



CONTENTS SPRING 2016

SCIENTIFIC PSYCHOTHERAPY

- 3 Psychopharmacology Corner
A Case of Chronic Pain
Howard Schneider

CLINICAL APPROACHES

- 8 Neuro-Linguistic Programming for Depression
David Murphy
- 11 Improve your Practice
Free Mentor Support for Ontario Medical
Psychotherapists
Daniel McBain

THE ART OF PSYCHOTHERAPY

- 12 Where Grief Meets Poetry—A Reflection
Janice Falls
- 13 The Mindful Raisin
E. Janet Warren
- 14 Therapist's Bookshelf
Is Food Addiction Real?
A Review of *Food Junkies*
Vivian Chow
- 15 Brain Healing and Neuroplasticity
Josée Labrosse

GPPA INTERESTS

- 16 Standards in Psychotherapy
Psychotherapy and Self-Disclosure
Michael Paré and Laura A. Dawson
- 22 Report from the GPPA Board of Directors
Catherine Low

GPPA JOURNAL ONLINE VERSION

<http://gppaonline.ca/journal/spring-2016>

From the Editor

The difficulty of literature is not to write, but to write what you mean; not to affect your reader, but to affect him precisely as you wish" (Robert Louis Stevenson).

This process sounds similar to the manner in which our counselling affects our patients. Indeed writing and psychotherapy have much in common. Both have communication at their heart, albeit in differing forms. Both seek to influence the recipient, hoping for growth and change. Both involve examining things with a fresh perspective, offering a new interpretation. Both are subtle and subject to varying interpretations and dependent on the author's/therapist's perspective. There are different styles of writing and different modes of therapy. Both incorporate aspects of science and art. Both have structure—a beginning, middle, and end. Both have purpose and intent; they move forward. Both are unique to the individual writer/therapist. Both are subject to rules and regulations. Both writer and therapist have tremendous responsibility. And of course, words in any form have therapeutic power.

In this journal, the similarities converge when we have psychotherapists writing about psychotherapy. In his psychopharmacology corner, Howard Schneider examines a case of chronic pain and opiate abuse. This is a case in which the art of psychopharmacology proves to be more important than the science; a case in which words are perhaps more effective than pharmacotherapy. David Murphy introduces us to his preferred style of therapy in the treatment of depression: neuro-linguistic programming. This model focuses on recognizing and discovering a patient's perspective on life, or internal map. Murphy quotes from *The Empire Strikes Back*: "the truths that we cling to depend on our own point of view." Michael Paré and Laura Dawson, in their column on Standards in Psychotherapy, discuss the pros and cons of self-disclosure in clinical practice, with helpful guidance and case examples. Sharing of oneself is another example of the power of words. And, in our new column, "Improve your Practice," in which GPPA members share ideas they have found helpful in their practice, Dan McBain introduces us to the Collaborative Mental Health Network, a model of shared care, and an excellent resource and mentor support for medical psychotherapists.

Continued on Page 2

From the Editor (cont'd)

In the more reflective part of our journal, we have two poems; a short, whimsical one by myself and a more serious one by José Labrosse on neuroplasticity. Vivian Chow reviews a recent book by GPPA member Vera Tarman entitled *Food Junkies* that elucidates food addiction. Vivian hopes to apply it to a patient in her practice. Psychotherapist Janice Falls reflects on the poetry of grief. In her personal experience, she found “refuge in the beauty of poems”—another example of the powerful therapeutic effect of writing.

Our soon-to-be-renamed organization is going through exciting times. As Catherine Low reports, not only are we to have a new name, but there is a new committee that is exploring courses in core essentials. Watch for a new name and style for the journal as well. And don't forget, our annual conference is coming up soon—I hope to see many of you there. Aspiring authors may be interested in my writing workshop. And new ideas for the journal are always welcome.

Grace and peace,

Janet Warren

CALL FOR SUBMISSIONS

Aspiring authors, researchers and other interested contributors for future issues of GP psychotherapist!
Be creative, share your experiences and knowledge.

If you have photographs that are your original work and haven't been commercially published, we will begin cataloguing photos to be used in future editions, as appropriate.

In order to meet printing and editing parameters, please check out our *Author Guidelines* at <http://www.gppaonline.ca/Journal.html>

If there is something novel you wish to explore and possibly have published, contact Janet Warren at journal@gppaonline.ca

SCIENTIFIC PSYCHOTHERAPY

Psychopharmacology Corner

A Case of Chronic Pain

Howard Schneider, MD, CGPP, CCFP

ABSTRACT

Patients with chronic pain must be evaluated carefully. The physician should be aware of the dangers of starting opiates for chronic and vague pains. Interventions that are recommended include psychotherapy, meditation, and referral to specialty pain centres.

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, Stahl released a case book of patients he has treated. In this column, I will examine one of his cases and highlight its important lessons.

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, arguably, artificial) criteria of randomized controlled trials and the guidelines that arise from these trials. Thus, as clinicians, we need to become skilled in the *art* of psychopharmacology. To quote Stahl (2011, p. xvii), this requires us "to listen, educate, destigmatize, mix psychotherapy with medications and use intuition to select and combine medications."

In this issue, we will consider Stahl's 37th case, "the painful man who soaked up his opiates like a sponge." The patient is a 58-year-old engineer, entrepreneur, inventor, and patent-holder (successful until about two years ago), who has been married for nine years. The patient was referred to Dr Stahl by

his family doctor who also specializes in chronic pain.

Past Psychiatric History and Past Medical History related to Pain:

- Little psychiatric and pain history until at age 52 the patient suffered from a right painful tinnitus. Consultation by a specialist did not yield a specific diagnosis.
- At age 52–55 he was treated successfully with hydrocodone at 15 mg/day, then at age 55–57 was treated successfully with hydrocodone 30 mg/day. For the past year, i.e., 57–58 years old, 30 mg/day of hydrocodone no longer was successful in treating the painful tinnitus.
- At approximately age 55 the patient was diagnosed with adiposis dolorosa, also known as Dercum's disease (this consists of multiple painful subcutaneous lipomas; prevalence is very low). Many of the lipomas were treated by surgical resection.
- At age 57 he complained of vague pains in his lower legs that were treated by increasing the hydrocodone to 80 mg/day.
- Four months ago the patient developed lower back pain and was diagnosed with degenerative disk disease. He increased his hydrocodone to 120 mg/day, and also underwent epidural blocks. Epidural blocks

helped his back pain but worsened the leg pain. Hydrocodone at 120 mg/day sedated the patient to the point where he was unable to do work. If the hydrocodone was lowered to 80 mg/day there was too much pain to work. However, the patient denied feelings of sadness or apathy accompanying this pain.

- The patient tried many different psychotropic medications since the age of approximately 54 years old, often with the development of unusual adverse effects. Various tricyclic antidepressants were not tolerated and were not effective for pain. Various selective serotonin reuptake inhibitors also were not tolerated and ineffective for pain. Quetiapine caused increased sedation even at tiny doses. Gabapentin caused increased sedation and increased tinnitus.
- Prior to the above trials, a different physician had prescribed a low dose of sulpiride (an antipsychotic that blocks dopamine D2, D3, and D4 receptors, as well as presynaptic dopamine D2 autoreceptors), which the patient said he tolerated and which helped his pain. The patient then moved to another city, and it is not clear why he did not continue the sulpiride.

A Case of Chronic Pain (cont'd)

Past Medical History:

- Hypercholesterolemia
- Overweight with a BMI of 29
- Obstructive sleep apnea
- Dercum's disease
- Sinus surgery
- Non-smoker
- No alcohol abuse, no illicit drug abuse

Intake Medications:

- Levothyroxine 75 mcg/d
- Duloxetine 60 mg/d
- Atomoxetine 40 mg/d
- Hydrocodone up to 120 mg/d
- Zolpidem 10 mg hs
- Ezetimibe (dose not reported)

Personal History:

- Married for 9 years, one daughter age 8
- Competitive engineering school graduate
- Successful (until two years ago) engineer, entrepreneur, inventor, and patent-holder

Family Psychiatric and Medical Relevant History:

- Father: chronic pain, anxiety

Chief Complaint: Family doctor referred for psychopharmacology consult.

History of Present Illness (HPI) and Mental Status Examination:

Much of the HPI was obtained during questioning about the patient's pain over the past few years. As stated earlier, hydrocodone at 120 mg/day sedates the patient to the point where he is unable to do work, but if the hydrocodone is lowered to 80 mg/day there is too much pain to work. The patient denies feelings of sadness or apathy accompanying this pain.

During this first session Stahl was unable to elicit any particular psychosocial stressors that could be responsible for the patient's pain. He comments that this is an area that deserves more time. Stahl notes that the patient complains of pain in various parts of his body without good medical explanations. In addition, Dercum's Disease is quite rare and many times the lipomas are not painful. Stahl wonders if the patient could be suffering from fibromyalgia. He worries about the way the patient has increased his opiate usage.

Stahl makes a working diagnosis of "one of the somatoform disorders," particularly pain disorder. Stahl notes that there are only pain symptoms and that it did not start before the age of 30 years old, and thus he is not making a diagnosis of somatization disorder.

Stahl recommends increasing duloxetine to 120 mg/day and stopping the atomoxetine. He also recommends adding low-dose pregabalin, hoping that a lower dose will not cause the sedation that had previously occurred. Stahl also recommended that modafinil be considered to overcome the sedation and impaired cognition caused by the opiates, believing that obstructive sleep apnea may be causing sleepiness and decreased executive function.

Current Medications:

- Levothyroxine 75 mcg/d
- Duloxetine 120 mg/d
- Hydrocodone advised to reduce from 120 mg/d
- Pregabalin low dose (dosage not reported)
- Modafinil
- Zolpidem 10 mg hs
- Ezetimibe (dosage not reported)

Stahl sees the patient six months later. The patient now wants to use sodium oxybate (also known as gamma hydroxybutyrate) for the pain, but Stahl cautions against doing so since the patient is already taking opiates and sedative hypnotics.

The patient has not reduced the opiates but instead now is taking oxycodone 40 mg tid (i.e., 120 mg/day). The patient justifies this by saying that he still has very painful tinnitus, pain all over from the Dercum's lipomas, and lower back pain that radiates into both legs. As well, the patient has added eszopiclone 6 mg to the zolpidem 10 mg at night. However, the patient has reduced his duloxetine to 40 mg–60 mg since the other medications caused his blood pressure to rise. The patient reports that the modafinil is helping significantly for his concentration and his fatigue. He reports that the pregabalin reduces his pain.

Stahl suggests a trial of venlafaxine-XR instead of the duloxetine. He advises reducing the hypnotic and opiate doses. However, the patient says his family doctor decides these things, and that given that his pain is better with these treatments, the patient is against lowering the dosages.

Current Medications:

- Levothyroxine 75 mcg/d
- Duloxetine 40 mg/d
- Oxycodone 120 mg/d
- Pregabalin 25 mg (dosage not reported)
- Modafinil (dosage not reported)
- Zolpidem 10 mg hs
- Eszopiclone 6 mg hs
- Ezetimibe (dosage not reported)

A Case of Chronic Pain (cont'd)

Stahl sees the patient again at the 24-month interval from the first encounter. The patient says his pain is worse and he is taking even higher doses of oxycodone (120 mg tid, i.e., 360 mg/day) in addition to another 80 mg of hydrocodone per day. The patient says that he was recently diagnosed with seronegative rheumatoid arthritis, but that he was not able to tolerate treatments such as methotrexate or azulfidine. As well, he has a new diagnosis of a small pituitary adenoma with decreased growth hormone and decreased testosterone, and he is now getting testosterone replacement cream. He works very little, does not exercise, and has gained 30 pounds.

Stahl is concerned that the patient is opiate dependent. He worries about the increasing opiate doses in combination with the other medications and the patient's obstructive sleep apnea, which could lead to respiratory depression or arrest. Stahl suggests that the patient consider attending a different pain physician, but the patient is not interested as he feels it would be disloyal to his current prescribing physician. Stahl suggests that he see the patient again to explore the "psychological dimensions" of the patient's condition, but the patient says his insurance will not cover frequent appointments. Stahl suggests that trazodone be used for insomnia, and that the patient reduce the zolpidem and eszopiclone.

Current Medications:

- Levothyroxine 75 mcg/d
- Duloxetine 120 mg/d
- Oxycodone 120 mg TID= 360 mg/d
- Hydrocodone 80 mg/d
- Pregabalin 50 mg qid; stops every few days due to clumsiness, then restarts

- Modafinil 400 mg a.m., 200 mg p.m.
- Zolpidem 10 mg hs
- Eszopiclone 6 mg hs
- Ezetimibe (dosage not reported)

Stahl next sees the patient 27 months after the first visit. The patient says that he was told that rheumatoid arthritis may be causing his wrist pains, and that a bone scan of the wrists was "positive." He wants to try anti-tumor necrosis factor (anti-TNF) medications such as adalimumab (brand name Humira) but the insurance company will not pay for them since there is no documentation that he has classic rheumatoid arthritis. Meanwhile, the patient's wife has asked for a divorce, and he is now feeling depressed.

Stahl advises that the patient urgently see a psychotherapist and, since the patient feels that his marriage can be saved, that he also see a couples' therapist with his wife. With regard to medications, Stahl tells the patient that he now believes that psychopharmacology was not the solution to his problems. The patient says he will "think about it."

Stahl next sees the patient 30 months after the first visit. The patient's wife still wants a divorce. The patient has developed attacks of pain in his wrists. He was given a trial of leflunomide, an immunosuppressant treatment for rheumatoid arthritis, but says that it caused anxiety, itching, nonspecific infections, and worsening of the arthritic pain, and so it was stopped.

Current Medications:

- Levothyroxine 75 mcg/d
- Duloxetine 120 mg/d
- Oxycodone sustained release 320 mg/d

- Oxycodone immediate release 120 mg/d
- Hydrocodone 15 mg/d in combination with ibuprofen (dosage not reported), as well as extra ibuprofen
- Pregabalin 50 mg qid; stops every few days due to clumsiness, then restarts
- Modafinil 200 mg a.m., 100 mg p.m.
- Unspecified herbs for sleeping
- Testosterone cream (dosage not reported)
- Unspecified nutritional supplements
- Zolpidem 10 mg hs
- Eszopiclone 6 mg hs
- Ezetimibe (dosage not reported)

The patient did not follow up on Stahl's suggestions to attend an opiate-reduction program or seek psychotherapy. However, the patient says he is doing his own therapy by reading up on George Gurdjieff, a 20th-century mystic. Stahl suggests that the patient might benefit from a meditation program, which the patient was willing to try.

Stahl next sees the patient at 34 months from the time of the first visit. The patient wants assistance in ongoing disability litigation—the insurance company is not treating his disability as "real" and, in addition, the insurance company feels his major problem is drug addiction, a condition they do not cover. Stahl explains to the patient that even if his pain condition is a somatoform disorder, it can be disabling, and the drug "condition" is secondary to the pain problem.

Current Medications:

- Levothyroxine 75 mcg/d
- Duloxetine 120 mg/d
- Oxycodone sustained release 320 mg/d

A Case of Chronic Pain (cont'd)

- Oxycodone immediate release 120 mg/d
- Hydrocodone 30 mg/d in combination with ibuprofen, as well as extra ibuprofen
- Pregabalin 100 mg/day
- Modafinil 200 mg a.m., 100 mg afternoon
- Clonazepam 1 mg tid
- Alprazolam 1 mg bid
- Unspecified “herbs” for sleeping (again not specified)
- Testosterone cream (again not specified)
- Unspecified nutritional supplements (again not specified)
- Zolpidem 20-30 mg hs
- Ezetimibe (again not specified)

The patient says he wants to take sulpiride again as he did years ago. However, sulpiride is not approved in USA and the patient previously had to order it from Europe. Stahl will not prescribe it until the patient reduces his opiate usage and gets psychotherapeutic and nonmedical treatments.

Stahl next sees the patient 37 months after the first visit. His wife and daughter have moved out, and his wife will not let him see his daughter. The patient is trying to run his consulting business a few hours each day, but he remains in poor financial condition. He says that he stopped the hydrocodone but Stahl reports that the patient is still taking oxycodone at “huge doses.” Other medications are still at the same dosages. Stahl asks the patient why he returns to see him if he does not follow his advice. The patient replies, “I respect you.”

Stahl next sees the patient at 41 months from the time of the first visit. Medications are the same but the patient has started to see a psychotherapist. The

form of psychotherapy is not specified.

Stahl next sees the patient at 45 months from the time of the first visit. He has found a physician in New York who prescribed sulpiride, which he orders via mail. He has started it at 50 mg hs and has reduced duloxetine to 60 mg/day. As well, he now is occasionally using medical marijuana. The other medications remain unchanged. The patient says he has less pain and overall feels better with these treatment changes. He continues to see a therapist, but the therapist and the family physician now want the patient to go into a detoxification program, although the patient says he cannot afford it. This is the last time that Stahl sees the patient.

Stahl’s concluding remarks about this case are that the patient was avoiding a psychotherapeutic approach to his problems, and was “always chasing a solution in another drug.” Stahl felt there was a high risk of an accidental overdose or in fact a high risk of a suicide.

The DSM-IV term “somatoform disorders” is replaced in the DSM-V by the term “somatic symptom and related disorders.” The diagnostic criteria for DSM-V Somatic Symptom Disorder, a more current diagnosis for the above patient, are:

- A. One or more somatic symptoms that are distressing or result in significant disruption of daily life.
- B. Excessive thoughts, feelings, or behaviors related to the somatic symptoms or associated health concerns as manifested by at least one of the following:
 1. Disproportionate and persistent thoughts about the seriousness of one’s symptoms.

2. Persistently high level of anxiety about health or symptoms.
3. Excessive time and energy devoted to these symptoms or health concerns.

C. Although any one somatic symptom may not be continuously present, the state of being symptomatic is persistent (typically more than 6 months).

Specifier: “with predominant pain” (previously pain disorder). This specifier is for individuals whose somatic symptoms predominantly involve pain. There are additional specifiers to somatic symptom disorder with regard to persistence and current severity.

Patients with chronic pain must be evaluated carefully. Stahl recommends that the physician be aware of the dangers of starting opiates for chronic and vague pains (even proposing the pearl, “once you go opiate, you never go back”). He further strongly recommends psychotherapy, meditation, and referral to specialty pain centers. It may not be possible to cure what are now called somatic symptom disorders, but patients can learn to live with their condition and have a better life.

Conflict of Interest: None

Contact: howard.schneider@gmail.com

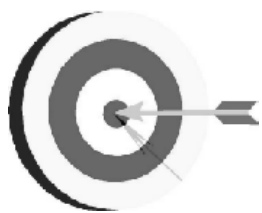
Howard Schneider started his career performing psychiatric consultations and short-term follow-up care in the emergency department in Laval, Québec. For the last 17 years he has taken care of psychiatry and psychotherapy patients in the community in the Toronto area.

A Case of Chronic Pain (cont'd)

References

- American Psychiatric Association (2013). *American Psychiatric Association: Diagnostic and statistical manual of mental disorders, fifth edition*. Arlington, VA: American Psychiatric Publishing.
- Stahl, S.M. (2011). *Case studies: Stahl's Essential Psychopharmacology*. Cambridge, MA: Cambridge University Press.
- Stahl, S.M. (2014). *Prescriber's guide: Stahl's Essential Psychopharmacology: Applications—5th ed.* Cambridge, MA: Cambridge University Press.

Generic Name	Trade Name
	(Common, Canadian names where possible)
hydrocodone	Hydrocodone
gabapentin	Neurontin
quetiapine	Seroquel
sulpiride	Not approved in USA or Canada
levothyroxine	Synthroid
oxycodone	OxyContin
clonazepam	Rivotril
alprazolam	Xanax
pregabalin	Lyrica
duloxetine	Cymbalta
zolpidem	USA: Ambien (Canada: Sublinox sublingual form)
atomoxetine	Strattera
modafinil	Alertec
sodium oxybate	Xyrem
eszopiclone	USA: Lunesta
venlafaxine-XR	Effexor-XR



ADVERTISE IN THE GP PSYCHOTHERAPIST

Reach your target audience

When you advertise in the GP Psychotherapist, your word will be distributed to over 350 GPs in Canada. Our journal will reach GPPA members and doctors interested in psychotherapy who are on our mailing list.

Contact journal@gppaonline.ca for information on our reasonable rates.

CLINICAL APPROACHES

Neuro-Linguistic Programming for Depression

David Murphy, M.B., Ch.B., CGPP

Introduction

The medical literature abounds with studies of the biology of depression and the benefits of pharmacotherapy but there has been a much more limited analysis of the psychological causes and treatments for symptoms of depression. In this article I will discuss treating symptoms of depression with Neuro-linguistic Programming (NLP), a psychotherapeutic modality.

A Brief History of Depression

In 1952, the first edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) recognized traditional psychological models of depression by including *Depressive Neurosis* along with *Affective Disorders* and *Melancholia*. In 1980, DSM-III radically changed the model for depression. The concept of *neurosis* was excluded altogether and *melancholia* became a sub-type of depression. DSM-III founded the new concept of *Major Depressive Disorder*. DSM-IV, in 1994, and DSM-5, in 2013, have maintained the same biological model for depression. By excluding the concept of *neurosis*, DSM-III effectively ignored psychological causes for depression. With the general acceptance of the DSM model, at least in the U.S.A. and Canada, the biological model of depression has become the focus of scientific study. The concept of a psychological basis, for both the symptoms of depression and the diagnosis of depression, seems to have faded into the background.

The Map is Not the Territory

Alfred Korzybski (1933) was an independent scholar who coined the phrase: "The Map Is Not the Territory." A road map of Ontario does not accurately or

even closely describe the actual territory of Ontario that we would see, hear and touch as we drive along the road indicated on the map. The map is merely a representation of the roads that are a part of the territory. The map is a tool that we can use to guide us to our destination. Korzybski argued that we all have internal maps with which we interpret our external world. It is our internal maps that create our perceived reality. As we all use different maps, based on our experiences and the internal language that we use, then we will all have different realities. Some of us may agree with each other on our realities and some of us will disagree on our realities. Korzybski argued that no one person has a lock on the truth. There are an infinite number of truths. In the movie *Star Wars: Episode V—The Empire Strikes Back*, Obi-Wan Kenobi succinctly summarizes this idea with the words: "The truths that we cling to depend on our own point of view, Luke" (Brackett & Kasden, 1980).

It can be argued, then, that DSM is a model or map for theorizing about depression. It is a scientific theory, with scientific evidence to support it. However, it is not the absolute truth. In this article I will be offering an alternative psychological map, which utilizes the Neuro-linguistic Programming model of psychotherapy, for both assessing and treating symptoms of depression; a map that can offer a quicker and more satisfying journey to lasting health than the biological model and one that can be implemented without the use of pharmacotherapy.

Neuro-linguistic Programming

The model of psychotherapy that has been called NLP was developed by two American psychologists, Richard Bandler and John Grinder (1975a, 1975b). They expanded on Korzybski's concept of "The Map is not the Territory." They coined the term *neuro-linguistic* to describe how humans create language patterns within the central nervous system to process sensory information. Bandler and Grinder theorized that we create personal maps that represent our external and internal worlds and become our perceived reality. The term *programming* refers to how our life experiences create psychological programs that both process the sensory information we perceive and drive our behavior, in the same way that computer software programs run the hardware of a computer. It is unfortunate that the term *programming* can lead to the misconception that the therapeutic model is a type of brainwashing, because the model is remarkably patient-centred and is not therapist-driven.

Bandler and Grinder decided to base their model of therapy on the work and theories of three other leading clinicians: Milton Erickson, a psychiatrist, Fritz Perls, a psychiatrist and psychoanalyst, and Virginia Satir, a social worker. Erickson (1976, 1979, 1981) had become known for reviving the use of hypnosis in mental health care treatment. Perls (1951), with his wife Laura, had developed the model of psychotherapy that became known as Gestalt Therapy. Satir (1976) developed Transformational Systemic Therapy and has been credited with initiating the concept of family therapy.

Neuro-Linguistic Programming (cont'd)

Bandler and Grinder adapted Satir's therapeutic concepts that the presenting problem is not the problem. It is how individuals cope with the problem that is the real problem. From that aphorism, Bandler and Grinder developed the *metaprogram* model. This model theorizes that we have all developed unconscious programs that we use to both create our reality and to cope with our problems. These programs include our beliefs about ourselves and the world and the assumptions that we make based on those beliefs. These *core* beliefs may lead us to distort or even delete sensory information that would challenge those beliefs, leading to dysfunctional coping skills. Satir also theorized that we all have the solution to our own problems within us. She promoted the idea that psychotherapy treatment should focus on wellness as opposed to illness and pathology.

Bandler and Grinder also applied aspects of Perls' Gestalt Therapy to their own model of therapy. Perls promoted the concept of a phenomenological approach to psychotherapy, focusing on symptoms, instead of diagnosis and disease. Bandler and Grinder adapted Perls' *empty chair* technique and created a *perceptual position* model, whereby a relationship between two people can be viewed from four positions: The personal perspective, the perspective of the other person or persons in the relationship, an objective perspective and the bigger picture. They also adopted Perls' theories of the mind being made up of fragmented ego states. Bandler and Grinder chose to describe Perls' model of fragmented ego states as *parts* of the mind.

Finally, Bandler and Grinder incorporated Erickson's hypnosis techniques, which use the power of words to not only create a state of hypnosis but also to encourage and give the patient per-

mission to make healthy changes. They adapted Erickson's methods of utilizing hypnotic states to help the patient create visual imagery to access internal psychological resources. And they incorporated Erickson's methods for *anchoring* new resources, so that they become incorporated into the patient's coping strategies. Anchors can be visual, auditory or kinesthetic triggers for consciously and unconsciously accessing complex mental, physical and emotional states. The same techniques can be utilized for recognizing anchors that are already triggering dysfunctional coping strategies.

With the NLP model, symptoms of depression can be considered as psychological manifestations of learned programs that have developed in response to a multitude of environmental triggers that have been experienced throughout life. Those programs drive emotional responses to environmental triggers and, secondarily, drive behaviour. Some aspects of the NLP model overlap with the cognitive-behavioral model of therapy and other models of therapy that have been subjected to clinical research.

There is, unfortunately, a dearth of scientific evidence in the medical literature on the management of depression using NLP techniques. A recent meta-study on the effects of NLP on health care outcomes found only ten experimental studies in the literature (Sturt et al, 2012). Five studies were randomized controlled trials and five studies were pre-post studies. The sample sizes in the studies range from twenty-two to one hundred and six patients. Four randomized controlled trials reported no significance between the groups and the fifth study reported that NLP strategies were beneficial. The targeted health conditions were anxiety disorders, weight maintenance, morning sickness,

substance misuse and claustrophobia during MRI scanning. The interventions were delivered across as few as four and as many as twenty sessions. Three of the studies involved only a single session. The meta-study concluded that the quantity of NLP research was too limited to draw conclusions concerning the efficacy of the therapeutic model. Of course, the absence of scientific evidence for efficacy should not be generalized to mean that there is an absence of efficacy. The evidence for efficacy of NLP in the management of symptoms of depression remains largely anecdotal. An internet search quickly elicits large numbers of websites that both describe the NLP model and provide descriptions, by both clinicians and patients, of case studies with successful outcomes. Many self-help books have been written that utilize the NLP model, such as those written by John Bradshaw (1990) and Anthony Robbins (1992).

In a follow-up article, I will be providing specific examples of NLP techniques for treating and resolving symptoms of depression.

Conflict of interest: none

Contact: davidmurphy@bell.net

David Murphy is a graduate of the University of Manchester Medical School (1973). He is a Medical Psychotherapist, Master Practitioner of Neuro-linguistic Programming and Certified Anesthesiologist, whose medical practice is focused on the management of chronic pain, psychological trauma, anger and stress. He provides forensic psychotherapy and pre-sentence reports for sexual and other offenders.

Neuro-linguistic Programming for Depression (cont'd)

References

- American Psychiatric Association (1950). *Diagnostic and statistical manual of mental disorders, First Edition*. Washington, DC: American Psychiatric Publishing, Inc.
- American Psychiatric Association (1980). *Diagnostic and statistical manual of mental disorders, Third Edition*. Washington, DC: American Psychiatric Publishing, Inc.
- Bandler, R. & Grinder, J. (1975a). *The Structure of Magic I: A Book about Language and Therapy*. Palo Alto, CA: Science and Behavior Books.
- Bandler, R. & Grinder, J. (1975b). *The Structure of Magic II: A Book about Communication and Change*. Palo Alto, CA: Science and Behaviour books.
- Brackett, L. & Kasdan, L. (1980). *Script of Star Wars Episode V*. San Francisco CA: Lucasfilm.
- Bradshaw, J. (1990). *Homecoming: Reclaiming and Healing Your Inner Child*. New York, Bantam Books.
- Erickson, M., Rossi, E. & Rossi, I. (1976). *Hypnotic Realities*. Stratford NH: Irvington Publishers.
- Erickson, M. & Rossi, I. (1979) *Hypnotherapy—An Exploratory Casebook*. Stratford NH: Irvington Publishers.
- Erickson, M. & Rossi, E. (1981) *Experiencing Hypnosis*. (1981) Stratford NH: Irvington Publishers.
- Korzybski, H. (1933). *Science and Sanity: An Introduction to Non-Aristotelian Systems and General Semantics*. Brooklyn, NY: Institute of General Semantics.
- Perls, F. (1951) *Gestalt Therapy*, Houston TX: Julian Press.
- Robbins, A. (1992) *Awaken the Giant Within: How to Take Immediate Control of Your Mental, Emotional, Physical and Financial Destiny*. New York, NY: Simon and Schuster.
- Satir V. (1976). *Making Contact*. Berkeley, CA: Celestial Arts.
- Sturt J et al. (2012) Neurolinguistic programming: a systematic review of the effects on health outcomes. *Brit J Gen Pract*, 62 (604), 757–764.

OFFICE FOR RENT

One all-inclusive office available in a magnificent modern new building in a luxuriously finished suite of two offices with a beautiful waiting room, kitchen and washroom available for a GP Psychotherapist to sub-lease in Midtown Toronto at Eglinton and Avenue Road. Huge terrace with treed view overlooking quiet neighbourhood.

Close to Eglinton subway, Hwy 401 and Allen Road.
Public parking steps away \$9/day.
The monthly rent is \$1800.00 inclusive.

Please contact Cinthia at cinthia.mcandrew@rogers.com
or at 416-480-1562.

Improve Your Practice

Free Mentor Support for Ontario Medical Psychotherapists

Daniel McBain, MD, CCFP

With apologies to one of Canada's banking institutions, Ontario members may well be richer than they think! Family Physicians and Medical Psychotherapists in some Canadian jurisdictions find themselves poorly supported by psychiatry and bewildered by mental illness. This was the case fifteen years ago in Ontario, according to needs assessments showing that Ontario FPs felt stressed, lacking confidence in providing psychiatric care. Members of the Ontario College of Family Physicians admitted to uncertainty about diagnosis and treatment, and often could not access psychiatric consults. Now, Ontario MDs can turn to the Collaborative Mental Health Network for support, advice, information, and education.

Created in 2001, the Collaborative Mental Health Network was the brainchild of a few visionaries, including Drs Patricia Rockman and Ty Turner. Under the auspices of the Ontario College of Family Physicians, in 2000 they presented a grant proposal to the Ministry of Health and Long-Term Care entitled "A Shared Care Network: Enhancing Mental Health Services In Ontario." The Ministry accepted the proposal and continues to support the program today.

The stated mandate of the Collaborative Mental Health Network is to provide support to Ontario Family Physicians seeking guidance in the care of mental health patients. Family Physicians are paired with two mentors, a GP Psychotherapist and a Psychiatrist, chosen by a combination of mutual interest and geo-

graphical location. They may consult their mentors face-to-face or via email, telephone, or fax, regarding diagnosis, psychotherapy, psychopharmacology, and ethical, professional, or medicolegal issues. They can expect a response within 48 hours.

Although not stated on the OCFP website, mentor support is also available to Medical Psychotherapists with focused practices, whether they are affiliated with the College of Family Physicians or the Royal College of Physicians and Surgeons of Canada. Mentees may benefit not only from case-by-case consultation with their mentors, but also from the collegial support of a group of other mentees. Each group is encouraged to engage in CME activities, either in person or by teleconference.

The key word in the Network's name is "Collaborative." As presented in the 2000 grant proposal, the prevailing model of the day was "Split-Care": a Family Physician referred a patient to a Psychiatrist, after which the patient's treatment occurred "in relative isolation from the Family Doctor." (An experience not unknown to many Family Physicians across Canada today.) A shortage of Psychiatrists meant that Family Physicians, unless they were fortunate enough to hand over patients to a specialist, often managed psychiatric illnesses on their own, and often struggled. The co-authors of the OCFP grant proposal advocated a "Shared-Care" model, introducing various levels of collaboration—between Family Physicians and Psychiatrists, and also between clinicians, patients, and families.

Today, Ontario's Collaborative Mental Health Network is a well-functioning model of Shared-Care for the rest of Canada. Yet curiously, many well-informed Medical Psychotherapists practising in Ontario remain unaware of this invaluable service. To learn more about Ontario's Collaborative Mental Health Network, to request a mentor, to inquire about becoming a mentor (this service is not only meaningful but also remunerated), or merely to study a well-crafted grant proposal, enter the following URL in your internet browser: <http://ocfp.on.ca/cpd/environment-and-health-conference/collaborative-networks/cmhcn>.

Conflict of Interest: none

Contact: doc@danielmcbain.ca

Daniel McBain is a Medical Psychotherapist residing in Kamloops, BC. He has provided psychotherapy to Ontario residents through the Ontario Telemedicine Network since 2010.

THE ART OF PSYCHOTHERAPY

Where Grief Meets Poetry: A Reflection

Janice Falls RP, MEd

Ah, Grief, I should not treat you
like a homeless dog
who comes to the back door
for a crust, for a meatless bone
I should trust you
(Levertov, 1978, lines 1–5).

We don't really know how to trust so raw an emotion as grief. It appears in our lives suddenly, the dog at our back door looking for a home we don't want to give. In our culture, we tend to perceive grief as something that happens to someone else, something to be met with stoicism and a steady eye to the future when we will have gotten over it. The challenge in our own lives, much less our clients, is to learn to trust this deep sadness, to turn toward rather than avoiding it. So how do we do this?

One way I have found to learn to trust is through poetry. Certain poems bring me solace because they speak words I cannot not find myself in the moment. They allow me to feel understood and they show me that the person writing has survived their sorrow. They become a kind of pathway, a guide to experiencing and expressing this pain.

In my world view, grief is part of living a meaningful life. Without it, we cannot fully comprehend what it is to be human. I want to share with people that we need not be afraid of sadness and death so that they can fully open themselves to joy. The more deeply you love, the more you will hurt when that person dies. So, if you don't want to feel the anguish of grief, you must not let yourself feel the joy of loving fully. It became clear to me that that was not a choice I was prepared to make.

Poetry may seem an odd companion to learning about grief and loss but, in fact, it has been both necessary and healing for me. This has led me to believe that poems are one of the few things we can offer ourselves or others when we are grieving.

My first encounter with a significant death was through two miscarriages. What I experienced from others was avoidance, embarrassment, false cheer (you'll get pregnant again) and silence. Later, a course on bereavement was transformative; it acknowledged my grief as nothing else had. At that point, though I searched the written word for comfort, I had not yet found refuge in the beauty of poems.

As part of my healing, I began to talk about death and dying and grief out loud despite the changes of subject and discomfort I knew I was causing. I was persistent because I knew it was important. I avoided the platitudes I'd heard (and, sadly, repeated in the past). I used the word died, rather than "passed away" in my condolences because it felt important to be real that way. And I began to explore the words of the poets who so eloquently expressed my own grieving heart.

It is not the weight you carry
but how you carry it—
books, bricks, grief—
it's all in the way
you embrace it, balance it, carry it
when you cannot, and would not,
put it down (Oliver, 2006, lines 16–22).

This was my companion after my father's death when my world was radically altered. Suddenly the one person who loved me unconditionally was gone and at the same time I became a caregiver to my mother with Alzheimer's, shortly followed by the death of my dear sister-in-law. But it was the loss of my father I grieved the most and Oliver's words made sense to me, became my guide.

And when my world was turned inside out some years ago by the sudden and many cancer diagnoses of close friends, I wrestled with disbelief, rage, grief and perhaps most of all helplessness. Still, it wasn't until the last round of diagnoses and deaths that the words of Stephen Dunn's "Sweetness" (1989, lines 1-7) arrived to bear me up:

Just when it has seemed I couldn't bear
one more friend
waking with a tumor, one more maniac
with a perfect reason, often a sweetness
has come
and changed nothing in the world
except the way I stumbled through it.

The more deeply I move into this life, the more certain I am that grief is as natural a part of living as joy. And grief, for me, is no longer a heavy sadness that permeates everything continuously. It is an acute sensation that comes with certain losses, not a chronic condition. I have learned that like all beings, I have the resilience to meet my losses and I know, too, there will be poems to guide me, comfort me, challenge me. I "placed my grief/in the mouth of language,/the only thing that would grieve

Where Grief Meets Poetry (cont'd)

with me" (Mueller, 1996, lines 19–21).

I have noticed how all the poems I am drawn to about grief are also about joy. They give voice to my deepest convictions and they create beauty in the world—the necessary and inevitable outcome when you mix sorrow with joy. What I have learned about the dark emotions, grief in particular, is that they can be trusted. When we mindfully listen to them, there is an innate wisdom that emerges, allowing for profound healing and a renewal of life. I believe that the underlying challenge we all face is to seek some balance between the exhilaration and beauty of life, and its counterpoint of darkness. As Jane Hirshfield (1994, lines 15–20) writes in "The Weighing":

So few grains of happiness
measured against all the dark
and still the scales balance.
The world asks of us
only the strength we have and we
give it.
Then it asks more, and we give it.

Conflict of Interest: None

Contact: janfalls@rogers.com

*Janice Falls is a Registered Psychotherapist with 30 years of training and experience. She has a long-held interest and experience in working with grieving clients in her private practice. For the past four years she has worked with Kim Rosen, author of *Saved By a Poem*, and a teacher of self-inquiry, and is learning the transformative medicine of poetry as a way to embody words and deepen the connection with self and others.*

References

- Dunn, Steven (1989). *Sweetness*, in *New and Selected Poems 1974-1994*. New York: W.W. Norton & Co, Inc.
- Hirshfield, Jane (1994). *The Weighing*, in *The October Palace*. New York: HarperCollins.
- Levertov, Denise. (1978) *Talking to Grief*, in *Life in the Forest*. New York: New Directions.
- Mueller, Lisel (1996). *When I Am Asked*, in *Alive Together: New and Selected Poems*. Louisiana: Louisiana State University Press.
- Oliver, Mary (2006). *Heavy*, in *Thirst*. Boston: Beacon Press.

The Mindful Raisin

E. Janet Warren, MD

Oh ugly, shriveled bit of dead fruit
How mightily you are regarded
What depths of attention are deposited on you
What lengths of touch, smell and taste you elicit
You are prodded and probed, interrogated and investigated,
considered and contemplated...

But I can eat you in less than a second

Janet Warren is a Family Physician who practices psychotherapy part-time in Burlington, ON. She enjoys writing and is editor of the GP Psychotherapist.

Therapist's Bookshelf

Is Food Addiction Real? A Review of *Food Junkies*

Vera Tarman, M.D. with Philip Werdell. Toronto: Dundurn; 251pp. \$24.99

Vivian Chow, MD

I was given the opportunity to read and comment on this book when a colleague had to abandon the review. At first, I was a bit skeptical of the notion of food as an addiction. Junkies are addicted to heroin, crack, cigarettes, and alcohol. How could someone be addicted to food?

Then I recalled a grossly obese patient of mine. My 50-something patient is the child of two alcoholics, and has never been able to stay on a diet long enough to lose more than 20 pounds (9 kilograms). I would have appreciated any advice to help treat this patient.

This book is very readable, with plenty of case histories and personal anecdotes. At only 199 pages of actual material, it was also a quick read. The authors are both food addicts, and successfully convey what their struggles feel like and how they cope. Dr. Tarman has a specialty in addiction medicine, which gives credibility to her explanations and treatment suggestions. As a medical practitioner, she also provides lots of references and research.

The first part of this book is spent answering my question "How could someone be addicted to food?" I like that Tarman uses sound scientific reasoning to explain how sugar can be addictive. She goes through a general description of addiction, starting with our "happy" neurochemicals—namely serotonin, dopamine, and endorphins—and explains exactly what "rewards" they produce. Serotonin makes us feel safe and content, dopamine gives us a natural high, as when we are excited about an upcoming event, and endorphins are natural pain relievers. She then goes on to explain how addiction develops in relation to consuming unnatural substances that are more intense and more concentrated than natural substances (e.g., alcohol vs. fermented fruit), and

which provide a "quick fix" of the rewards that these neurochemicals provide. The addict, of course, is constantly seeking these rewards and needs higher and higher doses of the drug of choice in order to achieve the same high. The other side of addiction is that an addict who stops using his or her drug of choice, goes through unpleasant withdrawal symptoms. In the case of sugar, it is now so refined (e.g., high-fructose corn syrup) that it creates an artificial high, and when consumed in huge quantities (not uncommon in jumbo-sized soft drinks, for example), it can produce withdrawal symptoms. According to Tarman, these include "snappy moods, insomnia, tremors, nausea, aching muscles and a mental fog" (p. 70).

Tarman does not try to paint every overweight or eating-disordered person as a food addict. She makes a clear distinction between a true food addict and an emotional eater. The true addict is chemically dependent on food, whereas the emotional eater is eating to "treat" a negative emotion. She also makes clear that the treatments for the two problems are completely different. Emotional eaters can benefit from an eating disorder program and psychotherapy to recognize their triggers and deal with them in a positive manner. Food addicts, on the other hand, are advised to follow typical addiction treatments, including the Alcoholics Anonymous model. Of the limited information on psychotherapy, most favours Behavioural techniques, with one example of a patient benefitting from Psychodynamic treatment. The main message of this book is that the food addict needs to practise abstinence from trigger foods, which usually include sugar and starch.

This book is really geared for the food addict or anyone who suspects they might be one. A big chunk of the book is spent proving the existence of food addiction

and how to make the diagnosis, with relatively less emphasis on treatment. In spite of its limitations, though, I would recommend this book to all medical practitioners, especially psychotherapists. We all have binge eaters in our practices, and some of them could be food addicts. I think it's worthwhile to distinguish one set from the other. Any patient that does not benefit from typical eating disorder treatments could have a food addiction.

In the case of my grossly obese patient, I now believe that I truly am dealing with a food addict. This is partly supported by a strong family history of addiction. Moreover, after losing the proverbial 20 pounds on the Atkins diet, (only proteins and vegetables in the first stage, followed by the reintroduction of starchy trigger foods in the second stage), my patient promptly re-gained the lost weight and then some when a stressful life event led to a relapse. I have strongly urged this patient to avoid all sugary and starchy foods for life. We'll see how it goes.

Conflict of Interest: None reported.

Contact: drvchowccfp@hotmail.com

Vivian Chow switched from Family Practice to Psychotherapy in 2002 and focusses on the Cognitive Behavioural Techniques. Her practice is in downtown Toronto.

Brain Healing and Neuroplasticity

Josée Labrosse, MD, MEd

(inspired by Norman Doidge, *The Brain's Way of Healing*, Penguin, 2015)

Electrodes on tongues create miracle cures!
Un-invasive path to the brain
To soothe the busy mind.
A miracle of science
To heal the unthinkable mendable and
So-called plastic nature.

But what if
Maybe
The miracle was basic nature?
Biology herself.

The infant sucking, full tonged at the breast
Soothing power of the NUK! Or soother, of any kind.
And birthday cake. A good enough mother.
Transitional objects, Winnicot style.

The deliciousness of food
Or grape, or raisin,
raw or fermented
Really, really, well.
Or chocolate, the good kind. Of any brand.

A kiss
Long, succulent, passionate, playful,
Delicate, exploring
And, or, raw.

Ice cream, Sarah M style.
Love. Better than
Anything.

Meditation,
Tongue apposed just so
The miracle of nectar in *that* place
Arising from perfect practice.
Or just plain practice.

Heal thyself.
Strange route to the soul.
Miracle of healing.
Neo-linguist of neuroplasticity.

Josée Labrosse is a physician-therapist who practices at the River House, an integrative centre in Ottawa. She incorporates mindfulness and reflective practice, connection with nature, and principles of coaching in her work with individuals and organizations.

GPPA INTERESTS

Standards for Psychotherapy: Psychotherapy and Self-Disclosure

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

The purpose of this article is to help Primary Care Physicians in Ontario become acquainted with the expectations concerning the standards of psychotherapy in medicine. This is the seventh in our ongoing series of articles that discusses these complex and important topics.

Introduction

This article will explore and discuss some of the various ideas concerning self-disclosure in relation to the often hotly-debated question: How much self-disclosure is appropriate in psychotherapeutic practice? This article will focus on the regulatory aspects surrounding self-disclosure. However, future articles will incorporate practical case-studies and tools psychotherapists can utilize along with professional judgement in order to determine when self-disclosure should and should not be utilized in certain practice settings or situations. To whet your appetite on the topic of self-disclosure, we have included a complex, practical case study for you to contemplate that will be examined in future articles:

Case Study 1:

A physician providing Cognitive Behavioural Therapy (CBT) has been treating a patient for the past five months for Major Depressive Disorder. The patient tells the physician that lately he has been struggling with alcohol abuse, and asks him if he has ever struggled with a similar problem. The physician indicates that many people suffering from Ma-

jor Depressive Disorder have been known to abuse alcohol, and states "I, myself, struggled with alcohol abuse in the past." The patient and physician then discuss some of the difficulties the patient is facing during and after consuming alcohol, which the physician indicates that he also experienced in the past. As noted above, the model of therapy being provided is CBT and not an explicit type of substance use/abuse counselling, which is often provided by a physician practicing psychotherapy who explicitly acknowledges if he or she has recovered from previous addiction problems to reduce fear of stigmatization and judgement.

Was it a good idea for the psychotherapist to self-disclose this information to the patient? What are some reasons this physician's self-disclosure may have been beneficial or detrimental to the patient?

"Like drugs and surgery, physicians' self-disclosure and advice are powerful interventions that have indications, contraindications, potential side effects, and potential adverse effects" (General Practice Psychotherapy Association, 2010, p. 36). The standards surrounding this issue are broad and, subsequently, open to widely varying interpretations. However, as this article is dedicated to the standards of self-disclosure in psychotherapy as they apply to physicians in general practice, we hope to illuminate the regulations of our particular

College and other medical, professional requirements concerning this issue.

Self-disclosure may be broadly defined as "the revelation of personal rather than professional information about the therapist to the [patient]" (Zur, 2011, p.1). Self-disclosure has also been defined as the process through which a "therapist shares their own personal views or experience with a client with the purpose of improving the [patient's] emotional or mental state. It should be done solely for the purpose of helping the client, and not to meet the needs of the therapist" (LoFrisko, 2012, p. 1). The College of Physicians and Surgeons of Ontario (CPSO) provides us with some insight into appropriate versus inappropriate self-disclosures in its documents concerning "Values of the Profession" and the "Guidebook for Managing Disruptive Physician Behaviour." At its most basic level, the College requires physicians to "practice unselfishly and with regard for others," with their "primary responsibility [being] to the individual patient before them" (CPSO, 2007c, p. 12). Therefore, the use of self-disclosure for selfish or personal purposes would be considered highly inappropriate. The CPSO emphasizes that physicians have:

a fiduciary duty to their patients—because the balance of knowledge and information favours the physician, patients are reliant on their physicians and may be vulnerable... the physician [must] put the needs of

Psychotherapy and Self-Disclosure (cont'd)

the patient first. This principle should inform all aspects of the physician's practice (CPSO, 2007b, p. 1).

The College also identifies a number of physician behaviours that are considered disruptive, and that have the potential to manifest as self-disclosures in practice. These include, for example, the use of "inappropriate words, actions or inactions... [which] interferes with, or is likely to interfere with, quality health care delivery" (CPSO, 2008a, p. 2). A list is also supplied by the College that identifies examples of these inappropriate behaviours. For example:

- jokes or non-clinical comments about race, ethnicity, religion, sexual orientation, age, physical appearance or socioeconomic or educational status...
- insensitive comments about the patient's medical condition, appearance, situation, etc. [that a competent physician would recognize, and which would have the potential to generate patient distress and/or breach of the alliance]
- inappropriate arguments with patients...
- boundary violations with patients (CPSO, 2008a, p. 3).

Though the first two examples may seem obvious, the issues of inappropriate arguments and boundary violations with patients may not directly come to mind when considering whether a self-disclosure will be appropriate or inappropriate in a psychotherapeutic setting.

Self-Disclosure and Arguments

In terms of the issue of physicians arguing with their patients, it is essential to note that we are required to respect the autonomy, cultural backgrounds, values and decisions of patients, even when those patients' decisions do not

align with our personal beliefs (CPSO, 2007a). If an argument arises between a patient and a physician, the physician must attempt to "work with the patient, the patient's family (if the patient consents) and any other supports to resolve the conflict respectfully," instead of inappropriately arguing with the patient (CPSO, 2007a, p.1). Of course, it is difficult to define the terms "argument" and "confrontation" in terms of psychotherapy as some gentle confrontation is often utilized as a psychotherapeutic tool. *However, therapeutic challenges would center on self-harming thoughts and actions of the patient, not the physician's beliefs and typical behaviours.*

In other words, physician psychotherapists may use other accepted techniques of confrontation if needed. Indeed, the CPSO's policy on this matter is not suggesting that we cannot gently challenge patients in a clinical manner in order to facilitate discussion and assist patients in attaining insight into some of their issues. For instance, the basis of CBT is to "argue", in a sense, against patients' faulty cognitions. This would be a reasonable way of challenging patients, done within the confines of the psychotherapeutic relationship with consent, which should be done with compassion and care. Ultimately, the physician must use clinical judgment in order to determine how forceful this challenging of the patient should be given the physician's rapport with the patient, and the circumstances in which the confrontation takes place.

Boundaries and Self-Disclosure

The CPSO explicitly states that physicians' self-disclosures may be boundary crossings. When self-disclosure is done excessively or done with a purpose that is not in the patient's best interest, these boundary crossings may become a boundary violation (CPSO, 2004). Generally speaking, a boundary crossing is

a situation in which there is no exact rule regarding a particular behaviour or interaction between a psychotherapist and a patient. For example, there is no precise regulation concerning a psychotherapist offering personal information about him or herself to a patient (e.g., "Everyone feels stress at times, even myself"). This is certainly not forbidden and some boundary crossings may be highly beneficial, and yet boundary crossings could at times lead to some potential issues within therapy. For example,

If the physician has disclosed excessive aspects of their personal lives and their own choices, the patient may begin to consider the therapist a friend. This mistaken identity could lead to the patient expecting increasing amounts of advice and reassurance, much as one would from a close friend (Paré, 2001, p. 105).

A boundary violation, on the other hand, is a strictly forbidden occurrence that takes place between a psychotherapist and a patient and results in harm to the patient. An example of this is the initiation or continuance of sexual contact between a physician and a patient. This is strictly forbidden by the College and the law (CPSO, 2008b).

Boundary violations are not only physical, but can involve verbal components such as the aforementioned list of inappropriate behaviours. This includes "behaviour or remarks of a sexual nature by the member towards the patient," which is defined by the Regulated Health Professions Act (RHPA) as "sexual abuse of a patient" (Service Ontario E-Laws, RHPA, 1991, s.3). The RHPA governs all regulated healthcare professions in Ontario in order to protect and assist the public, as well as health professionals, in navigating the

Psychotherapy and Self-Disclosure (cont'd)

practical rules that all health college members must follow; this now also includes the new College of Registered Psychotherapists of Ontario.

There is also an important disclaimer which clarifies this issue of sexual abuse by stating that “touching, behaviour or remarks of a clinical nature appropriate to the service provided do not constitute sexual abuse” (CPSO, 2008b, p. 2). Thus, for instance, completing a sexual history of the patient, if necessary for medical reasons, would typically be considered appropriate. Yet, even in this case, it is prudent to provide the patient with information regarding informed consent, and the patient should be offered the option of refusing to provide such information.

It is important for physicians to understand the possible implications of the regulation prohibiting sexual abuse, outlined by the RHPA. This is because the potential ramifications of contravening this regulation can be very broad. For example, even if a physician's behaviour or remarks are not intended to be sexual in nature, a patient's perception of the behaviour or remarks as being “sexual, but not clinical in nature” will be enough for the patient to submit a complaint against the physician. The acronym “WAIT”, put forward by Richard Schwartz, presents a helpful method of determining whether or not a physician's self-disclosure could be beneficial to a patient during psychotherapy (Sadighim, 2014). This acronym stands for ‘Why am I Telling?’ and encourages physicians to self-evaluate and seriously contemplate whether their reasoning for self-disclosing is for the benefit of the patient or for the benefit of the physician (or, alternatively, is thoughtless chatting, which is to be avoided). If the physician's reason for self-disclosing is

to benefit him or herself (and not to help the patient), then Schwartz indicates that it would be inappropriate for the physician to self-disclose.

Types of Self-Disclosure

The “*amount and type* of self-disclosure are important factors to consider when deciding on whether or not to disclose in a given situation” (Sadighim, 2014, p. 23). Also of importance are the timing of the disclosure and the strength of the psychotherapeutic relationship between the physician and the patient (Sadighim, 2014). Some studies have demonstrated that patients who have a closer psychotherapeutic relationship with their physician, are less symptomatic, and are nearer to the end of treatment benefit more highly from physicians' self-disclosures (Gibson, 2012; Audet, 2011). Studies such as these have also indicated that physicians' self-disclosures that are related to the interaction between the physician and the patient, as opposed to self-disclosures about the physician's life outside of the psychotherapy session, tend to be of greater benefit to the patient.

The amount of self-disclosure is also a factor, as patients may perceive the physician to be less experienced or less professional based on the amount (and type) of self-disclosure the physician provides (Sadighim, 2014). Of course, these findings could vary widely based upon the type of psychotherapy provided by a physician. As there are over 400 types of psychotherapy, the amount and/or type of self-disclosure that is considered reasonable in one form of psychotherapy may not be seen to be as appropriate when utilized in another psychotherapeutic treatment modality. We must also add to this complexity the fact that most psychotherapists do not practice a pure form of psychotherapy. For example, most psychotherapists do not provide a pure form of CBT or Psy-

chodynamic Psychotherapy etc., but rather, use techniques and interventions from various types of therapy. This is often referred to as an “eclectic” approach (Beutler, 2000).

According to Zur, there are four standard types of self-disclosures: “deliberate, unavoidable, accidental, and client initiated” (2011, p.1). Deliberate disclosures occur when the psychotherapist consciously and intentionally discloses personal information about him or herself to the patient. Unavoidable self-disclosures refer to physical elements about the psychotherapist or medical office that identify something personal about the therapist (e.g., gender). Accidental disclosures refer to unplanned situations or reactions which occur and reveal something personal about the psychotherapist (e.g., unknowingly parking your motorcycle beside the patient's car). Finally, client-initiated self-disclosures occur when patients inquire about the psychotherapist's opinions and/or personal life. Each of these types of self-disclosure has potential merits as well as possible drawbacks. However, regardless of whether or not a physician will utilize these types of disclosures, it is important for physicians to be familiar with the various types of self-disclosures in order to be well prepared for future patient interactions.

Benefits and Dangers

Edmund Howe identified a number of “pros” and “cons” that are often associated with self-disclosure. Below, we have produced a condensed list, informed by Howe's (2011) original list in order to prepare physicians for the uses, and avoid misuses, of self-disclosure in psychotherapeutic practice. This list has also been informed by Barbara LoFrisco's (2012) pros and cons list concerning physicians' self-disclosures.

Psychotherapy and Self-Disclosure (cont'd)

<i>Pros</i>	<i>Cons</i>
<ul style="list-style-type: none"> • Can strengthen the psychotherapeutic relationship • May instil hope in the patient • Helps patient minimize feelings of isolation • Can reduce patient's feelings of shame • Helps identify commonalities and strengthen sociability between the patient and the psychotherapist • Can reduce the power differential between the physician and the patient • May increase the patient's trust in the psychotherapist 	<ul style="list-style-type: none"> • Patient may believe the psychotherapist is "impaired" in terms of ability • Patient may feel that the psychotherapist does not want to listen to him/her • Patient may misidentify the psychotherapist's openness as intimacy • Psychotherapist may unintentionally burden the patient • The patient may view the psychotherapist as a friend rather than a professional

It may also be helpful to review the information provided by The College of Alberta Psychologists (Cap Monitor, 2002) regarding additional, important self-reflection questions to consider before engaging in self-disclosure; see Appendix A.

Another excellent list regarding important questions to contemplate before choosing to self-disclose has been summarized below, from psychotherapist Irvin Yalom's four general principles of self-disclosure:

- Remember that it is for the patients' benefit that physicians' self-disclosure should be utilized; therefore, physicians should reveal themselves judiciously.
- Think about how the physician's self-disclosure would sound to another psychotherapist.
- Always consider the current stage and progress of the therapy.
- Physicians should be careful to avoid self-disclosing things which are sources of great conflict within themselves. It would be appropriate to seek supervision or insight from a colleague in this situation (see Paré, 2001).

In Summary

The concept of self-disclosure in psychotherapy exists as a sort of balancing act between a possible overuse or underuse of self-disclosure by a physician

in psychotherapeutic practice; where the results can range from strengthening the therapeutic alliance to potentially serious accusations of malpractice and/or even sexual abuse (as defined by the RHPA). It is the responsibility of the physician to always act in the patient's best interest, to be aware of the professional standards and requirements of the profession concerning self-disclosure, and to acknowledge the potential consequences that may arise from misusing the psychotherapeutic tool of self-disclosure in practice.

This article has focused primarily on regulatory aspects concerning self-disclosure in order to provide a useful reference for physicians practicing psychotherapy. Future articles will delve deeper into the many possible practical applications of self-disclosure, including practical case studies and tools regarding the many uses, and possible misuses, of self-disclosure in psychotherapeutic practice. Our next article on self-disclosure will also attempt to clarify some of the most common types of self-disclosure utilized in the field of psychotherapy, even though the terms utilized to define the types vary quite widely in the field, and the terminology utilized may not be consistent across all psychotherapeutic modalities or preferences.

Conflict of Interest: none

Contact: michaelpare@rogers.com

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 has also completed the Osgoode Certificate in Professional Regulation & Discipline in the Ontario Health Care Sector, and the Osgoode Professional Development Certificate in Mental Health Law.

Laura A. Dawson currently assists Michael Paré as a researcher focusing on standards of care. She is also a Co-Curriculum Development Assistant in the creation and submission of professional development educational programs, and is currently working toward applying to medical school.

Appendix A

This list has been directly reproduced from the article "Professional Boundaries in Professional-Client Relationships," presented by The College of Alberta Psychologists (*The Cap Monitor*, 2002):

In terms of providing self-disclosure, and determining how to proceed, consideration of the following questions may be helpful.

Psychotherapy and Self-Disclosure (cont'd)

- Is this in my client's best interest?
- Whose needs are being served?
- Will this have an impact on the service I am delivering?
- Should I make a note of my concerns or consult with a colleague?
- How would this be viewed by the client's family or significant other?
- How would I feel telling a colleague about this?
- Am I treating this client differently (e.g.,...extent of personal disclosures)?
- Does this client mean something "special" to me?
- Am I taking advantage of the client?
- Does this action benefit me rather than the client?
- Am I comfortable in documenting this decision/behaviour in the client file?
- Does this contravene the Regulated Health Professions Act, the Standards of Professional Conduct, the Code of Ethics, etc.?"

References

- Audet, C. T. (2011). Client perspectives of therapist self-disclosure: Violating boundaries or removing barriers? *Counselling Psychology Quarterly*, 24 (2), pp. 85–100.
- Beutler, L. E. (2000). Eclectic Psychotherapy. *Encyclopedia of Psychology*, 3. Ed. A. E. Kazdin. American Psychological Association. Retrieved on February 4th 2016 from <http://search.proquest.com.ezproxy.lib.ryerson.ca/docview/614165999?pq-origsite=summon>
- Cap Monitor (2002). Professional Boundaries in Professional-Client Relationships. *The College of Alberta Psychologists. Issue 8*. Spring Ed. p. 3.
- CMA (2004). CMA Policy: Code of Ethics. *Canadian Medical Association*. p. 1-3. Retrieved January 26th 2015 from: <http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf>
- CPSO (2004). Maintaining Boundaries with Patients. *Member's Dialogue*. September/October Ed. p. 8, 11. Retrieved on February 3rd 2015 from: <http://www.cpso.on.ca/CPSO/media/images/Maintaining-Boundaries.pdf>
- CPSO (2007a). Duties to the Patient. p. 1. Retrieved on February 3rd 2015 from: <http://www.cpso.on.ca/Policies-Publications/The-Practice-Guide-Medical-Professionalism-and-Col/Principles-of-Practice-and-Duties-of-Physicians/Duties-To-the-Patient/Communicating-with-Patients-and-Others/Duties-to-the-Patient-Communicating-with-Patients>
- CPSO (2007b). Principles of Practice and Duties of Physician. p. 1. Retrieved on February 2nd 2016 from: <http://www.cpso.on.ca/policies-publications/the-practice-guide-medical-professionalism-and-col/principles-of-practice-and-duties-of-physicians>
- CPSO (2007c). Values of the Profession. p. 12. Retrieved on February 3rd 2015 from: <http://www.cpso.on.ca/policies-publications/the-practice-guide-medical-professionalism-and-col/values-of-the-profession>
- CPSO (2008a). Policy Statement #4-07: Physician Behaviour in the Professional Environment. pp. 2-3. Retrieved on February 3rd 2015 from: <http://www.cpso.on.ca/CPSO/media/uploadedfiles/policies/policies/policyitems/behaviour.pdf?ext=.pdf>
- CPSO (2008b). Policy Statement #4-08: Maintaining Appropriate Boundaries and Preventing Sexual Abuse. p. 2. Retrieved on February 3rd 2015 from: http://www.cpso.on.ca/CPSO/media/uploadedfiles/policies/policies/policyitems/sexual_abuse_boundaries.pdf?ext=.pdf
- General Practice Psychotherapy Association (2010). Guidelines for the Practice of Psychotherapy by Physicians. p. 36. Retrieved January 26th 2015 from: <http://www.gppaonline.ca/GPPADocuments/3.1.B.i.A%20Guidelines%20for%20the%20Practice%20of%20Psychotherapy%20by%20Physicians.pdf>
- Gibson, M. F. (2012). Opening up: Therapist self-disclosure in theory, research, and practice. *Clinical Social Work Journal*, 40 (3), pp. 287–296.
- Howe, E. (2011). Should Psychiatrists Self Disclose? *Innovations in Clinical Neuroscience*, 8(12). 14–17.
- LoFrisko, B. (2012). The Skill of Self-Disclosure: What You Need to Know. *Masters in Counseling.org*. p. 1. Retrieved on February 3rd 2016 from: <https://www.mastersincounseling.org/self-disclosure-what-you-need-to-know.html>
- Paré, M. (2001). Boundaries in Primary Care Medicine and General Practice Psychotherapy. *Patient Care Canada*, 12 (10). p. 105.
- Sadighim, S. (2014). The Big Reveal: Ethical Implications of Therapist Self-Disclosure. *Psychotherapy Bulletin*, 49 (4). pp. 23.
- Service Ontario E-Laws (1991). Regulated Health Professions Act. c. 37 s. 3. Retrieved February 3rd 2014 from: http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_91r18_e.htm#BK24
- Zur, O. (2011). Self-Disclosure & Transparency in Psychotherapy and Counseling: To Disclose or Not to Disclose, This is the Question. p. 1. Retrieved January 26th 2015 from: <http://www.zurinstitute.com/selfdisclosure1.html>



Physician Work Opportunity

The Medical Clinic for Person-Centred Psychotherapy



We must be doing something right: just ask our doctors!

265 Yorkland Blvd. (3 lights east of Don Mills / off Sheppard Corner)

Unit 403, North York, Ontario, M2J 1S5

Tel: 416-229-2399

Fax: 416-229-9771

Benefits of our Medical Psychotherapy Clinic:

Interesting / Meaningful Work

Positive Collegial Interaction

Professionally Run Clinic with a 20+ year track record of success

An Excellent and Fair Fee Split

Earning Potential Very Reasonable

In house educational sessions

Full and Part Time Work

**Our many doctors are happy here. If you have an interest in this important clinical area
we would like you to join our very successful busy clinic.
Psychotherapy training and supervision is available.**

Doctors' Testimonials:

"I have had the pleasure of working with Dr. Michael Paré for almost two decades. He and his excellent staff provide me with a full range of support and a constant stream of patients. The environment is efficient, pleasant and collegial. There is always someone to whom I can speak for advice on a difficult case. The CME programs that are offered here are extremely valuable."

Dr. Brian Bustard, M.D., CGPP, Associate of the Medical Clinic for Person-Centred Psychotherapy

"When I decided to refocus my practice from family medicine to solely psychotherapy, I thought that the transition would be quite challenging. But the environment of the Medical Clinic for Person-Centred Psychotherapy, with its educational opportunities and with its supportive staff made the transition very smooth. To join the clinic has been one of the best decisions of my career."

Dr. Louis Girard, M.D., FCFP, Associate of the Medical Clinic for Person-Centred Psychotherapy

"I have worked with Dr. Michael Paré for over a decade and I enjoyed my time at the clinic immensely. I have never experienced a shortage of interesting patients and the staff here at the clinic has always been friendly and helpful. I would not hesitate one iota in recommending Dr. Paré's clinic as a place to work or as a place to receive treatment."

Dr. Garry Shapiro, M.D., Associate of the Medical Clinic for Person-Centred Psychotherapy

"I started working at the Medical Clinic for Person-Centred Psychotherapy full-time in July 2012, after finishing my psychiatry residency. I have been very happy with my decision to join the clinic and Dr. Paré has been very supportive in helping me set up my new practice. There is a very collegial and easy-going work environment, which I value. Dr. Paré has also given me an opportunity to become involved in educational activities and this experience has been very rewarding."

Dr. Joel Shapiro, MD, FRCPC, Psychiatrist Associate of the Medical Clinic for Person-Centred Psychotherapy

For more information contact.

Dr. Michael Paré, M.D. MSc. M.Ed., C-IPT, C-GT, is coordinator the Medical Clinic for Person Centred Psychotherapy. Website at www.medicalpsychclinic.org / 1-888-229-8088 for more information

Report from the GPPA Board

Catherine Low, MD, CGPP

New Name

The Board is pleased to announce that the GPPA has a new legal name. Although this name will not be used in public forums until the process of re-branding has been completed, likely within the next year, the name **Medical Psychotherapy Association Canada** was registered as our new name with Industry Canada on December 22, 2015. This new name better reflects who our members are and the important work that they do. It also reflects that our membership now extends right across Canada from British Columbia to Newfoundland/Labrador. Making this change required a concerted and sustained effort on the part of a multitude of our members as well as the able support of Carol Ford. Ballots were mailed out to all clinical, clinical/CPSO, certificant and mentor members in early December. The mail-in ballots were overwhelmingly in favour of the new name; however, our bylaws also required an in-person meeting with a quorum of members eligible to vote. This meeting occurred on December 20, 2015 at the OMA headquarters in Toronto. A special thank you to all of you who rearranged holiday plans at the last minute in order to attend. The vote at the in-person meeting was unanimously in favour of the new name. The final vote (both mailed in and in person) was 117 in favour and 10 against.

The 29th Annual Conference of the GPPA

This year's conference will be held in Toronto at the Hilton Doubletree Hotel (Chestnut Street) on Friday, May 27 and Saturday, May 28, 2016. The title and theme of the conference is "Frontiers of Brain Science." By now you will have received your registration forms. I am

excited by the range of topics and the excellent speakers. I hope to see many of you there.

The Fifth Annual GPPA Retreat

This retreat will take place the weekend of November 4–6 at Geneva Park. The theme is "Strengthening Resilience with Mindfulness and Self Compassion." The retreat will be led by three facilitators from Barrie, Ontario: a family physician, his partner (a musician), and a yoga teacher. The facilitators are experienced in leading mindfulness and self-compassion workshops and courses.

Outreach Committee

The committee is working hard to secure professional help in redesigning the GPPA website to reflect our new name. The work of re-branding also requires a new logo and an Ad Hoc committee has been established to work on this task.

Core Essentials in Primary Care Medical Psychotherapy Committee

This new committee came about as a result of brainstorming over the past 15 months between members of the Outreach Committee and Michael Paré, a longstanding member of the GPPA and a previous recipient of our Theratree Award. The Outreach Committee has been researching the possibility of reviving the Basic Skills Core Curriculum that was taught for several years through the GPPA. Michael Paré has developed a series of MainPro C presentations for physicians interested in furthering their psychotherapy skills. It was out of a desire to pool resources and to move forward with a new basic skills course endorsed by the GPPA that the Core Essentials in Primary Care Medical Psychotherapy Committee was

formed. This committee began meeting in December and is co-chaired by Muriel vanLierop and Michael Paré. The committee hopes to have a full program of core essential courses for new and seasoned GPPs available in the spring of 2017. The course would have to be taken as a whole but will be divided up into two separate weekends over the course of a month.

GoToMeeting APP

The Board of Directors, the Outreach Committee and the Core Essential committee have been using this web platform very successfully over the past year. I would urge all committee chairs to adopt this or at least try it out over the next few months. Requests to use this application must go through Carol Ford who will determine the availability of the app and send out email invitations with a link to the site prior to the meeting to all those who will be participating. The app GoToMeeting must be downloaded onto the participant's computer or tablet prior to the first time it is used. There is no charge to the participants for the use of this service.

Conflict of Interest: none

Contact: mclow98@gmail.com

Catherine Low, 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.



29th Annual Conference of the General Practice Psychotherapy Association

May 27-28 2016

DoubleTree by Hilton Hotel, Toronto

Frontiers of the New Brain Sciences

Why Should You Attend the GPPA Conference?

- The GPPA Conference program presents a variety of topics from the practical to the theoretical, blending the art and science of psychotherapy and psychopharmacology.
- Many opportunities will be available to learn and interact with colleagues, gain new insights and obtain support for your practice of medical psychotherapy.
- Excellent plenary speakers and workshop choices to suit the novice to the experienced psychotherapist.

Conference Learning Objectives:

- To provide new information to improve clinical assessment skills
- To improve techniques for psychotherapy interventions
- To learn about new developments in the field and their applicability to assessment and treatment
- To understand the need for and importance of clinical self-awareness and boundaries in working with clients in psychotherapy
- To identify areas for further learning and development.

Accreditation

CFPC: The Annual Conference meets the accreditation criteria of the College of Family Physicians of Canada.
6.0 hours MAINPRO-M1 credit for Friday, 6.0 hours MAINPRO-M1 credit for Saturday

GPPA: The Annual Conference is awarded Continuing Education (CE) and Continuing Collegial Interaction (CCI) credit.
6 hours of Group CE for each day.
1 hour CCI for Annual General Meeting
1 hour CCI for Friday Reception (Discussion with colleague(s) (Group/individual)
1 hour of CCI for each day - Discussion with colleague(s) at all day Group CE

**FOR MORE INFORMATION AND TO REGISTER,
VISIT <http://gppaonline.ca/conferences>**



*Journal of the General Practice
Psychotherapy Association*

Contact Person: Carol Ford, Association Manager
312 Oakwood Court, Newmarket, ON L3Y 3C8
Tel: 416-410-6644
Fax: 1-866-328-7974
Email: info@gppaonline.ca

Whom to Contact at the GPPA

Journal – to submit an article or comments,
e-mail Janet Warren 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.

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

GP Psychotherapist ISSN 1918-381X

Editor: Janet Warren
journal@gppaonline.ca

Editorial Committee
Vivian Chow, Howard Eisenberg, Josée Labrosse, Daniel McBain,
Norman Steinhart

General Practice Psychotherapy Association
312 Oakwood Court
Newmarket, ON L3Y 3C8
Tel: 416-410-6644
Fax: 1-866-328-7974
info@gppaonline.ca
www.gppaonline.ca

The GPPA publishes the GP Psychotherapist three times a year.
Submissions are accepted up to the following dates:
Spring Issue - February 1
Fall Issue - June 1
Winter Issue - October 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

2015/2016 GPPA Board of Directors

Brian McDermid, President (416) 972-0691
brianmcdermid@icloud.com
Catherine Low, Chair, (613) 962-3353
mclow98@gmail.com
Irving Brown, Treasurer (416) 657-8900
irvbrown@rogers.com
Margaret Abell (204) 824-2327
matabell@shaw.ca
David Levine, (416) 229-2399 X272
dzlevine@rogers.com
Helen Newman, (613) 829-6360
helencollins21@gmail.com
George Neeson, (613) 498-1602
therapist@gbneeson.ca
Stephen Sutherland, (613) 531-3706
stephensutherland@gmail.com
Yves Talbot, (416) 586-4800
y.talbot@utoronto.ca
Gary Tarrant, (709) 777-6301
gtarrant@mun.ca

Committees

CPSO/CPD Committee

Muriel J. van Lierop, Chair
Alan Banack, Helen Newman, Chantal Perrot, Andrew Toplack,
Lauren Torbin
Liaison to the Board – Helen Newman

Conference Committee

Alison Arnot, Chair
Brian Bailey, Jeanie Cohen, Howard Eisenberg, Nadine French,
Larry Lacey, Lauren Torbin, Lauren Zeilig.
Liaison to the Board – Catherine Low

Education Committee

Mary Anne Gorcsi, Chair
Bob Cowen, Andre Roch, Yves Talbot
Liaison to the Board – Yves Talbot

Finance Committee

Irving Brown, Chair
Brian McDermid, Andrew Toplack, Muriel J. van Lierop, Peggy Wilkins
Liaison to the Board - Irving Brown

Journal Committee

Vivian Chow, Chair
Josée Labrosse, Daniel McBain, Howard Schneider,
Norman Steinhart, Janet Warren
Liaison to the Board - David Levine

Listserv Committee

Edward Leyton, Chair, Webmaster
Marc Gabel, Lauren Zeilig
Liaison to the Board - George Neeson

Membership Committee

Mary Alexander, Chair
Kevin Foster, Kevin Foster, Paul Martin, Richard Porter, Andrew Toplack,
Lauren Torbin, Muriel van Lierop, Debbie Wilkes-Whitehall.
Liaison to the Board—Helen Newman

Professional Development Committee

Muriel J. van Lierop, Chair
Barbara Kawa, Caroline King, Stephen Sutherland, Barbara Whelan
Liaison to the Board – Stephen Sutherland

Certificant Review Committee

Victoria Winterton, Chair
Louise Hull, Louise Lefort, David Levine, Howard Schneider

5 Year Strategic Visioning Committees

Outreach Committee

Edward Leyton (Chair)
Howard Eisenberg, Josée Labrosse, Gary Tarrant, David Levine,
Lauren Zeilig, Dan McBain, Brian McDermid

Core Essentials in Primary Care Medical Psychotherapy Committee

Michael Paré and Muriel J. van Lierop - Co-Chairs
Laura Lee Copeland, Catherine Low, Brian McDermid,
Andre Roch, Yves Talbot
Liaison to the Board - Catherine Low