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From the Editor

"When I use a word," Humpty Dumpty said in a rather scornful tone, "it means just I choose it to mean—nothing more nor less" (according to Lewis Carroll in *Through the Looking Glass*). As psychotherapists, we know that language is not quite this simple. Yet I love language. Words may humiliate, ulcerate, mystify, penetrate, taunt, and yell; but they also dance, unify, mesmerize, pacify, teach, and yield. Therefore, it is with both humility and delight that I begin my time as editor of the *GP Psychotherapist*.

Let me introduce myself. I did my first degree in Psychology and my interest in the subject has not waned. My 20-plus year career in Family Medicine has been diverse. In my "early" years, my practice included Emergency work as well as Obstetrics. I have worked in various group practices, as well as walk-in clinics, community health, and student health centers. Teaching has also been an interest, and having a medical student always reminds me of the reasons I enjoy practising medicine. I recently completed my PhD in theology and enjoy juggling my medical career with research and writing. Most relevant for readers of this journal, I have been practising psychotherapy for my entire career, although have increased my hours in the past few years. This was the impetus for joining the GPPA a year and a half ago. I have found this group to be very encouraging, informative, and challenging.

My predecessor, Maria Grande, has done an excellent job at moving our journal along a path of excellence that I hope to continue. Fortunately, Maria is continuing to contribute to the editorial team and I am grateful to her and Vivian Chow for their support and assistance. We continue to standardize our approach and the author's guidelines on the GPPA website help with this. We have also added to the collegiality of the GPPA by including a brief biographical note on each author. Our editorial team does a wonderful job; every submission is reviewed by me and at least one other member of the team.

At the recent GPPA conference, I was amazed and encouraged to note what a diverse and professional group we are. There has been much discussion about the art and science of medicine in general, and psychotherapy in particular. Both subjec-

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From the Editor (cont'd)

tive and objective are important. Both observation and interaction are important. Both concrete and abstract are important. Both logic and intuition are important. The endorsement of both art and science is reflected in the content of this issue of the *GP Psychotherapist.*

Our two regular columns focus more on the objective side of psychotherapy. Howard Schneider, in Psychopharmacology Corner, discusses the diagnosis and management of mild traumatic brain injury, an increasingly common condition that we are all likely to see. Michael Paré and colleagues, in their ongoing series on Standards in Psychotherapy, write about express versus implied consent. Case studies add life to this important topic.

The art of medical care is evident in two articles on meditation, a poem and a self -reflection article. Josée Labrosse contributes a provocative poem on processing pain and a reflection on the surprises of spring, and Lori Chamberland shares her experience with Ayurveda yoga and meditation. Barry Dolin writes about his 30 years of involvement in a Balint group and how it has made him a more compassionate physician.

If anyone has doubts about the artistic interests and abilities of Medical Psychotherapists, be sure to look at the photographs from our recent conference, in which attendees participated enthusiastically (and bravely at times).

The conference is summarized nicely by a team of authors, Josée Labrosse, Emma Mitchell and Tobi Abdul, in our section on GPPA matters. We also welcome our new president, Brian McDermid, who shares his enthusiasm about his new role as well as visions and new initiatives for the GPPA. And check out GPPA chair Catherine Low's report for an update of all the GPPA has to offer its members. We also welcome David Levine as our liaison to the board.

The art of psychotherapy. The science of psychotherapy. The language of psychotherapy. And the language of journals. Happy reading and, as always, we welcome your input!

Grace and peace,
Janet Warren

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SCIENTIFIC PSYCHOTHERAPY

Psychopharmacology Corner

Mild Traumatic Brain Injury

Howard Schneider, MD, CGPP, CCFP

ABSTRACT

The prevalence and behavioral effects of mild traumatic brain injury (mTBI) are so widespread that most therapists and primary care physicians are treating patients with it, whether recognized or not. Despite the word mild, mTBI can severely impact the life of the patient, and its symptoms can persist. The clinician should attempt to best treat the symptoms of the mTBI and as well attempt to improve the patient's cognition.

In this issue of the GP Psychotherapist, I present a follow up to the 2013 Psychopharmacology Corner article on Traumatic Brain Injury (Schneider, 2013), covering the work of neurologist Dr. David B. FitzGerald.

FitzGerald is an electronics engineer and a neurologist with a strong interest in the behavioral effects of traumatic brain injury. He is an Assistant Professor at the University of Florida and works in the North Florida/South Georgia Veterans Health System. FitzGerald received the 2015 VA Employee of the Year award from the Military Officers Association of America, which is notable, as physicians are not usually given this award.

FitzGerald presented two talks at the 168th Annual Meeting of the American Psychiatric Association in Toronto – *Mild Traumatic Brain Injury: Assessment and Initial Management with Neuropsychopharmacology* on May 17, 2015, and *Diagnosis and Treatment of Mild Traumatic Brain Injury in a Case Study Format* on May 19, 2015. This article is based on his presentations as well as audience discussion with FitzGerald. (It should be noted that FitzGerald's opinions are his own and not that of the US government or the VA [United States Veterans Health Administration].)

FitzGerald, a neurologist, was talking at a *psychiatric* conference, because the behavioral effects of traumatic brain injury (TBI), generally mild traumatic brain injury (mTBI), are so widespread that almost all physicians are treating patients with it. In the United States military population that served in Iraq and Afghanistan, there are at least 200,000 patients who sustained significant mTBI (or more severe TBI) during active duty. In the general US population FitzGerald notes that in the past year 1.7 million persons suffered mTBI or more severe TBI. The CDC (United States Centers for Disease Control and Prevention) estimated that 10% of these patients, ie, 170,000 persons per year, will have long-lasting symptoms from their TBI. In Canada he says the figures he found showed 94,000 concussions, ie, mTBI at minimum, in the past year. Of interest, he came across the 2014 CMAJ article by Dr. Jane Topolovec-Vranic et al (2014) of St. Michael's Hospital which looked at 111 homeless men in downtown Toronto and found that 45% of these men had experienced a TBI, with 87% of this group having this injury before becoming homeless. Work by Roozenbeek and colleagues (2013) estimate that 5.3 million people in the USA and 7.7 million people in the European Union are living with a TBI-related disability. They also note that, "Despite claims to the contrary, no clear decrease in TBI-related mortality or improvement of overall outcome has been observed over the past two decades."

FitzGerald notes that there are no FDA-approved indications for any medications in the treatment of TBI. Therefore every medication being discussed is an off-label treatment. As well, he notes, even the definitions of different types of TBI leave much to be desired, with very arbitrary factors looked at that may not give a realistic appraisal of the brain damage which has occurred.

The severity of Traumatic Brain Injury can be classified according to the Glasgow Coma Scale (GCS), the duration of post-traumatic amnesia (PTA), the alteration of consciousness (eg, confusion, disorientation) (AOC), or duration of loss of consciousness (LOC). The USA Department of Veterans Affairs uses these four criteria together (Department of Veterans Affairs and Department of Defense, 2009). FitzGerald notes that these classifications may not correspond with the actual brain injury which has occurred, and later showed a slide of a patient with shrapnel in his brain with a diagnosis of mTBI. With regard to the concept of mTBI, he noted, "It's only 'mild' if it happens to someone else."

The scores on the GCS can range from 3 (deep coma) to 15 (fully awake person).

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Mild Traumatic Brain Injury (cont'd)

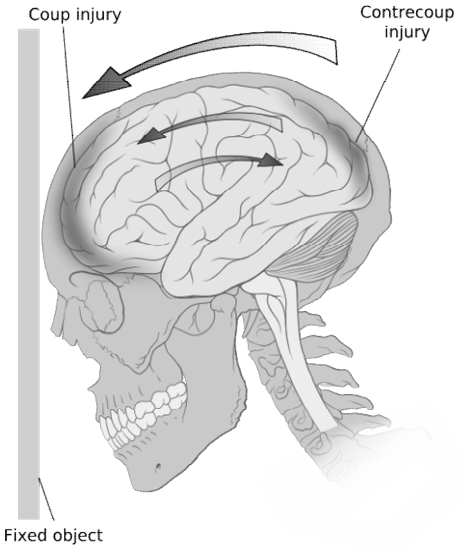
Eye response is graded from 1 (does not open eyes) to 4 (opens eyes spontaneously). Verbal response is graded from 1 (makes no sounds) to 5 (oriented to normal conversation). Motor response is graded from 1 (makes no movements) to 6 (obeys commands). Adding the scores from eye response, verbal response and motor response gives the GCS score.

Mild Traumatic Brain Injury is arbitrarily defined as having a GCS score of 13-15, a duration of post-traumatic amnesia less than 1 day, an alteration of consciousness of less than 1 day, or a duration of loss of consciousness less than 30 minutes. The ways which these criteria are combined for the USA Department of Veteran Affairs and Department of Defense is defined in the DoD-VA handbook (Department of Veterans Affairs and Department of Defense, 2009). FitzGerald noted that in mTBI, "neuroimaging," a term which the TBI community does not rigorously define, but which can be assumed to be some sort of structural neuroimaging, is not required to be done, or if it is available it must be "normal" for mTBI.

In Moderate Traumatic Brain Injury the GCS is 9-12, the PTA is 1-7 days, the AOC is greater than 1 day, or the LOC is 30 minutes to 24 hours. Structural neuroimaging can be normal or abnormal. In Severe Traumatic Brain Injury the GCS is 3-8, the PTA is 7 days or more, the AOC is greater than 1 day (which makes using this criteria on its own confusing since this is the same as in Moderate TBI) or the LOC is greater than 24 hours. Structural neuroimaging can be normal or abnormal.

FitzGerald noted that in military TBI there is both a blast wave, causing overpressures up to perhaps a thousand atmospheres with resultant damage to the brain and other tissues, and the rapid deceleration of the brain, while in civilian TBIs it is mainly blunt trauma. In deceleration of the brain there is a *coup* injury, typically the prefrontal cortex slams into the skull, and then it reverses direction and there is a *contrecoup* injury, in this example in the occipital region.

FitzGerald noted that while in such coup-contrecoup injuries investigation and research is directed towards the contusions which occur at the coup and



A coup-contrecoup injury. Diagram by Patrick J. Lynch. Reproduced under the terms of the Creative Commons Attribution 2.5 License 2006.

the contrecoup sites, much of the serious long-term damage may occur at the corticomedullary junction, at the upper brainstem, at the internal capsule, and at the corpus callosum – areas that receive little attention in neuroimaging studies. A variety of neuropsychological sequelae can result after mTBI. Typically information processing is reduced, working memory is reduced, and there is some executive dysfunction, but the symptoms are varied, depending on the exact injury which occurred. The most common symptoms in the VA System after mTBI are headaches.

With regard to neuroimaging, FitzGerald noted that it was problematic that no standards existed as to what type of neuroimaging should be done for mTBI, or even for the implementation details for any of the neuroimaging techniques used. For example, when looking at a single imaging type such as magnetic resonance imaging (MRI) the type of sequencing done can affect the results (e.g., T1 weighted versus T2 weighted). Diffusion Tensor Imaging (DTI) can show structural integrity of tissue fibers (due to diffusion of water molecules in an aligned direction) such as neural axons. (FitzGerald researches DTI, e.g., FitzGerald, 2011). However, it is not widely available nor is it well-structured for clinical work unfortunately. FitzGerald noted that functional imaging had no role at present in assessment and management of TBI. However work by myself and colleagues (Raji et al, 2014) showed the clinical utility of SPECT neuroimaging after Traumatic Brain Injury, particularly mTBI.

FitzGerald then discussed treatments for mTBI, noting again that all recommendations are off-label and all recommendations are his own, as well as not being official recommendations of the United States Department of Defense. First, he tries to remove alcohol and all other neurotoxin exposure to the patient's brain. He would prefer that patients not smoke marijuana as he feels that it is a neurotoxin. He also tries to encourage tobacco smoking cessation. He will consider adding benzodiazepines, SSRIs or trazodone if the patient is using alcohol for sleep, anxiety or mood issues, and would prefer these rather than the alcohol. There appears to be an increased risk of dementia with long term use of anticholinergics, and

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Mild Traumatic Brain Injury (cont'd)

he reviews the patient's medications for these agents. Commonly used general medications with significant anticholinergic properties include diphenhydramine, dimenhydrinate, and oxybutynin. Antidepressant medications with significant anticholinergic properties include some of the tricyclic antidepressants such as nortriptyline.

FitzGerald then considers the patient's sleep. There is a high prevalence of poor sleep in his mTBI patients. If possible, a sleep study should be obtained. Even if it is difficult to arrange a sleep study, the clinician should at a minimum screen the mTBI patient for sleep disorders. Many mTBI patients also have Gastroesophageal Reflux Disease (GERD) and may be on proton pump inhibitors such as omeprazole. Proton pump inhibitors can reduce the absorption of iron which in turn can increase the risk of restless leg syndrome and consequent sleep derangement. In such cases, iron supplements should be considered. Many mTBI patients will have Post-traumatic Stress Disorder (PTSD) which can result in trouble initiating sleep. Many mTBI patients may be using energy drinks during the day to keep their mood and energy levels up, and other mTBI patients may have obstructive sleep apnea, both which will cause difficulties in maintaining sleep. Nightmares may be an issue for mTBI patients, and a trial of prazosin and/or benzodiazepines can be considered. FitzGerald notes that cognitive decline may be an issue associated with the use of benzodiazepines, but sometimes they are simply needed for anxiety or for sleep issues.

FitzGerald then considers headaches, a common problem in mTBI patients. Headaches are often coupled with poor sleep, and restoring sleep quality can greatly improve the headaches. Musculoskeletal (MSK) complaints are common in mTBI patients and can affect sleep. The practitioner should be careful with MSK treatments that frequently involve anticholinergic medications. Headaches should be treated. If supportive medications do not work, then consider triptans. (Triptans are a family of tryptamine-based medications which can abort migraine and cluster headaches. An example of a triptan would be sumatriptan.) Topiramate (at the lowest possible dose to avoid cognitive impairment) can be tried for the prevention of migraine headaches. Acupuncture seemed to help with headaches in service personnel in Afghanistan.

FitzGerald then considers what can be done to enhance memory. Treating sleep can help, and may be the single most effective intervention according to him. Treating PTSD can help. Reviewing medication lists and removing medications which cause cognitive impairment can enhance memory and general cognitive skills. Sometimes Acetylcholinesterase Inhibitors (AChEIs), for example, donepezil, can help with cognition. Sometimes memantine (NMDA receptor antagonist) can help with cognition. Sometimes stimulants, methylphenidate or amphetamine formulations such as Adderall-XR, can help with cognition. FitzGerald was asked about using modafinil instead of a stimulant, but responded he was likely to just use methylphenidate rather than try modafinil. B vitamins might help with cognition. He was unsure if statins (HMG-CoA reductase inhibitors, for example, atorvastatin) cause cognitive issues in many patients.

FitzGerald did not discuss the use of stimulants in mTBI in much detail. Looking at the literature, there is some controversy as to the efficacy of stimulants in post-traumatic brain injury. Animal models do suggest that enhancing monoaminergic activity via amphetamines help motor recovery from focal brain injury. However, in a *Cochrane Database Review*, Forsyth, Jayamoni and Paine (2006) found that there is "insufficient evidence to support the routine use of monoaminergic agonists to promote recovery after traumatic brain injury." Although in studies amphetamines have not been found to be that useful for post-traumatic brain injuries, there is more support for the use of methylphenidate. In a recent fMRI scan study by Kim and colleagues (2012), methylphenidate-related deactivation of the left posterior superior parietal cortex and parieto-occipital junction, correlating with an improvement in reaction time, was observed.

In the December 2011 *Journal of Clinical Psychopharmacology*, Wheaton and colleagues did a meta-analysis of pharmacological treatments on cognitive and behavioral outcomes in post-acute adult traumatic brain injury. One dopaminergic agent – methylphenidate – was found to improve behavior (less anger, less aggression, improvement in psychosocial functioning) and one cholinergic agent – donepezil – was found to improve cognition (better memory functioning, better attention). However, if the injury-to-treatment interval was allowed to include treatments that were started just before the post-acute phase (greater than 4 weeks after injury) then amantadine also showed benefit for behavior, while sertraline showed benefit with cognition.

FitzGerald then discussed a number of other problems which are associated with mTBI patients. Depressive states are frequently present, and should be treated. If MSK pain is present, as noted above, it should be treated, as it affects

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Mild Traumatic Brain Injury (cont'd)

sleep and is a distraction to learning and functioning in day to day life. Vitamin D deficiency is frequently observed in mTBI patients. FitzGerald noted that the mechanism is not well understood. He wonders if low Vitamin D levels are a marker for sleep disturbance. Thyroid problems are frequently observed in mTBI patients. The shaking and shearing the brain undergoes will also affect the pituitary which will often result in neuroendocrine problems including thyroid function. Social integration problems and family functioning problems are often observed in mTBI patients, and these should receive the social and psychotherapeutic support that they deserve and is available to the practitioner.

FitzGerald did not discuss HBOT (hyperbaric oxygen treatment) in the treatment of mTBI. At the time of this writing, it is not medically available (i.e., it is not an insured service for this indication) to most practitioners in Canada. However, it may be a potentially useful technology for these patients. Bennett, Trytko and Jonker (2004) reviewed the literature on hyperbaric oxygen therapy for the adjunctive treatment of traumatic brain injury and concluded that HBOT reduced the risk of death but not of favourable outcome, and thus "the routine application of HBOT to these patients cannot be justified from this review." Looking more closely at the data of this meta-analysis, there actually was a good improvement (relative risk of 1.94 on normalization of activities of daily living) in the patients receiving HBOT compared to controls, but it was not considered statistically significant being at a p=.08 level.

However, Huang and Obenaus (2011), in their review, note that:

> Traumatic brain injury (TBI) is a major public health issue. The complexity of TBI has precluded the use of effective therapies. Hyperbaric oxygen therapy (HBOT) has been shown to be neuroprotective in multiple neurological disorders, but its efficacy in the management of TBI remains controversial….Early or delayed multiple sessions of low atmospheric pressure HBOT can reduce intracranial pressure, improve mortality, as well as promote neurobehavioral recovery. The complimentary, synergistic actions of HBOT included improved tissue oxygenation and cellular metabolism, anti-apoptotic, and anti-inflammatory mechanisms.

Harch et al (2012) examined 16 military subjects who had received mild to moderate TBI via blasts, underwent neuropsychological evaluation, and then received 40 HBOT sessions over 30 days. The HBOT was at 1.5 atmospheres of oxygen. Neuropsychological evaluations were then done within one week after treatment. There was actually an increase of 14.8 IQ points ($p<0.001$) as well as improvements in depression and anxiety indices. However, the use of HBOT for TBI is still controversial with Cifu et al (2014) not finding improvement in a randomized double blind study. A review article by Mitchell (2014) concluded that TBI was still not an indication for HBOT.

FitzGerald noted that one current controversy in the field is whether we are observing effects from a physical head injury or from the PTSD which develops from the traumatic event. Dr. FitzGerald feels that it is much more than PTSD we are observing. For example, how could PTSD explain the central obstructive sleep apnea often seen in mTBI patients? Another current controversy is the difference between blast injuries and deceleration contusion injuries (blunt trauma). Another current controversy is that conventional wisdom says that in mTBI the symptoms are resolved in 3 months, but in his practice he frequently sees patients 3 years after an mTBI still with significant symptoms. Another current controversy is correlating the neuropsychological symptoms with the physical damage observed.

FitzGerald did not discuss the use of psychotherapy with mTBI patients in much detail. Of interest, work by Bédard and colleagues (2012) at Lakehead University in Thunder Bay, Ontario, showed that mindfulness-based cognitive therapy reduced depression symptoms ($p<.05$) in subjects recruited from a hospital brain injury program and a local head-injury association.

In summary, the prevalence and behavioral effects of mild traumatic brain injury are so widespread that most therapists and primary care physicians are treating patients with it, whether recognized or not. Despite the word *mild*, mTBI can severely impact the life of the patient, and its symptoms can persist. The clinician should attempt to best treat the symptoms of the mTBI and as well attempt to improve the patient's cognition.

Conflict of Interest: None

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Mild Traumatic Brain Injury (cont'd)

Generic Name	Trade Name
	(common, Canadian names where possible)
trazodone	generic trazodone (USA: Desyrel)
diphenhydramine	Benadryl, Nytol Extra Strength, Sleep-eze, Unisom
dimenhydrinate	Gravol (USA: Dramamine)
nortriptyline	Aventyl (USA: Pamelor)
oxybutynin	Ditropan, Uromax
omeprazole	Losec (USA: Prilosec)
prazosin	generic prazosin
sumatriptan	Imitrex
topiramate	Topamax
donepezil	Aricept
memantine	Ebixa (USA: Namenda)
methylphenidate	Ritalin, Biphentin, Concerta (delivery systems different)
amphetamine mixed salts	Adderall-XR
modafinil	Alertec (USA: Provigil)
atorvastatin	Lipitor
amantadine	generic amantadine
sertraline	Zoloft

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THE ART OF PSYCHOTHERAPY

Doctor Michael Balint Revisited: A Reflection

Barry Dollin MDCM, FRCP (C)

As part of a reflective process, clinical practitioners inevitably come to a point when they ask themselves what they consider to be the most significant and meaningful elements of their practice. After forty years of working in psychiatry, I find myself inquiring what it is that keeps me interested in my work. My thoughts have changed over time, but for the past ten years I have found myself circling a crucial question: How are people able to enrich one another's lives? I have come to the conclusion that in the clinical situation I stand to benefit as much from the encounter as my patient. This is a difficult proposition to accept. How can there be reciprocity between a professional caregiver and the person who is suffering from an existing illness? Although the relationship is meaningful to them both, surely a greater gift must be given to the one who has the most obvious need. It is commonly thought that the professional is there to earn a living and that the fee gained should be reward enough. Surely the professional must be there for reasons of altruism rather than self-interest. I have concluded that my relationships in the clinical setting are a two-way street. Although I may temporarily be in a more comfortable position than my patients, I have learned that the people I help can offer me an important gift. We can receive life-changing lessons from all the people who we meet, whether in our homes, on the street or in a clinical office. I would argue that individuals facing medical challenges often have more to offer us because they are dealing with the most powerful lessons that their lives have to teach. Surely it is true that, when the best clinical work is done, both the doctor and the patient emerge from the encounter changed for the better.

This thought is not new to me, but it has endured, becoming more certain with time. We are all searching for some form of enlightenment; for a more vibrant experience of being alive and an increased sense of mastery in our lives. We are perennial seekers. My formal quest began as a young doctor and it may have influenced my choice of a career in Psychiatry. When I was a student of Psychiatry in my late twenties, forty years ago, I attended bi-weekly seminars at the Tavistock Centre in London, England. It was there that I encountered the benefits of the Balint Group, named after the originators of this approach. Those early experiences seemed like adventures at that stage of my life. Only time could tell how influential they would be in the nurturing of my approach to clinical practice. I was starting to discover my individual style of work. There was an intelligence at work that I could not see at that time. While I cherished what I experienced in groups at the Tavistock, I was not aware of the long-term effects those experiences would have on my practice and my life.

Dr. Michael Balint was a Hungarian physician and psychoanalyst who had worked for many years at the Tavistock. His wife Enid was a social worker and one of the streams of their mutual interest was to develop a method of training health professionals that used psychoanalytic methods in a group. From a traditional medical perspective, Balint's methods were unusual for two reasons. The first was that he was a psychoanalyst and so he saw value in the meaningful connection with his patients as well as in the causal and empirical study of their illness. The second distinction may relate to his relationship with his wife. They shared a respect for professional diversity and group work. He ran his first training groups with social workers and later published a book on the work that he did with general practitioners. I continue to value a copy of that book, *The Doctor, his Patient and the Illness* (1974), which I purchased in my days as a student. Recently, I reviewed it to revisit his writing and renew my understanding of some of his ideas. Here is a quote that speaks about how a health care professional can step outside of the usual formalities of his trade and enter a larger and more fruitful two-person collaboration.

> Our experience has invariably been that if the doctor asks questions in the manner of medical history taking, he will always get answers—but hardly anything more. Before he can arrive at what we called "deeper" diagnosis, he has to learn to listen. This listening is a much more difficult and subtle technique than that which must necessarily precede it—the technique of putting the patient at ease, enabling him to speak freely. The ability to listen is a new skill, necessitating a considerable though limited change in the doctor's personality. While discovering in himself an ability to listen to things in his patient that are barely spoken be-

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Doctor Michael Balint Revisited: A Reflection (cont'd)

> cause the patient himself is only dimly aware of them, the doctor will start listening to the same kind of language in himself. During this process he will soon find out that there are no straightforward direct questions which could bring to light the kind of information for which he is looking. Structuring the doctor patient relationship on the pattern of a physical examination inactivates the processes he wants to observe as they can happen only in a two-person collaboration (121).

After starting my clinical practice in individual and group psychotherapy in Ottawa, I began to work with a group of Family Doctors in a seminar that we then called "Psychological Aspects of General Practice." It was 1984, about ten years after my experience at the Tavistock. I facilitated the meetings as a form of consultation and initially modelled the project on Balint's experience. I continue to lead a group of family doctors to this day. About half of the eight members have been involved for over thirty years. Our professional development project has passed through a number of different stages over time. It continues to be an area of my practice that supports my belief that our work as health care practitioners can become a personally enriching enterprise. I see that happening with my colleagues and experience it myself. We can find illumination in clinical practice. At this point in my career it is intriguing to revisit Balint's writing and find the seeds of a practice that has turned out to be so rewarding.

In order to work at what Balint calls a "deeper level," he proposes that the doctor initiate a more creative dialogue in which we find the reciprocity that I spoke of earlier. Both the practitioner and the patient find themselves on equal ground. They listen to one another other by virtue of the questions that arise deeply within themselves. Both are exploring a new domain in an effort to move beyond the bounds of the life they have been living up until now. Both are in need of insight and they both find what they need when the exercise goes well. In the end the patient benefits from the evolving wisdom of the doctor and the doctor himself experiences a "considerable though limited change in personality," to use Balint's phrase. Although I did not know it at the time I participated in groups at the Tavistock, Balint was the first to show me how compassion could become an engine for personal growth.

Another transformative element of the clinical encounter can be found in Balint's concept of "apostolic function." Although he makes little direct reference to spiritual matters in his work, Balint does make metaphorical allusion to the importance of non-scientific experience. He refers to insight that may not be verifiable by immediate proof. He believes in the power of the practitioner's faith. He acknowledges that all health care practitioners have a strong set of personally held beliefs that guide their behaviour, both inside and outside of the clinical consulting room. He accepts that the clinical worker also has an ethical duty to become aware of those deeply held beliefs and to share them with clients when necessary. Balint speaks of the healer this way:

> Apostolic mission or function means in the first place that every doctor has a vague, but almost unshakeably firm, idea of how a patient ought to behave when ill. Although this idea is anything but explicit and concrete, it is immensely powerful, and influences, as we have found, practically every detail of the doctors work with his patients. It was almost as if every doctor had revealed knowledge of what was right and what was wrong for patients to expect and to endure, and further, as if he had a sacred duty to convert to his faith, all the ignorant and unbelieving among his patients (216).

Part of the beauty of his way of looking at clinical practice is that it stirs a spiritual inquiry in the practitioner. An apostle is a unique companion, both witness and champion to the wonders in the life of their patient. If indeed we possess an apostolic mission, then we can also come to enjoy the inevitable blessings experienced by apostles. Those benefits are the direct outcome of the development of our ethical imagination and what we could call an alchemical experience with our patients. The practice of helping others and of ongoing personal development available in clinical practice can transform it into an apostolic or spiritual mission.

While Balint offered some technical guidelines to the structuring of his group experience, it was primarily his holistic vision that informed the way that I worked with therapy groups and professional development groups over the years. Of course, I was also inspired by many other mentors over my career as a psychiatrist. To summarize the enduring elements of Balint's method of practice, I would say that he focused on three principal issues in his groups. The chief interest was to study the doctor-patient relationship. He was more interested in the practitioner's relationship with the patient than with an objectification of the suffering person or the illness that the doctor met in the consulting room. Secondly, he was interested in the patient's relationship with their illness. While he acknowledged the importance of best clinical practices, he

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Doctor Michael Balint Revisited: A Reflection (cont'd)

emphasized the equal importance of the patient's understanding of their illness. Thirdly, there was a focus on the doctor's relationship with his or her peer group. When a clinician presented a clinical encounter in the group, Balint believed that a therapeutic experience could take place between the group members. It thereby became the aim and responsibility of individual members to enrich one another. This last functional element allowed the group experience to take on an unpredictable life of its own.

And so it was over thirty years, in my Ottawa Balint group, as well as in other areas of my clinical and my personal life, that I learned the most important gift that medical practice had to offer its practitioners. Collaborative enrichment proved its merit both inside and outside of the clinic but it was within the professional setting that I was able to study and promote it most effectively. The lessons were simple; we grow in our relationships with other people. We can be favourably transformed in the context of healing relationships. Repeatedly, I observed my patients move beyond their troubles into a larger and richer life. In addition, I watched my physician colleagues in the Balint group grow to be stronger and more compassionate individuals. I saw them become more capable of practicing the kind of medicine that they truly believed in. In the end I also came to recognize my own enrichment from clinical work. Now, in reflection, I endeavour to share that story and its benefits with you.

Conflict of Interest: None

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Reference:

Balint, M. (1974). The doctor, his patient and the illness. London, England: Pitman Medical.

Processed Pain

Josée Labrosse, MD, MEd

Tamed
Black dogs
Wake Fierce,
Even after
Peaceful sleep.

Shit disturbed
Smells foul,
Even deep in caïbo's keep.

Fruit trees bear well
From compost's mercy,
Riches reaped.

With Spring In Mind

Josée Labrosse, MD, MEd

I have the privilege, opportunity, and sometimes discipline to walk daily along the shores of a lovely river. There are exceptions, like the rainy late-winter day when an icy bank pulled me towards a rising torrent. "I could actually slide in unnoticed and be dragged into the falls" I mused. I decided to turn back, reminded that my youthful invincibility had…matured.

A few weeks later, spring was due. Clocks sprung forward, the sun offered hope when it could. Monday morning I believed it had strong intentions, and so I failed to dress respectfully. Bracing against the chill, I cursed the uncooperative season, and my lack of judgment, and clenched hard to suppress the chatter. So much for maturity—I made the same sartorial mistake on Tuesday.

But Wednesday the sun's radiance broke through, igniting cells in my bones. It sent blood surging with procreative urgency through artery and vein, sharpening bleary eyes, bursting open dormant ears, and flowing through my dammed-up brain. What a rush! "Maybe this is how maples feel when the sap begins to flow in spring." I pondered this a while, then realized "I sound like I'm on drugs."

I really enjoyed the walk. Throughout the day's work, everyone showed or described a similar visceral awakening. I decided to embrace spring and break my *love-of-sleeping-in-until-I-must-by-duty-rise* habit, by attending Friday's early morning meditation at my nearby office, The River House. I woke and rose with surprising ease, bleary eyes notwithstanding, and stepped outside. Piercing bird song startled me and sent my heart racing. I love birds in the morning. But this was different. It was loud and frenzied, overwhelming and funny at the same time. Not like Hitchcock's birds, more like the remote memory of a song from *The Music Man* reverberating "pick-a-little-talk-little, pick-a-little-talk-little, cheep-cheep-cheep, talk-a lot, pick a little bit."

I walked over and found a spot to sit among the meditators and breathed in fresh air through finally opened windows. As I tried to settle the birds seemed to be getting louder, their pitch and pace building towards some mad crescendo. They were disturbing my peace, '*noising me*', as my baby-daughter used to say. "Damn birds", I thought. "I'm trying to meditate".

"Really? I'm judging the birds I claim to love? Don't judge the birds. Accept the birds. Accept their chirping. Listen without hearing. Be joyful in their presence. *Where is my brother with his BB gun when I need him…?* Out, out! damned shameful, violent thought. May the birds be safe...Focus on breathing. *Cheep-cheep-cheep-talk-a-lot, pick-a-little-bit.* Sooo much chatter!"

Then it dawned on me: Birdbrain.

"Birdbrain."

"Birdbrain!"

"This is birdbrain. Birdbrain of spring."

"It's the vibrancy trees feel when sap flows after the long freeze. It's what my mind does when it wakes up. What is the point of meditation, but to awaken to what is? What is. So present this morning? The quickening of spring. And *my very own birdbrain*."

Such insight! I mock my own mind's need to schmooze this thought into a metaphor of meditation-acceptability, cracking myself up with my lame joke. A chuckle surges silently from belly to brain, and ripples back down through throat and shoulders, pooling deep in my core. The ripples subside, slowly, as I sit. Still. Quietly amused. And welcome spring. All of it, even its twittering and babbling, bursting and rushing, wild surges that disturb serious cold stillness.

Stillness comes with practice, but in a style befitting time and season. And one's own true nature. With spring in mind, I welcome this birdbrain home.

Conflict of Interest: None

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Using Intentions to Find Your Zen Again: A Reflection

Lori Chamberland, RRPr, BA

I've finally cracked the code. I've uncovered the core cause of my worries: My thoughts.

Most of my life I've struggled with anxiety. Nothing debilitating, just a fairly frequent gnawing at my gut like something was going to go wrong at any moment. Even when things were going well I was always waiting for the other shoe to drop.

Nine years ago, I started a long and intense study of yoga and Ayurveda (India's traditional system of mind-body medicine) and have since helped clients find ways to relax using the powerful tools and techniques from these two ancient traditions.

One of the most powerful tools I learned as a student of yoga and Ayurveda is to be more aware of our thoughts. What I came to realize was that many of my thoughts revolved around lack: "I don't have enough time." "I don't have enough money." "I don't have enough knowledge."

I learned that these thoughts (called samskaras in yoga and Ayurveda) have a direct effect on our nervous system, setting off the switch to get us ready to run, fight or freeze in defense of some invisible predator. Psychologists refer to this pattern of thinking as "negative automatic thoughts" or NATS.

What I also learned is that we can shift NATS into more positive, supportive thoughts. In fact, we can create whole new pathways in our brains. Instead of our thoughts taking the well-worn path of least resistance—the ones we've carved out through years of negative thinking—we can create new pathways. These new pathways can lead us to take action that supports our dreams and desires instead of taking us into a loop of doom, dread and worry.

One of the most powerful tools used in yoga and Ayurveda for changing mental bad habits is meditation.

Although I had been working with yoga postures and even some of the breathing practices regularly, it was not until about two years ago that I started a regular practice of meditation. There are numerous ways to meditate, but I gravitated towards a technique called japa meditation. Japa meditation uses the power of words. Traditionally Sanskrit phrases or "mantras" are used as a focal point during the meditation. Since Sanskrit is difficult to pronounce and the meanings of the phrases sometimes challenging to grasp, I decided to swap Sanskrit for some simple intentions in hopes of changing those dreaded NATS into something more constructive.

What I discovered through my exploration was powerful. (I would never have had the confidence to even attempt getting published in a professional journal even one year ago.) I have since shared the technique of meditating on an intention with many of my clients.

One thing that makes japa meditation user-friendly is a string of beads called a "mala." A mala looks like a rosary and is used to count repetitions of a mantra or intention, just as a rosary is used to count prayers. The challenge is that malas are traditionally 108 beads, which can be intimidating for a first-time meditator, someone who has very little time, or a person who claims to have the attention span of an eight-week old fox terrier.

I use a 27-bead wrist mala rather than the traditional 108-bead mala. My clients usually feel comfortable using the bracelet as a starting point. The other thing clients really like is that the bracelets are a great reminder to meditate or at least keep their intention top of mind.

I also use a short practice using some simple grounding yoga postures and conscious breathing to prepare the mind and body to sit in stillness for meditation. Bracelets can be personalized as can the intentions. Each practice ends with a moment of gratitude.

This combination of relaxation, repetition and gratitude is a powerful tool to help clients tap into their inner optimist. This is important I learned, because when we think more positively we live longer, get sick less often and generally enjoy life more.

The yoga-based practice using the bracelet is short and simple so it works well for people who are working with the "I don't have enough time" or "I can't sit still long enough to meditate" NAT. It's also very basic and gentle, so works for people who are stuck on the "I can't do that" NAT.

I know from my own journey through self-doubt and anxiety that we don't have to live with monkeys on our backs (aptly referred to as the "monkey mind" in yoga and Ayurveda). According to yoga and Ayurveda, we are all inherently peaceful, joyful and content. Meditating on a positive intention is a great way to find our way back to that place of zen again.

Conflict of interest: None

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GPPA INTERESTS

GPPA 28th Annual Conference

Josée Labrosse, MD, MEd, Emma Labrosse Mitchell, and Tobi Abdul, BA

The theme for this year's conference was *The Use of Integrative Psychotherapy; Mind, Body and Soul.* Over one-hundred and fifty-five delegates gathered at the DoubleTree Hilton in Toronto, marking a historic time for the Association. Inspiring key-note addresses from patient advocates and seasoned professionals were followed by a range of workshops. Theory and practice, art and science, presentation and experiential learning fostered collegial exchange and brought new insights. The conference reinforced ancient and acquired wisdom, all in support of professional development truly applicable to the range of needs in general practice psychotherapy. Success in securing a new role in maintenance of certification brought added importance to the event, with great opportunity and responsibility for ensuring quality and reaching out to new members across the country. It marked a turning point, an opportunity to engage the successes and reach out and increase access to quality psychotherapy through education, collegial exchange, and support.

The opening keynote from Mark Henick, *Giving Face and Voice to the Cause We All Share: Healing Minds, Bodies and Souls,* set the tone with messages about compassion, resilience, and healing that would echo throughout the conference. Henick is the youngest board member in the history of the Mental Health Commission of Canada and the youngest President of a provincial Canadian Mental Health Association division. His 2013 TEDx video went viral, reaching over 500,000 views. He recounted his painful experience of mental illness and inaccessible care as a young man. Serious suicidal intent was interrupted in a chance encounter with a compassionate stranger that saved his life and led him to transformative change. His mission is to give back. His message is clear: to help end the stigma and discrimination around mental illness, and to issue a call for quality compassionate care, hope, and resilience. The message was not new to this audience, resonating with the collective experience, the very *raison d'être* for the association and the conference. This was more than just a gathering of medical professionals; it was a room full of compassionate physicians and therapists dedicated to making the kind of difference Mark described. An irony was apparent to many in attendance. The association's historic commitment to supporting these ideals remains relatively unknown within the medical, mental health, and larger communities.

Mark Henick gives a face and a voice to depression in the opening keynote.

Dr. David Posen acknowledged support from founding GPPA members and presented an approach honed through 30 years of clinical practice, writing, teaching, and practicing what he preaches. He shared his approach, *Stress Mastery: A Toolkit for Patients (and their Doctors),* recognizing the need among patients and professionals for effective manageable changes to support health in modern life. He offered eight "Best Bang for The Buck" suggestions to change unhelpful habits he calls "losing games"—among them caffeine elimination, commitment to improve sleep, pacing, setting realistic goals and expectations, and making time for exercise and leisure.

Dr David Posen engages participants in a lively discussion on stress mastery.

The Annual General Meeting marked several transitions in leadership, honoured significant accomplishments and pioneering work, and offered updates about GPPA's stellar 2013-2014 year and future direction. Among accolades too numerous to mention here, it was announced that Dr. Ted Leyton would receive the Theratree Award for his contributions, and outgoing president Dr. Muriel van Leirop would be honoured at a reception. Incoming presi-

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GPPA 28th Annual Conference (cont'd)

dent Dr. Brian McDermid emphasized the need to build capacity for outreach, education, and accreditation monitoring, all facets of the association's work. Delegates were invited to join in the various committees' educational work and outreach initiatives and to build on the accomplishments of the many dedicated physicians and supporters of the GPPA.

Day One continued with a variety of workshops on Integrative Psychotherapy. These offered a range of pertinent experiences: *Mindful Self-Compassion* (Dr. Ginny McFarlane), *Interpersonal Psychotherapy* (Drs. Michael Paré and James Whyte), *Building Mental and Physical Health* (Dr. Greg Wells), *Naturopathic Approach to Psychotherapy* (Dr. Johnathan Prousky), *Gut Microbiota and Mental Health* (Dr. Jane Foster), and *Evidence -Based Psychotherapy for Insomnia in Medical Settings* (Dr. Colleen Carney). Participants engaged with the presenters and each other, with insights and practical approaches emerging.

A reception to welcome new members

An exercise in self-compassion, led by Dr Ginny McFarlane.

capped the first day. We witnessed renewed friendships and connections, and new acquaintances. There was dialogue and some debate, networking and lively exchange as folks enjoyed delicious refreshments and a few good laughs.

Cameron Algie, another young man

A demonstration of interactions.

who transcended severe mental illness—in his case crippling anxiety, shared his experiences of care, and the discovery that participation in improv theatre helped him recover mental health and well being. He recounted his own panic and terror at the mere thought of doing improv, and how he came to join the Second City Training Center where he now teaches *Improv for Anxiety.* He led participants in exercises that he teaches, engaging the large audience in playful and challenging behaviour experiments. Unconventional for a professional conference, the presentation brought laughter and presented a brave side of recovery that can be rooted in leisure and even silliness.

Dr. John Denninger followed with a more serious tone, *Healing the Mind and Body with Meditation: Ancient Practices, Modern Evidence.* He is the director of research at the Benson-Henry Institute for Mind Body Medicine and presented cutting-edge research into the art and science of integrative medicine and psychotherapy, raising important new

questions for research and clinical applications, while providing solid grounding for innovations being explored at the conference.

Delegates were able to expand their understanding and skills through the afternoon workshops, which included approaches to mindfulness practices for physicians' self-care and patient care, with Dr. Heidi Walk, and another with Dr. Paul Kelly. Dr. Joaqin Farias introduced an approach to harness neuroplastic change to treat a movement disorder (focal dystonia). Mathew Remski guided exploration of integrating Ayurveda and Yoga as embodied psychotherapy. Dr. Denninger hosted viewing and discussion of the film *The Connection: Mind Your Body*, a documentary that presents patient experiences, and clinician-scientists' understanding of the healing power of integrative mind-body-soul approaches.

Dr Matthew Remski presents on ayurveda and yoga: embodied psychotherapy of the elements .

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GPPA 28th Annual Conference (cont'd)

This year's focus was enlightening for many. The conference introduced new concepts and ideas to outsiders, new members, seasoned physicians, and GPPA members who built skills and mindfulness practices, and received support for personal insights and experience. Emphasis on self-care, self-awareness, and collegiality to support the practice of psychotherapy was welcomed. At closing, there was much to reflect on, to integrate and to apply in personal life and practice. The work of building the association's active role in providing effective psychotherapy and mental health care in Canada appeared strengthened. After two days combining fun and serious learning, the organizers succeeded in the primary goal of exploring the use of integrative psychotherapy. To quote incoming president Dr. Brian McDermid: "KUDOS!" to organizers and presenters, with ample heartfelt appreciation. He invites ongoing sharing of insights in the GPPA's Listserv conversation.

Conflict of Interest: None

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Emma Labrosse Mitchell, a conference volunteer, is studying anthropology and is the coordinator of the Student Health Education Centre at McMaster University.

Tobi Abdul, a conference volunteer, is in Communication Studies at McMaster University, ready to take on the world of postgrad. Her passion lies in pop culture criticism and commentary.

Dr Jane Foster presents on gut microbiota and mental health.

Practicing empathic listening.

Dr Colleen Carney presents an evidence-based psychotherapy approach to insomnia.

Dr Michael Paré presents with passion.

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GPPA 28th Annual Conference (cont'd)

Are doctors allowed to have this much fun? An exercise in improv, by Cameron Algie.

Standards for Psychotherapy

Informed Consent Part 2: Express Versus Implied Consent[1]

Michael Paré, MD, MEd, MSc, Laura A. Dawson, BA, and Bryan Walsh, MA

[1] Note correction: the article on Standards for Psychotherapy published in the previous issue of GP Psychotherapist (vol 22 #2, Spring 2015) should have been titled, "Standards for Psychotherapy: Informed Consent Part 1" and the order of the authors should have been Michael Paré, MD, Laura A. Dawson, and Bryan Walsh.

The purpose of this article is to help ensure that Primary Care Physicians, General Practitioners and Family Practitioners in Ontario are well acquainted with the expectations concerning the standards of psychotherapy in medicine. This is the fourth in our ongoing series of articles which discusses these complex and important topics.

Introduction

This article will continue to investigate the requirements of informed consent by providing additional examples, information, and a detailed discussion of express versus implied consent in psychotherapy. The information provided in this article will stem from the *Health Care Consent Act (HCCA)* and the policy summary of the *HCCA,* entitled *Consent to Medical Treatment*, created by the College of Physicians and Surgeons of Ontario (2006). The *HCCA* is quite lengthy and covers many areas which are beyond the scope of this paper. It may be important for physicians to review the document themselves, especially with regard to information pertaining to patients deemed incapable of providing consent. However, a new policy summary of the *HCCA* will soon be released by the CPSO, which also pertains to the aforementioned issues.

Considering that the *HCCA* and the CPSO's policy summary largely focus on issues of the determination of capacity and incapacity, the details of these documents are not particularly relevant to medical psychotherapy involving adult patients. A detailed analysis and focus on the determination of capacity and the need to choose a substitute decision maker (SDM) are rarely, if ever, necessary in a typical medical psychotherapy practice with adult patients. However, for your reference we have listed a number of possible "red flags" which indicate that a patient may be incapable of granting consent (Appendix A). To reiterate, the information provided in this article is *not* comprehensive and will focus on apparently capable patients who do not appear to suffer from any diminished capacities which could impede their ability to provide legitimate consent to treatment.

Legal Observations

Our primary ethical and legal mandate, as medical professionals, is to *primum non nocere*, meaning: "First, do no harm…whatever the intervention or procedure, the patient's well-being is the primary consideration" (First do no harm, n.d.). Since it is felt that treatment without consent could potentially be harmful, the obtaining of consent not only protects the patient mentally and physically, but also protects the psychotherapist legally.

The expectation that doctors will obtain consent before administering treatment has been increasingly imposed upon medicine over the past generation: first for surgical procedures, then for some aspects of general medical practice, at times for medication, and finally for psychotherapy. However, as mentioned in our previous article, physicians still maintain significant latitude over how consent is obtained for psychotherapy in our medical practices. Here is a sample case in which a psychotherapist utilizes this latitude within her practice:

Case 1: Determining Capacity & Postponing Consent

During an initial therapy session, the client appeared quite excited. Speaking rapidly, he told the psychotherapist he was planning a gambling trip that he was sure would win him millions of dollars. After some probing, the therapist learned that the client had recently stopped taking his medication prescribed for bipolar disorder because he had been feeling so happy.

The therapist decided to postpone discussions of some elements of informed consent and focus the initial session on helping the client deal with his manic episode and the immediate crisis. After assessing the client and deciding that he was not in immediate danger, at the end of the session, the therapist and client made a follow up appointment for the next day and the therapist gave him a referral for an appointment with a psychiatrist with whom she often consulted.

During the second appointment, the practitioner felt the situation was stable enough to present the client with information pertaining to informed consent including the anticipated nature and course of therapy, and a discussion of fees and confidentiality policies (Fisher & Oransky, n.d.).

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Informed Consent Part 2 (cont'd)

Obtaining Valid Consent

You may recall that valid consent is determined by four main standards: (1) consent must be directly related to treatment, (2) it must be informed, (3) voluntary, (4) and must not be obtained by "misrepresentation o fraud" (Service Ontario E-Laws, *HCCA*, s. 11.1, 1996). In order to further facilitate an understanding of these standards we have provided a sample case below. This case portrays a therapist who properly discusses other available psychotherapists and treatment options with the patient, respects the CPSO's "advertising" rules, and subsequently avoids the likelihood of obtaining consent through fraud or misrepresentation.

Case 2: Respecting the CPSO's "Advertising" Rules

Patient: I understand you can provide psychotherapy?

Doctor: Yes, I am a General Practice Physician who practices psychotherapy. That means I am not a specialist Physician. There are two kinds of physician specialists in Ontario: some are Family Physicians who are specialists in Family Medicine, and some are members of the Royal College. In the area of Mental Illness, these are Psychiatrists who have four additional years of training in the areas of mental illness, diagnosis and treatment.

Patient: (Smiling) Is that a yes or no?

Doctor: (Smiling) Ha, Ha, Ha. It is a yes! Even though I am a generalist – not a specialist – I am fully able and credentialed to provide psychotherapy. I refer to myself as a "General Practice Physician Practicing Psychotherapy." To clarify, I am not a psychiatrist or psychologist. Nevertheless, I have taken several additional courses of postgraduate training in the area of Mental Health. To be entirely upfront with you – there are many other types of psychotherapists, many of whom have more impressive credentials and higher academic positions than I have.

Patient: Is that important?

Doctor: Well, I'm not sure – in my reading of the literature: No. Yet, you may also want to ask others about that. If a psychotherapist is fully licensed to practice, it is generally unnecessary to have more advanced credentials in order to be fully competent and highly helpful – at least – in one's scope of practice of psychotherapy.

Benefits and Risks

In order to obtain valid consent it is critical that the likely benefits and risks associated with treatment are related to the patient. The American Psychological Association (2012) identifies some examples of potential societal benefits which may be associated with psychotherapy. These benefits include, but are not limited to:

- A reduction in overall medical utilization and expenses, compared to an increase in medical costs for those who do not obtain treatment for a mental disorder.
- Research indicating that psychotherapy is "cost-effective, reduces disability, morbidity, and mortality, improves work functioning, decreases use of psychiatric hospitalization, and at times also leads to reduction in the unnecessary use of medical and surgical services including for those with serious mental illnesses."

On the other hand, a number of material risks may also be present throughout the psychotherapeutic process. The Medical Clinic for Person-Centred Psychotherapy identifies a number of these risks in the following statements:

Psychotherapy is an emotional process that can at times evoke unwelcome emotions, like pain, anxiety and even anger. A patient can even experience a worsening of depression symptoms. A patient may at times feel angry and frustrated at the therapist. Other strong feelings a patient may feel towards the therapist are those of dependency, love, [and/or] personal concern ... for the psychotherapist's well-being (Paré, 2014).

Another material risk that may be present throughout therapy is the possibility of stigma. Stigma is often associated with attending therapy sessions and consists of many negative aspects such as *Labeling, Stereotyping, Separation, Emotional Reaction, Discrimination,* and a *Power Differential* (Abbey et. al., 2011).

Express vs. Implied Consent

One area of consent which has been the source of some debate concerns permission to utilize implied versus express consent when obtaining informed consent from a patient. The CPSO (2006) has defined express consent as being: "…directly given, either orally or in writing. It is positive, direct, unequivocal consent, requiring no interference or implication to supply its meaning." Based on this definition, what should a physician do when a patient expresses a desire to avoid or abstain from talking about a certain topic in psychotherapy? Here is a case in which a therapist must recognize the difference between what is often labeled "resistance" and the patient's express withdrawal of consent:

Case 3: Withdrawal of Consent vs. Resistance

A psychotherapist greets a new client and begins taking an assessment of the client's current circumstances. After asking a series of routine questions, the therapist feels it is necessary to take a sexual history of the patient as well. When asked about his past and current sexual experiences, the patient says, "I don't want to talk about it." The thera-

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Informed Consent Part 2 (cont'd)

pist prods, "Oh, come on now, you can talk to me about this kind of thing. Sometimes the issues we most resist talking about are the ones we really need to discuss." The patient moves uncomfortably in his chair and says, "No, really. I don't want to discuss it."

Considering that patients have the right to withdraw consent to treatment at any time this patient's refusal should not be taken lightly (Service Ontario E-Laws, HCCA, s. 2, 1996).

Implied consent, on the other hand, is described as: "consent that occurs when surrounding circumstances are such that a reasonable person believes that consent has been given, although no direct, express or explicit words of agreement had been uttered" (CPSO, 2006). It is important to note that implied consent does not suppose that the usual activities and processes of the psychotherapist – such as taking a history, conducting a mental status examination, and developing rapport – are necessarily sufficient to "imply" consent to the subsequent provision of psychotherapy.

It is also important to restate that implied consent is *not* the same as waiving consent (Silberfeld & Fish, 1998). A noted lawyer, Kenneth Evans (2006) – a member of the General Council of the Canadian Medical Protective Association – has emphasized this point by stating that, "in many situations the extent to which consent was implied may later become a matter of disagreement. Physicians should be reasonably confident the actions of the patient imply permission for the examination, investigations and treatments proposed."

As previously mentioned, consent – whether express or implied – is only valid if the patient has been given sufficient information to make an informed decision (Silberfeld & Fish, 1998). Below, we have illustrated a sample case in which implied, rather than express, consent is utilized by a practitioner.

Case 4: Implied Consent
Susan is a Family Physician practicing psychotherapy on a part-time basis. She provides a variation of short-term, supportive psychotherapy. Although she does not obtain any written or signed consent, she sufficiently explains her fairly simple type of psychotherapy in some detail: she outlines alternative treatments and highlights both the extent of her training and her clinical experience. Susan also outlines her relatively modest formal credentials as compared to a number of other professional psychotherapists. She briefly outlines both the benefits and difficulties patients may experience when participating in psychotherapy (the time commitment, the potential emotional upheaval, and that there is no guarantee of improvement, etc.). Susan also mentions that there is a chance that refraining from treatment may result in continuing or worsening symptoms and, finally, she answers a few questions the patient has concerning the treatment. She does not write in the Medical Record that consent has been discussed or obtained for the provision of her variation of short-term, supportive psychotherapy.
Disclaimer: this case provides an example of what we consider may likely be seen as sufficient, implied consent. However, due to the vague description of the standards of implied consent, the example illustrated in this case is not to be taken as medical or legal advice.

Interestingly, the Transitional Council of the College of Registered Psychotherapists of Ontario (2013) has a more stringent standard for the documentation of informed consent, stating that: "Any consent that is obtained should be included in the record such as copies of signed consent and any notations of consent including verbal or implied." It may be prudent for physicians practicing psychotherapy to follow this more demanding requirement, and yet it is not the standard for the profession of medicine, as far as the authors can determine.

Conclusion
To understand a number of the many facets of consent, it is advised that this article be read in conjunction with our previous article entitled *Standards for Psychotherapy: Informed Consent* (Part 1). This article is meant to provide a brief overview of a number of important aspects of consent, in conjunction with practical examples and cases which may assist physicians with the process of obtaining consent from patients for psychotherapy. For a more thorough approach, we suggest practitioners view the *Health Care Consent Act* and the CPSO policy summary of the *HCCA* entitled *Consent to Medical Treatment*.

Conflict of Interest: None

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Michael Paré practices psychotherapy in Toronto. He is the Chair of the OMA Section on Primary Care Mental Health and has a particular interest in medico-legal issues of the practice of medicine. Michael recently completed the Osgoode Certificate in Professional Regulation & Discipline in the Ontario Health Care Sector, and is currently completing the Osgoode Professional Development Certificate in Mental Health Law.

Laura A. Dawson currently assists Michael Paré as a researcher focusing on Supervisory Reports for submission to the CPSO. She is also a Co-Curriculum Development Assistant in the creation and submission of MainPro-C programs for physicians practicing Psychotherapy in the Toronto area.

Continued on Page 20

Informed Consent Part 2 (cont'd)

Bryan Walsh has been practicing group and individual psychotherapy in Toronto since 2014. He primarily uses IPT, though has been trained in CBT.

Appendix A

"Red Flags" indicating that a patient may be incapable, with regard to treatment (Culo, 2011).

This list is by no means exhaustive:

- Apparent diminished neurological or cognitive capacity (e.g., psychosis, dementia, etc.)
- Inability to adequately understand the elements of the treatment
- One or a combination of the following:
  - Substance Abuse or Intoxication
  - Refusal of Apparently Necessary Treatment
  - Disorientation and/or Confusion
  - Fearfulness, Suspiciousness, Paranoia
  - Frank Suicidal Thoughts and Plans
  - Impaired Insight, Poor Judgment
  - Impaired Executive Function (e.g., task initiation, reasoning, planning, problem solving etc.).

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Reflections from Incoming GPPA President

From Where I Stand
Brian McDermid, MD, MTFAPA, CCFP, CGPP

In my new role as Incoming President of the General Practice Psychotherapy Association (GPPA), there would appear to be many possible places to plant my flag. One thing for certain—this role now seems very different than when Catherine and Muriel first suggested that I agree to come aboard as Vice President two years ago. There are already many new opportunities and initiatives that we as a Board are working on in order to support our core vision and to sustain the central objectives of our association. One of the most important initiatives that you are bound to hear a great deal about is the potential for enhancing our education program through greater collaboration with the OMA section's Mental Health offerings. This will not provide for everything that we want in a more comprehensive psychotherapy training program, but we are doing our best to utilize resources at hand, not wanting to miss the many opportunities that are already available to us—most often developed by our members themselves. Additionally, we would more than welcome a small number of our GPPA members, some yet to be discovered, with excellent research and presentation skills, to help us with the development of this program.

We are already engaged in technological change, with Catherine introducing the Committees and our Board to "Go to Meeting," which enables audio-visual communication. And Ted Leyton is giving us reason to experiment with alternative possibilities for enhancing our Listserv communications and our small group communications with one another. If that weren't enough, the longer term goals of our Outreach Committee are moving along with Catherine's first attempts to enhance our social media presence. And this initiative is likely none too soon, given the pace at which we are all moving, even though so many of us would like to use our tools to help us all slow down enough to better experience what's going on right in front of our faces.

One of the most important concerns we currently face relates to the issue of our identity at a time when the politics of mental health is in the spotlight. This relates not only to how we think of ourselves, in terms of who we are, but how other stakeholders, including governmental and regulatory bodies, the general public, other mental health professionals, and most importantly, our patients themselves, think of us as Medical Psychotherapists. Because of the recent impetus to enhance our visibility from within our committees, several Committee Chairs and Members of the Board have supported my efforts toward rebranding our Association. The consensus thus far is that we need to incorporate the core of who we are professionally, within our Association title, recognizing the importance of our medical roots, while emphasizing our national identity. For this reason I am recommending to the Board that we consider changing our name to "Medical Psychotherapy Association of Canada" (MPAC or perhaps, M-PAC). Of course, there will be much discussion amongst the membership about this proposal, which I personally encourage and welcome. Thus far, the early feedback would appear to be very positive. Our next steps, yet to be approved by the Board, may involve communications with our Third Pathway regulator, the College of Physicians and Surgeons of Ontario.

While at the recent GPPA conference, I reminded just about everyone who congratulated me, or asked about the transition of leadership, that no one person can, or likely will, "replace" Muriel van Lierop, our outstanding and outgoing many-term President. Muriel will continue to offer, to both me and the rest of the leadership, ongoing consultative support as needed. While the Annual Conference provided opportunity to meet many members individually, meeting more of you will require ongoing effort. Muriel has certainly done her utmost to provide a wonderful model for leadership within the GPPA. One secret that has not been passed along to me however, is how to accomplish so much with so little available time. There simply is no App for that. The GPPA can only be a strong and effective voice, organizationally, to the extent that our Membership will allow, through the

Continued on Page 22

Reflections from Incoming GPPA President (cont'd)

voluntary offering of your individual voice and your individual participation. So please, do remember, whenever a call is placed asking for the support of members in filling a position on a committee, how important it is for each of us to make a contribution to the GPPA, as the voice of Medical Psychotherapy in Canada.

I look forward to meeting with new Members and having ongoing discussions with Members who have been part of the GPPA journey over the years. Those who are tuned in to our Listserve know how strongly many of us feel about the importance of having a Certificate of Added Competence (CAC) in Mental Health and Psychotherapy. Your Board has maintained an active interest and involvement in this important issue and has recently begun to address our current position, given that the College of Family Physicians of Canada (CFPC) has recently expressed interest in the need for developing further CAC's. We are awaiting a response to our recent letter to the CFPC and hopefully will have it by the time you are reading this report from me. That's it for now, from where I stand.

Conflict of Interest: None

Contact: brianmcdermid@icloud.com

Brian McDermid is a Toronto medical psychotherapist. Prior to receiving his MD at McMaster, he co-founded the first children's mental health treatment centre in Northern Ontario, directed Special Services for "Hard to Serve Youth" for the Province of Ontario, worked in several senior capacities at the Children's Aid Society of Toronto, and completed his PhD (ABD) in clinical psychology at York University.

Report from the GPPA Board of Directors

Catherine Low, MD, CGPP
Chair, Board of Directors

The 28th Annual Conference of the GPPA

This year's conference was held in Toronto at the Hilton Doubletree Hotel (Chestnut Street) on Friday, April 24 and Saturday, April 25, 2015. The title and theme of the conference was The Use of Integrative Psychotherapy: Mind, Body and Spirit. Please see an overview of this event elsewhere in this issue. This year's committee is now hard at work to create another energizing and informative annual conference for us next spring.

The Fourth Annual GPPA Retreat

The fourth annual GPPA Retreat will take place on the weekend of October 23-25, 2015 at the YMCA's Geneva Park facilities in Orillia. The retreat will feature an introduction to Internal Family Systems. David Berceli's Trauma Release Exercises and the concept of Integrative Rest will also be explored. The facilitators will be Dr. Harry Zeit MD, CGPP, and Amy Alexander, MD, MHSc, CCFP.

Outreach Activities

The GPPA was well represented by enthusiastic GPPA member volunteers at the Primary Care Today conference (May 6-9, 2015) and will also be represented at the upcoming Family Medicine Forum (November 12-14, 2015) in Toronto. Volunteers have been vital to the success of our booths at these events in past years. The booths offer pamphlets, handouts, and a promotional video to show to prospective new members. The Outreach Committee welcomes additional volunteers to sign up and spend some time at the booth in November. CCI credits can be given for these discussions with colleagues at the booth.

Presentation to the Education Committee of the College of Physicians and Surgeons of Ontario (CPSO)

The GPPA is now entering the third year of the three-year provisional period granted to us as a third pathway by the CPSO. One of the requirements during this provisional period is that the GPPA make an annual presentation to the Educational Committee of the College. The second annual report occurred at the CPSO offices on May 22, 2015. The GPPA was represented by Muriel van Lierop, Andrew Toplack, and Stephen Sutherland. Muriel gave a PowerPoint presentation outlining the work that various committees have done over the past year to ensure that we are able to offer top quality education, accreditation, and auditing for our members. This was followed by a question-and-answer period. The report was very well received and the members of the Education Committee were very pleased with the progress the GPPA has made.

GoToMeeting APP

The GPPA has purchased a one-year subscription to this web-based meeting application. This application will facilitate video conferencing and the display of documents for drafting and editing during committee and Board meetings. It can also be used to deliver distance education for groups of up to 25 participants. Requests to use this application must go through Carol Ford, who will determine the availability of the app and send participants e-mail invitations with a link to the site prior to the meeting. The app GoToMeeting must be downloaded to the participant's computer or tablet prior to first use. There is no charge to the participants for the use of this service.

Conflict of Interest: None

Contact: mclow98@gmail.com

Catherine, the current chair of the board, has been a member of the GPPA since 1996 and involved in committee work since 2007. Her medical practice began in Scarborough with an interest in women's health, and continued in Ottawa where work with immigrant women led to her interest in psychotherapy. She currently practices in Belleville.

Muriel van Lierop is thanked for her many years of service to the GPPA Board.

(Left to right)
David Levine,
Helen Newman,
Muriel van Lierop,
Catherine Low,
Gary Tarrant,
Mary Louise Hull

Journal of the General Practice Psychotherapy Association

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e-mail Janet Warren at journal@gppaonline.ca

To Contact a Member - Search the Membership Directory or contact the GPPA Office.

Listserv
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Questions about submitting educational credits – CE/CCI Reporting , or Website CE/CCI System - for submitting CE/CCI credits,
contact Muriel J. van Lierop at vanlierop@rogers.com or call 416-229-1993

Reasons to Contact the GPPA Office
1. To join the GPPA.
2. Notification of change of address, telephone, fax, or email address.
3. To register for an educational event.
4. To put an ad in the Journal.
5. To request application forms in order to apply for Certificant or Mentor Status.

The views of individual Authors, Committee and Board Members do not necessarily reflect the official position of the GPPA.

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