PSYCHOTHERAPY PROGRAM
POSTGRADUATE GOALS AND OBJECTIVES 2014
## Contents

PSYCHOTHERAPY TRAINING REQUIREMENTS ................................................................. 4
SUPPORTIVE PSYCHOTHERAPY ...................................................................................... 7

<table>
<thead>
<tr>
<th>General Goals:</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEDICAL EXPERT</td>
<td>7</td>
</tr>
<tr>
<td>Knowledge</td>
<td>7</td>
</tr>
<tr>
<td>Skills</td>
<td>7</td>
</tr>
<tr>
<td>COMMUNICATOR</td>
<td>8</td>
</tr>
<tr>
<td>PROFESSIONAL</td>
<td>9</td>
</tr>
<tr>
<td>MANAGER</td>
<td>9</td>
</tr>
<tr>
<td>COLLABORATOR</td>
<td>9</td>
</tr>
<tr>
<td>SCHOLAR</td>
<td>10</td>
</tr>
<tr>
<td>HEALTH ADVOCATE</td>
<td>10</td>
</tr>
</tbody>
</table>

LONG-TERM PSYCHODYNAMIC PSYCHOTHERAPY ......................................................... 11

<table>
<thead>
<tr>
<th>General goals</th>
<th>11</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRAINING OBJECTIVES – Junior Residents</td>
<td>11</td>
</tr>
<tr>
<td>MEDICAL EXPERT</td>
<td>11</td>
</tr>
<tr>
<td>COMMUNICATOR</td>
<td>13</td>
</tr>
<tr>
<td>PROFESSIONAL</td>
<td>13</td>
</tr>
<tr>
<td>MANAGER</td>
<td>14</td>
</tr>
<tr>
<td>COLLABORATOR</td>
<td>14</td>
</tr>
<tr>
<td>SCHOLAR</td>
<td>14</td>
</tr>
<tr>
<td>HEALTH ADVOCATE</td>
<td>14</td>
</tr>
</tbody>
</table>

| TRAINING OBJECTIVES – Senior Residents | 15 |
| MEDICAL EXPERT | 15 |
| COMMUNICATOR  | 17 |
| PROFESSIONAL  | 17 |
| MANAGER       | 18 |
| COLLABORATOR  | 18 |
| SCHOLAR       | 18 |
| HEALTH ADVOCATE | 18 |
COGNITIVE-BEHAVIORAL THERAPY ................................................................. 19

General Goals: ................................................................................................. 19

TRAINING OBJECTIVES – Junior Residents .................................................. 19

MEDICAL EXPERT ......................................................................................... 19
COMMUNICATOR ............................................................................................ 21
PROFESSIONAL .............................................................................................. 21
MANAGER .......................................................................................................... 21
COLLABORATOR ............................................................................................. 21
SCHOLAR .......................................................................................................... 22
HEALTH ............................................................................................................. 22

TRAINING OBJECTIVES – Senior Residents ................................................... 22

MEDICAL EXPERT ......................................................................................... 22
COMMUNICATOR ............................................................................................ 23
PROFESSIONAL .............................................................................................. 24
MANAGER .......................................................................................................... 24
COLLABORATOR ............................................................................................. 24
SCHOLAR .......................................................................................................... 24
HEALTH ADVOCATE ....................................................................................... 25

INTERPERSONAL PSYCHOTHERAPY .............................................................. 26

MEDICAL EXPERT ......................................................................................... 26
COMMUNICATOR ............................................................................................ 27
PROFESSIONAL .............................................................................................. 27
MANAGER .......................................................................................................... 27
COLLABORATOR ............................................................................................. 28
SCHOLAR .......................................................................................................... 28
HEALTH ADVOCATE ....................................................................................... 28

COUPLE AND FAMILY PSYCHOTHERAPY ..................................................... 30

General Goals: ................................................................................................. 30

TRAINING OBJECTIVES – Junior Residents .................................................. 30

MEDICAL EXPERT ......................................................................................... 30
COMMUNICATOR ............................................................................................ 32
PROFESSIONAL .............................................................................................. 32
COLLABORATOR ............................................................................................. 32
SCHOLAR .......................................................................................................... 32

Revised April 07, 2014
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRAINING OBJECTIVES – Senior Residents</td>
<td>32</td>
</tr>
<tr>
<td>MEDICAL EXPERT</td>
<td>33</td>
</tr>
<tr>
<td>COMMUNICATOR</td>
<td>34</td>
</tr>
<tr>
<td>PROFESSIONAL</td>
<td>34</td>
</tr>
<tr>
<td>SCHOLAR</td>
<td>35</td>
</tr>
<tr>
<td>Couple and Family Therapy Appendices</td>
<td>36</td>
</tr>
<tr>
<td>Appendix 1 – The Three Levels of Family Therapy Training</td>
<td>36</td>
</tr>
<tr>
<td>Appendix 2 – Relevant References &amp; Readings</td>
<td>37</td>
</tr>
<tr>
<td>GROUP THERAPY</td>
<td>41</td>
</tr>
<tr>
<td>MEDICAL EXPERT</td>
<td>41</td>
</tr>
<tr>
<td>COMMUNICATOR</td>
<td>42</td>
</tr>
<tr>
<td>PROFESSIONAL</td>
<td>42</td>
</tr>
<tr>
<td>MANAGER</td>
<td>42</td>
</tr>
<tr>
<td>COLLABORATOR</td>
<td>43</td>
</tr>
<tr>
<td>SCHOLAR</td>
<td>43</td>
</tr>
<tr>
<td>HEALTH ADVOCATE</td>
<td>43</td>
</tr>
<tr>
<td>APPENDICES</td>
<td>44</td>
</tr>
<tr>
<td>Appendix II</td>
<td>45</td>
</tr>
<tr>
<td>Appendix III</td>
<td>46</td>
</tr>
<tr>
<td>Appendix IV</td>
<td>46</td>
</tr>
</tbody>
</table>
PSYCHOTHERAPY TRAINING REQUIREMENTS

The learning of psychotherapy will be achieved through supervised clinical experience in a number of modalities and patient specific populations in addition to seminars. Proficiency is required in long-term psychodynamic, cognitive behavioural, and one of multi-person modalities of group or couple/family therapies. Working knowledge is required in a short-term one-on-one interpersonal modality, and another multi-person modality. In combination with the required centralized seminars, learning through participation in hospital-based psychotherapy seminars is encouraged. The Royal College of Physicians and Surgeons requires a minimum of 32 weeks of training in Psychotherapy during residency years (includes seminars; clinical work; and, supervision). Thus, residents must devote, on average, 7 hours weekly for psychotherapy training. (These requirements represent approximately 50% of the time allotted to psychotherapy training.) Residents are thus encouraged to seek proficiency in additional modalities.

PROFICIENCY REQUIREMENTS 1-

1 MODALITIES
Residents must obtain proficiency in both long-term dynamic and CBT.

Long-term Psychodynamic Psychotherapy: a minimum of two years of supervised treatment of two adult patients. To satisfy proficiency requirements totalling 150 hours of treatment: once weekly treatment of an adult for two years (up to 80 hours) and an additional adult case (2 years, once weekly OR 1 year twice weekly). If a psychodynamic case is done with a child or adolescent during the child rotation, it can be counted towards this requirement. Ideally one adult case will be conducted during the junior years of residency and the second adult case during the senior years. Written reports are encouraged to consolidate learning. In addition, two year long centralized seminars are required - a foundational course in the PGYII year, and an advanced seminar to be taken in the PGYIV or V year.

Cognitive Behavioral Therapy: four, weekly, supervised CBT Cases*, one of which must be a child case along with the centralized CBT seminars in the PGYII year. Residents must do at least one case for treatment of an anxiety disorder and another case for treatment of depression. DBT can be counted towards this requirement. If a CBT Group is conducted, it can be counted for both group and CBT.

MULTI-PERSON MODALITIES
Residents must obtain Proficiency in either group or family and working knowledge in the other multi-person modality.

Group: one weekly supervised group for a minimum of 5 months in addition to attending two Group Days in any one of the PGY2 to PGY5 residency years. If a group is conducted in CBT, DBT or IPT, it can be counted for both group and the modality specific requirements.
Couple/Family: two weekly supervised couple/family treatments. Residents are encouraged to complete this requirement during their child rotation where supervision in this modality is more available.

WORKING KNOWLEDGE REQUIREMENTS

SHORT-TERM 1-1 MODALITIES: (IPT, CCRT/Brief Psychodynamic, Supportive, Crisis Counselling) - two weekly, supervised cases* are required, one of which must be IPT. A full-day foundational didactic workshop in IPT is provided yearly for PGY2 residents. Cognitive Behavioural Analysis System of Psychotherapy (CBASP) can be counted towards this requirement.

Group Psychotherapy: one weekly supervised in-patient or psychoeducation group for working knowledge and attending one Group Day in any one of the PGY2 to PGY5 residency years.

Couple/Family: one weekly supervised couple/family treatment. Residents are encouraged to complete this requirement during their child rotation, where supervision in this modality is more available.

Dialectical Behaviour Therapy (DBT): Attendance at PGY2 and PGY4 DBT seminars and observe 2 sessions of a skills based DBT group between the PGY3 to PGY5 years.

*Case, length of treatment or number of required clinical hours = a minimum of >50% of the standard usual completed course in a modality. For example, in CBT where 20 sessions are agreed upon for treatment of depression, at least 11 must be completed; for supportive therapy or crisis counselling a minimum of 6 sessions per case.
Individual Therapeutic Modalities
SUPPORTIVE PSYCHOTHERAPY

General Goals:

1. To develop knowledge and skills to provide supportive psychotherapy, where applicable, during patient encounters.
2. To integrate, throughout the residency training experience, the knowledge and skills learned in other psychotherapy training experiences, with the principles of supportive psychotherapy.

MEDICAL EXPERT

Knowledge

With regards to supportive psychotherapy, residents should be able to:

1. Describe the supportive-expressive continuum in psychotherapy. In particular, knowledge that supportive psychotherapy encompasses the following with elaboration of this knowledge throughout the residency training program:
   a. Maintenance or improvement of the patient’s self-esteem
   b. Amelioration or prevention of recurrence of symptoms
   c. Improvement of psychological functioning
   d. Enhancing adaptive capacities

2. Relate the theoretical underpinnings of supportive psychotherapy.

3. Identify the indications and contraindications for supportive psychotherapy.

4. Recognize when not to use a modality specific approach and to use supportive techniques.

5. Distinguish how supportive psychotherapy differs from a dynamic, expressive psychotherapeutic approach.

6. Describe appropriate boundaries in supportive psychotherapy.

Skills

During the course of a supportive psychotherapeutic treatment, residents should be able to:
1. Establish and maintain a positive therapeutic alliance and interact with the patient in an empathic, respectful, direct, responsive and non-threatening manner.

2. Confront a patient about behaviours that are dangerous or damaging to the patient in a non-threatening, collaborative manner.

3. Demonstrate the ability to understand/formulate the patient as a unique individual within his or her family, socio-cultural and community structure.

4. Demonstrate an appreciation for the patient’s developmental (past) history whilst focusing on present-day life/problems in the service of improving self-esteem, promoting adaptation, psychological functioning and amelioration of symptoms.

5. Provides education and advice about the patient’s psychiatric condition treatment, and adaptation whilst being sensitive to specific community systems of care and sociocultural issues

COMMUNICATOR

1. Conveys effective oral and written information about the clinical encounter with the patient which includes the following:
   a. Timely, accurate documentation of clinical encounters (written or electronic).
   b. Maintenance of clinical notes that meet practice standards and capture the ongoing therapeutic process, including evidence of review of departmental (Department of Psychiatry, University of Toronto) and CPSO (College of Physician and Surgeons of Ontario) standards for documentation of psychotherapeutic encounters.

2. Develops rapport, trust and ethical therapeutic relationships with patients and their families/caregivers where appropriate, within the frame of supportive psychotherapy.

3. Confronts* in a non-threatening and collaborative manner behaviours that are dangerous or damaging to the patient.

4. Demonstrate responsiveness to the patient, with the ability to provide feedback and advice to the patient when appropriate, balancing the patient’s need for autonomy.

*Confrontation here does not imply arguing with the patient but is used in reference to a technique utilized in psychotherapy to help patients integrate aspects of experience that may be painful and thus avoided in the therapy.
PROFESSIONAL

1. Demonstrates a strong commitment to patient care.

2. Maintains the highest standards of confidentiality and ethical behaviour vis a vis their patients.

3. Treats their patients with respect and honour, maintaining an attitude of warmth, acceptance, friendliness, discretion and curiosity that neither burdens the patient nor invites the patient to cross boundaries.

4. Brings a professional and respectful attitude to all interactions with their supervisor and colleagues.

5. Accepts and makes constructive use of supervision and feedback.

MANAGER

1. Recognizes the issues related to access to and allocation of psychotherapeutic resources within the medical system and the place of supportive psychotherapy in that system.

2. Sets priorities and manages time that balances patient care, other clinical and education requirements, as well as outside activities and personal life.

3. Addresses through supervision and personal therapy if so desired strong affective responses that may be evoked in the care of patients (i.e. manages countertransferential responses).

COLLABORATOR

1. If applicable to the care of a patient, participate effectively and appropriate in an interprofessional healthcare team by:
   a. Clearly describing their roles and responsibilities in provision of supportive psychotherapy to other professionals within the health care team.
   b. Work within the team to assess, plan, provide and integrate care for their patients contextualized within the framework of a supportive psychotherapy.
   c. Developing a common understanding on issues, problems and plans with patients, families, colleagues and other professionals that informs the supportive psychotherapeutic interventions with the patient.
SCHOLAR

1. Actively seeks articles and books relevant to supportive psychotherapy and their work with their patients (specific to their supportive psychotherapy cases).

2. Adopts a lifelong learning approach to psychotherapy through acknowledging the need to enhance psychotherapeutic skills in an ongoing manner within residency and ultimately as an independent practitioner.

HEALTH ADVOCATE

1. Identifies the possibility of conflict inherent in their role as a health advocate for a patient with that of manager or gatekeeper, given limited resources within the mental health system in the provision of psychotherapy.

2. Demonstrates the capacity to balance advocacy for the patient within a supportive psychotherapeutic frame with fostering the patient’s self-efficacy.
LONG-TERM PSYCHODYNAMIC PSYCHOTHERAPY

General goals:

1. For residents to be able to use long-term psychodynamic psychotherapy with appropriately selected patients

2. For residents to be able to utilize the principles of psychodynamic psychotherapy, where applicable, in all their clinical work

TRAINING OBJECTIVES – Junior Residents

MEDICAL EXPERT

Knowledge

1. Working knowledge of the following concepts as demonstrated by:
   
   a. the ability to discuss them in supervision
   
   b. the ability to identify, in supervision, the way these concepts are relevant to the work they are doing with their psychodynamic patient(s)

   A. Dynamic Unconscious
   B. Transference
   C. Countertransference
   D. Therapeutic Relationship
   E. Empathic listening
   F. The role of affect and affect regulation
   G. The connection between early relationships and experience and later patterns and psychopathology
   H. Knowledge of criteria for patient selection for psychodynamic psychotherapy
   I. Knowledge of the nature of the concepts of frame and boundaries as they apply to such topics as: office set up (chairs position, lighting, tissues, personal effects, clocks etc.), time management, waiting room communication, ‘door-knob’ comments, phone calls/email communication, gifts, personal information and self-disclosure, and other issues, as relevant to particular therapies.
   J. The ability to describe the role of supervision in training, including preparation for supervision, boundary issues in supervision and how to manage difficulties in supervision.

2. Working knowledge of the following theories as demonstrated by:
a. the ability to discuss them in supervision

b. the ability to apply these theories, with some assistance from a supervisor, to their psychodynamic patient(s)

c. the effective use of at least one of these theories in their PGY2 case report

A. Classical (Drive) Theory
B. Ego (Defense) Psychology
C. Kleinian Theory
D. Object Relations Theory
E. Self Psychology
F. Relational Psychoanalysis
G. Attachment Theory/ Mentalization Therapy

Skills

1. An ability to establish and maintain a therapeutic alliance in psychodynamic therapy, including:

   a. the ability to engender trust

   b. the ability to develop rapport

   c. the ability to adapt personal style sufficiently to mesh with that of the patient

   d. ability to interact in fashion that displays authenticity while not breaking the frame, crossing boundaries or burdening the patient

   e. an ability to identify, discuss and, where appropriate, help regulate affective states in their patient

   f. an ability to avoid negative interpersonal behaviours, including impatience, frustration, aloofness or insincerity

2. A capacity to experience and display curiosity about their patient in supervision and therapy

3. An ability to establish and maintain psychodynamically-informed boundaries and a psychodynamic frame in a flexible and therapeutic fashion.

4. An ability to identify and discuss evidence of transferential material in psychotherapy, with some assistance from the supervisor..
5. Able to identify and discuss countertransference material as it plays out in therapy

6. Can provide a succinct and accurate oral summary of patients in therapy, including some theoretically informed thoughts on temperament, early experience and later life events may have resulted in current difficulties (basic formulation)

7. Engages in supervision as a process and can utilize supervision appropriately to guide therapy

8. An ability to identify enactments and ruptures in therapy (both large and smaller), discuss them in supervision, and identify relevant therapist and patient factors

COMMUNICATOR

1. Can engage in active and reflective listening as demonstrated by:
   
   a. retention of essential, relevant material from a session, even without reference to their notes
   
   b. ability to connect material from earlier sessions to the current session, with both patient and supervisor
   
   c. can communicate their dynamically informed thoughts to the patient in a manner and at a time that allows the patient to make use of them
   
   d. can interpret unconscious (including transference) material sensitively and effectively
   
   e. can reflect on the therapeutic process, with some help from the supervisor

2. Can identify unconscious processes in therapy, discuss the material in supervision, and show some ability to utilize such processes in therapy

3. Maintain clinical notes that meet practice standards and capture the ongoing therapeutic process, including evidence of review of departmental and CPSO standards.

4. Can receive and give feedback in supervision.

PROFESSIONAL

1. Attains the highest standards of confidentiality and ethical behaviour vis a vis their patients
2. Treats their patient with respect and honour, and maintains an attitude of warmth, acceptance, friendliness, discretion, and curiosity that neither burdens the patient nor invites the patient to cross boundaries

3. Brings a professional and respectful attitude to all dealings with their supervisor, including the giving and receiving of feedback

4. Discuss possible boundary transgressions in supervision, and utilize supervision in a way that minimizes harm

**MANAGER**

1. Consistently attends supervision having reflected on the clinical material

2. Can reflect on the role of psychodynamic therapy and principles in clinical practice with non-long-term dynamic patients

**COLLABORATOR**

1. Can describe psychodynamic psychotherapy to other health care professionals, including describing suitability of patients, the dynamic process and general principles of psychodynamic therapy.

2. Can integrate their psychodynamic therapy with a patient with the work of other members of a treatment team (when relevant)

**SCHOLAR**

1. Develops the ability to read psychodynamic literature, as demonstrated through discussions in supervision

2. Actively seeks articles and books relevant to their psychodynamic patient

3. Appreciates the need to enhance psychotherapeutic skills in an ongoing manner

**HEALTH ADVOCATE**

1. Can explore, in supervision, the desire to advocate on behalf of the patient, appreciate both therapist and patient factors leading to that desire, and appreciate the effect such behaviour might have on the therapy
2. Where appropriate, can advocate for the patient, in conversation or in writing, in an appropriate and effective manner.

TRAINING OBJECTIVES – Senior Residents

MEDICAL EXPERT

Knowledge

1. 
   a. Working knowledge of the following concepts as demonstrated by:
      i. the ability to discuss them in supervision
      ii. the ability to identify, in supervision, the way these concepts are relevant to the work they are doing with their psychodynamic patient(s)
   b. Proficient knowledge of these concepts as demonstrated by:
      i. the ability to utilize these concepts in therapy, and discuss that usage in supervision
         
         A. Dynamic Unconscious
         B. Transference
         C. Countertransference
         D. Therapeutic Relationship
         E. Empathic listening
         F. The role of affect and affect regulation
         G. The connection between early relationships and experience and later patterns and psychopathology
         H. An ability to discuss impasses/enactments/negative therapeutic reactions from at least two theoretical standpoints

2. 
   a. Working knowledge of the following theories as demonstrated by:
      i. the ability to discuss them in supervision
      ii. the ability to apply these theories, with minimal assistance from a supervisor, to their psychodynamic patient(s)
   b. Proficient Knowledge of at least three theories as demonstrated by:
      i. the effective use of at least one of these theories in their PGY4 case report
      ii. the ability to utilize theoretical understanding in therapy in a non-dogmatic and effective manner
iii. the ability to discuss, in supervision, how different theories would apply to their patient(s), and would affect the therapeutic process

A. Classical (Drive) Theory  
B. Ego (Defense) Psychology  
C. Kleinian Theory  
D. Object Relations Theory  
E. Self Psychology  
F. Relational Psychoanalysis  
G. Attachment Theory/ Mentalization Therapy

**Skills**

1. An ability to establish and maintain a therapeutic alliance in psychodynamic therapy, including:

   a. the management of cycles of disruption and repair

   b. an ability to recognize the way the alliance evolves as therapy progresses and discuss that process in supervision

   c. the ability to track and explore in-session affective shifts, even if subtle

2. An ability to establish and maintain psychodynamically-informed boundaries and a psychodynamic frame in a flexible and therapeutic fashion, including the management of boundaries and frame as therapy progresses

3. An ability to identify and discuss evidence of transferential material in psychotherapy with minimal assistance from the supervisor, and to utilize transferential material effectively in therapy

4. An ability to identify and discuss countertransferential material as it plays out in therapy, and utilize that understanding in therapy. This includes an understanding of countertransference as potentially both an impediment to and facilitator of the process

5. Can provide a succinct and accurate oral summary of patients in therapy, including a psychodynamic formulation that is both theoretically informed and relates to the specific processes in therapy with that patient

6. Engages in supervision as a process and can utilize supervision appropriately to guide therapy. Ability to discussion indications for the need for supervision or consultation post-residency
7. Manages termination (if relevant) and transitions

COMMUNICATOR

1. Can engage in active and reflective listening as demonstrated by:
   a. retention of essential, relevant material from a session, even without reference to
      notes, which includes some comments on major themes, transference and
      countertransference (as evident n that particular session).
   b. ability to connect material from earlier sessions to the current session, with both
      patient and supervisor
   c. the ability to communicate their dynamically informed thoughts to the patient in a
      manner and at a time that allows the patient to make use of them, and is part of
      ongoing dialogue with the patient
   d. can interpret unconscious (including transferenceal) material sensitively and
      effectively, as part of the ongoing dialogue with the patient
   e. can reflect on the therapeutic process, with minimal help from the supervisor

2. Can hear unconscious processes in therapy, discuss the material in supervision, and utilize
   such processes in therapy

3. Maintain clinical notes that meet practice standards and capture the ongoing therapeutic
   process, and can describe departmental and CPSO standards

4. Can receive and give feedback in supervision

PROFESSIONAL

1. Attains the highest standards of confidentiality and ethical behaviour vis a vis their patients

2. Treats their patient with respect and honour, and maintains an attitude of warmth, acceptance, friendliness, discretion, and curiosity that neither burdens the patient nor invites the patient to cross boundaries

3. Brings a professional and respectful attitude to all dealings with their supervisor, including
   the giving and receiving of feedback
4. Discuss possible boundary transgressions in supervision, understand the relevant patient and therapist factors, and utilize that understanding therapeutically

**MANAGER**

1. Consistently attends supervision having reflected on the clinical material, and with questions and thoughts related to process, difficulties, transference and countertransference

2. Can reflect on the role of psychodynamic therapy in the clinical practice of general psychiatry

**COLLABORATOR**

1. Can describe psychodynamic psychotherapy to other health care professionals, including describing suitability of patients, the dynamic process and general principles of psychodynamic therapy.

2. Can integrate their psychodynamic therapy a patient with other members of a treatment team (when relevant)

**SCHOLAR**

1. Develops the ability to read psychodynamic literature, as demonstrated through discussions in supervision

2. Actively seeks articles and books relevant to their psychodynamic patient

3. Appreciates the need to enhance psychotherapeutic skills in an ongoing manner and can describe options to maintain and enhance skills upon graduation

**HEALTH ADVOCATE**

1. Can explore, in supervision, the desire to advocate on behalf of the patient, appreciate both therapist and patient factors leading to that desire, and appreciate the effect such behaviour might have on the therapy

2. Where appropriate, can advocate for the patient, in conversation or in writing, in an appropriate and effective manner.
COGNITIVE-BEHAVIORAL THERAPY

General Goals:
Upon completion of training, the residents must demonstrate the requisite knowledge, skills, and attitudes for competent and independent delivery of cognitive-behavioral therapy for a range of mental disorders.

TRAINING OBJECTIVES – Junior Residents

MEDICAL EXPERT

Working Knowledge

1. Discusses basic principles of the cognitive behavioral model and rationale for treatment (including the inter-relationship between thoughts and images, feelings, behaviors and physiology; the concept of automatic thoughts and cognitive distortions; the common cognitive errors; the significance and origin of core beliefs and relationship of schemas to dysfunctional thoughts and assumptions, behavioral strategies and psychopathology).

2. Describes common cognitive biases relevant to CBT

3. Explains the role of safety-seeking behaviors

4. Lists indications and contraindications for CBT in the treatment of mental disorders

5. Discusses basic cognitive conceptualization for depression and anxiety disorders

6. Describes commonly used questionnaires and rating scales

7. Discusses basic rationale for structuring a cognitive therapy session, and the focus on active collaborations and problem solving

8. Describes basic principles of psychoeducation and skills training during therapy, and when termination approaches, for relapse prevention

9. Explains basic principles underlying the use of behavioral techniques (including activity scheduling, exposure and response prevention, relaxation training, graded task assignment, exposure hierarchies/ systematic desensitization)
10. Explains basic principles underlying the use of cognitive techniques (including identifying automatic thoughts, examining the evidence, thought recording, cognitive restructuring, problem solving, advantage/disadvantages analyses, and identifying core beliefs)

**Skills**

1. Performs a cognitive behavioral assessment, and assesses suitability for CBT
2. Develops individual cognitive case conceptualization and uses it to plan treatment
3. Explains and demonstrates the rationale for cognitive behavioral therapy to their CBT patient(s)
4. Formulates concrete behavioral treatment goals
5. Structures and focuses the therapy sessions (including collaboratively setting the agenda, plan and review homework, working on key problems, using summaries and feedback)
6. Employs measures and self-monitoring to guide therapy and to monitor outcome
7. Applies activity monitoring and scheduling and graded task assignment
8. Utilizes relaxation techniques
10. Demonstrates use of Socratic dialogue
11. Utilizes thought records (and measures the impact this has on mood on behavior)
12. Identifies assumptions, attitudes, rules and core beliefs
13. Plans and conducts behavioral experiments
14. Recognizes and identifies affects in the patient and himself/ herself
15. Plans therapy termination and teaches relapse prevention techniques
16. Integrates CBT with pharmacotherapy
COMMUNICATOR

1. Engages patient in a collaborative decision-making to develop a treatment plan

2. Keeps effective and timely written records of CBT including cognitive behavioral formulation, agenda covered and homework assigned and reviewed with a patient for each individual session

PROFESSIONAL

1. Demonstrates accountability, integrity, honesty and compassion

2. Demonstrates sensitivity to the sociocultural and socioeconomic issues that arise in the therapeutic relationship.

3. Demonstrates empathic, respectful, curious, open-minded and nonjudgmental attitude with the ability to tolerate ambiguity and display confidence in the efficacy of cognitive behavioral therapy

4. Demonstrates openness to audio or videotapes or direct observations of treatment sessions.

5. Fulfills the medical, legal, ethical and professional obligations of a psychiatrist. Notably, completes reports in a timely manner.

6. Demonstrates responsibility, dependability, self-direction, and punctuality.

7. Accepts and constructively utilizes feedback

MANAGER

1. Carries out appropriate therapy in the context of limited resources and limited time available for the resident

2. Consistently attends supervision having reflected on the clinical material

COLLABORATOR

1. Implements the CBT approach in a collaborative manner which stresses the shared responsibility of therapist and patient and which takes a collegial approach to therapy.
2. Describes CBT to other health care professionals, including describing suitability of patients, and general principles of CBT

3. Integrates their CBT with a patient with the work of other members of a treatment team (when relevant)

SCHOLAR

1. Demonstrates an understanding that continued education in cognitive behavioral therapy is necessary for further skill development.

2. Demonstrates an appropriate awareness of psychotherapy literature and research

HEALTH ADVOCATE

1. Advocates for the patient (where appropriate), in conversation or in writing, in an appropriate and effective manner.

TRAINING OBJECTIVES – Senior Residents

MEDICAL EXPERT

Knowledge

As delineated in Training Objectives for Junior Residents, plus:

1. Explains advanced principles underlying the use of behavioral techniques including behavioral rehearsal, modeling, and role-playing

2. Explains advanced principles underlying the use of cognitive techniques including modifying underlying assumptions and core beliefs

3. Discusses cognitive conceptualization and cognitive and behavioral strategies for particular disorders including:
   a. PTSD
   b. Eating disorders
   c. Alcohol and drug abuse
   d. Psychosis
   e. Bipolar disorder
   f. Personality Disorders including borderline personality disorder
4. (Dialectical Behavior Therapy
   a. Marital distress and sexual dysfunction
   b. Psychophysiological disorders (e.g., headache, hypertension)
   c. Medical illnesses

5. Describes research literature on the efficacy of CBT; treatment-outcome literature, including combined treatments; predictors of outcome

_**Skills**_

As delineated in Training Objectives for Junior Residents, plus:

1. Modifies assumptions, attitudes and rules
2. Modifies core beliefs
3. Plans and conducts behavioral experiments
4. Employs wide range of cognitive restructuring techniques
5. Identifies one’s own cognitions triggered by the therapeutic process
6. Manages to work therapeutically with alliance ruptures within a CBT frame
7. Demonstrates ability to continue to work in a manner, which is congruent with the CBT model when patient’s symptoms/problems worsen
8. Deals effectively with issues of compliance and motivation
9. Integrates CBT with other modalities (e.g., marital and family therapies, group therapy, interpersonal psychotherapy)
10. Applies CBT for special populations (e.g., children, adolescents, geriatric, culturally diverse patients)
11. Demonstrates use of CBT in special circumstances – resistance, therapeutic ruptures, suicidality

**COMMUNICATOR**

As delineated in Training Objectives for Junior Residents, plus:
1. Establishes and maintains therapeutic alliance in the face of obstacles to CBT (e.g., poor homework compliance, difficulty following the treatment structure)

PROFESSIONAL

As delineated in Training Objectives for Junior Residents, plus:

1. Demonstrates appreciation of the potential for therapist biases, the importance of continually questioning one's therapeutic strategies, and the need to adjust these strategies depending on objective data collected during treatment
2. Demonstrates awareness of one's limitations as a cognitive-behavior therapist as well as the limitations of CBT in general
3. Demonstrates awareness of one's own contribution to the therapeutic process

MANAGER

1. Consistently attends supervision having reflected on the clinical material, and with questions and thoughts related to difficulties and interpersonal processes
2. Reflects on the role of CBT in the clinical practice of general psychiatry

COLLABORATOR

1. Implements the CBT approach in a collaborative manner which stresses the shared responsibility of therapist and patient and which takes a collegial approach to therapy
2. Describes CBT to other health care professionals, including describing suitability of patients, and general principles of CBT
3. Integrates their CBT with a patient with the work of other members of a treatment team (when relevant)

SCHOLAR

As delineated in Training Objectives for Junior Residents, plus:

1. Critically appraises psychotherapy research. Seeks out and successfully integrates information from a variety of sources. Conforms to standard research protocols or uses individually tailored approaches as appropriate.
1. Advocates for the patient (where appropriate), in conversation or in writing, in an appropriate and effective manner.

2. Explores, in supervision, the desire to advocate on behalf of the patient, appreciate both therapist and patient factors leading to that desire, and appreciate the effect such behavior might have on the therapy.
INTERPERSONAL PSYCHOTHERAPY

MEDICAL EXPERT

Knowledge

With regards to Interpersonal Psychotherapy, residents should be able to:

1. Describe the phase-, and focus-specific clinical guidelines of IPT (W).
2. Summarize how IPT differs from other kinds of psychotherapy (W).
3. Identify indications, and relative contraindications for IPT, listing what kinds of patients can most likely benefit from IPT (W).
4. Demonstrate use of attachment and interpersonal theories as applied to clinical case material (P).

Skills

During the course of an IPT treatment, residents should be able to:

1. Explain the rationale for IPT and psychoeducation about depression to a patient (W)
2. Establish and maintain a positive therapeutic alliance, gaining agreement on goals and clinically interacting with empathy, respect and responsiveness (W).
3. Demonstrate the ability to formulate an understanding of each patient as a unique individual within his or her family, socio-cultural and community structure in the context of current stressors and experience of illness and to choose a focus of treatment (W).
4. Demonstrate an appreciation for the patient’s developmental, past history while focusing on present life stressors and relationships with the goals of remitting symptoms, resolving current relational problems and improving functioning and relationships (W).
5. Track symptoms and adjust treatment if patient is not improving (W).
6. Demonstrate an ability to use at least one of the four, focus-specific IPT techniques (i.e. disputes, transitions, bereavement, deficits) (W)
7. Demonstrates an ability to perform the tasks of termination in IPT (P)

COMMUNICATOR

1. Document through charting that is timely, accurate and summative of the themes and observations that emerge in each session, and that complies with University of Toronto Department of Psychiatry and CPSO psychotherapy charting guidelines (W).

2. Utilize links between symptoms and interactions or problems aligned with the interpersonal focus of treatment in therapeutic communications with the patient (W).

3. Reflects and discusses interpersonal aspects of a patient’s treatment experience, including impasses, during supervision (W).

4. Demonstrate an ability to use communication analyses or role plays in sessions to identify and work on interpersonal problems - exploring and expanding a patient’s perspective and understanding of choices related to communication/behaviours (P).

5. Demonstrate rapport, responsiveness to and therapeutic alliances patients (W)

PROFESSIONAL

1. Demonstrate a commitment to active learning, making constructive use of supervision and feedback (W).

2. Maintain professional standards of confidentiality and ethical behaviour with patients, family members and colleagues (W).

3. Demonstrate consistency and reliability, with conscientiousness across all aspects of IPT practice (including respectful, professionally-boundaried engagement of patients in treatment, managing disruptions in care, in supervision and in discharge) (W)

MANAGER

1. Manages time/schedule with attention to priorities to balance: patient care that includes psychotherapy; educational responsibilities that include clinical supervision; and personal life (W).

2. Uses supervision (and if desired, personal therapy), to manage and understand counter-transference that may be evoked in the context of clinical interactions and patient care (W).
3. Recognizes and advocates for fair and timely access of psychotherapy within differing psychiatric clinical settings (P).

4. Identifies and addresses practical issues regarding norm and frame of treatment (W).

COLLABORATOR

1. Where applicable to patient care, actively participates within an interprofessional healthcare team: describing their role, its purpose for the benefit of the patient in providing IPT to the other professionals on the team; working collaboratively in the assessment, plan and provision of integrated care; developing a shared understanding of prioritized issues and feasible plans with patients, families and colleagues that can be explicitly integrated into IPT treatment.

SCHOLAR

1. As an active learner, read articles and/or books on IPT and other psychotherapy approaches or theories that are relevant to their supervised clinical casework in IPT (W).

2. Appreciates the empirical underpinning of IPT (W), and able to apply and integrate this knowledge into clinical work (P)

3. Evaluates with rigour both the process and outcome of treatment, iteratively adjusting treatment and formulation to take into account individual differences that become apparent over time (P)

HEALTH ADVOCATE

1. Where appropriate, helps a patient to engage with community resources, work/school/family, or others in their circle of care and to connect with social supports in a time of need (W)

2. Fosters a patient’s self-efficacy, and their recruiting of, or utilizing of supports to aid recovery (W).

3. Appreciates the role of evidence-supported psychotherapy treatments in mental healthcare (W) and can discuss this clearly to colleagues, patients and their family members (P).
Multi-Person Modalities
COUPLE AND FAMILY PSYCHOTHERAPY

General Goals:

The goal of training is to enable residents to integrate psychodynamic, cognitive and behavioral principles in dealing with couples or families.

Couple therapy refers to the conjoint process in which two persons in a close relationship (marital, common-law, prenuptial or other, homo or heterosexual, or two members of a family subsystem meet with the therapist to redefine the causes, the dynamics and the possible solutions to conflicts that have obstructed their joint development and well-being.

Family therapy refers to the conjoint process in which all available/interested members of a multiperson system meet with the therapist to redefine problems and solutions. The term "Family" refers to the many ways in which kith and kin systems are lived and constructed.

Requirements

1. Attend Family/Couple core seminars
2. Attend one Family or Couple Workshop/Day during residency training.
3. Provide supervised treatment for six sessions with one couple or family.
4. Observe 20 Couple/Family sessions.

TRAINING OBJECTIVES – Junior Residents

MEDICAL EXPERT

Knowledge

1. The trainee can describe:
   a. The indications and contraindications of Couple and Family Therapy
   b. The role of the therapist with each member of a couple or a family
   c. The common objectives in a couple or family assessment
   d. The impact of culture, socio-economic status and life cycle stage on a couple or family
2. The trainee can explain the basic concepts of the following theories applied to a couple or family.

   a. Systems
   b. Developmental
   c. Communication
   d. Psychodynamic
   e. Cognitive-Behavioral

*Skills*

1. The trainee can apply the theoretical concepts to develop treatment goals for a course of couple or family therapy.

2. In supervision and case discussion, the trainee is able to anticipate some challenges which will arise in the therapy based on both the assessment of the couple/family and the psychopathology of the individual patients.

3. The trainee is able to demonstrate the following in the clinical care of a couple or family:

   a. Negotiating a therapy contract with the couple or family.
   b. Interviewing couples and families while maintaining a neutral stance.
   c. Support patients to explore in the session where their problems come from and what solutions they have tried.
   d. Engage patients in experimenting with ways of communicating and addressing conflict.
   e. Regulate the emotion and aggression level of the sessions, using support and psycho-education, so the sessions do not overwhelm the patients.

4. The trainee is able to use supervision to discuss counter transference and couple/multi-person specific issues such as the pull towards taking only one side and the therapist role in family triangles.
COMMUNICATOR

1. The trainee effectively manages multi person interactions including: setting an agenda, balancing input from all participants, supporting communication between participants and providing feedback and psychoeducation during the session.

2. The trainee maintains clinical notes that meet practice standards and capture the ongoing therapeutic process, including evidence of review of departmental and CPSO standards.

3. The trainee can receive and give feedback in supervision.

PROFESSIONAL

1. The trainee will demonstrate awareness of the personal prejudices we all have regarding couples and families and discuss these in supervision.

2. The trainee will adhere to the ethics of couple and family therapy, which excludes exploitation of patients (sexual, financial or otherwise) or omnipotent deciding for them what their destiny should be; this includes accepting and respecting the couple's or family's goals and constructive methods of problem solving.

COLLABORATOR

1. Demonstrates a respectful attitude to all clinicians involved in the care of the couple or family as demonstrated by timely written and verbal communication and interest in seeking feedback and input from other providers.

SCHOLAR

1. The trainee demonstrates familiarity with the basic literature in family/couple therapy related to the topics outlined in Medical Expert. (See Appendix 2).

TRAINING OBJECTIVES – Senior Residents

All trainees seeking proficiency in Couple & Family Therapy are expected to consistently demonstrate the knowledge and skills required for WORKING KNOWLEDGE.
Requirements

1. Attend additional (non-core) seminars and workshops when offered.
2. Get supervision for two family or couple cases – with a minimum of 6 sessions each.
3. Observe and discuss 40 Couple/Family sessions conducted by another clinician.

MEDICAL EXPERT

Working Knowledge

1. The trainee is able to describe the history and evolution of couple or family therapy.

2. The trainee can identify the key components associated with the following specific approaches and theories:
   a. Systems (Constandine, 1986)
   b. Communication (Watzlawick et al, 1967)
   d. Psychodynamic - Classical and Object relations (Scharff et al, 1987 and 1991)
   e. Cognitive/Behavioral (Dattilio et al, 1990)
   f. Sex therapy (Singer, 1987)
   g. Psychoeducation (Falloon et al, 1981)
   h. Divorce therapy (websites)

Clinical Skills

1. During observed or supervised care of a couple or family, the trainee demonstrates the ability to:
   a. Keep redefining goals during therapy, according to its evolution,
   b. Delineate the obstacles found in the treatment with input from the participants
   c. Assess the willingness of the couple or family to continue treatment and address ambivalence
2. The trainee can provide a succinct and accurate oral summary of couple or family in therapy, including a formulation that is both theoretically informed and relates to the specific processes in therapy with that couple or family.

3. In clinical care and supervision, the trainee demonstrates the ability to use the self as a therapeutic tool, with full awareness of how the therapist uses his/her verbal and non-verbal communication, to support or modify couple or family stances as the treatment proceeds.

COMMUNICATOR

1. The trainee can establish and maintain a therapeutic alliance with each member of the therapeutic system including managing alliance ruptures with supervision.

2. The trainee allows the time required for the process of working-through and to avoid premature closure of therapeutic challenges with supervision.

3. The trainee is able to communicate to the couple/family an understanding of the issues facing them and the therapist’s understanding their etiology.

4. The trainee maintains clinical notes that meet practice standards and capture the ongoing therapeutic process, and can describe departmental and CPSO standards.

5. The trainee can receive and give feedback in supervision.

PROFESSIONAL

1. The trainee displays openness to recognizing when the therapeutic relationship becomes dysfunctional, when to refer the couple or family to another therapist, or for the therapist to seek a consultation with a colleague.

2. The trainee can identify indications for the need for supervision or consultation post-residency.

3. The trainee uses supervision to reflect upon and refine his/her own therapeutic style and is able to identify areas of strength and vulnerability in their therapeutic style.
SCHOLAR

1. The trainee can identify the evidence-based interventions available for couple and family therapy.

2. The trainees demonstrate familiarity with the literature through application of evidence and literature to case discussion and treatment planning in supervision.
Couple and Family Therapy Appendices

Appendix 1 – The Three Levels of Family Therapy Training

Whitaker et al (1981) distinguish three levels of training:
1) Learning about family therapy;
2) Learning to do family therapy, and
3) Becoming a family therapist.

The first level involves acquiring some theoretical knowledge about the method. This is achieved in the core training seminars.

The second involves residents performing Couple/Family Therapy as part of their training. The trainee is expected to be able to:
- assess couple/family structure and dynamics,
- recognize couple/family processes which generate, use and promote individual or family symptoms as defenses against anxiety.
- intervene in SOME couple/family crises.
- utilize consultation with an experienced couple/family therapist.

These objectives are achievable by giving Residents: a) theory seminars, b) the opportunity to observe a clinician doing the therapy and c) supervision of the treatment of two or three couples or families during one year.

The Psychotherapy Committee has stated that Residents can request protected time to attend Couple/Family Therapy workshops or events.

For the third level (becoming a family therapist) a Psychiatrist would have to undertake a two or three year immersion training program in the specialty. The time allotted for Couple and Family therapy in our Psychiatric Residency precludes this.
Appendix 2 – Relevant References & Readings

Bertolino B, O’Hanlon B: Collaborative, Competency-Based Counseling and Therapy. Toronto. Allyn and Bacon. 2002


WW Norton. 1996


Tomm K: Interventive interviewing. Part II: Reflective questioning as a means to enable self healing, Family Process 26: 167-184, 1987a


Websites:

http://www.camh.net/about addiction mental health/couple therapy, html
http://www. articles. flndarticles.com/p/articles/mi_mOAZV/is_2_41
http://www.psync.leeds.ac.uk/research/lftrc/index.htm
Click on Manuals: SFT&TAP

This document was originally prepared by: Charlotte Chagoya, RN, Fam Ther, Leopoldo Chagoya MD, FRCPC and Richard Sugarman MSW.

It was reviewed in 2014 by the first two, plus Jeffrey Genik, MD, FRCPC, Kalam Sutandar MD, FRCPC and Toula Kourgiantakis, MSW, RSW, RMFT
GROUP THERAPY

MEDICAL EXPERT

Knowledge

1. Ability to identify patients who are suitable for different forms of group therapy (Working Knowledge)

2. Awareness of the importance of group dynamics in therapy, educational, social and professional groups (W)

3. Appreciates therapeutic factors unique to group therapy (e.g. universality, altruism, modelling, interpersonal learning) (W)

4. Appreciates the unique elements of the specific group model being practiced (e.g. CBT, DBT, MBSR) and implements specific therapeutic interventions reflecting the unique aspects of the respective model (W)

5. Appreciates the range of group treatments and their applications in relation to particular patient diagnoses, group modalities, formats and treatment settings (Proficiency)

Skills

1. Establishes and maintains therapeutic alliance with group members (W)

2. Ability to identify cohesion (W) and to promote its development in the group setting (P)

3. Ability to identify group dynamics and group process as manifested in the group (W) and to intervene appropriately (P)

4. Ability to plan and initiate the formation of a psychotherapy group (P)

5. Ability to prepare group members for termination (P)

6. Able to manage interpersonal conflict and premature termination in the group setting (P)

7. Ability to make a choice point analysis regarding levels of intervention in the group setting (individual, interpersonal, group as a whole) (P)

8. Demonstrates ability to utilize group therapeutic factors for therapeutic benefit (P)

9. Ability to intervene differentially at different group developmental stages (P)
10. Understands and addresses individual psychopathology manifested in the group (P)

11. Ability to work effectively with a range of group treatments and utilize their applications in relation to particular patient diagnoses, group modalities, formats and treatment settings (P)

COMMUNICATOR

1. Documentation is timely, accurate and summarizes group themes with specific comments on each member’s response to the group (W)

2. Able to summarize group process, group themes and interactions in the group during supervision (W)

3. Ability to reflect upon and discuss countertransference to the various elements of group (W)

4. Understands one’s role and impact as therapist in the group (W)

5. Ability to utilize therapeutic transparency appropriately for therapeutic benefit (P)

6. Ability to work in the here-and-now and make appropriate links to patient’s past and to the clinical formulation (P)

PROFESSIONAL

1. Demonstrates consistency and reliability across all aspects of group practice (including pre and post group debriefing, co-therapy, supervision) (W)

2. Demonstrates a strong commitment to patient care (W)

3. Appreciates ethical dilemmas specific to group setting (e.g. limits of confidentiality and privacy, subgrouping, focus on group versus individual) (W) and demonstrates an ability to resolve these effectively (P)

4. Accepts and makes constructive use of supervision and feedback (W)

MANAGER

1. Ability to identify and address practical issues regarding norm and frame of treatment (W)
2. Understands and able to apply for therapeutic benefit the various leadership functions of a group therapist (executive functions, caring, emotional stimulation, meaning attribution, establishing group norms) (P)

COLLABORATOR

1. Ability to work effectively and collaboratively with the co-therapist, supervisor and other treatment providers in the circle of care (W/P)

2. Ability to resolve differences constructively at all levels (P)

3. Ability to work effectively in both a conjoint (different therapist providing group and individual treatment) and combined (same therapist for both) treatment arrangement (P)

SCHOLAR

1. Appreciates the empirical underpinnings of group psychotherapy (W) and able to apply and integrate this knowledge into the group work (P)

2. Ability to evaluate the process and outcome of treatment (including quantitative measurements) (P)

HEALTH ADVOCATE

1. Appreciates the role of group therapy in contemporary mental health care (W) and able to articulate this clearly to colleagues and patients (P)
APPENDICES
Appendix II
Appendix III

University of Toronto
Psychotherapy Documentation and Communication Guidelines

Rationale: Timely, comprehensive documentation/charting is a key skill for any psychiatrist in the face of the establishment of more rigorous standards with regards to accountability from licensing bodies (for example, the CPSO here in Ontario). Moreover, maintaining the highest documentation standards is an integral part of providing good clinical care.

Below is a brief algorithm to guide trainees in psychotherapy documentation. For more comprehensive guidelines, please refer to the CPSO guidelines (Section 3), which can also be found at: http://www.cpso.on.ca/policies/policies/default.aspx?ID=1686

Section 1: The Documentation Lifecycle

Beginning
- Register patient at your site
- Establish chart for patient that includes a comprehensive initial psychiatric consultation note (see CPSO Guidelines regarding the minimum content)
- Storage of chart /medical records must be secure and must ONLY be at the site where the patient is being seen – do NOT bring chart or any medical records pertaining to the patient home with you
- In the case of off-site psychotherapy supervision and/or where the patient cannot be registered under the psychotherapy supervisor, the resident must register the patient under their primary supervisor (or another staff) with permission at the site where they are seen. The primary supervisor should be kept up to date as to patient progress and the patient should be made aware of the arrangement. (Please see off-site supervision guidelines:


Middle
- Progress notes
  o Include:
    f Assessment/opening note
    f Progress Notes
    f Termination note
    f Photocopies of homework (if any)

  o See Section 2 for further guidance regarding progress notes
• **Process Notes**
  o from supervision need to be securely stored (NEVER at home or in your brief cases) and are not part of the chart; supervision notes should not be recorded on the patient’s chart; leave identifying data of the patient off of the process/supervision not (no full names; for example initial of first name would be acceptable); they should be shredded at the end of each rotation.

**Transitions**
• Transferring patients between sites
  o when a resident and his or her patient changes sites: chart should be closed from the site that the resident is leaving and the patient should be registered, along with a new chart being opened at the site where the patient will be subsequently seen consent must be signed for transfer/communication of information to the new site (post- form online) what is transferred?, with consent....
  • **HIGHLY RECOMMENDED** - 6 month summaries of progress, themes discussed, changes in mental status/functioning/goals, and formulation, along with a plan that documents who the supervisor was and who the supervisor will be (when known) along with the new site that the care will be delivered in; and this summary would be the only thing transferred to the new chart
  • Alternatively, all notes can be copied and transferred to the next site’s new chart

**Ending (Termination)**
• A summary note of the nature and course of the therapy including (but not limited to the following) o Progress made during therapy
  o Discharge plans, if any (e.g. referral for long-term therapy after course of CBT, marital therapy, return to GP for follow-up etc)
  o Patient’s response to termination
  o Mental status at time of termination
  o Comment on patient’s clinical status at time of termination (e.g. if being treated for MDD, if depression is in partial or full remission etc., including any relevant rating scores if relevant)
  o Send the summary discharge note to the GP or referring physician to inform them of the termination of therapy and any discharge plans

**Section 2: Progress Notes for Individual Psychotherapy**
**All notes MUST:**
• Include the date, start and stop time, patient’s name and medical record number
• Be legible, permanent, completed the same day, signed (legibly and identifiably)
• Be stored in a secure place ONLY at the site where the patient is being seen
• Document cancellations or no-shows, document telephone calls, document if the patient was
seen with anyone, document information from other sources (if any)

**Recommend use of SOAP format (however if you don’t use the SOAP format, please ensure that the following information is included in progress notes):**

- Subjective – Content that the patient reports during the session (using quotation marks and paraphrases where appropriate), (*should not be speculative or interpretive*)
- Objective – pertinent mental status (may be brief but must contain information relevant to the process of the session and the patient’s condition), must comment on presence or absence (and nature) of suicidal ideation
- Assessment – diagnosis (if any), themes, course / trajectory, response to treatment, safety concerns
- Plan – therapy (type, total number of sessions if time-limited, frequency of appts, next appt), medications (*type and dosages of all medications, specify any changes), referrals, review in supervision (include supervisor’s name)

**Forgotten or late entries, errors or omissions**
- Enter forgotten or late information at the earliest opportunity in the next available space in the chart – include the date and time the session was held AND the date the information was recorded
- Additional comments go in a separate entry – do not add to / remove from or alter a prior entry
- Corrections should still leave the erroneous information visible / retrievable

**All charts are potentially shared charts**
- Do not add to or alter someone else’s note
- Do not leave blank lines between entries

**Patient’s rights**
- Patients have the right to view their chart if they so request; however, patients must make such requests through health records
- If such a request arises it should be discussed in supervision

**E-mailing / electronic communication**
- Please see recent CMPA 2009 guidelines on using email communication with patients: [http://www4.cmpa-acpm.ca/cmpapd04/docs/resource_files infosheets/2005/pdf/com_is0586-e.pdf](http://www4.cmpa-acpm.ca/cmpapd04/docs/resource_files infosheets/2005/pdf/com_is0586-e.pdf)
- AVOID this type of communication if possible as it is difficult to guarantee secure confidentiality

**Legal risks:** There are three potential areas for liability in email communication: confidentiality, privacy and security; timeliness of responses; and clarity of communication.
- If this mode of communication is used, all identifying data must be removed
• Consider using written email consent form (sample provided by CMPA in above link)
• All documents need to be encrypted with password protection

Note that this guideline cannot cover all possible scenarios arising during the conduct of psychotherapy and any situations the resident is uncertain about can and should be discussed in supervision.

Group and multi-person documentation guidelines

Family/Couple Therapy: If the family of an identified patient is interviewed for the purpose of obtaining collateral history and information, this can be entered into the chart of the identified patient; if family therapy is the primary treatment, notes can also be entered into the chart of the identified patient; however, if couple therapy is the primary treatment, each partner should be registered as a patient, and the same note for each session should be entered (copied) into both charts (*please confer with you supervisor to comply with documentation standards at your site).

Group Treatment: Documentation of group therapy involves a lower level of confidentiality and anonymity that can be achieved in individual psychotherapy and patients should be informed of this.

The ideal standard would be to have a separate entry for each member of each group session, and in some hospital settings (i.e. where there are electronic records), this is a requirement. However, the burden of documentation in this model is such that an alternative method of documentation is sometimes used. This includes the following:

i. A notebook is kept for the group as a whole, into which is entered an attendance log noting attendance at each meeting; the nature of issues addressed in that particular group; progress or obstructions to progress; any unusual developments or difficulties emerging in that session. This book becomes a permanent record of the group treatment and should be maintained as the treatment record.

ii. At the beginning of treatment patients should be listed in this book by their name and last initial, and a hospital identifying number. Last names should not be used in this treatment record.

iii. A progress note that is relevant to each individual patient should be charted at regular intervals in each individual’s chart. It should refer to the group record. These progress notes supplement the combined group therapy record that serves as the permanent group therapy record. It is proposed that the following intervals be utilized, for groups:

16 weeks duration or less, a progress note should be charted every four weeks

16 - 40 weeks, a progress note should be charted every eight weeks
Ongoing and open-ended groups, a progress note should be charted every three months

**NOTE** that residents should consult with their group psychotherapy supervisor to receive guidance on which format of documentation should be used in the hospital setting where the group is held.

**Section 3: CPSO Guidelines for Psychotherapy Records**

Source: College of Physicians and Surgeons of Ontario
http://www cpso on ca/policies/policies/default.aspx?ID=1686
(Retrieved June 8, 2009)

**Patient Encounters where Focus is Psychotherapy**
Psychotherapy is a form of treatment for mental illness, behavioural maladaptations or other problems that are thought to be of a psychological nature or to have an emotional component. The same legal requirements apply to records maintained for psychotherapy as to other sorts of records. Maintaining records that “tell the patient’s story” is particularly crucial in the psychotherapeutic context because there may be less objective physical data upon which to base treatment plans.

The following are the minimum components of a complete psychotherapeutic record:
- History;
- Mental status;
- Diagnosis and assessment;
- Medical Health and allergies
- Current (and past) medications
- Treatment plan (medications, treatment methodology, etc.);
- Progress notes/follow-up visits (which, in the psychotherapeutic context, should include the physician’s input and also information regarding the patient’s response);
- Outcome assessment (at the end of the treatment period);
- Termination note (which describes the patient’s reaction to the conclusion of the doctor-patient relationship).

**SOAP Documentation for Psychotherapy**

The SOAP record-keeping format may be easily adapted to gather and document information obtained during psychotherapeutic sessions. The College recommends that physicians use the SOAP format but recognizes that other systems are acceptable as long as they capture all of the information stipulated above.

**Subjective**

- Initial visit: problem statement, duration, relevant background history, evolution of the problem, and present status;
Follow-up visits (progress notes): development since last visit, response to therapy.

Objective

- Exploration of the biopsychosocial axis (such as the effects of physical symptomatology on the patient’s personal life, family life, work and relationships);
- Mental status (may not be noted in a particular progress note if there is no change).

Assessment

- Diagnosis (may not be noted in a particular progress note if there is no change);
- Summation of issues/physician’s input (for example, even though the physician has been silent throughout the session he or she may record an analysis of the patient’s ongoing issue).
- Plan
  - Therapeutic goals/plans;
  - Types of psychotherapeutic approaches/models; for example, psycho-dynamic (insight oriented), behavioural modification, cognitive therapy (whether supportive or instructional);
  - Medications;
  - Referral details.
### Appendix IV

**PSYCHOThERAPY SUPERVISION OFFERED WITHIN THE TEACHING HOSPITAL SETTING (As of September 2013)**

**Off site supervision is available when there is no available supervisor in a specific modality; however approval must be obtained by the psychotherapy site coordinator, the hospital site coordinator,** and the Psychotherapy Program.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Site/Coordinator</th>
<th>Dynamic Psychotherapy (Long Term &amp;/or Child)</th>
<th>CBT</th>
<th>IPT</th>
<th>Group Therapy</th>
<th>Brief Psychodynamic</th>
<th>Integrative/Supportive</th>
<th>Couple/Family</th>
<th>DBT</th>
<th>Child Psychotherapy (<strong>child &amp;/or adolescent sites</strong>)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baycrest - Dr. Michael O'Mahony 416-505-8501 x6999 <a href="mailto:o_mahony@baycrest.org">o_mahony@baycrest.org</a></td>
<td>M. O'Mahony</td>
<td>R. Madan; David Mynard</td>
<td>R. Madan</td>
<td>K. Schwartz; R. Madan</td>
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<td>CAMH - Dr. Jan Malat 416-505-8501 x6999 <a href="mailto:jn_malat@camh.net">jn_malat@camh.net</a></td>
<td>F. Ali; H. Brod; M. Byrne (Queen); D. Doreenbaum; J. Farewell; M. Felger; D. Futerman; B. Gilbert; D. Greben; J. Halpern; J. Malat (Queen); P. Stevent (Queen); G. Voineskos; P. Voore (Queen); G. Warme; J. Wiener</td>
<td>Danielle Bourdeau (am); Mark Felger; John Klukach (psychosis); Chloe Leon; Psychologist; Donna Ferguson; Nikki Fitzgerald</td>
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<td>George Hull - Dr. Greg Lodenique GLodenquai <a href="mailto:Georgehull@nr.gov.ca">Georgehull@nr.gov.ca</a></td>
<td>G. Lodenique; T. Armstrong; Senior Multidisciplinary staff</td>
<td>Senior multidisciplinary staff</td>
<td>T. Armstrong; Senior multidisciplinary staff</td>
<td>Greg Lodenique; Taylor Armstrong; Chetana Kulikarny</td>
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<td>Reem Abdul Qadir</td>
<td>T. Armstrong; G. Lodenique; C. Kulikarny</td>
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<td>Heath &amp; DeCicco - Dr. Diane Philip 416-922-1903 x3330 <a href="mailto:dphilip@heathdecicco.org">dphilip@heathdecicco.org</a></td>
<td>M. Krenitsen (adolescent therapy); T. Zehr; Janice Lawford (TF-CBT)</td>
<td>T. Zehr; Janice Lawford (TF-CBT)</td>
<td>E. Katz; Ellen Levine; Helen O’Hair; Jaspal Tulsidas; Christie Hayes</td>
<td>M. Krenitsen</td>
<td>Diane Philip; Susan Dudais</td>
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<td>H. O’Hair; Janine Lawford; Christie Hayes; Ellen Katz; Diane Philip; Erica Watson; Therese Zehr; Susan Yabaleby (infant preschool); Arla Gans; Kevin Gabel; Tanya Peter; Dr. Philip; Debra Stein</td>
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<td>HSC - Dr. Nicola Keyhan 416-813-6180 <a href="mailto:Nicola.keyhan@sickkids.ca">Nicola.keyhan@sickkids.ca</a></td>
<td>J. Wittenberg; H. Golubek; M. Hanson</td>
<td>ChildAdolescent</td>
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<td>J. Wittenberg; H. Golubek</td>
<td>Richard Sugerman; Abel Ickowicz</td>
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<td>MSH - Dr. Paula Ravitz 416-505-8501 x7500 <a href="mailto:pravitz@trentai.on.ca">pravitz@trentai.on.ca</a></td>
<td>L. Chagnay; C. Dunbar; J. Halpern; S. Horodiskey; R. Kay; P. Keeve; C. Pain; R. Kan; J. Sadavoy; M. Shaw; E. Keyhan; T. Tug</td>
<td>J. Peck; Greg Chandler</td>
<td>P. Rawitz; S. Light (JPT &amp; CBASP); P. Westland; E. Mckranna</td>
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<td>NYGH - Dr. Victor Feder 416-635-2421 <a href="mailto:victor.feder@nygh.on.ca">victor.feder@nygh.on.ca</a></td>
<td>Victor Feder; Saul Marks; D. Natson; Mike Paquet; B. Stein; Ian Weinroth; L. Tug</td>
<td>N. Levitsky (adults)</td>
<td>Bob Stein (adolescents)</td>
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<td>Ontario Shores - Dr. Tim Gofine 905-686-5881 ext. 6641 <a href="mailto:tgofine@ontarioshores.ca">tgofine@ontarioshores.ca</a></td>
<td>Dr. Tim Gofine</td>
<td>Robyn Wazman (group only)</td>
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