of discrimination</td>
<td></td>
</tr>
</tbody>
</table>
D. Pursues professional development about individual and cultural diversity

1. Recognizes the limitations in their abilities to work with individuals from diverse backgrounds
2. Reviews and applies relevant literature and practice guidelines on providing services to diverse populations
3. Seeks supervision to enhance their abilities to work with individuals from diverse backgrounds
4. Pursues continuing education and multicultural experiences to enhance their abilities to work with individuals from diverse backgrounds

**Comments on Individual & Cultural Diversity Competency:**
*(Integrates supervisor comments for this competency. Optional - May be left blank.)*

**Overall Rating for this Competency Category**
*(This integrates all supervisor numerical ratings)*

<table>
<thead>
<tr>
<th>Category III: Professional Values, Attitudes and Behavior</th>
<th>Ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competencies &amp; Their Elements</td>
<td>Jul-Oct</td>
</tr>
<tr>
<td>A. Displays professional behavior</td>
<td></td>
</tr>
<tr>
<td>1. Maintains appropriate personal hygiene and professional attire</td>
<td></td>
</tr>
<tr>
<td>2. Utilizes appropriate language and non-verbal communications, including in difficult interactions</td>
<td></td>
</tr>
<tr>
<td>3. Demonstrates sound judgement in their responses to routine, complex and/or challenging situations</td>
<td></td>
</tr>
<tr>
<td>4. Responds professionally in increasingly complex situations with a level of independence that matches their professional role</td>
<td></td>
</tr>
<tr>
<td>5. Clarifies expectations and engages in behavior appropriate for their professional role and adjusts behavior to the setting and situation</td>
<td></td>
</tr>
<tr>
<td>B. Engages in self-assessment and self-reflection</td>
<td></td>
</tr>
<tr>
<td>1. Uses multiple methods to routinely assess professional strengths and areas for growth (e.g., supervision, peer supervision/consultation, audio/video recordings, patient feedback)</td>
<td></td>
</tr>
<tr>
<td>2. Is open, receptive and responsive to feedback around performance and professional functions</td>
<td></td>
</tr>
<tr>
<td>3. Recognizes and observes the limits of personal knowledge and skills</td>
<td></td>
</tr>
<tr>
<td>4. Recognizes changes in the field that require the development of new or enhanced competencies</td>
<td></td>
</tr>
<tr>
<td>C. Demonstrates accountability</td>
<td></td>
</tr>
<tr>
<td>1. Acts responsibly (e.g., organizes workload; completes assigned duties efficiently; keeps appointments; honors commitments; follows policies, procedures and administrative requirements)</td>
<td></td>
</tr>
<tr>
<td>2. Demonstrates reliability (e.g., arrives on time, completes work on time, documents in an accurate and timely manner)</td>
<td></td>
</tr>
<tr>
<td>3. Remains available and accessible as their role requires</td>
<td></td>
</tr>
<tr>
<td>4. Acknowledges and assumes responsibility for errors, lapses in judgment, and deviations from professional ethics and values</td>
<td></td>
</tr>
<tr>
<td>D. Demonstrates professional identity</td>
<td></td>
</tr>
<tr>
<td>1. Exhibits knowledge of the profession and awareness of issues central to the field</td>
<td></td>
</tr>
<tr>
<td>2. Reflects the professional value of life-long learning by pursuing continuing education</td>
<td></td>
</tr>
<tr>
<td>3. Articulates and pursues professional and career goals</td>
<td></td>
</tr>
<tr>
<td>4. Demonstrates emerging leadership skills</td>
<td></td>
</tr>
</tbody>
</table>
**E. Engages in the self-care essential for functioning effectively as a psychologist**

1. Uses multiple self-care approaches to maintain health and wellness
2. Uses positive coping strategies to tolerate ambiguity and uncertainty and to manage stress
3. Recognizes personal challenges and addresses them so as to minimize their impact on professional performance

**Comments on Professional Values, Attitudes and Behavior:**

(Integrates supervisor comments for this competency. Optional - May be left blank.)

---

**Overall Rating for this Competency Category**

(This integrates all supervisor numerical ratings)

---

<table>
<thead>
<tr>
<th>Category IV: Ethical and Legal Standards</th>
<th>Ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Competencies &amp; Their Elements</strong></td>
<td>July-Oct</td>
</tr>
<tr>
<td><strong>A. Demonstrates awareness of ethical and legal standards applicable to Health Service Psychology practice, training, and research</strong></td>
<td><img src="null" alt="Ratings" /></td>
</tr>
<tr>
<td>1. Recognizes the ethical values and principles held by professional psychology and the institutions in which they work</td>
<td><img src="null" alt="Ratings" /></td>
</tr>
<tr>
<td>2. Demonstrates awareness of relevant laws, regulations, rules and policies governing health service psychology practice at the organizational, local, state, regional and federal levels</td>
<td><img src="null" alt="Ratings" /></td>
</tr>
<tr>
<td>3. Demonstrates awareness of specific concepts that underlie the above laws, regulations and policies (e.g., informed consent, confidentiality, mandated reporting)</td>
<td><img src="null" alt="Ratings" /></td>
</tr>
<tr>
<td>4. Articulates own ethical values and priorities</td>
<td><img src="null" alt="Ratings" /></td>
</tr>
<tr>
<td><strong>B. Recognizes and manages ethical and legal issues in Health Service Psychology practice, training, and research</strong></td>
<td><img src="null" alt="Ratings" /></td>
</tr>
<tr>
<td>1. Adheres to all ethical and legal standards in all professional activities</td>
<td><img src="null" alt="Ratings" /></td>
</tr>
<tr>
<td>2. Recognizes and helps others recognize ethical and legal issues as they arise</td>
<td><img src="null" alt="Ratings" /></td>
</tr>
<tr>
<td>3. Demonstrates a clear decision-making process in the development and implementation of plans to resolve ethical and legal issues</td>
<td><img src="null" alt="Ratings" /></td>
</tr>
<tr>
<td>4. Takes appropriate action when others behave in an unethical or illegal manner</td>
<td><img src="null" alt="Ratings" /></td>
</tr>
<tr>
<td>5. Seeks supervision or consultation on ethical and legal issues</td>
<td><img src="null" alt="Ratings" /></td>
</tr>
<tr>
<td><strong>C. Adheres to the APA Ethical Principles and Code of Conduct</strong></td>
<td><img src="null" alt="Ratings" /></td>
</tr>
<tr>
<td>1. Strives to benefit others and do no harm</td>
<td><img src="null" alt="Ratings" /></td>
</tr>
<tr>
<td>2. Develops relationships of trust with others and accepts responsibility for their behavior</td>
<td><img src="null" alt="Ratings" /></td>
</tr>
<tr>
<td>3. Maintains personal integrity</td>
<td><img src="null" alt="Ratings" /></td>
</tr>
<tr>
<td>4. Promotes fairness and justice</td>
<td><img src="null" alt="Ratings" /></td>
</tr>
<tr>
<td>5. Respects the dignity, worth, and rights of all people</td>
<td><img src="null" alt="Ratings" /></td>
</tr>
</tbody>
</table>

**Comments on Ethical & Legal Standards:**

(Integrates supervisor comments for this competency. Optional - May be left blank.)

---

**Overall Rating for this Competency Category**

(This integrates all supervisor numerical ratings)
<table>
<thead>
<tr>
<th>Category V: Assessment</th>
<th>Ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Competencies &amp; Their Elements</strong></td>
<td><strong>July-Oct</strong></td>
</tr>
<tr>
<td><strong>A. Conducts clinical interviews</strong></td>
<td></td>
</tr>
<tr>
<td>1. Quickly establishes rapport with individuals being interviewed</td>
<td></td>
</tr>
<tr>
<td>2. Formulates relevant and culturally responsive interview questions</td>
<td></td>
</tr>
<tr>
<td>3. Conducts semi-structured interviews</td>
<td></td>
</tr>
<tr>
<td><strong>B. Appropriately selects and applies evidence-based assessment methods</strong></td>
<td></td>
</tr>
<tr>
<td>1. Screens referrals and identifies clear goals for assessments</td>
<td></td>
</tr>
<tr>
<td>2. Selects psychometrically sounds assessment methods and tools that draw from the best empirical literature and that are relevant to assessment aims</td>
<td></td>
</tr>
<tr>
<td>3. Administers methods and tools accurately and efficiently</td>
<td></td>
</tr>
<tr>
<td>4. Scores and interprets results</td>
<td></td>
</tr>
<tr>
<td><strong>C. Collects and integrates data</strong></td>
<td></td>
</tr>
<tr>
<td>1. Obtains and integrates multiple sources of information (e.g., observations, historical information, interview data, test results, information from collateral sources, and findings from the literature)</td>
<td></td>
</tr>
<tr>
<td>2. Demonstrates current knowledge of diagnostic classification systems and awareness of cultural (and other) limitations of such systems</td>
<td></td>
</tr>
<tr>
<td>3. Uses above systems to classify and differentiate functional and dysfunctional behaviors as well as identify strengths and protective factors</td>
<td></td>
</tr>
<tr>
<td>4. Formulates case conceptualizations that demonstrate a clear understanding of behavior within its context (e.g., familial, societal, cultural, social, etc.)</td>
<td></td>
</tr>
<tr>
<td>5. Formulates treatment recommendations that arise from collected data</td>
<td></td>
</tr>
<tr>
<td>6. Uses alternative, non-diagnostic approaches to conceptualizing individuals and their environments, groups, and organizations</td>
<td></td>
</tr>
<tr>
<td><strong>D. Summarizes and reports data</strong></td>
<td></td>
</tr>
<tr>
<td>1. Writes clear, accurate and timely integrated reports</td>
<td></td>
</tr>
<tr>
<td>2. Communicates findings and recommendations clearly to patients and other providers</td>
<td></td>
</tr>
<tr>
<td>3. Recognizes and reports the strengths and limitations of assessments and findings</td>
<td></td>
</tr>
</tbody>
</table>

**Comments on Assessment:**
(Integrates supervisor comments for this competency. Optional - May be left blank.)

**Overall Rating for this Competency Category**
(This integrates all supervisor numerical ratings)

<table>
<thead>
<tr>
<th>Category VI: Intervention</th>
<th>Ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Competencies &amp; Their Elements</strong></td>
<td><strong>July-Oct</strong></td>
</tr>
<tr>
<td><strong>A. Formulates case conceptualizations and treatment plans</strong></td>
<td></td>
</tr>
<tr>
<td>1. Collaborates with patients and families to identify goals and plans</td>
<td></td>
</tr>
<tr>
<td>2. Links case conceptualizations and treatment plans to assessments</td>
<td></td>
</tr>
<tr>
<td>3. Utilizes at least one theoretical orientation and theory of change</td>
<td></td>
</tr>
<tr>
<td>4. Selects appropriate evidence-based interventions and best practices</td>
<td></td>
</tr>
<tr>
<td><strong>B. Implements evidence-based interventions</strong></td>
<td></td>
</tr>
<tr>
<td>1. Displays clinical skills with a wide range of evidence-based interventions, patients and patient service needs</td>
<td></td>
</tr>
<tr>
<td>2. Implements interventions with fidelity and adapts them to honor diversity characteristics and contextual factors as is appropriate</td>
<td></td>
</tr>
<tr>
<td>3. Recognizes and manages problems and issues that arise with interventions</td>
<td></td>
</tr>
<tr>
<td>4. Modifies and adapts evidence-based approaches effectively when a clear evidence-base is lacking</td>
<td></td>
</tr>
</tbody>
</table>
### C. Monitors the impact of interventions

1. Routinely evaluates progress toward service delivery goals
2. Measures outcomes
3. Modifies intervention methods and treatment goals based on evaluation findings
4. Monitors and adapts own role and performance with the intervention

**Comments on Intervention:**

(Integrates supervisor comments for this competency. Optional - May be left blank.)

### Category VII: Consultation and Interprofessional/Interdisciplinary and Systems-Based Practice

**Competencies & Their Elements**

<table>
<thead>
<tr>
<th>July-Oct</th>
<th>Nov-Feb</th>
<th>Mar-June</th>
</tr>
</thead>
</table>

**A. Provides consultation (e.g. case-based, group, organizational systems)**

1. Forms effective consultative relationships
2. Clarifies and refines referral questions and consultation goals
3. Develops and implements a consultation plan, recognizing the individual, group, organizational, and systems issues that may impact it
4. Communicates consultation results and recommendations

**B. Engages in interprofessional/interdisciplinary collaboration**

1. Demonstrates awareness and respect of the roles, beliefs, values, practices and contributions of other professionals, providers, patients, family, and community members
2. Contributes psychological information while working flexibly with others to develop and implement a plan of care
3. Represents their professional opinions, encourages others to express their opinions, and works to resolve differences of opinion or conflicts
4. Integrates behavioral healthcare with other services (e.g., primary and specialty medical care; rehabilitative, recovery, vocational, residential and social services)
5. Shares and receives information from others in a sensitive manner when authorized by the patient and permissible under applicable laws, regulations, policies, and ethical codes

**C. Engages in systems-based practice**

1. Delivers care using knowledge of healthcare benefits, coverage limits, utilization management procedures, billing, and reimbursement
2. Analyzes and understands problems within organizations and systems from individual, interpersonal, group, and intergroup perspectives
3. Recognizes the potential influence of group memberships on the behavior of individuals in organizations and systems
4. Responds appropriately to problems within organizations and systems given their role

**Comments on Consultation, Interprofessional/Interdisciplinary and Systems-Based Practice:**

(Integrates supervisor comments for this competency. Optional - May be left blank.)

**Overall Rating for this Competency Category**

(This integrates all supervisor numerical ratings)

---

60
### Category VIII: Supervision

#### Competencies & Their Elements

<table>
<thead>
<tr>
<th>Competency</th>
<th>July-Oct</th>
<th>Nov-Feb</th>
<th>Mar-June</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Seeks and uses supervision effectively</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Establishes strong working relationships with supervisors of diverse practice orientations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Clarifies broad personal goals for supervision and specific agendas items for supervisory sessions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Seeks supervision routinely and when specifically needed (e.g., complex cases, unfamiliar patients or services, ethical and legal issues, strong personal reactions to patients)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Uses multiple methods to provide supervisors with timely, accurate information about their work and is open to being observed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>B. Uses supervisory feedback to improve performance</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Accepts feedback without being overly defensive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Acknowledges challenges and areas for professional growth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Follows supervisors’ direction</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Adjusts professional behavior based on feedback</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>C. Facilitates peer supervision/consultation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Leads peer supervision/consultation groups</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Structures the groups using an explicit method to guide discussions by peers of their work</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Maintains a constructive and supportive environment within the groups</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Gives constructive and supportive feedback to peers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>D. Provides individual supervision (if applicable)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Establishes supportive supervisory relationships with explicit roles and responsibilities for supervisor and supervisee (or does so by engaging in simulated practice of supervision)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Uses multiple methods to monitor the quality of care provided and assess supervisee level of development, strengths, and learning needs (e.g., observation; audio and video recording; case discussion and presentations; review of documentation; clinical measures; QA data; and feedback from others)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Uses an explicit model of supervision and multiple methods to ensure the quality of care being provided and to address supervisee learning needs (e.g., case discussion, feedback, instruction, modeling, coaching, providing publications)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Provides feedback that is direct, clear, timely, behaviorally anchored, and mindful of the impact on the supervisee and supervisory relationship</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Maintains accurate and timely documentation of supervision and supervisee performance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Requests and uses feedback from supervisees to improve the quality of supervision</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Comments on Supervision:**

*(Integrates supervisor comments for this competency. Optional - May be left blank.)*

**Overall Rating for this Competency Category**

*(This integrates all supervisor numerical ratings)*

### Category IX: Research & Scholarship

#### Competencies & Their Elements

<table>
<thead>
<tr>
<th>Competency</th>
<th>July-Oct</th>
<th>Nov-Feb</th>
<th>Mar-June</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Displays critical scientific thinking</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
1. Demonstrates scholarly curiosity and routinely questions assumptions
2. Understands and values evidence-based practice
3. Formulates questions that can be addressed by the literature, research, and program evaluation
4. Critically evaluates and shares ideas with others through teaching and scholarly writing

B. Uses the scientific literature
1. Accesses, summarizes, and evaluates the literature related to their professional activities
2. Discusses the relevant literature in case conferences, lectures, and/or professional presentations
3. Applies the scientific literature to their work (e.g., clinical, consultation, research, program evaluation, quality assurance)

C. Implements scientific methods
1. Selects and implements methods appropriate to the question, setting, and/or community
2. Uses scientific methods to evaluate interventions and programs and to engage in continuous quality improvement
3. Manages, analyzes, and interprets quantitative and qualitative data
4. Collaborates with other professionals, persons in recovery, family members, and stakeholders in developing questions, implementing methods, and understanding results
5. Contributes to the preparation of manuscripts, technical reports, case studies, or other scholarly work

Comments on Research & Scholarship:
(Integrates supervisor comments for this competency. Optional - May be left blank.)

Overall Rating for this Competency Category
(This integrates all supervisor numerical ratings)

Section E: Integrative Summary Statement of Fellow’s Progress, including Signatures (Typing your name electronically on this document is equivalent to a written signature).

OCTOBER EVALUATION
Advisor’s Overall Assessment of Progress: Place an X in one box.

Fellow has made adequate progress in developing the core competencies that I am assessing.
Fellow has NOT made adequate progress in developing the core competencies that I am assessing.

Advisor’s Integrative Summary of Fellow Progress. This summary integrates all supervisor ratings and comments into a narrative summary. Identify strengths, areas for growth, and major concerns. Advisors are reminded to include specific behavioral descriptors that highlight fellows’ demonstration of competencies in this narrative summary. Please consider providing feedback that addresses each of the competency areas.

Psychology Fellow’s Comments: These comments are optional.

Advisor’s signature  Date  Fellow’s signature  Date
(Signatures indicate that the advisor and fellow have discussed this evaluation)
<table>
<thead>
<tr>
<th>Advisor’s Overall Assessment of Progress: Place an X in one box.</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Fellow has made adequate progress in developing the core competencies that I am assessing.</td>
</tr>
<tr>
<td>[ ] Fellow has NOT made adequate progress in developing the core competencies that I am assessing.</td>
</tr>
</tbody>
</table>

**Advisor’s Integrative Summary of Fellow Progress.** This summary integrates all supervisor ratings and comments into a narrative summary. Identify strengths, areas for growth, and major concerns. **Advisors are reminded to include specific behavioral descriptors that highlight fellows’ demonstration of competencies in this narrative summary.** Please consider providing feedback/progress that addresses each of the competency areas.

**Psychology Fellow’s Comments:** These comments are optional.

<table>
<thead>
<tr>
<th>Advisor’s signature</th>
<th>Date</th>
<th>Fellow’s signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Signatures indicate that the advisor and fellow have discussed this evaluation)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**JUNE EVALUATION**

**Advisor’s Overall Assessment of Progress:** Place an X in one box.

[ ] Fellow has made adequate progress in developing the core competencies that I am assessing.

[ ] Fellow has NOT made adequate progress in developing the core competencies that I am assessing.

**Advisor’s Integrative Summary of Fellow Progress.** This summary integrates all supervisor ratings and comments into a narrative summary. Identify strengths, areas for growth, and major concerns. **Advisors are reminded to include specific behavioral descriptors that highlight fellows’ demonstration of competencies in this narrative summary.** Please consider providing feedback/progress that addresses each of the competency areas.

**Psychology Fellow’s Comments:** These comments are optional.

<table>
<thead>
<tr>
<th>Advisor’s signature</th>
<th>Date</th>
<th>Fellow’s signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Signatures indicate that the advisor and fellow have discussed this evaluation)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
DOCTORAL INTERNSHIP IN CLINICAL & COMMUNITY PSYCHOLOGY

SUPERVISOR EVALUATION OF PSYCHOLOGY FELLOWS

(Revised 9-10-19)

Fellow ___________________________________________ Supervisor ________________________________

Facility & Placements ______________________________

Instructions:

For each fellow use one evaluation form for the entire year. The evaluations for each evaluation period (October, February & June) are added to a single form. Complete the form electronically using this MS Word template.

Place the cursor where you want to type. Do Not Use the Tab Key to move through the document.

For Supervisors: For each evaluation period (October, February, and June):

a. Save the document electronically as follows: Eval of [fellow last name] by [your last name] [date].

b. Section A: Insert the date the evaluation was completed.

c. Section B: Indicate all methods you used to assess the competencies during the current evaluation period.

d. Section C: Review the Competency Rating Scale.

e. Section D: For the evaluation period, complete the ratings of each competency and give an Overall Rating for each competency category (this does NOT have not to be a numerical mean). Insert “NA” for any competency or competency category that you cannot rate. Comments for each competency category are optional, though encouraged.

f. Section E: At the end of this form, write a summary that integrates the fellow’s progress for that period. **Supervisors are reminded to include specific behavioral descriptors that highlight fellows’ demonstration of competencies in their narrative summary.** When done, type your name as your electronic signature and insert the date of signature; review the evaluation with the fellow; ask the fellow to insert comments (optional), sign electronically, and date the document. The fellow then returns the document electronically to the Primary Advisor and will copy you.

For Fellows: For each evaluation period (October, February, and June):

a. Review and discuss with the supervisor the completed evaluation.

b. Add optional comments at the end of the form, sign it electronically by typing your name, add the date, and forward the document electronically to your Primary Advisor, with an electronic copy to the supervisor.

<table>
<thead>
<tr>
<th>Section A: Completion Dates (Insert dates for each of the following):</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Section B: Methods Used to Assess Competencies (place an X in the box for all that apply during this evaluation period):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct</td>
</tr>
<tr>
<td>-----</td>
</tr>
<tr>
<td>Direct Observation</td>
</tr>
<tr>
<td>Videotape</td>
</tr>
<tr>
<td>Audiotape</td>
</tr>
<tr>
<td>Case presentations</td>
</tr>
</tbody>
</table>
Section C: Competency Rating Scale

<table>
<thead>
<tr>
<th>RATING</th>
<th>1 Beginning proficiency</th>
<th>2 Basic proficiency</th>
<th>3 Developing proficiency</th>
<th>4 Intermediate proficiency</th>
<th>5 Advanced proficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Typical developmental level:</td>
<td>Early or mid-practicum</td>
<td>Internship entry</td>
<td>Internship mid-year</td>
<td>Internship completion</td>
<td>Post-internship</td>
</tr>
<tr>
<td>Skill level:</td>
<td>Learning basic skills</td>
<td>Has acquired basic skills</td>
<td>Developing more advanced skills</td>
<td>Flexibly integrating a range of skills</td>
<td>Competence at an advanced level</td>
</tr>
<tr>
<td>Supervision required:</td>
<td>Extensive with close supervision</td>
<td>Frequent</td>
<td>Routine</td>
<td>Minimal</td>
<td>Functions independently</td>
</tr>
<tr>
<td>Nature of supervision:</td>
<td>Supervisor sets agenda</td>
<td>Supervisor sets agenda with fellow input</td>
<td>Agenda set jointly by supervisor &amp; fellow</td>
<td>Fellow largely sets agenda with supervisor input</td>
<td>Seeks consultation on an as needed basis</td>
</tr>
<tr>
<td>Direction required:</td>
<td>Very frequent &amp; explicit</td>
<td>Frequent &amp; explicit</td>
<td>Moderate &amp; decreasing</td>
<td>Occasional</td>
<td>Infrequent</td>
</tr>
<tr>
<td>Structure required:</td>
<td>Very high</td>
<td>High</td>
<td>Moderate</td>
<td>Low</td>
<td>Very minimal</td>
</tr>
</tbody>
</table>

*Note: Ratings of NA (not applicable or not observed): Supervisors may use NA for rating competency categories or individual competencies if these are not applicable to the work the supervisor is supervising or if the supervisor has no information on which to rate the competency.

Section D: Competency Ratings

a. In the column for this evaluation period provide one rating of each Individual Competency (the bolded items that begin with a letter, such as “I.A. Communicates effectively”). Do not rate the elements of each competency (listed as 1, 2, 3, etc.).

b. Provide one rating for the overall competency Category (e.g., I. Communication and Interpersonal Skills). The space to insert this rating occurs at the end of the Category. This does not have to be a numerical mean of the ratings for competencies in this category.

Category I: Communication & Interpersonal Skills

<table>
<thead>
<tr>
<th>Competencies &amp; Their Elements</th>
<th>Ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Communicates effectively</strong></td>
<td></td>
</tr>
<tr>
<td>1. Listens attentively to others</td>
<td></td>
</tr>
<tr>
<td>2. Identifies differences in communication needs across contexts and intended recipients and adjusts communications accordingly</td>
<td></td>
</tr>
<tr>
<td>3. Demonstrates a thorough grasp of professional language and concepts and uses them appropriately and clearly in oral and written communications</td>
<td></td>
</tr>
<tr>
<td>4. Produces and comprehends written work that is organized, comprehensive and well-integrated</td>
<td></td>
</tr>
<tr>
<td><strong>B. Forms positive relationships with others</strong></td>
<td></td>
</tr>
<tr>
<td>1. Develops, maintains, and effectively terminates therapeutic relationships with individuals receiving professional services</td>
<td></td>
</tr>
<tr>
<td>2. Develops and maintains productive working relationships with colleagues, communities, organizations, supervisors and supervisees</td>
<td></td>
</tr>
</tbody>
</table>


3. Interacts in a manner that is honest, straightforward, and flexible
4. Expresses genuine interest in others, providing them support and encouragement
5. Displays compassion and empathy toward others, including those dissimilar from oneself

C. Manages complex interpersonal situations
1. Maintains appropriate boundaries (e.g., sharing of personal information, personal touch, dual relationships)
2. Acknowledges and tolerates others’ feelings and attitudes, including those expressed toward them
3. Allows and facilitates patients’ exploration of emotionally laden issues
4. Maintains emotional equilibrium and judgment when faced with interpersonal conflict and patient distress
5. Recognizes and uses problem solving strategies to address interpersonal conflicts
6. Offers and accepts feedback constructively

D. Demonstrates self-awareness as a professional
1. Identifies and monitors personal attitudes, values, beliefs, individual and cultural identities, and their typical role in groups
2. Recognizes how others experience them and the impact of self on others
3. Uses personal reactions to inform work with patients and other professionals
4. Adjusts professional behavior based on awareness of self and awareness of impact on others

Comments on Communication & Interpersonal Skills Competency (Optional):

Overall Rating for this Competency Category

---

Category II: Individual and Cultural Diversity

<table>
<thead>
<tr>
<th>Competencies &amp; Their Elements</th>
<th>Ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Demonstrates awareness of diversity and its influence</td>
<td>July-Oct</td>
</tr>
<tr>
<td>1. Identifies the various dimensions of individual and cultural diversity (e.g., age, race, ethnicity, national origin, language, socioeconomic status, gender, gender identity, sexual orientation, religion, spiritual beliefs, physical and mental ability)</td>
<td></td>
</tr>
<tr>
<td>2. Recognizes and appreciates complexities inherent to individual and cultural diversity (e.g., intersectionality)</td>
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<tr>
<td>3. Recognizes the potential influence of individual and cultural diversity on others and on the interactions between individuals, groups and systems of care</td>
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<tr>
<td>4. Explores and monitors how they are influenced by individual and cultural characteristics and experiences</td>
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</tr>
<tr>
<td>5. Moves beyond recognition and identification toward an integrated and developed framework for working with populations that are diverse</td>
<td></td>
</tr>
<tr>
<td>B. Develops effective relationships with culturally diverse individuals, families, and groups</td>
<td></td>
</tr>
<tr>
<td>1. Recognizes and respects differences between self and others</td>
<td></td>
</tr>
<tr>
<td>2. Communicates in patient’s preferred language or uses interpreter services as needed</td>
<td></td>
</tr>
<tr>
<td>3. Explores with patients their individual and cultural identities and the meaning of these identifications to them</td>
<td></td>
</tr>
<tr>
<td>4. Recognizes and responds appropriately to the impact of individual and cultural diversity in clinical, consultative, and supervisory relationships</td>
<td></td>
</tr>
<tr>
<td>C. Applies knowledge of individual and cultural diversity in practice</td>
<td></td>
</tr>
<tr>
<td>1. Selects assessment instruments, uses assessment tools, and interprets findings within the context of patients’ linguistic and cultural characteristics and identities</td>
<td></td>
</tr>
</tbody>
</table>
2. Considers individual and cultural characteristics and identities in developing treatment plans and selecting, modifying, implementing, and monitoring interventions.
3. Is aware of and integrates knowledge of individual and cultural diversity across aspects of professional role (intervention, assessment, consultation, research, leadership, etc.)
4. Connects patients to culturally responsive services and resources.
5. Recognizes, brings attention to, and/or addresses disparities in access to services, or other forms of discrimination.

D. Pursues professional development about individual and cultural diversity
1. Recognizes the limitations in their abilities to work with individuals from diverse backgrounds.
2. Reviews and applies relevant literature and practice guidelines on providing services to diverse populations.
3. Seeks supervision to enhance their abilities to work with individuals from diverse backgrounds.
4. Pursues continuing education and multicultural experiences to enhance their abilities to work with individuals from diverse backgrounds.

Comments on Individual & Cultural Diversity Competency (Optional):

Overall Rating for this Competency Category:

<table>
<thead>
<tr>
<th>Category III: Professional Values, Attitudes and Behavior</th>
<th>Ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competencies &amp; Their Elements</td>
<td>July-Oct</td>
</tr>
<tr>
<td></td>
<td>Nov-Feb</td>
</tr>
<tr>
<td></td>
<td>Mar-June</td>
</tr>
</tbody>
</table>

A. Displays professional behavior
1. Maintains appropriate personal hygiene and professional attire.
2. Utilizes appropriate language and non-verbal communications, including in difficult interactions.
3. Demonstrates sound judgement in their responses to routine, complex and/or challenging situations.
4. Responds professionally in increasingly complex situations with a level of independence that matches their professional role.
5. Clarifies expectations and engages in behavior appropriate for their professional role and adjusts behavior to the setting and situation.

B. Engages in self-assessment and self-reflection
1. Uses multiple methods to routinely assess professional strengths and areas for growth (e.g., supervision, peer supervision/consultation, audio/video recordings, patient feedback).
2. Is open, receptive and responsive to feedback around performance and professional functions.
3. Recognizes and observes the limits of personal knowledge and skills.
4. Recognizes changes in the field that require the development of new or enhanced competencies.

C. Demonstrates accountability
1. Acts responsibly (e.g., organizes workload; completes assigned duties efficiently; keeps appointments; honors commitments; follows policies, procedures and administrative requirements).
2. Demonstrates reliability (e.g., arrives on time, completes work on time, documents in an accurate and timely manner).
3. Remains available and accessible as their role requires
4. Acknowledges and assumes responsibility for errors, lapses in judgment, and deviations from professional ethics and values

**D. Demonstrates professional identity**
1. Exhibits knowledge of the profession and awareness of issues central to the field
2. Reflects the professional value of life-long learning by pursuing continuing education
3. Articulates and pursues professional and career goals
4. Demonstrates emerging leadership skills

**E. Engages in the self-care essential for functioning effectively as a psychologist**
1. Uses multiple self-care approaches to maintain health and wellness
2. Uses positive coping strategies to tolerate ambiguity and uncertainty and to manage stress
3. Recognizes personal challenges and addresses them so as to minimize their impact on professional performance

**Comments on Professional Values, Attitudes and Behavior (Optional):**

**Overall Rating for this Competency Category**

---

**Category IV: Ethical and Legal Standards**

<table>
<thead>
<tr>
<th>Competencies &amp; Their Elements</th>
<th>July-Oct</th>
<th>Nov-Feb</th>
<th>Mar-June</th>
</tr>
</thead>
</table>

**A. Demonstrates awareness of ethical and legal standards applicable to Health Service Psychology practice, training, and research**
1. Recognizes the ethical values and principles held by professional psychology and the institutions in which they work
2. Demonstrates awareness of relevant laws, regulations, rules and policies governing health service psychology practice at the organizational, local, state, regional and federal levels
3. Demonstrates awareness of specific concepts that underlie the above laws, regulations and policies (e.g., informed consent, confidentiality, mandated reporting)
4. Articulates own ethical values and priorities

**B. Recognizes and manages ethical and legal issues in Health Service Psychology practice, training, and research**
1. Adheres to all ethical and legal standards in all professional activities
2. Recognizes and helps others recognize ethical and legal issues as they arise
3. Demonstrates a clear decision-making process in the development and implementation of plans to resolve ethical and legal issues
4. Takes appropriate action when others behave in an unethical or illegal manner
5. Seeks supervision or consultation on ethical and legal issues

**C. Adheres to the APA Ethical Principles and Code of Conduct**
1. Strives to benefit others and do no harm
2. Develops relationships of trust with others and accepts responsibility for their behavior
3. Maintains personal integrity
4. Promotes fairness and justice
5. Respects the dignity, worth, and rights of all people

**Comments on Ethical & Legal Standards (Optional):**
### Category V: Assessment

#### Competencies & Their Elements

**A. Conducts clinical interviews**
1. Quickly establishes rapport with individuals being interviewed
2. Formulates relevant and culturally responsive interview questions
3. Conducts semi-structured interviews

**B. Appropriately selects and applies evidence-based assessment methods**
1. Screens referrals and identifies clear goals for assessments
2. Selects psychometrically sound assessment methods and tools that draw from the best empirical literature and that are relevant to assessment aims
3. Administers methods and tools accurately and efficiently
4. Scores and interprets results

**C. Collects and integrates data**
1. Obtains and integrates multiple sources of information (e.g., observations, historical information, interview data, test results, information from collateral sources, and findings from the literature)
2. Demonstrates current knowledge of diagnostic classification systems and awareness of cultural (and other) limitations of such systems
3. Uses above systems to classify and differentiate functional and dysfunctional behaviors as well as identify strengths and protective factors
4. Formulates case conceptualizations that demonstrate a clear understanding of behavior within its context (e.g., familial, societal, cultural, social, etc.)
5. Formulates treatment recommendations that arise from collected data
6. Uses alternative, non-diagnostic approaches to conceptualizing individuals and their environments, groups, and organizations

**D. Summarizes and reports data**
1. Writes clear, accurate and timely integrated reports
2. Communicates findings and recommendations clearly to patients and other providers
3. Recognizes and reports the strengths and limitations of assessments and findings

**Comments on Assessment (Optional):**

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### Category VI: Intervention

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### Competencies & Their Elements

<table>
<thead>
<tr>
<th>Competency</th>
<th>July-Oct</th>
<th>Nov - Feb</th>
<th>Mar-June</th>
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</thead>
<tbody>
<tr>
<td><strong>A. Formulates case conceptualizations and treatment plans</strong></td>
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<tr>
<td>1. Collaborates with patients and families to identify goals and plans</td>
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<tr>
<td>2. Links case conceptualizations and treatment plans to assessments</td>
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<tr>
<td>3. Utilizes at least one theoretical orientation and theory of change</td>
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<tr>
<td>4. Selects appropriate evidence-based interventions and best practices</td>
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<tr>
<td><strong>B. Implements evidence-based interventions</strong></td>
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<tr>
<td>1. Displays clinical skills with a wide range of evidence-based interventions, patients and patient service needs</td>
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<tr>
<td>2. Implements interventions with fidelity and adapts them to honor diversity characteristics and contextual factors as is appropriate</td>
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<tr>
<td>3. Recognizes and manages problems and issues that arise with interventions</td>
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<tr>
<td>4. Modifies and adapts evidence-based approaches effectively when a clear evidence-base is lacking</td>
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<tr>
<td><strong>C. Monitors the impact of interventions</strong></td>
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<tr>
<td>1. Routinely evaluates progress toward service delivery goals</td>
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<tr>
<td>2. Measures outcomes</td>
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<tr>
<td>3. Modifies intervention methods and treatment goals based on evaluation findings</td>
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<tr>
<td>4. Monitors and adapts own role and performance with the intervention</td>
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</table>

**Comments on Intervention (Optional):**

**Overall Rating for this Competency Category**

### Category VII: Consultation and Interprofessional/Interdisciplinary and Systems-Based Practice

<table>
<thead>
<tr>
<th>Competency</th>
<th>July-Oct</th>
<th>Nov - Feb</th>
<th>Mar-June</th>
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</thead>
<tbody>
<tr>
<td><strong>A. Provides consultation (e.g. case-based, group, organizational systems)</strong></td>
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<tr>
<td>1. Forms effective consultative relationships</td>
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<tr>
<td>2. Clarifies and refines referral questions and consultation goals</td>
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<tr>
<td>3. Develops and implements a consultation plan, recognizing the individual, group, organizational, and systems issues that may impact it</td>
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<tr>
<td>4. Communicates consultation results and recommendations</td>
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<tr>
<td><strong>B. Engages in interprofessional/interdisciplinary collaboration</strong></td>
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</tr>
<tr>
<td>1. Demonstrates awareness and respect of the roles, beliefs, values, practices and contributions of other professionals, providers, patients, family, and community members</td>
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<tr>
<td>2. Contributes psychological information while working flexibly with others to develop and implement a plan of care</td>
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<tr>
<td>3. Represents their professional opinions, encourages others to express their opinions, and works to resolve differences of opinion or conflicts</td>
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<tr>
<td>4. Integrates behavioral healthcare with other services (e.g., primary and specialty medical care; rehabilitative, recovery, vocational, residential and social services)</td>
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</tbody>
</table>
5. Shares and receives information from others in a sensitive manner when authorized by the patient and permissible under applicable laws, regulations, policies, and ethical codes

C. Engages in systems-based practice
1. Delivers care using knowledge of healthcare benefits, coverage limits, utilization management procedures, billing, and reimbursement
2. Analyzes and understands problems within organizations and systems from individual, interpersonal, group, and intergroup perspectives
3. Recognizes the potential influence of group memberships on the behavior of individuals in organizations and systems
4. Responds appropriately to problems within organizations and systems given their role

Comments on Consultation, Interprofessional/Interdisciplinary and Systems-Based Practice (Optional):

Overall Rating for this Competency Category

<table>
<thead>
<tr>
<th>Category VIII: Supervision</th>
<th>Ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competencies &amp; Their Elements</td>
<td>July-Oct</td>
</tr>
<tr>
<td>A. Seeks and uses supervision effectively</td>
<td></td>
</tr>
<tr>
<td>1. Establishes strong working relationships with supervisors of diverse practice orientations</td>
<td></td>
</tr>
<tr>
<td>2. Clarifies broad personal goals for supervision and specific agendas items for supervisory sessions</td>
<td></td>
</tr>
<tr>
<td>3. Seeks supervision routinely and when specifically needed (e.g., complex cases, unfamiliar patients or services, ethical and legal issues, strong personal reactions to patients)</td>
<td></td>
</tr>
<tr>
<td>4. Uses multiple methods to provide supervisors with timely, accurate information about his/her/their work and is open to being observed</td>
<td></td>
</tr>
<tr>
<td>B. Uses supervisory feedback to improve performance</td>
<td></td>
</tr>
<tr>
<td>1. Accepts feedback without being overly defensive</td>
<td></td>
</tr>
<tr>
<td>2. Acknowledges challenges and areas for professional growth</td>
<td></td>
</tr>
<tr>
<td>3. Follows supervisors’ direction</td>
<td></td>
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<tr>
<td>4. Adjusts professional behavior based on feedback</td>
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<tr>
<td>C. Facilitates peer supervision/consultation</td>
<td></td>
</tr>
<tr>
<td>1. Leads peer supervision/consultation groups</td>
<td></td>
</tr>
<tr>
<td>2. Structures the groups using an explicit method to guide discussions by peers of their work</td>
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<tr>
<td>3. Maintains a constructive and supportive environment within the groups</td>
<td></td>
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<tr>
<td>4. Gives constructive and supportive feedback to peers</td>
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<tr>
<td>D. Provides individual supervision (if applicable)</td>
<td></td>
</tr>
<tr>
<td>1. Establishes supportive supervisory relationships with explicit roles and responsibilities for supervisor and supervisee (or does so by engaging in simulated practice of supervision)</td>
<td></td>
</tr>
<tr>
<td>2. Uses multiple methods to monitor the quality of care provided and assess supervisee level of development, strengths, and learning needs (e.g., observation; audio and video recording; case discussion and presentations; review of documentation; clinical measures; QA data; and feedback from others)</td>
<td></td>
</tr>
<tr>
<td>3. Uses an explicit model of supervision and multiple methods to ensure the quality of care being provided and to address supervisee learning needs (e.g., case discussion, feedback, instruction, modeling, coaching, providing publications)</td>
<td></td>
</tr>
</tbody>
</table>
4. Provides feedback that is direct, clear, timely, behaviorally anchored, and mindful of the impact on the supervisee and supervisory relationship
5. Maintains accurate and timely documentation of supervision and supervisee performance
6. Requests and uses feedback from supervisees to improve the quality of supervision

**Comments on Supervision (Optional):**

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**Overall Rating for this Competency Category**

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<table>
<thead>
<tr>
<th>Category IX: Research &amp; Scholarship</th>
<th>Ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Competencies &amp; Their Elements</strong></td>
<td>July-Oct</td>
</tr>
<tr>
<td><strong>A. Displays critical scientific thinking</strong></td>
<td></td>
</tr>
<tr>
<td>1. Demonstrates scholarly curiosity and routinely questions assumptions</td>
<td></td>
</tr>
<tr>
<td>2. Understands and values evidence-based practice</td>
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<tr>
<td>3. Formulates questions that can be addressed by the literature, research, and program evaluation</td>
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</tr>
<tr>
<td>4. Critically evaluates and shares ideas with others through teaching and scholarly writing</td>
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<tr>
<td><strong>B. Uses the scientific literature</strong></td>
<td></td>
</tr>
<tr>
<td>1. Accesses, summarizes, and evaluates the literature related to their professional activities</td>
<td></td>
</tr>
<tr>
<td>2. Discusses the relevant literature in case conferences, lectures, and/or professional presentations</td>
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</tr>
<tr>
<td>3. Applies the scientific literature to their work (e.g., clinical, consultation, research, program evaluation, quality assurance)</td>
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<tr>
<td><strong>C. Implements scientific methods</strong></td>
<td></td>
</tr>
<tr>
<td>1. Selects and implements methods appropriate to the question, setting, and/or community</td>
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</tr>
<tr>
<td>2. Uses scientific methods to evaluate interventions and programs and to engage in continuous quality improvement</td>
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</tr>
<tr>
<td>3. Manages, analyzes, and interprets quantitative and qualitative data</td>
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<tr>
<td>4. Collaborates with other professionals, persons in recovery, family members, and stakeholders in developing questions, implementing methods, and understanding results</td>
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<tr>
<td>5. Contributes to the preparation of manuscripts, technical reports, case studies, or other scholarly work</td>
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</tbody>
</table>

**Comments on Research & Scholarship (Optional):**

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**Overall Rating for this Competency Category**

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Section E: Summary Assessment, Comments, & Signatures (Affixing your name electronically to this document is equivalent to a written signature).
**Supervisor’s Summary Assessment:** Place an X in one box.

- Fellow has made adequate progress in developing the core competencies that I am assessing.
- Fellow has NOT made adequate progress in developing the core competencies that I am assessing.  
  (Supervisors who select this answer should follow up with the Primary Advisor to discuss the concerns.)

**Supervisor’s Comments:** Identify (a) a minimum of two areas of strength, (b) a minimum of two areas for growth, and (c) all areas of major concern. **Supervisors are reminded to include specific behavioral descriptors that highlight fellows’ demonstration of each of the competencies being assessed in this narrative summary.**

**Psychology Fellow’s Comments:** These comments are optional. If you choose not to make comments write “none”.

<table>
<thead>
<tr>
<th>Supervisor’s signature</th>
<th>Date</th>
<th>Fellow’s signature</th>
<th>Date</th>
</tr>
</thead>
</table>

(Signatures indicate that the supervisor and fellow have discussed this evaluation)

**FEBRUARY EVALUATION**

**Supervisor’s Summary Assessment:** Place an X in one box.

- Fellow has made adequate progress in developing the core competencies that I am assessing.
- Fellow has NOT made adequate progress in developing the core competencies that I am assessing.  
  (Supervisors who select this answer should follow up with the Primary Advisor to discuss the concerns.)

**Supervisor’s Comments:** Identify (a) a minimum of two areas of strength, (b) a minimum of two areas for growth, and (c) all areas of major concern. **Supervisors are reminded to include specific behavioral descriptors that highlight fellows’ demonstration of and/or progress in each of the competencies being assessed in this narrative summary.**

**Psychology Fellow’s Comments:** These comments are optional. If you choose not to make comments write “none”.

<table>
<thead>
<tr>
<th>Supervisor’s signature</th>
<th>Date</th>
<th>Fellow’s signature</th>
<th>Date</th>
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</thead>
</table>

(Signatures indicate that the supervisor and fellow have discussed this evaluation)

**JUNE EVALUATION**

**Supervisor’s Summary Assessment:** Place an X in one box.

- Fellow has made adequate progress in developing the core competencies that I am assessing.
- Fellow has NOT made adequate progress in developing the core competencies that I am assessing.  
  (Supervisors who select this answer should follow up with the Primary Advisor to discuss the concerns.)
**Supervisor’s Comments:** Identify (a) a minimum of two areas of strength, (b) a minimum of two areas for growth, and (c) all areas of major concern. **Supervisors are reminded to include specific behavioral descriptors that highlight fellows’ demonstration of and/or progress in each of the competencies being assessed in this narrative summary.**

**Psychology Fellow’s Comments:** These comments are optional. If you choose not to make comments write “none”.

<table>
<thead>
<tr>
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<th>Date</th>
<th>Fellow’s signature</th>
<th>Date</th>
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</thead>
</table>

(Signatures indicate that the supervisor and fellow have discussed this evaluation)
**Fellow Evaluation of a Supervisor**

_Doctoral Internship Policy & Procedures_

_Revised 7-01-15_

This form is completed online via MedHub

Evaluator: __________________________________________
Evaluation of: ______________________________________
Date: ____________________

As part of a continuous quality improvement effort, your feedback is used to strengthen the quality of supervision provided to psychology fellows. Supervisors do receive a summary of their evaluations. Although your responses are anonymous, if a supervisor has only one or two students it may be possible for the supervisor to discern the identity of the fellow submitting ratings or comments.

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. This supervisor placed a high priority on my learning needs and professional goals.*</td>
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<td>2. The supervisor offered a supportive professional relationship.*</td>
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<tr>
<td>3. This supervisor taught me practical skills and gave me practical guidance that was relevant and useful in my placement.*</td>
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<td>4. The faculty member directed me to appropriate literature and helped me to apply information from the literature in practice.*</td>
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<tr>
<td>5. This supervisor provided fair, timely, and useful feedback about my knowledge and skills and worked to make sure I understood the feedback.*</td>
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<tr>
<td>6. The frequency and length of scheduled supervision sessions was satisfactory.*</td>
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7. This supervisor consistently was available for scheduled supervision sessions and provided the scheduled amount of time.*

8. The faculty member was accessible, if needed, between supervisory sessions.*

9. This faculty member was an effective role model who demonstrated respectful professional interactions with me and, if observed, with others.*

10. Overall, I would rate this faculty member's ability to supervise as highly effective.*

11. Please comment on specific ways for this faculty member to improve as a supervisor and a role model:

12. Please comment on specific strengths of this faculty member:
PROCEDURES

1. **Purpose of the Skill Development Plan:** In completing one of the three formal evaluations for this fellow, the Primary Advisor has concluded that the fellow is not making adequate progress in achieving an intermediate level of proficiency (Rating of 4) on: (a) an individual competency and/or (b) all competency domains. The Skill Development Plan is executed to support the fellow’s progress toward attaining the competency at the Minimum Level of Achievement (MLA) by the end of internship. Implementation of the Skill Development Plan should be undertaken with enough time to reasonably expect that the fellow will be able to achieve the objectives and goals outlined within the plan.

2. **Initial Development Process:** The Skill Development Plan process should represent a collaborative effort between the Primary Advisor and the fellow. The Primary Advisor necessarily incorporates feedback from other training faculty and supervisors directly involved with assessing the fellow’s competency attainment.

3. **Reviews and Approvals:** The Skill Development Plan will be submitted to the Chief of Psychology at the facility and the Director of Training of the internship for review and approval. The fellow will sign the plan as an acknowledgement that it has been received, reviewed and agreed upon. Disagreements about the content (below) or need for the plan should be resolved in the Initial Development Process. For unresolvable differences of opinion, the fellow is made aware of their right to follow the Grievance & Due Process procedures (See Grievance and Due Process Policy). The internship program will also act in accordance with the Graduate Program Communication Policy and notify the fellow’s graduate Director of Clinical Training to resolve disagreements in the plan facilitate development of a plan intended to support the successful remediation of the Fellow.

4. **Content of the Plan:** In keeping with best practice guidelines (e.g., Vasha-Haase, et al., 2019) for remediating problems with professional competency attainment, the Skill Development Plan will necessarily: (a) clearly identify the competency (ies) of concern giving behaviorally anchored
examples; (b) behaviorally anchored benchmarks for success; (c) expected time frame for completion of the plan; (d) clarify the nature and level of expected performance on the identified competency (ies) necessary to successfully complete the internship; and (e) the planned activities by the fellow and by faculty and/or staff to foster the expected levels of performance.

5. **Frequent Feedback on Plans**: The Primary Advisor will provide verbal and written feedback to the fellow monthly regarding progress, or lack thereof, in achieving the level of competence necessary to successfully complete the internship. In making these assessments, the Advisor will, as needed, gather and document verbal and written feedback from other supervisors and staff. This monthly feedback will indicate in writing if, in the opinion of the Primary Advisor, the fellow is or is not making adequate progress toward completing the internship successfully. Copies of the written feedback are to be provided to the fellow, the Chief of Psychology at the facility, the Director of Training and the Fellow’s graduate program DCT.

6. **Communication/Confidentiality**: University Office of The General Counsel may be consulted to ensure that plans are consistent with local, state and federal statutes and guidelines. As is detailed in the Graduate Program Communication Policy, which outlines the nature of communications between the fellow’s graduate institution and the internship, the Yale Doctoral Internship in Clinical and Community Psychology has the ability to (and will) share the Skill Development Plan with the fellow’s Graduate Institution. That is, communication about competency remediation is in alignment with the Graduate Program Communication Policy. The Graduate Program Communication Policy is communicated to Fellows upon initiation of their training in the program and is made available to them in physical copy and electronically on the Internship webpage for reference. Thus, it is not considered a violation of the fellow’s confidentiality to share the Skill Development Plan with the fellow’s graduate institution.
SKILL DEVELOPMENT PLAN

Competency 1:

Problem description:

Expected performance:

Actions to be taken by Fellow:

Actions to be taken by Faculty and/or staff:

[add additional competencies as necessary]

SIGNATURES

Primary Advisor ________________________________ Date ________
Fellow ________________________________ Date ________
Chief of Psychology (Facility) ________________________________ Date ________
Director of Training ________________________________ Date ________

SKILL DEVELOPMENT PLAN- UPDATE

Competency 1:

Problem description:

Expected performance:

Update on Progress:

[add additional competencies as necessary]

SIGNATURES- Update

Primary Advisor ________________________________ Date ________
Fellow ________________________________ Date ________
Chief of Psychology (Facility) ________________________________ Date ________
Director of Training ________________________________ Date ________
The Yale Medical School and its educational programs have an obligation to protect clients, other students, and employees, as well as an obligation to protect its educations, clinical and research missions from harm caused by actions or conditions of a fellow. Thus, the Executive Training Committee, comprised of the Chief of the Psychology Section, the Chiefs of Psychology in the training facilities, the Program Director of Training, and faculty representatives, reserves the right to require at any time, either Probation or Termination of a fellow. When in the opinion of the Executive Training Committee, and as documented through evidence available for review, a fellow has demonstrated lack of competency attainment/competency deficits and/or engaged in behaviors that create potential for harm or cause harm to clients, staff or community members, they may be subject to Probation or Termination.

Program Definitions
1. Probation: Probation within the Yale Doctoral Internship in Clinical and Community Psychology, is an intermediate action step, in which an individual is provided with a written Skill Development Plan (that is, a remediation plan) to address lack of competency attainment and/or to intervene or address potential harm to recipients of psychological services, staff or community members. While on probation any limitations placed on a fellow’s professional activities are clearly specified and the actions necessary to end probation status and correct areas of concern are outlined in the Skill Development Plan and agreed upon. The Fellow’s graduate program Director of Clinical Training (DCT) is also notified of Fellow difficulties and of the Skill Development Plan as outlined in the Graduate Program Communications Policy.

2. Termination: Termination within the Yale Doctoral Internship in Clinical and Community Psychology, is a final action step, in which an individual is withdrawn from the internship program.

Judging Deficits in Competency and Potential Harm
1. Lack of Competency: As documented in the Evaluation of Fellows Policy, Fellows are expected to achieve an intermediate level of competency across each of the nine profession-wide competencies. Fellows who are unable, per documentation, to achieve an intermediate level of competency across each of the categories are subject to a final determination at the end of the internship that they have failed to complete the program successfully. The Evaluation of Fellows Policy process allows for identification of competency attainment problems at three points of the internship year. When identified, fellows may be provided with a written Skill Development Plan. Though they may (and do frequently) co-occur, a Skill Development Plan does not require that a fellow be placed on probation. Thus, it is possible that a fellow can participate in the program for a full 12 months without being placed on probation and yet still fail to successfully complete the program. However, being placed on probation, necessitates a Skill Development Plan.

   a. Problems with Professionalism: Though considered under the scope of the profession-wide competencies, the internship program outlines special considerations regarding deficits in professionalism. The program takes seriously any unprofessional conduct of its fellows.
Professional values, attitudes and behaviors include, but are not limited to: adherence to the APA Ethical Principles of Psychologists and Code of Conduct (http://www.apa.org/ethics/code/index.aspx); adherence to applicable rules, policies, and requirements of the program, training facilities, and School of Medicine; and appropriate respect for colleagues, faculty, staff and peers.

2. **Potential Harm**: Potential harm may be described as arising from: behavior regarded by faculty, clients or the public as alarming, threatening, bizarre, hostile, or otherwise inconsistent with the duties and responsibilities of a fellow; behavior that is disruptive for working groups, clinical management and treatment of clients or educational process; or the inability to function adequately in the role of a fellow due to illness while refusing the option of medical leave. Potential harm to other people that occurs in the context of a fellow’s professional or training duties is a legitimate concern of the program because they may indicate the existence of a potential hazard if the person continues in their role as a fellow (e.g., conviction for a criminal offense).

**Procedures for Probation and Termination**

1. **Notification**: Serious concerns or allegations about lack of/deficits in competence, professionalism, or potential or actual harm to clients, staff or members of the community will be reported by the Primary Advisor immediately to the Director of Training and the Chief of Psychology of the training facility and the Department Psychology Section Chief. They will investigate the concerns, meet with the fellow, and present a report of the findings and recommendations for review and decision (probation or termination) to the Executive Training Committee and necessarily, the Chief of Psychology for the Section.

2. **Decisions of Probation or Termination**: Final decisions for probation or termination are only to be made following the necessary investigation of concerns and allegations within the Executive Committee. A written justification will accompany any decision for probation or termination. Termination without a period of probation, while possible, is rare.

3. **Documentation and Communication**: If it is determined that the fellow should be placed on probation, the fellow will be provided with a written notice of the probationary status that explains the terms of probation. They will also receive a Skill Development Plan that outlines the actions required of the fellow and the process by which the fellow’s progress in meeting those required actions will be assessed. If it is determined that a fellow should be terminated and withdrawn from the program, a written notice of this decision will be immediately provided to the fellow.

4. **Graduate School Communication**: As per the internships Graduate Program Communication Policy, the fellow’s graduate school DCT will be provided with a copy of a written notice for probation. If, during the course of investigation it becomes clear that termination is a possible outcome, the internship will advise the Graduate Program’s Director of Clinical Training of the investigation underway and the range of outcomes. In either circumstance, the program will receive a written communication of the ultimate outcome.

5. **Fellows on Leave**: Fellows may be placed on paid administrative leave for the duration of the investigation provided that reasonable efforts are made by the Director of Training, in concert with the members of the Executive Committee to conclude their review in a timely manner.

**Grievance and Due Process**

Throughout the process of investigation and decision on matters related to probation and termination, the fellow is afforded the rights and protections as outlined in the program’s Grievance and Due Process Policy. The only modification is that appeals of decisions made by the Executive Committee are not heard by an ad hoc committee but go directly to the Deputy Dean for Education within the Yale School of Medicine.
1. **The Value of Communication:** Communication between doctoral training programs and internship programs is of critical importance to the overall development of competent new psychologists. The doctoral internship is a required part of the doctoral degree, and while the internship faculty members assess the student’s performance during the internship year, the doctoral program is ultimately responsible for evaluation of the student’s readiness for graduation and entrance to the profession. Therefore, evaluative communication must occur between the two training partners.

2. **Request for Information Post-Match:** After a student has matched to this internship site, the Director of Training of the Yale Doctoral Internship in Clinical and Community Psychology will invite the doctoral program Director of Clinical Training to provide additional written information about the student’s strengths and training needs.

3. **Internship Evaluations Provided to Graduate Program:** Copies of each fellow’s competency evaluation completed by the Primary Advisor in October, February, and June will be sent to the Director of Clinical Training in the student’s graduate program. The standard Year End Evaluation letter will accompany the June evaluation. These documents will be sent to graduate programs by the internship Student Coordinator.

4. **Communication Regarding Problems:** In the event that problems occur during the internship year, such as a fellow struggling to make expected progress, the faculty of the internship in coordination with the Director of Training and the graduate program will communicate and document the concerns and the planned interventions to address these concerns. The Fellow’s Primary advisor will also communicate problems early internally to the relevant Facility Chief and Director of Training. In turn, the Director of Training will communicate any known concerns to the Psychology Section Chief. Both doctoral training program and internship program policies for resolution of training concerns will be considered in developing the necessary competency remediation needs and subsequent skills development plans. Progress in required remediation activities will be documented and that information will be communicated to the doctoral program Director of Clinical Training.

5. **Fellows’ Rights to Information:** All fellows will be informed of the practice of communication between internship and doctoral program faculty. Each fellow has the right to know about any communications that occur between the internship and his or her graduate program and will be given copies of any information that is exchanged.

*This policy was adopted from recommendations issued by the Council of Chairs of Training Councils (CCTC)*
ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT

Adopted August 21, 2002
Effective June 1, 2003

With the 2010 Amendments
Adopted February 20, 2010
Effective June 1, 2010
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2010 AMENDMENTS TO THE 2002 “ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT”
INTRODUCTION AND APPLICABILITY

The American Psychological Association’s (APA’s) Ethical Principles of Psychologists and Code of Conduct (hereinafter referred to as the Ethics Code) consists of an Introduction, a Preamble, five General Principles (A–E), and specific Ethical Standards. The Introduction discusses the intent, organization, procedural considerations, and scope of application of the Ethics Code. The Preamble and General Principles are aspirational goals to guide psychologists toward the highest ideals of psychology. Although the Preamble and General Principles are not themselves enforceable rules, they should be considered by psychologists in arriving at an ethical course of action. The Ethical Standards set forth enforceable rules for conduct as psychologists. Most of the Ethical Standards are written broadly, in order to apply to psychologists in varied roles, although the application of an Ethical Standard may vary depending on the context. The Ethical Standards are not exhaustive. The fact that a given conduct is not specifically addressed by an Ethical Standard does not mean that it is necessarily either ethical or unethical.

This Ethics Code applies only to psychologists’ activities that are part of their scientific, educational, or professional roles as psychologists. Areas covered include but are not limited to the clinical, counseling, and school practice of psychology; research; teaching; supervision of trainees; public service; policy development; social intervention; development of assessment instruments; conducting assessments; educational counseling; organizational consulting; forensic activities; program design and evaluation; and administration. This Ethics Code applies to these activities across a variety of contexts, such as in person, postal, telephone, Internet, and other electronic transmissions. These activities shall be distinguished from the purely private conduct of psychologists, which is not within the purview of the Ethics Code.

Membership in the APA commits members and student affiliates to comply with the standards of the APA Ethics Code and to the rules and procedures used to enforce them. Lack of awareness or misunderstanding of an Ethical Standard is not itself a defense to a charge of unethical conduct.

The procedures for filing, investigating, and resolving complaints of unethical conduct are described in the current Rules and Procedures of the APA Ethics Committee. APA may impose sanctions on its members for violations of the standards of the Ethics Code, including termination of APA membership, and may notify other bodies and individuals of its actions. Actions that violate the standards of the Ethics Code may also lead to the imposition of sanctions on psychologists or students whether or not they are APA members by bodies other than APA, including state psychological associations, other professional groups, psychology boards, other state or federal agencies, and payors for health services. In addition, APA may take action against a member after his or her conviction of a felony, expulsion or suspension from an affiliated state psychological association, or suspension or loss of licensure. When the sanction to be imposed by APA is less than expulsion, the 2001 Rules and Procedures do not guarantee an opportunity for an in-person hearing, but generally provide that complaints will be resolved only on the basis of a submitted record.

The Ethics Code is intended to provide guidance for psychologists and standards of professional conduct that can be applied by the APA and by other bodies that choose to adopt them. The Ethics Code is not intended to be a basis of civil liability. Whether a psychologist has violated the Ethics Code standards does not by itself determine whether the psychologist is legally liable in a court action, whether a contract is enforceable, or whether other legal consequences occur.

The modifiers used in some of the standards of this Ethics Code (e.g., reasonably, appropriately, potentially) are included in the standards when they would (1) allow professional judgment on the part of psychologists, (2) eliminate injustice or inequality that would occur without the modifier, (3) ensure applicability across the broad range of activities conducted by psychologists, or (4) guard against a set of rigid rules that might be quickly outdated. As used in this Ethics Code, the term reasonable means the prevailing professional judgment of psychologists engaged in similar activities in similar circumstances, given the knowledge the psychologist had or should have had at the time.
In the process of making decisions regarding their professional behavior, psychologists must consider this Ethics Code in addition to applicable laws and psychology board regulations. In applying the Ethics Code to their professional work, psychologists may consider other materials and guidelines that have been adopted or endorsed by scientific and professional psychological organizations and the dictates of their own conscience, as well as consult with others within the field. If this Ethics Code establishes a higher standard of conduct than is required by law, psychologists must meet the higher ethical standard. If psychologists’ ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists make known their commitment to this Ethics Code and take steps to resolve the conflict in a responsible manner in keeping with basic principles of human rights.

PREAMBLE

Psychologists are committed to increasing scientific and professional knowledge of behavior and people’s understanding of themselves and others and to the use of such knowledge to improve the condition of individuals, organizations, and society. Psychologists respect and protect civil and human rights and the central importance of freedom of inquiry and expression in research, teaching, and publication. They strive to help the public in developing informed judgments and choices concerning human behavior. In doing so, they perform many roles, such as researcher, educator, diagnostician, therapist, supervisor, consultant, administrator, social interventionist, and expert witness. This Ethics Code provides a common set of principles and standards upon which psychologists build their professional and scientific work.

This Ethics Code is intended to provide specific standards to cover most situations encountered by psychologists. It has as its goals the welfare and protection of the individuals and groups with whom psychologists work and the education of members, students, and the public regarding ethical standards of the discipline.

The development of a dynamic set of ethical standards for psychologists’ work-related conduct requires a personal commitment and lifelong effort to act ethically; to encourage ethical behavior by students, supervisees, employees, and colleagues; and to consult with others concerning ethical problems.

GENERAL PRINCIPLES

This section consists of General Principles. General Principles, as opposed to Ethical Standards, are aspirational in nature. Their intent is to guide and inspire psychologists toward the very highest ethical ideals of the profession. General Principles, in contrast to Ethical Standards, do not represent obligations and should not form the basis for imposing sanctions. Relying upon General Principles for either of these reasons distorts both their meaning and purpose.

Principle A: Beneficence and Nonmaleficence

Psychologists strive to benefit those with whom they work and take care to do no harm. In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons, and the welfare of animal subjects of research. When conflicts occur among psychologists’ obligations or concerns, they attempt to resolve these conflicts in a responsible fashion that avoids or minimizes harm. Because psychologists’ scientific and professional judgments and actions may affect the lives of others, they are alert to and guard against personal, financial, social, organizational, or political factors that might lead to misuse of their influence. Psychologists strive to be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work.

Principle B: Fidelity and Responsibility

Psychologists establish relationships of trust with those with whom they work. They are aware of their professional and scientific responsibilities to society and to the specific communities in which they work. Psychologists uphold professional standards of conduct, clarify their professional roles and obligations, accept appropriate responsibility for their behavior, and seek to manage conflicts of interest that could lead to exploitation or harm. Psychologists consult with, refer to, or cooperate with other professionals and institutions to the extent needed to serve the best interests of those with whom they work. They are concerned about the ethical compliance of their colleagues’ scientific and professional conduct. Psychologists strive to contribute a portion of their professional time for little or no compensation or personal advantage.

Principle C: Integrity

Psychologists seek to promote accuracy, honesty, and truthfulness in the science, teaching, and practice of psychology. In these activities psychologists do not steal, cheat, or engage in fraud, subterfuge, or intentional misrepresentation of fact. Psychologists strive to keep their promises and to avoid unwise or unclear commitments. In situations in which deception may be ethically justifiable to maximize benefits and minimize harm, psychologists have a serious obligation to consider the need for, the possible consequences of, and their responsibility to correct any resulting mistrust or other harmful effects that arise from the use of such techniques.

Principle D: Justice

Psychologists recognize that fairness and justice entitle all persons to access to and benefit from the contributions of psychology and to equal quality in the processes, procedures, and services being conducted by psychologists. Psychologists exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of
their competence, and the limitations of their expertise do not lead to or condone unjust practices.

Principle E: Respect for People’s Rights and Dignity

Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination. Psychologists are aware that special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision making. Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status, and consider these factors when working with members of such groups. Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices.

ETHICAL STANDARDS

1. Resolving Ethical Issues

1.01 Misuse of Psychologists’ Work

If psychologists learn of misuse or misrepresentation of their work, they take reasonable steps to correct or minimize the misuse or misrepresentation.

1.02 Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority

If psychologists’ ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights.

1.03 Conflicts Between Ethics and Organizational Demands

If the demands of an organization with which psychologists are affiliated or for whom they are working are in conflict with this Ethics Code, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights.

1.04 Informal Resolution of Ethical Violations

When psychologists believe that there may have been an ethical violation by another psychologist, they attempt to resolve the issue by bringing it to the attention of that individual, if an informal resolution appears appropriate and the intervention does not violate any confidentiality rights that may be involved. (See also Standards 1.02, Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority, and 1.03, Conflicts Between Ethics and Organizational Demands.)

1.05 Reporting Ethical Violations

If an apparent ethical violation has substantially harmed or is likely to substantially harm a person or organization and is not appropriate for informal resolution under Standard 1.04, Informal Resolution of Ethical Violations, or is not resolved properly in that fashion, psychologists take further action appropriate to the situation. Such action might include referral to state or national committees on professional ethics, to state licensing boards, or to the appropriate institutional authorities. This standard does not apply when an intervention would violate confidentiality rights or when psychologists have been retained to review the work of another psychologist whose professional conduct is in question. (See also Standard 1.02, Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority.)

1.06 Cooperating With Ethics Committees

Psychologists cooperate in ethics investigations, proceedings, and resulting requirements of the APA or any affiliated state psychological association to which they belong. In doing so, they address any confidentiality issues. Failure to cooperate is itself an ethics violation. However, making a request for deferment of adjudication of an ethics complaint pending the outcome of litigation does not alone constitute noncooperation.

1.07 Improper Complaints

Psychologists do not file or encourage the filing of ethics complaints that are made with reckless disregard for or willful ignorance of facts that would disprove the allegation.

1.08 Unfair Discrimination Against Complainants and Respondents

Psychologists do not deny persons employment, advancement, admissions to academic or other programs, tenure, or promotion, based solely upon their having made or their being the subject of an ethics complaint. This does not preclude taking action based upon the outcome of such proceedings or considering other appropriate information.

2. Competence

2.01 Boundaries of Competence

(a) Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience.
2.02 Providing Services in Emergencies

In emergencies, when psychologists provide services to individuals for whom other mental health services are not available and for which psychologists have not obtained the necessary training, psychologists may provide such services in order to ensure that services are not denied if they make a reasonable effort to obtain the competence required by using relevant research, training, consultation, or study.

2.03 Maintaining Competence

Psychologists undertake ongoing efforts to develop and maintain their competence.

2.04 Bases for Scientific and Professional Judgments

Psychologists’ work is based upon established scientific and professional knowledge of the discipline. (See also Standards 2.01e, Boundaries of Competence, and 10.01b, Informed Consent to Therapy.)

2.05 Delegation of Work to Others

Psychologists who delegate work to employees, supervisees, or research or teaching assistants or who use the services of others, such as interpreters, take reasonable steps to (1) avoid delegating such work to persons who have a multiple relationship with those being served that would likely lead to exploitation or loss of objectivity; (2) authorize only those responsibilities that such persons can be expected to perform competently on the basis of their education, training, or experience, either independently or with the level of supervision being provided; and (3) see that such persons perform these services competently. (See also Standards 2.02, Providing Services in Emergencies; 3.05, Multiple Relationships; 4.01, Maintaining Confidentiality; 9.01, Bases for Assessments; 9.02, Use of Assessments; 9.03, Informed Consent in Assessments; and 9.07, Assessment by Unqualified Persons.)
origin, religion, sexual orientation, disability, language, or socioeconomic status.

3.04 Avoiding Harm

Psychologists take reasonable steps to avoid harming their clients/patients, students, supervisees, research participants, organizational clients, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable.

3.05 Multiple Relationships

(a) A multiple relationship occurs when a psychologist is in a professional role with a person and (1) at the same time is in another role with the same person, (2) at the same time in a relationship with a person closely associated with or related to the person with whom the psychologist has the professional relationship, or (3) promises to enter into another relationship in the future with the person or a person closely associated with or related to the person.

A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist’s objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists.

Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical.

(b) If a psychologist finds that, due to unforeseen factors, a potentially harmful multiple relationship has arisen, the psychologist takes reasonable steps to resolve it with due regard for the best interests of the affected person and maximal compliance with the Ethics Code.

(c) When psychologists are required by law, institutional policy, or extraordinary circumstances to serve in more than one role in judicial or administrative proceedings, at the outset they clarify role expectations and the extent of confidentiality and thereafter as changes occur. (See also Standards 3.04, Avoiding Harm, and 3.07, Third-Party Requests for Services.)

3.06 Conflict of Interest

Psychologists refrain from taking on a professional role when personal, scientific, professional, legal, financial, or other interests or relationships could reasonably be expected to (1) impair their objectivity, competence, or effectiveness in performing their functions as psychologists or (2) expose the person or organization with whom the professional relationship exists to harm or exploitation.

3.07 Third-Party Requests for Services

When psychologists agree to provide services to a person or entity at the request of a third party, psychologists attempt to clarify at the outset of the service the nature of the relationship with all individuals or organizations involved. This clarification includes the role of the psychologist (e.g., therapist, consultant, diagnostician, or expert witness), an identification of who is the client, the probable uses of the services provided or the information obtained, and the fact that there may be limits to confidentiality. (See also Standards 3.05, Multiple Relationships, and 4.02, Discussing the Limits of Confidentiality.)

3.08 Exploitative Relationships

Psychologists do not exploit persons over whom they have supervisory, evaluative, or other authority such as clients/patients, students, supervisees, research participants, and employees. (See also Standards 3.05, Multiple Relationships; 6.04, Fees and Financial Arrangements; 6.05, Barter With Clients/Patients; 7.07, Sexual Relationships With Students and Supervisees; 10.05, Sexual Intimacies With Current Therapy Clients/Patients; 10.06, Sexual Intimacies With Relatives or Significant Others of Current Therapy Clients/Patients; 10.07, Therapy With Former Sexual Partners; and 10.08, Sexual Intimacies With Former Therapy Clients/Patients.)

3.09 Cooperation With Other Professionals

When indicated and professionally appropriate, psychologists cooperate with other professionals in order to serve their clients/patients effectively and appropriately. (See also Standard 4.05, Disclosures.)

3.10 Informed Consent

(a) When psychologists conduct research or provide assessment, therapy, counseling, or consulting services in person or via electronic transmission or other forms of communication, they obtain the informed consent of the individual or individuals using language that is reasonably understandable to that person or persons except when conducting such activities without consent is mandated by law or governmental regulation or as otherwise provided in this Ethics Code. (See also Standards 8.02, Informed Consent to Research; 9.03, Informed Consent in Assessments; and 10.01, Informed Consent to Therapy.)

(b) For persons who are legally incapable of giving informed consent, psychologists nevertheless (1) provide an appropriate explanation, (2) seek the individual’s assent, (3) consider such persons’ preferences and best interests, and (4) obtain appropriate permission from a legally authorized person, if such substitute consent is permitted or required by law. When consent by a legally authorized person is not permitted or required by law, psychologists take reasonable steps to protect the individual’s rights and welfare.

(c) When psychological services are court ordered or otherwise mandated, psychologists inform the individual of the nature of the anticipated services, including whether the services are court ordered or mandated and any limits of confidentiality, before proceeding.

(d) Psychologists appropriately document written or oral consent, permission, and assent. (See also Standards 8.02,
Informed Consent to Research; 9.03, Informed Consent in Assessments; and 10.01, Informed Consent to Therapy.)

3.11 Psychological Services Delivered to or Through Organizations
(a) Psychologists delivering services to or through organizations provide information beforehand to clients and when appropriate those directly affected by the services about (1) the nature and objectives of the services, (2) the intended recipients, (3) which of the individuals are clients, (4) the relationship the psychologist will have with each person and the organization, (5) the probable uses of services provided and information obtained, (6) who will have access to the information, and (7) limits of confidentiality. As soon as feasible, they provide information about the results and conclusions of such services to appropriate persons.

(b) If psychologists will be precluded by law or by organizational roles from providing such information to particular individuals or groups, they so inform those individuals or groups at the outset of the service.

3.12 Interruption of Psychological Services
Unless otherwise covered by contract, psychologists make reasonable efforts to plan for facilitating services in the event that psychological services are interrupted by factors such as the psychologist’s illness, death, unavailability, relocation, or retirement or by the client’s/patient’s relocation or financial limitations. (See also Standard 6.02c, Maintenance, Dissemination, and Disposal of Confidential Records of Professional and Scientific Work.)

4. Privacy and Confidentiality

4.01 Maintaining Confidentiality
Psychologists have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium, recognizing that the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship. (See also Standard 2.05, Delegation of Work to Others.)

4.02 Discussing the Limits of Confidentiality
(a) Psychologists discuss with persons (including, to the extent feasible, persons who are legally incapable of giving informed consent and their legal representatives) and organizations with whom they establish a scientific or professional relationship (1) the relevant limits of confidentiality and (2) the foreseeable uses of the information generated through their psychological activities. (See also Standard 3.10, Informed Consent.)

(b) Unless it is not feasible or is contraindicated, the discussion of confidentiality occurs at the outset of the relationship and thereafter as new circumstances may warrant.

(c) Psychologists who offer services, products, or information via electronic transmission inform clients/patients of the risks to privacy and limits of confidentiality.

4.03 Recording
Before recording the voices or images of individuals to whom they provide services, psychologists obtain permission from all such persons or their legal representatives. (See also Standards 8.03, Informed Consent for Recording Voices and Images in Research; 8.05, Dispensing With Informed Consent for Research; and 8.07, Deception in Research.)

4.04 Minimizing Intrusions on Privacy
(a) Psychologists include in written and oral reports and consultations, only information germane to the purpose for which the communication is made.

(b) Psychologists discuss confidential information obtained in their work only for appropriate scientific or professional purposes and only with persons clearly concerned with such matters.

4.05 Disclosures
(a) Psychologists may disclose confidential information with the appropriate consent of the organizational client, the individual client/patient, or another legally authorized person on behalf of the client/patient unless prohibited by law.

(b) Psychologists disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose such as to (1) provide needed professional services; (2) obtain appropriate professional consultations; (3) protect the client/patient, psychologist, or others from harm; or (4) obtain payment for services from a client/patient, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose. (See also Standard 6.04e, Fees and Financial Arrangements.)

4.06 Consultations
When consulting with colleagues, (1) psychologists do not disclose confidential information that reasonably could lead to the identification of a client/patient, research participant, or other person or organization with whom they have a confidential relationship unless they have obtained the prior consent of the person or organization or the disclosure cannot be avoided, and (2) they disclose information only to the extent necessary to achieve the purposes of the consultation. (See also Standard 4.01, Maintaining Confidentiality.)

4.07 Use of Confidential Information for Didactic or Other Purposes
Psychologists do not disclose in their writings, lectures, or other public media, confidential, personally identifiable information concerning their clients/patients, students, research participants, organizational clients, or other recipi-
ents of their services that they obtained during the course of their work, unless (1) they take reasonable steps to disguise the person or organization, (2) the person or organization has consented in writing, or (3) there is legal authorization for doing so.

5. Advertising and Other Public Statements

5.01 Avoidance of False or Deceptive Statements

(a) Public statements include but are not limited to paid or unpaid advertising, product endorsements, grant applications, licensing applications, other credentialing applications, brochures, printed matter, directory listings, personal resumes or curricula vitae, or comments for use in media such as print or electronic transmission, statements in legal proceedings, lectures and public oral presentations, and published materials. Psychologists do not knowingly make public statements that are false, deceptive, or fraudulent concerning their research, practice, or other work activities or those of persons or organizations with which they are affiliated.

(b) Psychologists do not make false, deceptive, or fraudulent statements concerning (1) their training, experience, or competence; (2) their academic degrees; (3) their credentials; (4) their institutional or association affiliations; (5) their services; (6) the scientific or clinical basis for, or results or degree of success of, their services; (7) their fees; or (8) their publications or research findings.

(c) Psychologists claim degrees as credentials for their health services only if those degrees (1) were earned from a regionally accredited educational institution or (2) were the basis for psychology licensure by the state in which they practice.

5.02 Statements by Others

(a) Psychologists who engage others to create or place public statements that promote their professional practice, products, or activities retain professional responsibility for such statements.

(b) Psychologists do not compensate employees of press, radio, television, or other communication media in return for publicity in a news item. (See also Standard 1.01, Misuse of Psychologists’ Work.)

(c) A paid advertisement relating to psychologists’ activities must be identified or clearly recognizable as such.

5.03 Descriptions of Workshops and Non-Degree-Granting Educational Programs

To the degree to which they exercise control, psychologists responsible for announcements, catalogs, brochures, or advertisements describing workshops, seminars, or other non-degree-granting educational programs ensure that they accurately describe the audience for which the program is intended, the educational objectives, the presenters, and the fees involved.

5.04 Media Presentations

When psychologists provide public advice or comment via print, Internet, or other electronic transmission, they take precautions to ensure that statements (1) are based on their professional knowledge, training, or experience in accord with appropriate psychological literature and practice; (2) are otherwise consistent with this Ethics Code; and (3) do not indicate that a professional relationship has been established with the recipient. (See also Standard 2.04, Bases for Scientific and Professional Judgments.)

5.05 Testimonials

Psychologists do not solicit testimonials from current therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence.

5.06 In-Person Solicitation

Psychologists do not engage, directly or through agents, in uninvited in-person solicitation of business from actual or potential therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence. However, this prohibition does not preclude (1) attempting to implement appropriate collateral contacts for the purpose of benefiting an already engaged therapy client/patient or (2) providing disaster or community outreach services.

6. Record Keeping and Fees

6.01 Documentation of Professional and Scientific Work and Maintenance of Records

Psychologists create, and to the extent the records are under their control, maintain, disseminate, store, retain, and dispose of records and data relating to their professional and scientific work in order to (1) facilitate provision of services later by them or by other professionals, (2) allow for replication of research design and analyses, (3) meet institutional requirements, (4) ensure accuracy of billing and payments, and (5) ensure compliance with law. (See also Standard 4.01, Maintaining Confidentiality.)

6.02 Maintenance, Dissemination, and Disposal of Confidential Records of Professional and Scientific Work

(a) Psychologists maintain confidentiality in creating, storing, accessing, transferring, and disposing of records under their control, whether these are written, automated, or in any other medium. (See also Standards 4.01, Maintaining Confidentiality, and 6.01, Documentation of Professional and Scientific Work and Maintenance of Records.)

(b) If confidential information concerning recipients of psychological services is entered into databases or systems of records available to persons whose access has not been consented to by the recipient, psychologists use coding or other techniques to avoid the inclusion of personal identifiers.
Education and Training

6.03 Withholding Records for Nonpayment

Psychologists may not withhold records under their control that are requested and needed for a client’s/patient’s emergency treatment solely because payment has not been received.

6.04 Fees and Financial Arrangements

(a) As early as is feasible in a professional or scientific relationship, psychologists and recipients of psychological services reach an agreement specifying compensation and billing arrangements.

(b) Psychologists’ fee practices are consistent with law.

(c) Psychologists do not misrepresent their fees.

(d) If limitations to services can be anticipated because of limitations in financing, this is discussed with the recipient of services as early as is feasible. (See also Standards 10.09, Interruption of Therapy, and 10.10, Terminating Therapy.)

(e) If the recipient of services does not pay for services as agreed, and if psychologists intend to use collection agencies or legal measures to collect the fees, psychologists first inform the person that such measures will be taken and provide that person an opportunity to make prompt payment. (See also Standards 4.05, Disclosures; 6.03, Withholding Records for Nonpayment; and 10.01, Informed Consent to Therapy.)

6.05 Barter With Clients/Patients

Barter is the acceptance of goods, services, or other nonmonetary remuneration from clients/patients in return for psychological services. Psychologists may barter only if (1) it is not clinically contraindicated, and (2) the resulting arrangement is not exploitative. (See also Standards 3.05, Multiple Relationships, and 6.04, Fees and Financial Arrangements.)

6.06 Accuracy in Reports to Payors and Funding Sources

In their reports to payors for services or sources of research funding, psychologists take reasonable steps to ensure the accurate reporting of the nature of the service provided or research conducted, the fees, charges, or payments, and where applicable, the identity of the provider, the findings, and the diagnosis. (See also Standards 4.01, Maintaining Confidentiality; 4.04, Minimizing Intrusions on Privacy; and 4.05, Disclosures.)

6.07 Referrals and Fees

When psychologists pay, receive payment from, or divide fees with another professional, other than in an employer–employee relationship, the payment to each is based on the services provided (clinical, consultative, administrative, or other) and is not based on the referral itself. (See also Standard 3.09, Cooperation With Other Professionals.)

7. Education and Training

7.01 Design of Education and Training Programs

Psychologists responsible for education and training programs take reasonable steps to ensure that the programs are designed to provide the appropriate knowledge and proper experiences, and to meet the requirements for licensure, certification, or other goals for which claims are made by the program. (See also Standard 5.03, Descriptions of Workshops and Non-Degree-Granting Educational Programs.)

7.02 Descriptions of Education and Training Programs

Psychologists responsible for education and training programs take reasonable steps to ensure that there is a current and accurate description of the program content (including participation in required course- or program-related counseling, psychotherapy, experiential groups, consulting projects, or community service), training goals and objectives, stipends and benefits, and requirements that must be met for satisfactory completion of the program. This information must be made readily available to all interested parties.

7.03 Accuracy in Teaching

(a) Psychologists take reasonable steps to ensure that course syllabi are accurate regarding the subject matter to be covered, bases for evaluating progress, and the nature of course experiences. This standard does not preclude an instructor from modifying course content or requirements when the instructor considers it pedagogically necessary or desirable, so long as students are made aware of these modifications in a manner that enables them to fulfill course requirements. (See also Standard 5.01, Avoidance of False or Deceptive Statements.)

(b) When engaged in teaching or training, psychologists present psychological information accurately. (See also Standard 2.03, Maintaining Competence.)

7.04 Student Disclosure of Personal Information

Psychologists do not require students or supervisees to disclose personal information in course- or program-related activities, either orally or in writing, regarding sexual history, history of abuse and neglect, psychological treatment, and relationships with parents, peers, and spouses or significant others except if (1) the program or training facility has clearly identified this requirement in its admissions and program materials or (2) the information is necessary to evaluate or obtain assistance for students whose personal problems could reasonably be judged to be preventing them from performing their training- or professionally related activities in a competent manner or posing a threat to the students or others.
7.05 Mandatory Individual or Group Therapy

(a) When individual or group therapy is a program or course requirement, psychologists responsible for that program allow students in undergraduate and graduate programs the option of selecting such therapy from practitioners unaffiliated with the program. (See also Standard 7.02, Descriptions of Education and Training Programs.)

(b) Faculty who are or are likely to be responsible for evaluating students’ academic performance do not themselves provide that therapy. (See also Standard 3.05, Multiple Relationships.)

7.06 Assessing Student and Supervisee Performance

(a) In academic and supervisory relationships, psychologists establish a timely and specific process for providing feedback to students and supervisees. Information regarding the process is provided to the student at the beginning of supervision.

(b) Psychologists evaluate students and supervisees on the basis of their actual performance on relevant and established program requirements.

7.07 Sexual Relationships With Students and Supervisees

Psychologists do not engage in sexual relationships with students or supervisees who are in their department, agency, or training center or over whom psychologists have or are likely to have evaluative authority. (See also Standard 3.05, Multiple Relationships.)

8. Research and Publication

8.01 Institutional Approval

When institutional approval is required, psychologists provide accurate information about their research proposals and obtain approval prior to conducting the research. They conduct the research in accordance with the approved research protocol.

8.02 Informed Consent to Research

(a) When obtaining informed consent as required in Standard 3.10, Informed Consent, psychologists inform participants about (1) the purpose of the research, expected duration, and procedures; (2) their right to decline to participate and to withdraw from the research once participation has begun; (3) the foreseeable consequences of declining or withdrawing; (4) reasonably foreseeable factors that may be expected to influence their willingness to participate such as potential risks, discomfort, or adverse effects; (5) any prospective research benefits; (6) limits of confidentiality; (7) incentives for participation; and (8) whom to contact for questions about the research and research participants’ rights. They provide opportunity for the prospective participants to ask questions and receive answers. (See also Standards 8.03, Informed Consent for Recording Voices and Images in Research; 8.05, Dispensing With Informed Consent for Research; and 8.07, Deception in Research.)

(b) Psychologists conducting intervention research involving the use of experimental treatments clarify to participants at the outset of the research (1) the experimental nature of the treatment; (2) the services that will or will not be available to the control group(s) if appropriate; (3) the means by which assignment to treatment and control groups will be made; (4) available treatment alternatives if an individual does not wish to participate in the research or wishes to withdraw once a study has begun; and (5) compensation for or monetary costs of participating including, if appropriate, whether reimbursement from the participant or a third-party payor will be sought. (See also Standard 8.02a, Informed Consent to Research.)

8.03 Informed Consent for Recording Voices and Images in Research

Psychologists obtain informed consent from research participants prior to recording their voices or images for data collection unless (1) the research consists solely of naturalistic observations in public places, and it is not anticipated that the recording will be used in a manner that could cause personal identification or harm, or (2) the research design includes deception, and consent for the use of the recording is obtained during debriefing. (See also Standard 8.07, Deception in Research.)

8.04 Client/Patient, Student, and Subordinate Research Participants

(a) When psychologists conduct research with clients/patients, students, or subordinates as participants, psychologists take steps to protect the prospective participants from adverse consequences of declining or withdrawing from participation.

(b) When research participation is a course requirement or an opportunity for extra credit, the prospective participant is given the choice of equitable alternative activities.

8.05 Dispensing With Informed Consent for Research

Psychologists may dispense with informed consent only (1) where research would not reasonably be assumed to create distress or harm and involves (a) the study of normal educational practices, curricula, or classroom management methods conducted in educational settings; (b) only anonymous questionnaires, naturalistic observations, or archival research for which disclosure of responses would not place participants at risk of criminal or civil liability or damage their financial standing, employability, or reputation, and confidentiality is protected; or (c) the study of factors related to job or organization effectiveness conducted in organizational settings for which there is no risk to participants’ employability, and confidentiality is protected or (2) where otherwise permitted by law or federal or institutional regulations.
8.06 Offering Inducements for Research Participation

(a) Psychologists make reasonable efforts to avoid offering excessive or inappropriate financial or other inducements for research participation when such inducements are likely to coerce participation.

(b) When offering professional services as an inducement for research participation, psychologists clarify the nature of the services, as well as the risks, obligations, and limitations. (See also Standard 6.05, Barter With Clients/Patients.)

8.07 Deception in Research

(a) Psychologists do not conduct a study involving deception unless they have determined that the use of deceptive techniques is justified by the study’s significant prospective scientific, educational, or applied value and that effective nondeceptive alternative procedures are not feasible.

(b) Psychologists do not deceive prospective participants about research that is reasonably expected to cause physical pain or severe emotional distress.

(c) Psychologists explain any deception that is an integral feature of the design and conduct of an experiment to participants as early as is feasible, preferably at the conclusion of their participation, but no later than at the conclusion of the data collection, and permit participants to withdraw their data. (See also Standard 8.08, Debriefing.)

8.08 Debriefing

(a) Psychologists provide a prompt opportunity for participants to obtain appropriate information about the nature, results, and conclusions of the research, and they take reasonable steps to correct any misconceptions that participants may have of which the psychologists are aware.

(b) If scientific or humane values justify delaying or withholding this information, psychologists take reasonable measures to reduce the risk of harm.

(c) When psychologists become aware that research procedures have harmed a participant, they take reasonable steps to minimize the harm.

8.09 Humane Care and Use of Animals in Research

(a) Psychologists acquire, care for, use, and dispose of animals in compliance with current federal, state, and local laws and regulations, and with professional standards.

(b) Psychologists trained in research methods and experienced in the care of laboratory animals supervise all procedures involving animals and are responsible for ensuring appropriate consideration of their comfort, health, and humane treatment.

(c) Psychologists ensure that all individuals under their supervision who are using animals have received instruction in research methods and in the care, maintenance, and handling of the species being used, to the extent appropriate to their role. (See also Standard 2.05, Delegation of Work to Others.)

(d) Psychologists make reasonable efforts to minimize the discomfort, infection, illness, and pain of animal subjects.

(e) Psychologists use a procedure subjecting animals to pain, stress, or privation only when an alternative procedure is unavailable and the goal is justified by its prospective scientific, educational, or applied value.

(f) Psychologists perform surgical procedures under appropriate anesthesia and follow techniques to avoid infection and minimize pain during and after surgery.

(g) When it is appropriate that an animal’s life be terminated, psychologists proceed rapidly, with an effort to minimize pain and in accordance with accepted procedures.

8.10 Reporting Research Results

(a) Psychologists do not fabricate data. (See also Standard 5.01a, Avoidance of False or Deceptive Statements.)

(b) If psychologists discover significant errors in their published data, they take reasonable steps to correct such errors in a correction, retraction, erratum, or other appropriate publication means.

8.11 Plagiarism

Psychologists do not present portions of another’s work or data as their own, even if the other work or data source is cited occasionally.

8.12 Publication Credit

(a) Psychologists take responsibility and credit, including authorship credit, only for work they have actually performed or to which they have substantially contributed. (See also Standard 8.12b, Publication Credit.)

(b) Principal authorship and other publication credits accurately reflect the relative scientific or professional contributions of the individuals involved, regardless of their relative status. Mere possession of an institutional position, such as department chair, does not justify authorship credit. Minor contributions to the research or to the writing for publications are acknowledged appropriately, such as in footnotes or in an introductory statement.

(c) Except under exceptional circumstances, a student is listed as principal author on any multiple-authored article that is substantially based on the student’s doctoral dissertation. Faculty advisors discuss publication credit with students as early as feasible and throughout the research and publication process as appropriate. (See also Standard 8.12b, Publication Credit.)

8.13 Duplicate Publication of Data

Psychologists do not publish, as original data, data that have been previously published. This does not preclude republishing data when they are accompanied by proper acknowledgment.
8.14 Sharing Research Data for Verification

(a) After research results are published, psychologists do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and who intend to use such data only for that purpose, provided that the confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release. This does not preclude psychologists from requiring that such individuals or groups be responsible for costs associated with the provision of such information.

(b) Psychologists who request data from other psychologists to verify the substantive claims through reanalysis may use shared data only for the declared purpose. Requesting psychologists obtain prior written agreement for all other uses of the data.

8.15 Reviewers

Psychologists who review material submitted for presentation, publication, grant, or research proposal review respect the confidentiality of and the proprietary rights in such information of those who submitted it.

9. Assessment

9.01 Bases for Assessments

(a) Psychologists base the opinions contained in their recommendations, reports, and diagnostic or evaluative statements, including forensic testimony, on information and techniques sufficient to substantiate their findings. (See also Standard 2.04, Bases for Scientific and Professional Judgments.)

(b) Except as noted in 9.01c, psychologists provide opinions of the psychological characteristics of individuals only after they have conducted an examination of the individuals adequate to support their statements or conclusions. When, despite reasonable efforts, such an examination is not practical, psychologists document the efforts they made and the result of those efforts, clarify the probable impact of their limited information on the reliability and validity of their opinions, and appropriately limit the nature and extent of their conclusions or recommendations. (See also Standards 2.01, Boundaries of Competence, and 9.06, Interpreting Assessment Results.)

(c) When psychologists conduct a record review or provide consultation or supervision and an individual examination is not warranted or necessary for the opinion, psychologists explain this and the sources of information on which they based their conclusions and recommendations.

9.02 Use of Assessments

(a) Psychologists administer, adapt, score, interpret, or use assessment techniques, interviews, tests, or instruments in a manner and for purposes that are appropriate in light of the research on or evidence of the usefulness and proper application of the techniques.

(b) Psychologists use assessment instruments whose validity and reliability have been established for use with members of the population tested. When such validity or reliability has not been established, psychologists describe the strengths and limitations of test results and interpretation.

(c) Psychologists use assessment methods that are appropriate to an individual’s language preference and competence, unless the use of an alternative language is relevant to the assessment issues.

9.03 Informed Consent in Assessments

(a) Psychologists obtain informed consent for assessments, evaluations, or diagnostic services, as described in Standard 3.10, Informed Consent, except when (1) testing is mandated by law or governmental regulations; (2) informed consent is implied because testing is conducted as a routine educational, institutional, or organizational activity (e.g., when participants voluntarily agree to assessment when applying for a job); or (3) one purpose of the testing is to evaluate decisional capacity. Informed consent includes an explanation of the nature and purpose of the assessment, fees, involvement of third parties, and limits of confidentiality and sufficient opportunity for the client/patient to ask questions and receive answers.

(b) Psychologists inform persons with questionable capacity to consent or for whom testing is mandated by law or governmental regulations about the nature and purpose of the proposed assessment services, using language that is reasonably understandable to the person being assessed.

(c) Psychologists using the services of an interpreter obtain informed consent from the client/patient to use that interpreter, ensure that confidentiality of test results and test security are maintained, and include in their recommendations, reports, and diagnostic or evaluative statements, including forensic testimony, discussion of any limitations on the data obtained. (See also Standards 2.05, Delegation of Work to Others; 4.01, Maintaining Confidentiality; 9.01, Bases for Assessments; 9.06, Interpreting Assessment Results; and 9.07, Assessment by Unqualified Persons.)

9.04 Release of Test Data

(a) The term test data refers to raw and scaled scores, client/patient responses to test questions or stimuli, and psychologists’ notes and recordings concerning client/patient statements and behavior during an examination. Those portions of test materials that include client/patient responses are included in the definition of test data. Pursuant to a client/patient release, psychologists provide test data to the client/patient or other persons identified in the release. Psychologists may refrain from releasing test data to protect a client/patient or others from substantial harm or misuse or misrepresentation of the data or the test, recognizing that in many instances release of confidential information under these circumstances is regulated by law. (See also Standard 9.11, Maintaining Test Security.)
Therapy

(b) In the absence of a client/patient release, psychologists provide test data only as required by law or court order.

9.05 Test Construction

Psychologists who develop tests and other assessment techniques use appropriate psychometric procedures and current scientific or professional knowledge for test design, standardization, validation, reduction or elimination of bias, and recommendations for use.

9.06 Interpreting Assessment Results

When interpreting assessment results, including automated interpretations, psychologists take into account the purpose of the assessment as well as the various test factors, test-taking abilities, and other characteristics of the person being assessed, such as situational, personal, linguistic, and cultural differences, that might affect psychologists' judgments or reduce the accuracy of their interpretations. They indicate any significant limitations of their interpretations. (See also Standard 2.05, Delegation of Work to Others.)

9.07 Assessment by Unqualified Persons

Psychologists do not promote the use of psychological assessment techniques by unqualified persons, except when such use is conducted for training purposes with appropriate supervision. (See also Standard 2.05, Delegation of Work to Others.)

9.08 Obsolete Tests and Outdated Test Results

(a) Psychologists do not base their assessment or intervention decisions or recommendations on data or test results that are outdated for the current purpose.

(b) Psychologists do not base such decisions or recommendations on tests and measures that are obsolete and not useful for the current purpose.

9.09 Test Scoring and Interpretation Services

(a) Psychologists who offer assessment or scoring services to other professionals accurately describe the purpose, norms, validity, reliability, and applications of the procedures and any special qualifications applicable to their use.

(b) Psychologists select scoring and interpretation services (including automated services) on the basis of evidence of the validity of the program and procedures as well as on other appropriate considerations. (See also Standard 2.01b and c, Boundaries of Competence.)

(c) Psychologists retain responsibility for the appropriate application, interpretation, and use of assessment instruments, whether they score and interpret such tests themselves or use automated or other services.

9.10 Explaining Assessment Results

Regardless of whether the scoring and interpretation are done by psychologists, by employees or assistants, or by automated or other outside services, psychologists take reasonable steps to ensure that explanations of results are given to the individual or designated representative unless the nature of the relationship precludes provision of an explanation of results (such as in some organizational consulting, preemployment or security screenings, and forensic evaluations), and this fact has been clearly explained to the person being assessed in advance.

9.11 Maintaining Test Security

The term test materials refers to manuals, instruments, protocols, and test questions or stimuli and does not include test data as defined in Standard 9.04, Release of Test Data. Psychologists make reasonable efforts to maintain the integrity and security of test materials and other assessment techniques consistent with law and contractual obligations, and in a manner that permits adherence to this Ethics Code.

10. Therapy

10.01 Informed Consent to Therapy

(a) When obtaining informed consent to therapy as required in Standard 3.10, Informed Consent, psychologists inform clients/patients as early as is feasible in the therapeutic relationship about the nature and anticipated course of therapy, fees, involvement of third parties, and limits of confidentiality and provide sufficient opportunity for the client/patient to ask questions and receive answers. (See also Standards 4.02, Discussing the Limits of Confidentiality, and 6.04, Fees and Financial Arrangements.)

(b) When obtaining informed consent for treatment for which generally recognized techniques and procedures have not been established, psychologists inform their clients/patients of the developing nature of the treatment, the potential risks involved, alternative treatments that may be available, and the voluntary nature of their participation. (See also Standards 2.01e, Boundaries of Competence, and 3.10, Informed Consent.)

(c) When the therapist is a trainee and the legal responsibility for the treatment provided resides with the supervisor, the client/patient, as part of the informed consent procedure, is informed that the therapist is in training and is being supervised and is given the name of the supervisor.

10.02 Therapy Involving Couples or Families

(a) When psychologists agree to provide services to several persons who have a relationship (such as spouses, significant others, or parents and children), they take reasonable steps to clarify at the outset (1) which of the individuals are clients/patients and (2) the relationship the psychologist will have with each person. This clarification includes the psychologist's role and the probable uses of the services provided or the information obtained. (See also Standard 4.02, Discussing the Limits of Confidentiality.)

(b) If it becomes apparent that psychologists may be called on to perform potentially conflicting roles (such
as family therapist and then witness for one party in divorce proceedings), psychologists take reasonable steps to clarify and modify, or withdraw from, roles appropriately. (See also Standard 3.05c, Multiple Relationships.)

10.03 Group Therapy

When psychologists provide services to several persons in a group setting, they describe at the outset the roles and responsibilities of all parties and the limits of confidentiality.

10.04 Providing Therapy to Those Served by Others

In deciding whether to offer or provide services to those already receiving mental health services elsewhere, psychologists carefully consider the treatment issues and the potential client’s/patient’s welfare. Psychologists discuss these issues with the client/patient or another legally authorized person on behalf of the client/patient in order to minimize the risk of confusion and conflict, consult with the other service providers when appropriate, and proceed with caution and sensitivity to the therapeutic issues.

10.05 Sexual Intimacies With Current Therapy Clients/Patients

Psychologists do not engage in sexual intimacies with current therapy clients/patients.

10.06 Sexual Intimacies With Relatives or Significant Others of Current Therapy Clients/Patients

Psychologists do not engage in sexual intimacies with individuals they know to be close relatives, guardians, or significant others of current clients/patients. Psychologists do not terminate therapy to circumvent this standard.

10.07 Therapy With Former Sexual Partners

Psychologists do not accept as therapy clients/patients persons with whom they have engaged in sexual intimacies.

10.08 Sexual Intimacies With Former Therapy Clients/Patients

(a) Psychologists do not engage in sexual intimacies with former clients/patients for at least two years after cessation or termination of therapy.

(b) Psychologists do not engage in sexual intimacies with former clients/patients even after a two-year interval except in the most unusual circumstances. Psychologists who engage in such activity after the two years following cessation or termination of therapy and of having no sexual contact with the former client/patient bear the burden of demonstrating that there has been no exploitation, in light of all relevant factors, including (1) the amount of time that has passed since therapy terminated; (2) the nature, duration, and intensity of the therapy; (3) the circumstances of termination; (4) the client’s/patient’s personal history; (5) the client’s/patient’s current mental status; (6) the likelihood of adverse impact on the client/patient; and (7) any statements or actions made by the therapist during the course of therapy suggesting or inviting the possibility of a posttermination sexual or romantic relationship with the client/patient. (See also Standard 3.05, Multiple Relationships.)

10.09 Interruption of Therapy

When entering into employment or contractual relationships, psychologists make reasonable efforts to provide for orderly and appropriate resolution of responsibility for client/patient care in the event that the employment or contractual relationship ends, with paramount consideration given to the welfare of the client/patient. (See also Standard 3.12, Interruption of Psychological Services.)

10.10 Terminating Therapy

(a) Psychologists terminate therapy when it becomes reasonably clear that the client/patient no longer needs the service, is not likely to benefit, or is being harmed by continued service.

(b) Psychologists may terminate therapy when threatened or otherwise endangered by the client/patient or another person with whom the client/patient has a relationship.

(c) Except where precluded by the actions of clients/patients or third-party payors, prior to termination psychologists provide pretermination counseling and suggest alternative service providers as appropriate.
1. **Right to Address Dissatisfactions**: Doctoral fellows can during the course of the internship become dissatisfied with some aspect of their experience. The fellows are entitled to clear and easily accessible mechanisms to address these issues and will be educated about these mechanisms during the orientation of new fellows at the beginning of the training year. Fellows may use the procedures outlined in this policy without fear of reprisal or prejudice. If a fellow believes that they have been retaliated against as a result of raising a concern or pursuing a grievance, a separate claim of retaliation may be pursued through this process.

2. **Expressing a “Concern”**: Fellows may express a “concern” about some aspect the internship experience. A concern shall be considered an informal expression of dissatisfaction communicated verbally communicated or by email. The internship program encourages, but does not require, fellows to address dissatisfactions in this informal manner soon after the dissatisfaction arises so that members of the faculty can work proactively with the fellow to review and, if indicated, address the issue.

3. **Levels of Redress**: Fellows may express concerns to a range of faculty members. As general guidance, fellows are strongly encouraged, though not required, to first address the concern with the faculty member most immediately involved in the issue and then work through the organizational ladder in the training program, which is as follows:
   a. Supervisor
   b. Advisor
   c. Chief of Psychology in the facility (Facility Chief)
   d. Director of Training
   e. Psychology Section Chief, Department of Psychiatry

4. **Filing a “Grievance”**: Whether or not they have made an expression of “concern”, all fellows may at any time file a formal “grievance”. A grievance is a written statement of complaint and request for redress. With respect to APA/CoA accreditation requirements, this internship program considers the terms “grievance” and “complaint” synonymous.

5. **Elements of a Grievance**: A written grievance must contain the following information:
   a. Date of submission
   b. Clear statement that the communication is a grievance
   c. Clear statement of the complaint
   d. Clear statement of the redress or remedy requested
   e. Previous actions taken to address the complaint
   f. Handwritten or electronic signature of the fellow
6. **Initial Processing of a Grievance:**
   a. Grievances related to the facility or placement should be submitted to the Facility Chief with copies sent to the Director of Training and the fellow’s Primary Advisor.
   b. The responsibilities of the Facility Chief of Psychology are to: (1) acknowledge to the fellow receipt of the grievance within two working days; (2) take immediate action if there are allegations of abuse, harassment or other urgent issues; (3) meet with the fellow within five working days to gather additional information about the dissatisfaction; and (4) provide to the fellow a written response to the grievance within 15 working days of its receipt, with copies to the Director of Training and the Primary Advisor as well as the Department’s Psychology Section Chief.
   c. Grievances of issues that are not specific to the facility or placement should be submitted to the Director of Training, with copies to the Facility Chief and the Primary Advisor. The Director of Training will respond with the same actions and timelines outlined immediately above, copying the Chief of Psychology and Primary Advisor on the written response to the grievance and also immediately notify the Psychology Section Chief of any grievances.

7. **Appeal of a Grievance:**
   a. If the fellow is dissatisfied with a response provided by the Facility Chief, they may file a written appeal with the Director of Training, stating clearly the reason for the appeal and the requested redress. The responsibilities of the Director of Training in this situation are to: (1) acknowledge to the fellow receipt of the grievance within two working days; (2) meet with the fellow within five working days to gather additional information about the appeal; and (3) provide the fellow with a written response to the grievance within 15 working days of its receipt, with copies to the Chief of Psychology of the facility and the Primary Advisor. The Psychology Section Chief is notified immediately of the Appeal.
   b. If the fellow is dissatisfied with the response provided by the Director of Training, either to a review of an initial response by the Chief of Psychology of the facility or to a review conducted by the Director of Training, the fellow may submit in writing a request to the Director of Training for appeal to an ad hoc Grievance Committee. In response to such a request the following will occur: (1) acknowledgement to the fellow of the request within two working days; (2) designation within five working days of an ad hoc faculty Grievance Committee of three members previously uninvolved in matters related to the grievance, with notice to the fellow of its membership; (3) convening of the committee within 15 working days of receipt of the request for appeal and arranging for the fellow to meet with the committee; and (4) issuance by the committee of its report and decision within 30 working days of receipt of the request for appeal, with copies to the fellow, Director of Training, Facility Chief, Primary Advisor and the Psychology Section Chief. Should the fellow object to the membership of the ad hoc committee he or she must file in writing the nature of the objection within two working days of receipt of notification of the membership. If the grievance involves a specific faculty member that individual may not serve on the Grievance Committee. The Psychology Section Chief shall be consulted and notified of each of these processes by the Director of Training and Facility Chiefs at each of the above steps.
   c. Decisions made by supervisors regarding professional assessments and judgments, such as performance evaluations, are not subject to review under this procedure by the ad hoc committee unless it is alleged that the professional assessment or judgment resulted from unlawful discrimination. In reviewing a complaint of discrimination, the ad hoc committee may have to inquire into the process by which professional judgments were made, but the grievance committee may not substitute its judgment for that of the supervisor.
d. If the fellow remains dissatisfied with the decision of the committee, they may appeal the decision in writing to the Deputy Dean for Education of the Yale School of Medicine who shall employ the resources and procedures within the Medical School to review the complaint and render a decision (http://www.yale.edu/equalopportunity/complaint/dean-student.html).

8. **Modification of Timelines**: If the School of Medicine is in recess during a grievance process, or in instances where additional time may be required because of the complexity of the grievance or unavailability of the parties or witnesses, any of the time periods specified herein may be extended by the Director of Training in consultation with the Psychology Section Chief and with written notice to the fellow, Facility Chief, and Primary Advisor.
Top 10 Personal Safety Tips

Provided by The Yale University Police Department

1. No lock works UNLESS YOU LOCK IT.
2. Lock public doors or gates to your apartment building, or office. Lock your doors when you leave your office or apartment. Lock your doors before you go to sleep. Always lock windows that are accessible from the outside. Never leave a public door propped open, even for a friend. Leave spare keys with a trusted neighbor or friend, never hidden near your door.
3. Take precaution in safeguarding your valuables (i.e. laptops, cell phones, I-Pads etc.) Do not leave valuables unsecured and unattended. Register your bikes and laptops (more info at http://publicsafety.yale.edu). Write down the Serial Numbers of valuable items.
4. Keep house and car keys on separate key chains. When leaving your car for service, or at a parking lot, leave only the car keys. Never attach your address to your keychain. Yale urges you never to attach your Yale ID tag to your keychain.
5. Identify visitors through a window or peephole before opening the door.
6. Request that service people show proper credentials before you let them in. If necessary, call the company to verify employment. Do not lend your keys or Yale ID tag to anyone.
7. If a stranger asks to use your telephone, politely refuse. Offer to call for assistance for them.
8. Please do not walk alone at night. Remain aware of your surroundings (i.e. remove ear buds.) Use lighted pathways. When well-lit areas are not available, please call 432-WALK (432-9255). A uniformed Security Officer will be dispatched to your location and escort you to your on-campus destination. You will recognize these officers by their white shirts, navy pants, prominent SECURITY labels, and an official security badge on the left side of their chest.
9. Sign up for the Bulldog Mobile Program: http://publicsafety.yale.edu/bulldog-mobile. Bulldog Mobile gives students, staff and faculty on campus an effective way to coordinate with Yale Police (YPD) via mobile device to help provide a safe and secure campus environment. With Bulldog Mobile, you can use your cell phone as a personal security device to activate the GPS tracking technology and escort timer options.
10. Report to police any unusual or suspicious activity near your home, room, or around your neighbors' homes or apartments. Program the Yale Police Phone number into your cell phone: 203-432-4400. Remember, IF YOU SEE SOMETHING, SAY SOMETHING.

Emergency Dial 911

Additional Safety Tips can be accessed through the YPD website: http://publicsafety.yale.edu/personal-property-safety
Emergency Management at Yale
Important Phone Numbers

Yale Police
911 or 203-432-4400

Yale Security
203-785-5555

Facilities Operations Center
203-432-6888

Yale Health
203-432-0123

Blue phones
400+ around campus

Yale ALERT (program number into your phone)
203-432-5830

Yale Escort
203-432-WALK (9255)
Preparing for Emergencies

Though preparation takes a bit of time and planning, it brings awareness to the choices you may have during an emergency. By preparing both mentally and logistically, you can increase your confidence and ability to handle a real emergency situation. Remember the basics: be informed, make a plan, and get a kit (from ready.gov).

Basic emergency kit for dorm or office

- food and water
- flashlight with batteries
- brightly colored cloth for waving out of the window
- towel to seal the gap under your door or cover your face if smoke is present
- first aid kit
- life-sustaining supplies (medication, insulin, etc.)
- emergency whistle
- hammer or similar device to break the window if necessary

Beyond the basics

- important family documents (insurance policies, ID, bank records in a waterproof container)
- prescription medication; contact lenses and supplies; extra eye glasses
- denture needs
- cash/traveler’s checks and change
- sleeping bag or warm blanket for each person
- complete change of clothing (long shirts, long pants, sturdy shoes, etc)
- fire extinguisher
- matches in a waterproof container
- personal hygiene products
- mess kits, disposable plates, utensils
- emergency references (a first aid book, information from ready.gov)
- activities for children
- pet supplies
- household chlorine bleach & medicine dropper (Dilute nine parts water to one part bleach to use as a disinfectant. Treat water by using 16 drops of regular (not scented, color safe, or with added cleaners) household liquid bleach per gallon of water.)
Other useful items

☐ battery-powered or hand-cranked radio with extra batteries
☐ dust mask
☐ moist towelettes, garbage bags, plastic ties for personal sanitation
☐ wrench/pliers to turn off utilities
☐ local maps
☐ cell phone and charger
☐ supplies and medications for infants

Yale Alert

Yale Alert is the University’s emergency notification system. If there is a condition which threatens the health and safety of persons on campus, University officials will warn the campus community through text, email, and voice messages as well as Twitter and Facebook, exterior and interior speaker systems, and the flatscreen panels around campus.

Remember to review and update your information every fall!
Program the Yale Alert number into your phone: 203-432-5830.

Students Keep your phone number up to date on sis (Student Information System). This is the number that will be used as your emergency contact.

Faculty & staff Keep your contact information up to date through the Yale Portal, Oracle, or your business manager. Yale Alert will use your home and cell phone numbers to contact you.

Parents Encourage your children to add your contact information online through sis.

For more information on preparedness, visit emergency.yale.edu.

Emergency Actions

Begin your planning today. The more you do, the more confident you will be that you can protect yourself and the people around you in an actual emergency.

Evacuation

When you hear the fire alarm in your building, always evacuate. You may be asked to evacuate in the event of a fire, hazardous material spill, etc.

Stay calm and proceed to the nearest exit. Use alternate exit if primary exit is obstructed.

Close doors behind you as you leave.

Do not use elevators.

Keep low to the floor if smoke is present.

Proceed to the designated emergency assembly location. Enter primary and secondary locations below.

Do not re-enter the building until emergency personnel declare it is safe to do so.

Once assembled, begin to account for evacuated occupants; report any missing people to emergency officials as soon as possible.

If smoke, heat or flames block your exit routes, or you are unable to evacuate on your own, stay in the room with the door closed. Place a rolled towel underneath the door. Signal for help by waving a brightly colored cloth or shining a flashlight at the window. If there is a telephone in the room, call the fire department at 911 or YPD at 203-432-4400 and let them know your exact location.

If you need assistance evacuating—whether you have a permanent or temporary special need—please review “special needs guidelines” in this document.
Shelter-in-place

Shelter-in-place means selecting a small, interior room (when possible) with no or few windows and taking refuge there. It does not mean sealing off your entire building. Shelter-in-place is a precaution intended to keep you safe while remaining indoors.

In the event of a tornado or other sudden severe weather event, an environmental release of chemical, biological, or radiological contaminants, a person with a gun, or when safe evacuation is not possible, you may be advised to shelter-in-place. Information will be provided through the Yale Alert system and other means of notification. The important thing is for you to follow instructions of authorities and know how to safely shelter-in-place.

How to shelter-in-place

Stop classes or work, or close business operations.

If there are students, customers, clients, or visitors in the building, provide for their safety by asking them to stay, not leave. When authorities provide directions to shelter-in-place, they want everyone to take those steps immediately, where they are, and not drive or walk outdoors.

Unless there is an imminent threat, ask students, staff, customers, clients, and visitors to call their emergency contact to let them know where they are and that they are safe.

Close and lock all windows, exterior doors, and any other openings to the outside. If you are told there is danger of explosion, close the window shades, blinds, or curtains. Bring everyone into the room(s). Shut and lock the door(s) if possible.

Wait in the safest location possible until you are given the “all clear” or told to evacuate.

It is imperative that you follow the instructions given by authorities if they advise you to shelter-in-place.

Responding to a person with a gun

Remember OUT!

Get out. If possible, leave the area and seek cover.

Call out. Once you reach a safe area, call 911.

Hide out. If you can’t leave, take cover where you are.

Keep out. Barricade doors to keep the shooter out.

Take out. Only as a last resort, consider aggressive action against the shooter.

Adapted from “Preventing Mass Casualty Shootings in a Campus Setting” with permission from the University of Wisconsin-Madison Police Department and the Board of Regents for the University of Wisconsin System.
Emergency Resources

The United States has more than 150,000 household fires, 10,000 violent thunderstorms, 5,000 floods, 800 tornadoes, and numerous forest fires, hurricanes, and earthquakes that affect two to three million people every year. Being prepared can reduce the fear, anxiety, and losses that often accompany disasters.

Planning considerations

- Have you reviewed the University Emergency Response Guidebook? Read it online at emergency.yale.edu
- Is your Yale Alert information up-to-date? Keep your information current on SIS & Yale Portal.
- Identify your emergency contact and program their information into your cell phone as ICE (In Case of Emergency). Tell the contact you’ve listed them.
- Use texts/sms when possible. They often get around network disruptions when a phone call might not be able to go through.
- Increase your awareness on campus by noticing evacuation signs, fire extinguishers, pull stations, and blue phones.
- At home, what kinds of disasters, both natural and man-made, are most likely to occur in your area? How you will be notified? Does your community use emergency radio? Television broadcasts? Telephone calls? Sirens? How is mass communication handled?
- Create evacuation plans for leaving your home, your neighborhood, and your region. If you care for someone who cannot care for themselves, make sure to include them in your planning.
- Don’t forget to plan for your pets. More than half of the households in the United States include pets!

Useful websites

emergency.yale.edu
www.ready.gov
www.redcross.org
www.yalecollege.yale.edu/content/resource-office-disabilities
www.yalecollege.yale.edu/content/campus-access-maps

Special Needs Guidelines

Do you experience any of the following conditions that could interfere with your ability to quickly evacuate a building? If so, you may need assistance in an evacuation. Read this section to prepare for yourself and for others.

- Limitations that interfere with walking or using stairs (joint pain, use of wheelchair, cane, crutches, or walker)
- Reduced stamina, fatigue, or tire easily
- Respiratory symptoms triggered by stress, exertion, or exposure to dust and smoke (asthma, emphysema, cardiac conditions)
- Emotional, cognitive, thinking, or learning difficulties (confusion when dealing with unfamiliar activities, loss of sense of direction, need directions explained in simple steps or basic concepts)
- Vision loss (may require assistance learning evacuation routes)
- Hearing loss (may require modifications to announcements of emergency instructions)
- Temporary limitations resulting from surgery, accidents and injuries, pregnancy
- Reliance on technology or medication which may not work in an emergency (hearing aids, wheelchair, gas mask, elevator, lighting, sound)

Preparation

Get involved in emergency and evacuation planning. If you are a part of the discussion, you can provide information on your specific abilities and limitations and tell people how best to provide you with effective assistance.

Practice drills increase skills and instill confidence in one’s ability to cope in an emergency.

Know how to get to all the exits and review them regularly.

Report safety hazards (fire extinguishers, blocked exits, furniture, etc).
Teach your support network how to operate your equipment in an emergency (i.e. how to disengage the gears of a power wheelchair).

If you are hard of hearing or deaf, practice having co-workers communicate important information to you through gestures.

If you are blind, have co-workers practice guiding you.

If you use a service animal, include the animal in drills.

Carry emergency health information and emergency contact numbers with you at all times. Make multiple copies of this information to keep in your emergency supply kits, car, workplace, wallet, wheelchair pack, backpack, etc.

During evacuation

If you need assistance evacuating a building, determine the most direct evacuation route.

Identify your evacuation assistant. This person should know how to help you without causing injury to themselves, to you, or to others, even if you need to be lifted or carried.

Be prepared to quickly give critical information on how someone can assist you without causing injury. Take charge and practice how to quickly explain to people how to best assist you.

Don’t wait until an emergency occurs: prepare now!

Students: call the Resources on Disabilities Office (203-432-2324). Faculty & staff: talk to your supervisor, a building manager, or the University’s Office for Equal Opportunity programs (203-432-0849). They can help you through the planning process.
1. **Standard Resources Available to Fellows:** There are many members of the full time faculty available to assist with problems or issues that arise for a fellow. These faculty members include the primary advisor, secondary advisor, other placement-based supervisors, the Chief of Psychology in the institution, seminar leaders, and the Director of Clinical Training. Fellows are encouraged to reach out to members of the full time faculty to address problems and issues as they arise. Fellows also frequently turn to assigned supervisors from the voluntary faculty to discuss sensitive issues.

2. **Voluntary Faculty Resource Members:** At times, fellows may have problems or issues that they are uncomfortable raising, at least initially, with members of the full time faculty or their assigned supervisors from the voluntary faculty. The internship program designates Voluntary Faculty Resource Members who are available to meet with fellows in such situations. The ultimate goal of these meetings is to assist the fellows in taking a next step in addressing the problems and issues that they are currently confronting. Voluntary Faculty Resource Members do not have an evaluative role with the fellows.

3. **Typical Issues Addressed:** Fellows have sought the counsel of Voluntary Faculty Resource Members on topics such as: accessing personal therapy; managing relationships with full-time faculty advisors, supervisors, or other fellows; and uncertainty regarding career directions. Talking with one of these Voluntary Faculty Resource Members may be sufficient, in and of itself, or the Resource Member might assist the fellow with a referral for therapy. With respect to problems or issues that a fellow is experiencing with the internship, the goal of the Resource Member is almost always to help the fellow find a constructive way to address these within the program with full time faculty.

4. **Limitations of this Role:** Voluntary Faculty Resource Members do not have administrative authority within the internship and so must work with the fellow or through the full time faculty to address problems or issues. The Voluntary Faculty Resource Members do not provide therapy to fellows.

5. **Confidentiality:** Communications by fellows to Voluntary Faculty Resource Members are confidential. The only exceptions are (a) when there is a significant risk to the fellow or others, or (b) when the issue relates to a concern about sexual misconduct. Under both the law and Yale policy, the Voluntary Faculty Resource Member, like all faculty, must report issues related to sexual misconduct to a Yale Title IX Coordinator, or can help a fellow make such a report (http://provost.yale.edu/title-ix). Fellows can contact the Yale Sexual Harassment & Assault Response & Education Center (SHARE) to have a confidential discussion about sexual misconduct (http://sharecenter.yale.edu).

6. **Current Voluntary Faculty Resource Members:** Current members have a principal affiliation with one of the internship’s training institutions, but a fellow in any institution and placement can reach out to any Voluntary Faculty Resource Member.
Debra Boltas, Ph.D.
Assistant Clinical Professor of Psychiatry
(Principally affiliated with YNHH)
66 Trumbull Street
New Haven, CT 06510
(203) 787-9119
debra.boltas@yale.edu

David C. Tate, Ph.D.
Assistant Clinical Professor of Psychiatry
(Principally affiliated with CMHC)
357 Whitney Avenue, Suite 303
New Haven, CT 06511
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Knowing When to Ask for Help and How to Get It

A Guide for Postgraduate Fellows in Psychiatry on Considering Personal Psychiatric Consultation and Treatment

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Yale University School of Medicine
Introduction

The faculty of the Yale Department of Psychiatry welcomes you to your postgraduate fellowship and takes a special interest in your personal and professional growth and development. This guide grew out of the faculty’s concern for your well-being during your postgraduate fellowship. It was designed to alert you to the possibility of emotional strain or difficulty during your training and to encourage you to seek appropriate professional consultation. The faculty considers your taking your own mental health seriously to be a sign of strength and maturity, and we have developed this guide to support your recognition of potential problems and to facilitate you getting the help you need. In advising you about how to seek help for emotional difficulties that can arise during postgraduate fellowship, this guide is meant to supplement, not replace, personal conversations with family, friends, colleagues, physicians, faculty advisors, and mentors. In this guide, we detail many of the stresses and strains of internship and residency, especially those specific to psychiatric training. We look at the interplay of adult development and cultural differences with the challenges of postgraduate training. We examine the kinds of vulnerabilities that fellows bring with them to their training. And we consider how to decide whether professional help is indicated and, if so, how to get it.

The Challenges of Training

Postgraduate fellowship in psychiatry can be a fascinating and enriching learning experience. After years of intensive study of the basic and clinical sciences in medical school, PGY 1’s have a rigorous first year of applying that knowledge with patients during various medical and surgical rotations. PGY 2’s begin your specialty training in psychiatry fulltime. The field of psychiatry is in an exciting phase of growth where the rate of knowledge acquired within our discipline is expanding exponentially. Whether your interests are in research of the molecular biology of the brain or in the diagnosis and treatment of patients or both, there is much to learn and apply as you progress in your training.

As with any new, intensive learning experience, psychiatric residency can also be challenging. At times, it can be frustrating, overwhelming, frightening, sometimes discouraging. There are many reasons for this. An important one is the model of learning during residency. Psychiatric residency requires simultaneous immersion in many different aspects of the field. You will be taking courses in the molecular biology of the brain as a foundation for learning psychopharmacology. You will be studying the complex interface between psychiatry and medicine. You will learn about the various ways that psychopathology manifests itself and the different courses and outcomes of psychiatric illnesses. Seminars in child and adolescent development will lay the groundwork for understanding and working with adults. You will be learning how to interview patients, make differential diagnoses, and initiate treatments. You will meet patients who suffer with many different kinds of psychiatric and emotional disorders. No
one excels at everything. We recognize that some aspects of training will be more difficult than others.

Most residents find the clinical encounter with a wide variety of emotionally disturbed and disturbing patients—arguably the crux of psychiatric training—a challenge. After all, in order to learn how to practice psychiatry, we ask you to sit with other human beings who may be in the midst of a terrifying psychotic disintegration, backed against a psychic wall, cowering in a corner of delusional misperception and paranoia. Or we ask you to listen to someone who feels such abject despair, hopelessness, and self-lacerating guilt, is so haunted by horrifying internal dybbuks and persecutory demons that they feel driven to end their very existence. You might hear the story of someone who has been raped or tortured, or has been in violent and brutal combat, or who has witnessed their child being killed in an accident. Listening to such dramatic and moving stories is difficult. How, then, do we learn to sit with and listen emphatically to people who suffer from and with such intense, overwhelming emotional disturbances without becoming so overwrought ourselves that we are useless as helping professionals or so detached, inured, unaffected by the person’s story that our interaction is mechanical, impersonal, just going through the motions?

**Psychiatry: A Special Form of Listening**

As psychiatrists, we are medical specialists in the diagnosis and treatment of mental disorders. Our purview thus includes the biological, sociocultural, and psychological factors that cause mental illness and emotional suffering. For psychiatrists, listening to a patient involves a complex form of listening. As physicians, for example, we listen for symptoms and observe signs of formal psychiatric disorders as well as being alert to any evidence of medical and neurological disorders that may have a psychiatric presentation. As social scientists, we listen for the stresses and strains in the patient’s social environment—family, friends, work, school, cultural milieu—that may have precipitated or contributed to the onset of the disorder or may serve as useful resources later if treatment proves indicated. As scientists of the mind, we also listen to the patient’s story—it’s form and content, what is said and how it is said, what is said and what isn’t—and note what the story reveals about the psychological make-up of the person—strength, weakness, patterns of conflict, sense of humor, developmental crisis, passion, inhibition, introspection, intellect and talent.

And we listen in another way, too. We attend to our own internal dialogue about what the patient tells us. Always curious, we allow a flood of silent questions to permeate our thoughts as we listen. Is the patient’s speech easy to follow or difficult? Does the patient’s story generate a sympathetic reaction within us or an antagonistic one? Are we interested or bored? Does the story move us emotionally in some discernible way? Do we find ourselves feeling sad or anxious, irritated or offended, intimidated or fearful, self-doubting or demeaned? Do we find the patient’s story funny and if so, do we feel like chuckling to ourselves, laughing out loud, or belly laughing so loudly that we could be
heard down the hall? These internal reactions to our patient’s story provide us important data to consider in our evaluation.

And from these widely different ways of listening, we begin to construct a diagnostic model that weaves into a coherent formulation how and whether and with what weight the various biological, sociocultural, and psychological factors contribute to and interact with the presenting illness or problem. This formulation then helps us devise a preliminary treatment plan that we revise and refine as we continue to listen to the patient. While this seems straightforward enough, there are hidden emotional risks to this kind of clinical listening.

Hidden Liabilities of Therapeutic Listening

It is a paradox of our profession that listening- the fundamental diagnostic instrument of psychiatry upon which all our efforts to understand and help the patient is based- may also cause psychiatrists and psychiatrists-in-training to be more vulnerable to emotional strain or difficulty than other medical specialists. It is well documented in the scientific literature, for example, that listening to certain kinds of stories has a more profound and enduring effect on the listener than other stories. In particular, listening to stories of catastrophic trauma- stories which depict events involving actual or threatened death or serious injury such as military combat, violent personal assault, being kidnapped or taken hostage, torture, being a prisoner of war or in a concentration camp- is often profoundly unsettling to the listener. On occasion, even the listener herself may develop symptoms of a traumatic stress syndrome, a process known as secondary traumatization.

Another way patients may powerfully affect the listener is less by the content of their story and more by the compelling way they interact with us. A patient, for example, may directly and insistently demand things from the listener, and the listener may experience these demands as virtually irresistible. The pressure exerted on the listener to yield to the patient’s forceful demands may lead to inappropriate or even dangerous interactions between clinician and patient- all under the listener’s self-deluding guise of rescuing the patient. In a further possible complication, these demands sometimes remain unspoken and are expressed subtly and nonverbally, and as a result, may apply even more powerful, through indirect pressure on the listener to comply. Patients with addictions, a history of sexual abuse, or with severe personality disorders are especially likely to present this way during clinical encounters. These types of clinical interactions are some of the most difficult to handle even for experienced clinicians. And yet it is extremely common for postgraduate fellows to work with such patients on a daily basis.

For example, a situation may develop where the patient, desperate to assuage some unbearable state of anxiety, despair, and craving, demands that his doctor provide a “quick fix” to his problems. The fellow, also wanting to assuage her barely tolerable, though expectable insecurity about her new professional role- what do I say? what do I do? how do I handle this?- desperately wants to help her patient. These forces sometimes converge in the resident’s overly identifying with the patient’s plight and
seeking to rescue the patient in unprofessional ways. The patient, for example, might demand explicit signs of caring on the part of the treater, stating or implying that without it, he might end his life. Such pressure is an expected part of treatment with more disturbed patients and both novice and experienced clinician alike will find it hard to bear. These demands for instant gratification leave the therapist precious little time and space to think. Given such apparent clinical “catch-22”, the challenge is to find a way to help the patient in a responsible and professional way.

Sexual seduction by or of such a patient or the violation of other professional boundaries is unfortunately a real and significant occurrence in our field today. The effect of such an occurrence for the patient is often to magnify and deepen his previous difficulties as well as to exacerbate problems of interpersonal trust of other helping professionals so as to jeopardize effective future treatment altogether. The effect on the resident’s personal life and future career— including professional embarrassment, professional liability, censure, or even temporary or permanent loss of medical license—can also be devastating. Learning how to deal with such interactions before they result in boundary violations is a vital and integral part of residency training, but one that obviously can cause substantive emotional strain on the fellow.

The Anxieties of a New Professional Role

These expectable insecurities related to adopting a new professional role, mentioned above, are commonly experienced during psychiatric training. As novice psychiatrists, you may find that the patient’s anxieties intrinsic to his emotional difficulties as well as those stirred by presenting anew to a stranger for evaluation and treatment resonate with your anxieties about taking on this new professional role with all its attendant responsibilities. The patient may be worried whether or not you can be of help. Indeed, you, too, may wonder whether or not you can be of help. After all, you are still acquiring the knowledge and skills that can eventually result in competence in this new role. How does a resident know if professional self-doubt is realistic, based on inexperience with the new role, or exaggerated, based on predisposition to personal insecurity? To confuse things even more, who among us has no predisposition to personal insecurity?

Even though such feelings of self-doubt may be natural and understandable, they may not feel that way at all. Such insecurity may in fact feel like a confirmation of a fatal professional or personal flaw. If these new insecurities align with old ones, the problem is only intensified. Afraid of acknowledging such concerns to a colleague, trusted teacher, or mentor, the resident’s self-esteem plummets while having the added burden of trying to appear confident, in control, comfortable in the new role.

Another source of emotional strain during training may arise from working closely with a highly competitive group of postgraduate fellows who are all striving to establish themselves in their new professional role. Cohesive group dynamics can break down into conflicting ones of scapegoating or clique formation. Subjecting your clinical work, grant writing, and research efforts to the regular scrutiny of supervisors, ward chiefs, and
research mentors may offer rich and valuable opportunities for learning, but it also exposes your work to criticism which, even if well-meaning, may compromise your confidence, enthusiasm, and self-esteem. Early in your career, it may be difficult not to take such criticism too personally and overreact to it.

As postgraduate fellows, the patients you will see are among the sickest and most complicated you will ever encounter during your career. With some patients, the sheer foreignness of their internal worlds can be chilling, disquieting, even repellant. You may be tempted to see them as “other”, almost as non-people. You may feel at a loss as to how to connect with them. On the other hand, you will also see patients, for example, in the Long Term Psychotherapy Program- who seem quite similar to yourself. They may be near your age and facing similar issues in the course of their lives; they may speak of familiar shadows of self-doubt. Working with these “healthier”, higher functioning patients may add to the insecurities of adopting your new professional role. Such patients may make you doubt yourself again: “what do I have to offer such a person?” These doubts can increase the work-related stress that you already experience.

So, how might a personal psychotherapy be helpful to you? Talking regularly with your own therapist can significantly diminish or relieve your level of emotional distress, pain, and anxiety. And while your treatment is obviously for your personal benefit and development, professional development can be a welcomed by- product of ongoing treatment. If you have sat in the patient’s chair yourself, you may be able to listen to your own patients in more empathic ways that can make you a more effective, sensitive, and perceptive clinician. Ideally, you will experience first hand how psychotherapy can help you and you will then be better able to help others. You may be surprised to discover that people can change in psychotherapy. Your decision, however, whether or not to participate in therapy is a private one; it is not a Program or professional requirement.

**Supervision**

But let us be clear about consultation and treatment. People enter treatment because they are suffering, because of persistent emotional distress, because they are struggling with some old problem that will not yield to one’s own efforts. Even though there may be some serendipitous educational benefit, personal treatment is not the best place to learn how to conduct psychotherapy. That is the role of supervision. If you find yourself having difficulties working with a particular patient, supervision is the ideal place to discuss such problems.

Sitting with patients in a treatment relationship can stimulate powerful feelings. Some patients can make us feel frustrated, angry, enraged. Others can stir feelings of inadequacy, impotence, or helplessness. Certain patients can evoke in us anxiety, feeling intimidated, even outright fear. Sometimes we find we cannot shake these powerful reactions when we leave work. We may become preoccupied with patients. We may worry about them, dream about them, perhaps even dread seeing them again.
We encourage you to discuss openly and fully such reactions to patients in supervision. A good supervisor welcomes the therapist’s emotional responses, whether mild or intense, to her patients as vital and regular part of our everyday clinical work. In supervision, you will learn how to use such reactions as an important source of information about the implicit or unspoken aspects of the treatment. Distressing or unsettling reactions to patients are compelling indications to discuss such cases in supervision. But if you recognize such reactions as occurring repeatedly or especially limiting your clinical work or if such reactions are old, familiar ones that have previously had repercussions in your personal or work life, then private, professional consultation may prove illuminating and beneficial.

**Rowing Upstream: A Sea of Change in Health Care Delivery**

Learning the complexities of a new professional role occurs against a backdrop of the dramatic shift in the socioeconomic and political realities of health care practice and delivery in the United States and the particular impact that shift is having on the practice of psychiatry. This includes dramatically reduced lengths of stay in inpatient units and corresponding diminished numbers of outpatient visits. This has necessitated that sicker, more chronic patients are assessed, treated, and discharged in a much shorter time and are then referred to already strained outpatient systems. Psychiatric fellows, often the front line clinicians in these situations, may experience significant conflict between the ideal standard for treatment they are being taught during psychiatric training versus the everyday standard of treatment that is feasible and realistic in this high volume, fast paced climate of mental health care delivery. New to such realities, psychiatric fellows may at times feel discouraged at the limitations of our current treatment systems. Sometimes psychiatrists-in-training can feel overly responsible for these limitations.

**The Challenges of Adult Development and Psychiatric Training**

Interns and residents may begin their psychiatric training at different times in their lives. Some postgraduate fellows are young adults, having begun their training immediately following college and medical school. Others may be middle aged, having shifted into psychiatry from a different medical field or having had a previous, non-medical career altogether. Postgraduate fellowship is a different experience for young adults than for middle-aged adults, and each group faces different developmental tasks.

Young adults, for example, may find the transition from studenthood to work life challenging. Not only must you continue to learn medicine and psychiatry, but now the responsibilities of patient care are added. Long hours, sleep deprivation that accompanies being on call, a heavy work volume at a fast pace- all of these factors together stretch the emotional reserves of anyone.
Residents and interns who are single may feel torn between fulfilling their professional duties and their desire for an active social life in pursuit of an intimate relationship and life partner. And those who already have partners may be having and raising children. Some marriages experience significant strain during training. The joys of pregnancy often feel overshadowed during residency even if you are able to arrange a reduced workload and schedule. When spouses and partners are also pursuing careers, intimate and relaxed family time may be at a premium.

Gay, lesbian, and bisexual postgraduate fellows have been welcomed into the Yale Department of Psychiatry for decades. They face all of these same developmental tasks of finding and sustaining an intimate life partner, having/adopting and raising children, and finding time to share life with one’s family. They may have postponed some of these milestones because of the added challenges of coming to terms with their sexual orientation. Some homosexual interns and residents may have “come out” and consolidated their identities as gay men and lesbian women prior to their psychiatric training; some may not. Those residents who are still struggling with their sexual orientation may experience added strain during their training.

Middle aged postgraduate fellows are obviously spared the culture shock of the transition from studenthood to entering the work force. They have long been familiar with the commonly conflicting responsibilities of career and family as well as with the necessary juggling of schedules and emotional resources of dual career families. And it is precisely the prior stability and consistency of their family life and routines that are in for a shock during internship and residency. Middle aged fellows may have the added burden of aging parents and all the accompanying economic and emotional strain.

Cultural Differences, Adaption, and Mourning

Fellows who immigrate from one country to another to begin postgraduate training, face all of the aforementioned developmental tasks as well as special challenges arising from their immigration. Whether the immigration is temporary or permanent has a great impact on subsequent adaptation. The losses inherent in a permanent move can be staggering. The immigrant may lose family, friends, mentors, colleagues. A resident may or may not be able to visit or speak with them by phone during training. In most cases, the fellow loses regular use of her own language, often her mother tongue, and supplants it with another. Linguistic difference always complicates adaptation to a new country, but the centrality of language in psychiatry with all its rich complexity and nuance magnifies this problem. The differences of social, religious, and cultural customs and habits, from the mundane to the sublime, may be striking. An intern or resident who has immigrated for psychiatric training, then, will virtually always be in a state of mourning in addition to all of the other potential developmental strains already mentioned. For the temporary immigrant, a second state of mourning may occur near the end of training, as you leave the institution and nation where you were “born” as a psychiatrist and face a changed relationship to your homeland.
The Possibility of Serious Psychiatric Illness

Psychiatric residents and interns are not immune to serious psychiatric disorder. Some types of problems present more definitive indications for consultation and treatment. A personal history of serious psychiatric illness, treated or untreated, is certainly a clear indication for consultation early in your training. These conditions would include any history of psychotic symptoms, of depressive illness, of bipolar or manic-depressive disorder, or of alcohol or drug dependency. Significant traumatic experience at any time during your life should also prompt professional consultation. Experiences of incest, sexual molestation or overstimulation, or threats of or actual physical violence during childhood make psychiatric interns and residents especially vulnerable to the reactivation of these catastrophic traumas when you have to evaluate and treat patients with similar histories. Such serious childhood trauma can have several different sequelae in adulthood. One of these is the danger of sexual seduction by, or of, such patients, or the violation of other professional boundaries referred to earlier in this guide. These risks may be substantial and are the strongest indicators for early consultation and treatment.

Less Serious Difficulties

While we have addressed the possibility of more serious psychiatric illnesses during training, residents and interns may also experience less severe though no less personally significant emotional difficulties that could benefit from individual psychotherapy. These troubles may or may not be directly related to psychiatric training. These include such problems as frequent states of tension, apprehension, or worry. You may find it hard to get through the day, as though you are surmounting one obstacle after another, and that work feels like you are just going through the motions. Perhaps you feel tired all the time even when you get adequate sleep and are not physically ill. Or maybe you are unable ever to get a restful night of sleep and awake feeling refreshed, even on weekends or on vacation. You may feel that your situation is hopeless and could never get better, that you don’t have any friends and are alone in the world, that your zest for life is gone. Maybe you have noticed yourself wanting to eat or drink excessively when you feel nervous or discouraged, that you gain or lose weight when you don’t want to. Or you find that you have lost any desire for sex, or that you need sex frequently but are unable to enjoy it or feel passionate with your partner. You might find it difficult to become and stay sexually aroused. Perhaps you feel irritable all the time and fly off the handle easily; or similarly, that you often feel sad and cry at the least provocation. Maybe you cannot allow yourself to work at your full potential. Perhaps you find that you always fail on important projects just before the finish line, that you procrastinate and never finish things, or that you repeatedly shoot yourself in the foot at work or in personal relationships. All of these are examples of milder forms of emotional difficulties that can improve dramatically in psychotherapy.
Getting Help or “Toughing it Out”- How to Decide

We have reviewed some of the stresses and strains inherent in psychiatric training, various developmental and cultural vulnerabilities, the possibility of serious psychiatric illness, as well as less severe emotional difficulties that postgraduate fellows may bring with them. How much personal distress is too much? How do you decide whether and when to seek treatment? Our advice is simple: if you are feeling enough emotional pain or distress to wonder about treatment for yourself, why not seek professional consultation? A consultation is a series of conversations with a mental health professional- a psychiatrist, a psychologist, or a clinical social worker. During these meetings you will have an opportunity to talk with your consultant in depth and detail about your current difficulties and what led to your seeking a consultation at this time. You will also be able to review your history of these difficulties as well as of previous treatment (if any) for these or other problems. You will also have the chance to speak about yourself more broadly. A variety of relevant topics might be discussed to give the consultant a sense of who you are as a person. Such topics as your family of origin and your growing up years, where you are from, significant friendships and relationships, religious beliefs, work life, sexuality, avocational interests and talents- all of these subjects and others might be discussed in the consultation.

After having the opportunity to discuss these matters fully and in depth, you and your consultant can then decide together if the difficulties you describe merit treatment or not. Deciding to enter treatment is a deeply personal matter that may involve many different private concerns. This is why the discussions with your consultant are confidential. No one is privy to what you talk about in these conversations- not faculty, not family, not friends, not colleagues- unless you divulge the information yourself. The faculty wants to be clear on this point. We support your decision to seek consultation or to enter treatment if that is what you choose. We understand the initiative, self-regard, and maturity involved in such a step and respect the importance of absolute confidentiality of this endeavor. In line with this philosophy, we strongly advise against “toughing it out”. If you are in any enduring emotional discomfort, we encourage you to seek consultation. Then, you and your consultant can decide what to do from there.

Reluctance to Consider Professional Consultation: Social Stigma

Some residents and interns are reluctant to consider a professional consultation because of the social stigma they perceive or experience related to issues of mental health or emotional difficulty. Many residents worry that seeking a consultation or treatment is a sign of personal weakness or will somehow professionally disqualify them from psychiatric training. Neither is true, but given these biases, that may be difficult to recognize. Despite your field of vocational interest, psychiatric residents and interns are not exempt from the effects of such stigma. These concerns often derive from powerful experiences in our past in which derisive, demeaning, or devaluing attitudes towards
mental illness, emotional suffering, and their treatment were expressed by or towards someone of special significance in our lives. Such experiences may intensify your difficulty in considering professional consultation and might be beneficially discussed with your consultant.

**Financial Concerns**

Other postgraduate fellows may balk at the prospect of a consultation because of worries about the financial cost. Many residents and interns begin training with enormous debt acquired from borrowing the cost of their undergraduate and medical education. Repayment of these debts usually commences after graduation from medical school. After paying for housing, transportation, and other basic costs of living— in addition to school loans— there is often little surplus left in fellowship salaries. The added costs of a family make financial resources even thinner. The faculty recognizes that professional consultation and treatment are real expenses that may confront real budgetary constraints.

The Office of Education in the Department keeps an updated list of faculty clinicians who have agreed to treat postgraduate fellows at affordable fees. A frank discussion of your financial resources with your consultant is important in arriving at a mutually agreeable fee. This discussion should occur at or before the first face to face consultation. In those instances where you cannot negotiate an affordable fee, special arrangements will be made to ensure that you get needed consultation and treatment. In such a case you should speak with the Chair of the Clinical Faculty Liaison Committee.

For some fellows, “moonlighting” may be a way to afford the consultation and/or treatment. Sometimes, however, financial resources are stretched thin even with moonlighting jobs which can in themselves add to work-related stress (working even longer hours, more sleep deprivation, more time away from family). Although it may feel awkward, asking for financial help from your family can be a solution.

The realities of scarce financial resources notwithstanding, the concern about the monetary “bottom line” may be more complicated than it at first appears. If your physical health and well-being were in jeopardy, for example, would you feel the same reluctance towards medical consultation based on whether you could afford the cost? In the face of serious physical illness, we usually pursue the best possible treatment whatever the cost. What prevents us from having the same attitude about obtaining treatment for serious emotional problems? If the difficulty is not life-threatening, however, similar conflicts that gave rise to the social stigma associated with psychiatric treatment that we just mentioned may also generate, figuratively and literally, *devaluing* attitudes about the worth and value— both personal and financial— of such treatment. Further, there can be a convergence of internalized social stigma deriving from conflicts in your past and actual, current discrimination by the insurance industry against its subscribers who seek treatment for mental illness or emotional suffering. This real prejudice against psychiatric treatment, so commonly observed in the current “managed
care” climate, can serve as a powerful reinforcement to irrational conflicts about considering your own treatment.

**Talking with Friends and Family**

Some postgraduate fellows unwisely avoid consideration of professional consultation by preferring to talk about their problems with friends, spouses, and life partners. What could be more natural than to talk about everyday problems of living with the people to whom you feel the closest? But if the problems involve emotional illness or suffering, that is another story. It may take awhile to grasp fully the fundamental differences between the emotional support and opportunities for growth that a friendship can offer and the emotional and psychological work offered in psychotherapy. Friends, family, spouses, and partners are simply too personally involved with you to make treatment possible. The impact of affectively powerful, personal disclosures—often necessary in treatment—on the relationship can be a difficult issue. Not only would you have to worry about how you feel about what you reveal, but you would also be concerned about how your friend, spouse, or partner would react. Most friends, even though personally sympathetic and supportive, are not professionally trained to be clinically helpful when emotionally charged disclosures are made. Distinguishing and maintaining professional and personal boundaries in our clinical work are crucial principles to learn during your psychiatric training. Talk with friends and family by all means, but be prepared to hear that your problems need outside, professional help.

**When a Friend or Colleague is Troubled**

It may happen during your internship and residency that you become aware of a friend and colleague who seems to be in emotional distress and is taking no apparent steps to seek help. Perhaps you have noticed a pattern of drug or alcohol abuse, signs of depressive illness like persistent sadness, irritability, social withdrawal, or suicidal ideation, episodes of dissociation, including periods of “spacing out”, confusion, or disorientation, or evidence of severe relationship problems involving emotional or physical abuse or repeated, volatile breaks-ups and reconciliations. Sometimes a colleague will confide in you about a problem; at other times you may observe or sense it without your friend ever mentioning it. How would you handle such a situation?

Since these issues can be ethically and professionally complex, you should not handle them alone. We urge you to bring your concerns to the attention of the Residency Training Director or another member of the full-time faculty. Then there can be a discussion about how to proceed and whether it is necessary for the Training Director or faculty member to know the name of the person for whom you have become concerned and whether further action is needed. The latter might seem necessary when the stakes are high: when the risk of harm to herself or others seems worrisome, when your friend is suicidal or very seriously depressed, if she is placing the lives of her patients at risk.
because of an addiction or manic episode that interferes with her clinical judgment, or if she has become sexually involved with a patient.

**How to Choose a Consultant**

Once you have decided to seek professional consultation, how do you decide whom to see? The Office of Education in the Department of Psychiatry keeps an updated list of faculty clinicians who have agreed in advance to consult with and treat postgraduate fellows at affordable fees. Refer to the section of this guide entitled “Financial Concerns” for the details of this arrangement. Review the clinicians on this list with a trusted teacher, mentor, supervisor, or friend, and obtain the names and telephone numbers of one or more possible consultants. Call up the consultant and tell her that you would like a consultation to consider beginning treatment. Ask the consultant if she has time available both for initial consultations and for ongoing treatment if it proves indicated. During the consultation, not only will you be talking about yourself, but it is also important to assess how you feel sitting with this particular consultant. Of course, the context of this conversation may well intensify any existing anxiety or tension, but in general, you should feel relatively comfortable talking with your consultant. If you do not, speak about this during the consultation and discuss the possibility of seeing another consultant so that you can compare how you feel with each of them. At some point during the initial consultation, ask about the fee. Inquire directly whether the consultant can be flexible in setting the fee based on her agreement with the Department and also based on your financial situation; which you should openly discuss. Ask about scheduling future appointments and try to get a sense of whether your schedules will permit you to have a regular meeting time with your consultant. The clinical realities of ward life may require some give and take on scheduling, but eventually the resident’s treatment should be accommodated. Some people meet with a few consultants once or twice and then choose among them based on how the consultation felt. Others prefer to have a more extended consultation and decide during it whether to continue with this particular consultant. Occasionally, a consultant may recommend someone else who, by reason of specialized clinical experience, or other related factors, may be a more appropriate clinician for you. The important thing, of course, is to see someone for an adequate consultation.

**Conclusion**

The faculty wants your internship and residency to be an outstanding learning experience that will help you become a caring and competent psychiatrist who will make significant contributions to our field. We are interested in your personal growth and development and concerned about your emotional well-being during your training. This is why we have taken the time to prepare and distribute this guide. We welcome your comments about the guide itself or any issues that it raises for you.
Resources

The Office of Resident Education
maintains an updated list of clinicians who are willing
to treat postgraduate fellows at affordable fees: 203-785-2095

Director of Residency Training: Robert M. Rohrbaugh, M.D.
robert.rohrbaugh@yale.edu, 203-737-2433

Chair, Clinical Faculty Liaison Committee: Stephen Atkins, M.D.
stephen.atkins@yale.edu, 203-782-0044

Yale University Employee Benefits:
http://www.yale.edu/hronline/benefits/pda.html
The Doctoral Internship on Clinical & Community Psychology adheres to the sexual misconduct policy of the Yale School of Medicine, which is as follows:

Yale University and the School of Medicine are committed to maintaining and strengthening an educational, working, and living environment founded on civility and mutual respect. Sexual misconduct is antithetical to the standards and ideals of our community and will not be tolerated. Yale aims to eradicate sexual misconduct through education, training, clear policies, and serious consequences for violations of these policies. Sexual misconduct incorporates a range of behaviors including rape, sexual assault (which includes any kind of nonconsensual sexual contact), sexual harassment, intimate partner violence, stalking, and any other conduct of a sexual nature that is nonconsensual, or has the purpose or effect of threatening, intimidating, or coercing a person or persons. When there is a lack of mutual consent about sexual activity, or there is ambiguity about whether consent has been given, a student can be charged with, and found guilty of, committing a sexual assault or another form of sexual misconduct.

Much sexual misconduct includes nonconsensual sexual contact, but this is not a necessary component. Threatening speech, which is sufficiently serious to constitute sexual harassment, for example, will constitute sexual misconduct. Photographs, video, or other visual or auditory records of sexual activity made without explicit consent constitute sexual misconduct, even if the activity documented was consensual. Similarly, sharing such recordings without explicit consent is a form of sexual misconduct. For example, forwarding a harassing electronic communication may also constitute an offense.

Sexual misconduct also includes a violation of Yale’s Policy on Teacher-Student Consensual Relations.

The University Wide Committee (UWC) on Sexual Misconduct will formally and informally address allegations of sexual misconduct. Many forms of sexual misconduct are also prohibited by Connecticut and federal law including Title IX of the education amendments of 1972, and could result in criminal prosecution or civil liability.

The Yale School of Medicine Grievance Board on Sexual Misconduct is authorized to receive informal complaints brought by YSM faculty members, students, trainees, and Managerial & Professional staff members against YSM faculty members (full-time, part-time, or voluntary), students, administrators, or Managerial & Professional staff members. Complainants may also bring an informal complaint or a formal complaint to the UWC.
The Doctoral Internship on Clinical & Community Psychology adheres to the sexual misconduct policy of the Yale School of Medicine, which is as follows:

The integrity of the teacher-student relationship is the foundation of the University’s educational mission. This relationship vests considerable trust in the teacher, who, in turn, bears authority and accountability as a mentor, educator, and evaluator. The unequal institutional power inherent in this relationship heightens the vulnerability of the student and the potential for coercion. The pedagogical relationship between teacher and student must be protected from influences or activities that can interfere with learning and personal development.

Whenever a teacher is or in the future might reasonably become responsible for teaching, advising, or directly supervising a student, a sexual relationship between them is inappropriate and must be avoided. In addition to creating the potential for coercion, any such relationship jeopardizes the integrity of the educational process by creating a conflict of interest and may impair the learning environment for other students. Finally, such situations may expose the University and the teacher to liability for violation of laws against sexual harassment and sex discrimination.

Therefore, teachers (see below) must avoid sexual relationships with students over whom they have or might reasonably expect to have direct pedagogical or supervisory responsibilities, regardless of whether the relationship is consensual. Conversely, a teacher must not directly supervise any student with whom he or she has a sexual relationship. Undergraduate students are particularly vulnerable to the unequal institutional power inherent in the teacher-student relationship and the potential for coercion, because of their age and relative lack of maturity. Therefore, no teacher shall have a sexual or amorous relationship with any undergraduate student, regardless of whether the teacher currently exercises or expects to have any pedagogical or supervisory responsibilities over that student. Teachers or students with questions about this policy are advised to consult with the University’s Title IX Coordinator, the Title IX Coordinator of his or her school, the department chair, the appropriate dean, the Provost, or one of his or her designees. A student or other member of the community may lodge a formal or informal complaint regarding an alleged violation of this policy with the University’s Title IX Coordinator, with the Title IX Coordinator of his or her school, or with the University-wide Committee on Sexual Misconduct.

Violations of the above policies by a teacher will normally lead to disciplinary action. For purposes of this policy, “direct supervision” includes the following activities (on or off campus): course teaching, examining, grading, advising for a formal project such as a thesis or research, supervising required research or other academic activities, serving in such a capacity as Director of Undergraduate or Graduate Studies, and recommending in an institutional capacity for admissions, employment,
fellowships or awards. “Teachers” includes, but is not limited to, all ladder and non-ladder faculty of the University.

It also includes graduate and professional students and postdoctoral fellows and associates only when they are serving as part-time acting instructors, teaching fellows or in similar institutional roles, with respect to the students they are currently teaching or supervising. “Students” refers to those enrolled in any and all educational and training programs of the University. Additionally, this policy applies to members of the Yale community who are not teachers as defined above, but have authority over or mentoring relationships with students, including athletic coaches, supervisors of student employees, advisors and directors of student organizations, Residential College Fellows, as well as others who advise, mentor, or evaluate students.
1. **Overview:** A record will be created for each fellow admitted to the internship program. The format can be either electronic or hard copy.

2. **Security:** Hard copy records will be stored in a locked file. Electronic records will be stored on a password protected device.

3. **Retention:** All records will be stored permanently.

4. **Contents:**
   a. AAPI application
   b. CV submitted at the time of application
   c. Supervision and Time Log for the year
   d. Primary Advisor evaluations for November, January & June
   e. Summary of Experience
   f. Copy of Diploma
1. **Overview:** Each committee, work group, or task force of the internship shall have designated Diversity Representatives.
   a. There will be at least two Diversity Representatives per group and no limit to the number of individuals that can serve in this role within each group.
   b. The designation of Diversity Representatives will be periodically reviewed and updated.

2. **Responsibilities of Diversity Representatives:**
   a. Highlight issues related to diversity and inclusion in the deliberations and actions of each group.
   b. Advocate for equity, access, opportunity, and inclusion in the activities, actions, and work products of each group.
   c. Promote a focus on diversity and inclusion in efforts to recruit and retain fellows, faculty advisors, supervisors, and seminar presenters if the focus of the group bears on these activities.

3. **Selection and Appointment:**
   a. The Executive Training Committee will ensure that at least two of its members are designated as Diversity Representatives for this committee.
   b. All members of the Committee on Diversity and Inclusion will be automatically be deemed to be Diversity Representatives for that committee given its focus.
   c. The Director of Clinical Training for the internship will request volunteers and ensure the selection of Diversity Representatives for all other internship committees, work groups, and task forces.
1. **Avoiding Dual Professional Relationships**: Fellow responsibilities should be limited to those that are required elements of the internship and of each fellow’s placement. Generally, dual professional relationships in which fellows engage with faculty in professional activities that are not part of the formal internship are to be avoided.

2. **Exceptions Require Approval**: Any exceptions to this policy require review and approval by the Chief of Psychology at the training institution and the Director of Clinical Training for the internship.

3. **Dual Professional/Personal Relationships**: Personal relationships between faculty and fellows are governed in part by the Yale University Policy on Teacher Student Consensual Relations, which can be found at: [http://medicine.yale.edu/sha/whatisit/teacher_student.aspx](http://medicine.yale.edu/sha/whatisit/teacher_student.aspx).
**Administrative Assistance Policy**

Revised 02-11-2020

1. **Program Level Support** - The Doctoral Internship has a Student Coordinator who supports the fellows administratively. The Student Coordinator assists fellows in navigating university, medical school, department, and program level systems and tasks. These include, but are not limited to: providing information to fellows on housing resources, completing background checks, accessing the Yale Human Resources Portal, registering for health benefits, enrolling in direct deposit, obtaining an ID, obtaining a Net ID and computer access, completing online mandatory training, logging on to the Yale Box online application for program and seminar documents, and submitting supervision tracking documentation. The Student Coordinator is available five days per week to respond to questions and concerns from fellows. Additionally, the Department of Psychiatry has a designated Information Technology specialist available to address for fellows any IT related problems that arise with Yale IT systems and Yale Computers.

2. **Placement/Facility Level Support** - The placements and the facilities in which the placements are based provide a range of administrative supports. Each has an administrative staff that facilitates registration for service recipients and the management of medical records. Placements vary in the level of secretarial support, though like most healthcare systems, such support is limited. Professionals manage most tasks related to the provision of services independently, aided by access to information systems.
Welcome to Yale University! Please take some time to read over this document. It contains important information necessary to ensure that your entry to Yale is a smooth experience.

1. Activate Your Net ID

When: Prior to July 1st
You will be provided with a Net ID, PIN number, and Yale email address. You will use your Net ID and a password you create to access many of the applications used here at Yale, including your email account. The PIN is used for the initial activation of your Net ID only.

To activate your Net ID, visit the Net ID Activation web page at https://www.yale.edu/netid.

If the PIN above does not allow you to activate your Net ID, please call Client Accounts at 203-432-6627, Monday-Friday, 8:30 a.m. to 5:00 p.m.

2. Yale Email Account

When: Prior to July 1st, after activating NET ID
After you have activated your Net ID you will be able to access your email account.

To access your email account, visit https://connect.yale.edu. You will be prompted to login using (1) your email address or your Net ID, and (2) your Net ID password. To login using your Net ID, enter it following the format indicated (Yale\Net ID).

3. I-9 Form

When: Prior to July 1st or within the first 3 days of internship. You will be required to complete an I-9 form as required by federal law and needed to create your employment file.

Review the attached list of acceptable documents and ensure that you will be able to present to an I-9 Center with one unexpired document from List A or one document from List B and one document from List C. You can access the I-9 form through the Yale Portal (https://your.yale.edu/). Select Workday, personal information, complete I-9 form. Bring a copy of the form and your approved form of ID to the I-9 centers throughout the Yale Campus.
Take your Employment Eligibility Verification Form and your forms of acceptable identification to the University I-9 Center of your choice. These documents must be presented in person no later than your third day of internship. Attached is a list of Yale University I-9 Centers.

If you visit an I-9 Center prior to your first day of work, please be sure to bring a copy of your offer letter with you. Below are several important links to assist you in this process:

1. To locate Employment Eligibility Verification form (i-9) resources:
   https://your.yale.edu/work-yale/financials/business-operations/operations-managers-resource-guide/tasks/employment

2. Human Resources Employee Services Center https://your.yale.edu/work-yale/support/employee-services
   a. Email: employee.services@yale.edu
   b. Phone: 203-432-5552


4. Yale Photo ID

   When: On or after July 1st

   Your ID card identifies you as a member of the Yale University community. You should carry it at all times while you are on campus and present it, on request, to University officials whose assigned responsibilities authorize them to seek proper identification.

   Go to the Medical School ID Center on or after your start date to obtain your Yale ID. The University requires one of these forms of identification when obtaining a Yale University ID card at the ID Center. NOTE: Name on government authorized ID cards must match the name in Yale’s database (no nicknames):

   - Passport (USA or International)
   - Driver’s License (USA Only)
   - State Issued Non-driver ID
   - US Military ID
   - INS ID (Green card)

   The Medical School ID Center is located at 333 Cedar St. SHM-CE-1B. Its hours of operation are Monday through Friday, 8:30 am – 12 Noon and 1:00pm – 3:00pm. The office number is 203-785-4286. Email: med.idcenter@yale.edu

5. Direct Deposit

   When: On or after July 1st

   You are encouraged to set up direct deposit. As a reminder, fellows receive a stipend once a month on the last working day of the month.

   Please remember that Yale does not withhold any taxes from this payment. To ensure you meet any Federal/State tax obligations that may apply to you, consult with a tax advisor.
To set up your direct deposit:

Go to the Yale Portal; http://portal.yale.edu/staff

a. Select the Login option and log in  
b. Select “My Pay and Information”  
c. Select “Direct Deposit”  
d. Following the prompts

For assistance, you may contact the Employee Service Center at 203-432-5552; employee.services@yale.edu; or visit their offices at 221 Whitney Ave., 1st Floor; Monday-Friday 8am-5pm.

6. Managing Your Health Benefits

When: On or after July 1st

Enroll in Benefits

You must enroll in a health benefit plan within the first 30 days of your appointment. You will be able to enroll on or after July 1st. You will need your Net ID to begin the process. Coverage through the Yale Health Plan is provided at no charge to you and your family. You will be responsible for the difference in premium cost if you select other insurance options. Once you complete enrollment, you will need to complete a subsidy form and return to Joan Cricca no later than July 10th, 2015.

To enroll:

a. Visit http://portal.yale.edu/staff  
b. Select “My Benefits”  
c. Follow the prompts

For assistance, you may contact the Employee Service Center at 203-432-5552; employee.services@yale.edu; or visit their offices at 221 Whitney Ave., 1st Floor; Monday-Friday 8am-5pm.

Complete a Health Subsidy Form

Fellows who have signed up for the health benefits must complete a healthcare subsidy form to ensure that Yale pays for your health insurance. Each month an amount equal to the cost of your healthcare benefits will be deducted from your paycheck. In order for the department to add the healthcare subsidy to your monthly paycheck (which will eliminate or reduce the amount of the withdrawal, depending on which health plan you choose) the department must have a subsidy form on file.

You must complete the form and return it to Joan Cricca within 10 days of the start of your internship. The form is attached for your convenience, but can also be found at: https://your.yale.edu/sites/default/files/healthcare-subsidy-form_final_updated_09072016.pdf Complete the top portion of the form. The department will complete the middle section - Leave the space for “Yale ID” blank. The department will fill this in.
For assistance, you may contact the Employee Service Center at 203-432-5552; employee.services@yale.edu; or visit their offices at 221 Whitney Ave., 1st. Floor; Monday-Friday, 8am-5pm.

Additional information on your benefits can be found online at: http://www.yale.edu/hronline/benefits/pd.html

Additional Information:

For questions or concerns as you transition into your role; you may contact Joan Cricca at 203-785-2090 or psychsec@yale.edu

Links for Attachments:

Form I-9 Employment Eligibility Verifications: https://your.yale.edu/sites/default/files/i-9-.pdf

Yale University I-9 Centers: https://your.yale.edu/sites/default/files/yale-i-9-centers_2.pdf

Healthcare Subsidy Form: https://your.yale.edu/sites/default/files/healthcare-subsidy-form_final_updated_09072016.pdf
1. **Training Management System**: The Yale University Training Management System (TMS) manages information related to required training and required forms that must be completed by University faculty, staff, and trainees. TMS helps educate the Yale community about required training and forms, facilitates online training registration, and ensures training completion.

2. **Complete a Training Assessment**: Log in to [http://www.yale.edu/training/](http://www.yale.edu/training/) with a Net ID and password. Click on “Take Your Assessment”, which is located on the left hand side of the page. Once finished with this assessment, click on “My Training Information” to complete all training requirements that were selected based on the outcome of the assessment.

3. **Priority Trainings**: It is a priority to complete the following three requirements at the start of an internship or practicum: HIPAA Privacy Training, HIPAA Security Training, and Yale University HIPAA Attestation.

4. **Deadlines**: The Assessment and all required trainings should be completed within the first two weeks of internship or practicum, and absolutely no later than the first month.

5. **Questions**: Inquiries about the Training Management System or training requirements should be directed to the Department of Psychiatry Compliance Officer, Kathy Underkofler, by email at kathy.underkofler@yale.edu or by phone at 203-737-1375.
1. **Purpose:** Fellows are welcome to participate in a number of internship committees. Their role in these committees is to work with faculty to continue to improve the internship program, bringing the perspective of fellows to these efforts.

2. **Optional:** Participation of fellows in committees is optional. There is no expectation or obligation of fellows to participate. The time involved in participation is above and beyond the time expectations for required responsibilities.

3. **Scheduling:** The meeting times of some committees is fixed. Fellows should consider those times in indicating their interest to participate. For other committees, an effort is made to consider fellows’ schedules when setting meeting times, but it is not always possible to accommodate the schedules of all fellow members.

4. **Committees:**
   
   a. **Fellow Advisory Committee**
      
      i. Fellow Advisory Committee (FAC): Committee members, who are all fellows, work with the internship director to improve the quality of the program. (See the FAC description)
      
      ii. Monthly one-hour meetings with the Director of Training from 5:45pm-6:45pm on Tuesdays (or at an alternate time based on Director and committee availability)
      
      iii. Modest additional work outside of the meetings
   
   b. **Committee on Diversity, Equity and Inclusion:**
      
      i. A committee of faculty and fellows who develop and implement plans to increase diversity and inclusion in the internship program.
      
      ii. Quarterly meetings of 90 minutes, Wednesdays at 3:00pm
      
      iii. Minimal work outside of the Committee meetings

5. **Indicating Interest:** Fellows should indicate their rank order preference for committee participation, if any, to the Director of Training by July 31st.
1. **Continuous Quality Improvement:** The Yale Doctoral Internship in Clinical and Community Psychology, which is operated under the auspices of the Yale Department of Psychiatry, is committed to a process of continuous quality improvement. To be effective, that process must be fully informed by the experience and opinions of fellows participating in the program.

2. **Sources of Fellow Input:** Input from fellows is obtained from multiple sources including: their ratings of seminar presentations, supervisors, and placements; completion of an end-of-the-year evaluation of the training program; and through verbal feedback provided to placement supervisors, institutional Chiefs of Psychology, and the Director of Clinical Training. The Fellow Advisory Committee (FAC) was established to strengthen the feedback mechanisms, the connection between students and faculty, and involvement of fellows in program quality improvement.

3. **Selection of FAC Members:** During the initial phase of the internship, fellows are invited to express interest in participating in this committee. The Director of Clinical Training selects between three and five self-nominated students for the FAC, ensuring a diversity of representation from facilities and placement sites within the program.

4. **Tasks of the FAC:** The FAC will be convened by the Director of Clinical Training periodically to address a range of tasks that potentially include, but are not limited to the following:

   a. Track and promote the progress and group development of the internship class
   b. Identify areas of student concern
   c. Discuss areas of faculty concern
   d. Engage in problem solving regarding identified issues or problems
   e. Identify and help implement potential strategies for strengthening the internship program
   f. Provide input into policy development or policy changes
   g. Provide input into strategic planning activities of the program
   h. Assist in reviewing and developing strategies to address accreditation standards
   i. Plan program special events
   j. Coordinate fellow participation in recruitment activities with applicants
   k. Conduct an orientation teleconference with newly accepted fellows
5. **Responsibilities of FAC Members:** The responsibilities of FAC members are to:

   a. Establish an open line of communication with other fellows about the internship program
   b. Gather information about problems and student recommendations for program improvement
   c. Attend FAC meetings regularly and represent student interests in this forum
   d. Assist in planning and coordinating selected program events
   e. Contribute to activities of the Fellow Advisory Committee

**Focus on Group Level Issues:** The Fellow Advisory Committee is not intended to replace the standard process for resolving issues specific to an individual fellow. When a fellow has difficulty with some aspect of the internship experience, he or she should discuss it with the immediate supervisor and/or primary and secondary placement advisors. If the issue is not satisfactorily resolved at that level, the fellow should reach out in turn to the facility Chief Psychologist and the Director of Clinical Training. The Fellow Advisory Committee will play a role in identifying problems that are experienced by multiple fellow
Purpose
There are many ways in which psychology fellows in the Department of Psychiatry's Doctoral Internship in Clinical and Community Psychology get to know each other. This occurs through work-related and social experiences. Nonetheless, since this is a large internship program, a fellow may know some of his or her peers in the internship less well, particularly if they work in a different institution or in a different placement or building in the same institution.

In previous years, the internship’s Fellow Advisory Committee (FAC) implemented a strategy to deepen the personal connection between fellows who have not gotten to know each other well during the first half of the academic year.

Method
Each member of the FAC will invite one to two members of the internship class that they know less well to a lunch or dinner. The FAC will coordinate the invitations so that all members of the class will be included and will participate once. A minimum of 90 minutes will be set aside to dine together. The schedule and commitments of each participating fellow will be taken into consideration in selecting the date and time. This is a voluntary experience, though the FAC encourages all fellows to participate.

Historically, each participating fellow has been asked to come to the meal with two questions that they might like to ask the other fellows in order to get to know them better. These questions should be more personal than professional. The FAC member hosting the meal will come prepared with a variety of strategies for using the questions to facilitate discussion (e.g., each fellow gets to ask one question; the group decides on which questions to discuss). The FAC host will select the strategy and guide the discussion.

Cost
The internship program will cover the cost of these meals to a maximum of $50.00 per fellow inclusive of tip and tax. The FAC member hosting the meal will pay for the meal and submit for reimbursement through the Student Coordinator. Alcohol expenses during lunches on weekdays will not be reimbursed. Alcohol expenses will be reimbursed for dinners and weekend lunches, with a two drink maximum per person. To submit for reimbursement, the Student Coordinator will require an itemized receipt (displays the drinks and food items—not just the total) and list of participating fellows, including the FAC member.

Miscellaneous
The Fellow Advisory Committee will subsequently debrief and discuss the value of repeating this Fellow to Fellow experience in future years. Sensitive information discussed during the meals will not be shared.
Doctoral Internship Policy & Procedures

Photo Policy

Revised 04-04-15

1. **Permission:** During the course of the internship year, photos of fellows, their family members, and faculty will be taken or collected on varied occasions by faculty, fellows, and professional photographers. This policy is distributed to fellows and faculty to inform them that such photos may be displayed by the program on its website, in marketing documents, at social and ceremonial events, and used for other internship purposes. Permission to take and use photos is assumed and implied by an individual’s participation in the program and its activities.

2. **Revoking implied permission:** Any individual can notify the internship program that photos of him/her or his/her family cannot be used by the program. This notice is provided by sending an email to the student coordinator at psychsec@yale.edu.

3. **Use of discretion:** Fellows, faculty, and other photographers will use discretion in taking photos. No photos should be submitted that include images of clients or their families. Internship program staff will use discretion in the posting and other uses of photos.

4. **Requests regarding specific photos:** Any person who is a subject of a photo may request that it not be used by the program, or if in use, no longer be used.

5. **Submitting photos:** The internship has established an email address for use by fellows and faculty members in submitting photos. To submit photos follow these instructions:
   a. Email the photo as an attachment to: selfie@yale.edu.
   b. Attach “large” file sizes so that the program receives the highest quality photos.
   c. In the body of the email please provide a very brief description of the content of the photo.

6. **Photo sharing site:** The internship will maintain a photo sharing website accessible to fellows and faculty where photos will be posted and can be viewed and downloaded.

7. **Reposting:** Photos from the photo sharing website should not be reposted to other social media sites. However, the owner of the photo can provide it directly to others with permission to post it.