THE ROLE OF PSYCHOTHERAPY IN PRIMARY CARE.

DISCUSSION PAPERS ON GP PSYCHOTHERAPY PREPARED FOR AND APPROVED BY THE GPPA BOARD OF DIRECTORS.
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Committee Members:

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(Editors note: These papers have been lightly edited for clarity and hopefully spelling and grammar. Errors are my responsibility, and not the responsibility of the GPPA.)

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I. PREAMBLE.

Committee Mandate.
On July 27, 1995 the General Practice Psychotherapy Association set up a Committee to develop a position paper on The Role of Psychotherapy in General Practice. The decision to develop a position paper was based on the perceived challenges to the practice of GP Psychotherapy implicit in the reduction in Government funding for Health Care, the movement to reform Primary Care, and the recommendations made by the Task Force on Sexual Abuse of Patients of The College of Physicians and Surgeons of Ontario.

The GPPA objective was to have a Board approved position on GP Psychotherapy in preparation for discussions with:

- The College of Physicians and Surgeons of Ontario.
- The Ontario College of Family Physicians.
- The OMA Sections on:
  - General Practice/Family Practice.
  - Addiction Medicine.
  - Clinical Hypnosis.
- OHIP
- Other relevant bodies or organizations. i.e. OPA and Section on Psychiatry Joint Task Force on Psychotherapy (OPA and OMA Section on Psychiatry)

The Role of Psychotherapy in General Practice position paper is made up of a number of papers each one written by a single author. Most of these papers have had several drafts reviewed by the GPPA Board, the Executive Committee and Professional Development Committee. A draft was also reviewed by a group of the Ottawa GP Psychotherapists. During the OMA negotiations with the Ontario government, an early draft was sent to the Executive of the OMA Section of GP/FP.

A printed final draft was presented to the GPPA Annual Meeting in May 1996. At that meeting, a motion was made to approve the document with minor alterations, and to present the document to the CPSO Quality Improvement Committee. The motion was passed by the seventy voting members with three votes against. The final draft of the document has also been presented to the OCFP Executive Committee with positive response.

As well as the members of the above mentioned groups, I would like to thank the following: Mr. John Krauser the OMA Director of Health Policy, Jim Bews MD (Calgary) and Janet Christie-Seely MD (Ottawa) who critiqued early drafts. Mr. Boris Krajl OMA Economics Division who provided me with statistics, Greg Dubord MD and Michael Pare MD who supplied numerous references and Marc Gabel M.D. Who has been a supportive and constructive editor, often at short notice.
The GPPA and GP Psychotherapy.
In 1984 Bob James and Terry Burrows, two Toronto GPs with a common interest in Psychotherapy created and fostered a GP Psychotherapy support network. The status of the GP Psychotherapy Association today, attests to the validity and significance of Bob and Terry’s vision. In the twelve years from 1984 to 1996, the Association has:

- Held eight successful Annual GP Psychotherapy Conferences, and will be hosting it’s ninth Annual Conference this year (June 6 - 9, 1996).
- Become incorporated as a non-profit organization.
- Developed a standardized form, for GP Psychotherapy Records, available both on computer diskette and on hard copy.
- Developed the following minimum standards for GPPA Full Membership:
  - Experience. (100 hours of psychotherapy practice per year.)
  - Ongoing training. (25 hours per year of CME in Psychotherapy)
  - Ongoing Supervision. (25 hours per year of peer supervision)
  - A reference from a colleague.
- Developed criteria for a Mentor Status Membership based on commitment of service to the GPPA and the following minimum base of experience:
  - Experience (3000 hours of psychotherapy practice).
  - Ongoing training (50 hours per year of CME in Psychotherapy).
  - Supervision (100 hours).
  - Personal therapy (50 hours).
  - Two references; one from a colleague and one from a supervisor.
- Made a presentation to the Task Force on Sexual Abuse and was identified in the 1994 Final Report on Sexual Abuse as one of the groups that should be represented on a Joint Committee on Medical-Psychotherapy that the Task Force recommended be established.
- Maintained an information telephone line which receives an average of fifty calls a week.
- Published and distributed quarterly newsletters to approximately 1300 physicians and other interested health professionals.
- Maintained a database on active members.

The GPPA mission is to support and encourage quality Medical Psychotherapy in Canada and to encourage GP Psychotherapists to network and to develop sustaining collegial relationships. It represents members who do variable amounts of psychotherapy ranging from two hours, to forty hours a week.

A 1992 report of the OMA Committee on Medical Care and Practice recommended that OMA make the doctor-patient relationship an explicit focus for OMA strategic planning.

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2 OMA Reports to Council May 1994, p 103.
Specifically, it recommended that the OMA create a strategy to promote medical humanism and the arts of medicine. The GPPA Board supports the promotion of Humanism and Arts of Medicine, and believes that psychotherapy is a core and essential service in the delivery of good Primary Health Care.

The body-mind split in medicine has widened. The role of healer has been pushed aside by the increased role of technician/scientist over the last decades. Major challenges to medical practice today come from the demands for fiscal responsibility and as a result, the very usefulness of psychotherapy is being questioned. Key phrases used are "medically necessary" and "Evidence based clinical guidelines". The old dictum "To cure sometimes, to relieve pain often and to comfort always" seems to have dwindled to an emphasis on cure only. Nevertheless although society supports the search for heroic cures, suffering and death is inevitable and the relief of emotional, psychological and spiritual suffering is as central to the profession of medicine as the relief of the pain of a fractured bone.

Psychotherapy is practised by the majority of primary care physicians. In Ontario approximately 80% of GPs practice psychotherapy. OHIP figures for a three month period in 92/93 indicate that 8703 GPs billed psychotherapy. Six percent of these GPs billed psychotherapy for more than 60% of their practice, and accounted for 40% of the total amount of psychotherapy billed by GPs in the Province.

The development of GP practices limited to psychiatry/psychotherapy follows a long tradition in General Practice of individual GPs limiting their practice to a clinical field of special interest, experience and expertise. The GPPA supports psychotherapy as a core service for all Primary Care Physicians and also supports GPs who have restricted their practice to psychiatry/psychotherapy. These "GP Psychotherapists" who have responded to the demand for psychotherapy services and who take cases referred to them by colleagues, often decide to stop or curtail other areas of primary care practice for two reasons: to make time to respond to the demands for intensive psychotherapy, and to set appropriate boundaries for intensive psychotherapy. The GPPA is especially concerned that the particular political needs of this group of GP Psychotherapists may not be addressed in the current debates on Primary Care Reform, and on what is to be included in the list of insured core medical services.

The GPPA sets high priority on the development of Standards for the practice of GP Psychotherapy. The requirements for full membership now include a minimum of 100 hours of psychotherapy practice per year (2/week), as well as ANNUALLY 25 hours of psychotherapy related CME and 25 hours of peer interaction or supervision.

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6. OHIP 1993 documents, obtained by GP Psychotherapists of Ottawa through Freedom of Information Act. Copies held by GPPA.
A review of the GPPA database in September 1995 revealed that 93% of the paid up members\(^8\) practice over 250 hours a year (5/week) and 80% practice over 500 hours a year (10/week). These figures indicate that a large section of GPPA paid up members are physicians who practice psychotherapy as a major component of their work and that their level of experience and skill is under represented by the present minimum membership standards. Presumably these physicians see a need for membership in an organization that specifically represents their interests.

The preponderance of Ontario GPPA members is often interpreted as the result of better remuneration in Ontario and of greater restrictions on psychotherapy in other Provinces; however, the members outside Ontario occur in pockets. Twenty eight of the two hundred and eighty paid members (Sept. 95) practice outside the province of Ontario. Of these, 6 practice in Saskatoon, and 4 of these practice over 20 hours of psychotherapy per week. The occurrence of these pockets may indicate that the GPPA may not be seen as national by physicians outside of these pockets, or it may indicate the presence of a strong local network and the presence of a teacher/mentor within the area. Members from these "pockets" make the effort to come to GPPA Annual meetings in Toronto. This supports the previous argument that GP Psychotherapists who practice a large amount of psychotherapy have a higher need for an organization that represents their interests and are willing to pay the required membership fees. The GPPA needs to examine how it can better support its members outside of Ontario. As a final point one needs to remember that 4870 of the 11,500 members of the College of Family Physicians as of January 1993, practised in Ontario\(^9\).

**Position Summary.**

A bio-psycho-social approach to diagnosis and treatment is a prerequisite for good Primary Medical Health Care.

Psychotherapy is a core medical service performed by the vast majority of Primary Care Physicians and is not confined to specialist psychiatric care.

The prevalence of psychosocial illness in primary care is high and requires primary care physicians to integrate treatment using biological, psychological and social modalities.

Failure to provide for the recognition and treatment of psychological and social illness in primary care results in increased somatization and consultations focused on physical complaints, with increasing costs and unsatisfactory results.

Basic skills in psychotherapy are a requirement for Primary Care Physicians and are increasingly taught to Family Practice residents.

GP Psychotherapists must have the appropriate training, skill and personal development to perform the levels of psychotherapy they undertake.

There are three categories of Gps providing Psychotherapy:

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\(^8\) 1995 was the first year that membership fees were required. In September 1995 there were 280 paying members, as of January 1996 there are over 350.

a. GP/FPs whose practice includes the provision of psychotherapy to patients for whom they provide comprehensive primary care. (Primary Care)
b. GP/FPs whose practice is restricted to providing only psychotherapy to referred patients. (Referral Practice)
c. GP/FPs whose practice is a mix of comprehensive primary care and referral psychotherapy. (Combined Practice)

If Primary Care Reform leads to some method of capitation fees for Primary Care, alternative methods of reimbursement will be required to meet the needs of physicians with referral practices and combined practices.

The Fee Schedule for GP Psychotherapy is below relative value and mitigates against the recognition and treatment of depression and other emotional and mental disorders.

Fifteen Recommendations are proposed for discussion.

Five clinical guideline parameters for GP Psychotherapy are formulated for discussion.
II. PSYCHOTHERAPY IN PRIMARY CARE  
by Dr. Roy Salole

Recommendation 1. That GP/FPs make multi-axis diagnoses based on a biopsycho-social model of illness.

Recommendation 2. That GP/FPs integrate therapy from three categories:  
Biological/Physical.  
Psychological.  
Social (advocacy).

Recommendation 3. That by definition all GP/FPs have to practice some counselling/psychotherapy (psychological treatment) to develop and maintain the therapeutic alliance and to facilitate change: to prevent disease, cure illness, alleviate pain, and comfort those in distress.

Recommendation 4. That in psychotherapy as in any other form of treatment, GP/FPs treat their patients within the level of their competence, refer when appropriate, and provide ongoing care when the patient is returned to their care.

Recommendation 5. That the decision to refer be based on the individual physician's skills, interest, experience and on the local availability of other resources.

Recommendation 6. That GP Medical Psychotherapy be recognized as a therapeutic procedure performed by a physician to treat a diagnosed medical condition in one or more of the following categories:

1) Organic physical illness. (DSM IV - Axis III)  
2) Psychosomatic Illness. (DSM IV - Axes I and III)  
3) Mental illness. (DSM IV - Axis I)  
4) Personality Disorders. (DSM IV - Axis II)  
5) Socio-economic stressors. (DSM IV-Axis IV)

The scope of primary medical care.
There is widespread recognition of the importance of an emotional/psychological focus in Primary Care. The Canadian College of Family Physicians, the UK Royal College of General Practice, the OMA Committee on Medical Care and Practice and the Educating Future Physicians for Ontario Project all emphasize the high requirement for emotional/psychological focus in good Primary Medical Practice.

1. CCFP  
The College of Family Physicians in its member handbook enumerates four principles of Family Practice.
"The doctor-patient relationship is central to the role of family physician."
"The discipline of Family Medicine is based on a relationship rather than a body of knowledge, and the family physician is committed to a person rather than a technique or a group of illness....."

"The family physician must be a skilled clinician."
"The effective family physician must be skilled in the diagnosis and management of diseases common in the population that he or she serves..."

"The family physician is a resource to a defined practice population"
"..This includes being an effective manager of health care resources..."

"Family Medicine is a community based discipline."
"..Clinical problems presenting to a community based physician are not pre-selected and are commonly encountered at an undifferentiated stage. The family physician must therefore be prepared to deal with any problems that patients present and must be able to mobilize appropriate services to address these problems..."

2. **RCGP**
The Royal College of General Practice in 1969 defined General Practice as follows:

"The general practitioner is a doctor who provides personal, primary and continuing medical care to individuals and families. He may attend his patients in their homes, in his consulting-room or sometimes in hospital. He accepts the responsibility for making an initial decision on every problem his patient may present to him, consulting with specialists when he thinks it appropriate to do so.

... ... His diagnoses will be composed in physical, psychological and social terms. He will intervene educationally, preventively and therapeutically to promote his patient’s health."

3. **Public expectation.**
Educating Future Physicians for Ontario, is a project funded by the five Ontario medical schools, the Ministry of Health and Associated Medical Services. In their 1993 report “Part 1-What people of Ontario need and expect from physicians”, the identified expected roles for physicians included:

- Communicator/educator/humanist/healer
- Health Advocate
- Gatekeeper/resource manager
- Person (Physician as a person)

4. **OMA Committee on Medical Care and Practice.**
"the medical profession is at its best when excellence in biological care is balanced with excellence in psychological care of patients."

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11 *OMA Reports to Council* May 1994, p 103.
The committee goes on to recommend that OMA create a strategy to promote medical humanism and the arts of medicine, which is then defined as:

- Make a multi-axis diagnoses in biological, psychological and social terms.
- Treat most common illness
- Refer when he/she thinks it is necessary.
- Have sufficient self-awareness to protect him/herself (i.e. burnout, boundary violations etc).

Referral patterns in General Practice are variable and depend on an individual GP’s training, interest and experience, as well as on the levels of access to specialists, support staff and other resources. This applies across the spectrum of clinical disciplines within the scope of General Practice, i.e. anaesthesia, emergency, obstetrics, paediatrics, psychiatry and surgery.

**Emotional disorders in general practice.**

Professor Denis Pereira Gray in the 1992 RCGP Members’ Reference Book wrote: “General practice has a special relationship with psychiatry, since these are the only two disciplines in medicine which have a specific focus on the emotions rather than the physical side of the body and both these disciplines have been described at different times by different people as ‘the other half of medicine’

General Practice shares with Psychiatry a multi-axis diagnostic approach.

General Practice differs from Psychiatry because General Practice is relationship and community based. Thus the GP has to deal with whatever is presented and continues treating the individual as long as the relationship continues. The Psychiatrist limits his practice to specific diagnoses and the relationship ends when the patient has recovered.

Medical treatments fall into one of three categories.

- **Physical,** i.e.: Diet, exercise, change of habits, surgery, acupuncture, light therapy, drugs, ECT, blood transfusion.
- **Psychological,** i.e.: Psychotherapy/counselling, hypnosis, meditation, placebo effect
- **Social,** i.e.: Advocacy in issues of work, family and community. (housing, work disability and rehabilitation, welfare agencies and adoption agencies.)
The two tools in psychological treatment are the therapeutic relationship and communication. Psychotherapy may be defined as the use of these two tools in the treatment of a defined patient problem. This definition fits all forms of Medical Psychotherapy.

Psychotherapy/counselling is central to Medical Practice and a core component of Primary Care Medical Practice. In Chapter two of "The Future General Practitioner" produced by a working party of The Royal College of General Practice (UK), is the following quote:

“The essential unit of medical practice is the occasion when, in the intimacy of the consulting room or sick room, a person who is ill or believes himself to be ill, seeks the advice of a doctor whom he trusts. This is a consultation and all else in the practice of medicine derives from it. The purpose of the consultation is that the doctor, having gathered his evidence, shall give explanation and advice. If it be the purpose of medicine to give explanation and advice in consultation as a prerequisite of technical treatment, how are we to train our students? How are we to give them the understanding of the individual they will need in consultation? How are we to maintain in doctors the sympathetic understanding of so many individuals, without which their work becomes a weariness of spirit and flesh? Can we in fact teach the art of consultation?”

The resemblance of the phrases "a doctor whom he trusts" and "sympathetic understanding" to the psychotherapy concepts, "therapeutic alliance" and "unconditional positive regard" is striking.

Further evidence of how important this element is in training physicians is a letter written by Dr. Harvey Barkun, MD, FRCPC, published in the Can. Med. Assoc. Journal, 15 September 1995. Dr. Barkun as Secretary of the Committee on Accreditation of Canadian Medical Schools, informs readers of resolutions made in 1995 that communication skills are integral to the education and functioning of physicians and that there must be specific instruction and evaluation of these skills. Dr. Barkun also writes that provincial bodies report that the main complaints they receive result from lack of communication between patients and physicians, and that the major adjustments in curriculum content, teaching and evaluation methods will be instrumental in improving physician-patient relationships.

In a study of factors that influence positive outcomes in Group psychotherapy, Irvine Yalom MD12 showed that there were four therapist activities related to positive outcomes. Two were exponentially related; the more "positive regard" and "meaning attribution" the therapist displayed the higher the positive outcome. The two other activities; "structuring" and "emotional experience" had optimum levels above and below which reduced positive outcome.

In "The Body Speaks; therapeutic dialogues for mind-body problems", James Griffith and Melissa Griffith write:

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"Skill for a therapist resides in knowing how to use language to build relationships, to create conversations, and to catalyze meaning that can serve as a new solution for an old problem. How can a clinician gain the competence to use language to solve mind-body problems? There are two sets of language skills in which expertise is especially needed if a clinician is to conduct therapy productively. The first is skill in establishing optimal conditions for the kind of reflection that generates new meaning; the second is skill in crafting questions that facilitate therapeutic change. With these skills a clinician hopes not only for patients and families to find good answers for their current problems, but also that they will learn how to ask fruitful questions that bring answers to future problems without the interventions of a professional".

In conclusion, GP Psychotherapy is the use of communication skills and the use of self (the capacity to be empathic, genuine and transparent) to foster a therapeutic alliance with a patient in order to facilitate change, to cure illness, to relieve pain and to comfort. This is the calling that most, if not all, physicians responded to at the start of their journey into the profession of Medicine.

INDICATIONS AND NEED FOR GP PSYCHOTHERAPY.
The conditions for which psychotherapy is appropriately prescribed in General Practice includes any category of illness presenting in primary care. Organic/biological illness. A counselling/caring component will be present to some extent in all a GP does. The outcome of treatment of "physical illness" is affected by the psychological and emotional concomitants. The patient requires first and foremost that his/her physician is present and concerned13.

"When people become ill they regress emotionally toward vulnerability and dependency. The more serious the illness, the more severe the regression. This process usually begins well before treatment starts, and the healing program must consider the patient's well-being, both emotional and physical, in order to expedite recovery"

This is a quote from a 1995 Canadian Medical Journal viewpoint article, written by Jack Rothstein MD, an otolaryngologist in Montreal. Dr. Rothstein goes on to state that communication with the patient is required to foster the positive attitude and emotional strength necessary to accelerate recovery and resumption of everyday life.

The GPPA’s position is that in primary care it is essential that the supportive psychotherapy required for most patients with severe and or chronic illness is provided by primary care physicians.

As well as the general regression involved in most patients who are ill, there is an increase in the prevalence of Major depressive disorder in medically ill people. A recent study showed a prevalence of Major depressive disorder in 9.7% of medical admissions;\(^1^4\) of these only 22% were recognized by medical staff. A review of the literature\(^1^5\) puts the prevalence of depression at much higher levels in medically ill patients.

**Mental, emotional and psychosomatic illness.**

Mental, emotional and psychosomatic illness comprise a large portion of what patients present with in primary care and may be the weakest diagnostic area\(^1^6\). In the treatment of these conditions psychotherapy is a major component. Failing to recognize the psychological or emotional aspects of patients presentations encourages patients to present with more acceptable physical symptoms that increase utilization of health services\(^1^7\). In an analysis of billing and pharmacy records for over 6000 matched controls in an USA HMO, depressed patients had annual health care costs 80% higher than non-depressed patients\(^1^8\). Increased costs where not limited to the treatment of mental illness. There was at least a 50% increase in costs in all aspects of medical care including emergency and laboratory costs. Better diagnosis and treatment of depression does reduce costs. Treated depressed patients had on average 13.8 days in hospital vs. 45.6 days for depressed patients not treated with antidepressants\(^1^9\).

In spite of fiscal restraints and the attempts by Ontario physicians to reduce utilization, annual payments to physicians for psychotherapy in Ontario in the year 1993-94 increased from the 1991-92 year. GP Psychotherapy (K007 ) was up by 6.7% and Psychotherapy by psychiatrists ( net of two codes K197; -7.5%, and K198; 25.4%) was up by 17.9%\(^2^0\). The growth in psychotherapy services arises out of the increased incidence and recognition of mental and emotional illness, and the demand of the general public for “care”, for “talking therapy” for personal understanding and healing of personal wounds\(^2^1\),\(^2^2\).

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\(^1^5\) Cassem EH, Depressive disorders in the Medically ill; *PSYCHOSOMATICS* 1995; VOL 36.


\(^1^9\) Hall, RCW, Wise MG; The clinical and Financial burden of Mood disorders: Cost and Outcome, *PSYCHOSOMATICS* 1995; VOL 36.

\(^2^0\) Kralj B., OMA Economics Department, The Utilization of Medical Services in Ontario, *OMA Review*, August 1995.

\(^2^1\) Salinsky J., Curtis G., Counselling in general practice, *BJGP* May 94 p. 194-

\(^2^2\) Consumer report survey November 1995
The increased incidence of psychological/emotional/social illness is international and not dependent on method of funding. Although it is generally accepted that it is more difficult to control health care costs under a fee for service structure23, in the UK where there is a capitation fee structure there has been a parallel rise in counselling/psychotherapy services in primary care. In 1994 one third of General Practices in UK employed counsellors.25 In a survey of 500 Canadian doctors, David Fish PhD found that out of 9 items proposed for de-insuring, counselling by GPs received the most support for retention. i.e. 91% opposed the de-insuring of counselling by GPs in comparison with 35% who opposed the de-insuring of obstetrics 26.

In a study of 274 Family doctors in West Sussex UK, Dr. Brian Marien found that 80% of visits were for psychological and social problems27. In a study done by the Economics department of the Ontario Medical Association, Anxiety and Depression were the third most frequent cause for a doctors visit28. In another survey of general practice attenders, 25% were identified as somatic presenters29.

Social - Economic factors.
Some of the factors contributing to the rise in psycho-social illness is the increase in violence, physical and sexual abuse, divorce, substance abuse, unemployment and an aging population. Patients increasingly complain of stress and the increased levels of stress caused by social “dis-ease” can be directly correlated to mental and physical health30, for example, suicide can be argued to be only 50% due to mental illness and 50% due to social factors31, and stressful life events have been shown to be a major factor in the development of depression32.

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23 Rachlis M., Defining basic services and de-insuring the rest, Can Med Assoc J, May 1, 1995, p 1402.
25 Salinsky J., Curtis G., Counselling in general practice, BJGP May 94 p. 194.
31 Suicide prevention should focus more on social issues, Medical Post March 12 1996.
32 Deborah Jones, Taking the measure of depression, Family Practice, December 4, 1995.
Unemployed adults have higher incidence of health care use, consult their primary care physician between 20% to 57% more often than employed adults\textsuperscript{33}, and have significantly higher rates of suicide attempts, family breakdown, drug and alcohol abuse and family violence\textsuperscript{34}. Medical clinical practice has not adequately come to terms with stress. The concept of stress is poorly defined in terms relevant to clinical practice and the distinction between stress-related medical or psychiatric illness and stress management is not clear\textsuperscript{35}. Recently there has been a general dissatisfaction with the role of physicians in the management and certification of medical disability and rehabilitation strategies and programs for timely return to work \textsuperscript{36}.

The ageing patient population, with the increase in chronic illness and disability will put further demands on primary care physicians for counselling. For example there will be increasing need to counsel the elderly in "end of life" health care decisions\textsuperscript{37}.

\begin{itemize}
\item \textsuperscript{33} Lin R. FRCPC; Shah C. FRCPC; Svoboda T. MSC MD; The impact of unemployment on health: A review of the evidence., \textit{CAN. MED. ASSOC. J.}, Sept. 1, 1995.
\item \textsuperscript{34} Kates N. FRCPC., Unemployment: Challenges to Mental Health; \textit{CPA Journal} October 1995, p 15.
\item \textsuperscript{35} Stenn P., MD., The role of the physician in the assessment and treatment of work-related stress; \textit{OMA Review} October 1994.
\item \textsuperscript{36} OMA Position Paper; Timely return to work programs and the Role of the Primary Care Physician, March 1994.
\item \textsuperscript{37} Nazerali N. CCFP, Counselling the elderly on decision making for the end of life., \textit{CAN FAM PHYS}, May 1995.
\end{itemize}
Interest in the mind's potential to heal physical illness is apparent in the earliest writings of the ancient world. Although the development of modern knowledge of microbial agents of disease, genetics, immunity, etc. and increasingly powerful imaging and surgical and pharmacological technologies have transformed medicine radically over the past 50 years, mind–body interactions increasingly are drawing the attention of scientists, clinicians and patients on a global scale. The need for cost effective treatments with less dependence on costly technology, concerns about risks of drug and surgical treatments, and a growing interest in humane medicine where patients' emotional and social experience (the bio–psycho–social model) are considered along with the biological factors, are recent trends in modern medicine that emphasize the importance of understanding and utilizing the mind–body interactions.

Since Selye's pioneering work on the General Adaptation Syndrome or Stress response, we have recognized that there are both specific and general aspects to disease, and that chronic activation of the stress system can interact with specific genetic, acquired, or diet induced factors that result in specific disease entities. For example immune dysfunction has been shown to follow bereavement and clinical depression, and a controlled trial of group psychotherapy for women with recurrent breast cancer reported by Spiegel et al, doubled the average survival rate of the treatment group, gained international attention, and has inspired similar trials for breast cancer patients in Ontario. Psychotherapy used as a treatment of physical illness must deal with general (stress system) and specific (organ disease) aspects of disease.

The stress system generates the general adaptation responses to challenges emerging from our social and physical environment. Perceived threat or frustration, lead to the 'flight or fight' response and a general attempt to modify environmental changes significant to the person.

The stress system is an excellent model of mind–body interaction, in which cognitive and automatic emotional responses to the environment lead rapidly to profound physiological changes. Table 1 below indicates that stress system disorders are associated with psychosomatic, organic physical, and psychiatric diseases. A key role for stress dysregulation in a broad spectrum of common illnesses is emerging from work done at the National Institute of Mental Health and elsewhere.
Table 1: Disorders Associated with Dysregulation of the Stress System

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<tr>
<th>Increased Stress System Activity</th>
<th>Decreased Stress System Activity</th>
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<tr>
<td>Severe chronic disease</td>
<td>Atypical Depression</td>
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<td>Anorexia Nervosa</td>
<td>Cushing's Syndrome</td>
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<td>Typical Depression</td>
<td>Seasonal Depression (SAD)</td>
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<td>Panic Disorder</td>
<td>Chronic Fatigue Syndrome</td>
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<td>Obsessive–Compulsive Disorder</td>
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<td>Chronic Alcoholism</td>
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<td>Alcohol and narcotic withdrawal</td>
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<td>Chronic Excessive exercise</td>
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<td>Malnutrition</td>
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<td>disease (animals)</td>
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<td>Hyperthyroidism</td>
<td>Premenstrual Tension syndrome</td>
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<td>Addictive tendency in animal</td>
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<td>studies</td>
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The increasingly important role that stress is shown to play in various illnesses suggests that medical psychotherapy can be important in the reduction of both organic and psychosomatic forms of physical illness through reduction of stress dysfunction. The specialized communication of psychotherapy has potential to serve as an effective treatment of stress disorders through the "transduction of semantic information into a form that is somatically encodable." Various research programs have discovered evidence that the Limbic–Hypothalamic system plays a central role in the translation of semantic and cognitive processes into somatic changes.

General Practice Psychotherapy is an important treatment modality for patients with physical complaints that involve psychological etiological factors. Researchers and clinicians have found that these mixed psychiatric/somatic conditions, often termed 'psychosomatic', include some of the commonest and most costly disorders encountered in general practice. The magnitude of the problem of psychosomatic disorders is indicated by the example of Irritable Bowel Syndrome, which is the second commonest cause of work absenteeism in the United States, and costs $1 Billion (US) per year to treat.
General Practitioners can use psychotherapy in treatment of physical illness in a wide variety of clinical situations, ranging from the treatment of acute anxiety symptoms or pain in the emergency room to the treatment of asthma, hypertension or irritable bowel syndrome in the office setting. These diverse applications of medical psychotherapy should emerge from an organized approach built on knowledge developed from clinical and basic research of relevant issues of mind body interaction. The purpose of this section is to provide such a framework for safe, effective and ethical use of psychotherapy by general practitioners in the treatment of physical illness. To accomplish this goal, a classification of physical illness, a set of indications for psychotherapy within these class, and finally a series of guidelines are presented.

**Classification of Physical Illness for Use of Medical Psychotherapy**

Patients present with two distinct patterns of physical illness which have different etiological factors, prognosis, and psychiatric/psychological presentations. When considering treating or referring a patient for medical psychotherapy with physical illness, recognizing the pattern of illness is important since they each have different indications for psychotherapy and require distinct approaches to treatment. Guidelines for treatment will therefore differ as well.

The two general patterns of physical illness that patients present with are:

**Group 1) Organic physical disease**

**Group 2) Psychosomatic disorders.**

1) **Organic Physical Disease** is characterized by:

- Symptoms, accompanied by signs, and positive objective (laboratory) findings that form a pattern consistent with a pathological process in the underlying organs/systems
- Progression to significant morbidity, or mortality occurs in many diseases unless appropriate treatment is instituted.
- Psychiatric disorders within normal limits for the population, or showing patterns of psychiatric problems that increase and decrease in parallel with the course of the organic illness. (eg. Inflammatory Bowel Disease)
- Life events and crises may immediately predate initiation or exacerbation of illness, but the types and frequency of such crises are within normal limits for the population
- Increase in stress system activity can exacerbate the disease but the presence of other factors (e.g. genetic, immunologic, microbial/ radiation/ toxic exposure) is required to initiate and maintain the disease state.

2) **Psychosomatic Disorders** are characterized by:

- Symptoms with minimal or absent signs or positive objective (laboratory) findings, and normal non–pathological anatomy, biochemistry, and physiology except for possible transient abnormal findings that reverse to normal (eg migraine with aura)
- Lack of progression to significant morbidity, mortality rate same as population
- Psychiatric disorders more frequent than in the general population
- History of traumatic childhood with violence/sexual abuse or victim of crime more frequent than in general population
- Presenting problems and complaints often resemble the pattern of stress system dysfunction (see below).
INDICATIONS FOR THE USE OF PSYCHOTHERAPY FOR PHYSICAL ILLNESS IN GENERAL PRACTICE

1) Indications for Use of Medical Psychotherapy in the Treatment of Organic Physical Disease.

- Failure to respond or unsatisfactory response to pharmacologic/surgical treatment,

- Need to reduce dosage of medication to reduce side effects or risk of pharmacologic/surgical treatment (e.g. reduce risk/side effects of: narcotics, anti–hypertensive medication, transfusions )

- Replacement for pharmacologic/surgical treatment in cases where medication/surgery can't be tolerated.(e.g. Hypnotic analgesia/anaesthesia when local or general anesthetic is contraindicated)

- Pain reduction

- Increased stress system activity or psychological factors are related to initiation or exacerbation of disease(coded as 316.00 in DSM–III–R)

- Psychiatric disorder (Axis I or II diagnosis) co–exists with physical disease (axis III diagnosis) and the psychiatric disorder negatively affects the physical disease treatment(eg. depression hinders self–treatment of diabetes, cardiovascular disease )

A growing number of peer–reviewed published scientific studies have shown that patients with positive test findings of organic disease but with normal psychological and psychiatric profiles benefit from psychotherapeutic interventions (see list below). Even genetic conditions such as hemophilia have responded to psychotherapeutic procedures. Psychotherapy can produce clinical improvement in the pathologic disturbance, and improve the prognosis. The following list indicates some of the many organic physical diseases that have been shown to respond positively to psychotherapeutic techniques.

-Asthma—positive response to hypnosis has been shown and outcome is positively correlated with hypnotizability measures, suggesting a specific effect.

-Cancer randomized study showed increased survival of average 18 months for treatment group of women with recurrence of breast cancer compared to a control(waiting list) group. Further studies are being done by the original authors, and in Canada as the BEST(Breast Expressive Support Study).
Hypertension – Innovative studies by Herbert Benson, a cardiologist at Beth–Israel Hospital and Harvard University have shown the ability of verbal interactions, procedures and methods of self–regulation such as self–hypnosis to positively affect mild hypertension patients and eliminate need for hypertensive medication.

Surgical Analgesia – Reduced need for intravenous analgesic and improved cardiovascular stability during invasive diagnostic procedure.

Pain related to organic illness: increasing body of research confirming the benefit of psychotherapy in coping with acute and chronic pain.

Haemophilia – reduction of transfusion, bleeding episodes.

Raynaud's phenomenon

2) Indications for the use of Medical Psychotherapy in the Treatment of Psychosomatic Disorders

- Psychiatric disorder (Axis I or II) is an etiologic factor in the initiation and/or maintenance of the physical disorder (axis III) and psychotherapy is indicated for treatment of the psychiatric disorder.
- Physical symptoms are disabling to normal function (eg. interfere with work, socializing).
- Inappropriate concern about symptoms despite reassurance, proper diagnostic tests and education/counselling.
- Failure to respond or poor response to pharmacotherapy.
- Need to reduce or eliminate medication due to side effects/risks.
- Pain reduction.

Treatment:
Psychotherapy is an important and often essential component of treatment of psychosomatic or functional disorders, because the CNS and psychiatric factors that are involved in these somatic disturbances cannot be directly treated by drugs whose site of action is the peripheral organs, and many of the drugs that are effective in treating these disorders have site of action in the CNS, which carries a risk of habituation (eg. narcotics for irritable bowel). Successful psychotherapeutic treatment of psychosomatic disorders has been reported in the clinical literature. Irritable bowel and headaches are two of the commonest psychosomatic disorders that have both been reported to respond well to psychotherapy.
Guidelines for Use of Medical Psychotherapy In Treatment of Physical Disorders

1) Organic Physical Illness

In addition to accepted methods of diagnosis and treatment of disease, using symptoms, signs, and objective tests, the physician can:

a) Understand the basic mental and emotional associations (eg. cognitive, psychodynamic, and/or imagery/metaphor patterns) the patient presents with related to the illness including psychosocial functioning and stress system dysfunction prior to illness
b) Incorporate the specific patient history and knowledge of behavioural medicine into the therapeutic suggestions and language, and integrate patient's specific subjective experience of disease into treatment.
c) Evoke positive changes in physiological function, by developing useful associations between mind and body such as cognitive reframing of illness, imagery, metaphors, analogies
d) Develop patients’ confidence in self-regulation of acute and chronic symptoms. (eg teaching patient to generate their own images, cognitive reframing etc. based on patients’ unique reaction to disease.)
e) Understand attitudes towards illness, in context of previous history of serious illness, learned illness behaviour growing up. Recognize chronic illness syndromes, typical emotional responses to physical illness, and have methods of resolving the emotional cognitive disorders.
f) Recognize, assess and treat both affective and physical components of pain
g) Recognize and treat stress dysfunction that exacerbates organic physical illness.(see below)

2) Psychosomatic Conditions:

In addition to accepted methods of diagnosis and treatment of disease, using symptoms, signs, and objective tests, the physician will:

a) Know of the increased incidence of psychiatric disorders amongst patients presenting with psychosomatic illness and assess patients for this problem.
b) Know of the increased positive history of traumatic incidents as adults and/or early physical/sexual abuse amongst patients presenting with psychosomatic illness and assess patients for this problem.
c) Treat patients according to presence or absence of problems in (a) and (b)
d) Recognize and help change the automatic tendency of these patients to convert or 'transduce' their increased perception of threat into somatic dysfunction.
e) Recognize and treat stress system disorders that are often part of psychosomatic problems.
f) Accomplish this by therapeutic re-conversion of the somatic disturbance back into emotional and cognitive and perceptual form, and then psychotherapeutically treat the emotional and cognitive disorders to reduce the threat/frustration perception and reduce somatizing responses.
g) Educate patients as to the self-limiting and non-progressive nature of their illness, assess and treat inappropriate concerns or obsessive thinking about physical problems
h) Understand attitudes towards illness, in context of previous history of serious illness, learned illness behaviour growing up and incorporate this into treatment.
Bibliography


**IV. BOUNDARIES: FAMILY PHYSICIANS AND PSYCHOTHERAPY**

by Dr. Mel Goodman

"Harry Stack Sullivan (1954) felt that psychotherapy was the most difficult of all professional activities because it offered the patient a unique situation in which the therapist’s own needs were excluded from the therapeutic arena”.

"Every psychotherapist struggles with the temptation to seek personal gratification from the therapeutic situation."

Sexual Exploitation in Professional Relationships
Glen Gabbard MD

There is a growing awareness among physicians of the complexity of professional boundaries as they are confronted in daily practice. In our personal lives, we learned that we need boundaries to establish our identity, maintain our privacy, and not become enmeshed. We learned, at an early age, when and where we could undress, and when we could leave open the bedroom door. We needed boundaries between our yard and the neighbour”s. We learned to respect our property and the property of others.

In our professional life, we also need boundaries. Often more does not necessarily lead to better. For example, empathizing with our patient is important, but if done to the extreme, it becomes overidentification and objectivity is lost. It is ironic that our strengths and assets can become our weaknesses and downfalls if there are no boundaries.

This section will deal with boundary issues for family physicians who do psychotherapy. Although much has been written about boundary issues in psychotherapy, physicians who care for their patients’ physical health and who also provide counselling and psychotherapy, present some unique and complex issues rarely addressed in the literature. General Practice psychotherapy, a growing area in the practice of medicine, will have many boundary and ethical issues in common with our colleagues who practice psychotherapy, and also ethical issues that set it apart from other disciplines. This section will therefore be organized to address general boundary issues, and then, specific issues for physician -psychotherapists.
Professional Boundaries: General Considerations.

Becoming a professional is a process. It does not suddenly occur when one graduates. As a process, it is never really completed. As long as a professional is working, there is learning and evolution.

Acting in a professional manner does not mean being aloof, distant or cold. It may be that "beginning" professionals act differently with the people they serve than more experienced ones.(1) Throughout one's professional life however, there are pitfalls that can occur. Someone who is at an early point in their career may be too accommodating, or may act too formally or rigidly. A more senior professional may make assumptions, take some things for granted, and cut corners. This practitioner may also be vulnerable to burn-out or cynicism.

In making the decision to become a professional, one simultaneously chooses to take on responsibilities and give up certain options. In choosing to enter a helping profession like medicine, it is likely that the individual has some strong idealistic ideas of what a doctor should do, and how a doctor should act. It is equally likely that there is little appreciation or understanding of the conflicts, restraints and limits that will be imposed, or the serious consequences of mismanaging a professional relationship.

Clearly, becoming a professional, does not mean acting in a cold and uninvolved manner. Although a physician does not stop caring about patients, he cannot become so involved that he is immersed in the patient's pain or grief.

Establishing and maintaining appropriate boundaries is the responsibility of the professional. Although a patient, particularly one in therapy, may need to work on their boundaries, it is the physician who is in charge. Expecting a patient to define the limits is a reversal of roles. One concise way to characterize the professional relationship is to act in the best interests of the patient. This does not mean that the physician does not have needs, but in the context of the professional relationship, those needs do not interfere with what is deemed to be acting and advocating for the patient.

The Patient-Physician Relationship.

The patient-physician relationship begins before the patient meets the doctor. The patient has a subjective sense that his or her well-being has been altered. This may lead to a need for help, and a realization that help may have to come from someone more knowledgeable in this area than themselves. The patient then becomes dependent on the physician, and vulnerable to the physician. The physician, the medical expert, is perceived as someone who has the knowledge and ability to help. The physician responds to the patient with a promise to help. (2)

If the relationship is positive and good, the physician acts in the best interests of the patient. If the relationship is dysfunctional, it may be characterized by paternalism, hostility, non-compliance as well as other negative features. There may be many reasons that this outcome occurs, but the commonality is that of the perceived roles of both the doctor and patient.
Sexual Transgression.

In all likelihood, the boundary violation receiving the most publicity is that of physician-patient sexual abuse. Statistics vary as to the incidence of such abuse, but it is seen as a significant problem. Media coverage has had the effect of encouraging patients and former patients to come forward to seek redress. It is the experience of the CMPA that this trend is continuing with its attendant serious consequences to the profession.(3)

Boundary Issues: Family Physicians and Psychotherapy.

"Modern Family Practice is thorough, holistic and efficient". This statement is quoted from a Family Practice textbook widely used in the 1970s.(4) It is still the goal of teaching departments of Family Medicine to train doctors to provide primary, continuing and comprehensive health care to any and all members of the family. To do this often requires the use of ancillary and consultant services.

Today, most family practices are limited in some respect. Although the majority of emergency rooms in the province are staffed by family physicians, most family physicians give up their emergency room privileges as they age, and the demands of their office practices increase. The number of family physicians practicing obstetrics, assisting in surgery, and providing primary care to their hospitalized patients has decreased over the years, for different reasons.

The character of current family practices is more reflective of the physician's knowledge, abilities, skills and interests, as well as the geographical location of the practice. In terms of psychotherapy, there are family physicians whose entire practice is given over to providing this service, often on a referral basis. There are also family physicians who do no psychotherapy at all, preferring to refer patients to colleagues or other practitioners. The majority of physicians do provide psychotherapy and counselling, mostly within the context of their medical practices.

A physician who cares for her patient's physical disabilities as well as addressing psychosocial problems and mental disorders, must become aware of complex boundary issues, if she is to be effective. It is not unusual for a physician to be in such a position. Most significant physical disorders have psychosocial implications. Psychological factors may initiate or exacerbate medical illness. Frequently, individuals present in a family practice setting with physical symptoms, and no discernible disease to explain the symptoms. Therefore, to the modern family physician, diseases can no longer be viewed in isolation from their patient victims. How then, does a physician provide comprehensive, thorough and empathic care to patients, and not cross boundary lines?

The answer, and ultimately, the successful management of boundary problems depends on one critical factor. This is the understanding and acceptance of the respective roles the physician and patient assume.

If the patient understands and accepts the physician as being someone trained to diagnose and treat both physical as well as psychological problems, then resolution of boundary issues can be negotiated. If the physician is uncomfortable, or is unable for a number of reasons, to adequately address psychological issues, this must be clearly communicated if the patient is to receive optimal care.
Can a physician who is consulted for a psychosocial problem also address a physical concern brought forward during the same visit? If a victim of past sexual abuse also complains of pelvic pain, should both areas be assessed by the same physician, at the same encounter? The answer ultimately is that it depends on the particular patient and physician. What expectations does the patient have, and what is the particular skill set and comfort level of the physician?

The successful resolution of boundary issues then rests with both the doctor and patient, understanding their roles and being openly communicative. The patient who then brings out physical complaints during psychotherapy, will do so, expecting the physician will be able and willing to address both issues.

Conclusion.

Boundary issues in professional relationships is an area that has received increasing attention in recent years. In both the medical and psychotherapeutic settings, efforts have been made to understand the respective roles of doctors and patients. In recent years, sexual transgression has emerged as a significant problem in both the practice of medicine and psychiatry. Family physicians who practice psychotherapy are in a unique position, being exposed to complex boundary issues. Successful resolution of these issues require the physician to examine his own abilities, skills and attitudes, as well as clearly communicate and negotiate the respective roles to be assumed in the relationship he has with his patient.

Bibliography.

2) Pierce L  The Patient-Physician Relationship: A Literature Review Canadian Medical Association 1993
3) Sexual Abuse by Physicians, Information Letter  CMPA 1992
4) Conn HF, Rakel RE, Johnston TW  Family Practice  WB Saunders 1973
V. PSYCHOTHERAPY TRAINING AND SUPERVISION

Glenn Faris M.D., in consultation with the Professional Development Committee.

The GPPA places great importance on training and supervision in the development and maintenance of competence in medical psychotherapy.

Recommendation 10.
That training for Primary Mental Health Care include:

1. Communication, counselling/psychotherapy training.
2. Personal experiential work to increase self-awareness and self-care.

Specialization in General Practice
Within any particular practice endeavor, physicians ensure their competence through adherence to their longstanding professional tradition of personal commitment to the development and maintenance of sufficient competence in each chosen area of medical practice. This is, indeed, the basis by which any provincial College assesses the physicians within its jurisdiction.

There is, moreover, a longstanding accepted tradition in general medical practice of the pursuit of further training and expertise in areas of particular interest to the individual practitioner. We believe this only serves to further expand on and deepen the quality and comprehensiveness of care in primary medical practice, through the attainment of greater skills of use to the primary care patient, and through the natural interchange of ideas and experiences amongst peers.

Balint (1964), in his seminal work on effective General Practice Psychotherapy, writes “the more one learns of the problems of general practice, the more impressed one becomes with the immense need for psychotherapy.”

Professional Development in Medical Psychotherapy

Medical psychotherapy is unique among approaches to mental health care, in that the practitioner is able to draw on and integrate a broad base of medical training with a variety of psychotherapeutic skills and knowledge. Professional development to a sufficient level of expertise in medical psychotherapy builds on the basic components inherent in medical training programs. This early training begins the process of understanding the centrality of the doctor-patient relationship, and the attainment of skills of empathic interviewing and assessment, of techniques of therapeutic interaction, and of a fundamental base of psychiatric and psychological knowledge (Balint, 1964).

The GPPA came into being to facilitate the process of continuous training and growth. Requirements for full membership in the GPPA include a demonstrated commitment to ongoing CME, and to the enhancement of abilities through supervision, peer interaction and consultation. Qualified mentors are now being identified within the membership to assist in the further development of opportunities for training and growth, and to function in a consultative role to other GP Psychotherapists.

We believe that the GPPA, in the setting of standards of excellence, and in the providing of opportunities for training and for peer interaction, is able to provide the most effective
means to ensure the ability of general practice psychotherapists to maintain their competence in the practice of medical psychotherapy.

Training
The needs of each practitioner have to be considered on an individual basis, reflecting the focus of psychotherapy in that practice. Training programs require a component of personal supervision, which will be discussed below, in order to foster the acquisition of some of the skills and awareness herein described. Adequate training, which will vary in depth and intensity according to the needs of the practitioner, should lead one to:
- skills and knowledge in primary medical care, incorporated in a holistic approach to the wellbeing of the patient;
- comprehensive knowledge of the theoretical underpinnings of the therapeutic process;
- and sufficient knowledge of psychiatry and psychology to be able to form: 1) a diagnostic assessment (following an organized approach), 2) a diagnostic or psychodynamic formulation in a recognized model of psychotherapy, and 3) an appropriate treatment plan;
- a working knowledge of current pharmacotherapies, including the ability to integrate these with psychotherapy into a comprehensive treatment plan;
- the development of empathic interviewing skills, and of adequate facility with the therapeutic process to be an effective agent of change;
- a familiarity with the ethical considerations of the therapeutic interaction, particularly with respect to an understanding of boundary issues, professionalism, and an awareness of and respect for the power dynamics of the therapeutic situation (particularly including an understanding of the processes of transference and countertransference);
- an awareness of the limitations of one’s knowledge sufficient to ensure appropriate consultation and referral to specialist care, and to ensure appropriate application of therapeutic modalities for which one is trained.

Supervision
The GPPA promotes the inclusion of consultation and personal supervision in the attainment of adequate training, and the maintenance of competence, in medical psychotherapy. Through consultation and supervision, one gains a more complete awareness of the nature of the therapeutic process (which is vital to being an effective and ethical practitioner), an enhanced awareness and development of one’s own personal communication skills, an articulation of one’s own therapeutic style, and an increased sensitivity to transferential issues and power dynamics within the therapy.

The GPPA also recognizes and recommends the value of personal therapy, or experiential training, to promote self-awareness and understanding, as a valuable component of the training process (to be undertaken, of course, at the expense of the trainee).
The capacity for attending to one’s self-care is the hallmark of the experienced psychotherapist.

“Given some of the special stresses of psychotherapy, it is particularly important that the practitioner develop and maintain patterns of self-care appropriate to the demands of his or her work. To reduce some of the distress associated with the isolation and emotional demands of psychotherapy, for example, increased interaction with colleagues and collaborative ‘peer supervision’ are recommended. . . taking care of one’s emotional needs must also be individualized. It is also here where personal therapy may constitute a worthwhile consideration”. (Mahoney, 1991, pp. 364-366)

**Personal Qualities: Physician Self-Awareness and Self-Care.**

A study of “heartsink syndrome” in the UK identified three factors that protect general practitioners from burnout: shorter working hours, certification in related mental health field, and training in counselling or communication (Mathers et al, 1995). A major factor in the effectiveness of a psychotherapist is the capacity to be in relationship, and to make good interpersonal contact. Carl Rogers (1951) writes: “This has raised in my mind the strong suspicion that the optimal helping relationship is the kind of relationship created by a person who is psychologically mature. Or to put it another way, the degree to which I can create relationships which facilitate growth of others as a separate person is a measure of the growth I have achieved myself”.

Warmth, empathy, unconditional positive regard, and genuineness are personal characteristics required in the effective therapist. These qualities are based to a large extent on the therapist’s ability to accept self. Physicians who have not resolved or who deny the issues in their own lives will at best be unable to help patients with the same issues (Christie-Seely, 1995), and at worst fail to maintain proper boundaries and be at risk for unethical behaviour. This development of the ‘person’ is best obtained by personal therapy. Ongoing supervision, which highlights the therapist’s blocks in any therapeutic impasses, is also a powerful safeguard.

In a survey of all graduates between 1979 and 1984, the Department of Family Medicine of the University of Western Ontario (Brown and Weston, 1992), found that the three highest ranked aspects of learning and developing psychosocial skills were:
1) Experiential learning
2) Physicians’ attitudes towards patients
3) Self-awareness

**General Practice Psychotherapy**

“They are not illnesses like pneumonia or cancer, They are all existential crises, encounters by individuals with the agonizing choices confronting them. To treat them as illnesses like any other would be to act as if a person is a mechanical system, without the capacity to make moral choices . . . some critics of medicine and of psychiatry have argued that it is no business of the physician to become involved in questions of this kind. To this, I think any family physician would reply: ‘Tell me how I can avoid it’.” (McWhinney, 1989, p. 68)

The General Practice Psychotherapist has a number of distinct advantages in his/her capacity to practice timely and efficacious medical psychotherapy:
-the ability to integrate an extensive fund of medical knowledge and experience into psychotherapeutic practice, including an awareness of the interaction of disease process and psychological state, the ability to apply psychotherapeutic skills to the medically ill patient (and hence improve adjustment and outcome), the recognition and inclusion of family systems into the total care of the patient, and the capacity to integrate both psychotherapeutic and pharmacotherapeutic modalities effectively (which, for certain cases, has been shown to be more effective and efficient than either alone). (Miller et al, 1989; Gabbard, 1990).

during his/her further training in psychotherapy, the GP Psychotherapist has often been able to draw on a wide array of different educational programs and therapeutic models, thus bringing into the practice of medical psychotherapy the extensive fund of knowledge that has been developed by other disciplines (such as psychology and social work).

-the general practitioner’s commitment to quality control within his/her own practice, as well as the open-mindedness engendered by ongoing clinical practice and the constant involvement with the distress of his/her patients and their families, often leads to a willingness to explore different ideas and models, and to pursue the development of considerable expertise and facility with divergent approaches. Further, general practice fosters as attitude of ongoing critical analysis and evaluation. (McWhinney, 1989).

“...The diagnosis of a depressive illness is often obscured when patients present with somatic rather than emotional symptoms of depression . . . In fact, one US study estimated that 2/3 of undiagnosed depressed patients make more than 6 visits per year to a primary care physician for somatic complaints. " (ICES, 1995).

-the approach of the general practitioner is towards providing care for the patient: in this, the centrality of the doctor-patient relationship is apparent in the ongoing care of the person, as opposed to the treatment of a disease state.

-the general practitioner is highly experienced in networking, liaison and advocacy on behalf of the patient, with social service agencies and community supports, and is well positioned to take maximal advantage of these resources.

-a primary care response to the mental health needs of the patient, often from within the context of ongoing total care, can be timely, relatively brief, and can therefore minimize disruption of the patient’s life and responsibilities to family, career, and community. Interventions can be aimed at prevention (e.g., stress management), and towards adoption of a healthy lifestyle, both physically (through diet, exercise, sleep hygiene, etc.) and socially (such as through social advocacy or housing support). These can result in multimodal, comprehensive balanced support for the ongoing integrated functioning of the patient in the community. This is both efficient and cost effective, and often results in the least disruption and distress for the patients, the family, the work environment and the community at large. (McWhinney, 1989).

“...the cumulative effects of neurotic disorders on quality of life and effectiveness at work are staggering, particularly since many of those who are badly affected are in what should be their most productive years. The question of whether psychotherapy is a luxury . . . really comes down to the broader question of what quality of health care we are hoping to provide. The case for short term psychotherapeutic interventions seems to me to be very strong. Failing to provide adequate treatment of this type will in the long run lead to more rather than less expense”. (Rubin, in Holmes, 1994).

All General Practice Psychotherapists have this orientation towards a biopsychosocial understanding of the mental health needs of the patient, whether they integrate psychotherapy into a full general practice, or they devote their fulltime attention to psychotherapy.
Training programmes and CME in medical psychotherapy that are specifically directed to the further professional development of the GP Psychotherapist, should ideally take full advantage of a holistic understanding of mental health needs: integrating biological, psychological and social approaches, recognising the effectiveness of primary prevention and of timely interventions in the context of ongoing total care, drawing on the expertise of different disciplines, and cultivating a recognition of the need for continuing professional development and ongoing critical evaluation of one’s clinical practice, should all be integral components of an effective, comprehensive training programme. Attitudes of professionalism and the maintenance of an ethical practice must be stressed.

The further training that GP Psychotherapists voluntarily undertake adds a valuable dimension to the overall quality of primary care. Neglecting to adequately attend to psychosocial issues in the context of a primary care practice will result in substandard care for the people of this province.
REFERENCES


THE REGULATION OF GP MEDICAL PSYCHOTHERAPY.

Dr. Roy Salole

Recommendation 7. That Standards and Guidelines for GP Psychotherapy be developed by the CPSO with input from:
   (1) OCFP
   (2) OMA Section on GP/FP
   (3) OMA Section on Hypnosis
   (4) OMA Section on Addiction Medicine
   (5) OMA Section on GP Psychotherapy (Application for new section in process)
   (6) GPPA.

Recommendation 8. That Criteria for GPPA FULL Membership include:
   The capacity to make multi-axis diagnoses using a recognized system of diagnosis such as DSM-IV or ICD-10.
   The capacity to integrate biological, psychological and social treatments.
   Hours of training, supervision, and practice experience to be on par with standards set by recognized Professional Psychotherapy Associations.

Recommendation 9. That the GPPA develop a curriculum and training workshops to enable members to meet GPPA membership criteria.

CPSO and GP Psychotherapy

In 1991 the College of Physicians and Surgeons of Ontario set up a Task Force on Sexual Abuse of Patients. In its final Report on November 25, 1991, this Task Force made several recommendations specific to the practice of Psychotherapy. The following are of particular relevance for GP Psychotherapy.

1. On page 116 under the heading "Particular Problems in Psychotherapy," the report reads:

   "It seems that many physicians believe that little or no special training is required to do psychotherapy. However, providing effective therapy requires a high level of skill and training just as other medical specialities, such as surgery or pediatrics, do."
2. In Recommendation 9 page 112, the Task Force recommends that a Joint Committee on Medical Psychotherapy be formed to address two issues:

"Ensuring that physicians practising Psychotherapy are adequately trained and ensuring that physicians who have had their licenses revoked are not practising psychotherapy."

The Canadian Psychiatric Association (CPA) and the Ontario Medical Association (OMA) Section of Psychiatry responded by creating a Joint Task Force On Standards For Psychotherapy. This Task Force finalized its report (Feb. 1995) in the form of Guidelines and Standards for the practice of Psychiatric Medical Psychotherapy 38. The CPSO had the intention to bring together a task force to develop Guidelines for non-psychiatric medical psychotherapy by November 1996 and the GPPA was to be invited to have a representative on the Committee39. The issue of Standards and Guidelines for GP Psychotherapy has now been referred to the Quality Assurance Committee of the CPSO. (Ed note:, the GPPA involvement continues with the QAC.)

There are at present approximately 500 physicians with a general practice licence who practice psychotherapy extensively, and about 100 non-psychiatric specialists who practice psychotherapy as well as about 8500 GPs who bill for some psychotherapy. The recommendations of the Sexual Abuse Task Force and the present move towards the registration of patients in primary care begs the question of qualification and competence for GP Psychotherapy both as a component in a comprehensive primary care practice and in practices restricted to psychotherapy. The GPPA thinks that the setting of standards and guidelines will soon be mandatory and supports the development of such standards, at the same time it strongly opposes the view that GPs are not adequately trained to practice some level of psychotherapy. The results of an evaluation of counselling in general practice, indicates that patients did better with counselling from a physician, than with counselling from a practice employed professional counsellor40.

In Canada at present the only form of psychotherapy under regulation is Hypnotherapy. The practice of Hypnosis is restricted by law to physicians, dentists and psychologists. Other forms of counselling or psychotherapy can be practised by anyone without training or licence. Physicians and psychologists are the only regulated professions practising psychotherapy. A large number of people practise psychotherapy without regulation.

38 Dr. Paul Cameron, Task Force Chair, Personal communication.
39 Report to GPPA Board, Giselle Microys, GPPA and OCFP representative on AAC Subcommittee on Psychotherapy.
40 King M., FRCGP., Broster G., MRCGP., Lloyd M., FRCGP., Horder J., FRCGP., Controlled trials in the evaluation of counselling in general practice; BJGP, May 1994.
In other countries this is changing. Several European countries now have laws governing psychotherapy and have National Psychotherapy Associations. Umbrella organizations have been formed, namely, the European Association of Psychotherapy and a World Council of Psychotherapy based in Vienna will have its first annual conference in 1996. In an article "Psychotherapy in Europe", July 1995, ITAA Newsletter, Willem Lammers writes:

"The criteria of the professional associations set the frame for laws regarding the training and licensing of professional psychotherapists. Generally, these laws contained criteria for:

* Basic training in psychology or medicine or other relevant professions.
* Contact with mentally ill people in institutions
* theoretical-technical training
* supervision
* personal therapy

The criteria for training, supervision, and therapy are mostly set in hours, acquired in the training programs of the recognized professional organizations...... The associations, which were well organized at the start of this process, had considerable advantages:

* They were in a position to define what psychotherapy is
* they could assist in developing legal standards, which were, of course, in line with their own tradition
* their members were immediately recognized.

Thus psychotherapy training standards were developed within the traditional mainstream, which also defined criteria for scientific psychotherapy. In the follow up, these were taken over by local governments. As a result, many European countries have a law governing this now. Countries in which these laws do not exist yet - for example, England and France, but also most countries in Eastern Europe - tend to go through the same process"

"In most countries in Europe, a sharp distinction exists between psychotherapy done by medical doctors and by other psychotherapists. There are exceptions to this, such as The Netherlands, where training for psychologists and medical doctors is the same, or Austria, where psychotherapy became a special academic training. Until recently, however, in many countries, even psychiatrists without specific training used to be paid for "psychotherapeutic" work. This is, however, rapidly changing. To become a psychiatrist, medical doctors now usually obtain at least basic psychotherapeutic training."
Canada and the USA have not as yet developed National Standards for Psychotherapy. However most professional psychotherapy organizations have criteria for clinical member status based on hours of training, supervision and personal therapy similar to professional associations in Europe. It is to be expected that at some point National Psychotherapy Associations will be formed in Canada and that laws will be passed to regulate all psychotherapy. It would be wise for GPPA to set criteria for Membership to be on par with developing international standards. The following table is a comparison of GPPA membership criteria with the criteria of some other Psychotherapy Associations:

A number of GP Psychotherapists have met the criteria, and are members of one or more of these organizations.
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<td>Graduate Criteria</td>
<td>Graduate degree (psychology, counselling, social work, medicine, divinity, humanities)</td>
<td>Licensed professional (Nurses, Occ. Health, PhD, MSW, MD.)</td>
<td>Licensed professional (As previous)</td>
<td>Licensed professional (as previous)</td>
<td>Licensed Physician</td>
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<td>Specific training not specified. 90 hours didactic (syllabus)</td>
<td>600 hrs</td>
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<td>Practice Experience</td>
<td>2 years -1000 hours</td>
<td>180 hrs</td>
<td>1500 hrs</td>
<td>1 year 100 hrs</td>
<td>100 hrs per yr</td>
<td>3000 hrs</td>
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<td>Supervision</td>
<td>100 hrs</td>
<td>120 hrs</td>
<td>150 hrs</td>
<td>waived till 1996</td>
<td>25 per yr ongoing</td>
<td>100 hrs</td>
<td>200 hrs</td>
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<td>Personal Therapy</td>
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<td>90 hr personal Group Therapy.</td>
<td>90 hrs</td>
<td>waived till 1996</td>
<td>25 per yr ongoing</td>
<td>50 hrs</td>
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<td>Written and oral exams</td>
<td>First exam planned for 1995</td>
<td>Essay</td>
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VII. ECONOMIC RESTRAINTS, UTILIZATION AND PRIMARY CARE

Dr. Roy Salole

Recommendation 11.
That the GPPA develop guidelines to determine when psychotherapy is medically necessary and to lobby for Psychotherapy to be included in insured Core Medical Services.

Recommendation 12.
That the GPPA support the setting of guidelines for deciding when Brief Psychotherapy (<30 Hours\textsuperscript{41}) and Long Term therapy(>30 Hours) are indicated,

Recommendation 13.
That any new code introduced to define Episodic Primary Mental Health Care be at the same relative value of K007.

Recommendation 14.
That GP Psychotherapists with practices restricted partially or totally to providing psychotherapy to referred patients, be exempt from patient registration and rostering, and be paid fee-for-service.

Recommendation 15.
That GPPA seek support for its position from:
(1) Ontario College of Family Physicians.
(2) OMA Section on General Practice/Family Practice.
(3) OMA Section on Clinical Hypnosis
(4) OMA Section on Addiction Medicine

\textsuperscript{41} Peterkin, A., FRCPC; Dworkind, M., CCFP., Comparing Psychotherapies for Primary Care, \textit{CAN. FAM. PHYS.} VOL. 37: March 1991.
Economic restraints, utilization and Primary Care Reform.

Since 1982 the Federal Government has reduced transfer payments to Provincial Governments. In the last three years Provincial Governments have been under increasing pressure to cut expenses. As a result The Ministries of Health have been under similar pressure to cut costs. In Ontario the rate of growth in spending by the Ontario Ministry of Health has changed from 11.5% in 1987-88 to 12% in 1990-91, 0.8% in 1992-93 and -0.6% in 1994-95\(^42\). Federal and Provincial Health Ministries are reviewing the level of Health Care Insurance and are discussing ways to reduce Health Care costs.

One strategy under discussion is the de-insuring of procedures thought not to be medically necessary. The CMA, the Health Action Lobby, the National Forum on Health, and Regional Health Boards are studying the possibility of creating a list of Core Comprehensive Medical Services. Medical Psychotherapy is at the edge of the "envelope" of insured services\(^43\). It is insured unevenly across the country, several provinces have set limits for psychotherapy and as of May 1, 1995\(^44\), the Newfoundland Government unilaterally de-insured hypnotherapy. Documents obtained from OHIP imply that In Ontario the future of GP Psychotherapy as an insured medical service is uncertain \(^45\). OHIP's position in these documents is that the present schedule definition of psychotherapy "enables GPs to bill a relatively high priced service ($47.30 per half hour) for what is often merely short term support of a patient through an emotional problem". OHIP also suggests the introduction of a "Primary Care Mental Health Code" of lesser value, and that they may request CPSO to rule on competence of non-psychiatrists who bill exclusively for psychotherapy.

Since mind-body illness is such a large component of what patients present with in Primary Care, it is difficult to imagine a responsible Health Care program which does not insure some psychotherapy services. This position is supported in "Focused Psychotherapy" by Cummings and Sayana, Brunnel Mazel 1995.

“In summarizing the 20 years of Kaiser Permanente experience, Cummings and VandenBos(1981) concluded that not only is outcome research useful in programmatic planning, but no comprehensive health plan can afford to be without an effective psychotherapy benefit. The Kaiser Health Plan went from regarding psychotherapy as an exclusion, to becoming the first large scale health plan to include psychotherapy as an integral part of its benefit structure. In fact, the absence of a psychotherapy benefit leaves the patient little alternative but to translate stress into physical symptoms that will command the attention of a physician. Even the presence of a copayment for psychotherapy when none exists for medical care will incline the patient toward somaticizing.”


\(^{43}\) Wyman M., CCFP OMA President, Speech at GPPA Annual meeting 1995.

\(^{44}\) Quinn M., Nfld. Doctors left out; *Family Practice*, June 5, 1995.

Evidence is now emerging to prove that psychotherapy can reduce health care costs. Medical consultations with primary care doctors dropped after a single psychiatric session with mothers of schoolchildren with psychiatric disorder\textsuperscript{46}. In a study of matched patients with somatization disorder who were assigned to group therapy or no group therapy there was a reduction in medical utilization with cost savings averaging $513.00 for the year.

In Oregon at present all serious mental illness and most other mental health conditions are included in Oregon’s prioritized list of conditions covered. The November 1995 Consumer Guide reported a survey of a large number of readers and concluded that psychotherapy not only helps, but that more is better than less. Patients receiving psychotherapy for more than 6 months had significantly better results and patients having more than two years of therapy did the best.

Nevertheless at the same time in most jurisdictions, time limitations are being imposed. The Kaiser Permanente studies found that 85.6% of patients seen in psychotherapy came for 15 or less sessions, and another 10% came for a mean of 19.2 sessions. They found that only 5.3% were interminable.\textsuperscript{47} Thus it would seem that a large majority of patients would be covered by short term psychotherapy defined as less than 30 sessions\textsuperscript{48}.

Most time-limited psychotherapy protocols (Brief psychotherapy by intent) have guidelines for evaluating the suitability of patients for short-term therapy\textsuperscript{49}, and accept less than 50% of evaluated patients. One psychotherapy models, Schema focused Cognitive therapy for Personality Disorders has been specifically developed because of the inadequacy of short-term therapy to deal with personality disorders\textsuperscript{50}. Further Guidelines to correlate diagnostic categories with the choice of time-limited or prolonged psychotherapy will be required.

Primary Care Physicians are ideally positioned to evaluate, diagnose medical conditions and prescribe psychotherapy for medical reasons when needed. They should be in a position to practice psychotherapy within the limits of their skill and time resources, and to refer when they need to. In that respect psychotherapy is no different than any other field of practice in which Primary Care Physicians evaluate, diagnose, treat and refer if necessary. \textbf{The results of a survey of 500 GPs showed that GPs consider that the insurance of psychotherapy is more essential than of obstetrics}\textsuperscript{51}.

Some form of psychological treatment is provided by most GPs, nevertheless the requirements on time and availability restricts a GP’s ability to provide all the psychotherapy required within a medical practice. The most frequent reason given for

\textsuperscript{46} Coverley, CT., Garralda, ME., Bowman F.; Psychiatric intervention in primary care for mothers whose schoolchildren have psychiatric disorder; \textit{BJGP}, May 1995.


\textsuperscript{48} Peterkin, A., FRCPC; Dworkind, M., CCFP., Comparing Psychotherapies for Primary Care, \textit{CAN. FAM. PHYS.} VOL. 37: March 1991.

\textsuperscript{49} Garfield, S., \textit{The Practice of Brief Psychotherapy}, Pegamon 1989.


\textsuperscript{51} Wsong P., Will health-access be better in Canada? \textit{The Medical Post}, May 2, 1995.
not doing more psychotherapy is the demands of other parts of the practice. Most GPs thus restrict long-term individual psychotherapy to a few cases, one to five per week - and refer the others appropriately to whom they can. Psychiatrists are usually fully booked and it is difficult to get patients to see them for psychotherapy within 6 to 12 months. GP Psychotherapists who limit their practice to psychotherapy have done so in part to respond to the need for psychotherapy, and are a resource for their GP/FP colleagues. Patients who can afford to pay go to see psychologists or other non-medical psychotherapists, and patients who cannot afford to pay wait for months or get no therapy.

Any limitation or reduction of Medical Psychotherapy will only result in a greater differential in the access to psychotherapy between the rich and the poor. Unfortunately patients who are severely incapacitated with traumatic life experiences, personality disorders, dysthymia, major Depression and Addictions, are the most likely to need longer term psychotherapy and also the most likely to be unable to afford it. Limits applied to psychotherapy needs to be related to the individual medical diagnosis. It is interesting if not paradoxical that following the Final Report of the Task Force on Sexual Abuse of Patients, there has been legislation requiring the CPSO to create a fund to pay up to $10,000.00 per patient for psychotherapy. At approximately $100 per hour this amounts to 100 hours. One would hope that patients abused by non-physicians would have the same benefit.

**Primary Care Reform.**

Patient registration and Rostering are increasingly being advocated in Primary Care Reform. GP Psychotherapists providing restricted services and secondary care will obviously need to be exempted from this system. The OMA Section on GP/FP and the OCFP have indicated to the GPPA that in their view GP Psychotherapists with restricted practices would be best regarded as providing secondary care to referred patients. This would enable the patient's Primary Care physician to act as gatekeeper and coordinator of medical care and enable patients to have access to psychotherapy while still registered with a primary care physician or group.

A second option might be the association of a GP Psychotherapist with a group of Primary Care Physicians.

**VIII. GP PSYCHOTHERAPY CLINICAL GUIDELINE PARAMETERS FOR DISCUSSION.**

Dr. Roy Salole et al.

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52 Swanson J.G., Family Physicians approach to Psychotherapy and counselling; *CAN. FAM. PHYS.* Jan 1994.
CGP FOR GENERAL PRACTICE MENTAL HEALTH CARE.

All GPs need to be able to conduct an evaluation, make a diagnosis, formulate a treatment plan and keep records that clearly document what they do. They need to be able to:

- Identify patients with medical conditions in the following categories that require psychotherapy\textsuperscript{57}:
  - Organic physical illness. i.e. Cancer.
  - Organic illness accompanied by adjustment disorder, anxiety or depression.
  - Psychosomatic and somatization illness.
  - Substance abuse and eating disorders.
  - Sexual and relationship problems with underlying organic and or psychological problems.

- Identify which modality or combination of therapy would be appropriate:
  - Individual Group or Marital and Family Therapy.

- Identify which patients are suitable for short-term psychotherapy within general practice.

- Identify patients and conditions that require extended and intensive therapy.

- Identify which patients require combined pharmacotherapy and psychotherapy

- Provide supportive therapy in adjustment disorder and grief management.

- Conduct a Brief Individual Psychotherapy.

- Set appropriate boundaries and limits.

- Recognize when he/she develops feelings (fear, anger, helplessness or affection) identify whether the feelings are appropriate or due to counter-transference issues, and respond appropriately

\textsuperscript{57} Adapted from “The psychological care of medical patients” A Report of the Royal College of Physicians and the Royal College of Psychiatrists. UK.
CGP FOR INDIVIDUAL PSYCHOTHERAPY IN GENERAL PRACTICE.
In addition to the above general guidelines, Physicians practising "insight-oriented/reconstructive psychotherapy" need to be able to:
Make a diagnosis using DSM-IV or other multi-axis diagnostic system.
Make a diagnostic formulation using the concepts of a recognized school of psychotherapy.
Formulate a treatment plan using concepts of a recognized school of psychotherapy.
Formulate a contract jointly with the patient.
Initiate and conduct a Brief Individual Psychotherapy.
Initiate and conduct a Long-term Individual Psychotherapy.
Conduct psychotherapy integrated with psycho pharmacotherapy.
Recognize, diagnose and manage a therapeutic impasse. (Diagnosis, Contract or Therapy impasse.)
Recognize and address boundary violations.
Record and document the psychotherapy evaluation and progress in a standard manner.

CGP FOR THE USE OF PSYCHOTHERAPY FOR PHYSICAL ILLNESS IN GENERAL PRACTICE
Please refer to section III:GP Psychotherapy in Organic and Psychosomatic Illness, Page 15.

58 As defined by national councils for psychotherapy (ref to main document).
60 Standardized GPPA Record Forms. GPPA.
CGP FOR MARITAL THERAPY IN GENERAL PRACTICE.

Marital therapy is often regarded as supportive therapy through a crises or conflict. In practice, marital conflict and or distress is often founded on severe psychopathology such as personality disorders, substance abuse or severe depressive syndromes. These underlying medical disorders may become obvious only in tragic outcomes such as murder-suicide. On a less obvious but still tragic note is the disruption of family life, and effect on all family members. A physician practising marital therapy will want to explore the following process:

Evaluation and diagnostic formulation of both the Dyad and of the Individuals.

- Conduct a joint evaluation.
- Diagnose the couples developmental stage. (Bader/Pearson or other)
- Use diagnostic tools to pin-point areas of dysfunction. (Marital Satisfaction Q- Sex inventories-genograms)

Evaluate dyadic function:

- Communication.
- Sex and affection.
- Values and goals compatibility.
- Negotiating skills.
- Management of anger and violence.

Evaluate each individual on a multi-axis system with special reference to:

- Substance abuse
- Depression
- Physical and Sexual abuse
- Personality traits/disorder
- Endocrine and other medical conditions.

Evaluate systemic issues:

- Family of origin issues. (Enmeshment/Disengaged/Alcoholic))
- Work and Money
- Children
- Community

Treatment issues:

- Maintenance of neutrality.
- Awareness and resolution of therapist gender bias (Transference and countertransference)
- Awareness of therapist’s value bias.
- Choosing focus of therapy:
  - Individual
    - Biological
    - Individual counselling
  - Interpersonal
    - Skills
    - Anger management
    - Negative cycle interventions
  - Systemic
    - Time management
    - Work/money/family issues

Awareness of limitations when negotiating financial and legal matters and referring to financial and legal negotiators.
CGP FOR SEX THERAPY IN GENERAL PRACTICE.

(Composed by Dr. Katrina Eastwood)

A number of GPs have been certified by the Board of Examiners in Sex Therapy and Counselling in Ontario (BESTCO). Physicians are ideally suited to practice sex therapy. Their ability to assess organic, physiological, emotional and psychological causes allows for an efficient and one provider service. Skills required are:

- Listening and communication skills: the therapist needs to:
  - Be non-judgemental
  - Be comfortable with his/her sexuality.
  - Use language/jargon appropriate to patient.
  - Be aware of boundaries.

- Knowledge of and ability to assess relationship dynamics and their role in sexual dysfunction.

3. Take a detailed Sexual History.
4. Offer a sexological Examination (if appropriate) and investigate for organic problems. I.e. Biochemical, hormones, blood etc.
5. Diagnose(s)- there may be more than one.
6. Assess partner (if relevant)
7. Know of specific treatment protocols and home exercises for specific diagnoses:
   - Behavioural.
     - Reading lists
     - Writing/drawing
     - Touching
     - Talking
   - Surgical.
   - Pharmacological.

CGP FOR GROUP THERAPY IN GENERAL PRACTICE.

The Canadian Group Psychotherapy Association has a structured training program and requirements for Clinical Membership (Doc. #2B -Table A). Training programs run for two years and are offered by the CGPA in most major cities in Canada. Physicians who have undertaken the training and fulfilled the requirements for Clinical Membership should be recognized as competent and qualified group therapists. GPPA advocates that a physician group therapist would be required to:

- Know the indications and contraindications for group therapy.
- Know how to provide for safety in a group.
- Be an associate (in training) or clinical member of the CGPA.
- Practice one of the ten modalities recognized by CGPA62.

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