MUHC Cognitive Behavioural Therapy Fellowship
February 15, 2016
General Information
Name of Institution: McGill University Health Centre
Location: RVH site
Type of Fellowship: Clinical or Combined Clinical Research Fellowship in Cognitive Behavioural Therapy (CBT)
Program Information (see attached):
• Number of fellowship positions: - max 2 concurrently
• Academic affiliation: McGill University
• Name of hospitals involved in training
McGill University Health Centre – RVH Site
% time spent by the fellow in each institution
MUHC - RVH site – 100% at present
• **Background**
• **Research activity**
- areas of research –suitability for short-term CBT; single case psychotherapy process research; attachment & CBT; cost-effectiveness of CBT; computerized CBT; Virtual Reality Exposure Therapy;
• Selected **Publications**

Villemaire-Krajden,R*., Myhr,G. Evaluating the use of a computerized CBT program for outpatients on a waitlist in a university CBT Unit. Journal of Psychiatric Practice. 2019;25;268–278. DOI: 10.1097/PRA.0000000000000396
Lis, E., Myhr, G. The Effect of Borderline Personality Pathology on Outcome of Cognitive Behavior Therapy. Journal of Psychiatric Practice. 2016; 22:270–282, DOI: 10.1097/PRA.0000000000000167
Bédard M, Russell JJ, Myhr G. Impact of personality psychopathology on outcome in short-term cognitive-behavioral therapy for Axis I disorders. Psychiatry Res. 2015; 230(2):524-30.
Renaud, J., Russell, J.J., Myhr,G. Predicting who benefits most from cognitivebehavioral therapy for anxiety and depression. Journal of Clinical Psychology. 2014; 70(10), 924–932.
Renaud, J., Russell, J.J., Myhr,G. The association between outcome expectancies and avoidance in predicting the outcome of cognitive-behavioural therapy for major depressive disorder. British Journal of Clinical Psychology. 2013; 42-52. DOI:10.1111/j.2044-8260.2012.02044.x. Epub 2012 Aug 13. PMID: 23398111
Myhr, G., Russell, J.J., Saint-Laurent, M., Tagalakis, V., Belisle, D., Khodary, F.,Faridi, K., Pinard, G. Assessing Suitability for Short-Term Cognitive Behavioral Therapy in Psychiatric Outpatients with Psychosis: A Comparison with Depressed and Anxious Outpatients. Journal of Psychiatric Practice. 2013; 29-41.
Payne K., Myhr, G. Increasing Access to Cognitive-Behavioural Therapy (CBT) for the Treatment of Mental Illness in Canada: A Research Framework and Call for Action. Health Care Policy. 2010; 5:e173-e185. PMID: 21286263

Myhr, G., Talbot, J., Annable, L., & Pinard, G. Suitability for short-term cognitivebehavioral therapy. Journal of Cognitive Psychotherapy. 2007; 21, 334-345.
Myhr, G., Payne K. Cost-effectiveness of cognitive-behavioural therapy for mental disorders: implications for public healthcare funding policy in Canada. Canadian Journal of Psychiatry. 2006; 51:662-670. PMID: 17052034

• **Mission**

While CBT is one of the most effective, and cost-effective , evidence-based psychological interventions in the treatment of mental disorders, its availability is limited. Furthermore, as psychiatry residents are clamoring for training, the availability of expert supervision is also scarce. This primarily clinical fellowship is designed to increase the number of expert practitioners and supervisors of CBT, who will then be expected to practice and train future mental health professionals, including psychiatry residents and interns. This fellowship is intended to train the candidate to a high level of expertise in the clinical administration and supervision of CBT. The fellow may specialize in a clinical area (e.g. psychotic disorders, mood disorders, anxiety disorders, Cognitive Behavioural Analysis System of Psychotherapy (CBASP) for chronic depression), but should be able to conduct CBT for a wide range of disorders. All fellows are expected to contribute to the academic life of the Unit, and be involved in the clinical research activities of the Unit. Original thinking and initiation of pertinent clinical research projects are encouraged.

• Outline how intended fellowship will enhance residency training
(see previous paragraph)

Name of the Fellowship Program Director

Gail Myhr, MD, CM, MSc, FRCPC

Names of the Teaching Faculty & Roles

Gail Myhr, psychiatrist, Director MUHC CBT Unit, coordinator of didactic teaching, seminar series lecturer, clinical supervisor, research supervisor,
Marie Saint Laurent, psychiatrist, seminar series lecturer, clinical supervisor
Kia Faridi, psychiatrist, seminar series lecturer, clinical supervisor
Vicky Tagalakis, psychologist, seminar series lecturer, clinical supervisor
Jennifer Russell, psychologist, seminar series lecturer, research consultant

o Summary of clinical practice

The MUHC CBT Unit receives referrals for short-term CBT from the community as well as secondary and tertiary care centers. A wide range of disorders are treated including psychotic, mood, anxiety and impulse control disorders, with or without underlying Axis II traits.

o Major Strengths

Clinical:The number of referred cases is plentiful. The cases are assessed for suitability, and only those considered suitable for short-term CBT are accepted for therapy, thus guaranteeing that the trainees are given cases which can be helped with the modality

being taught. The turnover ensures that the trainee will have experience in a number of cases and diagnoses through-out the year. A recent innovation is the addition of Virtual Reality Exposure therapy to the skills being taught.

Teaching: Trainees tape all clinical sessions, so that supervision is based on direct observation of the trainees' clinical interventions with their patients. Supervision is one-to one, and may also include group supervision in addition, depending on the number of trainees and common interests. Standardized rating scales are used to assess the fellow's competency, both clinical and in the case formulation. The experience of the fellow has been designed to prepare him or her for accreditation by the Academy of Cognitive Therapy (USA) or the Canadian Association of Cognitive and Behavioural Therapies (CACBT) which can be applied for after a year of working in CBT.

Evaluation: Fellows are observed directly in their clinical sessions and assessments. Their case formulations are rated, as are their therapy sessions, using accepted rating scales. Often, this is the most intense direct observation that they have received in their training, and is invaluable in teaching them therapy skills and their interpersonal impact on patients.

Research: The Unit is set-up to do clinical research with pre and post test measures done on all patients, as part of the ongoing suitability study. The Suitability database can be used to answer research questions of interest in our real world, heterogenous sample of patients. A recent RCT involved waitlist participants randomized to computerized CBT vs an online workbook. Currently, Virtual Reality Exposure therapy is being evaluated to compare its effectiveness compared to tradition exposure techniques.

Academic Facilities

All fellows will have a computer, as well as audiovisual equipment to digitally record their clinical sessions for supervision purposes. Virtual reality equipment is available for clinical use of selected cases. Fellows have access to McGill libraries, as well as the Allan Memorial Institute's psychiatric library. There is also a collection of specialized CBT books, videotapes and DVDs in our private offices, which are lent out to facilitate learning. All fellows participate in the seminar series, and thus have electronicaccess to the 700 pages of pertinent articles and handouts, available through Dropbox.

Fellow Duties and Responsibilities

The fellow is only responsible for his/her own patients. There are no on-call duties during the fellowship year. While the fellow is not expected to supervise residents or students, h/she can begin to be involved in group supervision of residents in the second half of the year, depending on the fellow's own clinical progress and interest. If he/she is particularly advanced, then the fellow may be called upon to share clinical, teaching or research experience with the residents.

The fellow is expected to be plan and administer short-term CBT for his/her own patients in treatment (usually about 12 at a time, about 24-30 over the whole year). S/He must attend the weekly assessment clinic and the weekly seminar series. S/He will do intake assessments with the staff in alternance with other trainees (usually once in 3-4 weeks) and do the required case write-ups. The fellow must attend all teaching activities, all new assessments and participate in the research of the Unit. All of the fellow's cases must follow the patient trajectory set down by the Unit, and follow-up testing must be assured. See below for details. Academic activities include:

1. Cognitive behavioural assessment clinic (CBAC) Tues 2-4
2. CBT Seminar Series Thurs 2-3:30
3. Weekly supervision – about 3 hrs weekly (individual, +/- group)

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4. CBT Journal Club –every second Tuesday, 1-2
5. Other academic activities – OPD Rounds Tues 12-1; Grand Rounds 11-12:30; Any resident teaching of interest (e.g. pertinent diploma courses etc.)

Support staff available to the fellow:

Full time MUHC CBT Unit coordinator.

Part time MUHC CBT Unit Research Coordinator

Fellow must have one publication ready by the end of the fellowship year. If not an original research project, then a pertinent review of an area of interest.

Curriculum:

Case load:

Full time – 12 cases concurrently. Usually 24-30 in a year. The average length of treatment of resident cases is under 20 sessions, though cases with co-morbidity or underlying personality disorders may take longer. The usual distribution of cases in the CBT Unit is 60% anxiety disorders, 25% mood disorders, and the rest psychotic disorders and other disorders. The fellow may, for example, plan to increase his/her expertise in psychotic disorders, in which case up to a half of cases can entail work with this population.

Required: as below

CBT CLINICAL FELLOWSHIPS
McGill University Health Centre CBT Unit
Faculty and Professional Associates

Gail Myhr MD,CM, MSc, psychiatrist, Unit director
Marie Saint Laurent, MD,psychiatrist
Vicki Tagalakis, MA psychologist
Kia Faridi, MD psychiatrist
Jennifer Russell PhD, psychologist, research consultant
Florianna Ianni MD, psychiatrist, Jewish General Hospital site
Zoe Thomas MD, psychiatrist, Jewish General Hospital site
Daniel Kunin PhD, psychologist, Lakeshore General Hospital

General Objective

By the end of training, the trainee should be able to competently and independently conduct cognitive behavioural therapy for a range of mental disorders. The successful fellow will be eligible for accreditation by the Academy of Cognitive Therapy (ACT), or the Canadian Association of Cognitive and Behavioural Therapies (CACBT). While a clinical fellowship focuses on acquiring a high level of CBT expertise, fellows are also expected to participate in the clinical research of the Unit, and produce an academic paper.

Specific Objectives

1. Knowledge:

Learn the basic theoretical cognitive behavioural framework including: the Rationalists (Ellis, Beck), the Schema-focused and Developmental Schools (Young, Guidano Liotti, Mahoney), the Constructivists (Leahy, Mahoney, Neimeyer), and Third Wave mindfulness based cognitive therapy (Segal).
Learn the indications for CBT in the treatment of mental disorders.
Know the techniques of treatment for various Axis I disorders, including anxiety, mood and psychotic disorders, as well as Axis II disorders (Dialectic Behavior Therapy, Schema-focussed CBT).
Learn applications of CBT for special populations (eating disorders, addictions, adolescents, children etc.).
Know the CBT approaches in special circumstances – resistance, therapeutic ruptures, suicidality.

2. Skills:

Be able to do a cognitive behavioural assessment, and assess suitability for CBT.
Be able to set goals and plan treatment based on individualized CBT formulations.
Be able to educate the patient about the CBT model and therapy interventions.

Be able to use Socratic dialogue, thought records and other structured cognitive strategies in guided discovery of dysfunctional beliefs.
Be able to use behavioural techniques such as activity scheduling, exposure and response prevention, and graded task assignment appropriately.
Be able to utilize relaxation techniques, skills training and motivational interviewing when indicated.
Be familiar with virtual reality exposure method.
Can utilize relapse prevention methods.

3. Attitudes:

Be empathic, open-minded and non-judgemental for the suffering and dilemmas brought by patients.
Be aware of one's own contribution to the therapeutic process, and develop the ability to

recognise and deal with strains in the therapeutic alliance.
Develop scientific curiosity about the process of psychotherapy.

Methods

1. Seminar series:

The CBT Seminar Series is a 6 month series, given twice a year, which covers the basics of CBT for the treatment of mental disorders. It is on Thursday afternoons from 2:00 to 3:30, in the South Seminar Amphitheatre, ground floor, Allan Memorial Institute. The presentations typically consist of 40-50 minutes of didactic presentation, with the rest of time spent in interactive activities such as role plays, demonstrations and experiential exercises. There is one clinically-oriented article for each topic, which participants are expected to read prior to the presentation. All trainees must have attended the series in its entirety to be eligible for clinical supervision (See attached schedule and list of readings.)

2. Cognitive Behavioural Assessment Clinic (CBAC):

The Cognitive Behavioural Assessment Clinic is on Tuesday afternoons from 2:00 to 4:00, in the Day Hospital mirror room. The specific learning objectives of this Clinic are:

1. Know the indications for short term CBT
2. Recognize predictors of outcome
3. Assess and judge a patient's suitability for short term CBT
4. Formulate an understanding of the patient's problem in cognitive-behavioural terms
5. Use the formulation to plan treatment and predict likely obstacles
6. Suggest measures to assess severity of pathology and monitor progress with treatment (i.e. think about clinical problems and treatment with "empirical" interest)

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Intake evaluations are done by trainees, accompanied by a staff, while the rest of the team observes through a one-way mirror. The suitability of the patient for therapy is then discussed with other members of the team and appropriate empirical measures are used to refine decision making. Trainees must be familiar with Safran et al's article, Patient Selection for Short-term Cognitive Therapy (1990), and the accompanying "Suitability for Short-Term Cognitive Therapy Rating Form." which is filled out for all new referred patients.

3. Direct Clinical Supervision:

Fellows will treat approximately 10-12 cases concurrently from the CBT Unit list of referred patients, under direct clinical supervision, resulting in a total of 20-30 cases over the year. These cases will have been screened by the CBAC clinic, and deemed suitable for short-term CBT. Fellows are encouraged to treat a mix of diagnoses, including OCD, other anxiety disorders, mood disorders and psychotic disorders. Fellows with a full clinical load with receive 3 hours of supervision weekly.

All therapy sessions of trainees are videotaped and used as a basis for direct clinical supervision. Supervision hours will be structured, not unlike therapy sessions. Trainees are expected to bring their videotapes to supervision, set an agenda for the supervision, and, for each therapy session to be discussed, to briefly summarize (5 minutes):

- the agenda
- main points covered
- CBT techniques utilized
- homework given, with an explanation of its link to session goals
- the question arising from the session to be discussed in supervision

Supervisors will independently view two session tapes in their entirety during each six

months: the first after 2-3 months of training, and again towards the end. These sessions will be rated using the Cognitive Therapy Scale (Young and Beck 1990).
For each patient, trainees must complete their **cognitive conceptualization worksheets** (usually after 3-4 sessions), and supply a copy to the supervisor for use a roadmap in therapy, and as a way to understand therapeutic process and progress. The trainee must also complete a more elaborated **case formulation** in the style of the Academy of Cognitive Therapy (sample provided) for at least one of their patients, for the supervisor to mark.

4. Readings:

Mandatory:

1. All seminar articles.
2. Safran JD, Segal ZV, Shaw BF, Vallis TM. Patient selection for short-term cognitive therapy. In: Safran JD, Segal ZV, editors. Interpersonal process in cognitive therapy. New York: Basic Books; 1990.

and one of the following two basic texts:

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3. Beck JS. Cognitive therapy: Basics and beyond. New York: The Guilford Press, 1995.
4. Wright J, Basco MR, Thase ME. Basis principles of cognitive-behavior therapy. Learning cognitive-behavior therapy. Washington,DC: American Psychiatric Publishing, Inc; 2006 p1-26.

Recommended:

Beck AT, Rush AJ, Shaw B, Emery G. Cognitive therapy of depression. New York: The Guilford Press, 1979.

Kingdon DG, Turkington D. Cognitive therapy of schizophrenia. New York: The Guilford Press, 2005.

Leahy RL, Holland SJ, McGinn LK. Treatment plans and interventions for depression and anxiety disorders. 2nd Edition. New York: Guilford Press, 2012

Padesky CA, Greenberger D. A clinician's guide to mind over mood. New York: Guilford, 1995.

Persons JB. The Case Formulation Approach to Cognitive-Behavior Therapy. New York, NY: Guilford; 2008.

Zayfert, C. & Becker, C. B. Cognitive-Behavioral Therapy for PTSD: A Case Formulation Approach. New York: Guilford, 2007

Evaluation

Interviewing and assessment skills are observed and evaluated during weekly group CBAC assessments.

Psychotherapy skills are assessed by individual psychotherapy supervisors during each supervision session. A minimum of 2 tapes per 6 month period are rated in their entirety, using the Cognitive Therapy Scale (Young and Beck, 1980). To be considered competent, the fellow must achieve at score of at least 40 on of his/her sessions, before the end of the rotation.

Fellows are expected to fill out case conceptualization worksheets on all patients. A more elaborated **case formulation** in the style of the Academy of Cognitive Therapy (sample provided) for at least one patient will be marked by the supervisor using the Cognitive Formulation Rating Scale. A minimum score of 20/24 is required. The exercise will be repeated until this competency is achieved.

Evaluation is ongoing. Each 6 months, an evaluation of the fellow's progress individual learning goals, and Unit resources will determine the length of training. Supervisors meet on a bi-weekly basis to discuss observations. Global evaluations reflect composite of psychotherapy and academic skills, knowledge base, and participation in all aspects of training. Formal education credits are given through

the McGill Faculty of Medicine, for the exact number of hours of didactic teaching (seminar attendance) and the number of hours of CBT supervision completed. Record of these hours may be used in future should the trainee decide to continue practicing CBT and later apply for accreditation by ACT or CACBT. For psychiatrists in training, the training is an accredited learning activity (Section I) as defined by the Maintenance of Certification program of the Royal College of Physicians and Surgeons of Canada.