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From the Editor

This issue of the Journal holds many psychotherapeutic treasures, from the concrete to the sublime, in terms of information and perspective.

The former is found in *Standards of Care* by Dr. Michael Paré as he reviews the *Regulated Health Professions Act* as it applies to Psychotherapy. He also explores the possible consequences of psychotherapy soon becoming a restricted, controlled act under the *Psychotherapy Act*.

The sublime is delicately dissected in *Research Foundations* by Dr. Norman Steinhart as he explores the question: *How Do We Use Science to Improve the Art and Efficacy of Psychotherapy?* By using the following definition of art: "the practiced skill of applying generalized knowledge to a specific patient," he reviews the evidence for brain dysfunction in mental health disorders and then details the specific CNS improvements that psychotherapy brings.

Expanding the concept of the art of medicine in mental health takes us directly to Dr. Howard Schneider's *Psychopharmacology* column. There, the possibilities for treatment interventions in a depressed man who "thought he was out of options" are delineated. The case study illustrates the true-to-life complexities found in many of our patients.

We then move effortlessly into another area of discovery, *Clinical Approaches: Attachment Theory* where Dr. Vicky Winterton briefly reviews the four basic attachment styles from her previous article. In this second article, she explains the value of applying attachment concepts in the early stages of the therapeutic relationship, especially regarding what to expect in terms of an individual's engagement in therapy and challenges that could present themselves.

From Newfoundland-Labrador, Dr. Gary Tarrant shares the results of his invitation to the province's 1200 physicians to participate in developing a psychotherapy network. He also discusses how he helps coordinate psychotherapy and counselling training for medical students and residents.

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From the Editor (cont'd)

Closer to home, Drs. Chris Toplack and Vicky Winterton disseminated a survey on the presence and qualities of shared care to all GPPA members in March 2014. Their article summarizes the highlights of the survey and poses questions for us all to consider. Of special importance is the finding that 72% of respondents prescribe and monitor medication for their patients.

Dana Eisner, MD, offers her reflections on the Third Annual GPPA Retreat, *The Power of Self Awareness in Therapy: When you take care of a client, who is taking care of you?*, which was presented November 7-9 at Geneva Park in Orillia. The Satir model, a transformational form of therapy, formed the basis of the workshops.

Elizabeth King, MD, brings us back to the days of clerkship, internship, and residency in her poems, *Housestaff* and *Night Calls*.

Find the answer to this question: "So what draws a geeky medical scientist/academic to become captivated by psychotherapy and whole person care?" in this edition's *Profile* by yours truly. Hint: he is heavily involved in GPPA Research and is also discussed in the *Report from the Board* by Catherine Low.

Other highlights from the *Report from the Board* include: the date and location of the upcoming GPPA conference on Friday April 24 and Saturday April 25,

2015 at the Toronto Hilton Doubletree Hotel on Chestnut Street; and, information about the new web application on the GPPA website which makes it easier to enter, approve, and tabulate CE/CCI credits.

In closing, I would like to thank our Copy Editor, Vivian Chow, for her always informative and practical column, *Cognitive Bytes*, over the past 3 years. She, like the topic of her final column, has decided to "graduate herself."

Namaste,

Maria Grande



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SCIENTIFIC PSYCHOTHERAPY

Research Foundations

How Do We Use Science to Improve the Art and Efficacy of Psychotherapy?

Norman Steinhart, MD

Medicine has two great branches: science, fed by experimentation and objectivity, and art—practiced skill in applying *generalized* knowledge to the *specific* physical, social, and cultural context, needs, and tolerance of each patient. Psychiatry, and in particular medical psychotherapy, desperately needs a coherent base of scientific knowledge, and fortunately, that is beginning to emerge. Transforming research into practical skill, however, remains a great challenge. In this article, I suggest three areas in which mental health research can benefit psychotherapy practice.

1. Psycho-education and Self-Acceptance of Mental Disorder

Patients can still face stigmatization, denial of the existence of mental disorders, and respond with self-blame and self-condemnation, accepting that they are “weak, lazy or crazy.” Educating patients about the demonstrated brain dysfunction in mental disorders from neuroimaging (Steinhart, 2014) can potentially reduce self-blame, moralizing and denial of illness. I have found in my practice that discussing the evidence for brain dysfunction, and the specific CNS improvements that psychotherapy brings, can improve patients’ motivation to take a more active role in treatment, reduce fear of being stigmatized, and may increase their willingness to discuss their symptoms and seek support with family and in the workplace.

2. Seeking and Utilizing Specific Stimuli in Therapy: Evidence for the Importance of Agenda Setting

Since patients with depression and anxiety disorders commonly avoid distress-

ing situations and tasks, they may resist working with these triggers of symptoms both in sessions and in actual life situations, reducing or preventing progress. As well, their reports of symptoms may underestimate their functional disability if they are avoiding distressing stimuli. Recent research has shown that *only* specific stimuli derived from structured psychodynamic interviews that focused on patient descriptions of dysfunctional interpersonal relationships (and not impersonal stressors, e.g. traffic) evoked a very clear hyperactive response of limbic and subcortical regions in depressed patients (Kessler et al., 2011; Cierpka et al., 2007). Eight months of psychodynamic psychotherapy that reduced standardized depression scores was also shown to reduce the same areas of hyperactivity when specific, clinically derived stimuli were used in fMRI scanning before and after therapy (Wiswede et al., 2014).

This research suggests three important principles to consider in treatment:

(1) It is important to work with distressing stimuli in order to change patients’ emotional dysregulation, and subsequent avoidance and/or behavioral deactivation. Sessions that attempt to reduce distress, respond more actively to emotional triggers and then test for these changes may be more effective. This leads to the proposal that (2) agenda setting could be a key element of successful therapy, in which patients recognize the symptomatic aspects of their thoughts, feelings and behavior, and set goals to change these patterns. The research demonstrates

limbic hyperactivity and dysphoric states when discussing disordered relationships, so that (3) working to improve interpersonal conflicts and relationship satisfaction may be critical to helping some patients with depression, and some forms of anxiety—most obviously social anxiety disorder—regardless of therapy type used to achieve this.

3. Increasing Reward from Activities is Distinct from Reducing Distress

While most studies have focused on reducing the responses of depressed patients to negative stimuli, such as faces that express fear, surprise or anger, some recent studies have been exploring the brain responses of depressed patients to reward anticipation and feedback. While results have varied, the activity level in the dorsal striatum, that inputs into the basal ganglia and contributes to voluntary activities, has consistently been reduced in depressed patients, most significantly in the anticipatory phase of reward-seeking activities. Researchers suspect that this underactivity is a significant part of loss of motivation and interest in depression. Behavioural Activation Therapy for Depression (BATD) has been shown to normalize these areas in one study (Dichter et al., 2009). BATD conducted over 8 weeks normalized mood and activity in cortical regions in one cancer patient, but did not affect the subcortical striatal areas as expected when listening to music (Gawrysiak et al., 2012, 2013). These studies encourage us

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Art and Efficacy of Psychotherapy (cont'd)

to consider both the level of distress that patients experience, and the level of reward that they earn from activity. It is worth considering that partially treated patients and dysthymic patients can show chronic but low-level symptoms of distress, but also report low motivation and satisfaction. Since these problems involve different neural systems, they may need different methods of treatment. Lower distress allows patients to be more active than patients with major depressive disorder, and appear fairly functional; however, they may only do very limited activities outside of work or parenting (i.e. do the minimum to “get by”) and are at risk for major depression. Considering the degree of rewarding activities in patients’ routines through discussion and testing, and helping them to find ways to increase their satisfaction may be a useful approach to consider with passive patients who have low levels of overt sadness, emptiness, or hopelessness.

Conclusion

The emergence of functional neuroscience that measures the response of subjects to various stimuli provides scien-

tific support for some empirically-based psychotherapy approaches, offering explanations and encouragement to patients and clinicians. This article has briefly discussed three areas in which we can cautiously extrapolate research results into the clinical sphere to modify and improve the efficacy of psychotherapy.

Conflict of Interest: None

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Psychopharmacology

Untreatable Depression

Howard Schneider, MD

ABSTRACT

Treating resistant depression can take some time. Not giving up on the patient can result in a successful treatment. In some patients, normal dosages of medications do not deliver adequate doses to the brain because of various pharmacokinetic or genetic factors.

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, to quote Stahl (2011): "to listen, educate, destigmatize, mix psychotherapy with medications and use intuition to select and combine medications."

In this issue, we will consider Stahl's twenty-ninth case, "the depressed man who thought he was out of options." The patient is a 69 year old retired engineer, married with 3 children and 8 grandchildren. The patient is referred to Dr. Stahl for "unremitting, chronic depression."

Past Psychiatric History:

- Major Depressive Disorder (MDD), recurrent x 40 years, good response to treatment with remission between

episodes up to 5 years ago

- Major Depressive Episode, with intensity varying x 5 years to present, episode started 5 years ago after a relapse on venlafaxine 225 mg qDay, which had previously worked well (not specified, but we will assume it is venlafaxine-XR)
- 2 years ago: ECT (electroconvulsive therapy) x 9, with a partial response
- In last 5 years "adequate trials... essentially every known antidepressant and augmentation combination known...from many capable psychiatrists...numerous consultations fromdistinguished medical centers," including: 5 different SSRIs (selective serotonin re-uptake inhibitors), duloxetine, 2 different TCAs (tricyclic antidepressants), augmentation with 5 different AAPs (atypical antipsychotics), augmentation with lithium, thyroid, methylfolate and others
- After the 9 ECT treatments noted above, phenelzine (an MAOI : monoamine oxidase inhibitor) was started, there was a partial response but this soon disappeared, even with larger doses of phenelzine
- Combination of phenelzine with nortriptyline did not help

(Author's note: The combination of an MAOI plus a TCA is considered potentially dangerous, increasing the risk of various adverse effects, including a serotonin syndrome i.e. confusion, tachycardia, hyperthermia, myoclonus, among other possible symptoms.)

Intake Psychotropic Medications:

- Phenelzine 90 mg qDay
- Nortriptyline 50 mg qDay
- Lorazepam prn

Past Medical History and Other Intake Medications:

- Stahl describes PMH as "not contributory"
- Medical workups in the last year to rule out medical, including cancer and endocrine etiologies were negative
- Neurological assessment in the last year, including EEG and MRI: normal
- Neuropsychological assessment: indicates severe depression but not dementia
- Non-smoker
- No drug or alcohol abuse
- Ibandronate: a bisphosphonate for osteoporosis
- Irbesartan: an ARB, angiotensin II receptor blocker, for hypertension
- Atorvastatin: an HMG-CoA reductase inhibitor for hypercholesterolemia
- Tamsulosin: an alpha1A adrenergic receptor antagonist for enlarged prostate
- Meloxicam: an NSAID, i.e. nonsteroidal anti-inflammatory drug for arthritis

Personal History:

- Married with 3 children and 8 grandchildren
- Retired engineer
- Good marriage and close with his children
- No financial problems

Psychopharmacology (cont'd)

Family Psychiatric History:

He has first degree relatives with depression, but no suicide.

History of Present Illness:

As noted above, the patient's depressive episode has not abated in the last five years. In the last two years, he rates the depressive symptoms a 9/10 (higher being worse). He feels demoralized. He has no joy or pleasure from life. He endorses sadness, helplessness, hopelessness, worthlessness and trouble with concentration.

Stahl thinks to himself that treatment options are limited and considers the possibilities:

- Acetylcholinesterase inhibitor: no evidence of dementia was found, thus, wouldn't expect it to make a difference for the depression
- TMS (transcranial magnetic stimulation): generally doesn't work in cases of this severity where ECT has failed to give a good result
- DBS (deep brain stimulation): some promising results in similar cases, however only a few centers in the USA and Canada offer it and insurance probably does not cover it; (author's note: much of the work on developing DBS actually has been done at the University of Toronto [Kennedy et al 2011])
- Ketamine: IV single injection of Ketamine has been shown to produce relief of treatment resistant major depression, however the effect wears off within a day or two and it remains an experimental procedure; Ketamine is an NMDA (N-methyl-d-aspartate) receptor antagonist, therefore increases glutamate release
- Referenced EEG: an EEG protocol that can help direct treatment, however Stahl notes that Referenced EEG is not proven to predict response to a particular antidepressant and not in a case such as this one, and in any case

is still considered a research tool, and thus not appropriate for this patient; nonetheless work by DeBattista and colleagues at Stanford University School of Medicine (DeBattista et al 2011) showed that patients with rEEG-guided pharmacotherapy had larger improvements than controls

- SPECT (Single Photon Emission Computed Tomography): Stahl notes it is not well accepted in the scientific community and insurance does not cover its cost; however work by Thornton and colleagues done in Toronto, but not published until after Stahl's book, showed that a particular form of SPECT scans used as an additional guide to treatment, were associated with an improved outcome in patients (Thornton et al 2014)
- Genotyping: might be useful for a patient such as this one who doesn't respond to a multitude of medications; genetic variants of CYP450 (cytochrome P450) can cause abnormally low levels of certain drugs
- Phenotyping: for example, if a patient had a very low level of a medication, the patient could possibly be classified as having a phenotype of being an "extensive metabolizer"

Stahl's first recommendation was for the patient's psychiatrist to add a stimulant to the phenelzine. (Author's note: Guidelines for augmentation of MAOIs are poor, and another opinion should be sought before doing so. If a stimulant is added to an MAOI, careful monitoring of blood pressure should be done.)

The patient's psychiatrist did not want to add a stimulant to the phenelzine, as Stahl had recommended, but instead decided on a course of 11 more ECTs. The patient's psychiatrist also stopped the MAOI before ECTs and replaced it with venlafaxine 225 mg plus mirtazapine 30 mg.

The psychiatrist thought that the patient had improved "60%" after the ECT treatments but the patient remained "very discouraged," and now reported severe memory problems. The psychiatrist continued maintenance ECTs and increased the venlafaxine to 375 mg and the mirtazapine to 45 mg per day.

After the 20th ECT treatment, the patient developed an expressive aphasia. The consulting neurologist thought the aphasia was due to a complication of the ECT. The treating psychiatrist feared that it could have been a stroke and lowered the venlafaxine dosage to 225 mg per day to avoid an increase in blood pressure that could cause further cerebrovascular issues. As well, aspirin was added to the treatment.

Stahl was consulted again after the aphasia developed. This was 20 weeks since Stahl had first been consulted. The patient complained of worsening depression and now had memory and speech problems. Psychiatric medications at this time were:

- venlafaxine-XR 225 mg/day
- mirtazapine 45 mg/day
- alprazolam prn
- aripiprazole 10mg/day

Stahl advised obtaining venlafaxine blood levels and to increase venlafaxine -XR to 300 mg or 375 mg per day, while monitoring blood pressure.

Phone consultation 24 weeks after Stahl had first seen the patient showed that the aphasia had resolved and that memory was improving, i.e. they were likely due to the ECTs. However, the psychiatrist did not order venlafaxine blood levels or increase the venlafaxine but instead increased the aripiprazole to 15 mg. Stahl asked again for blood levels of venlafaxine.

Psychopharmacology (cont'd)

Phone consultation at 28 weeks indicated that, indeed, blood levels of venlafaxine were low and the treating psychiatrist agreed to raise the venlafaxine-XR to 300 mg/day and to stop the aripiprazole.

At 32 weeks the patient had not improved. Venlafaxine blood levels were repeated and Stahl advised that venlafaxine-XR be increased to 375 mg/day if blood levels were still low.

Phone consultation at 36 week indicated that even at 300 mg of venlafaxine-XR, blood levels of venlafaxine were low, and so the dosage was increased to 375 mg/day. The result was that the patient felt better stating "Pretty good few weeks." However the patient then relapsed somewhat. Since the patient did not experience adverse effects with the venlafaxine 375 mg, Stahl recommended to increase the dosage to 450 mg/day and get another blood level.

At 40 weeks, the patient was on venlafaxine-XR 450 mg/day (and although not specified it is assumed also on the mirtazapine 45 mg/day). Blood levels at this high dosage of venlafaxine were, in fact, only in the low normal range. Clinically, the patient was feeling better and starting to have hope. Stahl recommended increasing the venlafaxine-XR again, up to 600 mg/day if necessary.

At 52 weeks, the patient was on venlafaxine-XR 600 mg/day (and although not specified it is assumed the mirtazapine 45 mg/day) with a full remission of the depressive episode. However, adverse effects were noted: irritability and increased blood pressure. The venlafaxine-XR was reduced slowly downwards to 525 mg and then 450 mg/day. Blood pressure was now normal and there were no adverse effects. The patient remained in remission.

At the end of the case, Stahl speculates that due to changes in brain functioning, a treatable MDD became treatment-resistant MDD. Stahl notes that, in such cases, a combination of an MAOI with a stimulant, with monitoring of blood pressure, can be useful. He notes that an MAOI had been combined with a TCA (see intake medications above) in this patient, but had not worked. Stahl concludes with: "The future promises better guidance of drug and dose selection by genetic tests and neuroimaging."

Treating resistant depression can take some time. As this case showed, not giving up on the patient can result in a successful treatment. Also, this case showed that in some patients, normal dosages of medications do not deliver adequate doses to the brain because of pharmacokinetic or genetic factors.

Conflicts of Interest: None reported.

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Generic Name	Trade Name
	(common, Canadian names where possible)
venlafaxine-XR	Effexor-XR
duloxetine	Cymbalta
phenelzine	Nardil
nortriptyline	generic
lorazepam	Ativan
lithium	generic
mirtazapine	Remeron
alprazolam	Xanax
aripiprazole	Abilify

Clinical Approaches

Cognitive Bytes

Ending Therapy

Vivian Chow, MD

One of the most rewarding moments in psychotherapy is when your patient is ready to “graduate.” In this column over the past few years, a lot of basic principles and techniques used in Cognitive Behavioural Therapy (CBT) have been covered. The hope has been that you, the psychotherapist, by learning these tools, have been able to impart these techniques to your patients and allow them to be able to apply them and carry on without you.

When I first started practising CBT, I dutifully followed the contents of the workbook, *Mind Over Mood*, teaching my patients how to do thought records, and hoped that after 12 to 20 sessions, we would both miraculously know it was time to end therapy. It never occurred to me to prepare them for graduation from day one. Just like when we enter high school or university with the goal of graduating, so too, should CBT be thought of in this way. It's important to be on the same page as your patients not only with what they are thinking or feeling, but with their goals as well. These should include the overlapping goals of eventually terminating therapy and preventing relapse.

At an initial appointment, usually your patients will tell you their goal is to not feel depressed or anxious anymore, to cope better, etc. It's important to let your patients know that you have goals as well. I tell my patients that my goal is for them to not need me anymore. I tell them that I will give them a toolbox of techniques to use and that I will help them get so good at using them that they no longer need my services. I like

to remind my patients that I'm not with them 24/7 so they need to learn how to be their own psychotherapist. I think this is a great way to prepare them for what's ahead of them. Unfortunately the media and angst-ridden Woody Allen movies have created a misconception that all psychotherapists are life coaches who are always there for their patients. If you have the confidence that your patient will not need you anymore, then they will also believe this is possible and will look forward to that moment.

Throughout therapy you need to check in on both your goals in order to ensure that you and your patient understand and are working towards each other's goals from that moment forward. Make sure to commend your patients when they have successfully applied a technique and also take the opportunity to talk about relapse prevention when they are going through a setback. They need to be reminded that life is full of ups and downs and not everything is going to be rosy once they have completed therapy. They need to remember that they have the tools necessary to either improve themselves or at least not make things worse.

When both you and your patient agree that it's almost time to terminate therapy, you can start spacing out the appointments. If you've been seeing them weekly, go to once every two weeks, then once every 3 or 4 weeks. Some advocate cutting off treatment abruptly to prevent too much attachment on the part of the patient. I personally disagree

with this sentiment because you've been preparing them for graduation from the beginning. I think it's important for patients to know that you are not “kicking them out” of your practice. In tapering their appointments, I will then schedule a booster appointment every few months until they feel confident enough to go on without them. I always tell my patients that I keep the door open for them to come back and that I understand that times may get tough later on and they may need another booster appointment. I make sure that they are well aware that they need only contact me in times of need and I will fit them into my schedule.

Author's Note: Thank you to my wonderful editor, fellow journal committee members, and readers for all your support, feedback and helpful comments over the past 3 years. Having covered all the topics I felt were important to me, I have decided to “graduate” myself from writing this column.

Conflict of Interest: None reported

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Survey on Shared Care

How Do GPPA Members View Collaborative or Shared Mental Health Care?

Chris Toplack MD, Vicky Winterton MD

Abstract

This article reports on a survey answered by 27% of the members of the General Practice Psychotherapy Association (GPPA) inquiring into the degree to which members participate in collaborative or shared care scenarios, attitudes towards collaborative care and barriers against its further use. Fully 65% of those surveyed participate in this way with each other or colleagues in the field. The survey has been forwarded to the GPPA Board of Directors for their consideration. (Key words: shared, collaborative, GPPA psychotherapists, teaching, mentoring)

Collaborative Mental Health Care (sometimes referred to as Shared Care) is an important and growing trend in Mental Health Care which has been formally endorsed by both the College of Family Practice of Canada (CFPC) and the Canadian Psychiatric Association (CPA). As members of the Mental Health Program Committee of the CFPC, we sit on the Collaborative Working Group on Shared Mental Health Care, Vicky Winterton, MD as the representative for family physicians with a Focused Practice in Mental Health and Psychotherapy and Chris Toplack, MD as the representative of the GPPA. This committee has representation from across the country from the CFPC and CPA. Collaborative or Shared Care is here to stay. A formal Position Paper, referenced below, co-written by the CFPC and the CPA, clearly describes and supports this model.

Though this Position Paper reflects a Shared Care model between family practice and psychiatry, there are many other possibilities. In Family Health Teams and other organizations, there are models of Shared Care that involve family physicians, nurse practitioners, mental health workers, social workers, psychologists, pharmacists, and psychiatrists.

Collaborative or Shared Care is increasingly being seen as the model of mental health care for the future. There are many advantages within the broad model, both for the patient and the practitioner.

As we have participated in the work of this committee, we have asked ourselves: How do General Practice Psychotherapists (GPPs) fit into this model? We know that in Ontario and other provinces, funding structures greatly limit the possibilities of GPPs being included in Family Health Teams. What are the other barriers? Do we as GPPs with Special Interests or Focused Practices (SIFPs) work “collaboratively”? Do we want to? What are the pros and cons of working in this model for SIFP Family Physicians in Mental Health and Psychotherapy?

To begin exploring some of these questions, we circulated a survey to all GPPA members, who number approximately 300, in March 2014. This article summarizes the highlights of the survey and poses questions to consider. For complete Survey results, please see the GPPA website www.gppaonline.ca/CollaborativeCareSurvey.pdf. Please note that, because we did not originally state that we would post the survey on the web site, we elected to remove personal comments made by respondents to eliminate the risk of revealing identifying data.

First, we would like to thank the 81 respondents to the survey. Your participation is much appreciated.

Given that we knew that few, if any, Focused Practice General Practice Psychotherapists (GPPs) work in Family Health Teams we asked questions on how GPPs perceive their own work, their referral patterns, how they communicate with other practitioners and their general feelings about the concepts of Collaborative Care. As we review the results herein, please be aware that a number of questions allowed multiple answers, therefore the % responses often add up to more than 100%.

Our survey respondents are largely urban (70%), and from Southern Ontario. Fifty percent are from the Greater Toronto Area alone. Slightly more are female than male (55% vs 45%). The majority (80%) have been in practice for more than 20 years and the majority (75%) practice full time in Mental Health and Psychotherapy. Fifteen percent indicate that 50% or less of their practice is devoted to mental health.

Eighty percent of respondents work in a fee-for-service setting, mostly solo, some in groups. Another 8% work within another funding model and 10% in a variety of other situations.

Shared Care (cont'd)

In terms of referral sources, or where patients come from, 84% accept referrals from family physicians, 63% from other specialists, 60% from other community health professionals, and 43% from hospitals. About 50% of respondents accept self-referrals from patients. It would appear that GPPs are connected to their medical communities and are providing service in a variety of ways. Of note, only 6% of respondents indicated that they provide mental health care solely for their family practice patients. Referrals are received in several ways, the majority through written referrals from the referring professional (80%), though electronic methods are also used in 20%, and about 50% accept phone referrals from patients themselves.

We looked at how GPPs see themselves and their practice. We feel that a very important finding is that 65% of respondents see themselves as working collaboratively with other physicians and 52% as working collaboratively with other non-physician mental health practitioners. Twenty-seven percent are members of a defined Collaborative Care organization, for example the Collaborative Mental Health Network in Ontario. Thirteen percent do not see themselves in a collaborative role. Seventy-two percent prescribe and monitor medication for their patients, while roughly 10% expect the family physician to take on that role.

We explored what forms of communication are used for this collaboration. Seventy-five percent of respondents have telephone contact with the referring physician when clinically indicated, while 49% have written contact. Thirty-three percent provide a written assessment to the referring physician after the initial assessment. Twelve percent have formal case consultations and 18% have informal case consultations with the referring physician. About 27%

use electronic means to communicate. It appears that GPPs are communicating with other Family Practitioners frequently.

We asked about other ways in which GPPs collaborate with their peers. Thirty-seven percent of respondents report participation in teaching, with 31% teaching other physicians and 25% teaching other non-physician mental health professionals. Of those reporting a mentoring role (36%), 27% are in a mentoring role with other physicians and 19% with other colleagues. Over half of respondents (53%) participate in peer supervision, 42% with other physicians and 28% with other professionals. Eighty percent report participation in shared educational experiences, 70% with other physicians and 52% with other mental health professionals. It appears that GPPs are interacting collaboratively with other physicians and mental health professionals in a variety of settings.

Are there identifiable barriers to practicing collaboratively? We posed a number of options and asked respondents to rate the importance of these possible barriers and suggest others. Funding and remuneration issues are at the top of the list of barriers, with 60% of respondents citing lack of supportive funding models as a very high or high barrier and 57% reporting lack of remuneration for collaborative activities as very high or high.

Not surprisingly, time constraints are very important with 65% reporting that this potential barrier is of very high or high importance. Lack of clarity of roles and education about collaborative models are important but less so, with 23% and 17% reporting these potential barriers as of very high or high importance.

Thirty-three percent report a "culture" that does not support collaboration. Roughly a third report access to Family Physicians as an issue and the same proportion report geographic disparities, including distance to travel for collaborative care to occur, as being of very high or high importance.

About 20% report that collaborative care is not relevant to their practices. Several comments reflect this opinion, citing the importance of protecting patient confidentiality. This brings up important issues regarding collaborative care definition and practice. Does working collaboratively always imply a sharing of information about the patient between professionals? How are professional roles defined? What are the boundaries? What impact does working collaboratively have on the therapeutic relationship or alliance? Is there research on this issue?

Thirty-eight percent indicate that collaborative mental health care is an issue of high importance for GP Psychotherapists, 44% rate it of medium importance and 18% give it low importance.

Many important suggestions were made for ways in which the GPPA can address this issue, too numerous to summarize here. The full results of the survey, including all comments and suggestions, have been forwarded to the Board of the GPPA for their consideration of future actions that we may need to consider as an organization. We encourage further dialogue on this important issue.

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Attachment Theory: Part 2

Some Practical Applications of Attachment Theory

Victoria Winterton, MD

In an article published in the Spring 2013 *GPPA Journal*, I outlined a brief summary of *Attachment Theory*. This article is Part 2 and focuses on some very practical applications of attachment theory in clinical practice. I am going to discuss three general areas: a way to use knowledge of attachment style in the early stages of the therapeutic relationship, using the Adult Attachment Interview (AAI) as a Clinical tool, and a different way to think about Medically Unexplained Symptoms (MUS) based on attachment theory.

Attachment: A Brief Review of the Concepts and Methods of Assessment

Attachment theory refers to a theory originally developed by Dr. John Bowlby in 1951. It has been greatly expanded over the years. The attachment system is hardwired, but an individual's attachment style is more like software and is largely created by early experiences with a caregiver. There are four basic attachment styles that describe how an individual responds to threat or stress in the context of personal relationships. A person with a *secure* style will seek help and be able to access help from others and be able to help themselves (Berry et al., 2013). There are three types of **insecure** styles, and the names of the categories are different in childhood or adulthood: *anxious or preoccupied* (help seeking), *avoidant or dismissing* (self-reliant), and *disorganized or unresolved* (cautious).

In the original research on attachment, the Strange Situation experiment, infants at age 12 months were assigned an attachment category and then in early adulthood were studied again using the Adult Attachment Interview. There was strong correspondence between the

attachment classification in infancy and early adulthood. In other studies, the attachment category of the child of the parent studied was the same as that of the adult in a significant number of cases—suggesting a mechanism for the intergenerational transmission of certain kinds of emotional difficulties (Allen, 2013).

The (AAI) is a structured interview that was developed by Mary Main et al in 1984 (Allen, 2013). It was originally used for research purposes. The interview would be recorded, transcribed, and then analyzed. It is fascinating to me that the written text was analyzed not for content, but for the manner in which the subject recounted their history. Certain patterns of discourse were discovered to be closely linked to different attachment categories. A secure category is characterized by “narrative coherence,” while a narrative lacking in detail or having very limited capacity to describe emotionally significant events is closely linked to a dismissing style. Interviews of those with a preoccupied style will demonstrate excessive irrelevant detail, lack of narrative coherence, and they could be “rambling, vague, tangential and/or somehow hard to follow” (Allen, 2013).

Application of Patient Attachment Styles in Psychotherapy

1. Patient Engagement in Therapy

One simple application of attachment theory is how it helps me to understand the patient's engagement in therapy in the early stages of the development of the therapeutic relationship. Recognizing that I may temporarily serve as an attachment figure, and that coming into therapy is by definition a stressful experience, I try to get a sense of the per-

son's attachment style early on. Then I can have a better idea of what to expect in terms of their engagement in therapy and possibly be proactive about potential challenges.

For example, if I get the sense that an individual has an avoidant or dismissing style, I can have a conversation early on with them about engagement. “So, in getting to know you so far I can see that you are a person who is quite self-reliant and would tend to want to solve problems on your own. It's quite a step for you to consider entering into therapy at all. People with these characteristics will often conclude that they need to quit therapy since it isn't helping, or that I can't possibly be of assistance to them. Can we have an understanding that if you have that feeling you will bring it up with me to discuss? You are always free to stop therapy whenever you choose, but could we agree to talk about it when you are making that decision?” This simple intervention has resulted in a few individuals staying in therapy when they might have prematurely quit, and it does so in a non-pathologizing way.

Similarly with individuals with an anxious or preoccupied style, they and/or I may notice that their symptoms may initially worsen in starting therapy and I have in the past wondered what I am doing wrong. When I consider their attachment pattern, I can understand that their symptoms may worsen in order to be sure of engaging me in the therapeutic relationship. I can then take a deep breath and help us both be less anxious. I remind myself of the infant in the Strange Situation experiment. He

Attachment Theory (cont'd)

kept crying, despite his mother's attempts to soothe him, until he was absolutely sure she was going to give him her attention.

2. Understanding How Past Relationships Are Understood in the Present

Using the AAI as a clinical tool is more recent development. I would recommend reading Dr. Daniel Siegel's take on the subject (Siegel, 2010) and note that he also recommends that therapists self-administer the interview, as a way of deepening self-awareness. I use a clinical version of the AAI when I take a comprehensive history of family of origin. It takes a full 50 minute session. The questions are subtly different, and observing both what the person says and how they say it can give me important information about their attachment style and their insight and/or level of integration of these issues. How much have they "made sense" of their attachment patterns?

Though formally listing the questions here is too lengthy, here is one example. (For a full description, see Siegel, [2010] pg. 63-70). After a couple of usual questions about who was in the house growing up, you ask; "Can you give me five words that reflect your earliest recollection of your childhood relationship with your mother/father? Can you give me examples that illustrate those words?" Thus, you have shifted the conversation to be about the relationships in the person's early life, rather than only a description of events. Note carefully how much or how little detail the patient provides in their examples.

Another important series of questions in the interview again relates to relationships: "Were you ever terrified by your parent? What would you do when

you were upset?" Most people say that they have never been asked these questions in this way therefore opening a different discourse.

3. Attachment and Unexplained Medical Symptoms

A third area of practical application of attachment theory is in the area of Medically Unexplained Symptoms (MUS). Dr. Jon Hunter from Mt Sinai Hospital in Toronto is an expert in this area (Hunter and Maunder, 2001). Dr. Hunter and his colleagues have learned that those with a preoccupied (help seeking) attachment style experience the most MUS. They will experience a symptom as "an internal sign of potential danger" (Maunder and Hunter, 2013). They may unconsciously amplify a symptom in order to have a better chance of receiving care. Providing predictable, reliable care (in contrast to the unpredictable care they received as a child) may help reduce anxiety and may lessen the intensity of the symptom.

There are so many other rich areas to learn about in understanding the clinical applications of attachment theory in medicine and psychotherapy. Consider references below related to treating trauma (Allen, 2013), to working with couples (Johnson, 2004), and of course, to helping parents understand the importance of this key aspect of raising a healthy, resilient child (Siegel and Hartzell, 2004).

Conflict of Interest: none

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THE ART OF PSYCHOTHERAPY

Night Calls



Night calls me to walk.
 It has rained for two days straight
 Now the air is just misty and cools my face.
 It smells of earth and damp leaves.
 I feel soothed and comforted as I walk.
 More part of here than inside,
 With its artificial brightness and angular spaces.
 There is a softness to the sounds,
 A softening in my body
 As I move through the dark.
 I breathe deep
 Into my sorrow
 Into my fear
 And give it to the night.

Elizabeth King

Title: Palm tree sunset

Source: www.freephotobank.com/12231.html



View this photo online, in colour at www.gppaonline.ca/20145Winter.html

Housestaff

Dawn to dusk inside concrete walls
 Fluorescent glare in antiseptic rooms
 Humans with body malfunctions lie
 On plastic mattresses
 We stand over them
 Intravenous chemicals?
 Surgical excision?
 Radiation?
 A life to go on, a life to end, a life ended
 Hands turn
 Seconds
 Minutes
 Hours
 The day's objectives are complete
 With rushing feet, heart pounding
 I push through
 Double insulated doors
 Wet sweet air caressing
 In starry darkness I escape

Elizabeth King



View this photo online, in colour at www.gppaonline.ca/20145Winter.html

Title: Pressure gauge

Source:
www.freephotobank.com/10309.html

GPPA INTERESTS

Profile

Dr. David Z. Levine, MD, FRCP, CGPP

Maria Grande, MD, CCFP



“So what draws a geeky medical scientist/academic to become captivated by psychotherapy and whole person care?” (David Levine, 2013)

Ever since I first met Dr. David Levine at the GPPA

Annual Conference in 2013, I have been intrigued by him. He was the facilitator for a group of members who had a “possible” interest in research. There he sat, quietly listening to a tableful of rowdy MDs at the end of the conference, all bursting with ideas and all talking at the same time. He then, calmly and quite serenely, brought us all to order. This tranquility in the eye of a storm signalled to me that I was in the presence of a remarkable individual.

Shortly thereafter, I contacted him to ask if he could do an article on Research and Psychotherapy for the *GPPA Journal*. In what I was to learn was a signature maneuver, he told me about being the founding editor of the *Research News* in 1975 for the Faculty of Medicine at the University of Ottawa, and said he preferred to hold off on writing an article until he had something more concrete to report in his capacity as Chair of the GPPA Research Committee.

Fast forward to the fall of 2014. I asked David if he would consent to being featured in the Profile section of the *GPPA Journal* and if I could, therefore, interview him for that purpose. To prepare me, he sent me some material to review and we later spoke by telephone. What follows is a composite of the information gathered.

As a McGill undergrad, he was “smitten” by psychology courses he took. He knew he wanted to go to medical school but also knew that he had to follow his interest in the humanities. Thus, he switched from honours biochemistry to a general science curriculum, majoring in psychology and physiology. This change now gave him the freedom to take literature and poetry courses. One of the benefits of this change in focus is that Leonard Cohen would sometimes sit at the back of his modern poetry class! Later, when he was accepted into McGill’s medical school, he was fortunate to listen to the renowned Dr. Wilder Penfield describing his pioneering surgical procedures. This exposure to two icons of the Canadian collective consciousness served to enrich and guide his future endeavors.

After training in New York, Boston, and Munich, Dr. Levine went on to have a successful research and clinical career as a nephrologist at the Ottawa General Hospital and the University of Ottawa. He was Head of the Nephrology Division for 17 years, and was responsible for introducing the Royal College specialty training program to the Faculty of Medicine in 1980. In what must be a very rare occurrence, he had 40 years of uninterrupted grant support through the Medical Research Council (MRC), which was later renamed the Canadian Institutes for Health Research (CIHR). He is the author of over 100 major pub-

lications, including book chapters and articles in distinguished journals. His book, *Caring for the Renal Patient*, is in its 3rd edition. In the 1990s, in his own private way, David wrote short stories, a novel, and took a screenwriting course, continuing his pursuit of the inner creativity that served as a balance to his scientific approaches.

In 1996, he did a sabbatical at Harvard Medical School Division of Medical Ethics. This led to publications concerning nephrology ethics and end-of-life care plus the creation of the Nephrology Ethics Forum for the *American Journal of Kidney Disease*.

Additionally, he became interested in the newly formulated concept of narrative medicine, as pioneered by Dr. Rita Charon, MD, PhD, in the 1990s at Columbia University. Dr. Levine used narrative therapy techniques while directing and working in his dialysis unit, and now in his psychotherapy practice. The key message that he imparted to all caregivers and kidney patients, especially those on life-support dialysis, is that we are all *living our own narratives and those of our patients*. This means that *to be with our patients* we have to learn to really listen to their stories. Thus, if you want to elicit advance directives from a competent 85 year old patient on life-support dialysis, you should find the skills and the time to say more than hel-

Continued on Page 15

Profile (cont'd)

lo, listen to her current “story” and not rush to discuss end-of-life issues. If you are interested in learning more about this topic, you can watch Dr. Charon in a recent TED (Technology, Entertainment, and Design) Talks presentation, *Honoring the Stories of Illness* (<http://tedxtalks.ted.com/video/TEDxAtlanta-Dr-Rita-Charon-Hono>).

At the age of 65, rather than retire, he decided to formalize his skills in psychotherapeutic techniques in a very intense and organized fashion. His goal, he said recently, was to use the patients’ stories to help them achieve their goals. After joining the GPPA in 2006, Dr. Levine was committed to achieving Certificant status. To this end, he undertook extensive supervision sessions, courses in Cognitive Behaviour Therapy (CBT) at the University of Toronto and Relational Psychoanalysis at the Institute for Contemporary Psychoanalysis in Toronto. Since then, he has focused on CBT in his practice with continuing workshops by Dr. Christine Padesky, PhD, who is internationally renowned.

David is a very active reader of the GPPA Listserve, perusing postings daily and enjoying the conversations that engage diversity of opinion and perspective, and appreciative of the acceptance and value of everyone’s contributions. He continues to work three days a week in the offices of Dr. Michael Paré providing CBT to patients with a variety of adjustment disorders and major depressive states. As part of his “therapy package,” he engages many clients in meditation practice and constantly “pushes” exercise and enhanced interpersonal activities.

In 2012, he was asked not only to chair the development of a research committee for the GPPA, under the direction of the Steering Committee, but also to be on the Board of the GPPA. From June to August of 2012, he and Dr. Muriel van Lierop, GPPA President, were responsible for surveying the membership to determine the level of interest in clinical research. Of approximately 225 members, 75 responses were received. Of those, 15-20 individuals were very interested. The Research Committee began to meet formally in May 2014, having had 3 meetings to date. His passion is to foster a healthy and growing research culture in the organization. He cites the activity within and presence of the following as evidence that the membership is also invested in the continued growth of research: Listserve, the *GPPA Journal*, Annual Conference, PPRNet (Psychotherapy Practice Research Network), and collaboration of GPPA psychotherapists in research. As examples of the latter, he identifies the work of Drs. Muriel van Lierop, MD and Howard Schneider, MD in their publication, *Improved Outcomes Using Brain SPECT Guided Treatment vs Treatment as Usual in Community Psychiatric Outpatients*.

Importantly, in September 2014, Ottawa based PPRNet submitted a CIHR grant application, *Translating Knowledge of Alliance Rupture and Repair to Psychotherapy Practice*. David has been involved with PPRNet in developing this project. Several GPPA members have agreed to be co-investigators.

Of interest to all those who practice psychotherapy is the fact that PPRNet has several branches in North America, including the University of Ottawa, McGill and Pen State, to name a few. For more information on PPRNet, please refer to the article published in the Spring 2012 *GPPA Journal* issue, written by Dr. George Tasca, C.Psych, Research Chair in Psychotherapy Research, University of Ottawa and The Ottawa Hospital, senior investigator. To join PPRNet as a “Friend,” which would allow you to receive updates of their activities, please visit www.pprnet.ca.

Looking to the future, David has a dream that in 2-3 years, several GPPA members will be regularly discussing their own newly published research on the Listserve, at our Annual Meeting, and in the *GPPA Journal*.

“Over these decades, narrative medicine and other aspects of medical humanities have helped my patients, and enriched my professional and personal life” (David Levine, 2013).

Reflection

GPPA Third Annual Retreat: The Power of Self Awareness in Therapy

Dana Eisner, MD

This is the 3rd time I have attended the GPPA retreat in Geneva Park. The retreat is organized by the GPPA Educational Committee, and as usual they did an excellent job. The participants in attendance are GP psychotherapists and family physicians.

Geneva Park is owned and operated by the YMCA. This family camp and retreat centre is located on Lake Couchiching, which provides a beautiful environment for relaxation and learning. We have always enjoyed the good food and service.

I attend the retreat not only because I enjoy the chance to connect with my colleagues but also because I enjoy this type of reflective, experiential process of learning.

Last year the focus of the retreat was on self-reflection. This year we explored and learned about self-awareness of our bodies and energies in relationships. Both years it was facilitated by Dr. Robin Beardsley. She is a family physician and GP psychotherapist from Ottawa, who was trained in the Satir Model, a systemic growth model developed by Virginia Satir. This year Robin invited Kathlyne Maki-Banmen, to help facilitate the workshop with her. As the director of training with the Satir Institute of the Pacific, Kathlyne is very experienced, training therapists all over the world.

I like the fact that Satir therapy is very systematic. Changes in one system, the *intrapsychic* (or within the client), will bring about changes in the other system, the *interactive* (within relationships past and present). Transformational change is an energetic shift in the intrapsychic system which then changes the interactive system. The main goals are to raise self-esteem, have the client/patient become more aware that he has choices, have them take more responsibility for themselves, and become more congruent (authentic or grounded). As with other transformational forms of therapy, in order to bring about lasting change, that is, to lay down new neurological pathways, the process needs to be experiential, systemic, positively directional, change focused, and the therapist needs to be congruent.

We spent some time learning about the personal *iceberg* metaphor of the Satir model created by Virginia Satir and Kathlyne's husband, Dr. John Banmen, who worked with Virginia for many years. It is my understanding that the iceberg metaphor is a metaphor of a person's internal experience of themselves, the intrapsychic. It helps us to become aware of our feelings, judgments, beliefs, rules, expectations and methods of coping that we have learned. Once aware of this internal world and while connected to who we really are, we can choose to respond instead of react in a more positive way with our relationships and environment. We can be in our *life energy* and not in our *survival energy*.

We also learned that in order to become aware of the energies within and between ourselves we had to experience the feelings in our body. Through one of the experiential exercises, we were guided to be more aware of our own energy and to my surprise, I could sense the energy inside and between me and my dyad partner. It was also surprising that this process created a deep connection between us without the need to use words.

On the last day we practiced mindfulness, loving-kindness meditation, and self-compassion. I experienced even more connection to myself and others through these practices.

The retreat was about connections and self-awareness. The workshop was skillfully presented. The quality of knowledge was evident and the presence of both teachers was useful. I have deepened my knowledge and awareness of the energies present in all relationships, with myself and others. I enjoyed the connection I made with my colleagues and found the experiential aspect most helpful. I would attend such a retreat again. I am left with gratitude for a job well done.

Opinion

Standards for Psychotherapy: Some Regulatory Aspects

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

The purpose of this ongoing column is to help ensure that Primary Care Physicians, General Practitioners (GPs) and Family Physicians (FPs) in Ontario are acquainted with the expectations for the performance of psychotherapy in medicine. This is the second in a series of columns discussing this complex and important topic.

Introduction

In this issue we will be outlining some of the legal/regulatory framework within our profession and its association with the provision of psychotherapy. Physicians—like all regulated health professions in Ontario—are ultimately wrapped up in an essential legal framework. Since many doctors are not familiar with legal terminology, a glossary of terms has been included.

One key piece of legislation concerning this issue is the *Regulated Health Professions Act*, 1991 (RHPA). In simplified terms, the RHPA consists of two overarching elements: a general scope of practice statement for the profession of medicine, and a series of authorized or controlled acts. The first element, the scope of practice statement, is not legally or professionally protected. In other words, it does not prevent other regulated (or for that matter unregulated) individuals from performing these same health-related activities. Rather, it acknowledges that many health professions—professionals and even non-professionals—have overlapping scopes of practice. The second element, controlled acts, refers to professional activities that are considered to be potentially harmful if performed by unqualified persons, and are therefore more strictly controlled by law. There are currently

thirteen controlled acts established in Subsection 27(2) of the RHPA; for example, “administering a substance by injection or inhalation,” and “setting or casting a fracture of a bone or a dislocation of a joint” (Service Ontario E-Laws, RHPA, 1991).

Psychotherapy itself will soon be a restricted, controlled act. However, the current prediction is that this will not come into effect until the new College of Psychotherapy is enacted, which is expected to be in December of this year. However, only members of a select list of regulated health professional colleges will be permitted to provide the controlled act of psychotherapy:

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

The Ontario College of Social Workers and Social Service Workers

(Federation of Health Regulatory Colleges of Ontario, 2012)

In 2007, the *Health System Improvements Act* (also known as Bill 171) amended a number of acts, including the RHPA. Bill 171 also includes the new *Psychotherapy Act* of 2007, which establishes the new College of Psychotherapists of Ontario. It is this Act, under Bill 171, that created the new controlled act of psychotherapy. In its original form, the Psychotherapy Act stated, “No person other than a member (of the College of Psychotherapists and Registered Mental Health Therapists of Ontario) shall use

the title ‘psychotherapist,’ ‘registered psychotherapist,’ ‘registered mental health therapist,’ or a variation or abbreviation or an equivalent in other languages,” and the act also states that:

No person other than a member (of the College of Registered Psychotherapists and Registered Mental Health Therapists of Ontario) shall hold himself or herself out as a person who is qualified to practise in Ontario as a psychotherapist, registered psychotherapist or a registered mental health therapist (Service Ontario E-Laws, *Psychotherapy Act*, 2007).

This was a surprising event for members of other health colleges who had traditionally provided psychotherapy within their pre-existing regulatory frameworks. Examples of the affected professional groups—all of which have customarily provided psychotherapy—are Psychologists, Social Workers, Occupational Therapists, Nurses, and Physicians.

Since that time the RHPA, as amended in 2009, has revised the “title protection” provision of the *Psychotherapy Act* (which means the restriction of the health profession title, in this case psychotherapist) so as to acknowledge physicians and other professionals as potentially appropriate practitioners of psychotherapy. Nevertheless, each professional is expected to practice psychotherapy in a responsible and prudent manner while maintaining the standards, principles, and guidelines of practice established by his or her profession. In my previous column, I outlined the

Standards for Psychotherapy (cont'd)

complex concept of *Standard of Care*, that no one group or organization has a monopoly in this regard (Paré, 2014). It is also important to note that each profession, including theoretically all its members, may conceivably contribute to the development of its standards of care (for example, the College of Physicians and Surgeons of Ontario [CPSO], is only one of many potential “authors” of the overall standard of care in Medicine).

In order to better explore standards of care, in relation to psychotherapy, we must first review common definitions of psychotherapy. Because of its complex multidimensional nature and its historically rich development, there are many definitions. The Ministry of Health and Long-Term Care, under Bill 171, defines psychotherapy as:

Treating, by means of psychotherapy technique, delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgement, insight, behaviour, communication or social functioning (Ministry of Health and Long-Term Care, 2007).

The CPSO defines psychotherapy as:

any form of psychological intervention for psychiatric or emotional disorders, behavioural maladaptation and/or other problems that are assumed to be of a psychological nature, in which a practitioner deliberately established a professional relationship with a patient/client for the purposes of removing, modifying or retarding existing symptoms, or attenuating or reversing disturbed patterns of behaviour, and of promoting positive personality growth and development. Intervention or therapy is initiated after a thorough assess-

ment of the patient/client's presenting complaints, including exploration of biological, psychological, social and cultural factors contributing to the patient/client's disorder or condition. The relationship established between patient/client and practitioner is used to facilitate change in maladaptive patterns and to encourage the patient/client to learn and test new approaches. Psychotherapy includes psychoanalysis, psychodynamic psychotherapy, cognitive therapy, behaviour therapy, conditioning, hypnotherapy, couple therapy, group therapy and all other forms of treatment/intervention in which the major technique employed is communication, although drugs and other somatic agents may be used concurrently (CPSO, 2005).

The CPSO concedes that this definition may not conform to all the hundreds of currently published models and/or philosophies of psychotherapy and mental health care currently in widespread use. However, it does provide a base from which we can discuss and begin to understand some of the most fundamental aspects of psychotherapy, as it applies to physicians.

Psychotherapy as a controlled act will come into force when the new College of Registered Psychotherapists of Ontario (CRPO) is enacted. Amendments to the RHPA and the *Medicine Act* (1991) allow physicians to continue to perform the controlled act of psychotherapy.

Summary

The role of physicians includes the delivery of mental health care services. This is clearly outlined in the *Medicine Act* (Service Ontario E-Laws, *Medicine Act*, 1991) which defines the overall scope of medicine as “the assessment of the physical or mental condition of an individual and the diagnosis, treatment

and prevention of any disease, disorder or dysfunction.” The introduction of the *Psychotherapy Act* of 2007, and the apparently imminent future proclamation of that act, has raised concerns that directly impact physicians. The new college may indirectly impact a physician's responsibilities concerning the provision of the controlled act of psychotherapy. Physicians, as primary care providers, need to protect their ability to provide psychotherapy services under the RHPA. One of the most effective ways to accomplish this is for physicians to continue to work collaboratively with all stakeholders towards a common goal of achieving the establishment of physician-centric standards of practice for psychotherapy. Even as these standards are more firmly in place, it will take continued collaborative efforts of physicians to periodically review these standards and to update them so as to ensure that they are relevant to the profession and reflect the current practice standards of physicians practicing psychotherapy.

Physicians in Ontario must continue to go well beyond defining psychotherapy, and work together to develop this essential, collaborative set of standards for psychotherapy in medicine. This entails the formulation of guidelines, and the development of courses and training programs, for the practice of psychotherapy in primary care that are based on the standards and norms that are currently being practiced by physicians. This ongoing activity is to ensure that physicians meet the requirements of the RHPA. This incentive has led to the development of the follow initiatives:

1. Guidelines for the Practice of Psychotherapy by Physicians, the General Practice Psychotherapy Association, (GPPA Professional Develop-

Standards for Psychotherapy (cont'd)

ment Committee Guidelines Task Force, 2010).

2. The *GP Psychotherapy: Basic Skills Core Curriculum*.
3. The third pathway CME/CPD initiative of the GPPA recognized by the CPSO.
4. The Fundamentals of Psychotherapy Course at the University of Toronto. This MainPro-C® course was developed in collaboration with the GPPA, the OMA, and the Department of Psychiatry, University of Toronto.
5. Various Psychotherapy related courses accredited by MainPro-C® through McMaster University and/or the University of Toronto and/or the OMA section on Primary Care Mental Health.
6. The *Counselling and Psychotherapy in Family Medicine* course offered by the Department of Family and Community Medicine of the University of Toronto.
7. The courses and publications of the Collaborative Mental Health Network (of the Ontario College of Family Physicians).

How the new College of Psychotherapy and its standards might change the practice of Psychotherapy by the other five independent health colleges able to provide psychotherapy is far from clear. Nevertheless, it is important for all psychotherapists—no matter of which particular professional *stripe*—to continue to be mindful of, and active in, continuing the development, teaching, and publishing of current standards and guidelines of practice.

In this regard the continued organization and provision of CME/CPD by organizations such as the General Practice Psychotherapy Association, the Collaborative Mental Health Care Network and the OMA Section on Primary Care Mental Health, must be seen as fundamental to our status as professional psychotherapists.

Addendum: As it stands, the Psychotherapy Act of 2007 regulating the controlled act of psychotherapy will not be implemented in full force until the proclamation of the act, which is expected to occur in December, 2014 (and yet could be delayed).

Conflict of Interest: none

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Standards for Psychotherapy (cont'd)

Glossary

College of Physicians and Surgeons of Ontario (CPSO):

The College of Physicians and Surgeons of Ontario is the body that regulates the practice of medicine to protect and serve the public interest. This system of self-regulation is based on the premise that the College must act first and foremost in the interest of the public. All doctors in Ontario must be members of the College in order to practise medicine. The duties of the College include:

- *issuing certificates of registration to doctors to allow them to practise medicine*
- *monitoring and maintaining standards of practice through peer assessment and remediation*
- *investigating complaints about doctors on behalf of the public, and*
- *conducting discipline hearings when doctors may have committed an act of professional misconduct or may be incompetent" (CPSO, n.d., para.3)*

Controlled Acts (CA):

Controlled acts are specified in the Regulated Health Professions Act, 1991 (RHPA) as acts which may only be performed by authorized regulated health professionals. Of the 14 controlled acts, physicians are authorized to perform 13 and may, in appropriate circumstances, delegate the performance of those acts to other individuals who may or may not be members of a regulated health profession (CPSO, 1999).

Health Professions Regulatory Advisory Council (HPRAC):

HPRAC advises the Minister on whether unregulated health professions should be regulated, whether regulated professions should no longer be regulated, amendments to the Regulated Health Professions Act, a health profession act or a regulation under those acts, quality assurance and patient relations pro-

grams of Ontario's health regulatory Colleges, and on other matters referred to it by the Minister. Members of the Council are appointed by the Lieutenant-Governor in Council. In formulating its advice, HPRAC seeks knowledgeable information and comment from members of the public, community organizations, interest groups, health professional regulatory colleges and associations, and conducts extensive research. The Council aims to be accessible and open, and its consultative processes may include written submissions, public hearings, focus groups, research projects and community meetings in order to capture the experience and expertise of those with an interest in the matter (HPRAC, 2014).

Medicine Act (1991): *The practice of medicine is the assessment of the physical or mental condition of an individual and the diagnosis, treatment and prevention of any disease, disorder or dysfunction (Service Ontario E-Laws. Medicine Act. 1991).*

Regulated Health Professions Act (1991): *The Regulated Health Professions Act, 1991 (RHPA), and associated health profession Acts, set out the governing framework for the regulated health professions in Ontario. The RHPA framework is intended to:*

- *better protect and serve the public interest;*
- *be a more open and accountable system of self-governance;*
- *provide a more modern framework for the work of health professionals;*
- *provide consumers with freedom of choice; and*
- *provide mechanisms to improve quality of care (Ontario Ministry of Health and Long-Term Care, 2013)*

Health Professions Appeal and Review Board: *an independent third party with a mandate to review registration and complaints decisions of the health regulatory College (Ontario Ministry of Health and Long-Term Care, 2013).*

Title Protection: *Reserved titles, prescribed under law are for the exclusive use of registrants of regulatory colleges, are a central and critical public protection element of the health professions regulatory framework. The British Columbia Ministry of Health supplies a helpful definition of title protection:*

Reserved titles afford a means for consumers to identify the different types of health care providers, to distinguish the qualified from the unqualified and to differentiate those practitioners who are regulated from those who are not. Titles must adequately serve the public in describing the practitioner and the services being provided and must distinguish the practitioner from others performing services outside the jurisdiction of the regulatory body. The Seaton Commission explained that while it may not be in the public interest to maintain exclusive scopes of practice, it may be appropriate to grant an exclusive (reserved) title to a health profession so the public will know that the professional with whom they are dealing is regulated by a college and is therefore qualified and subject to disciplinary processes for incompetent, impaired or unethical practice (British Columbia Ministry of Health, 2014).

Ongoing

Psychotherapy in Newfoundland and Labrador

Gary Tarrant, MD

Newfoundland and Labrador (NL) has a population of approximately 500,000 people spread over an area more than one third the size of Ontario. St. John's, the province's capital, has a population of almost 200,000 in its metropolitan area.

There are approximately 1200 physicians in NL, of which approximately 600 are family doctors. There are few family doctors doing formal psychotherapy with referred patients but most family doctors doing psychotherapy are using supportive psychotherapy for their own patients. There may be several factors for this lack of a focused psychotherapy practice. First of all, there is a lack of knowledge about opportunities for family doctors to do a full-time or half-time psychotherapy practice. Most family doctors in NL that I speak with about psychotherapy are surprised when I inform them of the hundreds of family doctors doing full-time or half-time focused psychotherapy practice in Ontario. In addition, only within the last few years has the NL fee schedule for psychotherapy grown closer to the national average which only now makes it more economically feasible to develop a practice focused in psychotherapy. There is also a lack of local training opportunities for psychotherapy. A recent weekend Cognitive Behavioural Therapy (CBT) course offered through the Memorial University Professional Development and Conferencing Services attracted more than 50 family physicians (that is one twelfth of the province's total number of Family Physicians). However, these types of courses are rarely offered here. The cost of trav-

elling outside of NL can be prohibitive for family doctors interested in doing psychotherapy courses or programs that are offered in larger centres such as Toronto.

Other health professionals such as psychologists and social workers offer psychotherapy services but they are usually fee based or paid through Employee Assistant Programs. There are few psychiatrists that offer formal psychotherapy services besides supportive psychotherapy. This may be changing as the psychotherapy training in Psychiatry residency programs across the country has increased. Memorial University of Newfoundland (MUN), which is one of the largest university in Atlantic Canada, also has a counselling service available for university students at its Counselling Centre.

In my role as the Behavioural Medicine coordinator of our postgraduate program for family medicine at the MUN Medical School, I help to coordinate psychotherapy and counselling training. There is an emphasis throughout our residency program on the patient centred clinical method. In addition, our program offers first year family medicine residents, through the MUN Counselling Centre, thirty-six hours of counselling training including Motivational Interviewing and CBT. Starting this year, there is also an emphasis on Mindfulness training.

Currently, I am the lone GPPA member in the province. For the future, I see the need to develop a core group of family doctors in this province interested in doing psychotherapy to help "grow"

the importance of psychotherapy in family medicine. In 2013, I sent out a letter through our provincial association to all the family doctors in the province requesting those interested in psychotherapy to let me know their willingness in developing a network sharing our common interest in psychotherapy. There were only about twelve replies, but in my discussions with individual family doctors, I am impressed by the significant amounts of psychotherapy that they do in their practices. Despite quality work which a number of family doctors do with supportive psychotherapy and self-learned skills in explorative psychotherapy, few of them view themselves as having any skills in psychotherapy.

I believe that the GPPA could serve a valuable role in being a resource for psychotherapy training for family doctors in our province. Only when family doctors begin to see the value in the psychotherapy that they already do, will some of them then be able to move on to a position where they incorporate more psychotherapy in their practice, eventually leading to a practice focused in psychotherapy.

Report from the GPPA Board of Directors

*Submitted by Catherine Low, MD
Chair, Board of Directors*

The Power of Self-Awareness in Therapy

The third annual GPPA Retreat took place on the weekend of November 7-9, 2014 at the YMCA's Geneva Park facilities in Orillia. The presenters were Dr. Robin Beardsley, of the GPPA, and Kathlyne Maki-Banmen, of the Satir Institute of the Pacific. The retreat was very well received by a record setting number of attendees. There were 29 people registered for the event.

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. This new location was chosen in response to concerns about the ongoing construction in the Queen's Quay area. The title and the theme of the conference is *The Use of Integrative Psychotherapy: Mind, Body and Spirit*.

GPPA Research

In the spring of 2012, at the annual GPPA meeting, David Levine was asked to create a Research Committee and also to be on the GPPA Board. David and Muriel van Lierop undertook a survey of the GPPA members' interest in research to justify the creation of such a committee. By the end of the summer of 2012, the survey indicated that there was indeed significant interest in research and that some important research was already being undertaken by GPPA members. With several meetings, and a trip to the first Ottawa based Psychotherapy Practice Research Network (PPRNet) conference, David established

contact with University of Toronto psychotherapy investigators as well as with the PPRNet group, and is part of their resource committee. Ongoing work by Dr. George Tasca, PhD, who is head of the PPRNet Ottawa group, as well as Drs. Paula Ravitz and Molyn Leszcz at the University of Toronto (U of T), led to a large Canada-wide survey of psychotherapists concerning their priorities for research relevant to office based practice. By the end of September 2014, to obtain funding, PPRNet and the U of T submitted a research proposal to the Canadian Institutes for Health Research (CIHR): *Translating Knowledge of Alliance Rupture and Repair to Psychotherapy Practice*. The GPPA and our Research Committee have been involved in the process and several GPPA members have enlisted to join this research effort as co-investigators. The GPPA Research Committee has six members and the committee has met three times, providing reports to the Steering Committee and the GPPA Board. The Research Committee is endeavouring to create a vibrant research culture to ensure that the journal, annual GPPA Meetings, and the listserve are a source of psychotherapy research updates.

Sixth national accreditation conference

This conference took place September 29-30, 2014, at the Novotel Hotel Toronto Centre in Toronto. The GPPA was invited to send two delegates to the conference. Andrew Toplack and Muriel Van Lierop attended. There was a great deal of information presented and this is being disseminated through the Board and the various committees for incorporation into the procedures and protocols of the GPPA.

New Policies and Procedures

1. Recognizing Volunteers

Members who volunteered for the year October 1, 2013 to September 30, 2014, and met the criteria of having attended 50% or more of the meetings of their committees, received an appreciation coupon to be claimed against expenses over the year. Thirty nine members were recognized in this way for their contributions to the GPPA. Our organization depends on members being willing to contribute their time and their expertise in order to keep it running. If you have any particular area of interest that you would like to get involved in please contact me and I will put you in touch with someone who can guide you into a position where you can make a meaningful contribution.

2. New web application

A new web application is now in place on the GPPA website which makes it easier to enter, approve, and tabulate CE/CCI credits for our next three year cycle, which started on October 1, 2014 and ends on September 30, 2017. Please remember to enter your credits as you do them and to keep a copy of the necessary documents to send to the GPPA if you happen to be one of the members who is audited during this cycle.

Report from the Board (cont'd)

Some of the features of the new web program are:

Clear Progress: On opening the program you will be presented with the required CE and CCI hours for the current cycle (based on your category) and the number of CE and CCI hours that have been approved, including automatically granted carry-over credits. You can use this to verify your progress as the cycle progresses.

Carry over: The new program will calculate and apply your proper carry over allocation from the previous cycle automatically. You will not need to enter it or have it approved.

Copying items: The “create copy” feature will continue to be available.

Clear activity definitions: There will be definitions for the various types of activities in the programme. This should help you to decide on the correct CE or CCI activity.

Submissions: In the new program, entries will have to be “submitted” before a membership committee member can evaluate it.

Discussions: In the new program, membership committee members evaluating your entries can request clarification through the program, instead of via email. You will be sent an email when this occurs, and you can reply to the question in the program. In this way, clarifying email discussions with committee members will not get lost in private email discussions.

Auditing: Entries into the program will have the date that the entry was recorded and the dates that approving members enter questions and actually do the approval.

CCI for all-day Group CE: All-day CE events grant members the right to claim a few hours of CCI. In this old program this had to be entered and approved separately. In the new program, such all-day CE records will grant the correct number of CCI credits as well, automatically.

The end of our three year reporting cycle for educational credits (CE/CCI)

On November 3, 2014, GPPA members were invited to meet at the College of Physicians and Surgeons of Ontario (CPSO) offices in Toronto with Wade Hillier and Jennifer Gillingham, official representatives. Our policy concerning members who have insufficient educational credits was discussed, together with other issues that the CPSO wanted to inform us about.

The end of our three year reporting cycle for educational credits was September 30, 2014. Most of our members have reported the required, and often much more than the required, number of credits for this cycle. All members who are using the GPPA as their pathway in reporting their educational credits to the CPSO, need to have the required number of credits recorded in the GPPA

website application. Any member who has insufficient credits, for the cycle will have received a letter from the GPPA stating this, together with the number of credits they are short. A grace period of six months, to April 2015, will be given to make up the shortage in credits. If, however, by the time of the renewal of CPSO membership in June 2015, a member has not made up the shortfall, it is possible that the GPPA will be required to give this member's name to the CPSO as having insufficient credits.

In addition to making up the required number of credits by April 2015, each member will be asked to outline a plan to ensure that they have sufficient credits for the next complete cycle ending on September 30, 2017.

All members who have fulfilled the requirements for membership in their category will receive a certificate acknowledging this standing and, by the time you read this, you may have already received your certificate.

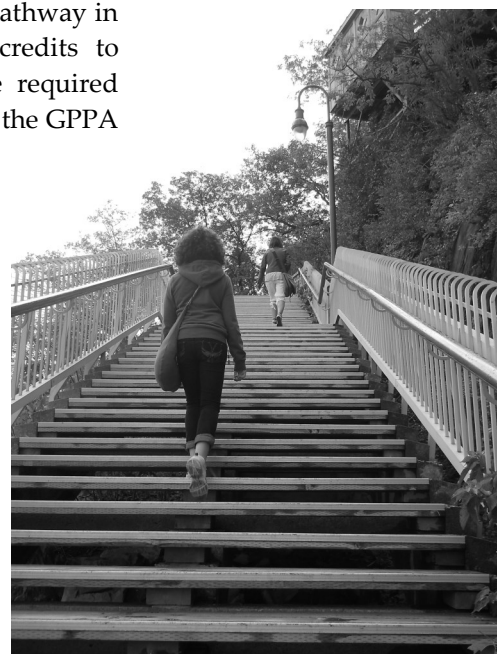


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the GPPA Office.

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 Committee and Board Members
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