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From the Editor

Caring for ourselves as medical psychotherapists can be challenging. As you read the articles by Drs. Paré and Labrosse, you will notice that their approaches are directed at different facets of the roles that we assume in our profession. Both articles have online supplements, which assist in applying their suggestions to our practices.

Michael Paré and his associates provide a convincing case on page 14 for a standardized approach to obtaining informed consent. They tellingly state that the process is becoming increasingly mandated by law. Aside from this consideration, I also agree with them that the therapeutic alliance is enhanced, which benefits the physician and the patient/client in diverse ways. Their liberal use of clinical case vignettes supports and enhances the points that they make.

From a more internal vantage point, Josée Labrosse provides a well-considered hypothesis of the advantages of linking mindfulness and reflective practice in our professional and personal lives. When the physician and the patient/client are similarly schooled in these practices and apply them consciously, the results can be extensive and profound. She challenges the GPPA to consider a leading role in bringing her proposed framework to the forefront of psychotherapy.

Broadening our perspectives is another component of this edition. Drs. Schneider and Bailey offer a look at two aspects of alternatives—to psychopharmacology and to conventional medicine respectively. As many readers are aware, Howard Schneider regularly examines the use of psychotropics in mood disorders. The case presented on page 3 differs from previous studies in that psychotherapy is the preferred approach in an individual with a mixed personality disorder and depression. Brian Bailey reviews Dr. Mel Borins' book, A *Doctor's Guide to Alternative Medicine: What works, what doesn't and why*, using personal experience to support his recommendation to have this well-referenced and comprehensive resource in easy reach!

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From the Editor (cont'd)

Speaking about what works, have you registered for the GPPA Annual Conference? The diligent preparations of the Conference Committee will be showcased on Friday and Saturday, April 24 and 25, 2015 at the Hilton Doubletree Hotel in Toronto. As with past conferences, *The Use of Integrative Psychotherapy: Mind, Body, and Soul*, promises to be informative and collegial.

Another favourite educational event, the Fourth Annual GPPA Retreat, is briefly detailed in the Report from the Board on page 19. And if you are still in need of CCI credits, check out the rest of the Report by Dr. Catherine Low, Chair of the Board, for some unique opportunities.

In a more creative vein, let us enjoy a reflective glance at winter as presented by Dr. Labrosse. Enjoy her well written story about a dog that can magically change a mood.

Here's hoping that *spring has sprung* when you receive this!

Namaste,
Maria Grande

GPPA ANNUAL GENERAL MEETING

Friday April 24 2015
Doubletree Hilton Hotel 108 Chestnut Street, Toronto
12:00—1:30 pm

28th Annual GPPA Conference
The Use of Integrative Psychotherapy: Mind, Body and Soul
Friday, April 24 and Saturday, April 25, 2015
Hilton Doubletree Hotel, Toronto

Highlights include:
Mainpro-C accredited workshop on Interpersonal therapy
The benefits of mindfulness and meditation
The Connection—a documentary about the importance of a healthy mind-body connection

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SCIENTIFIC PSYCHOTHERAPY

Psychopharmacology

Personality Disorder and Depression

Howard Schneider, MD

ABSTRACT

Major Depressive Disorder co-occurring with Borderline Personality Disorder (BPD) does not respond as well to antidepressant medication as Major Depressive Disorder in the absence of BPD. Treatment of Borderline Personality Disorder with psychotherapy gives a higher probability of remission of the depressive symptoms. While medications are useful to prevent overt mania or wild mood fluctuations, it may not be worthwhile to attempt to control short duration mood swings of a personality disorder with medications, but instead, psychotherapy should be the main treatment.

As medical psychotherapists, whether we prescribe or not, we are expected to be familiar with current psychopharmacotherapy. Psychopharmacologist Stephen M. Stahl of the University of California San Diego, trained in Internal Medicine, Neurology and Psychiatry, as well as obtaining a PhD in Pharmacology. In 2011, Dr. Stahl released a case book of patients he has treated. Where space permits in the GP Psychotherapist, I will take one of his cases and try to bring out the important lesson to be learned.

Stahl's rationale for his series of cases is that knowing the science of psychopharmacology is not sufficient to deliver the best care. Many, if not most, patients would not meet the stringent (and can be argued artificial) criteria of randomized controlled trials and the guidelines which arise from these trials. Thus, as clinicians, we need to become skilled in the art of psychopharmacology, described by Stahl (2011) as: "to listen, educate, destigmatize, mix psychotherapy with medications and use intuition to select and combine medications."

In this issue, we will consider Stahl's thirty-eighth case, "the woman with an ever fluctuating mood." The patient is a 27 year old unemployed woman, previously working at minimum wage jobs, the longest for two years, since graduation from high school. Currently the patient is receiving social security and disability payments. The patient is referred to Dr. Stahl for depression.

Past Psychiatric History:
Patient notes being depressed since the age of 5 years old, with suicidal thoughts starting at age 7 years old. Dissociative experiences (being outside her body) reported at 8 years old. Patient is unsure if she was sexually abused as a child.

Cutting herself started at 15 years old. She has longstanding picking at her skin, no formal diagnosis. At 16 years old, she saw a psychiatrist, diagnosis not specified, was prescribed paroxetine and referred back to the family doctor. She stopped paroxetine after 3 months as she felt it was ineffective.

At 18 years old, after graduation from high school, she was in residential treatment for 6 weeks for cutting behavior. She then notes being prescribed fluoxetine and then paroxetine, and says paroxetine helped her feel more optimistic. She took paroxetine for 1 year, then stopped after losing health care insurance, and notes depressive relapse occurring one month after stopping medication.

At 20 years old, paroxetine was restarted but then stopped due to non-specified adverse effects. At 21 years old, she was given a psychiatric diagnosis of Major Depression and paroxetine was prescribed again, with partial remission of depressive symptoms.

From 21-23 years old, she reports taking many different antidepressant medications, names not specified. The patient said she had adverse effects with most of them and did not try any of them for any significant length of time. Brief trial of lamotrigine was also tried, but patient stopped it due to weight gain. During this time an endocrinology evaluation revealed that perhaps the cause of her depression was low estrogen and the patient was treated with birth control pills.

At 25 years old, her only treatment being birth control pills, she went through a 4 month period of full remission. Patient then stopped her birth control pills and reports falling into depression. She then restarted her birth control pills but the depression remained. Paroxetine as well as several other non-specified medications did not reverse the depressive symptoms either.

At 26 years old, she was hospitalized for suicidal ideation. She was treated

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Personality Disorder and Depression (cont'd)

with lithium but complained about fatigue on it and stopped after 6 weeks. Repeat hormone tests at this time showed normal estrogen levels.

From 26-27 years old, patient was in outpatient psychiatry treatment, however she says she does not remember what medications were prescribed because she did not really take them. She does remember trying paroxetine and divalproex, both which did not help her.

Intake Psychotropic Medications:
- Paroxetine 30mg/d
- Quetiapine 50mg/d
- Thyroid (form and dose not specified)
- Modafinil (dose not specified)
- Zolpidem (dose not specified)

Past Medical History and Other Intake Medications:
- Birth control pills (form not specified)
- Smoker (quantity not specified)
- Marijuana daily (quantity not specified)—patient says helps make her feel calmer

Physical and Lab Intake:
- Normal blood pressure
- Normal BMI (Body Mass Index)
- Routine blood tests said to be all normal except for "light hypothyroidism" (TSH or other values not specified)

Personal History:
- Unsure if she was sexually abused as a child; not much else is specified about her childhood
- Graduated from high school
- 20 years old, had abortion
- No children, never married
- Employment, since high school, has been minimum wage jobs, the longest for two years
- Currently the patient is receiving social security and disability payments

Family Psychiatric History:
- Half-sister: Anxiety disorder
- Mother: Alcoholism
- Maternal Grandparents: Alcoholism

History of Present Illness and MSE (Mental Status Examination):
The patient tells Dr. Stahl that she feels agitated, that she is picking at her skin often and sometimes she feels so much energy that she "feels like crawling outside of her body." Although the marijuana is smoked daily to help the patient relax, she notes abusing it.

During the past month, the patient has been cutting every few days. She denies being suicidal, but notes that she wishes she was dead.

There is no history of actual mania. However, it is not clear whether episodes of the patient's unstable mood in the past could have represented hypomania.

With regard to the MSE, Stahl notes that the patient shows inappropriate affect in smiling when talking about her disability. The patient is also noted to be "nervous and fidgety." Stahl notes that the patient actually gives a very good history but has poor insight.

Evaluation:
Stahl's initial psychiatric evaluation is that the patient most likely has a mixed personality disorder with borderline, histrionic and dependent features, characterized by cutting behaviour, dissociative states, inappropriate affect and dependency. Stahl also notes that the patient has signs of compulsive picking behavior, social anxiety and avoidance. Stahl also reports that the patient has a "highly unstable mood," with the need to rule out etiologies due to a personality disorder, unipolar depressive disorder, bipolar spectrum disorder, or activation due to antidepressants.

Stahl notes that psychopharmacological treatment has not been successful for the patient over the last 10 years, but also that the patient has never had a significant psychotherapeutic treatment since her symptoms began as a child. Stahl advises that medication may not be as likely to give a successful treatment as they would in someone without these personality characteristics. Stahl notes that while aggressive psychopharmacological treatment may help, the main focus of treatment should really be psychotherapy.

Unlike in other Stahl cases, there is no follow up. Instead, the recommendation is that the patient's treatment be focused on psychotherapy at this point. However, with regard to what can further be done from a psychopharmacological point of view, Stahl makes the following suggestions:
- Quetiapine is currently at 50 mg/day but the therapeutic dose for bipolar depression is 300 mg/day—perhaps it would be worthwhile increasing it
- Paroxetine could be increased to 40mg/day
- Lamotrigine and lithium are both useful agents to try in this patient; however, the patient said she did not tolerate trials of either in the past, and thus, it is unlikely she would try them again
- Other treatments for treatment-resistant bipolar disorder such as riluzole, memantine or pramipexole, which Stahl describes as "low-yield" possibilities

In concluding, Stahl notes that while medications are useful to prevent overt mania or wild mood fluctuations, it

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Personality Disorder and Depression (cont'd)

may not be worthwhile to attempt to control short duration mood swings of a personality disorder with medications. Instead, psychotherapy should be the main treatment.

While, of course, this case likely involved a mixed personality disorder, Kernberg (2009) notes that Borderline Personality Disorder (BPD) has a prevalence of about 4% in the community, and as much as 20% in many clinical psychiatric populations. As medical psychotherapists, regardless of our practice interest, we see and treat these patients, often for a referring presentation of "depression."

The DSM (Diagnostic and Statistical Manual of Mental Disorders) is syndromal and thus favors comorbidities. BPD is often comorbid with depression, due to overlap for Major Depressive Disorder criteria. Many BPD patients are "depressed" at the time of clinical presentation, and indeed, BPD often presents at puberty with dysthymic symptoms. However, the depression in BPD differs from melancholia in that it lacks the classical vegetative features, it is often reactive to environmental stressors, it often manifests as a chronic dysphoria and, unfortunately, it responds more poorly to antidepressants (Paris 2009). The DSM-V (American Psychiatric Association 2013) cautions: "Because the cross-sectional presentation of borderline personality disorder can be mimicked by an episode of depression or bipolar disorder, the clinician should avoid giving an additional diagnosis of borderline personality disorder based only on cross-sectional presentation without having documented that the pattern of behavior had an early onset and a longstanding course." (Cross-sectional information is data obtained at a given point in time, a snapshot of the information so to speak. This is in contrast to obtaining information on a longitudinal basis, i.e., over a period of time.) Indeed, in Stahl's case above, there is an early onset and a longstanding course of the patient's symptoms.

While Bipolar Disorder (BD) also involves mood swings, in BPD mood swings are very rapid, often a matter of hours, and often in response to the environment. Anger is more prominent in BPD than the "highs" seen in BD. In Bipolar II Disorder, while mania is not required, the hypomania required must last for at least four days, something which is often not seen in BPD.

Canadian Borderline Personality Disorder expert, Joel Paris, MD, feels that the evidence base for psychopharmacological management of BPD is weak (Paris 2009). He notes that all agents actually were developed for other purposes. Neuroleptics can have an anti-impulsive effect in low doses, as well as antipsychotic effects at their usual dose. However, Paris advises to consider the adverse effects of neuroleptics before using them. SSRIs also have some anti-impulsive effects and can take the edge off low mood. Valproate, topiramate and lamotrigine have a mild anti-impulsive effect but little effect on mood. Benzodiazepines may be introduced for short-term use in BPD. However, there is little good evidence-based literature concerning such use. All agents above tend to primarily reduce impulsivity. Typically, psychopharmacological agents do not result in remission of the patient's condition.

A study by Ingenhoven (2010) did meta-analyses of RCTs (randomized controlled trials) of pharmacotherapy for severe personality disorders. Mood stabilizers had little effect on depressed mood, but they did have a large effect on impulsive-behavioral dyscontrol, anger and anxiety.

Stahl did not touch on the details of the psychotherapy which could be offered to his patient in the case above. According to BPD expert Joel Paris, the best evidence for psychotherapeutic management of BPD is Cognitive Behavioral Therapy (CBT) and Dialectical Behavioral Therapy (DBT) (Paris 2010a, 2010b, Wenzel 2006). In the 1980s, Marsha Linehan, Ph.D., introduced Dialectical Behavioural Therapy (Linehan 1987). DBT has been subjected to controlled studies and has shown to be superior to "treatment as usual" as well as treatment by community experts. However, of interest, Toronto psychiatrist Paul Links and colleagues (McMain 2009) found that a structured psychotherapeutic program, which did not necessarily have to be DBT, produced equivalent results to a DBT program. Goals of DBT are to decrease suicidal behaviours, to decrease therapy interfering behaviours, to increase problem solving skills, to learn to recognize when one is upset, to learn distress tolerance and, of course, to improve emotional regulation. There is a validation to the patient's world, with a dialectical approach taken towards change.

Stoffers and Lieb (2015) reviewed the evidence for psychopharmacological treatment of borderline personality disorder up to August 2014. They note some weak evidence for treatment with SGAs (second generation antipsychotics), mood stabilizers and omega-3 fatty acids. They note that the commonplace use of SSRIs with such patients is not supported by the evidence. Treatment of BPD patients with medications is indeed quite common. For example, Knappich and colleagues (2014) surveyed psychiatrists in the city of Munich, Germany, and found that 94% of

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Psychopharmacology (cont'd)

borderline personality disorder patients were treated with psychotropic medications, particularly antidepressants.

In a review of depression and borderline personality disorder, Beatson and Rao (2013) note that Major Depressive Disorder co-occurring with Borderline Personality Disorder does not respond as well to antidepressant medication as Major Depressive Disorder in the absence of BPD. Much as Stahl implied in the case above, treatment of Borderline Personality Disorder with psychotherapy gives a higher probability of remission of the depressive symptoms.

Conflict of Interest: None

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Generic Name	Trade Name
	(common, Canadian names where possible)
paroxetine	Paxil
fluoxetine	Prozac
lamotrigine	Lamictal
divalproex	Epival *in Canada (Depakote in USA)*
quetiapine	Seroquel
modafinil	Alertec *in Canada (Provigil in USA)*
zolpidem	Ambien in USA. Sublinox in Canada but is a sublingual form.
memantine	Ebixa *in Canada. (Namenda in USA)*
riluzole	Rilutek
pramipexole	Mirapex

Clinical Approaches

Mindfulness and Reflective Practice

Josée Labrosse, MD

This paper presents a framework for combining mindfulness and reflective practice in psychotherapy and family medicine. The framework has emerged over 30 years of evolving practice, in an ongoing dialogue (or critical exploration) of how to practice what is preached, and adhere to the central principle primum non nocere, *or deliberate non-harming. It is grounded in personal and professional practice, formal study and reflective learning individually and as part of organizations, projects and peer groups, and deliberate experiential learning activities and practices. This is not meant to be an exhaustive review of the literature. Instead, it embraces an approach to adult learning described by Gerard Artaud that integrated various adult education models, and was inspired by ground breaking educators, therapists, and scientists too numerous to name.*

Many elements of the combination of mindfulness and reflective practice have been well documented and researched by courageous pioneers. The model presented here has been presented at several continuing education events and one international conference on Reflective Practice. It is my hope that this article might inform, provoke thought, reflection, dialogue, and practice and possibly interest in action research as a support for our evolving roles within medicine, mental health care, and our personal and professional lives. It is hypothesized that linking mindfulness and reflective practice can legitimize and support actions that enhance care and clinical "effectiveness," improve patient client engagement, increase job satisfaction, build resilience, address compassion fatigue, enhance continuing professional development and professionalism, and improve health of physicians, colleagues, and families. It can be applied to all roles described by the CanMEDS framework, as found summarized in Appendix 2.

The terms Reflective Practice and Mindfulness have become more common in various medical and health care circles, and with the public at large, in recent years. Common usage can become superficial understanding and fail to reach deeper knowledge, skill, and ability to fully apply and benefit from them. I will offer a brief summary of each of these practices, while highly recommending the study of some of the original resources.

Reflective practice is a central element of continuing professional development (CPD) and maintenance of competence within The Royal College of Physicians and Surgeons of Canada, the Canadian College of Family Physicians (CCFP), and several allied health professions. However, as currently practiced in most environments and professional development activities, there is limited attention paid to creating conditions that foster true reflective practice and learning as originally described by Donald Schön in *The Reflective Practitioner* and *Educating the Reflective Practitioner*. As I was completing a Masters in Education course on the subject of creating such conditions, I recall reading an editorial in the *Annals of the Royal College of Physicians and Surgeons of Canada* by Dr. Craig Campbell who was leading the Maintenance of Competence Initiatives. I paraphrase from memory, having been grateful that he voiced a truth more relevant today than even then: "We cannot engage in reflective practice if we never make time to reflect." This is one of the issues that may be addressed by linking CPD with mindfulness practices. The CCFP has long recognized the importance of the "use of self," that is, personal experience, and appreciates the levels of uncertainty, diversity and complexity found in primary care. Perhaps the GPPA, as a Third Pathway for Accreditation, can lead the way by truly incorporating support for reflective practice and conducting research and evaluation to optimize its potential.

Reflective practice is a term coined by Donald Schön derived from his study of how outstanding (or master) professionals from diverse professions resolve difficult or challenging problems in practice. It is what excellent professionals engage in when they, or others who consult them, get stuck on a difficult dilemma. Some features of reflective practice are:

- engaging in a process of **problem setting** (defining the challenge in a sufficiently broad context),
- naming the various parameters and **reframing** the problem in a novel way (thinking outside the box), becoming aware of what is unique, unusual, uniquely challenging,
- **drawing on exemplars** (similar problems and solutions that may come from very different contexts, disciplines, or ways of knowing) while respecting the context of the situation,
- engaging in experimentation with the dilemma by **creating virtual worlds** ("safe" conditions that permit manipulation of the variables and predictions or permit actual trials and observations).

To expand on the last point, these can be "thought experiments" or behavioural experiments, where a professional thinks through a course of action and possible outcomes, while anticipating

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Mindfulness and Reflective Practice (cont'd)

the influence of the stressors and occurrences of daily life. Relevant to this are:

- **reflection *in* action** (real time parallel thought processes about what is evolving), like an observer mind operating in practice,
- **reflection *on* action** (protecting time after an encounter, outside of action time, to explore the problem within a larger context, through reflection, research, reference to theories and data, journaling or dialogue with peers) and back to trying out solutions with the actual problem situation.

The professional will deliberately and explicitly remain aware of the **respective roles, goals, and values** of those concerned in the situation (including themselves), intentionally and continually steering towards agreed upon outcomes while remaining attentive to what actually occurs, and modify the approach according to what really occurs, not just what was intended. An everyday example is prescribing a treatment with the intention of more good than harm, awareness of potential side and/or adverse events, and openness to modification depending on outcomes.

The professional must draw on **overarching theories**, as well as **underlying concepts and information** from specific and diverse bodies of knowledge about the problem and facets that are unique to that specific problem. Furthermore, Schön points out that the reflective practitioner draws on the hard "high" ground of science, but occurs in the real world of mess management, where there are too many variables to control, and success is not easily proscribed or standardized.

As we know, GP psychotherapy and family medicine are practiced in the real world. We are fortunate for the work of Schön, McWhinney, and others for validating the different conditions needed for the art and science of these areas of medicine. The process of discerning the true nature and most beneficial approach to undifferentiated and vexing problem complexes requires more than expert knowledge and skill in a particular domain. The practitioner must draw on knowledge and skill from multiple diverse domains as they relate to very unique individuals and circumstances.

At many a professional development workshop on one form of therapy or another, when a vexing problem is presented and stumps even the "expert" present, I have often heard the recommendation: "Well, then, send them back to their family doctor." These are the situations that benefit from mindfulness and reflective practice. At an inner city community health centre, an endocrinologist frequently referred patients to our team. One example was a young woman with borderline personality disorder, depression with frequent suicide attempts involving her brittle type 1 diabetes, complications of self-inflicted, poorly healed ankle trauma, and alcohol dependence. For such an encounter to succeed, the professional will need to draw on the ability to "hold" multiple variables in relation to one another, to be comfortable with uncertainty, to trust one's assessment of what is actually unfolding, discern crisis from usual chaos, mediate between multiple, perhaps conflicting, roles, goals, and values, and steer without forcing. This may be similar to what Daniel Khaneman has recently described as "slow thinking." Slow medicine can lead to better outcomes.

Professional development activities can more skilfully foster explicit exploration and dialogue in advanced problem posing education. Existing forms, such as the Balint group, might be modified to support this. Including guidance and practice in linking mindful movement, meditation, and reflective journaling, with Reflective Practice, in continuing professional development merits investment.

As with Reflective Practice, the term mindfulness has entered common usage, but the breadth and depth of mindfulness practices require learning that deepens with experience.

Mindfulness practices are deliberate exercises to train our mind to focus attention and awareness on a chosen facet of experience while cultivating attitudes of compassion, curiosity, patience, non-judgement, open-mindedness, acceptance, beginner's mind, non-striving, and surrender. Mindfulness practices can take many forms: formal meditation (itself with many forms), practices of yoga, tai chi, qi gong, or any physical or mental activity or activity of daily living. When accompanied with writing or journaling, it can become a mindful reflective exercise. The difference is the deliberate choosing and practice of paying attention in a particular way, as opposed to the more automatic pilot way of doing things. I have come to see it as an antidote to the more stressful ways of functioning. Finding time to practice and observe what one discovers can engender different stressors. When one has a genuine experience of the value of stopping the treadmill, transformative change becomes possible. One becomes more able to respond, rather than react, to unconscious stressors and drives that may lead to errors, jumping to conclusions, or missed opportunities to engage more effectively.

Formal practice creates space or windows of opening, within which novel approaches and awareness can arise. The ability to quiet the mind within stressful situations can help create the virtual world within which responses can be generated. It can permit confident and conscious claiming of space—time within a patient encounter by pausing to reflect and inviting the pa-

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Mindfulness and Reflective Practice (cont'd)

tient to do so as well—to defer diagnosis or treatment planning until appropriate reflection has taken place and to make room for uncertainty and discomfort to be held and explored with compassion and curiosity. Questions, possible solutions, or novel behaviour experiments can emerge and be deliberately explored with patients and with colleagues. Mindfulness practice can help restore balance between patient encounters.

Traditional CPD includes lectures, presentations, reading of research, workshops, and collegiality. However, quality and impact are highly variable, with many that do not engage the learners at a level that can truly transform practice. Knowledge transfer is insufficient—it is the areas of attitudes, skills, and the ability to change and sustain change and evolve in the real world of mess management that must be enhanced to ensure we are doing more good than harm. Practice makes perfect is an old, but erroneous adage. Practice makes habit. Practice with awareness and feedback, attention to goals, process, and outcomes, make for improvement. Moreover, perfection, as we know, is not a path to serene mental health. The practice of medicine can be supported by practicing mindfulness coupled with reflective practice! What follows is a suggestion about one way in which this could be done.

I propose forming groups of practitioners who practice mindfulness and engage in dialogue that permits an examination of the broader contexts and relevant parameters mentioned above. This can help create an environment that favours learning and reflective practice. For this to occur, however, the reflective practitioners, along with their peers, must carve out the appropriately supportive space and context. Use of affect, intuition, and awareness of attitudes has been frowned upon historically, but are necessarily cultivated for reflective practice. Mindfulness practices create the medium for growth. While our colleges may insist upon reflective practice for continuing education in a formal sense, we at the GPPA have the opportunity to create and lead CPD development on reflection and dialogue in practice. I append a sample worksheet used at a conference on Reflective Practice held at the University of Western Ontario a few years ago. I welcome comments, questions, dialogue, and feedback on others' experience.

Conflict of interest: the Author was the chief instigator and author of the study questionnaire and strategy used in a major research study that validated the CanMEDS roles

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Appendix 1

Framework for Reflection on Action

1) Select a situation (clinical or collegial) which you experienced as challenging.
2) Describe the situation and the problem. Include in your thinking: the individuals involved, the context, the roles, goals and values implicated. Note that the roles from CanMEDS should be included, in addition to any that are unique to the situation, or the practice of psychotherapy. Try to determine where and why you were getting stuck. Include appraisal of relevant attitudes, emotions, or stances towards the problem. Also consider expectations and attempted solutions vs actual outcomes and the reactions to that.
3) How would you frame the problem? What are the important variables? What are the core issues and what domain of learning or practice do they relate to? Are there attitudes cultivated in mindfulness that might help (for example, beginner's mind and compassionate curiosity)?
4) What principles (over arching theories, concepts or information, "models" or exemplars from past experience, underlying values and assumptions) could possibly help?
5) What additional resources--internal or external (human, material, educational or printed) could be drawn from?
6) How can space be created for virtual experimentation with the problem (e.g. reflection in or on action through journaling, dialogue with peers, virtual experiment with the patient) and to monitor outcomes towards goals in response to feedback?

The following documents can be found online at gppaonline.ca/journal/spring-2015

1. Definition of CanMEDS roles
2. Worksheet of Mindfulness and Reflective Practice Framework in Context of CanMEDS Competencies

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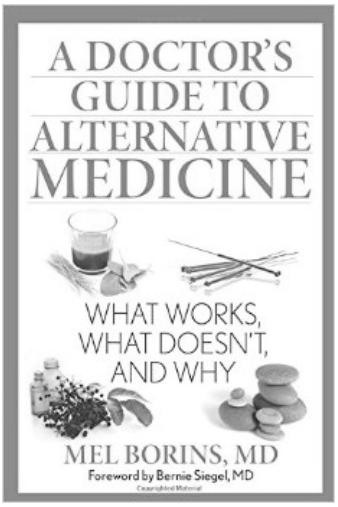
THE ART OF PSYCHOTHERAPY

The Therapists Bookshelf

A Doctor's Guide to *A Doctor's Guide*

Brian Bailey, MD



The next time somebody calls you a pain in the neck, tell them to go get acupuncture and stop needling you.
(Mel Borins, 2014)

It's refreshing to know that Dr. Mel Borins has a sense of humour since research can be a dry subject. As you open *A Doctor's Guide To Alternative Medicine*, which discusses the sometimes controversial topic of alternative and complementary medicine, Dr. Borins notes "I may not be able to give thrilling scenes of sex and car chases, but I do include historical background, curious folklore, and patients' anecdotal reports which will provide some entertainment as you become increasingly familiar with the language and methods of science." Yes, he does!

I chose to review this book because I had the impression that taking a mineral supplement had perhaps saved my life. And maybe it did! Stay tuned below.

True to his word, he gives an interesting treatment to an otherwise dull subject—making research, while not the most exciting topic—very informative to the practitioner and patients alike. And, to that end, he's done so in a very far-reaching, inclusive fashion, discussing it all in just the way he promises.

I was surprised by just how comprehensive this book is. Beyond herbal remedies, massage, spinal manipulation, vitamins, minerals, homeopathic remedies, and acupuncture, Mel even gets to the matter of psychological therapies. I don't know much, for instance, about Eye Movement Desensitization and Reprocessing (EMDR). Consider, therefore a theoretical patient who comes into my office struggling with some emotionally difficult memories of witnessing firsthand a close relative dropping dead of a heart attack. This patient has heard that EMDR can help him get over it and wants my opinion. I open my copy of Dr. Borins' book to Page 154 and read the following:

> A meta-analysis of 34 studies examined EMDR with a variety of populations and measures. Process and outcome measures were examined separately. EMDR showed a significant effect when compared with no treatment and with therapies not using exposure to anxiety-provoking stimuli. Post-treatment comparisons also showed an effect within EMDR. There was no significant difference found, however, when EMDR was compared with other exposure techniques.

The study above is from Davidson and Parker's: Eye movement desensitization and reprocessing: a meta-analysis: *Journal of Consulting and Clinical Psychology*, 2001; 69 (2): 305–16. Now, how much time did it save me to read that passage versus doing the research myself? Maybe an hour!

I was able to identify with one of the personal vignettes provided by Dr. Borins. In the early days of my practice, I, too, found myself in a busy Emergency Room as the only physician with a distraught patient from a distant city who'd been brought in by ambulance. He couldn't stand up. He told me it had it happened several times, and that he'd been to all manner of specialists, but the only treatment that worked had been pressing on an area of his back the size of a quarter. I tried to argue him out of his belief, but eventually I gave in, pressed on the spot he showed me, heard a click and saw him blithely get up off the stretcher, restored to normal. I was on my way to learning that not all therapeutics are taught in medical school.

Mel says a third of our patients rely on alternative methods. The most recent National Population Health Survey by Statistics Canada (1998/99) found that 3.8 million Canadians aged 18 and over had consulted an alternative health care provider at least once during the previous 12 months. This represented a 2% increase in consultations from the previous study of 1994/95. For this survey, alternative health care providers included massage therapists, homeopaths, herbalists, and acupuncturists.

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A Doctor's Guide to *A Doctor's Guide* (cont'd)

One thing I wish he had taken on is the issue of medical education. Medical school provides one to two hours of nutritional education to its students. I have found that some doctors, are quick to state that, in our Western diet, there are no vitamin or mineral deficiencies and that taking supplements is a waste of our finances. But this ignores the fact that so many of us either have taken medicines for years or have malabsorptive diseases, either or both which can deplete nutrients. I, for example, was about to be put on Amiodarone when I began to have runs of ventricular tachycardia (VT). My cardiologist reviewed my chart and saw there was a trail of low magnesium levels stretching back five years. He put me on magnesium which solved my VT problem in two months but it took a year to reverse the weakness in my legs which had occurred, likely, related to taking Metformin for several years.

Additionally, those of us who are general practice psychotherapists didn't learn about what we do today in medical school. We didn't count on the large number of visits for emotional problems nor did we learn that those with mental disorders were considerably more likely to resort to alternative and complementary medicine than those without those complaints. This point strengthens the need for and relevance of this book for general practice psychotherapists.

But who really should be making the decisions about alternative methods? While we could give our patients the guide, it will not replace the value of medical perspective. I, as a physician who only sees patients that have very chronic illnesses, have to make such decisions with one out of every two patients I see. As the College of Physicians and Surgeons of Ontario (CPSO) says about alternative and complementary medicine, "No physician should be expected to know everything about every such treatment." I had to ask "Why not?" We're expected to know a great deal about conventional treatment and every new drug that is released.

This is a great reference book to have in easy reach. It immediately multiplied what I knew about the subject by a factor of ten--and I'm no neophyte myself. Here we see things in perspective. Mel looks at the pros and cons of alternative therapies in a balanced way and, more often than not, sides with the alternative health care provider.

Buy Mel's book. Buy a second copy for your waiting room. It will save you and your patients a ton of time while expanding your competency exponentially.

We are Winter: And Winter Is Here!

Josée Labrosse, MD

The winter of 2014 in Ottawa was memorable for its extremes: cold, long, and hard. It was the hardest ever in the memories of many elders, and in mine. Here's my report from one bleak, cold, March morning, for the time capsule.

The general grumpiness factor in town is rising, but the temperature refuses to, even though it's March, and it should. Morale is falling.

TV ads for the *Game of Thrones* series pound us with warnings saying: "Winter is Coming." For them, it means a deep murderous freeze lasting years. I want to issue a spoiler alert: "There's been an early release in Canada!" but fear damning us to their fate. Our Olympic motto this year was "We are Winter." I guess Mother Nature is challenging us, saying "Prove it!"

It's a sunny morning, but the wind is too fierce for late March and our weary spirits. Our dog, Oliver, is a Sheppard-Husky mix. He was made for this. He drags us out, in spite of ourselves; his joy is mildly annoying. He dives his head into a snow bank, emerges dappled in flakes that show off his more tan-than-black fur. He is majestic in look, though not behavior. (We flunked dog training.)

We bristle against the cold, yet his enthusiasm starts to rub off. Hundreds of ash-trees have died from infestation and been recently felled. Our parkland is a disaster zone, but Oliver is ecstatic. He's on a mission to chew and eat the parkland clean of branches. Ice slicks have melted, then flash frozen, yet again. We grimace but they call him out for a playful romp. He investigates each one, in search of bubbles, driven to break through for a drink, or a bite of ice. He *scritch-scratches* with fervor. Such frenzy, for so little reward.

He bounds out onto a large expanse of ice, and we follow grudgingly. Looking up, the scene sparks our interest, then awe. We gaze wordless, and cameraless as the dog continues his playful romp. We struggle to find words to describe and capture the rare beauty--never seen by the likes of us in over 100 combined years of appreciating nature.

The ice-patch is black as slate and sheer, the surface and finish remarkably smooth and flat. Strange light seems to emanate from just below. It looks fire glazed with pale teal lacquer, or some subtle *raku*. The surface is dusted artfully with snow—fanciful wisps arced across the ice. Did some Zen master come in the night, to find open space with perfect strokes? Perhaps snow angels sought to replicate last summer's pollens rippled on the still lake. Or, a master chef plated icing sugar as an artful enticement to awaken delight beyond dessert. And we thought the last freeze was winter's last course…

We are now reluctant to leave. In spite of the cold, we want to claim this reward for following Oliver's playful adventure, looking out from our furred hoods to find and accept that "winter is still here." Still cold, but the beauty and the dog's play have melted some of the grumpiness away.

DOWNLOAD View this photo online, in colour at ww.gppaonlne.ca/2015Spring.html

CORRESPONDENCE

Letter to the Editor

March 3, 2015

To the Editor:
Re: Psychopharmacology, Fall 2014, Vol. 21, #3.

Dr. Schneider writes, "As medical psychotherapists, whether we prescribe or not, we are expected to be familiar with current psychopharmacotherapy." Expected? By whom? Expectations suggest that there is a standard of care. Where, then, does this standard come from?

The General Practice Psychotherapy Association (GPPA) has a set of guidelines for psychotherapy but no standards. The GPPA Guidelines do not mention psychopharmacotherapy at all. The College of Physicians and Surgeons of Ontario has neither standards nor guidelines for psychotherapy and, therefore, no standards regarding psychopharmacotherapy by medical psychotherapists.
It would seem, therefore, that there is neither an official standard nor an expectation for medical psychotherapists to be familiar with pharmacotherapy.

This is not the first edition of *GP Psychotherapist* that has contained this statement. The problem with statements that are not based in fact is that, if they are repeated often enough, then they eventually become perceived as fact.
With all due respect to Dr. Schneider, he is entitled to his opinion that medical psychotherapists should be familiar with current pharmacotherapy but his opinion should not be interpreted or published as fact.

But, that is just my opinion.
Sincerely,
David Murphy M.B., Ch.B., CGPP
davidmurphy@on.aibn.com

Response To Letter to the Editor

March 6, 2015
Reply from the Author:
Howard Schneider, MD, CGPP, CCFP
howard.schneider@gmail.com

Rather than provide my opinion, I would prefer to provide an evidence-based reply to Dr. Murphy. Between the dates of March 3-6, 2015, I asked the following question to 4 GP-Psychotherapists (other than myself or Dr Murphy) and to 5 Psychiatrists practicing in Ontario:

Question: Do you feel that physicians in Ontario who hold themselves out to be GP-psychotherapists, ie, physician psychotherapists, have an obligation to be knowledgeable about psychiatric medications, whether they prescribe such medications or not? Yes or No?

The following data was obtained:

Physician Asked Question	Yes	No
GP-Psychotherapist 1	x	
GP-Psychotherapist 2	x	
GP-Psychotherapist 3	x	
GP-Psychotherapist 4	x	
Psychiatrist 1	x	
Psychiatrist 2	x	
Psychiatrist 3	x	
Psychiatrist 4	x	
Psychiatrist 5	x	

Before applying statistical analysis to the above data, I am aware there could indeed be a sampling error; given Dr Murphy's letter there will be GP-Psychotherapists who feel the answer to this question should be "No." Thus in the interest of fairness, I will add such an entry "Other GP-Psychotherapist non-polled" to the data table:

The following revised data was therefore obtained:

Physician Asked Question	Yes	No
GP-Psychotherapist 1	x	
GP-Psychotherapist 2	x	
GP-Psychotherapist 3	x	
GP-Psychotherapist 4	x	
Psychiatrist 1	x	
Psychiatrist 2	x	
Psychiatrist 3	x	
Psychiatrist 4	x	
Psychiatrist 5	x	
Other GP-Psychotherapist 5 non-polled		x

If simple statistical analysis is applied to the above data, for example t-test analysis, then the two-tailed P value is less than 0.0001, ie, it is considered statistically significant that medical psychotherapist and psychiatrist physicians in Ontario feel that medical psychotherapists, whether they prescribe or not, are expected to be familiar with current psychopharmacotherapy.

GPPA INTERESTS

Opinion

Standards for Psychotherapy: Informed Consent

Michael Paré, MD, Bryan Walsh and Laura A. Dawson

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 third in our ongoing series of articles which discusses these complex and important topics.

Introduction

This topic will be presented in two parts, as the subject of informed consent consists of many multi-faceted elements. The main aim of these articles is to discuss, in very practical terms, the requirement of informed consent in psychotherapy. We will also address various aspects of informed consent in relation to 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). These documents outline important aspects of consent in medicine such as: legal and professional requirements, elements of consent, appropriate documentation, and patient capacity and incapacity. However, for the purposes of this article, we will be focusing on the elements of informed consent as provided to apparently capable, adult patients. To clarify, this article is not comprehensive and will, instead, 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

To begin, it is important to mention that we are permitted to assume a patient has the capacity to give or withhold consent "unless [we have] reasonable grounds to believe that the … person is incapable with respect to the treatment" (Service Ontario E-Laws, *HCCA*, s. 4(3), 1996). Loosely defined, informed consent is "a process of sharing information with patients that is essential to their ability to make rational choices among multiple options in their perceived best interest" (Simon, 1992). A key element to this process is obtaining consent before treatment in association with assumed capacity (Service Ontario E-Laws, *HCCA*, s. 10(1), 1996).

Confirmation of the provision and receipt of informed consent for those who practice psychotherapy in Ontario is in the process of becoming increasingly mandated by law. The penalty for not complying with this requirement can result in liability and regulatory judgments. In terms of legal requirements, the *Health Care Consent Act* explicitly requires informed consent to be obtained prior to the provision of health care services, including psychotherapy (Service Ontario E-Laws, *HCCA*, s. 10.1, 1996). The act also requires consent to be obtained throughout psychotherapy if the treatment approach changes significantly or the patient's capability to consent changes (Service Ontario E-Laws, *HCCA*, s. 12 & s. 16, 1996). However, physicians providing psychotherapy still retain substantial independence and latitude in defining precisely what constitutes informed consent for psychotherapy in their particular practices.

Importance of Obtaining Consent

There are a number of reasons why all physicians, including General Practitioners (GPs) and Family Practitioners (FPs) practicing psychotherapy, need to obtain consent. For instance, consent should be obtained for psychotherapy in order to reduce the possibility that patients will develop "regressive dependencies," or increased child-like attachments to their therapist, that negatively impact the psychotherapeutic relationship. Consent should also be obtained at the start of therapy in order to educate patients about therapy; empower patients to engage in therapeutic processes and behaviours; and, protect patients from power imbalances that often occur due to the well-recognized power differential between doctors and their patients. Here are two sample scenarios in which informed consent should be obtained before treatment begins:

Case 1: Agreeing Without Understanding

A new patient arrives in the psychotherapist's office for his second session. The psychotherapist asks the patient whether he has read the detailed Consent to Treatment document that was given to him at his first appointment. The patient replies, "Oh, well…I didn't read it, but that's OK. I'll sign it right now anyhow" and then proceeds to sign the document.

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Standards for Psychotherapy (cont'd)

Case 2: Deferring to the Power Differential
A new patient enters the office and begins a verbal dialogue with the psychotherapist. After the psychotherapist establishes some rapport and obtains some essential history, she informs the patient that it is important to review the implications of consent to treatment together, for a few minutes. The patient responds by saying: "There is no need to review the consent process. I trust you. You're the professional in mental health, after all, not me."

Neither of the above scenarios demonstrates an acceptable portrayal of obtaining informed consent. First, it has been made clear that the patient in Case 1 does not yet possess an appropriate understanding of the process of informed consent and the mere signing of the consent document by this patient does not constitute informed consent (CPSO, 2006). Case 1 also depicts a waiving of consent by the patient and demonstrates a neglect of the foremost principles associated with attaining consent which are: "Respect for the autonomy and personal dignity of the patient" (CPSO, 2006), and "the fundamental right of the individual to decide which medical interventions will be accepted and which will not," as determined by the Supreme Court of Canada (CPSO, 2006). The patient in Case 2, on the other hand, does not possess the facts necessary to provide genuine informed consent. Neither the first nor the second patient is provided with information regarding the implications of consent, as required by the CPSO (2006).

It would be impossible for a patient to make an informed choice about any type of treatment—in this case, psychotherapy—unless he or she is given sufficient information regarding the type or types of treatment available, along with other relevant information pertaining to his or her particular illness or condition.

Obtaining Valid Consent

There are four main standards used to distinguish a legally valid consent: (1) the patient's consent must be directly related to the treatment; (2) it must be informed; (3) it must be voluntary; (4) and it must not be obtained through "misrepresentation or fraud" (Service Ontario E-Laws, HCCA, s. 11.1, 1996).

It is important to note that Primary Care physicians often practice psychotherapy in a somewhat different manner than psychiatrists and psychologists. One form of treatment is not necessarily better, or more effective, than another. However, one type may be better suited to a particular patient's needs at a particular period of time.

Obtaining Informed Consent

In order to ensure that consent is not only free from any bias, but that it is also adequately "informed," there are two general criteria which must be met. First, the patient must receive information about his or her treatment in a way that could be understood by "a reasonable person in the same circumstances" (Service Ontario E-Laws, *HCCA*, s. 11.2, 1996). Second, the patient must receive responses when asking for additional information about the treatment he or she will potentially receive (CPSO, 2006). There are also six specific standards which must be met in order for consent to truly be considered "informed." These include providing the patient with information regarding:

1) The nature of the treatment
2) The expected benefits of the treatment
3) The material risks of the treatment
4) The material side-effects of the treatment
5) Alternative courses of action
6) The likely consequences of not having the treatment

(Service Ontario E-Laws, *HCCA*, s. 2, 1996).

Patients also retain the right to withdraw consent at any time (Service Ontario E-Laws, HCCA, s. 2, 1996). In addition, according to the Personal Health Information Protection Act, "… the withdrawal of the consent shall not have retroactive effect" (2004). In other words, withdrawal of consent for one aspect of treatment must not affect other aspects of the medical care received by the patient. Each of the above points will be more fully elaborated upon in the following sections.

1. The nature of the treatment

Although there are many different forms of psychotherapy available, there are a number of therapeutic factors that are commonly shared. The therapist's competency, mental and physical health, and commitment to help the patient are just a few of the aspects that are important to the success of the therapy (Reisner, 2005). Some other aspects that are commonly recognized as effective elements of therapy are: increases in feelings of self-efficacy, a re-evaluation of emotional experiences, and the strength of the psychotherapeutic relationship (Reisner, 2005).

Most forms of psychotherapy utilize an intensely personal, yet professional, patient-psychotherapist relationship; a caring, confidential, and emotionally open relationship between the patient and psychotherapist; the encouragement of emotional expression and release in a supportive and empathetic environment; the sharing of information on human development and psychology; a frank and honest discussion of an individual's unique "life problems and issues," the patient's distinctive "pathway through life," and an enhancement of their creative energy, resilience and self-empowerment skills.

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Standards for Psychotherapy (cont'd)

In stating the potentially positive aspects of many types of therapy, it is also important not to overstate the effectiveness or benefits of a particular type of psychotherapy, nor disparage another type of psychotherapy. See, for example, the following case:

Case 3: Overstating A Particular Type of Psychotherapy and Disparaging Another Type

Patient: *Is the psychotherapy you do Freudian psychotherapy? I was told that type of therapy could be helpful to me?*

Doctor: *No, that is really an old fashion-type of psychotherapy. The type of therapy I provide is more modern: it is called CBT, which stands for Cognitive Behavioural Therapy. It is by far the best kind of psychotherapy and is more contemporary. Basically, CBT blows the competition out of the water. There is no real evidence for Freudian psychotherapy, but there has been a ton of research conducted on the effectiveness of CBT!*

2. The expected benefits of the psychotherapeutic treatment

The benefits of psychotherapy will significantly vary from patient to patient. In addition, the benefits obtained by patients in therapy may change throughout the therapeutic process. There are, however, a few expected benefits that are widely held by psychotherapists of different theoretical and practical backgrounds. These include benefits such as: a decrease in psychological symptoms associated with stress, anxiety, and depressive affect; a greater ability to adapt to and cope with relationships; an increase in the patient's resiliency; and, a general increase in feelings of well being.

3. The material risks of the treatment

According to Silberfeld & Fish:

> A material risk is one that might affect a reasonable patient's willingness to accept treatment, and includes both common risks that are not particularly serious, and uncommon ones that may cause considerable harm…risks of psychotherapy include treatment failure, as a result of which the patient may end up worse off than he or she was at the outset of treatment, and intermediate worsening of the patient's condition as painful or warded-off feelings and experiences are reopened…It is often difficult to distinguish a side-effect from a risk, and, in practice, the two categories overlap (1998).

Although psychotherapy is usually helpful, it is only honest and fair to mention that there are problems that can occasionally be associated with psychotherapy. For example, over the course of psychotherapy new symptoms may develop or, in some cases, existing symptoms may get worse; the treatment might bring up traumatic memories of which the patient was previously unaware; or, the patient's life may not seem better or happier at the end of the treatment (Pare, 2014). Here we have outlined a short case which demonstrates a possible material risk of psychotherapy:

Case 4: A Material Risk of Psychotherapy

An experienced psychotherapist has been seeing a patient once per week for three months regarding her anxiety and depression. Each time the patient enters the therapist's office, the patient begins to whine, in a shaky voice, that she feels "completely stressed out." Her anxiety has not decreased in the past three months, and each time she starts speaking with the therapist, she begins to shake and sweat uncontrollably.

Case 4 presents a situation in which it is unclear whether this type of therapy is the most appropriate course of treatment for this patient, since the patient is experiencing the effects of a potentially severe material risk of anxiety during treatment. Depending upon the circumstances, it may be in the patient's best interest for the psychotherapist to refer her on for pharmacological treatment and/or another psychotherapist or type of therapy. However, depending upon the nature and severity of the problem, it may be possible for the psychotherapist and patient to continue working together to diminish the patient's anxiety over time, through a modification of treatment, and/or a continuation of the development of the therapeutic relationship.

4. The material side effects of treatment

A material side effect can be defined as "a foreseeable risk of harm to the patient that accompanies successful therapy or the effect that successful therapy may have on third parties who play an important role in the patient's life" (Silberfeld & Fish, 1998). To clarify this term, we will outline a number of material side effects which may result as a consequence of psychotherapy.

One material side effect could be that a patient's relationships are adversely affected when, for instance, the patient "grows" in psychotherapy, while his or her partner does not. Another material side effect could occur through the act of seeking treatment, which is occasionally used against patients when seeking disability compensation or life insurance. A third potential material side effect might be the impact of stigma, which is sometimes associated with attending psychotherapy/psychiatry sessions. The Mental Health Commission of Canada notes that stigma impacts a patient as a possible barrier to employment, housing, and educational opportunities (2014). Stigma can also negatively affect a patient's relationship with his or her family, friends, or coworkers, as well as adversely affecting a patient's own self-image when negative views of mental health, as expressed by others, are internalized (Livingston, 2013).

Continued on Page 17

Standards for Psychotherapy (cont'd)

Despite these negative associations, and to paraphrase one of Dr. Pare's patients, psychotherapy may be similar to taking Buckley's cough syrup: it is well worth enduring the discomforts to gain the benefits! These benefits often include positive outcomes such as: increases in mental health, hope, and feelings of connectedness (Saunders, 2002).

5. Alternative courses of action

In suggesting potential alternative courses of action for patients, it may be beneficial for a therapist to notify their patients of the six other Regulated Health Professions whose members may also provide psychotherapy. These six Regulated Health Professions include: The College of Nurses of Ontario, The College of Occupational Therapists of Ontario, The College of Physicians and Surgeons of Ontario, The College of Psychologists of Ontario, The College of Registered Psychotherapists of Ontario, and The Ontario College of Social Workers and Social Service Workers (Federation of Health Regulatory Colleges of Ontario, 2012). See our previous article entitled Standards for Psychotherapy: Some Regulatory Aspects for information regarding these six Colleges (Pare, Walsh, & Dawson, 2015). Another alternative course of action could be to refer patients to psychiatrists for evaluations to determine the effects of possible adjunct pharmacological treatments. Physicians may also refer patients to psychiatrists or psychologists for more specialized psychotherapeutic treatments.

6. The likely consequences of not having treatment

Consequences of not having treatment can, once again, vary on a case-by-case basis. A wide variety of consequences may occur due to the nature of the diagnosis, severity of the symptoms, progression of the illness, etc. It is important to outline any likely consequences that may occur if the patient does not engage in treatment, while being sensitive to the particular situation of each patient by making multiple options available when necessary or recommended. Presenting your patient with alternative courses of action could be suggested, for example.

Answering the patient's questions

Some patients may present a number of difficult, lengthy or pressing questions as they seek to understand the treatment they will potentially receive. Other patients will have few or no questions. It is the responsibility of the psychotherapist to ensure that the patient has had the opportunity to ask questions associated with the diagnosis and treatment, and to receive full responses to those questions.

Conclusion

To reiterate, this article does not provide a comprehensive review of informed consent. The focus has remained on apparently capable, adult patients, with the purpose of providing practical examples of the standards of medical practice regarding informed consent, for use by physicians practicing psychotherapy. The primary aim of the increasing requirements of informed consent is to encourage practitioners to actively engage with their patients, throughout treatment, in an ongoing process of informed consent in order to respect the fundamental rights, autonomy, and dignity of each patient. In order to attain a more comprehensive understanding of the requirements of informed consent, especially with regard to incapable patients, it is suggested that physicians review the CPSO's policy document on Consent to Medical Treatment, as well as the requirements outlined in the Health Care Consent Act.

Conflict of interest: none

Contact: michaelpare@rogers.com

Note: Dr. Paré has developed a consent form for psychotherapy, which can be viewed online at gppaonline.ca/journal/spring-2015
If you are interested, you may obtain a free copy from Dr. Paré to adapt for your own use.

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Report from the GPPA Board of Directors

Submitted by Catherine Low, MD
Chair, Board of Directors

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. There were 29 people registered for this event last year. This year's planning committee has decided to limit the number to 24. Be sure to register as soon as the invitations are sent out in order to avoid missing out on a spot.

The 28th Annual Conference of the GPPA

This year's conference will be 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 is *The Use of Integrative Psychotherapy: Mind, Body and Spirit.* Get your registration forms in as soon as possible as the conference has sold out in past years.

Video of New Members Luncheon, February 2014

As a result of the videotaping of the luncheon last February, a 22-minute comprehensive video was made for the purpose of giving new members a crash course in all things GPPA. The quality of the finished product, I believe, is outstanding. Please email Carol Ford at info@gppaonline.ca to obtain the link to view this video.

Outreach Activities

The GPPA will be represented at the *Primary Care Today* conference (May 6-9, 2015) and the *Family Medicine Forum* (November 12-14, 2015) in Toronto. There will be a booth at each event with pamphlets, handouts, and a shortened version of the New Members Welcome Luncheon video to show to prospective new members. The Outreach Committee would welcome any additional volunteers to sign up to spend some time at the booth and talk to physicians about our organization. CCI credits can be given for these discussions with colleagues at the booth. **Those who volunteer will also be able to attend any sessions available on their free time on the day they are at the booth.**

New Name of the SIFP group at the CFPC

The College of Family Physicians of Canada (CFPC) announced in January that they would be changing the name *Special Interest Focused Practice* to *Section of Communities of Practice*. The Mental Health Program Committee of the CFPC has a voting seat for a GP Psychotherapist and a seat for a representative from the GPPA. Currently, Vicki Winterton, MD, a longstanding member of the GPPA, is representing GP Psychotherapists as a member at large and Christine Toplack, MD, a member of our Board of Directors who practices GP psychotherapy in Nova Scotia, is representing the GPPA.

Presentation by Dr. Meuser, December 2014

Members of the GPPA Board of Directors, along with members of the various committees involved in CPD activities, attended a telephone conference call presentation by Dr. Jamie Meuser of the CFPC on December 4th, 2014. He outlined the upcoming changes to the CFPC Main Pro system. The program name will change from *Main Pro* to *Main Pro Plus* on July 1st, 2015. The presentation lasted 40 minutes and was accompanied by a PowerPoint presentation. This was followed by a 20 minute question period. The presentation was well received and the information gathered will be used by the various committees that were represented at the presentation.

New Policies and Procedures

<u>The Use of Skype in Educational Activities.</u>

Skype can be used for one or more persons as individual or group CE educational sessions if the following criteria are met:

- the course is a recognized didactic course,
- the GPPA member is paying for the course,
- the course has an interactive component,
- the course is a live session via Skype or a webcast.

March 7th Joint Meeting

<u>New CPD Activities Acceptable for Credit</u>

A joint meeting of the members of the GPPA Board of Directors, the Professional Development, the Membership and the CPSO/CPD Committees was held on March 7th, 2015 at the OMA headquarters in Toronto, to discuss expanding the definitions of CPD that are eligible for credits. As part of the planning for the meeting, a survey was sent out by e-mail to all GPPA members asking for their input and suggestions on expanding the scope of activities eligible for CPD credits. There were 44 replies to the survey and lots of written suggestions. Four additional people asked for an invitation to attend the meeting.

Journal of the General Practice Psychotherapy Association

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Whom to Contact at the GPPA

Journal – to submit an article or comments,
e-mail Maria Grande at journal@gppaonline.ca

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

Listserv
Clinical, Clinical CPSO/CPD, Certificant and Mentor Members may e-mail the GPPA Office to join

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.

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Winter Issue - October 1
Spring Issue - February 1
Fall Issue - June 1

For letters and articles submitted, the editor reserves the right to edit content for the purpose of clarity. Please submit articles to:
journal@gppaonline.ca

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