GUIDELINES FOR THE PRACTICE OF PSYCHOTHERAPY BY PHYSICIANS

Medical Psychotherapy Association Canada
Professional Development Committee
Guidelines Task Force

Approved by the Board of Directors MDPAC
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ACKNOWLEDGEMENTS

Dr. Catherine Carmichael, a founding member and enthusiastic contributor to the work of the Guidelines Task Force, tragically passed away September 22, 2013. We have carried on, but miss her very much.

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MEDICAL PSYCHOTHERAPY ASSOCIATION CANADA

Preface to 2017 Edition

The Guidelines Task Force (GTF) (Appendix 1) completed the Guidelines for the Practice of Psychotherapy by Physicians in 2010, and they were passed by the General Practice Psychotherapy Association (GPPA) Board. The GTF created a video of what NOT to do in 2011.

In 2015, the GPPA changed its name to the Medical Psychotherapy Association Canada (MDPAC), or Association Canadienne de Psychotherapie Medicale (ACPMD).

In 2016, the literature of the Guidelines required updating, which was accomplished with the assistance of the University of Toronto Department of Family and Community Medicine librarian Robyn Butcher, MLIS. Updates are included in the document in the appropriate sections.

The Chair of the GTF, Dr. Lynn Marshall, sought feedback on the 2010 version of the Guidelines from attendees at her presentation at the Ontario Psychiatric Association Clinical Pearls Conference on April 6, 2016, and the MDPAC Annual Conference on May 28, 2016. Dr. Joan Barr updated the Training section.

The GTF communicated and met over 2016 and agreed on suggestions for the 2017 version. All members reviewed the updated document, and then passed it to the MDPAC Professional Development Committee for review and approval, and then for review and approval by the MDPAC Board.

Executive Summary

The mission of the Medical Psychotherapy Association Canada (MDPAC) is to support and encourage quality medical psychotherapy by physicians in Canada and to promote professional development through ongoing education and collegial interaction.

In following through with its mission, the MDPAC Board mandated the Professional Development Committee (PDC) to develop a position paper to guide the practice of psychotherapy by its members. In fulfilling this mandate, the PDC selected a Guidelines Task Force that has produced this document in 2010, and updated it in 2017, guiding MDPAC members and other physicians towards a high quality level of psychotherapy practice that allows for a variety of approaches and is focused on the provision of **safe and effective care.**

The Guidelines Task Force elected to use a structured process articulated by the Guidelines Advisory Committee of the Ontario Ministry of Health and Long Term Care and the Ontario Medical Association (1997). Multiple resources were reviewed, including original and review articles, as well as existing codes, policies and guidelines. The available evidence for recommendations was categorized according to quality and strength as outlined by the Canadian Task force on Preventive Health Care (2003), and the Guidelines Advisory Committee (1997). The Task Force found that the majority of the available evidence was Level III B. Hence, literature review was followed by discussion, development of consensus via Delphi technique (Hsu and Sandford, 2007; Green and Dye, 2002), and documentation. Then internal reviews of drafts by MDPAC members was followed by an extensive external review by expert and stakeholder reviewers chosen by the MDPAC Board to represent a spectrum of views, recognizing various sources of potential bias (Detsky, 2006). Reviewers' suggestions were carefully examined by the Guidelines Task Force and incorporated when consensus was reached, or disagreement was recorded. The finalized guidelines were submitted to the MDPAC Board for approval prior to dissemination. They are intended to be a 'living document' that is reviewed and updated as psychotherapy continues to evolve.

Besides reiteration of the recommendation of **the fundamental** e**thical principle for medicine** (Canadian Medical Association, 2004), the Guidelines Task Force identified, discussed, and made recommendations regarding three main areas impacting on safety and effectiveness: **Professional Competence, Professional Conduct, and Office Environment/Record-keeping**. To assist busy readers, the **recommendations** are summarized below with notation of the relevant sections where they may be found. The quality and strength of the evidence for these recommendations and linked references can be found in the relevant document sections.

The Guidelines Task Force also included **self-reflective questions (SRQs)** as key strategies to enhance safety and effectiveness. The SRQ's are included throughout the text, and are listed together in Appendix 5.

Summary of Recommendations

Fundamental Medical Ethics

Recommendation I: ***Medical Ethics***

"Consider first the well-being of the patient." Details are included in the Canadian Medical Association Code of Ethics (CMA Update 2004:1-2).

Professional Competence

Recommendation II: ***Training***

Educational/competence guidelines include undergraduate training in communication skills, personal development of empathy and compassion, and the ethical duties of the doctor-patient relationship, to be incorporated throughout training rotations. By the end of basic medical training, physicians should be able to integrate the various contributors to illness, including biological, psychological, social, and other dimensions, and use them to formulate patient care. Sufficient training should continue in Family Medicine residency programs to enable primary care physicians to address the high demand for service by incorporating brief and intermittent psychotherapeutic interventions. Advanced training in psychotherapy for non-psychiatrist physicians should include a core curriculum, supervision, and collegial support, as well as self-awareness and self-care strategies. Details are outlined in *"Recommendations for Training in Medical Psychotherapy for Non-psychiatric Physicians"* (Salole et al, 2004) (Appendix 1) (endorsed by the GPPA Board, the Ontario Medical Association General Practice Psychotherapy Section, and the Ontario College of Family Physicians). (Section 5.1) The training for psychiatrists recommends the same basics (Cameron et al, 1998:348-370).

Recommendation III: ***Seeking Supervision***

Competence includes the ability to recognize one's limitations to assess/treat, and to deal with counter-transference issues, and to seek supervision on a regular basis. It is particularly important that a physician, upon recognizing therapeutic impasses, transference/counter-transference difficulties, or puzzlement and/or discomfort on self-reflection, should seek appropriate mentoring/supervision from a colleague or refer the patient. Suggestions made by the mentor/supervisor with regard to the patient's therapy and any notes re physician learning or dealing with counter-transference should be kept in the therapist's own notebook. (Section 5.2.3)

Recommendation IV: ***Self-care and Personal Growth***

To be proficient and comfortable providing psychotherapy, and to help prevent the possibility of verbal, emotional, physical, or sexual abuse of patients, physicians should become self-aware and explore family of origin issues with

personal growth work and/or personal psychotherapy. This may include seeking support from colleagues and appropriate qualified professionals in relevant disciplines for personal problems that might adversely affect service to the patient, society, or the profession. Physicians should develop clear communication and limit-setting skills with patients. It is also important for physicians to become aware of their own needs for companionship, security and physical contact, and to regularly seek their preferred forms of renewal within their personal lives. (Sections 5.2.4 and 5.2.5)

Recommendation V: ***Treatment Modality Choice***

Recognize that often more than one method of treatment is desirable and/or appropriate according to the particular clinical situation, and that flexibility is required. Where applicable to, and agreeable with individual patients, follow the Guidelines Advisory Committee-approved, evidence-based practice guideline for psychotherapeutic modalities (Bateman et al, 2001, reviewed for the Guidelines Advisory Committee by Pare and Gilbert, 2002), or other evidence-informed modalities for which the physician has adequate training, or refer to a qualified colleague. (Section 5.3)

Professional Conduct

Recommendation VI: ***Consent***

At the outset, and at times of potential change in therapy, determine the patient's capacity to consent or refuse the treatment, whether an adult or a child. If the patient is capable, discuss with him or her the nature of the proposed treatment, the expected benefits and risks, and potential alternative courses of action or inaction, solicit and answer questions, and make note in the medical record. Also discuss and record the agreed 'frame of psychotherapy', i.e. the scheduling, fees, other rules and obligations of treatment. If the patient is incapable of consent, follow the same process with the appropriate substitute decision maker (as defined by the relevant provincial health care consent act). (Section 6.2)

Recommendation VII: ***Confidentiality and Mandatory Reporting***

Obtain express consent for release of information about the patient in psychotherapy, even though within the patient's circle of care there is implied consent. Inform the patient at the onset of therapy of circumstances requiring mandatory reporting. These include such situations as threat of imminent, life-endangering harm to self or others, suspected child abuse, patient report of sexual abuse by a health professional, incompetence to drive a motor vehicle or to fly an airplane, incompetence of a patient who is a health professional, reportable infectious disease, request for benefits under the provincial workplace safety and insurance act, or court order. (Sect. 6.3)

Recommendation VIII: ***Prevention of Verbal, Emotional, or Physical Abuse***

> **The physician should seek regular supervision, but also recognize warning signs in interactions with patients and high risk situations and swiftly access supervision. When supervision cannot resolve the difficulties, possibilities include referring the patient, collaborating with another physician, and/or seeking personal therapy.** (Section 6.4.1)

Recommendation VIII: ***Prevention of Verbal, Emotional, or Physical Abuse***

> **The physician should seek regular supervision, but also recognize warning signs in interactions with patients and high risk situations and swiftly access supervision. When supervision cannot resolve the difficulties, possibilities include referring the patient, collaborating with another physician, and/or seeking personal therapy.** (Section 6.4.1)

Recommendation IX: ***Prevention of Sexual Abuse***

> **Follow the law (Health Professions Procedural code, Schedule 2 to the Regulated Health Professions Act, 1991; Ontario Regulation 856/93 made under the Medicine Act, 1991, as amended, and similar legislation in other provinces) prohibiting sexual abuse of patients, defined as sexual intercourse or other forms of physical sexual relations with a patient/client, touching of a sexual nature of a patient/client, and behaviour or remarks of a sexual nature towards a patient/client. Follow the policy prohibiting sexual relations at any time after termination of treatment when the doctor-patient relationship involved a significant component of psychoanalysis or psychotherapy** (CPSO, Policy Statement # 4-08, September, 2008) (Section. 6.4.2).

Recommendation X: ***Dual Relationships***

1. **It is advisable that psychotherapists set clear limits and refuse to undertake the care of their own relatives or friends** (Sections 6.5.1 and 6.5.3).

2. **It is recommended that Family Physicians make and communicate a clear separation of roles when entering into psychotherapeutic relationships with patients from their practices by finding ways to separate psychotherapy from other medical activities in time and space. In the case of those in dual roles as family physicians who provide care for physical medicine as well as providing psychotherapy, it is important to ensure that physical examination techniques reflect clear attention to boundaries. Patients can be informed that, in order to decrease the risk of adverse impacts or potential misunderstandings related to the physical components of health care provision, the physician has a policy of either referring to a colleague for physical examinations or having a third person present in the exam room. Patient consent should be obtained and documented in the chart.** (Sections 6.5.2 and 6.5.3)

3. **Physicians should refrain wherever possible, from establishing personal or business relationships with patients who are, or who have been, in a psychotherapeutic relationship with them. It is recognized that, after the termination of that relationship, patients may remain vulnerable and dependent and so be compromised in their ability to act autonomously.** (Section 6.5.4)

Recommendation XI: ***Conflict of Interest***

Physicians are bound by ethical standards and should refrain from personal benefit arising out of psychotherapeutic relationships with patients. Such benefits include those with respect to business and finances, as well as emotional or sexual benefits. (Section 6.6)

Office Environment Safety and Record-keeping

Recommendation XII: ***Office Environment***

1. **Assess and ensure that your office is accessible for your patient population. If it is not possible for your office to be reachable for patients with some impairment(s), assist such patients by referring them to colleagues with more accessible facilities.**
2. **Assess the degree of risk for emergencies in your practice and provide emergency equipment, supplies and protocols corresponding with the nature of your practice and patient population. Store emergency equipment together in one cabinet, cart or drawer for easy access and ensure that you and your staff are trained in its use. Familiarize yourself and your staff with written plans to follow in case of urgent events such as a disruptive or threatening patient, fire, or medical emergency.**
3. **Ensure that offices are adequately soundproofed to prevent others from overhearing personal health information, and that charts are securely stored and computer monitors strategically positioned to avoid others seeing patients' health information.**
4. **Password-protect patient files on computers and portable storage devices.**
5. **Do not leave messages with third parties or on answering machines that contain patients' personal health information without their express consent.** Detailed suggestions are outlined in *"A practical guide for safe and effective office-based practices"* (CPSO, May, 2012 from April 2009), which may be downloaded from www.cpso.on.ca→Policies and Publications)(Section 7.1).

Recommendation XIII: ***Record-keeping***

Maintain psychotherapy records that "tell the patient's story", and contain the following minimum components: history, observations of physical/mental status, diagnosis/assessment, treatment plan, progress notes that reflect input from both patient and physician, outcome assessment and a note of the patient's reaction at the end of the treatment. The SOAP (Subjective, Objective, Assessment, Plan) method for progress notes is useful. Detailed suggestions re record-keeping may be downloaded from www.cpso.on.ca →Policies and Publications, CPSO Policy #4-12, May, 2012 from Nov. 2000; 2005; Nov. 2006). (Section 7.2)

Process for Guideline Development

1.0 Background

1.1 About the Medical Psychotherapy Association Canada

In 1984, the General Practice Psychotherapy Network was founded by Drs. Terry Burrows and Robert James to offer mutual support to fellow physicians providing psychotherapy in their practices and to strive for continual quality improvement in psychotherapeutic care. The Network subsequently evolved into the non-profit General Practice Psychotherapy Association (GPPA), incorporated in 1995, and with physician members across Canada.

In 1996, on GPPA initiative, an Ontario Medical Association Section on General Practice Psychotherapy was started, and, in 2013, the name was changed to the OMA Primary Care Mental Health Section.

In 2015, the name of the General Practice Psychotherapy Association was changed to Medical Psychotherapy Association Canada (MDPAC), to be incorporated as a non-profit organization under that name.

The MDPAC's mission is to support and encourage quality psychotherapy by physicians in Canada and to promote professional development through ongoing education and collegial interaction.

1.2 The Need for Mental Health Services in Canada

The Standing Senate Committee on Social Affairs, Science and Technology (Kirby and Keon, Highlights and Recommendations, 2006:7) extensively studied mental health services in Canada and noted that each year, roughly 3% of the population will experience a serious mental illness (not defined) and another 17% will experience mild to moderate illness.

The Senate Committee observed that:
"There is nothing approaching universal agreement on how mental and physical factors influence the state of our mental health. Indeed, there are many different ways in which social, environmental, psychological, and biological factors are thought to interact in the development of mental disorders, although most people seem to agree that mental illnesses almost always entail some combination of these factors." (Kirby and Keon, Transforming Mental Health, Mental Illness, and Addiction Services in Canada, 2006: 67)

The Senate Committee also noted that:
"The customers of the Canadian mental health and addiction system have told the Committee that they cannot find services when they need them and that, when they are lucky enough to find help, they are often unhappy with the services they receive. These criticisms are not vague or insubstantial. They point exactly to what is wrong, providing valuable information that can serve to improve the targeting of future government investments and the accountability for outcomes…such as respect, preservation of dignity, as well as a focus on hope and recovery, since these figure amongst the things that persons[living with mental illness,] and their families value most."

(Kirby and Keon, Highlights and Recommendations, 2006: 39)

The Senate Committee indicated that community-based models of care have been shown to be largely equivalent in cost to institutionally-based services, and have recommended a blend of institutional and community-based supports and services to ensure that *"people have access to a seamless continuum of care across their lifespan"* (Kirby and Keon, Highlights and Recommendations, 2006: 13).

There is limited evidence on the economic impact of psychotherapy. Gabbard et al (1997) reviewed MEDLINE peer-reviewed papers published from 1984 to 1994 that included information on the cost effects of a variety of psychotherapeutic interventions, usually applied for a variety of illnesses by psychiatrists in academic settings. They included costs of implementing the interventions, subsequent medical care utilization, and the patients' or families' lost wages or productivity at work. They acknowledged the small number of eligible studies (18), the small groups of subjects studied, the inconsistent cost reporting, and the uncertainty of generalizability to care in the community. However, they found that 8 (80%) of the 10 clinical trials with random assignment, and all 8 (100%) of the studies without random assignment suggested that psychotherapy reduced total costs. They also noted that these studies indicated there is substantial cost in *not* providing psychotherapeutic support, both in human and economic terms.

A 2013 cross-sectional study of 20, 777 adults in the general population in France was carried out by telephone backed up with the World Health Organization Composite International Diagnostic Interview- short-form (CIDI-SF) and use of the Sheehan Disability Scale to assess severity. Using estimates of the proportion of patients that would attend psychotherapy according to methodology developed in the United Kingdom (UK), and the cost of the number of sessions recommended by the National Institute for Health and Clinical Excellence (UK) (10 sessions for anxiety disorders, and 18 for depressive disorders), taking into account government-sponsored sessions, a considerable cost saving to the community was computed, in addition to positive effects on health, quality of life, and absenteeism. The authors noted that even more savings would accrue if the impact on somatic disorders interacting with mental health disorders was included (Dezetter A. et al, December, 2013).

A review of the results from the 2012 Canadian Community Health Survey- Mental Health (Sunderland A. and Findley L.C., Statistics Canada, 2015) revealed 17% of 25,113 Canadians over age 15, excluding people who were institutionalized, full-time Canadian Forces members, or living on indigenous reserves, reported they had needs for mental health care, comprising information about problems, treatments or services, medication, counselling, therapy, or help for problems with personal relationships, and other mental health services. The needs were highest for those with "mental disorders", identified by an algorithm from responses to the Composite International Diagnostic Interview (not a clinical diagnosis), for those having elevated K6 distress levels higher than 4 (Kessler et al, 2010), and for those having chronic physical health conditions. Needs for medication were met by 91% of the sample population reporting they had mental health care needs, for information by 70%, but only 65% had their need for counselling or therapy met, 16 % partially met, but 20% unmet.

The Guidelines Task Force believes that the recognized substantial cost in *not* providing psychotherapeutic support for vaguely defined, but prevalent "mental" illnesses, as well as the positive, if limited, available evidence for cost savings from trials of psychotherapeutic interventions, implies that gradually more cost savings should be realized in the health care system as a whole with provision of a full range of integrated health services to address the physical and mental health and wellbeing needs of Canadians.

1.3 The Need for Guidelines for the Practice of Psychotherapy by Physicians

Guidelines for the psychotherapies had been written by psychiatrists for psychiatrists (Cameron et al, 1999; Mackenzie et al, 1999), and on legal issues in social work and counseling by social workers for social workers (Madden, 1998). There is a textbook about the theory and practice of counseling and psychotherapy by a counselor for counselors in general (Corey, 2005, 2008), and guidelines regarding treatment choices in psychological therapies and counseling were developed for psychotherapists from multiple disciplines by a Guidelines Development Group of the British Psychological Society (Bateman, et al, 2001). However, before 2010, guidelines for the practice of psychotherapy by physicians were not developed by and for physicians, particularly those who were not psychiatrists. MDPAC sought to develop guidelines geared especially to the needs of MDPAC physician members, recognizing some may have other interests in other communities of clinical practice.

In the fall of 2003, the GPPA Board asked its Professional Development Committee (PDC) to recommend standards and guidelines for GPPA members for the practice of psychotherapy. These standards and guidelines would need to be applicable to diverse patient populations throughout their life-spans. At that time, the PDC formed the Guidelines Task Force (GTF) to undertake this project. While the impetus was to develop practice guidelines for GPPA members, it soon became apparent to the Guidelines Task Force that such guidelines might have broader application for physicians, rather than being organization-specific. Hence, efforts were made to ensure that relevant physician groups were included in the iterative guideline development process, which involved multiple reviews and revisions.

In February 2005, the Ontario Minister of Health and Long Term Care requested advice from the Health Professions Advisory Council (HPRAC) on whether psychotherapy should be a controlled act under the Regulated Health Professions Act, 1991. The Council recommended both psychotherapists and the practice of psychotherapy should be regulated with a new profession-specific statute- the Psychotherapy Act (HPRAC, April, 2006: 206-08, *New Directions*). This Act was introduced by the Ontario legislature in 2007, and a College of Registered Psychotherapists of Ontario was established in 2009. The Act came into effect regulating psychotherapists and the practice of psychotherapy on April 1, 2015, and restricted psychotherapy as a controlled act to be carried out only by certain regulated professions (College of Nurses of Ontario, Mar. 24, 2016, *Psychotherapy and the controlled component of psychotherapy*).

HPRAC outlined four basic psychotherapeutic orientations as outlined by psychiatrists: psychodynamic, cognitive-behavioural, strategic systems, and experiential. Several methods of practice for care of patients were included under each of these categories (Cameron and Deadman,1998, *Standards and Guidelines for the Psychotherapies).* HPRAC made the distinction *"from both counselling where the focus is on the provision of information, advice-giving, encouragement, and instruction, and spiritual counselling which is counselling related to religious or faith-based beliefs."* (HPRAC, April, 2006: 208, *New Directions).*

1.4 Prevention of Abuse of Patients by Physicians

Since the College of Physicians and Surgeons of Ontario's Independent Task Force on the Sexual Abuse of Patients published their recommendations (CPSO, McPhedran et al, 1991), much effort has been expended within the medical profession to define standards and guidelines for psychotherapy that would protect patients not just from sexual abuse but from other abuses of power in the context of physician-patient relationships. While some progress was noted by the same Task Force in their Final Report (CPSO, McPhedran et al, 2000), they recommended "a more co-operative and efficient patient-centred model of self-regulation by health professionals" that would "honour the public trust". The General Practice Psychotherapy Association (GPPA) had been a part of the effort (Deadman and Goodman et al, 2003). However, consensus on standards and guidelines for psychotherapy had not yet been reached within the medical profession in 2003, leaving a void that was uncomfortable for patients, physicians, professional associations and regulatory bodies.

The CPSO has kept current with the opinions of the public and physicians, and updated policies have appeared on their website (December, 2014, May, September 10, 2015), which included a letter to the Minister of Health and Long Term Care that specified creating and publicizing sexual abuse principles, revising legislation, revising internal processes and practices, creating an education brochure for patients, and development of a plan for education of physicians and trainees.

2.0 Objectives

The overarching purpose of this project is to provide a framework to guide MDPAC members and other physicians, in providing ever-improving, safe, effective psychotherapeutic care, encouraging expertise in a variety of approaches to benefit patients with diverse needs and preferences.

Since the Guidelines for the Practice of Psychotherapy by Physicians were published in 2010, they have been widely distributed and broadly accepted.

3.0 Methods

3.1 Guiding Bases for Guidelines Development

The British Psychological Society Centre for Outcomes Research and Effectiveness (Bateman et al, 2001) made it clear that there was little research evidence to assure practitioners of the best treatment modalities for various "mental" health disorders:

"Nowhere is the gap between research and practice wider than in this field. Most psychological therapy in the NHS is pragmatic and eclectic, where therapists use a judicious mix of techniques drawn from varying theoretical frameworks. Most psychotherapy research, on the other hand, is on standardized interventions of 'pure' types of therapy, e.g. cognitive, behavioral or psychoanalytic. The most prevalent interventions are paradoxically the least researched." (Bateman et al, 2001: 4)

What sparse research results they found for specific modalities (Bateman, 2001) have been endorsed by the Ontario Guidelines Advisory Committee (GAC formed, 1997) (GAC Psychotherapy Recommended Guideline, 2002).

The Guidelines Task Force agreed with the British Psychological Society and Wampold (2001) that many empirically effective treatments have not yet been studied and, in actual practice, an eclectic combination of therapeutic techniques and tools frequently appears to be most beneficial and represents the skill and art of the individual therapist.

It therefore became the intent of the Guidelines Task Force, in developing guidelines for the practice of psychotherapy by physicians, to focus upon the principles and process for provision of competent, safe psychotherapy rather than upon specific treatment models and techniques. Further discussion of treatment modalities may be found in Section 5.3.

Farquhar (1997) noted:
"As practising physicians, we have little use for simple, prescriptive "recipes" for health care, knowing, as we do, the variability and unpredictability of the "ingredients": our access to diagnostic and therapeutic technologies, our proximity to specialists and subspecialists, and most of all, the defining characteristics of our patients (age, sex, co-morbid conditions and adherence to medical therapy), which may differ significantly from those of the select few enrolled in randomized controlled trials. ...It may be preferable to view CPGs [clinical practice guidelines] as "roadmaps" rather than "recipes". Our relationships with patients are like journeys that we share with them. Whereas a few of us seem to be blessed with an almost instinctive sense of direction, most of us need maps, particularly when the landscape keeps changing."

A task force appointed by the College of Physicians and Surgeons of Ontario stated that:
"Clinical practice guidelines must be based on the appropriate mix of current, scientifically-reliable information from research literature, clinical experience and professional consensus." (Deadman and Goodman et al, 2003: xi)

The Guidelines Task Force agreed with these views while recognizing that the reality of the dearth of available research evidence has necessitated reliance on empirical and consensus bases for development of these guidelines.

3.2 Definitions of Psychotherapy

The Regulated Health Professions Act (1991) defines psychotherapy as *"treatment for mental illness, behavioural maladaptations, or emotional problems, in which a physician deliberately establishes a professional relationship with a patient for the purpose of removing or modifying existing symptoms attributed to the problem."*

The Guidelines Task Force was uncomfortable with the vagueness of this definition of psychotherapy and considered a number of others. When consensus could not be reached on one, the GTF chose a combination of definitions from different sources that moved from general to more specific as follows:

"Physician psychotherapy is the deliberate establishment by licensed physicians of a professional relationship with patients for the purpose of communication and collaboration to address potential or actual health-impacting problems" (Marshall et al, 2001, updated June 2006:2, latest update October, 2017).

"…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" (Salole et al, 1996:11).

"Medical psychotherapy always entails continuing medical diagnostic evaluation and responsibility and may be carried out in conjunction with drug and other physical treatments. Medical psychotherapy recognizes that the psychological and physical components of an illness are intertwined and that at any point in the disease process, psychological symptoms may give rise to, substitute for, or run concurrently with physical symptoms and vice versa" (Katz, 1986).

As of May 31, 2007, The Health Systems Improvement Act was passed by the Ontario legislature, with Bill 171, the Psychotherapy Act, 2006 (www.ontla.on.ca), which has designated psychotherapy as a controlled act which physicians in Ontario are permitted to provide. According to this new Ontario legislation: *"The scope of practice of psychotherapy is the assessment and treatment of cognitive, emotional or behavioural disturbances by psychotherapeutic means, delivered through a therapeutic relationship based on verbal or non-verbal communication."*

3.3 Definitions of Standards and Guidelines

The Guidelines Task Force accepted the following definitions:

*"A **Standard** is usually defined as a minimum or basic level of acceptable practice.*

*A **Guideline**…guides the practitioner towards an ideal or high quality level of practice."* (Deadman and Goodman et al, 2003:4).

The GTF agreed that a licensed physician who follows the Guidelines for the Practice of Psychotherapy by Physicians would also be meeting the minimum standards of acceptable practice of psychotherapy and also would be adhering to the scope of practice of psychotherapy outlined in the Ontario legislation (Psychotherapy Act, 2006)**.**

3.4 Guidelines Advisory Committee Guiding Process

The criteria for guideline development, specified in the Appraisal of Guidelines for Research & Evaluation (AGREE) Instrument, a 23-item tool comprising 6 quality domains (AGREE Collaboration, 2003) were followed, as recommended by the Guidelines Advisory Committee (GAC, 1997) and Ontario Guideline Collaborative (OGC, 1999), which have now joined the non-profit Centre for Effective Practice. The systematic methodology developed by the AGREE Consortium to assess the methodological rigour and transparency in which a guideline is developed was generic to diagnosis, health promotion, or treatment related to any health condition (AGREE, 2001:2). For the 2017 Psychotherapy Guidelines update, the AGREE II instrument and the new Users' Manual were reviewed (Brouwers M. et al, Dec., 2010), as well as the update in Sept. 2013.

3.5 Definition of Target Users

The Guidelines Task Force defined the target users of this document as MDPAC members, all of whom are physicians, and other physicians:

a) who are practising predominantly (>50%) scheduled, focused psychotherapy (designated as Full Time [FT]), or
b) who are providing primary health and well-being care or scheduled, focused psychotherapy as part of their family medicine or specialty practices (designated as Dual Practice [DP]).

This target user designation was based on findings of a 2003 survey of members of the General Practice Psychotherapy Section of the Ontario Medical Association (Wilkins, 2003).

3.6 Measurement Issues

The Guidelines Task Force recognized that the number of variables operating in the interactions between patients and physicians in professional relationships is very large; hence it is extremely challenging to specify clear-cut measurable standards. Measurement of compliance or non-compliance with bare minimum standards would be easiest if it were a dichotomous yes or no, but this rarely occurs. Hence, we are offering guidelines or principles which contain the standards, for pursuit of ongoing learning and improvement, along with recognition and avoidance of pitfalls.

The Canadian Health Services Research Foundation (CHSRF) thinks that *"Evidence-informed decision-making"* is a more accurate and realistic description of the role of research in clinical practice:

"As interest in applying research spreads from the clinical world to the managerial and policy ones, the justifiable contaminants of "ideology" and "interests" crowd the purity of "ideas" from research. In recognizing these relative weightings, it may be less heroic but more appropriate to aspire to evidence-informed rather than evidence-based decision-making" (CHSRF, 2005:1).

A whole science is just beginning to develop around measurements of quality improvement in psychotherapy: standards, means, norms, and benchmarks for various clinical outcomes. Standards may be arbitrarily set, reflect expert consensus, or be based on statistically derived thresholds. The Guidelines Task Force's idea, then, is to inform 'best practices', or processes of care, not just through evidence-based practice i.e. efficacy research, but also through practice-based evidence of effectiveness in the 'real world' of psychotherapeutic care (Agency of Healthcare Research and Quality, 2000; Margison and McGrath, 2000; Hermann et al, 2003; Victoria's Mental Health Services, 2004).

"Not everything that counts can be counted, and not everything that can be counted counts." (Albert Einstein, 1879-1955).

3.7 Evidence Classification

Development of quality improvement measurement science and qualitative research should offer exciting opportunities for ongoing development of psychotherapeutic methods. In the meantime, recommendations in this document for safe, effective psychotherapeutic care are based on available evidence, categorized according to quality and strength by the Canadian Task Force on Preventive Health Care (www.ctfphc.org/), whose classification system has been widely adopted throughout the medical world. The highest quality of evidence in medicine was defined by the CTFPHC as evidence from at least one randomized clinical trial (RCT). However, the Guidelines Task force agrees that the following should be kept in mind when attempting to inform psychotherapeutic practice with RCT evidence:

"The logic of the randomized controlled clinical trial purports to establish linear, efficient causal relationships between treatment application and outcome. However this logic does not fit with therapies that are not conceived of as the application of specific procedures to alleviate specific disorders- therapies where healing ultimately results from personal discovery and where the primary modality is that of a flexible, creative, and dialogical relationship between therapist and client" (Bohart et al, 1997).

Recommendations in this document were informed by the following categories of quality and strength of evidence, as specified by the Canadian Task Force on Preventive Health Care (Table 1).

Table 1	
Evidence Classification	**By the Canadian Task Force on Preventive Health Care**
Quality of Evidence	**Description**
I	Evidence from at least one randomized clinical trial.
II	Evidence from at least one well-designed clinical trial without randomization, from cohort or case-control studies, or dramatic results from uncontrolled experiments.
III	Evidence from opinions of respected authorities on the basis of clinical experience, descriptive studies, or reports of expert committees.
Strength of Evidence	**Description**
A	There is **good** evidence to recommend the clinical [preventive] action.
B	There is **fair** evidence to recommend the clinical [preventive] action.
C	The existing evidence is **conflicting** and does not allow one to make a recommendation for or against use of the clinical [preventive] action; however, other factors may influence decision making.
D	There is **fair** evidence to recommend against the clinical [preventive] action.
E	There is **good** evidence to recommend against the clinical [preventive] action.
I	There is **insufficient** evidence (in quantity or quality) to make a recommendation; however, other factors may influence decision-making.

The Guidelines Advisory Committee (GAC, 1997), which, since February, 2010, continues their project-based activity at the Centre for Effective Practice (CEP), described Levels of Evidence as in Table 2, following. The Guidelines Task Force categorized the evidence for recommendations according to this GAC/CEP description as well.

Table 2	
Evidence Classification	**By the Guidelines Advisory Committee**
Levels of Evidence	**Description**
Excellent/Good Evidence to Recommend	Scientific evidence provided by well-designed, well-conducted, controlled trials (randomized and non-randomized) with statistically significant results; meta-analysis of randomized controlled trials
Fair Evidence to Recommend	Scientific evidence provided by observational studies, cross-sectional studies, systematic reviews and well done prospective, quasi-experimental, longitudinal studies, and case-control studies.
Insufficient Evidence to Recommend	Case reports and case series are generally rated insufficient evidence to recommend.
Consensus	Expert opinion that supports the guideline recommendation even though the available scientific evidence did not present consistent results, or controlled trials were lacking.

3.8 Process Used by the Guidelines Task Force

3.8.1 Parameters and Principles

The MDPAC Board, and previously the GPPA Board, requested that the PDC Guidelines Task Force undertake this work as a volunteer project. Neither Task Force members nor any of the GPPA Internal or External Reviewers participating in this project received any remuneration. All signed conflict of interest declarations. (Please see Appendices 1 and 2.) MDPAC only provided modest support for secretarial services, including formatting and distribution costs. To maintain editorial independence, none of the Guidelines Task Force members were members of the Board of Directors of MDPAC for the 2010 original version, nor for the 2017 update.

The Guidelines Task Force met regularly from 2003 until 2011, and over 2016, and it is comprised of physician members who practice full-time (>50%) psychotherapy and dual (<50%) psychotherapy with a subspecialty medical practice. Two of the members became CPSO Members Alumni in 2013 and 2016.

The Guidelines Task Force agreed with the accepted general principles that all licensed physicians practicing psychotherapy are responsible to:

- Apply learned communication skills to establish and continually build a therapeutic alliance in order to assist patients to address the unique problems they bring to the doctor, and, in general, to prevent disease, treat illness, relieve symptoms and comfort distress.
- Undertake education that enables them to specify contributors to ill health, including biological, psychological and social factors and, when helpful for the patient and other health care professionals sharing care, to use a recognized system of diagnosis.
- Develop the capacity to integrate multiple factors (including biological, psychological and social) in treatments.
- Diagnose and treat within the ethical boundaries of the medical profession.
- Treat within the therapist's level of competence or with support from a colleague with more advanced training and experience, with referral decisions based on the individual physician's skills, interest, and experience, the patient's preference, and on the local availability of other resources.
- Have sufficient self-awareness to understand the impact of therapy on both patient and physician.
- Develop sufficient self-care skills to protect themselves from burnout, substance abuse, boundary violations, etc. (adapted slightly from Marshall et al, 2001:2, June, 2006; latest update Feb., 2017)

From these principles, the Guidelines Task Force identified the main areas of potential concern to be examined as: **Professional Competence, Professional Conduct, and Office Environment/Record Keeping.** Areas of overlap were recognized within these categories, and with the **Fundamental Ethical Principles of Medicine.**

3.8.2 Literature Review

The Guidelines Task Force noted that considerable literature review regarding psychotherapy standards and guidelines had been done previously by MDPAC. Between 2003 and 2010, the Guidelines Task Force members conjointly identified the most relevant papers, books, reports and tools written in English to reflect the diversity of available evidence in the identified areas of potential concern (AGREE, 2003; Barr et al, 2001; Cameron et al, 1998; Canadian Medical Association, 1996, 2004; Canadian Psychoanalytic Society, 2002; Canadian Task Force on Preventive Health Care, 1997, 2003; College of Physicians and Surgeons of Ontario{CPSO}, 1998, Aug. 2004, Sept./Oct. 2004, March/April, 2006; Deadman and Goodman et al, 2003; Guidelines Advisory Committee, February 16, 2004; Mahoney, 1998; Marshall et al, 2003; Salole et al, 1996; Salole et al, 2004). Each of these works contained further relevant references, which the Guidelines Task Force members obtained and reviewed as necessary to clarify issues for discussion by the whole group.

Each member of the Guidelines Task Force reviewed specific documents from the identified relevant literature and submitted a list of issues pertinent to the practice of safe, effective

psychotherapy to the whole group for iterative discussion via e-mail, telephone, or face-to-face meetings.

Additional literature written in English was obtained from the National Library of Medicine via MEDLINE/Pubmed and the Google search engine, using topic search words "standards and guidelines and psychotherapy", "non-psychiatrist physicians" and "patient expectations of psychotherapy"(to find literature written specifically for patients/clients/consumers). The searches were narrowed by adding "review" to the key words. Further searches were made pertaining to the issues and topic subheadings discussed by the Guidelines Task Force. The literature available under topic subheadings was then reviewed for relevance by individual Task Force members. The relevant literature was discussed by the Guidelines Task Force together, and is referenced throughout this document. In 2016, the literature was updated to 2015, with the assistance of the University of Toronto Department of Family and Community Medicine librarian.

The College of Physicians and Surgeons of Ontario (CPSO) supplied the Guidelines Task Force with copies of the Participants' Handbook *"Understanding Boundaries: Managing the Risks Inherent in the Doctor-Patient Relationship"*(CPSO and University of Western Ontario Faculty of Medicine and Dentistry, April 8 & 9, 2005). In addition, the CPSO now has relevant policies and publications posted at: www.cpso.on.ca, and the most recent policies were accessed in 2016.

3.8.3 Stakeholder Consultation and Draft Development

In 2010, the Guidelines Task Force solicited input from the MDPAC Board on questions raised during guidelines development through its appointed liaison with the Board.

An e-mail request was sent to, and input received from, MDPAC Listserv members, and a list of members who expressed interest in reviewing draft documents was also generated from responses.

Personal contact was made with the CEO and Executive Director of the Ontario College of Family Physicians, the Chair of the Ontario College of Family Physicians' Collaborative Mental Health Network, and a representative of a consumer advocacy group, Citizens for Choice in Health Care.

Ideas were included in the guidelines from three written sources the Task Force found particularly useful and relevant to patients/clients/consumers (Beamish et al, 1998; Ainsworth, 2005, Association of Psychologists of Nova Scotia, 2006).

The Guidelines Task Force Chair gathered, retained, and collated the information provided by stakeholders. Qualitative phrases were highlighted that the Guidelines Task Force thought best expressed important themes, as well as stakeholder values and wishes. The material was compiled into the first draft according to an outline approved by the Professional Development Committee, and revised collectively in a series of e-mails and Guidelines Task Force meetings, using a Delphi technique (Dunham, 1998; Green and Dye, 2002; Hsu and Sandford, 2007).

3.8.4 Internal and External Review and Revision

- **Internal Review**

In 2010, drafts were circulated to the MDPAC Board and to MDPAC members who had agreed to be internal reviewers (Appendix 1), asking what they liked, did not like, and what changes they would suggest. Although the MDPAC has a preponderance of Ontario members, and so the Guidelines Task Force used internal reviewers and references that were most pertinent in that context, members from outside Ontario were also sought as internal reviewers, in order to include any references that they thought were more relevant to their provinces. The internal reviewers represented the two main target user groups of physicians providing psychotherapy either full time, or in dual practice. (Section 3.5) The Guidelines Task Force members also solicited face-to-face input from MDPAC members and Board reviewers at the MDPAC 2006 and 2008 Annual Conferences.

The Guidelines Task Force met and collectively discussed the suggestions for revisions from the internal reviewers. If consensus was reached, the revisions were made, or, if not, the areas of disagreement were noted and the various viewpoints reported within the document.

In 2017, the GTF-approved guidelines were circulated for review and approval by the MDPAC Professional Development Committee and then the MDPAC Board.

- **External Review**

After Board approval, in 2010, the internally reviewed and revised draft was sent to Board-chosen external reviewers (Appendix 1), along with a brief biographical survey and conflict of interest declaration (Appendix 2), and a brief questionnaire (Appendix 3).

The Board chose external expert and stakeholder reviewers to represent a spectrum of views from a list of potential reviewers provided by the Guidelines Task Force, recognizing various sources of potential bias (Detsky, 2006). The Guidelines Advisory Committee reviewed the draft guidelines and provided feedback and comments to help improve the quality of the guidelines and its presentation. By consenting to comment on guidelines in draft form, the GAC did not commit itself to either endorsing the guideline or considering it for endorsement once the guidelines were prepared in final form. Such consideration would take place only in the context of a full GAC review of evidence in the clinical topic area (or now, perhaps by the Centre for Effective Practice, as the GAC joined that organization in 2010), and only in comparison to all other guidelines identified in the literature search.

Responses were collated and suggested changes inserted into the document by the Guidelines Task Force, then sent to the MDPAC PDC, and, upon consensus, sent on to the MDPAC Board in 2010 and 2017 for approval prior to dissemination.

3.8.5 Dissemination and Application of the Guidelines

Research evidence about the adoption of clinical practice guidelines indicates that multiple types of intervention are most effective (Davis and Taylor-Vaisey, 1997).

The PDC Guidelines Task Force thus discussed and implemented several methods to enhance uptake and utilization:

- Inclusion of self-reflective questions (SRQ's) at key points during the guidelines document and a summary (Appendix 5), which can be distributed during GPPA training modules (Pilot testing of draft SRQ's was undertaken during two training modules and attendees' input sought).
- Posting the final document on the MDPAC website, and sending it to, or linking it with, other organizations on request.
- Publishing segments in the MDPAC newsletter for members.
- Having documents available for review by participants at annual MDPAC conferences.
- Making a role-playing video of what NOT to do, and presenting it at the 2011 MDPAC Annual Conference.

Other ideas in 2017:

- Collaboration with the College of Family Physicians of Canada on their Linking Learning to Practice Program, which offers MAINPRO-+ credits for applying accepted educational materials in practice.
- Partnering with the Ontario College of Family Physicians (OCFP) and the Ontario Medical Association (OMA) Sections on General and Family Practice and General Practice Psychotherapy to develop a fact sheet about psychotherapy which could be posted on the OCFP, OMA, and MDPAC websites. Non-psychiatrist physicians could download this tool to post in their offices or hand out to patients. Patients would also be able to access it online, and it could be sent to, or linked with other organizations on request. Such a fact sheet is consistent with recommendations for a Patients' Bill of Rights (CPSO, McPhedran et al, 2000).
- Incorporation of the Guidelines by the MDPAC Education Committee into the Core Curriculum by citing the document as pre-module reading.

3.8.6 Updating the Guidelines

The PDC and the Guidelines Task Force agreed that this should be "a living document" and should "be revised to meet the needs of consumers, to profit from the experience of practitioners, and to be informed by further empirical research" (Bohart et al, 1997: Coda).

To follow this principle, suggestions for revisions may be submitted at any time to the PDC by the MDPAC Board, the Guidelines Task force, MDPAC Committees, MDPAC members, or external stakeholders. The PDC itself may also suggest updates at any time. It was suggested an update was in order in 2016 by the MDPAC Board, some committees and members.

Upon receipt of a suggested update, the PDC will review the proposed revision and consult with the Guidelines Task Force before jointly sending it to the Board.

As recommended by the Guidelines Advisory Committee, and now perhaps the Centre for Effective Practice, if there is disagreement about proposed updates, further discussion and possibly consultation and/or literature review will ensue, until consensus is reached by the Guidelines Task Force, the PDC and the Board or if they continue to disagree, it will be noted in the document.

When the proposed revision is approved by the MDPAC Board of Directors, the MDPAC Administrator in the Central Office will secure the new document (by .pdf). Copies will be forwarded to the MDPAC Board of Directors, PDC Members, and Guidelines Task Force Members.

Guidelines

4.0 Fundamental Ethical Principles of Medicine

The PDC Task Force endorsed the Canadian Medical Association Code of Ethics as fundamental to the practice of safe, effective psychotherapy.

The Code states the following ethical responsibilities for physicians:

- *"Consider first the well-being of the patient.* The Guidelines Task Force believes this is *the* key principle, and that all the others follow.

- *Practice the profession of medicine in a manner that treats the patient with dignity and as a person worthy of respect.*
- *Provide for appropriate care for your patient, even when cure is no longer possible, including physical comfort and spiritual and psychosocial support.*
- *Consider the well-being of society in matters affecting health.*
- *Practice the art and science of medicine competently, with integrity and without impairment.*
- *Engage in lifelong learning to maintain and improve your professional knowledge, skills and attitudes.*
- *Resist any influence or interference that could undermine your professional integrity.*
- *Contribute to the development of the medical profession, whether through clinical practice, research, teaching, administration or advocating on behalf of the profession or the public.*
- *Refuse to participate in or support practices that violate basic human rights.*
- *Promote and maintain your own health and well-being."*
  (CMA Code of Ethics Update, 2004:1-2)

Since the time of Hippocrates (born circa 460 BC), physicians have followed ethical principles in their practice of medicine (Hippocratic Oath, translated from the Greek by Edelstein, 1943). For 155 years, the American Medical Association Code of Medical Ethics has offered similar guidance for physicians on a wide range of patient-physician issues (AMA, 2004-2005, latest update, 2015). In 1949, the World Medical Association approved a similar International Code of Medical Ethics. Freitas (2001-2002) compiled a multitude of other similar ethical codes. Most recently, the College of Physicians and Surgeons of Ontario has developed The Practice Guide: Medical Professionalism and College Policies, defined as *"the translation of the values of the profession- compassion, service, altruism and trustworthiness- into action"* (CPSO, Sept., 2007; revised online, 2008).

While it is recognized that the vast majority of physicians practising psychotherapy do practise in an ethical and competent manner, the Guidelines Task Force wishes to spotlight potential pitfalls for us all, and their prevention, in the following sections on professional competence and conduct in the practice of psychotherapy.

Recommendation I: ***Medical Ethics***

"Consider first the well-being of the patient".

Details are included in the Canadian Medical Association Code of Ethics (CMA Update 2004:1-2).

The evidence for this recommendation is A-III (Table 1, p. 15). This code has been accepted by all the Canadian provincial medical associations and regulatory colleges. The GAC level of evidence is: Consensus (Table 2, p. 16). (Hippocratic Oath, Edelstein, 1943; World Medical Association, 1949; Freitas, 2001-2002; American Medical Association, 2004-2005, latest version 2015)

5.0 Professional Competence in the Practice of Psychotherapy by Physicians

In order to interpret literature review findings and collective clinical experience in the most useful way for physicians, Guidelines Task Force members participated in active discussion with each other, and consulted with experienced internal (MDPAC) and external reviewers/contributors. During the discussions on competence, the analogy of surgery to psychotherapy was introduced, and the Guidelines Task Force wishes to share some of the insights.

"Both surgeons and physicians providing psychotherapy are 'opening' people and need to use exceptional hygiene. One has to know oneself as an instrument- the foundation of this is supervision and one's own therapy" (Dr. Larry Nusbaum, MDPAC GTF minutes, November 13, 2003).

"In the circumstances where surgery is technically less complicated it is safely and effectively provided within an office setting- typically referred to as 'office procedures' or 'minor surgery' and is provided by any physician trained in the techniques. In the circumstances where surgery is technically more complicated it is more safely provided within an OR and provided by a physician trained to this level of technique, typically referred to as 'major surgery'"(Dr. Peggy Wilkins, electronic communication to Drs. David Cree, Lynn Marshall, Michael Pare, and Roy Salole, January 24, 2004).

However, a major difference was noted between surgery and psychotherapy:

"…in surgery- at least once the cutting has begun- the physician has all the power. In therapy both the patient and the therapist share power. It is a complex situation with the therapist having more control and power over the frame of therapy (i.e. when, how, who) while the patient has more control and power over the content and direction of therapy (i.e. the material discussed)" (Pare, 2005).

The Guidelines Task Force acknowledged the important general maxims regarding professional competence in the CMA Code of Ethics, but recognized that there would need to be ongoing efforts to aid target users of this document to attain and maintain competence in specific key elements of medical psychotherapy (Barr, 2004-5; CMA, 2004; Salole et al, 2004; Deadman and Goodman et al, 2003; Margison and McGrath, 2000; Mahoney, 1998; CPSO, 1991).

Health is influenced by multiple determinants. The Public Health Agency of Canada (1999) lists the following factors as key:

- Income and social Status
- Social Support Networks
- Education and Literacy
- Employment/Working conditions
- Social Environments
- Physical Environments
- Personal Health Practices and Coping Skills
- Healthy Child Development
- Biology and Genetic Endowment
- Health Services
- Gender
- Culture

The weight of each factor, and how the different determinants interact in determining the health of individual patients varies enormously. Broadly speaking, biological, psychological, and social contributors often overlap, and can be predisposing, precipitating or perpetuating (McDowell and Newell, 1987; Moriarty and Chanko, 1988; Stewart et al, 1995, xix). Patients present to their primary care physicians for preventive health care or with undifferentiated problems. The physician's role is to establish a therapeutic alliance with each patient that will permit further exploration and understanding of the relative weight of contributors to that patient's state of health, and what would help prevent onset or worsening (Moriarty and Chanko, 1988; Rosser, 1999).

While all licensed physicians are able to make multi-axial biological, psychological and social diagnoses, division into these categories is inherently reductionistic, and has been dropped from the American Psychiatric Association's Diagnostic and Statistical Manual of Mental disorders (DSM-V- May, 2013).

The diagnostic system DSM, developed by the American Psychiatric Association in 1952 listed 106 disorders, which was increased to 265 categories in DSM-III in 1980, defined by consensus about the clinical symptoms, and lacking objective laboratory measurements. The DSM IV (1994) is introduced with the following caution: *"Although this volume is titled the Diagnostic and Statistical Manual of Mental Disorders, the term mental disorder unfortunately implies a distinction between "mental" disorders and "physical" disorders that is a reductionistic anachronism of mind/body dualism. A compelling literature documents that there is much "physical" in "mental" disorders and much "mental" in "physical" disorders. The problem raised by the term "mental" disorders has been much clearer than its solution, and, unfortunately, the term persists in the title of DSM because we have not found an appropriate substitute."*(xxi)

Since 1994, much debate was had by international mental health colleagues about the limitations of DSM-IV, in addition to more literature reviews and data analyses, in attempts to develop DSM-V. The focus was on aligning DSM-V with the International Classification of Diseases-11, which "*speaks to the importance of creating a unified text that embraces cross-cutting issues of diagnostics, such as developmental, age-related and cultural phenomena"* (Kupfer DJ et al, Nov. 2008, *On the road to DSM-V and ICD-11).*

Physicians need to consider first the well-being of each patient, and decide whether or not it may be beneficial for that individual for the doctor to specify diagnoses using DSM. On the one hand, its use can enable more precise communication that facilitates collaboration with a psychiatrist or other mental health colleagues in the care of patients, particularly those with severe and/or complex disorders (Buckley MH, 2016). On the other hand, as Evans and Frank (1997) pointed out, *"as a classification system, [it] does not properly describe many of the phenomena seen in primary mental health care".*

Furthermore, some MDPAC members and other physicians fear that labeling patients' complex conditions according to a specialist psychiatric classification system could do harm. There is well-known stigma associated with having psychiatric diagnoses (Ben-Zeev D et al, 2010; Manitoba Schizophrenia Society, 2007), including attribution of responsibility and blame to the patient (Miresco at al, 2006). Telephone and online surveys of Canadians in 2005 revealed substantial reluctance to revealing that a family member had been diagnosed with a "mental illness", and with associating socially or in business with someone who had been so diagnosed. In the same surveys, considerable variation in views was noted about classifying different conditions as "serious mental illness, a mental illness, or not a mental illness" (Canadian Medical Association, August 2008).

The following are the first self-reflective questions, or SRQ's, which are included throughout this document and are summarized in Appendix 5. It is hoped that they will be thought-provoking and enhance learning.

Self Reflective Questions (SRQs)- Standard Skills
Do I have sufficient knowledge and skill to offer therapy to patients of particular ages, gender, culture, ethnicity, socioeconomic status, diagnoses?
If not, how can I improve my knowledge and skill in the area(s) I think need improvement or should I limit my practice to avoid the(se) area(s) and inform potential patients and referring physicians?

5.1 Training- Undergraduate and Residency

In a MDPAC position paper, "Recommendations for training in medical psychotherapy for non-psychiatrist physicians" (Salole et al, 2004, Appendix 4) specific recommendations were made under five headings:

1. Psychotherapy training in undergraduate medical training.
2. Psychotherapy training in family practice residency programs.
3. Advanced training in psychotherapy for non-psychiatrist physicians (GP special interest practice).
4. Training program formats.
5. Maintenance of competence.

Recommendations were made that physicians undergo undergraduate medical training in communication skills, personal development of empathy and compassion, and the ethical duties of the doctor-patient relationship. By the end of basic medical training, physicians should be able to integrate the biological, psychological, and social dimensions of illness in providing patient care.

Sufficient training should continue in Family Medicine and other residency programs to enable physicians to address the high demand for service by incorporating brief and intermittent psychotherapeutic interventions.

5.2 Training- Post-graduate

MDPAC recognizes the importance of the following for its members with respect to competence in medical psychotherapy:

5.2.1 Foundational Skills
5.2.2 Graduated Education Requirements for Members
5.2.3 Supervision and Consultation
5.2.4 Collegial Support
5.2.5 Self Care and Personal Growth Work

5.2.1 Foundational Skills

Between 2001 and 2009, GPPA offered to members a basic skills training curriculum to consolidate physician learning in providing psychotherapy, consisting of seven weekend modules, each accredited for approximately 12 College of Family Physician of Canada MAINPRO-M1 (25 MAINPRO-C) credits, as well as 12 MDPAC Continuing Professional Development credits, and requiring 7 hours of individual supervision. (Barr et al, 2001- latest update, 2009). At the date of this update in 2017, MDPAC is developing an updated Foundational Skills course. Since this new course is in an early developmental stage, we list here basic skills in which we consider members need to be competent. These skills were interwoven throughout the modules of the original curriculum (Barr, 2016).

The key modules covered in this curriculum, which may be updated in the near future, include:

Initial Assessment

- Therapy Preparation- the indications and contraindications for individual, couple and family therapy
- Knowledge and practice in obtaining informed consent
- Doing a comprehensive assessment
- Records and note-keeping (in keeping with CPSO requirements)

Therapeutic Alliance

- Appreciation of the importance of, and a skillset in development of a therapeutic alliance with patients
- Self knowledge and basic communication skills
- Knowledge of attachment theory
- Conclusion of therapy issues and terminating treatment effectively

Ethics and Well-being of the Therapist

- Knowledge and practice in medical ethics
- Importance of psychological health and well-being (self-care) of the therapist

Case Formulation

- Construction of formulations leading to individualized treatment
- Identifying dysfunctional patterns
- Identifying and dealing with potential for violence against others or self

Treatment Planning

- Strategies for changing patterns and development of specific intervention skills
- Basic tenets of common psychotherapeutic models: Supportive; Mindfulness; Psychodynamic; Cognitive-Behavioural; Interpersonal; Group; Family & Marital; Humanistic/Experiential; Transtheoretical (Change Theory)
- Basic approaches to common problems such as Anxiety, Depression, Addictions, Eating Disorders, Obsessive-compulsive Disorders, Borderline Personality disorder, Post Traumatic Stress Disorder

Transference, Counter-transference and Personal Values of the Therapist

- Managing the therapist's own feelings-counter-transference
- The concepts of boundaries
- Personal values of the therapist and cultural bias
- Supervision and case consultation

Mind-Body Therapies

- Techniques in communication and reflective listening
- Relaxation and Stress Reduction Techniques
- Tips and pearls: basic strategies of psychotherapy for family doctors

Pharmacotherapy and Psychotherapy*

- Most responsible physician

*A note regarding education in the role of pharmacotherapy and psychotherapy
While the focus in the MDPAC Core Curriculum and in these guidelines is on psychotherapy, MDPAC Members are encouraged in the Initial Assessment and Record-keeping module to maintain a working knowledge of psychopharmacology, including the indications and doses for psychotherapeutic agents. As in the Guidelines Advisory Committee's summary (2002) of recommended guidelines on psychological therapy (Bateman et al, 2001), pharmacological treatments are beyond the scope of these guidelines. However, the Guidelines Task Force does not wish to imply that psychotherapy alone is necessarily better than medication alone, or the combination. Each patient needs to be assessed carefully to determine the therapies that are most likely to provide the greatest benefit and the least risk. If psychotherapy and pharmacotherapy are used concurrently, and more than one physician is involved in a patient's care, it needs to be discussed explicitly, and agreed by physicians and patient, which physician will provide and monitor which therapy. If the patient consents, it may also be very beneficial when there is additional collaboration and communication between physicians concerning the patient's care.

5.2.2 Graduated Education Requirements for Members

MDPAC has developed and implemented a system of graduated criteria for membership status that requires members to have obtained basic education in provision of psychotherapy for each membership category.

MDPAC has also set its own criteria, with appropriate verification, requiring members to earn Continuing Professional Development (CPD) credits on an ongoing basis to maintain their membership category.

Members must take part in educational activities to maintain their proficiency in provision of psychotherapy:

- Group learning activities such as conferences, participation in MDPAC or other psychotherapy-related seminars, workshops, or courses; teaching and preparation for teaching in educational activities.
- Self learning activities such as using books, audio/video tapes, CD-ROM, Internet, MDPAC Listserv.
- Table 3, p. 31, updated 2017, with the PDC/GTF and Membership Committee. (original cited by Marshall et al, 2001, updated June, 2006).

MDPAC's Certificant Review Subcommittee has been compiling a list of training institutes from applicants for MDPAC certificant status, obtaining information on the institutes, and maintaining a file of those that offer appropriate training opportunities for members and prospective members.

MDPAC has also encouraged and collaborated with the University of Toronto Departments of Family and Community Medicine and Psychiatry in provision of alternative, equivalent training modules (Borins, 2004; Ennis and Pare, 2004-5), and informs about other psychotherapy programs of interest on the MDPAC website at www.gppaonline.ca.

MDPAC has sought and attained accreditation for all its seminars, courses and conferences from the College of Family Physicians of Canada through the Mainpro + system (formerly MAINPRO-M1 and MAINPRO-C credits).

The PDC Accreditation Subcommittee reviews applications from other organizations in order to grant MDPAC CE or CCI (Continuing Collegial Interaction) credits for their educational events.

Self Reflective Question (SRQ)- Graduated Education
How am I continually improving my competence in psychotherapy?

Table 3

CREDENTIALS AND MAINTENANCE OF COMPETENCE

Category	**1. Clinical Member**	**2. Clinical CPSO/CPD**	**Certificant Member (MDPAC(C)** **One-time application fee**	**1.Mentor Member** **2.Mentor Emeritus (MDPAC(M))** **One-time application fee**
Graduate Criteria	MD	MD	MD	MD
Post-grad Training	.Medical school training in psychotherapy (PT)	Medical school training in psychotherapy (PT)	Qualified Clinical Member with 90 hrs minimum MDPAC-approved PT training (including specified topics), or 1000 hr paid professional work in scheduled focused PT	Qualified Certificant who has formal comprehensive PT training in at least 1 recognized discipline; or 8,000 hrs paid clinical PT with submission of individual training history; and supervisory training (MDPAC- approved)
Psychotherapy Practice Experience		Clinical CPSO-CPD Member practices a minimum of 51% psychotherapy, Mental Health, and/or Addictions	200 hrs minimum	2000 hrs minimum
Supervision, Individual or Peer Group Collegial Interaction (CI)			100 hrs supervision, individual or peer group CI	100 hrs individual supervision with at least two independent supervisors
Personal Growth Work/Psychotherapy			50 hrs individual or group personal growth work	50 hrs personal psychotherapy
MOCOMP – CE	.PT related CE -12 hrs/yr or 36 hrs q 3 yrs minimum	Clinical CPSO-CPD Member-25 hrs/yr or 75 hrs/3 yrs min.	PT related CE - 25 hrs/yr minimum or 75 hrs/3 yrs	PT related CE - 25 hrs/yr minimum or 75 hrs/3 yrs
MOCOMP- CI Ongoing Supervision or Collegial Interaction	12 hrs/yr individual or group (any combination of supervision and other focused peer interaction) or 36 hrs/3 yrs	Clinical CPSO-CPD Member-25 hrs/yr or 75 hrs/3 yrs min.	25 hrs/yr individual or group CI or 75 hrs/3 yrs	25 hrs/yr individual or group or 75 hrs/3yrs
Reporting	Clinical - report 12 hrs (any combination CE/CCI) each year	Clinical CPSO-CDP-report 25 hrs (any combination CE/CCI) each year	Report 25 hrs (any combination CE/CCI) each year	1.,2.Report 25 hrs (any combination CE/CCI) each year
References			One from a colleague familiar with applicant's PT work	2: One from a colleague familiar with applicant's PT work + one from a recent supervisor
Exams	LMCC	LMCC	LMCC + short essay about why you chose to practice psychotherapy	LMCC + successful completion of MDPAC-approved supervisory training + essay + possible interview
Ethics	CMA Code	CMA Code	CMA Code	CMA Code

Recommendation II: *Training*

Educational/competence guidelines include undergraduate training in communication skills, personal development of empathy and compassion, and the ethical duties of the doctor-patient relationship, to be incorporated throughout training rotations. By the end of basic medical training, physicians should be able to integrate the various contributors to illness, including biological, psychological, social, and other dimensions, and use them to formulate patient care. Sufficient training should continue in Family Medicine residency programs to enable primary care physicians to address the high demand for service by incorporating brief and intermittent psychotherapeutic interventions. Advanced training in psychotherapy for non-psychiatrist physicians should include a core curriculum, supervision, and collegial support, as well as self-awareness and self-care strategies. Details are outlined in *"Recommendations for Training in Medical Psychotherapy for Non-psychiatric Physicians"* (Salole et al, 2004) (Appendix 1) (endorsed by the GPPA Board, the Ontario Medical Association General Practice Psychotherapy Section, and the Ontario College of Family Physicians). (Section 5.1) The training for psychiatrists recommends the same basics (Cameron et al, 1998:348-370).

The levels of evidence for the recommendations in Salole et al's extensively researched document included A-I, A-III, and B-III (see Table 1, p. 15). The GAC levels of evidence included Excellent/Good Evidence to Recommend, Fair Evidence to Recommend, and Consensus (see Table 2, p. 16).

5.2.3 Supervision

MDPAC strongly encourages supervision, whether one-on-one or in a group of peers, for all its members and other physicians who practice psychotherapy on a regular, ongoing basis. The consensus of the MDPAC Board of Directors and the Guidelines Task Force is that regular supervision is key to the provision of effective, safe, continually improving psychotherapy (Salole et al, 2004; Marshall et al, June 2006; Feb. 2017). Working Group 2 of the Canadian Psychiatric Association Psychotherapies Steering Committee stated that *"Consultation with colleagues when one's judgment is felt to be impaired is imperative."* Circumstances noted that could impair the therapist's judgment included illness, pain, substance abuse, personal preoccupation, or strong personal subjective reactions (counter-transference) (Mackenzie et al, 1999).

The MDPAC developed and implemented a Supervisor's Training Course for members who are qualified Mentors. An initial prototype course was successfully completed and well received by MDPAC Mentors who attended. Subsequently, a comprehensive Supervisor's Training Course was designed by experienced senior GPPA member Mentor Supervisors and other expert Supervisors, utilizing evidence from the medical literature (GPPA, 2003).

While there are considerable papers on supervisor training and supervision efficacy (summarized and annotated by Duer, 2003), the research methodology has been strongly criticized (Ellis et al, 1996; Holloway, 1995). Thus Green and Dye (2002) conducted a Delphi survey to benefit from the first-hand professional experience of an expert panel in structuring supervisor training, which has been described as *"a new frontier"* (Murrihy and Byrne, 2005).

Some options for accessing supervision include consulting the MDPAC website (www.gppaonline.ca) for names of available trained individual or group supervisors, or contacting the Collaborative Mental Health Care Network of the Ontario College of Family Physicians (www.ocfp.on.ca), which provides group supervision and individual mentoring by teleconference, utilizing a psychiatrist and general practice psychotherapist as supervisors.

SRQ- Supervision

Do I have (a) skilled supervisor(s) I consult with regularly and can contact for advice whenever I am unsure of my ability to work with (a) particular patient(s)?

Recommendation III: *Seeking Supervision*

Competence includes the ability to recognize one's limitations to assess/treat, and to deal with counter-transference issues, and to seek supervision on a regular basis. It is particularly important that a member, upon recognizing therapeutic impasses, transference/counter-transference difficulties, or puzzlement and/or discomfort on self-reflection, should seek appropriate mentoring/supervision from a colleague or refer the patient. Suggestions made with regard to the patient's therapy and any notes re physician learning or dealing with counter-transference should be kept in the therapist's own private notebook. (Section 5.2.3).

The levels of available evidence for this recommendation range from I - III. The GAC level of evidence is Consensus. (Murrihy and Byrne, 2005; CMA, 2004; Salole et al, 2004:9; Rockman et al, 2004; Marshall et al, 2003: Table 1; Duer, 2003; Green and Dye, 2002; Ellis et al, 1996; Salole et al, 1996:25; Holloway and Neufeldt, 1995).

5.2.4 Collegial Support

Role modeling of how to develop therapeutic relationships and how to maintain boundaries is key in medical education, and may be facilitated by opportunities for interaction with professional colleagues.

In addition, the College of Physicians and Surgeons of Ontario has acknowledged:

"The practice of medicine is challenging. Physicians are expected by the profession and the public to meet high standards for excellence in the care they provide to patients. In addition, physicians often face competing demands- from patients, other health care professionals, the health care system, and from the expectations the physician holds for him or herself. These factors can give rise to stress, fatigue, exhaustion and frustration, which can have an impact on both the physician personally and the care the physician is able to provide to his or her patients.

Physicians as a group, should provide mentorship, support and care to one another, in order to ensure their patients receive quality care, as well as to maintain their own personal wellness" (CPSO, July 2007: 16).

The MDPAC has encouraged collegial support for its members by offering Continuing Collegial Interaction (CCI) credits for qualifying activities, such as participation in MDPAC or other psychotherapy-related committee meetings, in mentoring/Balint groups, and/or in discussions on the MDPAC Listserv. Other CCI-qualifying activities are case supervision, discussion of a case or disorder with a fellow health professional, and working as an examiner in psychotherapy. One hour per day of the annual MDPAC conference is CCI-credited to encourage discussion with other professionals.

Besides mutual support within the organization, MDPAC members also participate in other programs such as the **Collaborative Mental Health Network**, an ongoing Mentorship Program sponsored by the Ontario College of Family Physicians, where family physicians may request advice, either individually or in small groups, from assigned co-mentors (a psychiatrist and a non-psychiatrist physician who practices psychotherapy) (Rockman et al, 2004).

SRQ- Collegial Support
Do I have sufficient collegial contacts to help me maintain perspective on my practice of psychotherapy?

5.2.5 Self Care and Personal Growth Work

The CMA Code of Ethics (CMA, 2004) includes a section entitled *"Responsibilities to Oneself"*. In this section, the expectation is specified that physicians seek help from colleagues and appropriately qualified professionals for personal problems that might adversely affect service to patients, society, or the profession.

It is recognized that, in psychotherapy provided by physicians, as in other areas of medicine, physician well-being is key to the provision of competent, ethical care (CPSO, July 2007:17) and this is endorsed by the Guidelines Task Force.

Supervisory consultation is regarded as critical in situations where the physician may be personally undergoing life circumstances that may impact the doctor-patient relationship and complicate or confound variables in the psychotherapeutic relationship (Marshall et al, June 2006:2; MacKenzie et al, 1999:85).

There is an obligation to protect and enhance one's own health and well-being by identifying those stress factors in one's personal and professional lives that can be managed by developing and practising appropriate coping strategies. (CMA, 2004; CPSO, July 2007: 17). On the other hand, one needs to be aware of maladaptive coping strategies such as substance misuse. Physicians should avoid self-treatment and establish a patient-physician relationship with another physician for their own clinical care (CPSO, July 2007: 17).

Nicely (2004) reviewed the research related to therapist self-care. Several surveys of psychotherapists (Norcross, 2000; Kramen-Kahn and Hansen, 1998; Mahoney, 1997) revealed unique hazards of the profession such as suicidal threats, difficulty evaluating patients' progress, constant giving and caring. There were also concerns expressed about excessive workload, record keeping demands, and economic uncertainty.

Carroll et al (1999) suggested that key components of self-care included intrapersonal work to increase self-awareness, professional development, physical and recreational activities and interpersonal support.

The CPSO and University of Western Ontario *Understanding Boundaries* Course (April 8-9, 2005) supplied participants with a self-reflective questionnaire on their personal renewal resources. The questions included the following resources: professional (work) supports, family supports, mentors, non-work social supports, and private pursuits or alone-time supports and activities.

Surveys of large samples of psychotherapists by Mahoney (1997) and Kramen-Kahn and Hansen (1998) revealed that a wide variety of self-care activities were employed by these professionals.

The MDPAC recognized the importance of personal growth work in enhancing knowledge of transference and counter-transference in physician psychotherapy, which is highly important in preventing boundary crossings. The MDPAC thus made it a requirement for Certificant and Mentor membership status.

The MDPAC has indicated that:
"Personal Growth Work concerns activities that promote greater self-awareness and understanding of our own psychological make up and issues, as well as how these issues manifest in our lives, both personal and professional. We do this for our own self-awareness, self care and the hope that this will make us more skillful and conscious therapists. Typically, this takes the form of personal therapy, which we strongly encourage, and/or courses that include an experiential element" (MDPAC Certificant Application, 2004-6).

SRQs- Self-care and Personal Growth
Am I balancing my personal and professional life and actively pursuing my preferred ways of renewal in my personal life?
Do I know enough about myself to recognize the characteristics of patients, diagnoses, and/or histories that may elicit counterproductive thoughts and feelings about patients (counter-transference) in me?

Recommendation IV: ***Self-care and Personal Growth***

To be proficient and comfortable in the role of provision of psychotherapy, and to help prevent the possibility of verbal, emotional, physical, or sexual abuse of patients, physicians should become self-aware and explore family of origin issues with personal growth work and/or personal psychotherapy. This may include seeking support from colleagues and appropriate qualified professionals in relevant disciplines for personal problems that might adversely affect service to the patient, society, or the profession. Physicians should develop clear communication and limit-setting skills with patients. It is also important for physicians to become aware of their own needs for companionship, security and physical contact, and to regularly seek their preferred forms of renewal within their personal lives. (Sections 5.2.4 and 5.2.5)

The level of evidence for this recommendation is B-II. GAC level of evidence is Fair Evidence to Recommend. (CMA, 2004; Nicely, 2004; Norcross, 2000; Carroll et al, 1999; Kramen-Kahn and Hansen, 1998; Mahoney, 1997)

5.3 Therapeutic Modalities

Symptom severity and outcomes of psychotherapeutic treatment are linked to the severity of childhood trauma (Schilling et al, 2015). In addition, they are dependent on "enabling resources" to access psychotherapy, such as education, household income, employment status and rural vs urban geographical location as well as having chronic physical conditions (Sunderland A., and Findlay L.C, Nov., 2015). Also, persons with or without the presence of depression, bipolar disorder, generalized anxiety disorder, or alcohol and/or cannabis and/or other substance abuse may or may not seek psychotherapeutic care (Ibid).

Nevertheless, in spite of this complexity, studies have begun to assess the efficacy of certain types of psychotherapeutic modalities for specific types of problems to guide treatment choice. However, the complicatedness and high cost of the research have led to a paucity of evidence, which was discussed in Section 3.1.

The available studies are briefly summarized here, and they have mixed results. They are predominantly about cognitive behaioural therapy (CBT) because it is highly structured or manualized, and so most consistently applied in research (NHS, 15 July, 2016). Also, CBT can be provided individually or in groups with a therapist, with a manual, or online (Ibid).

CBT for treatment-resistant depression, compared with pharmacotherapy (Hollinghurst S. et al, Jan.2014), or compared with usual care (Button K.S. et al, Mar. 15, 2015) had no effect. Computerized CBT was ineffective for primary care depression (Gilbody S. et al, 2015), but repeated telephone CBT with a therapist (Simon G.E., et al, Oct. 2009) was effective for depression. The severity of alcohol abuse was associated with decreased response to CBT as an adjunct to pharmacotherapy for treatment-resistant depression, but not mild or moderate alcohol use (Wolitzky-Taylor K. et al, Mar. 2015). CBT for osteoarthritis pain compared with education in older adults and combined CBT for sleep and pain made no difference over six weeks, but the combined CBT may make a difference over 18 months (McCurry S.M. et al, Feb., 2014). Internet-delivered CBT for 7-10 sessions, guided by online therapists, for anxiety disorders, individualized to comorbidities and patient preferences, was found effective right after therapy and at one year follow-up (Nordgren L.B. et al, Aug. 2014). In addition, computerized CBT delivered by trained primary care staff led to a reduction of anxiety (Rose R.D. et al, Jul-Aug. 2011). Internet-based self-help played a role in patients with positive expectations for effects on their social anxiety, and, assessing patient expectations early on may lead to earlier step-up for the treatment program (Boettcher J. et al, 2013).

Interpersonal psychotherapy (IPT) was trialed in medically ill patients in three sessions- evaluation, support, and triage, and it allowed primary care physicians to explore psychosocial factors for depressive symptoms, and facilitated more effective treatment planning (Weissman M. and Verdeli H., Mar-Apr 2012). Brief IPT was also tried vs usual care in patients with multisomatoform disorders, and led to improved physical quality of life (Sattel H. et al, Jan. 2012). A comparison between IPT and pharmacotherapy (with selective serotonin re-uptake inhibitors- SSRIs) in treatment of primary care depression in nine centres in Italy revealed 58.7% of patients achieved remission at two months with IPT vs 45.1% with SSRIs. IPT responses were modified by depression severity, functional impairment, anxiety, previous depressive episodes, and smoking cigarettes (Menchetti M. et al, Feb. 2014). IPT was tried in older adults with depression in the United States, and it was noted that African-Americans with minor depression used IPT less (Joo J.H. et al, Jan.2010).

Two studies of primary care screening and brief psychotherapy to prevent onset of depression were successful- in a modelling study of adults, estimated cost effectiveness was 80% (van den Berg M. et al, 2011), and in a literature review of five randomized controlled trials, psychotherapy was "*a safe and cost-effective method to reduce the public health burden of depression among older adults with subthreshold depression"* (Lee S.Y. et al, Nov.-Dec. 2012). Also, perceived social support mediates both depression and anxiety, more so for depression in primary care (Dour H.J. et al, May 2014), although in a working population, it was ineffective in reducing sick leave (Ejeby K. et al, Jun. 2014). Psychotherapy process was studied in a systematic review of treatment of eating disorders, and family therapy, as opposed to group therapy, and booster sessions were found to be more effective (Brauhardt A. et al, Sep.2014). It was discovered in a study of 2,114 primary care physicians that their prescription of psychotherapy rather than antidepressant for mild-to-moderate depression was related to their thinking that antidepressants were over-prescribed, having had a personal history of psychotherapy, and being female, rather than education (Verdoux H. et al, January 2014).

Lastly, but importantly, a maternal-child (aged 0-3 years) psychotherapy service was established in South Africa for 179 infants, mostly referred because of concern about decreasing weight. 72%of mothers were exposed to more than four stress factors, and 75% of them were compliant with psychotherapy. 78% showed improvement in the relationship between mother and child, and 76% of the infants improved functioning (Berg A. Jun. 2012).

The Guidelines Task Force agreed that "black and white" consensus on specific psychotherapeutic techniques and methods for specific problems was not achievable because several effective options were usually available depending on the individual client and physician. (Bohart et al, 1997, Wampold, 2001).

Psychotherapies are *"discovery-oriented, holistic and relational"* … and *"the issue is ultimately one of freedom of choice for consumers, who must be allowed to choose the psychotherapy modality which best fits their needs, rather than have that choice made for them by a particular group of professionals"* (Bohart et al, 1997).

Wampold (2001) agrees that flexibility is required. Nevertheless, when credible research evidence is available that fits a particular clinical situation, it can offer a useful "roadmap" for physicians to offer to patients (Farquhar, 1997). If the therapist is adequately trained in the chosen modality, he or she can provide it, or, if not, can refer to a qualified colleague (Freebury et al in Cameron et al, 1998).

As knowledge of neuroplasticity continues to develop, more treatment options are likely to become available (Doidge N., 2007, 2015).

Recommendation V: ***Treatment Modality Choice***

Recognize that often more than one method of treatment is desirable and/or appropriate according to the particular clinical situation, and that flexibility is required. Where applicable to, and agreeable with individual patients, follow the Guidelines Advisory Committee-approved, evidence-based practice guideline for psychotherapeutic modalities (Bateman et al, 2001, reviewed by Pare and Gilbert, 2002), or other evidence-informed modalities for which the physician has adequate training, or refer to a qualified colleague. (Section 5.3)

The levels of evidence for these GAC-approved psychotherapy recommendations (2002) were wide-ranging, including A-I, B-II, C-III, and E-II (Bateman et al, 2001). GAC levels of evidence ranged through all their categories (Table 1 in Section 3.7, p. 18).

6.0 Professional Conduct in the Practice of Psychotherapy by Physicians: Understanding Boundaries

At the centre of psychotherapeutic practice by physicians is the relationship between the physician and the patient. As in all doctor-patient relationships, the doctor is obligated to conduct him/herself in an ethical manner. The Canadian Medical Association's Code of Ethics (CMA, 2004, Section 4.3) provides general guidelines for physician behaviour.

While it is generally expected that graduates of medical schools are familiar with the Code of Ethics and practice ethically, it is further expected that physicians practicing psychotherapy have theoretical and experiential training in forming a therapeutic alliance, creating and maintaining professional boundaries, and transference and counter-transference issues in psychotherapy. While use of these concepts is perhaps best known in psychodynamic psychotherapy (Canadian Psychoanalytic Society, July 2002), they are critical to medical psychotherapy no matter what theoretical model is used.

The maintenance of boundaries in the doctor/patient relationship is an important concept to help professionals navigate the complex and sometimes difficult experience between patient and doctor, where intimacy and power must be tilted in the direction of benefiting patients (Nadelson C. and Notman M., 2002).

Self-awareness, self care, the use of supervision, continuing medical education and collegial interaction are important ways that the physician who provides psychotherapy furthers understanding and knowledge of these issues and maintains safe and effective practice.

In addition, empowerment of patients through education about their rights in therapy adds another safeguard (Beamish et al, 1998; Ainsworth, 2005).

The Guidelines Task Force believes the conduct issues in the following sections (6.1-6.7) that relate to therapeutic alliance and boundaries are key.

The Guidelines Task Force found the Participants' Handbook (April 8-9, 2005) from the CPSO and University of Western Ontario Faculty of Medicine and Dentistry's *Understanding Boundaries* course very helpful in developing the Professional Conduct Sections. These courses continue to be offered annually.

6.1 Transference/Counter-transference

Freud's definition of transference has been summarized by Doidge and Freebury (1998):

"Transference is a universal unconscious tendency to transfer scenes from the past onto the present, often in the hopes of re-experiencing scenes or people from the past or in the hope of gaining satisfaction where one had formerly failed." (Freud, 1910/1957)

Counter-transference is the therapist's unconscious thoughts and feelings that are evoked in response to the patient, including thoughts and feelings in response to the patient's transference. Counter-transference reflects the therapist's past personal and professional experiences.

While transference and counter-transference occur in every medical relationship, they tend to be magnified by the intensity and intimacy of the psychotherapeutic relationship. It is important that the physician be aware of the potential impacts as trust develops between patient and doctor in the psychotherapeutic process. For instance, increased trust may allow for greater closeness and sharing, which are beneficial, but also could lead to a tendency to relax some boundaries, requiring astute awareness and monitoring for transference/counter-transference issues by the physician. While the transference and counter-transference may be explicitly identified and worked with in psychodynamic and psychoanalytic psychotherapy, they are implicit in every psychotherapy relationship.

The creation and maintenance of an effective treatment relationship, including the framing and maintenance of boundaries, depends on the physician's ability to recognize and manage transference and counter-transference. Hence, the Guidelines Task Force believes that didactic and experiential training in identifying and managing transference and counter-transference are essential to the practice of safe effective psychotherapy.

It is expected that practitioners understand their own reactions to clients and that they develop and enhance self-awareness and understanding. This is typically done in personal therapy and/or in supervision with experienced, trained psychotherapy supervisors.

The recommendations regarding transference and counter-transference are subsumed in the Professional Competence Recommendation III: Seeking Supervision (Section 5.2.3) and Recommendation IV: Self-care and Personal Growth (Section 5.2.4).

SRQs- Transference/Counter-transference
What indicators are there about how this patient may be thinking and feeling about me?
What am I thinking and feeling about this patient and why?
Would I be doing this with/for any other patient?

6.1.1 Physician Self Disclosure and Advice Giving

Because of the potential vulnerability that psychotherapy patients have in relation to their physician therapists, it is imperative to realize the profound effect that a physician's self disclosure and advice can have on the patient.

Just as physicians are trained to understand the prudent use of medical and surgical interventions they should also be trained to realize the potential effects of their behaviour on their patients.

Like drugs and surgery, physicians' self disclosure and advice are powerful interventions that have indications, contraindications, potential side effects, and potential adverse effects. Dose and overdose are also relevant.

The goal of psychotherapy is to encourage the patient's self discoveries and insights. As therapy progresses, it is natural that the physician's personal issues are evoked. The physician may feel prone to share her/his experiences, emotions and or ideas. Before acting on such impulses, it is important to consider who is being served. An ethical physician considers how self disclosure or advice may help or have adverse effects on the patient. An ethical physician also considers if an impulse to self disclosure or advice-giving is an attempt to meet an unmet need of his or her own, and should turn to supervision or personal therapy if this is so.

Putting the patient's needs first is paramount. As with any appropriate intervention, an ethical physician's self disclosure or advice can be very helpful for the patient, but if the physician discloses too much about her or his life for the wrong reasons, it can hurt the patient and lead the physician down the slippery slope towards other forms of patient exploitation.

Before self-disclosing or giving advice, consider the following questions.

SRQs- Physician Self-disclosure and Advice-giving
Is my urge to give advice and/or self disclose in my patient's best interest?
Am I aware of how and when my advice or self disclosure could hurt my patient?
Is my urge to give advice and/or self disclose an attempt to meet an unmet need of my own, to address an unresolved issue in myself, to be heard, to be admired, to feel in control?
Do I have personal and professional supports in place to help me meet my needs so that I use the power of self-disclosure and advice-giving in a safe and effective manner?

6.2 Consent

The treatment relationship between the patient and the physician providing psychotherapy is founded upon trust and mutual agreement.

"The patient's decision to consent to, or refuse, treatment must be informed; that is, the patient must receive information about the nature of the proposed treatment, its expected benefits, the material risks, special risks or material side effects associated with it, alternative courses of action and likely consequences of not having the treatment. Material risks comprise both common risks and serious risks.

The information provided to the patient about such matters must be the information a reasonable person in the same circumstances would require in order to make a decision about the treatment. As well, the person must have received responses to his or her requests for additional information about those matters". (CPSO, May/June 2001:4; updated with approval of Council on May 28, 2015)

The physician providing psychotherapy also makes agreements pertaining to scheduling, fees, and other rules and obligations of treatment, such as obtaining regular supervision, having consent for a third party to be present during physical examinations, and the circumstances for mandatory reporting.

When the patient is a minor, these same general principles apply, but the patient's age and stage of development should guide how specific arrangements will be handled and with whom.

These agreements can be done over a number of sessions, may be in written or verbal form, and, when documented in the medical record, are important evidence that the consent process has been followed (CPSO, May/June, 2001:4-5).

Recommendation VI : ***Consent***

> **At the outset, and at times of potential change in therapy, determine the patient's capacity to consent or refuse the treatment, whether an adult or child. If the patient is capable, discuss with him or her the nature of the proposed treatment, the expected benefits and risks, and potential alternative courses of action or inaction, solicit and answer questions, and make note in the medical record. Also discuss and record the agreed 'frame of psychotherapy', i.e. the scheduling, fees, other rules and obligations of treatment. If the patient is incapable of consent, follow the same process with the appropriate substitute decision maker (as defined by the relevant provincial health care consent act).** (Section 6.2)

The levels of available evidence range from I-III. The GAC level is Consensus. (CPSO, May/June 2001: 4-5, updated with approval of Council, May 28, 2015).

6.3 Confidentiality and Mandatory Reporting

Physicians, and other health professionals who practise under the Regulated Health Professions Act of Ontario, 1991, are considered to be health information custodians under the Personal Health Information Protection Act (PHIPA), which came into effect November 1, 2004. Detailed information on PHIPA is offered to physicians in the publication *"Physician Privacy Toolkit"* (Ontario Hospital Association et al, 2004), updated by Richler in 2013 and 2016 *"The Personal Health Information Protection Act, 2004: A Guide for Regulated Health Professionals".* There was an attempt to update PHIPA in Ontario by the Health Minister Deborah Matthews introducing ePHIPA, the Electronic Personal Health Information Act in 2014, but it is not yet proclaimed.

Information was provided for patients in a booklet *"Your health information and your privacy in our office."* (Information and Privacy Commissioner/Ontario and Ontario Bar Association, 2005), and updated in July, 2014 in a mini-guide on the Information and Privacy Commissioner of Ontario's website.

Protection of identity is a patient's basic right and this is an essential condition for effective psychotherapeutic treatment. In psychotherapy, the physician must take all measures necessary to not reveal present or former patient confidences without express consent.

The following points are particularly relevant to physicians practicing psychotherapy with regard to PHIPA:

- When you collect, use and disclose personal health information for health care purposes within the patient's 'circle of care', you can usually rely on *implied* consent, but you can ensure consent by posting notices or providing brochures describing why you collect, use and disclose personal health information, and informing patients that they may withhold or withdraw their consent, and how. (Ontario Hospital Association et al, 2004: 10, 11, 19). Physicians providing psychotherapy may wish to specifically discuss and document the patient's consent, or not, to disclosure of personal health information for health care purposes within that patient's 'circle of care'.
- If the purpose of collecting, using and disclosing personal health information is for reasons other than for health care, *express* consent may be required. Such purposes might include financial reimbursement, education, research, statistics, public health regulation compliance, litigation, quality improvement, or other purposes permitted or required by law (Ontario Hospital Association et al, 2004: 16-17). Sample forms for *express* consent and withdrawal of consent are available (Ontario Hospital Association et al, 2004: 15).
- For third party requests, it is essential to verify the identity of the requesting party, and ensure dated written *express* consent is in the patient's personal health record (Ontario Hospital Association et al, 2004: 20-21).
- Patients have the right to instruct you not to use specified personal health information for health care purposes, and can instruct you not to disclose specified health information to others, even within their 'circle of care'.

- If a patient has restricted you from disclosing all of the personal health information that you consider reasonably necessary to provide health care, you must notify the recipient that the information is incomplete. If you receive such notification, you may wish to discuss with the patient the implications that the restriction might have on treatment (Ontario Hospital Association, 2004: 21).
- If a patient requests access to the personal health record, it must be provided, generally within 30 days, unless a legal exception applies (Ontario Hospital Association, 2004: 33-34). A physician can refuse access if the physician believes it would result in a substantial risk to the physical, mental, or emotional health of the patient or harm to another person (Information and Privacy Commissioner/Ontario and Ontario Bar Association, 2005: 17).
- It is important to follow the recommended procedure to make requested corrections to the personal health record, as outlined in the "Physician Privacy Toolkit" (Ontario Hospital Association, 2004: 37).
- In an era of electronic data collection and transmission, it is especially important to obtain express consent to release identifiable personal health information, or to de-identify it before transport outside the office (i.e. carried, copied, remotely accessed, e-mailed).

The exceptions to the Standards of Confidentiality (Ontario Hospital Association et al, September 2004) include:

- Duty to warn if threat of imminent life-endangering harm to others
- Threat of imminent or actual life-endangering harm to self
- Suspected child abuse
- Patient report of sexual abuse by a health care professional
- Unsafe to drive a motor vehicle or airplane
- Reportable infectious diseases
- Court order

Recommendation VII: Confidentiality and Mandatory Reporting

Obtain express consent for releases of information about the patient in psychotherapy, even though within the patient's circle of care there is implied consent. Inform the patient at the outset of therapy of circumstances requiring mandatory reporting. These include such situations as threat of imminent, life-endangering harm to self or others, suspected child abuse, patient report of sexual abuse by a health professional, incompetence to drive a motor vehicle or to fly an airplane, incompetence of a patient who is a health professional, reportable infectious disease, request for functional abilities information to assist return to work or benefits under the provincial workplace safety and insurance act, or court order. (Section 6.3)

The levels of available evidence range from I-III. The GAC level is Consensus. (Information and Privacy Commissioner/Ontario and Ontario Bar Association, 2005; Ontario Hospital Association et al, September, 2004: 10, 11, 15, 16,17, 19, 20, 21; Personal Health Information Protection Act, November 1, 2004; RHPA, 1991)

6.4 Abuse

6.4.1 Verbal, Emotional, or Physical Abuse

The Canadian Medical Association defines physician abuse of patients as any behaviour (words or actions) that transgresses the patient-physician relationship in an exploitive manner. Exploitation implies that the physician is acting for his or her advantage against the patient's interests (CMA, 2000).

The definition of abuse extends to the relationship between physicians and family members or others whose involvement in the treatment and welfare of a patient includes direct interaction with the physician (e.g. a mother seeking advice from her child's physician) (CMA, 2000).

Examples of abusive behaviour that are inappropriate in any setting include yelling, name calling and hitting.

Even though they may not be exploitive, the physician providing psychotherapy needs to be aware that inconsistencies in the standard therapeutic frame such as changes and irregularities in location or appointment times and verbal "error" in empathy or feedback, as well as insensitivities to gender, ethno-cultural, and socioeconomic issues could be hurtful and have the potential to be experienced as abusive.

Risk factors increase physician vulnerability for abuse of patients. These include:

- Personal crises, burnout, substance abuse
- Lack of personal awareness of pre-morbid family of origin issues, such as:
    - unmet and denied needs as a child (may lead the physician to become overly involved in doctor-patient relationships)
    - problems with development of trust in childhood (may make feelings of dependency from a patient quite threatening to a physician)
    - instability during childhood (can lead physicians towards having some of their dependency needs met by patients)
- Pre-existing serious illness
- Excessive devotion to work to the point of denial of self-care.

SRQs- Prevention of Verbal, Emotional, or Physical Abuse
Am I paying attention to the content of the discussion?
Am I maintaining sufficient emotional distance from the patient?
Am I watching non-verbal cues carefully?
Am I watching body posture and physical distance?
Am I being aware of transference and counter-transference issues – i.e. being self-aware of personal needs and desires and personal issues that may arise, as well as watching for reactions such as judging and distancing from the patient, feeling overwhelmed, or having feelings of embarrassment, anxiety, impatience, anger, or frustration?

For more detailed questions, see CPSO Self-assessment Tool, Member's Dialogue, September/October 2004:9: *Maintaining boundaries with patients: 7-15*)

Recommendation VIII: ***Prevention of Verbal, Emotional, or Physical Abuse***

The physician should seek regular supervision, but also recognize warning signs in interactions with patients and high risk situations and swiftly access supervision. When supervision cannot resolve the difficulties, possibilities include referring the patient, collaborating with another physician, and/or seeking personal therapy. (Section 6.4.1)

The level of available evidence for this recommendation is B-III. The GAC level is consensus.(CMA, 2000; CPSO, September/October 2004:9; Epstein and Simon, 1990; Epstein, Simon, and Kay, 1992; CPSO Understanding Boundaries, April 8-9, 2005).

6.4.2 Sexual Abuse

"In every house where I enter I will enter for the good of my patients, keeping myself from all intentional ill doing and all seduction and especially free from the pleasure of love with women or men" (Hippocratic Oath).

Of all forms of boundary violations, sexual violation can be the most devastating for the patient and also for the physician. For this reason it is imperative for physicians practicing psychotherapy to thoroughly know and understand the letter and the spirit of the laws prohibiting sexual involvement with their patients. What follows is a review of these laws and strategies for preventing sexual abuse.

Policies and Legislation - The Letter of the Law:

The Canadian Medical Association (CMA) defines sexual abuse of patients as any behaviour (words or actions), that transgresses the patient-physician relationship in a sexually exploitive way (CMA Policy, 2000)

The College of Physicians and Surgeons of Ontario (CPSO) has the following policies concerning sexual relationships between patients and doctors (updated, September 2008 and September 10, 2015):

- Sexual relationships between doctors and patients during treatment are prohibited.
- When the doctor-patient relationship involves psychoanalysis or psychotherapy, sexual relations with the patient are prohibited at any time after the termination of the treatment.
- Where the doctor-patient relationship has, at any time, involved psychotherapy of such duration that it may be seen to have been a significant component* of treatment, sexual contact with the patient is also prohibited at any time after termination of treatment.
- In all other cases the general rule is that physicians should not have sexual contact with a former patient for a period of one year following the date of the last professional contact with the patient, even if the physician has formally terminated the professional relationship. In some instances, it may never be appropriate for a post-termination sexual relationship to develop. In others, it may be unnecessary to wait for one year before a sexual relationship can develop; for example an emergency room physician who has treated a patient on one occasion.

** "Significant component" is defined as distinct from superficial, supportive psychotherapy administered infrequently or on isolated occasions and as incidental to the overall doctor-patient relationship. "Counseling" which is to be considered distinct from psychotherapy, is defined as a form of treatment in which the physician engages in an educational dialogue with the patient, on an individual or group basis, where the goal of the physician and the patient is to become aware of the patient's problem or situation and of modalities for prevention and/or treatment*. (CPSO *Understanding Boundaries*, 2005; reaffirmed in CPSO Policy *Maintaining Appropriate Boundaries and Preventing Sexual Abuse*, September 2008)

The Regulated Health Professions Act (RHPA) of Ontario expressly defines "sexual abuse" of a patient by a regulated health professional as:

1. *sexual intercourse or other forms of physical relations with a patient/client*
2. *touching a patient/client in a sexual manner*
3. *behaviour or remarks of a sexual nature to a patient/client.* (RHPA, 1991)

The College of Physicians and Surgeons of Ontario proposed new principles (CPSO Initiative-*Sexual abuse principles*, December, 2014) whereby "All physical sexual contact between a physician and patient would fall within the definition of sexual abuse and would result in revocation" (immediate, without waiting for an appeal). "Sexual comments and gestures would be defined as sexual impropriety, and penalties for sexual impropriety would be at the discretion of the Discipline Committee". The CPSO publicized these amendments and sought advice from the profession and the public (CPSO. *Protecting Patients*, Members' Dialogue, Issue 2, 2015: 19-25). The principles were approved by the CPSO Board (CPSO-Sexual Abuse Principles-Update, September 10, 2015), and a letter was written to the Ministry of Health and Long Term Care requesting amendments. The amendments to the RHPA have not yet been made, but they are expected in response to the opinions of the public, the profession and the CPSO.

The RHPA explicitly makes sexual abuse of patients grounds for professional misconduct. If found responsible for such behaviour, a health professional can face any of the following penalties:

- revocation of certificate of registration
- suspension of registration for a specific time
- imposition of terms, conditions and limitations upon a certificate of registration for a specific or indefinite period of time
- mandatory reprimand by a disciplinary panel
- fine of up to $35,000.00
- reimbursement of the College for funding provided to the sexually abused patient
- provision of security to guarantee payment of the amounts required to reimburse the College for funding provided to the sexually abused patient.

Members of regulated health professions, and those who operate facilities in which regulated health professionals practice, have a legal obligation to report any member of a regulated health profession whom, in the course of practising the profession, they have reasonable grounds to believe has sexually abused a patient/client. Colleges may impose a fine of up to $25,000.00 for failure to report such abuse (RHPA, 1991, last amended 2009).

Discussion - The Spirit of the Law:

Medical psychotherapy involves creating a special and unusual relationship between a patient and a physician, and thus requires special and unusual guidelines. A patient reveals deeply personal, intimate information to a relative stranger, the therapist, with the hopes that this person is trustworthy and safe, and will only act in the patient's best interest.

Because of the unequal balance of power and the intimate nature of psychotherapy, it is not uncommon for the patient and/or the physician to develop intimate feelings for the other. These feelings can be sexual or romantic and are usually driven by the potent forces of transference and counter-transference. Any kind of sexual or romantic involvement with the patient can be very damaging. Even if the patient is initiating or consenting, the patient can be deeply hurt in ways that may not be initially obvious.

The vulnerability, dependency, and trust that patients develop with physicians providing psychotherapy is similar to that experienced in childhood with their parents or primary caregivers. There is an implicit and explicit responsibility to not take advantage of this vulnerability to meet the intimacy needs of the physician.

One way of looking at this transgression is as follows. Crossing this boundary would be like a parent or adult having sexual relations with a child. Even if the child seems interested, it is up to the adult to set the boundaries. Therefore, when treating an adult patient, the vulnerability of the patient requires that the physician set limits on him or herself and the situation to protect the patient from an experience of violation and betrayal that can scar for life.

Some Strategies for Preventing Sexual Abuse:

Physician Know Thyself

- **Recognize warning signs:** *"Research has shown that before actual physical contact or abuse occurs, there may be a number of warning signs or changes in the behaviour of a professional which should alert the physician that he or she may be starting to treat a particular patient in ways that are different from handling of other patients. These may include sharing personal problems with the patient, offering to do therapy in social situations-such as over dinner, offering to drive a patient home, not charging for therapy or making sure the patient is scheduled to see you when no one else is in the office."* (CPSO, Nov. 1993: 9)

- **Recognize and exercise caution in high-risk situations:** including dual relationships, conflict of interest, seductive patients, touch, and self-disclosure.

- **Attend to professional self care:** Develop knowledge and understanding of boundary issues, transference and counter-transference. Be able to recognize high risk situations. Engage in continuing education, collegial contact and supervision to avoid professional isolation (American Psychological

Association, 2006).

- **Attend to personal self care:** Physicians are less vulnerable to violating patients if their own physical, emotional, social, spiritual, and sexual needs are attended to in their personal lives (Norris et al, April 2003).

- **Increase self awareness through personal therapy and/or other means of personal growth:** By becoming more aware of one's own inner world a physician may be better equipped to navigate through counter-transference and transference issues that can lead to boundary crossings and violations.

Physician Know Thy Supervisor

- **Supervision is foundational** for safe practice in general, but may be essential to manage the complex feelings of attraction in the therapeutic setting. Recognize the need for help and have the courage to obtain it early.

- **Reasons to seek supervision may include:** feeling attracted to a patient; fantasizing about a patient; acting in flirtatious ways with a patient; feeling discomfort, excitement or pleasure when a patient is seductive towards you. Situations described above in the Section "Recognize Warning Signs" also warrant seeking supervision if the situation is not appropriately resolved.

- **Other sources of help:** Talk to a colleague whom you trust or contact the Physician Health Services at your Provincial Medical Association.

Physician Know Thy Laws

The rules are clear and the consequences for breaching them severe. Engaging in any kind of sexual contact with a psychotherapy patient, at any time, can be catastrophic for the patient and the physician. By understanding the letter and the spirit of the laws, a physician is better able to provide safe, respectful psychotherapeutic care for patients and to maintain personal and professional integrity.

SRQ's- Prevention of Sexual Abuse
Am I aware of the laws and potential consequences regarding sexual involvement with my psychotherapy patients?
Do I understand why crossing sexual boundaries with my psychotherapy patients could be so harmful to them?
Am I aware of high risk situations and warning signs in myself that may make me more vulnerable to crossing sexual boundaries with my psychotherapy patients?
Do I realize that good personal and professional self-care will minimize the risk of sexual involvement with my psychotherapy patients?
Do I have regular supervision and supportive colleagues I can turn to for help regarding concerns about attraction to or from my patient(s)?

Recommendation IX : ***Prevention of Sexual Abuse***

Follow the law (Health Professions Procedural code, Schedule 2 to the Regulated Health Professions Act, 1991; Ontario Regulation 856/93 made under the Medicine Act, 1991, as amended, and similar legislation in other provinces) prohibiting sexual abuse of patients, defined as sexual intercourse or other forms of physical sexual relations with a patient/client, touching of a sexual nature of a patient/client, and behaviour or remarks of a sexual nature towards a patient/client. Follow the policy prohibiting sexual relations at any time after termination of treatment when the doctor-patient relationship involved a significant component of psychoanalysis or psychotherapy (College of Physicians and Surgeons of Ontario, Policy Statement # 4-08, September, 2008).

Level of evidence is A-III. GAC level is Consensus. (Hippocratic Oath; RHPA, 1991; Goodman in Salole et al, 1996; CPSO, 2005, November 1993; 9, and September 2008; CMA Policy, 2000; Norris et al, April 2003; American Psychological Association, 2006).

6.5 Dual Relationships

There are many situations that have the potential to exploit the dependency of the patient on the doctor and the inherent power differential in this relationship. Given the inherent vulnerability of patients, physicians have a duty to never exploit patients for any financial or personal gain or any other private purpose (Sox, 2002:245).

An essential element of the physician's role is the idea that what is best for the patient must be the physician's first priority. Physicians must set aside their own needs.

6.5.1 Relatives and Friends

Relationships with relatives and friends, or with close relatives, friends or caregivers of patients, may lead to resentment or dependency that could interfere with the physician's ability to be empathic, sensitive and objective in the doctor-patient relationship. The 'special' relationship may make it difficult for the physician to confront such issues as non-compliance or certain diagnoses that are at variance with what one would consider possible in a friend or relative.

If you must proceed in treatment of friends or relatives, self-reflective questions can help to clarify the boundaries.

SRQs- Friends and Relatives
Am I too close to a friend or relative to probe the intimate history and do a complete physical examination?
Can I be objective enough with my friend or relative to be medically effective?
Will my friend/relative comply with my care?

6.5.2 Family Medicine and Psychotherapy

"A physician who cares for his/her patient's physical disabilities as well as addressing psychosocial problems and mental disorders, must become aware of complex boundary issues if he/she is to be effective. Most significant physical disorders have psychosocial implications. 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" (Goodman in Salole et al, 1996:29).

"Family physicians and their patients are in an especially sensitive situation in the dynamic of intimacy, vulnerability, and trust. Family Medicine sees patients as complete people in the context of their ongoing life stories. Physicians and patients sometimes have difficulty moving back and forth among these intimate facets and the intimacy of the patient's physical body. Boundaries can become blurred and signals are easily crossed" (Yeo and Longhurst, 1996).

"Can a physician who is consulted for a psychological problem also address a physical concern 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" (Goodman in Salole et al, 1996:31).

A physician must examine his or her own abilities, skills and attitudes, as well as clearly communicate and negotiate the respective roles to be assumed in the relationship he or she has with the patient.

The physician cannot know how a certain patient is likely to respond to various aspects of touching in the physical examination under normal daily circumstances. The additional role of emotional intimacy and trust that is formed in a psychotherapeutic relationship enhances the importance of potential negative interpretations of events. The physical examination can be especially charged with meaning when patients are also receiving psychotherapy from the physician. Physical contact in such cases, even a routine pelvic examination, is very risky.

As with any intervention, touching has indications and contraindications. It is imperative that the physician be mindful of situations where touch can be helpful (Osmun et al, 2000), and where it can be hurtful, and exercise caution. For instance, Kardener et al (1976) surveyed 460 physicians regarding sexual contact with patients, and found that the freer a physician was with non-erotic contact (e.g. touching to comfort a distraught patient), the more statistically likely the therapist was to engage in erotic contact.

It is preferable that in the role of family physician, physical medicine and psychotherapy not be combined because of the risks of misinterpretation of touch and examination. However, when both roles must be performed by the same physician, clear communication and policies are of the utmost importance (Nadelson and Notman, 2002).

Examples of policies would be:

- Attendance of a third person in the examination room.
- Attendance of a third person with patients with known history of previous sexual abuse.
- Attendance of a third person with patients with extreme anxiety.
- Attendance of a third person with patients who are experiencing, or may have a tendency to experience delusions, distorted perceptions, or dissociations.
- Attendance of a third person if the physician begins to feel concerned or uncertain with a particular patient.
- Attendance of a third person at time of pelvic examination.
- A way to physically separate psychotherapy from other medical activities in time and space. (For example, psychotherapy could be scheduled on specific days or part days in a specially designated separate room or clearly divided off section of a room).

It would be advantageous for a physician practising family medicine who is entering into a psychotherapeutic contract with a patient to establish policies at the outset. This could include a requirement for having a third person in the room during physical examinations, a signed consent form accompanied by discussion that determines patient understanding and agreement, and inclusion of documentation in the chart.

6.5.3 Rural Isolation

Special consideration must be given to the family physician who provides psychotherapy service in a rural or isolated area. If the doctor is the only physician available, there will commonly be requests to treat the physician's relatives or friends.

Also, it may be impossible to treat a patient's physical concerns and psychosocial problems separately.

Physicians' personal boundaries will be challenged, as they will have to see patients regularly who are also in their social, family and business domains.

The rural physician will need to make careful choices and develop policies in these areas, and be vigilant for any negative impact on the doctor/patient relationship.

6.5.4 Post-treatment Relationships with Patients

It is not recommended to have post-psychotherapy personal or business relationships with patients because the vulnerability of patients may remain long after the therapeutic relationship has ended. However, it is recognized that, in some circumstances, post-treatment relationships with patients may be unavoidable. It remains the responsibility of the physician post-therapy to maintain mindfulness to protect the potential vulnerability of former patients.

Recommendation X: ***Dual Relationships***

1. **It is advisable that physicians providing psychotherapy set clear limits and refuse to undertake the care of their own relatives or friends** (Sections 6.5.1 and 6.5.3).

2. **It is recommended that Family Physicians make and communicate a clear separation of roles when entering into psychotherapeutic relationships with patients from their practices by finding ways to separate psychotherapy from other medical activities in time and space. In the case of those in dual roles as family physicians who provide care for physical medicine as well as providing psychotherapy, it is important to ensure that physical examination techniques reflect clear attention to boundaries. Patients can be informed that, in order to decrease the risk of adverse impacts or potential misunderstandings related to the physical components of health care provision, the physician has a policy of either referring to a colleague for physical examinations or having a third person present in the exam room. Patient consent should be obtained and documented in the chart.** (Sections 6.5.2 and 6.5.3)

3. **Physicians should refrain wherever possible, from establishing personal or business relationships with patients who are, or who have been, in a psychotherapeutic relationship with them. It is recognized that, after the termination of that relationship, patients may remain vulnerable and dependent and so be compromised in their ability to act autonomously.** (Section 6.5.4)

Level of evidence is A-III. GAC level is Consensus. (Sox, 2002:245; Goodman in Salole et al, 1996: 29 and 31; Yeo and Longhurst, 1996; Osmun et al, 2000; Kardener, 1976; Nadelson and Notman, 2002; CPSO Understanding Boundaries, 2005).

6.6 Conflict of Interest

6.6.1 Business

An old business maxim warns: *"Never do business with friends or relatives"* (Linklater and MacDougal, 1993).

Medical professionals and their organizations have many opportunities to compromise their professional responsibilities by pursuing private gains for personal advantage. Physicians have an obligation to recognize and disclose to the public any conflict of interest that arises in the course of their professional duties and activities.

"Relationships such as business involvements that coexist simultaneously with the doctor-patient relationship, have the potential to undermine the physician's ability to focus primarily on the patient's well-being and can affect the physician's judgment" (Nadelson and Notman, 2002).

Violations of the therapeutic relationship with respect to business issues include the following (but this is not an exhaustive list):

- using information such as business or political or financial tips for your own gain
- participating in activity to deceive a third party, such as an insurance company
- participating in business deals with patients
- recommending treatments or making referrals that may indirectly benefit you (Canadian Medical Association, 2008)
- disclosing sensational aspects of your patient's life to others
- accepting chronic silence of a patient or their repeated tardiness as an acceptable way to get paid.

6.6.2 Gifts/Services

Grateful patients often wish to show their appreciation to their physicians by bringing gifts or performing services for free or at below market cost. While small token gifts may represent benign boundary crossings, more expensive gifts or the offer to perform services can compromise the physician/patient therapeutic relationship for the following reasons.

Services:
If the patient renders a service to the physician, he has de facto entered into a business relationship. Even though no money has changed hands, the nature of the physician/patient relationship has been altered to that of a buyer-seller. Instead of the physician performing services for the patient, the role is reversed and the patient becomes the one who is the service provider. If the service is not rendered to the physician's satisfaction, the ensuing dispute may also affect the therapeutic alliance between the physician and the patient. Furthermore, the patient may feel rejected as a patient if the physician decides in future to have the same or similar types of work done by someone else. Dual relationships are difficult and when push comes to shove, it is usually the therapeutic relationship that is sacrificed.

Physicians who live in a small town (where there is both a limited choice in available service providers and physicians) are especially vulnerable to offers from their patients to do work, either for free or at a reduced rate. In these settings, it is all too easy to take financial advantage of vulnerable patients. Physicians in these circumstances should advise any prospective service provider that they would prefer to pay fair market value for any service that is provided to them or their families.

Gifts:

It is not uncommon for patients to offer gifts in gratitude to a physician, especially if they feel that the physician has rendered exceptional service. However, when the gift becomes expensive and/or substantial (e.g. a car or a free vacation), then consciously or unconsciously, one or both parties may see it as a bribe. If expectations arise from the gift, or if the physician feels in some way obligated to the patient, then the therapeutic relationship is compromised and the acceptance of such a gift becomes a boundary violation. For example, the physician should not allow his or her judgment to be influenced or compromised by a gift (e.g. prescribing narcotics or tranquilizers to a patient in a therapeutic situation that would not ordinarily warrant the prescribing of such medications).

The physician has a position of trust and must not take physical, emotional or financial advantage of the patient.

Consider the following questions before accepting or rejecting a gift or service.

SRQs- Gifts/Services
What is the underlying meaning of the gift/service?
What is the underlying motivation of the giver (whether patient or physician)?
What is my underlying motivation in either rejecting or accepting the gift/service?
How will the acceptance/rejection of the gift/service change the psychotherapeutic relationship?

6.6.3 Professional Fees

Fees for services not covered by health insurance (including missed appointments, prescription renewals, and telephone advice) are to be explained and discussed with the patient early in the course of the professional relationship as part of setting the 'frame of therapy'.

"In determining fees to patients, consider both the nature of the service provided and the ability of the patient to pay" (CMA, 2004).

Recommendation XI: ***Conflict of Interest***

Physicians are bound by ethical standards and should refrain from personal benefit arising out of psychotherapeutic relationships with patients. Such benefits include those with respect to business and finances, as well as emotional or sexual benefits. (Section 6.6)

The level of evidence is A-III. GAC level is Consensus. (World Medical Association, 1949; Linklater and MacDougal, 1993; Nadelson and Notman, 2002; CMA, 2004, 2008; CPSO, 2005; 2008)

6.7 Motives for Boundary Crossings

The Guidelines Task Force thought it important to name the potential underlying motivations for the types of boundary crossings that have been discussed throughout the Professional Conduct Section. The following motivations were included in "The Exploitation Index" (Epstein and Simon, 1990) that is part of the CPSO and University of Western Ontario's *Understanding Boundaries* Course (April 8-9, 2005). These include social, erotic, exhibitionistic or dependency needs or wishes. They also encompass motives of greed and power-seeking, or shrinking from duty with enabling.

The Guidelines Task Force hopes that the following SRQ's about boundaries, adapted from "The Exploitation Index", will be helpful for physicians to tie the questions to potentially underlying motivations. In turn, we hope they may help prevent physicians from crossing any medical ethical lines with patients.

SRQs About Boundaries:
Social: Do I seek social contact and/or encourage a degree of familiarity with my patients that is not in keeping with the professional relationship? What is my policy re accepting individuals referred by former patients or those with whom I've had a personal connection? How do I respond when I discover that my patient has a significant relationship with someone I know or have known?
Erotic: Do I silently compare qualities in patients with those in my spouse, look forward to seeing particular patients, or daydream about them? Do I consider the potential impact on patients of touching and/or hugging them?
Exhibitionism: Do I feel proud or gratified by being able to help a patient achieve great potential or fame or from having clients with status? Do I want to tell others who my patient is?
Dependency: Do I have difficulty terminating therapy with certain patients because of the patient's or my dependency? Do I feel complacent about being paid for those clients who are not actively participating in their therapy?
Power: Do I feel a sense of gratification or power in being able to control the patient with my advice or medical treatment or want to influence others to align with my own views, such as political/religious opinions?
Greed: Do I use information from patients for my own personal or financial gain or accept gifts or give special treatment to ensure a more favourable position for myself?
Enabling: Do I fail to deal with patients on boundary issues such as late fees, missed appointments, extending session length etc? Do I make excuses to reduce fees, feel sorry for them or fear the confrontation?

7.0 Office Environment Safety and Record-keeping

The office environment in which therapy takes place is part of *the "secure frame"*, which *"includes the physical surroundings, the emotional environment, the psychotherapeutic structure, and the relationship between [the patient] and [the therapist]". "A secure frame is a private psychic space in which you feel safe, "held" and supported. A secure frame is an environment in which every detail reflects structure, containment, safety, and support*." (Ainsworth, 2005).

7.1 Office Environment Safety

The CPSO has developed *"A Practical Guide for Safe and Effective Office-based Practices"*, which offers guidelines on facility accessibility, cleanliness, safety, patient privacy, emergency preparedness, infection control, waste disposal, safe medication practices, and medical records systems for practices with widely varying levels of risk. Self-assessment tools are also provided and may be downloaded from www.cpso.on.ca. (CPSO, April, 2009; updated May, 2012).

Of particular relevance re facilities for physicians practicing psychotherapy are the following:

- The need to offer therapy in space that is private (e.g. not a coffee shop), and socially sanctioned (e.g. separated in some way from private living quarters).
- The need for dual practice physicians to separate psychotherapy from other medical services by time and space.
- The need for soundproofing between rooms to preserve confidentiality.
- The need for 'view-proofing' of paper charts and computer screens.
- The need for password protection of electronic files containing personal health information.

SRQ: Office Environment
"Can my office practice be modified to improve the environment in which I provide care for my patients?" (CPSO, April 2009:4)

Recommendation XII: ***Office Environment***

1. **Assess and ensure that your office is accessible for your patient population. If it is not possible for your office to be reachable for patients with some impairment(s), assist such patients by referring them to colleagues with more accessible facilities.**
2. **Assess the degree of risk for emergencies in your practice and provide emergency equipment, supplies and protocols corresponding with the nature of your practice and patient population. Store emergency equipment together in one cabinet, cart or drawer for easy access and ensure that you and your staff are trained in its use. Familiarize yourself and your staff with written plans to follow in case of urgent events such as a disruptive or threatening patient, fire, or medical emergency.**
3. **Ensure that offices are adequately soundproofed to prevent others from overhearing personal health information, and that charts are securely stored and computer monitors strategically positioned to avoid others seeing patients' health information.**
4. **Password-protect patient files on computers and portable storage devices.**
5. **Do not leave messages with third parties or on answering machines that contain patients' personal health information without their express consent.** Detailed suggestions are outlined in *"A practical guide for safe and effective office-based practices"* (CPSO, May, 2012, from Apr. 2009), and may be downloaded from www.cpso.on.ca.

The available evidence for this recommendation ranges from I-III. GAC level of evidence is Consensus. (CPSO, March 2005, April, 2009, May, 2012).

7.2 Record-keeping

The CPSO has published a guide that offers many helpful general suggestions, and specific suggestions for keeping a record for psychotherapy or counseling sessions using the SOAP (Subjective, Objective, Assessment, and Plan) format (CPSO, March/April, 2006:9-10). The CPSO has stated that physicians *"are encouraged to bring individuality and personal needs into the creation of a record-keeping system that is functional, practical and easy-to-maintain"* (CPSO, 2002:1). The CPSO Guide also offers self assessment questionnaires.

Of particular relevance for physicians practicing psychotherapy are the following:

- Every scheduled appointment must be documented in the daily diary, and every patient encounter must be documented and dated in the medical record. It is strongly recommended that all phone calls and home visits be documented.
- In Ontario, under the Health Insurance Act, the date, start and stop times of each psychotherapy session are to be recorded in the patient's medical record to establish that an insured service was provided, and the SOAP format helps satisfy the legal requirement that the service was medically and therapeutically necessary (CPSO, 2002:13).
- It is important to document all instances of a patient refusing or deferring tests or treatments, possibly with the reason given by the patient, and what course of action you recommended. If it is not in the record, it might be assumed that you did not offer the tests or treatments.

SRQ: Medical Records

"Do my medical records adequately tell each patient's story in a manner that will be understood by a person seeing the record for the very first time?"(CPSO, 2002:1)

Recommendation XIII: ***Record-keeping***

Maintain psychotherapy records that "tell the patient's story", and contain the following minimum components: history, observations of physical/mental status, diagnosis/assessment, treatment plan, progress notes that reflect input from both patient and physician, outcome assessment and a note of the patient's reaction at the end of the treatment. The SOAP (Subjective, Objective, Assessment, Plan) method for progress notes is useful. Detailed suggestions re record-keeping may be downloaded from https://www.cpso.on.ca/en/Physicians/Policies-Guidance/Policies

The available evidence for this recommendation ranges from I-III. GAC level of evidence is Consensus. (CPSO, 2002; CPSO, March/April 2006; CPSO, April, 2009, May, 2012).

REFERENCES

(American Psychological Association format)

Agency for Healthcare Research and Quality, Rockville, MD. (March 2000) *Outcomes research fact sheet*, Publication No. 00-P011. http://www.ahrq.gov/clinic/outfact.htm.

AGREE Collaboration (a group of researchers from 13 countries). (January 2003) *Appraisal of guidelines for research & evaluation instrument training manual.*

Ainsworth Martha.(accessed November 13, 2005) *How to choose a competent counselor-5-How a good therapist makes you feel safe-* http://www.metanoia.org/choose/gethelp05.htm. (re-accessed January 8, 2017).

American Medical Association (2004-2005) *Code of medical ethics*, www.ama-assn.org/ama/pub/category/2512/html.

American Psychiatric Association (1980) *Development of the DSM III and DSM III R*, **dsm**istory.umwblogs.org**/**dsm-iii**/**dsm-iii**-vs-**dsm-iii**-r**

American Psychiatric Association (1994) *Diagnostic and statistical manual of mental disorders*, Fourth Edition, Washington D.C.

American Psychiatric Association. (May, 2013) *Diagnostic and statistical manual of mental disorders (5th ed.), Arlington, VA.*

American Psychological Association (2002) *Ethical principles of psychologists and code of conduct*, American Psychologist, 57: 1060-1073.

American Psychological Association (2006) *Responding therapeutically to patient expression of sexual attraction*, http://www.apa.org/videos/4310570.html

Association of Psychologists of Nova Scotia (2017) http://apns.ca/.

Barr, J.E., Iwanowska, J.T., Marshall, L.M., Sykes, L.J. & Professional Development Committee, General Practice Psychotherapy Association (2001) *GP psychotherapy basic skills core curriculum.*(Report available from the General Practice Psychotherapy Association, 312 Oakwood Court, Newmarket, Ontario,Canada, L3Y 3C8.)) Latest curriculum update: 2009.

Barr J.E. Recommended Modules for Core Curriculum, e-mail correspondence to GTF, Jan. 22, 2017, 3:59 pm.

Bateman Anthony, Churchill Rachel, Clifford Paul, Hearnshaw Hilary, Khunti Kamlesh, Lundsay Ann, Moorey Stirling, Parry Glenys, Roth Anthony, Rowland Nancy, Tylee Andre, Guidelines Development Group, British Psychological Society Centre for Outcomes Research and Effectiveness.(2001) *Treatment choice in psychological therapies and counseling.* Evidence-based Clinical Practice Guideline, Department of Health, U.K., endorsed by GAC, June, 2002.

Beamish Susan, Melanson Michelle, Oladimeji Marilyn.(1998) *Client rights in psychotherapy & counseling, A handbook of client rights and therapist responsibility,* The Client Rights Project.

Ben-Zeev D, Young MA, Coruigan PW (Aug. 2010) *DSM-V and the stigma of mental illness,* J Ment Health, Aug. 19, 2010 (4): 318-27.

Berg A. (Jun. 2012) *Infant-parent psychotherapy at primary care level: establishment of a service.* South African Medical Journal. Suid-Afrikaanse Tydskrif Vir Geneeskunde. 102(6):582-4.

Boettcher J; Renneberg B; Berger T. (2013) *Patient expectations in internet-based self-help for social anxiety,* Cognitive Behaviour Therapy. 42(3):203-14.

Bohart Arthur C., O'Hara Maureen M. Co-Chairs, Leitner Larry M., Wertz Fred, Stern E. Mark, Schneider Kirk, Serlin Ilene, Greening Tom, Task Force for theDevelopment of Practice Recommendations for the Provision of Humanistic Psychosocial Services. (Spring, 1997) *Recommended principles and practices for the provision of humanistic psychosocial services: alternative to mandated practice and treatment guidelines.* The Humanistic Psychologist 25(1):64-107.

Borins Mel, Course Director.(2004) *Counselling and psychotherapy in family medicine*-a 5-weekend learning program, Department of Family and Community Medicine, University of Toronto.

Brauhardt A; de Zwaan M; Hilbert A. (Sep.2014) *The therapeutic process in psychological treatments for eating disorders: a systematic review. [Review],* International Journal of Eating Disorders, 47(6):565-84.

Brouwers M, Kho ME, Browman GP, Cluzeau F, feder G, Fervers B, Hanna S, Makarski J on behalf of the AGREE Next Steps Consortium. AGREE II: *Advancing guideline development, reporting and evaluation in healthcare.* Can Med Assoc J. Dec 2010, 182:E839-842; doi: 10.1503/cmaj.090449; update Sept. 2013.

Buckley Matthew H.(October, 2016) *Back to basics: Using the DSM-5 to benefit clients.* Professional Counsellor, Walden University.

Button Katherines S., Turmer Nicholas, Campbell John, Kessler David, Kuyken Willem, Lewis Glyn, Peters Tim J., Thomas Laura, Wiles Nicola (Mar. 15, 2015) *Moderators of response to cognitive behavioural therapy as an adjunct to pharmacotherapy for treatment-resistan depression in primary care,* J of Affective disorders 174:272-80.

Cameron Paul, Ennis Jon, Deadman John. (1998) *Standards and guidelines for the psychotherapies.* University of Toronto Press Incorporated, Toronto.

Cameron Paul M., Leszcz Molyn, Bebchuk William, Swinson Richard P, Antony Martin M, Azim Hassan F, Doidge Norman, Korenblum Marshall S., Nigam Tara, Perry J Christopher, Seeman Mary V.(1999) *The practice and roles of the psychotherapies: A discussion paper.* Working Group I of the Canadian Psychiatric Association Psychotherapies Steering Committee. Canadian J Psychistry, 44 Suppl 1: 18S-31S.

Canadian Health Services Research Foundation (Fall, 2005) *The evidence issue*, Links, 8(3):1.

Canadian Medical Association.(2000) *The patient-physician relationship and the sexual abuse of patients*- Update, CMA Policy.

Canadian Medical Association (1996, 2004) *Code of Ethics*, 1867 Alta Vista Drive, Ottawa Ontario, K1G 3Y6.

Canadian Medical Association.(2008) *Guidelines for physicians in interactions with industry.*

Canadian Medical Association.(August 2008) *8th Annual national report card on health care:* 18-32.

Canadian Psychoanalytic Society.(July 2002) *Principles of ethics for psychoanalysis*, Montreal, P.Q.

Canadian Task Force on Preventive Health Care. (last updated 2016) (re-accessed January 8, 2017).

Canadian Task Force on Preventive Health Care.(Aug. 5, 2003) *New grades for recommendations from the Canadian Task Force on Preventive Health Care,* CMAJ 169(3):207-208.

Carroll L., Gilroy P.J., Murra J. (1999) *The moral imperative: Self-care for women psychotherapists*, Women and therapy 22:133-143.

College of Family Physicians of Canada (2016) *Linking learning exercises*, http://cfpc.ca/Linking_Learning_exercises/ (re-accessed Jan.8, 2017)

College of Nurses of Ontario (Mar. 24, 2016) *Psychotherapy and the controlled act component of psychotherapy.*

College of Physicians and Surgeons of Ontario. (November 25, 1991) *Task Force on Sexual Abuse of Patients; The Final Report* (2000), Toronto; Chair: Marilou McPhedran..

College of Physicians and Surgeons of Ontario. (November, 1993) *Strategies for Preventing Sexual Abuse*. Members' Dialogue: 9.

College of Physicians and Surgeons of Ontario.(May 20, 1998) *Peer assessment report (psychiatry/psychotherapy).*

College of Physicians and Surgeons of Ontario.(May/June, 2001) *Consent to medical treatment*, updated with approval of counsel, May 28, 2015..

College of Physicians and Surgeons of Ontario.(November, 2000, revised June 2002) *A guide to current medical record-keeping practices: a focus on record-keeping in the office-based setting.* Reviewed and updated, September, 2006. Policy Statement #5-05, *Medical Records*, Publication Date, March/April, 2006.

College of Physicians and Surgeons of Ontario.(September/October 2004) *Maintaining boundaries with patients*, Members' Dialogue:7-15.

College of Physicians and Surgeons of Ontario (Apr. 8-9, 2005) *Understanding Boundaries,* reaffirmed in CPSO Policy *Maintaining appropriate boundaries and preventing sexual abuse (Sept, 2008).*

College of Physicians and Surgeons of Ontario, University of Western Ontario Faculty of Medicine and Dentistry.(April 8 & 9, 2005) *Understanding boundaries: managing the risks inherent in the doctor-patient relationship,* Participants' Handbook, The Faculty Development Office, Faculty of Medicine and Dentistry, 519-661-2074, facdev@fmd.uwo.ca.

College of Physicians and Surgeons of Ontario. (July-Sept., 2007, revised online 2008) *Medical professionalism and College Policies- A Practice Guide.*

College of Physicians and Surgeons of Ontario. (September 2008) *Maintaining appropriate boundaries and preventing sexual abuse*, Policy Statement #4-08..

College of Physicians and Surgeons of Ontario.(April 2009, updated May, 2012) *A practical guide for safe and effective office-based practice,* Policy Statement #4-12..

College of Physicians and Surgeons of Ontario Mambers' Dialogue (Issue 2, 2015:19-25) *Protecting Patients- Proposing measures to better protect and support patients from physician sexual abuse..*

College of Physicians and Surgeons of Ontario (September 10, 2015) *Sexual Abuse Principles-Update: Principles Approved.* http://policyconsult.cpso.on.ca/?page_id=6984

College of Registered Psychotherapists of Ontario (January 15, 2014). *Professional Practice Standards for Regulated Psychotherapists.*

Corey Gerald. (January 2005 and February 2008) *Theory and practice of counseling and psychotherapy,* Seventh and Eighth Editions.

Davis David A., Taylor-Vaisey Anne. (15 August, 1997) *Translating guidelines into practice: A systematic review of theoretical concepts, practical experience and research evidence in the adoption of clinical practice guidelines*, CMAJ 157(4):408-416.

Deadman John, Goodman Mel, Christie-Seely Janet, Korenblum Marshall, Marsh David, Qaadri Shafiq, Salole Roy, Silberfeld Michel (Task Force for the Development of Clinical Practice Guidelines for Psychotherapy by Physicians). (January, 2003) *Guidelines for clinical practice and facility standards: psychotherapy*, facilitated by the College of Physicians and Surgeons of Ontario, Draft: xii.

Detsky, Allan S. (Oct. 24, 2006) *Sources of bias for authors of clinical practice guidelines*- Guest Editorial, Canadian Medical Association Journal 175 (9):033.

Dezetter Anne, Britfault Zavier, Lakhdar Christian Ben, Kovess-Masfety Viviane (December, 2013). *Costs and benefits of improving access to psychotherapies for common mental disorders,* The Journal of Mental Health Policy and Economics 16 ($):161-77.

Doidge Norman, Freebury Ray. (1998) *Guidelines for the practice of individual psychodynamic Psychotherapy,* Chapter 3 in Cameron Paul, Ennis Jon, Deadman John. Standards and guidelines for the psychotherapies, University of Toronto Press: 48.

Doidge, Norman (May15, 2007) *The Brain That Changes Itself- Stories of Personal Triumph from the Frontiers of Brain Science,* James H. Silberman Books.

Doidge, Norman (2015) *The Brain's Way of Healing- Remarkable Discoveries and Recoveries from the Frontiers of Neuroplasticity*, James H. Silberman Books.

Dour HJ; Wiley JF; Roy-Byrne P; Stein MB; Sullivan G; Sherbourne CD; Bystritsky A; Rose RD; Craske MG. (May 2014) *Perceived social support mediates anxiety and depressive symptom changes following primary care intervention.* Depression & amp; Anxiety. 31(5):436-42.

Duer J.D. (2003) *Research on supervision: annotated bibliography and commentary.*Pensacola, Fla.: Council of Applied Masters Programs in Psychology. http://www.camppsite.org/documents/ab_supervision.pdf.

Dunham Randall B. (accessed 4/26/2006) *The Delphi technique,* Organizational Behavior, University of Wisconsin School of Business, (re-accessed April 9, 2010) http://www.medsch.wisc.edu/adminmed/2002/orgbehav/delphi.pdf

Edelstein Ludwig (1943) *The Hippocratic Oath: Text, translation, and interpretation,* Baltimore: Johns Hopkins Press.

Einstein Albert (1879-1955). *Not everything that counts can be counted, and not everything that can be counted counts.* http://www.alberteinsteinsite.com/quotes/einsteinquotes.html

Ejeby K; Savitskij R; Ost LG; Ekbom A; Brandt L; Ramnero J; Asberg M; Backlund LG. (Jun 2014) *Symptom reduction due to psychosocial interventions is not accompanied by a reduction in sick leave: results from a randomized controlled trial in primary care.* Scandinavian Journal of Primary Health Care. 32(2):67-72.

Ellis M.V., Landany N., Krengel M., Schutt D. (1996) *Clinical supervision research from1981 to 1993: A methodological critique.* Journal of Counselling Psychologist 43(1):35-50.

Ennis Jon, Pare Michael.(2004-2005) *The fundamentals of psychotherapy course*- Department of Psychiatry, University of Toronto, Ontario Medical Association General Practice Psychotherapy Section, and General Practice Psychotherapy Association.

Epstein R.S., Simon R.I.(Fall, 1990) *The Exploitation Index : an early warning indicator of boundary violations in psychotherapy,* Bull Menninger Clin 54(4): 450-465.

Epstein R.S., Simon R.I., Kay G.G. (1992 Spring) *Assessing boundary violations in psychotherapy: survey results with the Exploitation Index,* Bull Menninger Clin 56(2):150-66.

Evans Michael F, Frank John (March, 1997) *Critical appraisal and Canadian Family Physician*, Canadian Family Physician Vol 43:449.

Farquhar Donald R.E. (August 15, 1997) *Recipes or roadmaps? Instead of rejecting clinical practice guidelines as "cookbook" solutions, could physicians use them as roadmaps for the journey of patient care?* CMAJ 157(4):403-404.

Freebury Ray, Ennis Jon, Rideout Carolyn, Wright Martha (1998) *General guidelines for the practice of psychotherapy,* Chapter 2 in Cameron Paul, Ennis Jon, Deadman John (1998) *Standards and Guidelines for the psychotherapies, University of Toronto Press: 26.*

Freitas Robert A. (2001-2002) *Medical ethics, oaths, and codes,* Foresight Nanotech Institute, https://www.foresight.org/Nanomedicine/.

Freud S. (1957) *Five lectures on psychoanalysis,* In Strachey J (Ed. And Trans.) The standard edition of the complete psychological works of Sigmund Freud (Vol. 11), Hogarth Press, London (original work published 1910).

Gabbard Glen O., Lazar Susan G., Hornberger John, Spiegel David (February 1997) *The economic impact of psychotherapy: A review,* Am J Psychiatry 154(2):147-155.

Gabel Marc.(July 29, 2003) Communication via e-mail to Drs. David Cree and David Murphy. General Practice Psychotherapy Association.(2003-5) *Supervisor's Course,* 416-410-6644, info@gppaonline.ca

General Practice Psychotherapy Association (2003)- Joan Barr, Michael Cord, Helen Garvin, Prototype Supervisors' Training Course- personal communication, Joan Barr, January 22, 2017.

General Practice Psychotherapy Association.(2004-6) *Certificant application*-Tel 416-410-6644.

Gilbody S; Littlewood E; Hewitt C; Brierley G; Tharmanathan P; Araya R; Barkham M; Bower P; Cooper C; Gask L; Kessler D; Lester H; Lovell K; Parry G; Richards DA; Andersen P; Brabyn S; Knowles S; Shepherd C; Tallon D; White D; REEACT Team, (2015), *Computerised cognitive behaviour therapy (cCBT) as treatment for depression in primary care (REEACT trial): large scale pragmatic randomised controlled trial*.[Erratum appears in BMJ. 2016;352:i195; PMID: 26759375], BMJ. 351:h5627.

Goodman Mel.(1996) *Boundaries: family physicians and psychotherapy,* in The role of psychotherapy in primary care, GPPA:29.

Green David, Dye Louise (2002) *How should we best train clinical psychology supervisors? A Delphi survey,* Psychology Learning and Teaching 2(2):108-115.

Grol R. (2001) *Success and failures in the implementation of evidence-based guidelines for clinical practice*. Med Care 39(8 Suppl 2):1146-54.

Grol, R.(2001) *Improving the quality of medical care: Building Bridges Among Professional Pride, Payer Profit, and Patient Satisfaction.* Journal of the American Medical Association, 286: 2578-2585.

Guidelines Advisory Committee: a joint body, formed in 1997, of the Ontario Medical Association, and the Ministry of Health and Long Term Care, with ex-officio representation from the Institute for Clinical Evaluative Sciences in Ontario.

Guidelines Advisory Committee Psychotherapy Recommended Guideline.(June, 2002): Bateman A. et al.(2001) *Treatment choice in psychological therapies and counseling. Evidence based clinical practice guideline,* Department of Health, UK.

Guidelines Advisory Committee. (February 16, 2004) *Workshop in the appraisal of clinical practice guidelines,* Toronto, Ontario.

Health Professions Regulatory Advisory Council (HPRAC) (April, 2006) *New Directions:* 206-08.

Health System Improvement Act (May 31, 2007), containing Bill 171, the Psychotherapy Act (2006), www.ontla.on.ca.

Hermann Richard C, Provost Scott.(May, 2003) *Interpreting measurement data for quality improvement: standards, means, norms, and benchmarks,* Psychiatric Services 54 (51):655-57. http://psychservices.psychiatryonline.org (re-accessed April 9 2010 and February 5, 2017).

Hollinghurst S et al (2014): Cost-effectiveness of cognitive-behavioural therapy as an adjunct to pharmacotherapy for treatment-resistant depression in primary care: economic evaluation of the CoBalT Trial. British J of Psychiatry, January 2014 204:69-76

Holloway E., Neufeldt S.(1995) *Supervision: its contribution to treatment efficacy,* J of Consulting and Clinical Psychology 63(2):207-213.

Hsu Chia-Chien, Sandford Brian A. (August, 2007) *The Delphi Technique: Making Sense of Consensus,* Practical Assessment, Research and Evaluation, Volume 12, number 10: 1-8.

Information and Privacy Commissioner/Ontario, Ontario Bar Association.(2005) *Your health information and your privacy in our office*- available with posters, free of charge from (416) 325-9172 or ipc.publication@ipc.on.ca, or may be downloaded from www.ipc.on.ca.

Information and Privacy Commissioner/Ontario, *Ontario's Freedom of Information and Protection of Privacy Act. A Mini-Guide,* July, 2014, www.ipc.on.ca.

Joo JH; Morales KH; de Vries HF; Gallo JJ. (Jan. 2010) *Disparity in use of psychotherapy offered in primary care between older african-american and white adults: results from a practice-based depression intervention trial.* Journal of the American Geriatrics Society. 58(1):154-60.

Kardener SH, Fuller M, Mensh IN. (1976) *Characteristics of " erotic" practitioners*, American Journal of Psychiatry 133:1324-1325.

Katz P. (1986) *The role of the psychotherapies in the practice of psychiatry: The position of the Canadian Psychiatric Association,* Canadian Journal of Psychiatry 31: 458-465.

Kessler RC, Greif Green J, Gruber MJ, et al. (2010) *Screening for serious mental illness in the general population with the K6 screening scale*: results from the WHO World Mental Health (WMH) survey initiative. International Journal of Methods in Psychiatric Research 2010; 19(Suppl. 1): 4-22.

Kirby The Honourable Michael J.L., Keon The Honourable Wilbert Joseph. (May, 2006) *Out of the shadows at last, the final report on mental health, mental illness and addiction,* The Standing Senate Committee on social Affairs, Science and Technology.

Kirby The Honourable Michael J.L., Keon The Honourable Wilbert Joseph. (May, 2006) *Out of the shadows at last, highlights and recommendations,* The Standing Senate Committee on social Affairs, Science and Technology.

Kramen-Kahn B., Hansen N.D. (1998) *Rafting the rapids: Occupational hazards, rewards, and coping strategies of psychotherapists,* Professional Psychology: Research and Practice 29:130-134.

Kupfer DJ, Regier DA, Kuhl EA (Nov. 2008) *On the road tto DSM-V and ICD-11,* Eur Arch Psychaitry Clin Neurosci., 258 Suppl.5:2-6.

Lee SY; Franchetti MK; Imanbayev A; Gallo JJ; Spira AP; Lee HB. (Nov.-Dec. 2012) *Non-pharmacological prevention of major depression among community-dwelling older adults: a systematic review of the efficacy of psychotherapy interventions. Review]* Archives of Gerontology & Geriatrics. 55(3):522-9.

Linklater David, MacDougall Scott (1993) *Boundary issues: what do they mean for the family physician?* Canadian Family Physician, 39:2569-73.

Mackenzie K Roy, Leszcz Molyn, Abbass Allan, Hollander Yitchak, Kleinman Irwin, Livesley John, Pinard Gilbert, Seeman Mary V. (1999) *Guidelines for the psychotherapies in comprehensive psychiatric care: A discussion paper.* Working Group 2 of the Canadian Psychiatric Association Psychotherapies Steering Committee. Can J Psychiatry, 44 Suppl 1:4S-17S.

Madden Robert G.(1998) *Legal issues in social work, counseling, and mental health.* Sage Publications Inc.

Mahoney M.J. (1997) *Psychotherapists' personal problems and self-care patterns,* Professional Psychology: Research and Practice 28: 14-16.

Mahoney Michael J.(1998) *Essential themes in the training of psychotherapists,* Psychotherapy in Private Practice, 17(1):43-59.

Manitoba Schizophrenia Society, *A Reason to Hope. The Means to Cope,* http://www.mss.mb.ca/newsletter_reason_for_hope.php, Accessed Feb. 5, 2017.

Margison Frank R, McGrath Graeme (2000) *Measurement and psychotherapy, evidence- based practice and practice-based evidence,* The British Journal of Psychiatry 177: 123-130.

Marshall Lynn M, Barr Joan E, Iwanowska Jaga T, Sykes Lucinda J, and Professional Development Committee of the General Practice Psychotherapy Association. (2001, revised June, 2006; latest update Oct., 2017) *Education, credentialing and maintenance of competence for physician psychotherapists who are members of the GPPA,* first *approved by the GPPA Membership, November 15, 2001: 2.*

Matthews Deborah. *Bill 78, Electronic Personal Health Information Protection Act, 2014.* *http://www.ontla.on.ca/web/bills/bills_detail.do?locale=en&BillID=2801*

McCurry SM; Shortreed SM; Von Korff M; Balderson BH; Baker LD; Rybarczyk BD; Vitiello MV. (Feb. 2014) *Who benefits from CBT for insomnia in primary care? Important patient selection and trial design lessons from longitudinal results of the Lifestyles trial.* Sleep. 37(2):299-308.

McDowell, I.; Newell, C. (1987). ***Measuring health: A guide to rating scales and questionnaires.*** New York, NY: Oxford Univ. Pr.

Menchetti M; Rucci P; Bortolotti B; Bombi A; Scocco P; Kraemer HC; Berardi D; DEPICS group. (Feb. 2014) *Moderators of remission with interpersonal counselling or drug treatment in primary care patients with depression: randomized controlled trial.* British Journal of Psychiatry. 204(2):144-50.

Miresco Marc J, Kirmayer Laurence J (May, 2006) *The persistence of mind-brain dualism in psychiatric reasoning about clinical scenarios*, Am J Psychiatry 163:913-918.

Moriarty, Dick; Chanko, Cathy. Predisposing, Precipitating, Perpetuating, Professional Help, and Prevention Factors of Eating Disorders. 17 Nov, 1988: 32p.; Paper presented at the Annual Meeting of the Bulimia and Anorexia Nervosa Association (3rd, Essex, Ontario, Canada, November 17, 1988).

Murrihy Rachael, Byrne Mitchell K. (September 2005) *Training models for psychiatry in primary care: a new frontier,* Australasian Psychiatry 13(3): 296

Nadelson Carol, Notman Malkah.(2002) *Boundaries in the doctor-patient relationship,* Theoretical Medicine, 23:191-201, © 2002 Kluwer Academic Publishers, Printed in the Netherlands.

National Collaborating Centre for Methods and Tools (2011). *Critically appraising practice guidelines: The AGREE II instrument*. Hamilton, ON: McMaster University. (Updated 01 November, 2013) Retrieved from http://www.nccmt.ca/resources/search/100.

National Health Service (15 July, 2016) *Choices:Your Health Your Choices; Cognitive Behavioural Therapy http://www.nhs.uk/Conditions/Cognitive-behavioural-therapy/Pages/Introduction.aspx*

Nicely Eric (2004) *Therapist Self-care*. ttp://drnicely.com/downloads/TherapistSelfCare.pdf

Norcross J.C. (2000) *Psychotherapist self-care: Practitioner-tested, research-informed strategies,* Professional Psychology: Research and Practice 31: 710-713.

Nordgren LB; Hedman E; Etienne J; Bodin J; Kadowaki A; Eriksson S; Lindkvist E; Andersson G; Carlbring P. (Aug. 2014) *Effectiveness and cost-effectiveness of individually tailored Internet-delivered cognitive behavior therapy for anxiety disorders in a primary care population: a randomized controlled trial.* Behaviour

Research & Therapy. 59:1-11

Norris Donna M., Gutheil Thomas G., Strasburger Larry H. (April 2003) *This couldn't happen to me: Boundary problems and sexual misconduct in the psychotherapy relationship,* Psychiatric Services 54 (4): 517-522. http://psychservices.psychiatryonline.org

Nusbaum Larry. (November 13, 2003) GPPA Professional Development Committee minutes, quoted by L. Marshall. Professional Development Committee Report, GPPA Annual General Meeting, May 14, 2004.

Ontario Guideline Collaborative, formed in 1999, with representatives from: Guidelines Advisory Committee, College of Physicians and Surgeons of Ontario, Council of Ontario Faculties of Medicine- Continuing Medical Education and/or Health Services Research Sectors, Ontario Hospital association, Ontario Program for Optimal Therapeutics, Ontario College of Family Physicians, Royal College of Physicians and Surgeons of Canada, Institute for Clinical and Evaluative Sciences, Change Foundation, Cancer Care Ontario.

Ontario Hospital Association, Ontario Hospital eHealth Council, Ontario Medical Association, Office of the Information and Privacy Commissioner/Ontario.(September, 2004) *Physician Privacy Toolkit*, Queen's Printer for Ontario, Publication # 314.

Osmun WE, Brown JB, Stewart Moira, Graham Sharon.(December, 2000) *Patients' attitudes to comforting touch in family practice*, Canadian Family Physician, 46:2411-16.

Pare Michael. (2001) *Psychotherapy*. Retrieved July 25, 2005 from http://www.theberries.ns.ca/Archives/soo1Fall/psychotherapy.html (no longer available, April 9, 2010- may be accessed from Dr. Pare at michaelpare@rogers.com).

Pare Michael, Gilbert Barry (June, 2002) *Psychological therapy and counselling*, review of Batemen et al, 2001 for The Guidelines Advisory Committtee: 1-8.

Pare Michael, quote from e-mail communication to GTF via Lynn Marshall, 2005.

Personal Health Information Protection Act (Nov. 1, 2004).

Porter, Catherine. (Sept. 10, 2016) *Why doesn't province care about sex assault of most vulnerable?* Toronto Star. http://www.ourwindsor.ca/opinion-story/6850671-why-doesn-t-province-care-about-sex-assault-of-most-vulnerable-porter/

Public Health Agency of Canada (1999) *Toward a healthy future: Second report on the health of Canadians*, Federal, Provincial and Territorial Ministers of Health, http://www.phac-aspc.gc.ca/ph-sp/phdd/determinants/index.html (Accessed July 9, 2007, no longer available April 9, 2010).

Regulated Health Professions Act.(1991), last amended 2009, Schedule 2, Health Professions Procedural Code, Sections 85.1-86, 93.

Richler Erica, *The Personal Health Information Protection Act, 2004: A Guide for Regulated Health Professionals*, June 28, 2016 copyright Steinecke Maciura LeNlanc. Original by Richard Steinecke in 2004.

Rockman P, Salach L, Gottlib D, Cord M, Turner T.(2004) *Shared mental health care: model for supporting and mentoring family physicians*, Canadian Family Physician 50: 397-402.

Rose RD; Lang AJ; Welch SS; Campbell-Sills L; Chavira DA; Sullivan G; Sherbourne C; Bystritsky A; Stein MB; Roy-Byrne PP; Craske MG. (Jul.-Aug. 2011) *Training primary care staff to deliver a computer-assisted cognitive-behavioral therapy program for anxiety disorders.* General Hospital Psychiatry. 33(4):336-42.

Rosser WW. Inaugural address from the President, Ontario College of Family Physicians Chapter, Vol 11, No 1, Jan, 1999, 4.

Salole R, Goodman M, Faris G, Steinhart N. (September, 1996) *Role of psychotherapy in primary care*, General Practice Psychotherapy Association Position Paper:11.

Salole Roy, Barr Joan, Borins Mel, Brock Carol, Pare Michael, Rockman Patricia.(2004) *Recommendations for training in medical psychotherapy for non-psychiatrist physicians*, approved by the OMA Section on GP Psychotherapy, approved and adopted as a position paper by the General Practice Psychotherapy Association. Document available from GPPA (416) 410- 6644, info@gppaonline.ca.

Sattel H; Lahmann C; Gundel H; Guthrie E; Kruse J; Noll-Hussong M; Ohmann C; Ronel J; Sack M; Sauer N; Schneider G; Henningsen P. (Jan. 2012) *Brief psychodynamic interpersonal psychotherapy for patients with multisomatoform disorder: randomised controlled trial.* British Journal of Psychiatry. 200(1):60-7.

Schilling C; Weidner K; Schellong J; Joraschky P; Pohlmann K. (2015) *Patterns of childhood abuse and neglect as predictors of treatment outcome in inpatient psychotherapy: a typological approach.* Psychopathology. 48(2):91-100.

Simon GE; Ludman EJ; Rutter CM. (Oct. 2009) *Incremental benefit and cost of telephone care management and telephone psychotherapy for depression in primary care.* Archives of General Psychiatry. 66(10):1081-9.

Sox Harold C, Editor. Medical Professionalism Project, American Board of Internal Medicine, ACP-ASIM Foundation, European Federation of Internal Medicine. (5 February 2002) *Medical professionalism in the new millennium: a physician charter*, Annals of Internal Medicine, 136(3):243-6.

Stewart Sherry H., Peterson Jordan B., Pihl Robert O. (1995) *Anxiety sensitivity and self-reported alcohol consumption rates in university women.* Journal of Anxiety Disorders 9(4): 283-292.

Sunderlamd Adam, Findlay Leanne C.(27 November, 2015) *Perceived need for mental health care in Canada: Results from the 2012 Canadian Community Health Survey- Mental Health*, Statistics Canada 82-003-x Vol. 24, No. 9.

van den Berg M; Smit F; Vos T; van Baal PH. (2011) *Cost-effectiveness of opportunistic screening and minimal contact psychotherapy to prevent depression in primary care patients.* PLoS ONE [Electronic Resource]. 6(8):e22884.

Verdoux H; Cortaredona S; Dumesnil H; Sebbah R; Verger P. (Jan.2014) *Psychotherapy for depression in primary care: a panel survey of general practitioners' opinion and prescribing practice.* Social Psychiatry & Psychiatric Epidemiology. 49(1):59-68.

Victoria's Mental Health Services.(last updated October 26, 2004) *About outcome measurement,* Website managed by Mental Health Branch of the State Government of Human Services, Victoria, Australia.http://www.health.vic.gov.au/mentalhealth/outcomes/about.htm (re-accessed January 8, 2017).

Wampold, B.E. (2001). *The great psychotherapy debate: Models, methods and findings*. Mahwah, NJ: Lawrence Erlbaum, Publishers, 263 pp.

Weissman M; Verdeli H. (Mar.-Apr.2012) *Interpersonal psychotherapy: evaluation, support, triage.* Clinical Psychology & Psychotherapy. 19(2):106-12.

White W.L. (1986) *Incest in the organizational family: The ecology of burnout in closed systems,* Bloomington, Illinois, The Lighthouse Training Institute.

Wilkins P. (2003) for the Ontario Medical Association General Practice Psychotherapy Section. *Report of Survey of Members*.

Wilkins P.(January 24, 2004) *Standards for psychotherapy,* E-mail communication to Drs. David Cree, Lynn Marshall, Michael Pare, and Roy Salole.

Wolitzky-Taylor K; Brown LA; Roy-Byrne P; Sherbourne C; Stein MB; Sullivan G; Bystritsky A; Craske MG.(Mar. 2015) *The impact of alcohol use severity on anxiety treatment outcomes in a large effectiveness trial in primary care.* Journal of Anxiety Disorders 30:88-93.

World Medical Association (October 1949) *International Code of medical ethics of the World Medical Association- 1949,* World Medical Association Bulletin 1 (3):109, 111.

Yeo Michael, Longhurst Mark.(1996) *Intimacy in the patient-physician relationship,*Canadian Family Physician, 42:1505-8

Appendix 1

Brief Biographies

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Appendix 2

Brief Biographical and Conflict of Interest Survey for Guidelines Task Force Members and Reviewers

1. Name:

2. Degree(s):

3. Practice Location(s) [Town, City]:

4. Are you:
   A family physician/general practitioner? Yes No
   A psychiatrist? Yes No
   A specialist in another medical/surgical field? Yes No
   If yes, p*lease specify:*

5. Do you provide comprehensive clinical care? Yes No

6. Do you have an area or areas of special interest or focus in your practice?
   Yes No *If yes, please specify area(s):*

7. Do you practice: > 50% psychotherapy? Yes No

8. University Appointment(s):
   University: Department:
   University: Department:

9. Hospital Appointment(s):
   Hospital: Department:
   Hospital: Department:

10. Employment position(s) in the past 5 years (e.g. in research, education, administration):

11. Do you have any actual or potential conflicts of interest, such as financial affiliations, that may have, or could be perceived to have, influenced you in your development or review of these guidelines?
    Yes- *Please specify:* No

Date (YY/MO/DD): Signature:_____

Appendix 3

GUIDELINES FOR THE PRACTICE
OF PSYCHOTHERAPY BY PHYSICIANS
MEDICAL PSYCHOTHERAPY ASSOCIATION CANADA
(formerly the General Practice Psychotherapy Association)

Questionnaire for External Reviewers

Thank you for agreeing to review these guidelines.

It would be most helpful if, when making your comments,
you would quote section numbers (e.g. 3.3.1) whenever relevant.
Please use extra paper or space as required.

1. What did you like about these guidelines and why?

2. What did you not like about these guidelines and why?

3. In these guidelines, we attempted to address issues of importance to patients, collaborating psychiatrists, and non-psychiatrist physicians practicing psychotherapy. In your opinion, have we accomplished this?

   Yes ___ No ___

   If No, what needs to be included?

4. What specific changes would you suggest and why?
   (Please quote section numbers)

Thank you again for your time and expertise!

Appendix 4

Recommendations for Training in Medical Psychotherapy for Non-Psychiatrist Physicians

Position Paper Published by the Medical Psychotherapy Association Canada, formerly the General Practice Psychotherapy Association (2004)
Approved- Ontario Medical Association Section on GP Psychotherapy

Roy Salole MBBS DMJ, Joan Barr MD Hons BSc, Mel Borins MD FCFP, Carol Brock MD CGPP, Michael Pare MD MSc, Patricia Rockman MD FCFP

Recommendations

The recommendations are listed under the following five headings.

a) Psychotherapy Training in Undergraduate Medical Training.
b) Psychotherapy Training in Family Practice Residency Programs.
c) Advanced Training in Psychotherapy for Non-Psychiatrist Physicians (GP Special Interest Practice).
d) Training Program Formats.
e) Maintenance of Competence.

Each of the recommendations has the quality of evidence rating and the reference numbers to the supporting documents attached to it. A full discussion of the supporting evidence follows separately after the list of recommendations.

Psychotherapy Training in Undergraduate Medical Training

RECOMMENDATION 1: (A-I) Engagement in Doctor-Patient relationships starts at the undergraduate level and training in such skills should start at the undergraduate level and should evolve from the students clinical case-load [10, 11, 33-38].

RECOMMENDATION 2: (A-III) Undergraduate training in communication skills, personal development of empathy and compassion, and the ethics of the fiduciary nature of the doctor-patient relationship need to be incorporated throughout training rotations and not restricted to a rotation in psychiatry [34-38].

RECOMMENDATION 3: (A-III) Physicians at the end of basic medical training should:

1. Be able to integrate the biological, psychological, social and spiritual dimensions of illness and patient care [1-3, 10, 11]. This would include understanding:
   a) The nature of doctor-patient relationship and related ethics.
   b) The experience of illness by the patient and the patient's family.
   c) The impact of family on the illness, (ethnoculture, family dynamics, family health/stresses and attitudes to physicians).
2. Have knowledge and skill in the psychotherapeutic dimension of the doctor-patient relationship and in doctor-patient communication. This would include three basic communication skills [33].
   a) Skillful data gathering.
   b) Skillful emotional support.
   c) Skillful patient teaching and explanation.
3. Have developed personal qualities of empathy, congruence, compassion and ethics, as well as an understanding of the impact of the doctor-patient interaction

on the physician including an understanding of countertransference and compassion fatigue [34-39].

Psychotherapy Training In Family Practice Residency Programs

RECOMMENDATION 4: (A-III) Family Practice and General Practice residency training programs need to insure the provision of sufficient training in psychotherapy to enable family physicians to treat the high demand for this service in primary care medical practice [2, 4,16-22, 35, 40-44].

RECOMMENDATION 5: (A-II) Family Practice and General Practice residency programs will need to provide training in brief and intermittent psychotherapy interventions that have been designed to fit into the pattern of practice in primary care [17, 45-50].

Advanced Training in Psychotherapy for Non-Psychiatrist Physicians (GP Special Interest Practice)

RECOMMENDATION 6: (A-III) Non-psychiatrist physicians who:

- practice predominantly psychotherapy (50% or more)
- treat patients referred to them for psychotherapy
- treat complex cases (e.g. dual diagnosis)
- teach and/or supervise psychotherapy will require psychotherapy training beyond that provided in non-psychiatry residency programs [24-26]. Such training would ideally cover the entire course of therapy from intake to termination [51], and include:
    - assessment.
    - diagnosis & Case Formulation.
    - contract making & treatment planning including valid consent to treatment.
    - therapeutic interventions.
    - termination.

The training would also include Supervision and evaluation of Competence.

RECOMMENDATION 7 : (B-III) The standard for training in psychotherapy for physicians specializing in psychotherapy should be comparable to the criteria for membership in established psychotherapy associations for individual, family and group psychotherapy [Table-I]. This would include criteria for didactic training, psychotherapy practice, supervision and personal experience of psychotherapy [24-26, 51, 56, 57, 61].

RECOMMENDATION 8: (B-III) The curriculum for this level of psychotherapy should cover the following:

1. Knowledge and skill in managing the doctor-patient relationship and boundaries including issues of:
    a) Confidentiality.
    b) Physician-patient physical contact.
    c) Physician self-disclosure.
    d) Dual relationship with patients and ex-patients.
    e) Physician relationship with other professionals treating the patient.
2. Knowledge and skill in intake assessment including:
    a) Ability to make a diagnosis in biopsychosocial terms or multi-

axial formats such as DSM-IV or ICD-10 [26, 70, 75].

b) Ability to make a case formulation based on an internationally recognized school of psychotherapy [Table-II].

c) Ability to recognize limitations of their own form of therapy and referral to alternative methods of treatment [82].

d) Ability to provide the patient with the information necessary to obtain valid consent to treatment.

3. Knowledge and skill in psychotherapeutic interventions including:

a) Contract making and treatment planning including valid consent to treatment.

b) Recognition of dysfunctional patterns and of transference.

c) Ability to make psychotherapeutic interventions based on internationally recognized schools of psychotherapy [Table-II]. This could be interventions based on one model or an integration of several models.

4. Knowledge and skill in integrating pharmacotherapy and psychotherapy [75-80].

5. Knowledge and skills in group and family therapy if practice is to include group or couple and family therapy [66].

6. Knowledge of the supervision process and of ways to self-supervise and recognize counter-transference and therapeutic impasses [64].

Training Program Formats

RECOMMENDATION 9: (A-I) Psychotherapy training programs should integrate four training formats [9, 52-56].

1. Theoretical knowledge – didactic/lectures & literature.
2. Practical experience & skill development.
3. Evaluation/feedback and supervision.
4. Personal development.

RECOMMENDATION 10: (A-II) Supervision would ideally include some direct evidence of the therapy process such as the use of audio and/or video tapes or direct observation of therapy sessions [58-63]. These formats in supervision allow the supervisor and the supervisee access to multi-dimensional evidence of therapy sessions. The auditory and visual evidence is particularly useful early in training when the supervisee needs to hone perceptual skills. In later stages of development, videotapes and/or audiotapes provide physicians an opportunity to monitor and self-supervise their own practice for countertransference and therapeutic impasses.

Maintenance of Competence

RECOMMENDATION 11: (A-I) Continuing Medical Education is most effective if physician and practice-specific needs are identified, and training focused on those identified needs [18, 53-61].

RECOMMENDATION 12: (A-III) Supervision is an interactive process that focuses on the specific needs of the physician. It is therefore an indispensable format not only in psychotherapy training but also in the maintenance of competence for physicians practicing psychotherapy. It is also essential in monitoring for

countertransference phenomena and for therapeutic impasses which are regular occurrences in a psychotherapy practice [61, 62, 64].

References for Recommendations for Training in Medical Psychotherapy for Non-Psychiatrist Physicians (original document reference numbers):

1. OMA Committee on Medical Care and Practice; " Strategic Goals: A report on the Doctor-Patient relationship and Doctor-Patient Communication", December 1992.
2. Borins M., Morris B.; "Role of family physicians in counselling and psychotherapy." Can Fam Physician 1995;41:757.
3. CMA; "Code of Ethics of the Canadian Medical Association" CAN MED ASSOC J, Oct 15, 1996;155(8), 1176A.
4. McWhinney I.; "The importance of being different. Part 2: Transcending the mind-body fault line." Can Fam Physician 1997;43:405.
9. Levinson W., Roter D.; "The effects of two continuing medical education programs on communication skills of practising primary care physicians." Journal of General Internal Medicine. 8 (6): 318-24, 1993 June.
10. Stewart M.; "EFFECTIVE PHYSICIAN-PATIENT COMMUNICATION AND HEALTH OUTCOMES: A REVIEW." CAN MED ASSOC J. MAY 1, 1995; 152 (9) 1423-1433.
11. Stewart M., Brown J., Boon H., Galajda J., Meredith L., Sangster M.; "Evidence on Patient-doctor Communication." Cancer Prevention & Control. 1999;3(1) 25-30.
16. Arboleda-Florez J., Saraceno B.; "Mental health and primary care." CAN MED ASSOC J. Apr. 3, 2001:164 (7). 1013-1014.
17. Craven M., Cohen M., Campbell D., Kates N., Williams J.; "Mental Health Practices of Ontario Family Physicians: A Study using Qualitative Methodology." Report of The Ontario Mental Health Study Group, 1996.
18. Kerwick S., Jones R., Mann A., Goldberg D.; "Mental health care training priorities in general practice." British Journal of General Practice, April 1997, 225-227. 22 Published by the General Practice Psychotherapy Association
19. Klinkman M., Okkes I.; "MENTAL HEALTH PROBLEMS IN PRIMARY CARE: A RESEARCH AGENDA." INTL. J. PSYCHIATRY IN MEDICINE, Vol 28 (4) 361-374, 1998.
20. Lesage A., Goering P., Lin E.; "Family physicians and the mental health system. Report from the Mental Health Supplement to the Ontario Health Survey." Canadian Family Physician. February 1997;43: 251-256.
21. Parikh S., Lin E., Lesage A.; "Mental Health Treatment in Ontario: Selected Comparisons Between the Primary Care and Specialty Sectors." Can J Psychiatry, Vol.42, November 1997.
22. World Health Organization. "Diagnosis and Management of Common Mental Disorders in Primary Care." 1998, WHO/MSA/MNH/EAC/98.1.
24. College of Physicians and Surgeons of Ontario Task Force on Sexual Abuse of Patients; "The Final Report", 1991.
25. Microys G, Tudiver F.; "EXAMINING PSYCHOTHERAPY IN CANADIAN PRIMARY CARE." Ontario Medical Review 1994 September, 36-41.
26. Salole R., Goodman M., Faris G., Steinhart N.; "Role of psychotherapy in primary care." GPPA Position Paper, Sept. 1996.
33. St. Onge J.; "Medical education must make room for student-specific ethical dilemmas." CAN MED ASSOC J. April 15, 1997.
34. Bird J.; "The teaching of basic interviewing competence." Ch 13; 126-140 "The Patient-Therapist Relationship: It's many Dimensions" National Research Council (Rome) 1994, Ch 13.
35. Marcus E.; "Psychodynamic Social Science and Medical Education." J Psychother Pact Res 8:191-194, July 1999.
36. McNeilly D., Wengel S.; "The 'E.R.' Seminar: Teaching Psychotherapeutic Techniques to Medical Students." Acad. Psychiatry 2001; 25:193-200.
37. Garg A., Buckman R., Kason Y.; "Teaching medical students how to break bad news." CAN MED

ASSOC J. Apr. 15, 1997;156 (8).Salole et al.: *Recommendations for Training in Medical Psychotherapy for Non-Psychiatrist Physicians*. 23

38. Kurtz S., Laidlaw T., Makoul G., Schnabl G.; "Medical education initiatives in communication skills." Cancer Prevention & Control. 1999;3 (1) 37-45.
39. Novack D., Suchman A., et al; "Calibrating the Physician: Personal Awareness and Effective Patient Care." JAMA August 13, 1997 – Vol 278, No. 6.
40. Brown J., Weston W.; "Training in Psychosocial Issues. Survey of family medicine graduates." Can Fam Physician 1992;38:806-812.
41. Butler D., Seidl J., Holloway R., Robertson R.; "FP Residents' learning needs & beliefs about office based Psychological Counselling." Family Medicine, Vol. 27, No. 6, June 1995.
42. Hodges B., Inch C., Silver I.; "Improving the Psychiatric Knowledge, Skills, and Attitudes of Primary Care Physicians, 1950-2000: A Review." Am J Psychiatry 158:1579-1586, October 2001.
43. Hannaford P., Thompson C., Simpson M.; "Evaluation of an educational programme to improve the recognition of psychological illness by general practitioners" BJGP June 1996.
44. Williams J., Bhogte M., Flinn J.; "Meeting the needs of Primary Care Physicians: A Guide to Content for Programs on Depression." INT'L J. Psychiatry in Medicine Vol 28 (1) 123- 136 1998.
45. Stuart M., Lieberman III J.; "The Fifteen Minute Hour" 1993 Praeger.
46. Stuart M., Lieberman III J.; "Finding time for counselling in primary care." PATIENT CARE CANADA, Vol 6. No.4, May 1995.
47. Poon V.; "Short Counselling Techniques for Busy Family Doctors." Canadian Family Physician. Vol 43, April 1997.
48. Greenberg G., Ganshorn K.., Danilkewich A.; "Solution-focused therapy: Counseling model for busy family physicians." Can Fam Physician 2001;47;2289-2295.
49. Mynors-Wallis L M., Gath D H., Lloyd-Thomas A. R., Tomlinson D.; "Randomized controlled trial Comparing problem solving treatment with amitriptyline and placebo for major depression in primary care." BMJ 1995;310:441-445 (18 February).
50. Huibers M., Beurskens A., Van Schayck C., Bazelmans E., Metsemakers J., Knottnerus J., Bleijenberg G.; "Efficacy of cognitive-behavioural therapy by general practitioners for unexplained fatigue among employees: Randomized controlled trial." British Journal of Psychiatry (2004),184, 240-246.
51. United Kingdom Council for Psychotherapy; "National register of Psychotherapists." 1998.
52. Oxman T.; "Effective educational techniques for primary care providers: Application to the management of psychiatric disorders." Int"l J. Psychiatry in Medicine, Vol. 28(1) 3-9, 1998.
53. Davis D., Thomson M., Oxman A., Haynes B.; "Evidence for the effectiveness of CME; A review of 50 randomized controlled trials." JAMA, September 2, 1992-Vol 268, No 9, 1111-1117.
54. Davis D.; "Does CME work? An analysis of the effect of educational activities on physician performance or health care outcomes." INT'L J. Psychiatry in Medicine, Vol 28 (1) 21-39, 1998.
55. Haynes B., Davis D., McKibbon A., Tugwell P.; "A Critical Appraisal of the Efficacy of Continuing Medical Education." JAMA Jan 6, 1984-Vol 251 No. 1, 61-64.
56. Henry W., et al; "Effects of Training in Time limited Dynamic Psychotherapy: Changes in Therapist Behaviour." Journal of Consulting and Clinical Psychology; 1993, Vol 61, No 3, 434-440.
57. Henry W., et al; "Effects of Training in Time limited Dynamic Psychotherapy: Mediators of Therapists responses to Training." Journal of Consulting and Clinical Psychology; 1993, Vol 61, No 3,441-447.
58. Gask L.; "Small Group Interactive Techniques Utilizing Videofeedback." INT'L J. PSYCHIATRY IN MEDICINE, Vol. 28 (1) 97-113, 1998.
59. McCarthy M., "Fast Forward: The need for Videotaping in Psychotherapy Training Today." Harv Rev Psychiatry 1995; 3(Sept/Oct): 166-168.
60. Regan-Smith M.; "Teachers' Experiential Learning About Learning." INT'L J PSYCHIATRY IN MEDICINE, Vol.28(1) 11-20, 1998.
61. Orlinsky D., "Research-Based Knowledge as the Emergent Foundations for Clinical Practice." In Talley P. Strupp H., Butler S. (Eds) *Psychotherapy Research and Practice: Bridging the gap.*

Chapter 6 pg. 120 1994 Basic Books.
62. Holloway E., Neufeldt S.; "Supervision: Its contribution to Treatment Efficacy." J of Consulting and Clinical Psychology 1995, Vol. 63: No 2, 207-213.
63. Haber R.; "Dimensions of Psychotherapy Supervision." 1996, Norton NY.
64. Weiner M.; "The Psychotherapeutic Impasse: Diagnosis, Management, Resolution." 1982, Free Press NY.
66. Cameron P., Ennis J., Deadman J.; "Standards and Guidelines for the Psychotherapies", University of Toronto Press, 1998.
70. Lamberts H., Magruder K., Kathol R., Pincus H., Okkes I.; "The classification of Mental Disorders in Primary Care: A Guide through a Difficult Terrain." INT'L J Psychiatry in Medicine, Vol. 28(2) 159-176, 1998.
75. Beitman B., Klerman G.; (Eds) "Integrating pharmacotherapy and psychotherapy." 1991 Psychiatric Press.
76. Keller MB., McCullough JP., Klein DN., Arnow B., Dunner DL., Gelenberg AJ., Markowitz JC., Nemeroff CB., Russell JM., Thase ME., Trivedi MH., Zajecka J.; "A COMPARISON OF NEFAZODONE, THE COGNITIVE BEHAVIORAL-ANALYSIS SYSTEM OF PSYCHOTHERAPY, AND THEIR COMBINATION FOR THE TREATMENT OF CHRONIC DEPRESSION." New England Journal of Medicine. 342(20):1462-70, 2000 May 18.
77. Thase ME. "When are psychotherapy and pharmacotherapy combinations the treatment of choice for major depressive disorder?" Psychiatric Quarterly. 70(4):333-46, 1999 Winter.
78. Segal Z., Vincent P., Levitt A., "Efficacy of combined, sequential and crossover psychotherapy and pharmacotherapy in improving outcomes in depression." J Psychiatry Neurosci 2002;27(4):281-90.
79. Eells T. "Psychotherapy Versus Medication for Unipolar Depression." J of Psychother Pact Res, 8:2, Spring 1999.
80. Krull F.; "The Problem of Integrating Biological and Psychodynamic Views in Psychotherapeutic Training of Physicians." Psychother Psychosomat 1990: 53; 115-118.
82. Andrews J., Norcross J., Halgin R.; "Training in Psychotherapy Integration." in Handbook of Psychotherapy Integration (Eds) Norcross J., Goldfried M., 1992 Basic Books pg 564.

Appendix 5

Clinical Practice Tool: Self-reflective Questions (SRQs) for Physicians Providing Psychotherapy

Professional Competence Questions

Training- Post-graduate (5.2)

Self Reflective Questions (SRQs)- Standard Skills
Do I have sufficient knowledge and skill to offer therapy to patients of particular ages, gender, culture, ethnicity, socioeconomic status, diagnoses?
If not, how can I improve my knowledge and skill in the area(s) I think need improvement or should I limit my practice to avoid the(se) area(s) and inform potential patients and referring physicians?
SRQ- Graduated Education
How am I continually improving my competence in psychotherapy?
SRQ- Supervision
Do I have (a) skilled supervisor(s) I consult with regularly and can contact for advice whenever I am unsure of my ability to work with (a) particular patient(s)?
SRQ- Collegial Support
Do I have sufficient collegial contacts to help me maintain perspective on my practice of psychotherapy?
SRQ- Self-care and Personal Growth
Am I balancing my personal and professional life and actively pursuing my preferred ways of renewal in my personal life?
Do I know enough about myself to recognize the characteristics of patients, diagnoses, and/or histories that may elicit counterproductive thoughts and feelings about patients (counter-transference) in me?

Professional Conduct Questions

Transference/Countertransference (6.1)

SRQs- Transference/Counter-transference
What indicators are there about how this patient may be thinking and feeling about me?
What am I thinking and feeling about this patient and why?
Would I be doing this with/for any other patient?
SRQs- Physician Self-disclosure and Advice-giving
Is my urge to give advice and/or self-disclose in my patient's best interest?
Am I aware of how and when my advice or self disclosure could hurt my patient?
Is my urge to give advice and/or self disclose an attempt to meet an unmet need of my own, to address an unresolved issue in myself, to be heard, to be admired, to feel in control?
Do I have personal and professional supports in place to help me meet my needs so that I use the power of self-disclosure and advice-giving in a safe and effective manner?

Abuse (6.4)

SRQs- Prevention of Verbal, Emotional or Physical Abuse
Am I paying attention to the content of the discussion?
Am I maintaining sufficient emotional distance from the patient?
Am I watching non-verbal cues carefully?
Am I watching body posture and physical distance?
Am I being aware of transference and counter-transference issues – i.e. being self-aware of personal needs and desires and personal issues that may arise, as well as watching for reactions such as judging and distancing from the patient, feeling overwhelmed, or having feelings of embarrassment, anxiety, impatience, anger, or frustration?

For more detailed questions, see CPSO Self-assessment Tool, Member's Dialogue, September/October 2004:9 in *Maintaining boundaries with patients: 7-15*)

SRQ's- Prevention of Sexual Abuse
Am I aware of the laws and potential consequences regarding sexual involvement with my psychotherapy patients?
Do I understand why crossing sexual boundaries with my psychotherapy patients could be so harmful to them?
Am I aware of high risk situations and warning signs in myself that may make me more vulnerable to crossing sexual boundaries with my psychotherapy patients?
Do I realize that good personal and professional self-care will minimize the risk of sexual involvement with my psychotherapy patients?
Do I have regular supervision and supportive colleagues I can turn to for help regarding concerns about attraction to or from my patient(s)?

Dual relationships (6.5)

SRQs- Friends and Relatives
Am I too close to a friend or relative to probe the intimate history and do a complete physical examination?
Can I be objective enough with my friend or relative to be medically effective?
Will my friend/relative comply with my care?

Conflict of Interest (6.6)

SRQs- Gifts/Services
What is the underlying meaning of the gift/service?
What is the underlying motivation of the giver (whether patient or physician)?
What is my underlying motivation in either rejecting or accepting the gift/service?
How will the acceptance/rejection of the gift/service change the psychotherapeutic relationship?

Motives for Boundary Crossings (6.7)

SRQs About Boundaries:
Social: Do I seek social contact and/or encourage a degree of familiarity with my patients that is not in keeping with the professional relationship? What is my policy re accepting individuals referred by former patients or those with whom I've had a personal connection? How do I respond when I discover that my patient has a significant relationship with someone I know or have known?
Erotic: Do I silently compare qualities in patients with those in my spouse, look forward to seeing particular patients, or daydream about them? Do I consider the potential impact on patients of touching and/or hugging them?
Exhibitionism: Do I feel proud or gratified by being able to help a patient achieve great potential or fame or from having clients with status? Do I want to tell others who my patient is?
Dependency: Do I have difficulty terminating therapy with certain patients because of the patient's or my dependency? Do I feel complacent about being paid for those clients who are not actively participating in their therapy?
Power: Do I feel a sense of gratification or power in being able to control the patient with my advice or medical treatment or want to influence others to align with my own views, such as political/religious opinions?
Greed: Do I use information from patients for my own personal or financial gain or accept gifts or give special treatment to ensure a more favourable position of gain for myself?
Enabling: Do I fail to deal with patients on boundary issues such as late fees, missed appointments, extending session length etc? Do I make excuses to reduce fees, feel sorry for them or fear the confrontation?

Office Environment Safety and Record-keeping Questions

Office Environment Safety (7.1)

SRQ: Office Environment
"Can my office practice be modified to improve the environment in which I provide care for my patients?" (CPSO, April, 2009: 4)

Record-keeping (7.2)

SRQ: Medical Records
"Do my medical records adequately tell each patient's story in a manner that will be understood by a person seeing the record for the first time?" (CPSO, 2002:1)

APPENDIX 6

Recommendations Regarding Communication Between GP Psychotherapist and Patient's Primary Care Provider

Referral
It is our recommendation that a patient is referred to the GP psychotherapist in question by their primary care provider (PCP) who may be a physician or a nurse practitioner, where this is possible. This will allow for comprehensive care to be provided to the patient, and for the GP psychotherapist's role to remain one of providing support and therapeutic modalities focused primarily on the patient's mental health.

In cases where a patient does not have a primary care provider, it is at the discretion of the GP psychotherapist as to whether they are willing to accept patients who self refer for care with said therapist.

The GP psychotherapist should encourage the patient to secure a primary care provider (PCP) in the event that they do not have one.

Consent
When this referral is done from primary care provider to GP psychotherapist, although consent to share information is implied by the referral process, it is still advisable that the GP psychotherapist discuss consent with the patient as regards what and how their information, clinical history, progress and medications is shared with the referring provider. Written consent should be obtained wherever possible to share this information with the PCP.

In cases where no referral was provided by a patient's PCP or they do not have one, then sharing of any patient information with another healthcare practitioner at a later stage would require written informed consent from the patient.

Progress notes
While it remains good clinical practice to keep a patient's PCP informed of a patient's progress, updates on diagnoses, and therapeutic modalities being used in a patient's treatment, it remains at the discretion of the GP psychotherapist as to whether they do so without it being explicitly requested by the PCP.

In the event that the patient's **PCP does request a consult report** or progress note, the GP psychotherapist is advised to provide this within a reasonable time frame and may choose to share either their consultation notes, or write a dedicated report to the requesting physician. These notes should be shared via a secure platform such as secure facsimile, or other methods that meet HIPPA compliance standards for privacy. A telephone conversation which is documented by the GP psychotherapist is also a feasible option.

Should the GP psychotherapist become aware of any **new diagnoses**, signs or symptoms that may impact the patient's overall **physical health** (eg. dementia in an elderly patient, pain that is suspicious) and the patient's PCP is not already aware of this new diagnosis, we

recommend the GP psychotherapist share this information- with the patient's consent- with their PCP as soon as possible.

If the GP psychotherapist makes a **new diagnosis pertaining to the patient's mental health**, it is also advised this new diagnosis be shared with the patient's PCP as soon as possible by secure methods.

Safety concerns
If there are safety concerns (self harm, harm to others, driving etc) that arise in the patient in question, it is recommended that the GP psychotherapist **alert the patient's PCP** as soon as possible. The urgency of this communication will depend on the severity of the safety concern- for example if suicidal ideation is present, this should be communicated with the PCP urgently.

Medications
In the event that a GP psychotherapist **commences or changes the medications** of a patient, it is recommended that the patient's PCP is advised about this within a reasonable time frame after this change is made. If it would prove useful, the GP psychotherapist can also consult the patient's PCP prior to making this change or commencing this medication, particularly if a patient has other medical comorbidities and there is a chance of interactions between psychiatric and other medications the patient may be prescribed by their PCP.

It is also recommended that if a **significant adverse reaction** or event is experienced by the patient as a result of the medication prescribed by the GP psychotherapist, this be reported within a reasonable timeframe to their PCP such that records can be kept within their 'medical home' of this reaction or event.

If the patient's **PCP is interested and willing** to be the sole medication prescriber, and the GP psychotherapist is able to communicate their recommendations in a timely manner, the PCP is encouraged to take on this sole prescriber role and keep the GP psychotherapist informed of any changes and update the therapist on medication efficacy.

Discontinuation of therapy or discharge from care
If a GP psychotherapist reaches the end of their treatment plan with a patient, and both therapist and patient are in agreement that the patient is stable and well enough to manage without ongoing therapy, the GP psychotherapist may safely discharge the patient. In cases where a patient has a PCP, this discharge should be communicated to the PCP with details such as what medications the patient is being discharged on, and where applicable, signs and symptoms for the PCP to look out for in future that may warrant re-referral back to the GP psychotherapist.

If a patient terminates the relationship with the GP psychotherapist for other reasons than expected discharge (they chose to discontinue, fail to follow up after 12 months, or break the therapeutic contract through some other mechanism) this discontinuation in care should also be communicated as soon as possible with the patient's PCP. The GP psychotherapist can stipulate whether a new referral will be needed if the patient wishes to resume therapy with that same therapist.