CENTRE FOR
INTERPERSONAL RELATIONSHIPS

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DOCTORAL CLINICAL PSYCHOLOGY RESIDENCY PROGRAM: BROCHURE 2026-2027

Ottawa, Toronto, &. St. Catharines

Updated: August 2025

CFIR DOCTORAL PSYCHOLOGY RESIDENCY PROGRAM

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THE RESIDENCY PROGRAM AT
THE CENTRE FOR INTERPERSONAL RELATIONSHIPS

2026-2027 Academic Year

Director of Training: Dr. Marc Bedard, C. Psych.

THE CENTRE FOR INTERPERSONAL RELATIONSHIPS (CFIR) & CLINICAL COMMITTEE VALUES

The Centre for Interpersonal Relationships (CFIR) is a private organization that facilitates the provision of psychological assessment and treatment services (within multiple treatment services and assessment services) to children, adolescents, adults, couples, and families within Ottawa, Toronto, and St. Catharine's, Canada locations. Clinical services occurring at CFIR are provided by members of the College of Psychologists and Behaviour Analysts of Ontario (CPBAO), including Registered Psychologists, Registered Psychological Associates, and Psychologists in Supervised Practice.

Clinicians at CFIR provide evidence-based, psychological assessment and treatment services. They value working from multiple therapeutic modalities for the purpose of supporting a diverse group of clients with a wide range of concerns, disorders, and therapeutic goals. When appropriate, they integrate various evidence-based therapies on the basis of individualized case conceptualizations and individualized treatment plans. Psychologists within CFIR provide training to support other clinicians in the endevour of integrating empirically-supported treatment approaches when appropriate.

CFIR has a vibrant and rich professional culture that facilitates residents to become involved in numerous opportunities to engage in discourse and critical thinking about current scientific-clinical research, clinical theories, and the integration of treatment models in everyday clinical and private practice. Clinicians at CFIR value developing, on an ongoing basis, a wide breadth of knowledge about different therapeutic discourses, including Psychodynamic/Psychoanalytic/Attachment, Cognitive-Behavioural Therapy (CBT), Dialectical Behavioural Therapy (DBT), Acceptance and Commitment Therapy (ACT), Mindfulness-Based Therapies (e.g., MBCT), Emotion-Focused (EFT)/ Experiential/Person-Centered and Narrative/Post-Modern approaches. Residency supervisors offer residents opportunities to learn various therapeutic approaches and a unique model for psychotherapy integration.

For further information about the treatment and assessment services within CFIR, please visit www.cfir.ca.

The psychologists that comprise the Clinical Committee at CFIR have set out the following guiding values that inform the residency program:

Our professional practice is guided by the ethics, standards, and regulations set out by the College of Psychologists and Behaviour Analysts of Ontario, College of Registered Psychotherapists of Ontario, Ontario College of Social Workers and Social Service Workers and relevant provincial and federal laws.

The clinical practice of psychology (assessment, diagnosis, and psychotherapy) is most effective when guided by leading edge, scientifically-based knowledge. We are committed to adhering to best practices in psychological assessment and treatment.

Psychological services are most relevant when customized to meet the individual concerns, needs, and cultural differences of clients. Clinicians work collaboratively with clients to achieve their goals and offer a variety of treatment modalities within an integrative framework.

Confidential, compassionate, caring services and authentic engagement in-session is important to support clients in building a more secure, resilient self, and in strengthening their relationships.

Offering affordable assessment and treatment options increases accessibility to psychological services in the community.

A resilient, authentic self and healthy relationships are the cornerstones of optimal well-being in everyday life.

RESIDENCY

We are pleased to offer a total of four full-time (40 hours per week, with approximately 20 hours face-to-face client contact per week) residency positions across all CFIR locations (Ottawa, Toronto, St. Catharines) during the 2026-2027 academic year.

Training within a bilingual capacity is offered at all sites. Please note that remote opportunities are not available for this academic year.

The residency program will be of particular interest to applicants who are bound for careers in clinical practice, specifically within a private practice context. Emphasis is placed on training in integrative therapy, and developing a strong foundational understanding of psychodynamic, experiential, and relational theories to inform case conceptualization and individualized treatment planning. Notably, the residency also offers a rare opportunity to receive training and clinical experience in couples therapy and sex therapy, and their intersection.

Residents at CFIR are assigned to one of two residency tracks based on their clinical interests/training goals (i.e., 1. Adult; 2. Couples & Sex Therapy), each of which consists of one major treatment rotation and one major assessment rotation over approximately 3 days/week. Residents can also select one minor rotation (approximately 1 day/week), or two minor rotations (0.5 day/week each) within or outside of their major track. Residents also co-supervise a master's or doctoral-level psychology student, and complete a program evaluation project.

The residency runs from September 1 to August 31 annually, with 15 vacation days, 9 statutory holidays, and 5 professional development days (e.g., time off to attend conferences), as per the CFIR vacation policy. Residents do not receive supplemental health benefits.

The salary for the residency in 2026-2027 is $42,500 CDN/year, which is paid bi-weekly.

Given the private practice setting of the residency program, residents are asked to hold 4-6 weekly client contact hours across two weekday evenings. Additionally, during the first 3 months

of the program, residents complete 3-6 hours within Intake and the Virtual Clinic as part of their direct client contact hours. These measures address needs unique to a private practice setting, help to build resident caseloads, and provide insight into intake processes relevant to the program evaluation project. As resident caseloads build, hours in Intake and the Virtual Clinic are reduced.

Virtual Clinic: The Virtual Clinic is a web-platform that simplifies the client booking process. It provides clients the autonomy to select a clinician, along with the possibility to meet with that clinician on the same day that the booking is made. The Virtual Clinic is designed to reduce barriers in accessing therapy, and to increase capacity to reach under-serviced regions.

PHILOSOPHY OF RESIDENCY TRAINING

The residency program provides clinical training in the context of a scientist-practitioner model. Residents are expected to think critically about the clinical services they offer and make clinical decisions that are empirically-informed. This involves the use of evidence-based treatments, clinical research, and assessments, including information gathered from empirically-driven, comprehensive assessments of all clients.

Consistent with this philosophy, the residency program at CFIR is designed to provide training in the six general domains of:

1) Knowledge of psychological theories and clinical research;
2) Therapeutic interventions and their integration;
3) Clinical assessment and testing skills;
4) Clinical supervision;
5) Ethics and professional practice; and,
6) Program evaluation.

PSYCHOLOGISTS AT CFIR

At the present time, there are over 20 psychologists practicing within CFIR. Psychologists at CFIR have been trained extensively in multiple treatment modalities, including: Acceptance and Commitment Therapy (ACT); Cognitive-Behavioural Therapy (CBT); Dialectical Behavioural Therapy (DBT); Emotion-Focused Therapy (EFT); Mindfulness-based Therapies (e.g., MBCT); Psychodynamic/ Psychoanalytic/Attachment therapies; and Systemic Therapy. Many of these psychologists also hold, or have held, positions in major Ottawa and Toronto teaching hospitals (e.g., the Royal Ottawa Mental Health Centre, the Ottawa Hospital, the Centre for Addiction and Mental Health [CAMH], etc.), on Family Health Teams (FHTs), and hold clinical professor or professor statuses at Ontario Universities (e.g., Carleton University, the University of Ottawa, Université du Québec en Outaouais, the Ontario Institute for Studies in Education/University of Toronto). Psychologists at CFIR often have active, ongoing involvement in research and are published authors in peer-reviewed journals. They are actively involved in providing clinical training/supervision to Master's and Doctoral students within and outside of the Centre both in Ottawa and Toronto. In this regard, CFIR is currently a recognized practicum site for students from at least fifteen post-secondary institutions, including Adler School of Professional Psychology, Adler University, Fielding University, McGill University, Medaille College (United States), Ontario Institute for Studies in Education/University of Toronto, Toronto Metropolitan University, Saint-Paul University, University of Guelph, University of Ottawa, Université du Québec en Outaouais, University of Waterloo, Uppsala University (Sweden), York University, and Yorkville University.

Residency supervisors, including their clinical interests and areas of competency, are listed toward the end of this residency manual.

SUPERVISION AND EDUCATIONAL EXPERIENCES

Residents receive intensive supervision and educational experiences during the residency program. Notably, they receive a minimum of:

- 3 hours per week of individual supervision
- 1 hour per week of group supervision and,
- 2 hours of clinical seminar meetings in a group format per week.

Supervision in the residency includes the following activities, depending on the resident rotations: case reviews; live observation of testing/feedback or intervention sessions; audio/video review of sessions; individual supervision; review of written material; and role plays. Supervision involves discussion of cases, support for residents to develop competence in intervention and assessment, as well as addresses professional development more broadly.

Additional supervision and consultation opportunities available to residents include:

- Bi-weekly CBT Clinic group consultation-supervision
- Bi-weekly CFIR-CPRI group consultation-supervision (French-English)
- Monthly Integrative Adult Therapy group consultation-supervision
- Monthly Couples and Sex Therapy group consultation-supervision
- Monthly Trauma Clinic group consultation-supervision
- Monthly Neurodivergence Clinic group consultation-supervision
- Weekly individual consultations for the use of assessment measures to support case conceptualization and treatment planning
- Consultations available for professional identity and career development with a Director
- Consultations available with the diverse fold of mental health clinicians at CFIR, including psychotherapists.

There are a wide variety of educational experiences available to residents within CFIR. A general orientation to the residency and training in key considerations in the integration of psychotherapies takes place at the beginning of the year. Bi-annually, CFIR hosts weekend training workshops for our psychologists, psychotherapists, residents, and practicum students. Residents are also encouraged to take advantage of a wide variety of other professional development activities including lectures, workshops, seminars, and professional conferences.

Clinical Seminar Series

The Clinical Seminar Series provides doctoral psychology residents an opportunity to learn about the present-day, mainstream theoretical approaches to psychopathology, applied interventions within these schools, and how to consider person, personality, and individual differences, culture, and race/ethnicity in treatment and assessment. A framework to consider the integration of treatments and an integrative conceptualization of disorders is also proffered. Clinical case discussions and experiential role-plays are used when appropriate to support learning of clinical theory and application.

Furthermore, the Clinical Seminar Series covers topics related to ethics, jurisprudence and professional standards; private practice; self-care; and professional identity development and licensure processes.

TRAINING RESOURCES

CFIR-Ottawa, CFIR-Toronto, and CFIR-St. Catharines are facilities equipped with 15, 12, and 5 offices, respectively, large staff rooms, test storage/test scoring rooms, administrative offices, and reception desks.

As part of their assessment rotations, residents at all Centre locations have access to state-of-the-art testing/assessment tools, including psychoeducational, psychodiagnostic, personality, neuropsychological, and Autism-spectrum assessment tools, and a vast library of paper testing protocols and online test protocols. Residents also have access to computerized test scoring programs and have administrative support with respect to testing kits and protocol usage.

Residents also have access to the staff room, which consists of couches for relaxing and socializing with psychologists, therapists, and practicum students, a kitchen, and a large television. Large meetings, case conferences, and consultation groups are held in the staff room and residents are welcome to attend these meetings.

With exception to St. Catharines, each Centre has 2-3 administrative staff supporting psychologists and residents Mondays through Fridays from 7:45am to 6:00pm. Administrative staff supports residents in scheduling and re-scheduling clinical sessions, preparing and filing clinical files and invoices, and with other administrative duties (e.g., photocopying, etc.).

RESIDENCY EVALUATIONS

Residents receive and review with their supervisors their residency evaluation forms at the onset of the residency. Residents and supervisors are expected to review resident performance, informally during supervision, on an ongoing basis. In addition, residents then receive a formal, written evaluation of their performance at the mid-point (6th month) and end (12th month) of the residency year. Evaluations are completed with the resident and rotation supervisor, and are then sent to the Director of Training (DoT) for a final review. The DoT stores the evaluation in the resident's file, and also forwards copies of evaluations to the resident's university program's Director of Clinical Training (DCT).

MINIMAL STANDARDS FOR THE SUCCESSFUL COMPLETION OF THE RESIDENCY

Successful completion of the residency requires that residents complete two major rotations and one minor rotation to the satisfaction of the DoT. Specific requirements of each rotation are reviewed with the resident at the beginning of residency year as part of the creation of the supervision contract. At the end of the residency year, residents are expected to be able to competently and independently provide psychological services including assessment, diagnosis, and the provision of evidence-based psychotherapy and demonstrate proficiency in the integration of different therapeutic models based on client presenting concerns, goals, and individual differences. Residents are also expected to have advanced their knowledge of ethics and professional standards and further developed in their roles as professionals in the field of psychology. They are also expected to have supervised a master's level practicum student, and have completed a program evaluation project.

REMEDIATION PROCEDURES: DUE PROCESS, GRIEVANCE & RELATED POLICIES

The Residency Due Process Policy provides a framework and a process to ensure that any and all decisions made with respect to residents by the residency (i.e., decisions made by supervisors, the DoTs, etc.) are fair and not biased or arbitrary. The residency's DoT is responsible for ensuring the implementation and documentation of all due process-related processes.

Rights and Responsibilities

These procedures protect the rights of both the resident and the residency program; each has specific responsibilities in executing due process.

Residents: The resident has the right to be afforded every reasonable opportunity to remediate problems. Due Process procedures are not intended to be punitive; rather, they are meant as a structured opportunity for a resident to receive support and assistance to remediate concerns and successfully complete the residency program. The resident has the right to be treated in a manner that is respectful, professional, and ethical. The resident has the right to participate in the Due Process procedures by having their viewpoint heard at each step in the process. The resident has the right to appeal decisions with which they disagree, within the limits of this policy. The responsibilities of the resident include engaging with the residency program in a manner that is respectful, professional, and ethical; making every reasonable attempt to remediate behavioural and competency concerns; and striving to meet the aims and objectives of the program.

Doctoral Residency Program: The residency program has the right to implement these Due Process procedures when called for as described below. The residency program and its staff have the right to be treated in a manner that is respectful, professional, and ethical. The residency program has a right to make decisions related to remediation for a resident– including probation, suspension, and termination–within the limits of this policy. The responsibilities of the program include engaging with the resident in a manner that is respectful, professional, and ethical; making every reasonable attempt to support residents to the remediation of behavioural and competency concerns; and supporting residents to the extent possible in successfully completing the program.

Elements of Due Process

1) During group orientation meetings within the first week of the residency, the DoT presents (orally and in written format) to incoming residents the residency's standards and expectations with respect to professional, ethical, and behavioural functioning by residents and residency-related clinicians. *Problematic behaviour* is clearly defined (see below for definition), and residents are encouraged to discuss these expectations and definitions with the DoT and their supervisors.

2) During the residency orientation period, the DoT discusses with residents the process of resident evaluation, including how, when, and by whom evaluations are completed and also the content of the evaluations. Residents are then provided with written copies of the evaluation

form for review and are encouraged to review the evaluation form with their supervisors during the first week of residency. Supervisors are informed about the same prior to the onset of the residency year, and have knowledge and training in use of the evaluation forms and the evaluation process.

3) During the residency orientation period, the DoT explains and outlines the various processes, procedures, and actions that may be involved in managing and remedying problematic behaviour (e.g., assistance plans, remediation plans, termination, etc.). Residents are provided with these policies in written form during orientation week and encouraged to review them independently and with their supervisor.

4) The DoT, in collaboration with supervisors, the resident, and the CFIR Centre Director (when required) develops, modifies, and evaluates the assistance and remediation plans for identified behaviours requiring improvement or problematic behaviours (see "Assistance Plan Policy" and "Remediation Plan Policy" for details), respectively. All plans are behaviourally-oriented and focused on improving performance, and are shared with residents in a written format.

5) The DoT communicates in writing to the resident graduate program's Director of Clinical Training (DCT) about any problematic behaviours demonstrated by the resident and the plans to monitor and mitigate these behaviours. Plans are shared with DCTs in a written format.

6) During the residency orientation period, a written due process procedure is provided to residents and reviewed with them by the residency DoT. In addition, an appeals process document is given to residents.

7) The DoT is ultimately responsible for documenting in writing all the details of the decisions made and actions taken by the residency with respect to the resident, and providing documentation to all relevant parties in a timely manner. Written documentation must also be filed in the resident's file.

Note: Details of the above aspects of due process are elaborated in various policies and procedures listed below.

DUE PROCESS RELATED POLICIES

The Residency Program at CFIR is committed to ensuring all residents are provided with additional professional assistance should they require support beyond what is typically offered during their training (i.e., didactic trainings, informal and formal supervision, etc.). Additional assistance is offered when a resident's behaviour is identified by a supervisor as below expectation for the time of evaluation, and is intended to ensure a resident successfully enhances the skills required to complete the training program. The residency encourages all individuals dealing with residents to provide feedback to residents about a need for support in caring and constructive ways that focus on pathways to improving performance.

Informal Review. When a supervisor or other staff member believes that a resident's behaviour is becoming problematic or that a resident is having difficulty consistently demonstrating an expected level of competence, the first step is to raise the issue with the resident verbally and as soon as possible to informally resolve the problem. This may include increased supervision and resources, didactic training, and/or structured readings. No record is kept of this process.

The supervisor who raised the concern will monitor the outcome. If the problematic behaviour persists, a consultation with the DoT is initiated to determine if a second informal resolution is warranted or if the behaviour needs to be escalated to a formal review.

Formal Review. A formal review of the resident's behaviour can be initiated for the following reasons:

- The resident's behaviour that was becoming problematic has been addressed via an informal review (see above), but the behaviour remains unresolved.
- The resident does not achieve the specified minimum level of achievement in any of the major competency areas covered in the resident's formal evaluation

The following steps are taken once the need for a formal review has been identified, and occur prior to the development of a 1) *Assistance Plan* or 2) *Remediation Plan* (see below), depending on the severity of the behaviour:

Step 1. Notice: The resident is notified in writing by the DoT that the issue has been raised to a formal level of review, and that a meeting will be held. The Notice shall include a clear description of the problematic behaviour or competence concern. The Notice should occur no later than five (5) business days from determination of need for a Formal Review.

Step 2. Hearing: The DoT, supervisor, resident, and (if applicable) other staff raising concerns of problematic behaviour or competence problems, hold a formal meeting (the Hearing) to discuss the matter, and determine what action may need to be taken to address the issue. The resident can select an additional supervisor within the residency or from their academic program to attend the Hearing and is strongly encouraged to do so if the problem has been raised by their supervisor or DoT. The resident has the right to hear all facts with the opportunity to dispute or explain the behaviour of concern. The hearing must be held within ten (10) business days from determination of need for a Formal Review.

Step 3. Outcomes and Next Steps: The DoT provides a written Acknowledgement of the Hearing to the resident, the supervisor, and, when applicable, any other staff directly involved in the Hearing. This acknowledgment notice shall include the date of hearing, participants in the hearing, a clear description of the problematic behaviour or competence problem, and any outcome decisions, such as that the problem is not significant enough to warrant further action/intervention or describing any formal support, remediation, or sanctions that are deemed necessary. The written Acknowledgement of Hearing occurs no later than five (5) business days from the Formal Review Hearing.

The resident may choose to accept the conditions or may choose to challenge the findings and actions proposed. The procedures for challenging the action are presented in the Appeal Policy section below.

1. Assistance Plan Policy

The Assistance Plan is created to continue to support the resident in addressing the problematic behaviour or competence concern, as confirmed within the Hearing.

1) Based on the outcome of the Hearing, the supervisor and the resident should co-create a written assistance plan that includes the following: a) a clear definition of the resident's

behaviour that requires improvement and a rationale for the behaviour change; b) the behaviour the resident needs to engage in to improve the identified behaviour; c) the supervisor's role in helping the resident improve the behaviour; d) the frequency with which the supervisor and resident will review for behaviour change (**Note:** it is suggested a minimum of once per two weeks until the behaviour is changed) and the expected date that behaviour should be sufficiently changed; e) the actions that could occur if the behaviour does not improve with the plan; and, f) the resident's right to request a review of any and all actions related to the assistance plan and make a complaint.

2) The supervisor submits the written assistance plan for review to the DoT who ensures the plan is compatible with the goal of improving the resident's performance and the successful completion of the residency program. Following this review, the supervisor, resident, and DoT all sign the written plan.

3) The signed, written plan is placed in the resident's file by the DoT.

4) The resident's DCT is notified in writing by the DoT about the plan being implemented and, eventually, its outcome.

5) If the resident's behaviour demonstrates improvement, the supervisor and resident will maintain assistance plan and monitor the behaviour a minimum of once per 2 weeks until the behaviour has completely improved. The assistance plan can then be terminated and the resident's performance is monitored/evaluated as per standard residency practices (i.e., on an ongoing basis, at 6 months, and at 12 months).

6) If the resident's behaviour does not improve despite the plan being followed, the initial assistance plan may be revised by the supervisor and resident (a written, adjusted plan is reviewed and approved by the DoT, and the resident's DCT is notified in writing about the change). Alternatively, the resident may be placed on a remediation plan (see Resident Remediation Plan Policy) if the behaviour becomes increasingly impactful to the resident or clients.

2. Remediation Plan Policy

A remediation plan is created and implemented when the resident does not demonstrate improvement in a problematic behaviour despite repeated assistance attempts and/or when the resident exhibits behaviour that is deemed unprofessional or ethically concerning. A remediation plan provides a defined plan to address the resident's problematic behaviour once it is identified, and ensures fairness to all parties impacted by the problematic behaviours.

Problematic behaviour that can be considered for remediation plan includes but is not limited to, the following: 1) a violation of the Canadian Psychological Association's (CPA) Canadian Code of Ethics for Psychologists, Fourth Edition and/or federal or provincial laws and regulations governing the practice of clinical and counseling psychology; 2) demonstrated incompetence to provide clinical services following repeated training and supervision assistance efforts; and/or, 3) behaviours that are harmful or imminently harmful to the resident or to others (e.g., staff, clients).

When the resident exhibits a problematic behaviour, the following procedures should occur:

1) Based on the outcome of the Hearing, the remediation plan must be co-created by the DoT, supervisor, and the resident within two (2) business days, and must include: a) a detailed, behaviourally-based description of the problematic behaviour and the history of verbal warnings about this behaviour; b) the behaviours the resident needs to engage in to correct or stop the problematic behaviour; c) the supervisor's and DoT's roles in supporting the resident to stop or correct the problematic behaviour; d) the frequency and timeline that the supervisor and resident will monitor and review progress toward stopping or correcting the problematic behaviour (**Note:** a minimum of once per week until the behaviour is stopped, and possibly **daily** for the most serious concerns); e) the plan and actions that will be taken if the behaviour does not stop or improve; and, f) the resident's right to review any and all actions related to the remediation plan and make a complaint.

3) The Centre Director is provided a written copy of the remediation plan for review, edit, and approval within one (1) business day of its completion.

4) The supervisor, DoT, and Centre Director meet with the resident to review the written remediation plan. The supervisor, DoT, and Centre Director must ensure the resident understands all aspects of the remediation plan and the implications of not stopping or correcting the problematic behaviour. All four individuals sign the written plan, and this should occur within a maximum of four (4) business days of the problematic behaviour being observed but ideally sooner.

5) The DoT places the signed remediation plan in the resident's file.

6) Within one (1) business day, the resident's DCT is notified in writing by the DoT about the remediation plan being implemented and the reason it is being implemented.

7) The supervisor, DoT, and resident meet in-person a minimum of once per week to evaluate changes in the problematic behaviour. If the resident's problematic behaviour begins to improve, the remediation plan continues to be implemented and monitored a minimum of once per week until the supervisor and DoT determine the problematic behaviour has stopped. Written documentation of this evaluative/monitoring process is completed by the supervisor, placed in the resident's file, and submitted to the resident's DCT and the Centre Director at CFIR. The formal remediation plan will be ended and evaluation of the resident continues as per standard practice.

Specific Elements of Remediation Plans

All remediation plans outline specified timelines for behaviour change (e.g., the duration of remediation process, expected timelines for behaviour to stop or improve, etc.) and changes in supervision and monitoring of the resident. Depending on the nature and causes of the problematic behaviour, however, there are differential components to remediation plans.

1) Removal from client care: The resident may be prevented from providing clinical services to clients for a specified period of time (as determined by the DoT and supervisor) if it is determined clients have been or may be negatively impacted by the resident's problematic behaviour. The resident's supervisor and the DoT monitor and assess the resident's ability to provide to services to clients and if/when they can resume. If there is a suspension of clinical services, the supervisor may be required to provide clinical care to the resident's clients to prevent client abandonment and ensure continuity of care.

2) Probationary Period: A probationary period is specified time period that is used by the DoT to closely monitor and evaluate the resident's capacities to change a problematic behaviour and to return enhanced professional and ethical functioning.

The supervisor, DoT, and Centre Director determine whether the resident should be placed on probation, and a written notification about probation is sent to the resident by the DoT. This notification includes the following: a) detailed description about the problematic behaviour; b) what the resident has to do to stop or change the problematic behaviour; c) the role the residency may play in supporting the resident; d) the duration of probationary period; and, e) details about progress monitoring and evaluation of the behaviour change. The DoT places the written notification in the resident's file, and informs the resident's DCT in writing about the probationary period.

If the DoT and Centre Director determine the problematic behaviour has not adequately changed to end the probationary period, the DoT meets with the supervisor and Centre Director within three (3) business days of the expected end of the probationary period to discuss and determine the plan. The next day, the DoT provides a written statement to the resident that probationary period has not ended, the rationale for why, and suggestions for next steps. It is possible an extended probationary period and remediation plan is suggested.

3. Residency Termination Policy

When specific and repeated remediation plans do not stop or improve the resident's problematic behaviour, termination yet serious from the residency is a possible option. Termination is considered when there have been significant violations of an ethical or legal nature, when physical or psychological harm to self or others has occurred or could occur, if physical or psychological difficulties prevent completion of the residency, and/or when repeated remedial efforts have failed to change problematic behaviours.

a) The decision for termination is made by the DoT, in consultation with the supervisor and Centre Director following a thorough review of the resident's problematic behaviour and the history of failed remediation efforts related to the behaviour. This review must occur two (2) business days after the DoT considers termination as a possible option.

b) The DoT and Centre Director are required to meet with the resident to discuss termination and the termination process two (2) days after the review meeting; this meeting would have followed repeated in-person meetings with the resident regarding their remediation plans and failures to change behaviour despite remediation.

c) One (1) business day following this meeting, the DoT communicates in writing to the resident and the resident's DCT that the resident will not complete the residency. This written communication provides an overview of the history of the problematic behaviour, the verbal warnings issued, the remediation plans implemented and their failures to change the behaviour, and the process and timelines related to termination.

d) The resident and supervisor is notified in writing by the DoT about actions and plans related to their clinical work (e.g., creating a plan with the supervisor transfer clients to other clinicians, completing all clinical paperwork), their salary and benefits, and issues related to training certification. Notably, residents will receive certification for the residency hours they have completed prior to their termination date. The resident is also informed about the right to appeal any actions related to remediation and termination.

e) All written communications about termination are placed in the resident's file by the DoT.

RESIDENCY APPEAL POLICY

The resident has the right to challenge any and all actions taken by the DoT the supervisor, and/or the residency staff with respect to them.

1) If the resident wants to formally lodge a complaint against any action of the residency, he or she must notify the DoT in written form within five (5) business days after receiving the DoT's written decision. The resident's written notification to the DoT must include, at a minimum, the following information: a) the nature of the resident's disagreement with the residency's decision; b) the rationale for the resident's disagreement; and, c) information that supports the resident's grievance.

2) Within five (5) business days of receiving the written complaint from the resident, the DoT must meet with and discuss the statement with the Centre Director. The Centre Director must form and implement a review panel during this time as well.

3) The Centre Director must form and implement a review panel within five (5) business days of receiving the written statement from the resident. The review panel consists of three psychologists with practices at CFIR (one of which must be a supervisor within the residency program, but not a supervisor of the resident), who are chosen by the Centre Director.

4) Within five (5) business days of forming the review panel, a hearing is held over one or two days. The hearing involves the resident presenting (verbally and in writing) his or her grievance of the residency's actions to the panel. The residency presents their information about the resident. The resident is entitled to refute or challenge the information the residency presents and to provide explanations of his or her problematic behaviours.

5) Within five (5) business days of the hearing, and following the panel reviewing all evidence provided by the resident and the residency, the review panel must submit a written summary and recommendation report to the Centre Director. This report must summarize evidence presented by the resident and the residency, and include conclusions and recommendations for additional action by the resident and/or the residency (if applicable). The review panel may consult with Human Resources at CFIR on issues related to due process in order to determine their recommendations.

6) Within five (5) business days of receiving the panel's report, the Centre Director reviews it and may either accept or reject all or some of the panel's recommendations. If recommendations are accepted, the Centre Director finalizes the decision and informs the DoT in writing about the decisions/recommendations. If the Centre Director rejects all or some of the recommendations, the review panel is notified to produce additional and/or revised recommendations. The review panel must provide an updated written report to the Centre Director within three (3) business days. The Centre Director finalizes the decision and informs the DoT in writing about recommendations.

7) Within two (2) business days of receiving the recommendations from the Centre Director, the DoT must provide a written statement to the resident, the supervisor, and the DCT about the

decisions and recommendations made by the review panel and agreed upon by the Centre Director. The written decision and recommendations are placed in the resident's file.

8) If the resident does not agree with the final decision/recommendations, the resident has the right to appeal to CFIR's Chief Director. The appeal must be presented in written format to the Chief Director within five (5) business days of being notified. A written statement should include the reasons the resident is disputing the final decisions or recommendations. The Chief Director makes a final decision, and notifies the resident, the Centre Director, the DoT, and the DCT in writing within three (3) business days. This notification is placed in the resident's file by the DoT.

Note: The same above steps apply should a supervisor have a concern about a resident that is not resolved by the DoT. Should there be a conflict of interest (e.g., the resident is filing a complaint against the DoT), CFIR's Chief Director will participate in the appeal process when and where applicable as a replacement representative for the residency.

RESIDENCY GRIEVANCE POLICY

A resident has the right to file a complaint about any and all aspects of the residency program, the staff associated with the residency (e.g., the supervisor, the DoT), and/or the staff associated with the residency site. A resident may make complaints about, but not limited to, the following: a) issues with the supervisor that impact training and supervision; b) physical or psychological difficulties that interfere with the resident's ability to be trained by the supervisor; and, c) physical, emotional, and/or sexual harassment toward the resident by supervisors, the DoT, and residency staff; etc.

Grievance Procedures

Should a resident encounter a problematic or difficult issue with a supervisor, the resident should follow these steps:

1) The resident should request to meet in-person with the supervisor to discuss the problem. The resident is encouraged to speak about the grievance with the supervisor within two (2) weeks of the grievance in order to minimize the impact of the behaviour.

2) During the meeting with the supervisor, the resident should provide the supervisor with adequate, behaviourally-grounded detail about the issue. The two should attempt to determine ways to minimize or resolve the issue in a collaborative manner.

3) Should the resident and/or the supervisor be unable to resolve the problem together, the DoT should be notified in writing by the resident and the supervisor (in a joint email from both email accounts) about the problematic situation and their difficulty resolving it. This notification should occur within one (1) business day of the two determining they cannot resolve the issue together.

4) Within two (2) business days of the written notification, the DoT shall meet individually with the resident and the supervisor. The DoT should document each individual's perspective on the problem and the couple's difficulty resolving the problem.

5) Within two (2) business days of the individual meetings, the DoT shall meet with both resident and the supervisor to support the resident and supervisor to co-create a plan to resolve the

problematic situation. This plan should include, but not limited to, the targeted behaviours that need to be minimized or enhanced by one or both parties; the plan on how to change behaviours; and the timeline for monitoring changes. The agreed upon plan is written during the meeting, and all three individuals sign the written plan. The written plan is placed in the resident's file by the DoT, and the DoT notifies the resident's DCT about the plan.

6) The DoT again meets with the resident and supervisor two (2) weeks following the signing of the written plan to evaluate progress toward resolving the problematic situation. The grievance plan can end if the DoT deems the problematic situation to be resolved. If the problematic situation continues following the two-week evaluation, yet appears to be resolving, another evaluation within one (1) week is suggested. At that time, if the problematic situation has been resolved, the grievance process is terminated. Written documentation about the termination of the grievance process is placed in the resident's file by the DoT and the DoT notifies the resident's DCT.

7) Should the grievance not be resolved following the evaluation period, the DoT meets with the Centre Director at CFIR to discuss the problematic situation. The Centre Director provides suggestions and recommendations to the DoT on how to resolve the problem, and the two formulate a written plan within three (3) business days. The following then occurs:

a) The DoT meets with the resident and supervisor within two (2) business days of creating the grievance plan. The DoT discusses in detail the recommendations and grievance plan. The recommendations on resolving the problematic situation are provided in written form to both the resident and supervisor, and upon their agreement all three parties sign the written plan. The signed written plan is placed in the resident's file by the DoT, and the DoT informs the resident's DCT in writing about the plan.

b) The DoT meets with the resident and supervisor once per week to evaluate progress toward resolving the grievance until the grievance is considered successfully resolved by the DoT and both parties are agreeable.

8) Should the resident not be agreeable to the any solution proposed to the problematic situation, the resident should meet with the Centre Director to determine possible solutions that are favourable to him or her. The Centre Director and resident may formulate a new plan in writing. This plan is shared with the DoT and supervisor. If the supervisor is agreeable to the plan, the plan is signed by all parties involved, placed in the resident's file, and the DCT is notified by the DoT. Monitoring occurs once weekly by the DoT, until the problematic situation is resolved.

9) If the resident finds the solution remains unresolved following the meeting with the Centre Director, a formal grievance can be submitted in writing to the Chief Director within three (3) business days of the meeting.

10) The Chief Director reviews the resident's complaint, and may consult with the Centre Director and residency supervisors to understand the history of the problematic situation and the attempts to resolve the problem. The Chief Director makes a final decision and submits the decision in writing to the resident and relevant residency staff within two (2) business days of the resident's written complaint. This decision is placed in the resident's file, and the DCT is notified by the DoT.

Note: The above steps apply should the resident have grievances against other members of the residency staff. Should the resident have a grievance with the supervisor but does not feel able or comfortable to directly address it with the supervisor, the DoT should be contacted initially rather than the supervisor. If the resident has a grievance with the DoT, the supervisor should be contacted initially. If the resident does not feel comfortable addressing a grievance with either the supervisor and the DoT, he or she may contact the Centre Director to address the issue. In situations of conflict of interest, the Centre Director or Chief Director may represent the residency in place of the DoT and/or supervisor.

ROTATION ASSIGNMENTS

Residents matched to the residency at CFIR will be assigned, in collaboration with the DoT, to a residency track which consists of one major treatment rotation and one major assessment rotation that run concurrently for 12 months. One minor rotation is also assigned; the resident can choose a minor rotation within their major track, or outside of their major track (e.g., a resident in the Adult Track can choose a minor rotation within the Couples & Sex Track). Tentative rotation assignments are made at the time of interview, based on the applicant's experience and their ranking of rotation preferences during the interview.

APPLICATION PROCEDURES

Applicants must submit the following materials through the Association of Psychology Postdoctoral and Internship Centers (APPIC) portal:

1. The APPIC Application for Psychology Internships (AAPI);
2. A letter from their university program's DCT attesting to their readiness for residency, which should indicate the completion of 600 total hours of practicum experience and the status of their dissertation or major research project;
3. A cover letter that includes statement of interest in the residency program and professional goals;
4. The four APPIC application essays: a) Autobiographical, b) Research, c) Theoretical Orientation, and d) Diversity;
5. Official transcripts of all graduate-level course work;
6. A current curriculum vitae (CV);
7. Three letters of reference from individuals familiar with the applicant's clinical and research (if applicable) experience and performance. The applicant's dissertation/thesis advisors ideally serves as one referee.

Completed applications must be received **no later than Friday, November 1, 2025 at 11:59PM E.S.T.**

Residency applications are reviewed by the DoT and members of the Residency Clinical Committee.

All interview notifications will be made via email on **Friday, December 5, 2025**. Interviews will be held on the following dates:

Tuesday December 16, 2025
Wednesday December 17, 2025
Thursday December 18, 2025
Friday December 19, 2025
Monday December 22, 2025

Interviews are scheduled for two hours, and conducted by a senior member of the Training Committee and at least one rotation supervisor. As recommended by APPIC, all interviews will be completed **virtually**; a virtual photo tour of the office spaces will be given to interview candidates.

Please note in your cover letter preferences for site location (Ottawa, Toronto, or St. Catharines).

SELECTION PROCEDURES

The residency at CFIR follows the APPIC Match Policies in the selection of residents, which can be found on the APPIC website at www.appic.org. The residency program is currently APPIC-approved.

A key aspect of our evaluation process of residency applicants is to determine the goodness-of-fit between the applicant's experience and areas of interest and the residency's ability to provide advanced training in these areas within our private practice setting. Our goal is to help residents to build upon their existing clinical knowledge base and applied skills, and to introduce them to new areas of clinical theory, research, and applied practice.

Residency positions are open to students who are formally enrolled in a CPA-accredited and/or APA-accredited doctoral program in clinical or counseling psychology, who meet the CPA or APA academic and practicum criteria and who have received formal approval from their University's DCT to apply for the residency. Eligibility for residency requires that applicants have completed all requisite professional coursework and practica prior to beginning the residency year. In addition, applicants must have completed a minimum of 600 hours of practicum experience (direct + support + supervision) in assessment and intervention strategies comprised of at least 300 hours of total direct client contact and 150 hours of supervision to be eligible. Applicants from non-accredited programs will also be considered; additional information regarding program requirements may be requested.

The resident selection committee encourages applications from persons from all visible and non-visible groups, including but not limited to those who are Indigenous, disabled, gay, lesbian, transgendered, or a member of another sexual-minority group, a member of a racially visible group, or a member of any other minority group. The resident selection committee abides by the principle of equality in selecting residents. You may voluntarily identify yourself as a member of a designated group on your application.

PUBLIC DISCLOSURE

In Appendix A, data describing the number of applications we receive, how many applicants we interview, and the characteristics of those people who match to our program is presented.

CANADIAN PSYCHOLOGICAL ASSOCIATION (CPA) ACCREDITATION

The Residency Program at CFIR is accredited by the Canadian Psychological Association (CPA) for a 4-year term. Our next site visit will take place 2026-2027.

Information regarding accreditation can be obtained by contacting the CPA Accreditation Office at:

Canadian Psychological Association
141 Laurier Avenue West, Suite 702
Ottawa, Ontario, K1P 5J3
Tel: 613-237-2144
Toll Free: 1-888-472-0657
Email: accreditationoffice@cpa.ca
Website: https://www.cpa.ca/accreditation/

OVERVIEW OF CLINICAL ROTATIONS

Residents in each track are required to complete 2 main rotations (1 treatment rotation, 1 assessment rotation) within their selected track, and they select either 1 or 2 minor rotations either within their track or in a different track.

A) ADULT TRACK

The Adult Track involves a focus on clinical assessment and diagnosis, psychological testing, consultation, and therapeutic intervention with adults (18 years and older). Testing and assessment experiences possibly include experiences in clinical interviewing (semi-structured and structured) and testing in the areas of major mental disorders, personality disorders, substance use disorders, adoption-related issues, immigration and refugee concerns, and trauma disorders. There is a strong focus on diagnostic formulation from the DSM-5-TR and Psychodynamic Diagnostic Manual, Second Edition (PDM-2) perspectives.

Therapeutic intervention experiences involve predominantly working with anxiety and stress-related disorders, obsessive-compulsive and related disorders, major depressive disorders, and other mood-related conditions. This work will include working with individuals with significant co-occurring personality disorders, and relational/interpersonal difficulties. There is a strong focus on case conceptualization, the application of evidence-based treatments, and the integration of these evidence-based treatment approaches (e.g., acceptance and commitment therapy, cognitive-behavioural therapy, emotion-focused therapy, mindfulness-based therapy, psychodynamic/attachment/interpersonal therapies, etc.).

Residents may also co-supervise the clinical work of a master's or doctoral-level student.

Major Rotations within the Adult Track (approx. 3 days/week)

1. Anxiety & Stress/Obsessive-Compulsive/Depression, Mood & Grief Services [Treatment]
Supervisors: Dr. Karine Côté, C.Psych., Dr. Robert Hill, C.Psych., Dr. Aleks Milosevic, C.Psych., Dr. Dino Zuccarini, C.Psych. (Ottawa); Dr. Lila Z. Hakim, C.Psych., Dr. Jean Kim, C.Psych., Dr. Erica Tatham, C.Psych., Dr. Shaofan Bu, C.Psych., Dr. Renée Taylor, C.Psych. (Toronto); Dr. Mélodie Britt, C. Psych (St. Catharines)
This major, treatment-focused rotation involves training and intensive supervision in the assessment, diagnosis, and treatment of major anxiety disorders, obsessive-compulsive disorder, major depressive disorders and other mood-related difficulties, and co-occurring conditions. Residents will learn about various methods of assessing and diagnosing anxiety and mood disorders and related features, and receive training in multiple evidence-based psychological treatments including Acceptance and Commitment Therapy (ACT), Cognitive-Behavioural Therapy (CBT), Behavioural Therapy (BT), Emotion-Focused Therapy (EFT), Mindfulness-based Therapies (e.g., MBCT), and Psychodynamic/Attachment/Interpersonal therapies (with a focus on becoming a clinician who integrates these various treatment approaches based on client individual differences). Supervision will involve formal case discussion, with a focus on case conceptualization and treatment planning, and supplemented by didactics and learning related to basic therapeutic principles and working therapeutically with mood and anxiety disorders specifically.

2. Mental Health Evaluations & Psychodiagnostic Assessments [Assessment]
Supervisors: Dr. Marc Bedard, C.Psych., Dr. Karine Côté, C.Psych., Dr. Aleks Milosevic, C.Psych. (Ottawa); Dr. Lila Z. Hakim, C.Psych., Dr. Peter Egeto, C.Psych., Dr. Erica Tatham, C.Psych. (Toronto); Dr. Mélodie Britt, C.Psych. (St. Catharines)
This major, assessment-focused rotation involves training and intensive supervision in testing, assessment, and diagnosis of adults presenting with a range of psychological, emotional, behavioural, and relational concerns, including major mental disorders, personality and interpersonal/attachment disorders, trauma-related disorders, substance use disorders, independent medical evaluations, adoption and fertility-related assessments. Residents will also learn how to assess for ADHD and/or Autism. Residents will learn about various methods of assessing and diagnosing these conditions and/or working with these populations. This includes administration and scoring of psychological tests, case conceptualization, diagnosis, and treatment recommendations with report writing as a major component of this rotation. Supervision will involve formal case discussion, with a focus on case conceptualization, diagnosis, and formulation of treatment recommendations.

Minor Rotations within the Adult Track (either 1 rotation at 1 day/week, or 2 rotations at 0.5 day/week)

1. Cognitive-Behavioural Therapy Clinic [Treatment]
Supervisors: Dr. Marc Bedard, C. Psych. (Ottawa); Dr. Peter Egeto, C. Psych. (Toronto)
This minor, treatment-focused rotation involves training and intensive supervision in a transdiagnostic CBT approach. The CBT Clinic is uniquely designed to be able to address the growing need of mental health supports for clients looking for assistance with strategies and tools to aid symptom and distress reduction. Residents will learn evidence-based symptom reduction strategies to changing distressing thoughts and emotions, within a short-term 8-20 session model. Residents will also learn how to assess for and conceptualize clients with more complex difficulties associated with trauma (i.e., complex, PTSD) and personality disorders, requiring ongoing treatment for continued progress after completion of a course of CBT. Supervision will involve formal case discussion, with a focus on case conceptualization and

treatment planning, and supplemented by didactics and learning related to basic therapeutic principles and working transdiagnostically with adults experiencing symptom-distress.

2. Eating, Weight & Body Image Service [Treatment]
Supervisor: Dr. Jean Kim, C.Psych. (Toronto); Dr. Karine Côté, C. Psych. (Ottawa)
This minor, treatment-focused rotation involves training and intensive supervision in the assessment, diagnosis, and treatment of major eating disorders (e.g., anorexia nervosa, bulimia nervosa, binge eating disorders, etc.) and related personality, relational, and mental health difficulties, with a focus on an adult and couple populations. Residents will learn about various methods of assessing and diagnosing eating disorders and related features, and receive training in multiple evidence-based psychological treatments including Acceptance and Commitment Therapy (ACT), Cognitive-Behavioural Therapy (CBT), Behavioural Therapy (BT), Emotion-Focused Therapy (EFT), Mindfulness-based Therapies (e.g., MBCT), and Psychodynamic/Attachment/Interpersonal therapies (with a focus on becoming a clinician who integrates these various treatment approaches based on client individual differences). Supervision will involve formal case discussion, with a focus on case conceptualization and treatment planning, and supplemented by didactics and learning related to basic therapeutic principles and working therapeutically with adults and couples experiencing eating disorders and related concerns.

3. Fertility Counselling Service [Treatment]
Supervisor: Dr. Natalina Salmaso, C.Psych. (Ottawa); Dr. Lila Z. Hakim, C.Psych. (Toronto); Dr. Mélodie Britt, C.Psych. (St. Catharines)
This minor, treatment-focused rotation involves training and intensive supervision in the assessment, diagnosis, and treatment of a population reporting fertility-focused and other related difficulties, with a focus on adult and couple populations. Residents will learn about various methods of assessing fertility-related concerns, and receive training in multiple evidence-based psychological treatments including Acceptance and Commitment Therapy (ACT), Cognitive-Behavioural Therapy (CBT), Behavioural Therapy (BT), Emotion-Focused Therapy (EFT), Mindfulness-based Therapy (e.g., MBCT), and Attachment/Interpersonal therapies (with a focus on becoming a clinician who integrates these various treatment approaches based on client individual differences). Supervision will involve formal case discussion, with a focus on case conceptualization and treatment planning, and supplemented by didactics and learning related to basic therapeutic principles and working therapeutically adults and couples experiencing fertility-related concerns.

4. Multicultural Service [Treatment]
Supervisor: Dr. Lila Z. Hakim, C.Psych.; Dr. Jean Kim, C. Psych. (Toronto)
This minor, treatment-focused rotation involves training and intensive supervision in the assessment, diagnosis, and treatment of psychological, emotional, adjustment, and relational in adult populations from multicultural backgrounds (e.g., race, ethnicity, religion, ability, etc.). Residents will learn about various methods of assessing and diagnosing trauma-related conditions in these populations specifically, and receive training in multiple evidence-based psychological treatments including Cognitive-Behavioural Therapy (CBT), Behavioural Therapy (BT), Emotion-Focused Therapy (EFT), and Psychodynamic/Attachment/Interpersonal therapies (with a focus on becoming a clinician who integrates these various treatment approaches based on client individual differences). Supervision will involve formal case discussion, with a focus on case conceptualization and treatment planning, and supplemented by didactics and learning related to basic therapeutic principles and working therapeutically with psychological difficulties within a culturally-focused context.

5. Personality Service [Treatment]
Supervisor: Dr. Karine Côté, C.Psych., Dr. Aleks Milosevic, C.Psych., Dr. Dino Zuccarini, C.Psych., Dr. Marc Bedard, C.Psych. (Ottawa); Dr. Lila Z. Hakim, C.Psych., Dr. Shaofan Bu, C.Psych. (Toronto)
This minor, treatment-focused rotation involves training and intensive supervision in the assessment, diagnosis, and treatment of personality disorders, with a focus on adult and couple populations. Residents will learn about various methods of assessing, conceptualizing, and diagnosing personality disorders, and receive training in multiple evidence-based psychological treatments including Cognitive Behavioural Therapy (CBT), Dialectical Behavioural Therapy (DBT) and Psychoanalytic/Psychodynamic/Attachment/Interpersonal therapies (with a focus on becoming a clinician who integrates these various treatment approaches based on client individual differences). Supervision will involve formal case discussion, with a focus on case conceptualization and treatment planning, and supplemented by didactics and learning related to basic therapeutic principles and working therapeutically with adults and couples with personality disorders.

6. Substance Use/Sexual Addiction Services [Treatment]
Supervisor: Dr. Aleks Milosevic, C.Psych. (Ottawa only)
This minor, treatment-focused rotation involves training and intensive supervision in the assessment, diagnosis, and treatment of substance use disorders and sexual addiction, with a focus on adult populations. Residents will learn about various methods of assessing and diagnosing substance use disorders and sexual addiction, and receive training in multiple evidence-based psychological treatments including cognitive-behavioural therapy, behavioural therapy, mindfulness-based therapy, motivational enhancement therapy, and psychodynamic/attachment/interpersonal therapies (with a focus on becoming a clinician who integrates these various treatment approaches based on client individual differences). Supervision will involve formal case discussion, with a focus on case conceptualization and treatment planning, and supplemented by didactics and learning related to basic therapeutic principles and working therapeutically with adults with substance use disorders and sexual addiction.

7. Trauma Psychology & PTSD Service [Treatment]
Supervisors: Dr. Karine Côté, C.Psych., Dr. Dino Zuccarini, C.Psych. (Ottawa); Dr. Lila Hakim, C.Psych. (Toronto)
This minor, treatment-focused rotation involves training and intensive supervision in the assessment, diagnosis, and treatment of trauma disorders (e.g., post-traumatic stress disorder, complex post-traumatic stress disorder), dissociative disorders, adjustment disorders following traumatic incidents, and related personality disorders, in an adult population. Traumatic experiences include: developmental trauma (e.g., physical abuse, emotional abuse, sexual abuse) and single incident traumas in adulthood (e.g., accidents, witnessing violence, assaults). Residents will learn about various methods of assessing and diagnosing trauma-related disorders, and receive training in multiple evidence-based psychological treatments including cognitive-behavioural therapy, behavioural therapy, emotion-focused therapy, mindfulness-based therapy, sensorimotor psychotherapy, and psychoanalytic/psychodynamic/attachment/interpersonal therapies (with a focus on becoming a clinician who integrates these various treatment approaches based on client individual differences). Supervision will involve formal case discussion, with a focus on case conceptualization and treatment planning, and supplemented by didactics and learning related to basic therapeutic principles and working therapeutically with trauma and related disorders.

8. Family Service [Treatment]

Supervisors: Dr. Nalini Iype, C.Psych. (Ottawa); Dr. Lila Z. Hakim, C.Psych. (Toronto)
This minor, treatment-focused rotation involves training and intensive supervision in the assessment, diagnosis, and treatment of families experiencing relational difficulties. Residents will learn about various methods of assessing and diagnosing psychological and relational difficulties in families, and receive training in multiple evidence-based psychological treatments including cognitive-behavioural therapy, behavioural therapy, emotion-focused family therapy, and psychodynamic/attachment-based family therapies (with a focus on becoming a clinician who integrates these various treatment approaches based on family member individual differences). Supervision will involve formal case discussion, with a focus on case conceptualization and treatment planning, and supplemented by didactics and learning related to basic therapeutic principles and working therapeutically with families.

9. Neuropsychological Service [Assessment]
Supervisor: Dr. Marc Bedard, C.Psych., Dr. Mark Coates, C.Psych. (Ottawa); Dr. Peter Egeto, C.Psych., Dr. Erica Tatham, C.Psych. (Toronto)
This minor, assessment-focused rotation involves training and intensive supervision in testing, assessment, and diagnosis of adults presenting with various neuropsychological, neurocognitive, neurological, and neuropsychiatric disorders. Residents will learn about various methods of assessing and diagnosing neuropsychological disorders. This includes administration and scoring of psychological tests, case conceptualization, diagnosis, and treatment recommendations with report writing as a major component of this rotation. Supervision will involve formal case discussion, with a focus on case conceptualization, diagnosis, and formulation of treatment recommendations.

10. Neuropsychological Service [Treatment]
Supervisors: Dr. Mark Coates, C.Psych. (Ottawa); Dr. Peter Egeto, C.Psych., Dr. Erica Tatham, C.Psych. (Toronto)
This minor, treatment-focused rotation involves training and intensive supervision in the assessment, diagnosis, and treatment of neuropsychological (e.g., ADHD, acquired brain injury) conditions and associated-difficulties, with a focus on adult populations. Residents will learn about various methods of assessing and diagnosing neuropsychological and health-related conditions, and receive training in multiple evidence-based psychological treatments including cognitive-behavioural therapy, behavioural therapy, mindfulness-based therapy, and psychodynamic/attachment/ interpersonal therapies (with a focus on becoming a clinician who integrates these various treatment approaches, based on client individual differences). Supervision will involve formal case discussion, with a focus on case conceptualization and treatment planning, and supplemented by didactics and learning related to basic therapeutic principles and working therapeutically with adults experiencing neuropsychological-related difficulties.

11. Neurodevelopmental Service [Assessment]
Supervisor: Dr. Marc Bedard, C.Psych., Dr. Mark Coates, C.Psych., Dr. Nalini Iype, C.Psych. (Ottawa); Dr. Peter Egeto, C.Psych. (Toronto)
This minor, assessment-focused rotation involves training and intensive supervision in the assessment, and diagnosis of adults presenting with neurodevelopmental conditions (e.g., Autism-spectrum, ADHD, Learning Disorders), and associated difficulties (e.g., mood, anxiety, experiences of trauma). This includes administration and scoring of psychological tests, case conceptualization, diagnosis, and treatment recommendations with report writing as a major component of this rotation. Supervision will involve formal case discussion, with a focus on case conceptualization, diagnosis, and formulation of treatment recommendations.

12. Neurodevelopmental Service [Treatment]
Supervisors: Dr. Marc Bedard, C.Psych. (Ottawa); Dr. Peter Egeto, C.Psych. (Toronto)
This minor, treatment-focused rotation involves training and intensive supervision in the assessment, diagnosis, and treatment/support of neurodevelopmental (e.g., ADHD, Autism-spectrum) conditions and associated-differences, with a focus on adult populations. Residents will learn about various methods of assessing and diagnosing neuropsychological and health-related conditions, and receive training in multiple evidence-based psychological treatments and perspectives, in order to provide neuro-affirming, strengths-based support to neurodiverse peoples, across cognitive-behavioural therapy, behavioural therapy, mindfulness-based therapy, polyvagal theory approaches, and psychodynamic/attachment/ interpersonal therapies (with a focus on becoming a clinician who integrates these various treatment approaches, in a neuro-affirming fashion, based on client individual differences). Supervision will involve formal case discussion, with a focus on case conceptualization and treatment planning, and supplemented by didactics and learning related to basic therapeutic principles and working therapeutically with adults experiencing neuropsychological-related difficulties.

C) COUPLES & SEX THERAPY TRACK

The Couples & Sex Therapy Track involves a focus on clinical assessment and diagnosis, psychological testing, consultation, and therapeutic intervention with individual and couples experiencing relational and/or sexual difficulties. Testing and assessment experiences possibly include experiences in clinical interviewing (semi-structured and structured) and testing in the areas of relational and interpersonal functioning, and sexual disorders.

Therapeutic intervention experiences involve predominantly working with couples to build more emotionally and physically intimate relationships; restore trust; improve communication, problem-solving and negotiation skills; become stronger parents; and manage a difficult separation and divorce. With respect to sexual difficulties, therapeutic interventions focuses on resolving sexual issues (e.g., sexual arousal, desire, orgasm and sexual pain difficulties); improve sexual vocabulary and communication; learn new sexual techniques; enhance arousal, sexual desire, and eroticism; learn about different types of sexual practices; and, gain knowledge about sexual health and safer sex. There is a strong focus on case conceptualization and integrative approaches to intervention (e.g., cognitive-behavioural therapy, emotion-focused therapy, mindfulness-based therapy, psychoanalytic/ psychodynamic/attachment/interpersonal therapies).

Residents may also co-supervise the clinical work of a master's or doctoral-level student.

Major Rotations within the Couples & Sex Track (approx. 3 days/week)

1. Couple & Sex Therapy Services [Treatment]
Supervisors: Dr. Karine Côté, C.Psych., Dr. Dino Zuccarini, C.Psych., Dr. Nalini Iype, C.Psych. (Ottawa); Dr. Lila Z. Hakim, C.Psych. (Toronto); Dr. Mélodie Britt, C.Psych. (St. Catharines)
This major, treatment-focused rotation involves training and intensive supervision in the assessment, diagnosis, and treatment of relationship/attachment difficulties and sexual disorders (e.g., sexual arousal, desire, orgasm, sexual pain, etc.) and difficulties with a focus on adult and couple populations. Residents will learn about various methods of assessing and diagnosing relationship and sexual difficulties, and receive training in multiple evidence-based psychological treatments including cognitive-behavioural therapy, behavioural therapy, emotion-

focused therapy, mindfulness-based therapy, and psychoanalytic/psychodynamic/attachment/ interpersonal therapies (with a focus on becoming a clinician who integrates these various treatment approaches based on client individual differences). Supervision will involve formal case discussion, with a focus on case conceptualization and treatment planning, and supplemented by didactics and learning related to basic therapeutic principles and working therapeutically with adults and couples experiencing relational and/or sexual difficulties.

2. Couple & Sexual Functioning Assessment Service [Assessment]
Supervisors: Dr. Karine Côté, C.Psych., Dr. Dino Zuccarini, C.Psych. (Ottawa); Dr. Lila Z. Hakim, C.Psych. (Toronto); Dr. Mélodie Britt, C.Psych. (St. Catharines)
This major, assessment-focused rotation involves training and intensive supervision in testing, assessment, and diagnosis of adults and couples experiencing a range of psychological, emotional, behavioural, and relational difficulties that have an impact on couple and sexual functioning. Residents will learn about various methods of assessing and diagnosing couple and sexual-related difficulties. This includes administration and scoring of psychological tests, case conceptualization, diagnosis, and treatment recommendations with report writing as a major component of this rotation. Supervision will involve formal case discussion, with a focus on case conceptualization, diagnosis, and formulation of treatment recommendations.

Minor Rotations within the Couples & Sex Track (either 1 rotation at 1 day/week, or 2 rotations at 0.5 day/week)

1. Sexual Addiction Service [Treatment]
Supervisors: Dr. Aleks Milosevic, C.Psych., Dr. Dino Zuccarini, C.Psych. (Ottawa); Dr. Lila Z. Hakim, C.Psych. (Toronto)
This minor, treatment-focused rotation involves training and intensive supervision in the assessment, diagnosis, and treatment of sexual addiction and related disorders and difficulties, with a focus on adult and couples populations. Residents will learn about various methods of assessing and diagnosing sexual addiction and related difficulties, and receive training in multiple evidence-based psychological treatments including cognitive-behavioural therapy, behavioural therapy, mindfulness-based therapy, and psychoanalytic/psychodynamic/attachment/ interpersonal therapies (with a focus on becoming a clinician who integrates these various treatment approaches based on client individual differences). Supervision will involve formal case discussion, with a focus on case conceptualization and treatment planning, and supplemented by didactics and learning related to basic therapeutic principles and working therapeutically with adults and couples with sexual addiction and related difficulties.

2. Sexuality, Gender & Relationship Diversity [Treatment]
Supervisors: Dr. Dino Zuccarini, C.Psych. (Ottawa); Dr. Lila Z. Hakim, C.Psych. (Toronto)
This minor, treatment-focused rotation involves training and intensive supervision in the assessment and treatment of psychological, emotional, behavioural, and relational difficulties in adults and couples from diverse sexual orientation, gender, and relationship communities. Residents will learn how to provide treatment to various social identity groups, facilitate identity formation and transitions related to sexual orientation and gender, and work with diverse relationship structures. Supervision will involve formal case discussion, with a focus on case conceptualization and treatment planning, and supplemented by didactics and learning related to basic therapeutic principles and working therapeutically with adults and couples with diverse backgrounds and experiences.

RESIDENCY SUPERVISORS

Dr. Sara Antunes-Alves (CFIR-Ottawa)
Ph.D., McGill University (2017)
Populations: Adult
Clinical Interests: anxiety and depression; interpersonal difficulties; trauma; post-secondary students

Dr. Marc Bedard, C.Psych. (CFIR-Ottawa)
Ph.D., University of Ottawa (2021)
Populations: Adult
Clinical Interests: Clinical neuropsychology with neurodiverse populations; integration of psychodynamic and cognitive behavioural therapies

Dr. Mélodie Britt, C.Psych. (CFIR-St. Catharines)
Psy.D., Université du Québec en Outaouais (2021)
Populations: Adult, Couple
Clinical Interests: Self-esteem, attachment, ADHD, couples therapy

Dr. Shaofan Bu, C.Psych. (CFIR-Toronto)
Ph.D., McGill University (2023)
Populations: Adult
Clinical Interests: psychoanalytic psychotherapy; long-term psychotherapy; personality organization

Dr. Mark Coates, C.Psych. (CFIR-Ottawa)
Ph.D., University of Ottawa (2011)
Populations: Adult, Senior
Clinical Interests: Neuropsychological assessment and neuropsychological difficulties

Dr. Karine Côté, C.Psych. (CFIR-Ottawa)
Psy.D., Université du Québec en Outaouais (2018)
Populations: Adult, Couple
Clinical Interests: Personality disorders; adult mental health; couples therapy

Dr. Peter Egeto, C.Psych. (CFIR-Toronto)
Ph.D., Toronto Metropolitan University (2021)
Population: Adult
Clinical Interests: Neuropsychological assessment; psychological assessment; anxiety; OCD; depression; trauma; dissociative symptoms; personality disorders; interpersonal issues

Dr. Lila Z. Hakim, C.Psych. (CFIR-Toronto)
Ph.D., York University (2010)
Populations: Adult, Couple, Family
Clinical Interests: Personality, traumatic stress, adoption; fertility counseling; couples therapy; sex therapy

Dr. Robert Hill, C.Psych. (CFIR-Ottawa)
Ph.D., University of Ottawa (2022)
Populations: Adult, Health

Clinical Interests: anxiety and depression; health (post-concussion/mTBI, oncology, pain); perfectionism; PTSD and trauma; binge-eating; integrative psychotherapy: CBT, EFT, psychodynamic, attachment based-based mentalization therapy

Dr. Nalini Iype, C.Psych. (CFIR-Ottawa)
Psy.D., Pacific University (2018)
Populations: Adolescent, Adult, Child, Couple, Family
Clinical Interests: Depression and mood; trauma; grief/loss; transition age youth

Dr. Jean Kim, C.Psych. (CFIR-Toronto)
Ph.D., University of Windsor (2018)
Populations: Adolescent, Adult
Clinical interests: Eating disorders; anxiety; mood; trauma; culturally-informed therapy

Dr. Aleks Milosevic, C.Psych. (CFIR-Ottawa)
Ph.D., University of Windsor (2011)
Populations: Adult
Clinical Interests: Anger-related disorders; substance use disorders; sexual addiction; personality disorders

Dr. Natalina Salmaso, C.Psych. (CFIR-Ottawa)
Ph.D., Concordia University (2009)
Populations: Adolescent, Adults, Couple
Clinical Interests: Depression and mood; anxiety; gender; sexuality; chronic pain; neurobiology

Dr. Erica Tatham, C.Psych. (CFIR-Toronto)
Ph.D., York University (2022)
Populations: Adults, Senior
Clinical Interests: anxiety and depression; trauma, interpersonal difficulties, neurodevelopmental concerns, personality disorders; psychodynamic and emotion focused therapies

Dr. Renée Taylor, C.Psych. (CFIR-Toronto)
Ph.D., University of Windsor (2022)
Populations: Adult, Couple
Clinical Interests: Multicultural orientation and cultural humility; clinical psychological assessment; Integrative psychotherapy: EFT, psychodynamic, and ACT interventions

Dr. Dino Zuccarini, C.Psych. (CFIR-Ottawa)
Ph.D., University of Ottawa (2010)
Populations: Adults, Couple
Clinical Interests: Complex/developmental trauma; couples therapy; integrative therapy; personality disorders; psychoanalytic/psychodynamic therapy; sex therapy

APPENDIX A: Public Disclosure Table

CPA ACCREDITATION - INTERNSHIP PROGRAMMES

Table Type: PUBLIC DISCLOSURE TABLE 1: INCOMING INTERNS OVER PAST 7 YEARS

Programme: Centre for Interpersonal Relationships

Academic Year/Cohort	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
Positions	2	2	4	6	8	4	4	5
Applications	2	8	15	29	31	41	77	49
Interviewed/Short-Listed	2	8	14	23	19	23	23	20
Ranked	2	5	9	11	9	8	11	11
Matched	2	1	4	4	5	3	3	5
Matched as % Applications (Automatically Calculated)	100%	13%	27%	14%	16%	7%	4%	10%
Of those who Matched:								
Males	1	0	2	2	4	0	0	1
Self-Identify as Diverse (ie, minority, disability, LGBTQ)	1	0	2	2	3	2	3	2
From Outside of Province	1	1	2	1	1	1	1	0
From Outside of Canada	0	0	1	0	0	0	0	0
Mean Practicum Hours on AAPI -->Assessment & Intervention	250	299	767	633	511	798	830	514
-->Supervision	171	154	287	310	182	395	322	310
-->Support/Indirect	701	610	904	756	644	1,375	1,205	956
Mean Total Hours (Automatic)	1,122	1,063	1,958	1,699	1,337	2,568	2,357	1,780
Internship Stipend	$30,000	$30,000	$40,000	$35,000	$35,000	$37,500	$37,500	$42,500