The GPPA Journal continues to evolve in concert with the organization and member contributions. The GPPA, first formed in 1984, was recognized in 2013 by the College of Physicians and Surgeons of Ontario (CPSO) as a Third Pathway to Accreditation for the submission of Maintenance of Competence Continuing Professional Development (CPD) credits. We, therefore, are in the same category as the Royal College of Physicians and Surgeons (RCPS) of Canada and the Canadian College of Family Physicians (CCFP). In this issue, you will learn about GPPA President, Dr. Muriel van Lierop, and how she contributed to this accomplishment.

With this recognition, psychotherapy in general and physician psychotherapy in particular will become increasingly recognized as part of mainstream medicine. The responsibility of bringing trustworthy and reliable professional and academic writings to wider audiences then rests, to a certain degree, with the Journal.

There are several added features in this edition that will contribute to this development. Dr. Norman Steinhart, a co-founder of the Journal, begins his Research Foundations column, following in the scientific footsteps of Dr. Howard Schneider, the other co-founder of the Journal. Dr. Michael Pare will be providing his perspective on Standards of Care in Medical Psychotherapy. There are two Clinical Approaches articles in this issue – one on Gluten Sensitivity by Dr. Brian Bailey and the other, Art in Psychotherapy, by Dr. Will Irwin.

We hope to continue to celebrate the achievements of our members through a feature entitled Profiles. This issue’s inaugural individual is none other than our own Muriel van Lierop, MBBS, MGPP, who has been presented with an Award of Merit by the Ontario Medical Association’s (OMA) Section on Primary Care Mental Health. Please assist us in this continuing endeavor by bringing to our attention those people whose contributions have been and may continue to be important in the field of mental health care. Perhaps consider writing a profile yourself. To assist in the presentation of your profile.
Research Foundations
Using Modern Research to Explore the Mechanisms, Effectiveness, and Limitations of Psychotherapy

Norman Steinhart, MD, CGPP

Psychiatry, and psychotherapy in particular, suffer from a poverty of validated, evidence-based methods of diagnosis and treatment. The Diagnostic and Statistical Manual (DSM) of Psychiatric Diagnoses processes have not been shown to lead to better treatment outcomes, and yet, there is no psychotherapy-centered form of diagnostic system that serves as an alternative.

Psychotherapy, of all medical procedures, presents the greatest challenge to research practice, since the private and spontaneous nature of interactions greatly limit the data that can be collected, and deny researchers obvious patterns to analyze. Do we look at language, prosody (the patterns of stress and intonation in a language) or body movements? And is it just the patient we need to study or the interactions between doctor and patient? There is no clear guideline as to what are the appropriate targets of analysis in psychotherapy.

As a result, we have limited knowledge of the foundations of therapy. None of the following questions have yet been answered in a scientifically sound way:

1. What do skilled practitioners do that leads to perceived empathy by patients?
2. Why is empathy critical to successful treatment?
3. Why do different therapies, that seem to have different theoretical foundations, show similar results? (Carr, 2011; PPRNet, 2014)
4. Why does the individual efficacy of practitioners vary widely, even among trained, professionally regulated practitioners? (PPRNet, 2014)
5. What processes and methods lead to an effective alliance?
6. Repair of rupture is critical to success, but why is it so crucial and how is it achieved?

From the Editor (cont’d)

material, the Journal Committee has developed ‘Author Guidelines’, which can be found on our website at http://www.gppaonline.ca/Journal.html. As a group, we hope to encourage and showcase the skills, dedication, and creativity of all who play a part in keeping our professional approaches balanced and functioning optimally.

Another addition to this issue is our ‘Correspondence’ section, wherein suggestions and reflections from our members encourage healthy dialogue, discussion and new directions.

In March, Dr. George Lewis, a GPPA member, suggested that an article from the Globe and Mail, which appeared in the Friday, December 20, 2013 Toronto edition, could be interesting to our members. Written permission has been obtained from the author to reprint his work. If you are familiar with Charles Dickens’, A Christmas Carol, you might also find it thought provoking.

Share your thoughts about the inclusion of works such as this in our Journal by writing a Letter to the Editor via journal@gppaonline.ca.

Please enjoy all our usual features, as a result of the dedicated work of the Editorial Committee and Carol Ford, Association Manager, without whom this Journal would not exist. The individuals who take time to submit articles and work through the editing process are equally as important.

Sincere thanks are extended to you all.

Maria Grande

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

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

If there is something novel you wish to explore and possibly have published, contact Maria Grande at journal@gppaonline.ca
Research (cont’d)

7. Why are even experienced, respected psychotherapy practitioners so inept at detecting unsuccessful and even harmful encounters, and early signs of clinical deterioration? (PPRNet, 2014)

8. Are there some mental health patients that cannot be helped by current psychotherapy practices due to the nature of the pathology, and, if so, how do we identify them?

9. Finally- the biggest question, worthy of a research prize- What is the mechanism of change and improvement in psychotherapy? Is it on the level of neural/brain processes, emotional states, or self-initiated thoughts, or social cognition, or social competence? Or some or all of the above combined? Or other levels of organization of human function?

In this recurring section of the journal, I will explore and discuss the most useful and interesting aspects of the science of psychotherapy, hoping to offer some partial and tentative answers to these questions - science that I believe will enhance our understanding of the process, and our effectiveness in practicing, medical psychotherapy, in addition to stimulating our interest in reading and participating in medical psychotherapy research.

Initial readings to understand the scientific foundations of psychotherapy

Part 1: Neuroimaging and Psychotherapy of Depression
Two select reviews

Neuroscience progress has led to the accurate imaging of functional brain activities, including interactions between brain areas. This advance has allowed researchers to detect differences between the brain activities of healthy and mentally ill patients as they process emotionally-laden stimuli. Consistently, depression and anxiety show impairments of cortical-limbic pathways. Dysregulation of emotions results from the inability of cortical areas to modulate emotional and physiological activity. Psychotherapy enables patients to improve the cortical control of these functions by increasing the patient’s recognition of pathological emotionally-driven thinking and also changing brain activity to support thinking-regulated emotions.


This review article by Atkinson et al outlines some of the functional abnormalities in depression found in imaging studies and provides evidence for the normalization of these neural functions by psychotherapy. Of note, the elevated activity in the medial prefrontal cortex is associated with the excessive self-referencing of negative events (over-interpreting of situations to reflect negative self-characteristics) that depressed patients express, and their ruminations about these faults and errors. 16 weeks of Cognitive Behaviour Therapy (CBT) has been shown to reduce this activity, as well as over-activity in the amygdala-hippocampal circuits.


This review only focuses on the changes in brain function from psychotherapy without exploring neuroimaging of psychopathology, but considers research that is less commonly done on the brain functional changes from long term dynamic therapy (LTDT). It was shown that LTDT reduces the overactive amygdala-hippocampal complex and subgenual cingulate cortex. CBT was shown to reduce dorsal anterior cingulate cortical activity, indicating subtle differences in the mechanism of action of different forms of therapy. In the future, brain scanning will hopefully help us select the type of therapy that is most effective for the patient in the shortest time. This article also reviews psychotherapy-mediated changes in brain activity of patients with anxiety disorders.

Conflict of interest : none

Contact: norman_steinhart@utoronto.ca

References

Psychopharmacology
Treating ADHD in the Family  Howard Schneider MD, CGPP, CCFP

ABSTRACT
Undiagnosed ADHD (Attention Deficit Hyperactivity Disorder) is often recognized in adults after their child is diagnosed. Comorbidities are common in adult ADHD, including anxiety disorders and substance dependence, especially smoking. In adult ADHD comorbid with GAD (Generalized Anxiety Disorder), a stimulant can be the first psychopharmacological treatment, with the addition, if necessary, of an SSRI/SNRI and/or benzodiazepine later. Treatment must be tailored to the patient as patients respond very differently to different agents as well as dosage patterns.

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

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

In this issue we will consider Stahl’s fourteenth case. The patient is a 26 year old divorced mother of two children (8 and 6 years old), who works in retail. The father of the children is not actively involved in their lives. The patient has an 8 year old daughter with ADHD (Attention Deficit Hyperactivity Disorder). Her daughter had been seen earlier by Dr. Stahl when he noted that the mother also had symptoms of ADHD. The 26 year old mother returns to see a psychiatrist, whom we assume is Dr Stahl (it is unclear the way the case is written up) for her own assessment.

Past Psychiatric History:
There have been no formal diagnoses or treatments. However, Stahl notes that the mother shows multiple symptoms of ADHD going back to her childhood years:
• missing appointments or late for appointments
• seems disorganized
• couldn’t fill out her daughter’s forms on time
• can’t organize herself to take her child to Cognitive Behaviour Therapy (CBT) sessions
• can’t keep herself, nor manage to keep her daughter, on a regular schedule of going to bed and waking up
• can’t remember to remove her daughter’s skin patch medication
• has always done poorly academically
• mentally “freezes” when has to handle too much
• notes that she had similar problems as her child did when she was a child

There is no history of depressive disorders but Stahl notes that the patient also felt overwhelmed with having to take care of two children, and also may have some signs of depression.

Personal History:
• adopted as a child
• pregnancy at 17 years old and dropped out of high school
• married at 17 years but divorced 2 years later
• has two children, 6 and 8 years old
• father of children not active in their lives
• single mother
• works in retail

Past Medical History:
• no significant Past Medical History
• normal BMI
• normal blood pressure
• normal lab tests
• no drug abuse
• no significant use of alcohol
• smoker

Family Psychiatric History:
• 8 year old daughter has ADHD with comorbid ODD (oppositional defiant disorder)
• patient was adopted and other family history is not known

History of Present Illness:
The patient had filled out an Adult ADHD Self Report Scale Symptom Checklist when her daughter was evaluated. The patient endorsed many of the symptoms on the checklist, particularly the inattentive ones:

Continued on Page 5
Psychopharmacology (cont’d)

- trouble wrapping up the final details of a project once the challenging parts had been done
- difficulty getting things in order
- difficulty remembering appointments
- careless mistakes
- difficulty keeping attention on repetitive work
- distracted by activity around her
- difficulty listening to someone during a conversation
- losing things at home and at work
- also, difficulty unwinding when work is over

The patient was able to get her report cards from grade 1 and 2, which her mother had kept. As a child her grades were low and the teacher’s comments reflected on the same issues noted above in the Adult ADHD checklist.

The patient says that the above symptoms don’t let her take care of her family as well as she could. Also, she notes that since she was not able to stay focused in a conversation, her ex-husband used to feel that she was not interested in him.

The patient feels overwhelmed with the responsibilities of taking care of her two children. She blames herself for the academic problems her daughter is having. She feels irritated at her children at the end of the day, and then she feels guilty about this.

The patient notes trouble sleeping and worrying very much, particularly about the future of her family and about her own future.

Stahl notes that a diagnosis of ADHD is obvious, but that there are symptoms which also suggest a diagnosis of Generalized Anxiety Disorder (GAD):
- constant worry
- feeling on edge
- difficulty concentrating, the mind going blank
- fatigue
- irritability
- insomnia

Stahl notes that the majority of adults with ADHD also have another comorbid psychiatric diagnosis, with the most common one being GAD. Stahl also notes to himself that a larger than expected proportion of ADHD patients smoke, possibly because of the therapeutic effects of nicotine on ADHD symptoms.

There are two diagnoses for this patient: ADHD and GAD. Since ADHD seems to be the primary disorder, it should be treated first. Stimulants, the usual treatment for ADHD, can increase anxiety, and there is the risk of worsening the GAD symptoms. However, in ADHD a stimulant can often paradoxically improve the GAD symptoms. Thus Stahl thinks to himself that he will start treatment with a stimulant. He can always add an SSRI/SNRI and/or benzodiazepine later.

Stahl starts the patient on d,l-amphetamine mixed salts-XR (Adderall-XR). Stahl also refers the patient to a local mental health training program where she can get CBT for free from a trainee under supervision.

The starting dose of Adderall-XR is not mentioned, but Stahl notes that by the time the d,l-amphetamine mixed salts-XR had been titrated up to 20mg, the patient felt the medication was helping the ADHD symptoms, and at this time the patient received her first CBT session. The patient mentions that without the medication she would not have been able to do the CBT homework assignments.

There were no adverse effects at d,l-amphetamine mixed salts-XR 20mg qAM, so it was titrated up to 30mg. Blood pressure and pulse remained stable, but the patient felt jittery at this dosage. The dose was lowered to 25mg, but the jitteriness was still there, so the dosage was brought back to 20mg qAM. However, the patient felt that back at the 20mg dosage, her ADHD symptoms were not well treated. The patient had a vacation planned the following week, so Stahl did not want to adjust the dosage, since the activities during a vacation may not challenge a patient the same way their normal activities do.

Stahl saw the patient a few weeks after she had come back from her vacation. She had now received 12 weeks of CBT, and was still on d,l-amphetamine mixed salts-XR 20mg qAM. The patient was grateful for the medication; on days she forgot to take the d,l-amphetamine mixed salts-XR, she became aware how much the medication helped her concentrate. However, she still complained about problems with procrastination, with organizing her day and with losing things. At d,l-amphetamine mixed salts-XR 25 and 30mg, the medication was more effective for her ADHD symptoms, but unfortunately caused anxiety and jitteriness.

Stahl switched the patient’s medication to OROS methylphenidate (Concerta), starting at 18mg qAM at week 16 (ie, 16 weeks since seeing Stahl) and titrated up to 72mg qAM at week 20. The patient did not have the jitteriness she experienced on the mixed amphetamine salts, but unfortunately, the patient did not think the methylphenidate worked as well to help her ADHD symptoms. Since the patient’s blood pressure and pulse were normal, Stahl increased the dosage of the OROS methylphenidate to 90mg qAM.
Cognitive Bytes
Motivation  Vivian Chow, MD

Motivation can be defined as “that which moves people to act” (Ryan, Lynch, Vansteenkiste, & Deci, 2011). All around me, people are seeking the impetus that moves them to act in a way that leads to self-improvement. I have friends trying to lose weight, family members trying to become more organized and patients trying to improve their emotional well-being. Even some of my colleagues have asked me for suggestions on how to instill motivation.

Motivation is a key issue for psychotherapists, especially since many of the patients we see suffer from depression and one of the symptoms of depression is lack of motivation. So how do we get our patients motivated? I suggest two rules for my patients. First I would have them agree to engage in each activity for a minimum of five minutes (Chow, 2014). The rationale here is that the patient will likely continue the activity, as they have become motivated from their 5 minutes of engagement. The other rule I call “breaking it down.” This method involves breaking up tasks into components, working on the smallest or easiest component first, and then working one’s way up to the most difficult. For example, if a patient needs to file taxes, I would suggest organizing the paperwork into piles (that’s one component). Then, start with the smallest or easiest pile (second component) and only work with that. Continue in this fashion with slightly larger or harder parts until the task is completed.

If the patient is still feeling overwhelmed by the size of the components, I will suggest breaking them down even more, e.g. one envelope at a time. In order to encourage my patients further, I tell them to give themselves a pat on the back for every component they complete. Instead of feeling defeated and focusing on the parts of the task they haven’t completed, I tell them to focus on all the parts they have completed and try to feel pride.

The above techniques work for specific tasks, but a more generalized method for basic changes is necessary. Remember that we, the psychotherapist,

Continued on Page 7

Psychopharmacology (cont’d)

The patient returned for a follow up visit at week 24. She said that the 90mg methylphenidate dosage was now as effective as the d,l amphetamine had been at the 30mg dosage. Blood pressure and pulse were still normal, although Stahl notes a slight increase from baseline values. According to Stahl, now that the patient’s ADHD symptoms were better controlled, the patient became more aware of her anxiety symptoms, and said she was worrying more about the financial security of her children, worrying about what would happen if she lost her job or got sick. Stahl felt the first approach would be to focus on these anxiety symptoms in CBT and wrote a letter to her cognitive therapist.

In reviewing the case, Stahl notes that it took over a year of trial and error and combination treatment to succeed with this patient. Stahl (2011) writes: “prescribing stimulant to an ADHD patient is very much like tailoring a ‘bespoke’ treatment, one case at a time.”

The patient was seen for follow-up at weeks 24 and then 36. The CBT techniques had not reduced the anxious feelings much. Stahl added paroxetine to the patient’s medications. The patient was next seen at week 48. The OROS methylphenidate and paroxetine had worked well, and the patient stated that she “had her life back.”

In reviewing the case, Stahl notes that it took over a year of trial and error and combination treatment to succeed with this patient. Stahl (2011) writes: “prescribing stimulant to an ADHD patient is very much like tailoring a ‘bespoke’ treatment, one case at a time.”

Continued on Page 7

Conflicts of Interest: None reported.

References

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Trade Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>d,l-amphetamine mixed salts-XR</td>
<td>Adderall-XR</td>
</tr>
<tr>
<td>OROS methylphenidate</td>
<td>Concerta</td>
</tr>
<tr>
<td>paroxetine</td>
<td>Paxil</td>
</tr>
</tbody>
</table>
also need to be motivated. If we show interest in our patients’ lives, needs and desires, we can perhaps pique some motivation as well. Some patients believe that getting motivated is as difficult as mastering Latin, in that a great deal of hard work and natural talent (which they don’t have) is required. They may think there is some well-kept secret that only a small percentage of over-achievers know. The more it can be simplified for them, the more likely they are to succeed.

I will frequently draw the attached diagram for patients (Figure 1, adapted from Moore, 2013) to better illustrate this concept. In my practice, doing psychotherapy homework seems to be an issue, so I will use that as an example for becoming motivated. Referring to figure 1, I tell my patients that there are two “ingredients” to motivation – importance and confidence. In order for action to take place, both of these “ingredients” need to be at least a 7 out of 10. I then ask them outright if they think it is important enough to do their homework and to rate it on a scale of 0 to 10. If their score is less than 7, I will go over again why I have assigned a certain task. I will then engage them in discussing if and how their homework should be modified, with a view of giving them more confidence.

Hopefully, I can increase the confidence score to at least 7 out of 10. Obviously, if patients are scoring high on only one axis, we then focus on the lower-scoring axis. If they are scoring low on both axes, I would then tell them that they are just not ready to commit to the action. In the case of homework, I will ask them to consider how serious they are about therapy or suggest homework that is less demanding.

Once patients have achieved the level of motivation required to enact the necessary changes, they have taken the first step towards improvement.

Of course, motivation is not static and will fluctuate depending on numerous factors; however, I hope that the above techniques will provide additional tools to help clinicians keep patients motivated.

Conflict of Interest: None reported.

References

Next we focus on the other axis, confidence. I ask my patients how confident they are that they can commit to the homework and to rate this on a scale of 0 to 10. If their score is less than 7, I will go over again why I have assigned a certain task. I will then engage them in discussing if and how their homework should be modified, with a view of giving them more confidence.

Hopefully, I can increase the confidence score to at least 7 out of 10. Obviously, if patients are scoring high on only one axis, we then focus on the lower-scoring axis. If they are scoring low on both axes, I would then tell them that they are just not ready to commit to the action. In the case of homework, I will ask them to consider how serious they are about therapy or suggest homework that is less demanding.

Once patients have achieved the level of motivation required to enact the necessary changes, they have taken the first step towards improvement.

Of course, motivation is not static and will fluctuate depending on numerous factors; however, I hope that the above techniques will provide additional tools to help clinicians keep patients motivated.

Conflict of Interest: None reported.

References
The purpose of writing this article is to share my interest in art as a way to visually represent complex emotional subjects. The phrase 'a picture is worth a thousand words' describes this process well.

I would like to accomplish three things. First, I will start with introducing some of the principles of doing art as part of therapy. I will then share two examples how art has helped me explore and understand my own personal world. Finally I will share two of my experiences of having patients do art as part of their therapy.

My interest in art therapy dates back to the 1980’s. I had recently read 'The Secret World of Drawings' by Gregg Furth. I would recommend this to those interested in a more in depth look at the principles of Art Therapy. He provides a wide variety of examples of pictures drawn by both children and adults, with clear interpretations. His guidelines are easy to follow. Gregg Furth Ph.D. graduated from the C.G.Jung Institute in Zurich, Switzerland. I am sure there are many other informative books out there on art therapy, however this is the one I am familiar with.

Gregg Furth states there is no right or wrong in Art Therapy. He recommends that, after the drawing is done, let the patient talk about what the image means to them. Once they are finished speaking, the details of the drawing are approached gradually.

As the therapist, note your first reactions to the piece, but if commenting, merely admire the picture with a very general comment and ask if the patient would like to tell you anything about it. If you do not recognize an object or design say “Tell me about this object” rather than “What is this?” Avoid direct questions that call for yes or no replies. Encourage a narrative response with “Tell me more”.

Gregg Furth emphasized 'the meaning of a symbol must be defined in terms of the individuals own private symbolic language'. The picture comes from the same level as dreams. It is a reliable method of communicating with the unconscious. The mind and body are linked.

The patient should never be hurried. I essentially achieve this by having my patient work at home and bring their art to the next session. This is not ideal as I miss seeing the process unfold, for example erasures are to be considered relevant, as is the choosing of color. I have however had patients do quick sketches in the office to help them start expressing how they are feeling or to help a few patients remember they can make a picture. At some point in therapy, a useful request is, “Make a drawing of your family and yourself (at the age being explored). Make sure that everyone is doing something. Avoid using stick figures”.

Having art supplies on hand is essential. When I was in general practice, often a pencil or ball point pen plus paper was all that was available. While these work well, I would recommend having colour pencils as they allow for more detail and shading. Plain printer paper works well as a drawing surface. Having an eraser and an HB (or softer) pencil are also useful.

I will now explore two examples of my own art.

This picture was made sometime after reading Alice Miller’s book ‘For your own good’. It expresses some of the negative aspects of my own early education, which also had many positives. It can be very revealing, when discussing early learning, to ask about art. Troubled children are more likely to have their artistic sense repressed because a teacher or family member did not respond in an open way to a picture that was an honest representation of their dilemma.

Layers of self is somewhat abstract mandala (mandala is described below). This picture explores the body more from above and there is a series of layers as in an onion, the core is clearly seen in the picture. This is more an exploration as in Fritz Perls’ 5 layers of the neurosis. Interestingly Hindu philosophy also refers to five layers of the soul.

Continued on Page 9
Art and Art Therapy (cont’d)

Imagine this layered object with various personally chosen symbolic images placed on it and you have your own personal mandala. This can be re-drawn over time and it is a simple technique to both develop and follow your transformation over time.

Mandala is a Sanskrit word meaning circle and is found in Hindu and Buddhist traditions. Carl Jung, M.D. drew circle pictures daily, representing himself, for about a year during World War I, he did this as a way to observe his psychic transformations from day to day. Familiarity with the philosophical writings of India prompted Jung to adopt the word "mandala" to describe his circle drawings.

In his book ‘Memories, dreams, reflections’ Dr. Jung wrote “To the extent that I managed to translate the emotions into images—that is to say, to find the images which were concealed in the emotions—I was inwardly calmed and reassured. Had I left those images hidden in the emotions, I might have been torn to pieces by them.” In my experience, an image from the emotions is not quite so powerful. In general, using a picture to encourage a dialogue about some part of a person’s life that had not previously been expressed is a valid method of beginning that journey.

I will now look at art produced by two patients CG and ML who have given their permission for me to show their pictures.

1. CG, a depressed male patient, produced the picture below after a long series of difficult drawings. It is not hard to interpret this as a positive image. The figure appears to have both direction and energy.

The drawing shows how, in our culture, time flows from left to right as does the written word and in general pictures can be read this way. But note a possible need for more grounding in that there is no ground or horizon visible and the feet are not clearly drawn. The alignment of the head and neck to the body might be a clue. The chest is poorly developed and the neck appears to be to the left of the body, giving a sense of imbalance.

2. ML was a severely depressed, bulimic female patient who came out of hospital early, more depressed than when she went in. There were issues of dependency and so I could understand the premature discharge. She was still suicidal. As conversation was initially very difficult, I asked her to paint at home and to bring the images in. She started with images that she felt very safe painting—houses, gardens and flowers for example. I asked her to make an image of herself in a family social gathering which she had previously described as being a difficult place to be. She returned with the following picture. She is the stick figure in the corner.

This picture contained separate images and some brighter colours. Initially, she didn’t wish to show it to me. The eye-like image seen at bottom centre became part of our discussion and her pictures became wilder and almost psychotic.

The stick figure spoke to her diagnosis of bulimia where body image issues are common. There is a sense of shame and low self-esteem in the image. I wondered and asked about trauma and sexual abuse but these explorations were not helpful. We were still struggling. She was silent, which suggested to me an ongoing desire to be rescued or there was something she could not express. I encouraged her to be more exploratory with paint. After a number of visits, she produced the next image:

This picture contained separate images and some brighter colours. Initially, she didn’t wish to show it to me. The eye-like image seen at bottom centre became part of our discussion and her pictures became wilder and almost psychotic.

She was not psychotic but she was still far from being well. The eye-like image had progressed to what for me was more like a total-body energy scan expressing her dilemma. She produced many similar chaotic images over the next three months, and finally over a number of sessions her images became less troubled and she improved emotionally. She went on to take an art
Clinical Approaches

Gluten Sensitivity Presenting as Anxiety, Depression or Psychotic Symptoms

Brian C. Bailey, M.D., B.A.

Summary

Gluten sensitivity, a term greeted with derision in some quarters due to the wide North American adoption of the gluten free diet as a dietary fad, is becoming increasingly recognized in medical circles as a significant medical entity. Of interest to psychotherapists are the high rate of this inherited entity in the population (6% or more) and the relatively recent association of gluten sensitivity with severely lowered levels of neurotransmitters - a situation which both lessens the effect of psychoactive medications (rendering them useless in many cases) and severely limits the results of psychotherapy. In essence, many of our patients will be seen to be untreatable if they are gluten sensitive and have not adopted a strict gluten-free diet in advance of treatment.

Some of us are tempted to turn a blind eye to gluten sensitivity, which is now officially called Non-Celiac Gluten Sensitivity (NCGS), because some physicians are not (yet) sure it exists. Genuis and Lobo (2014) affirm not only that it does exist, but that is linked to mental and emotional symptomatology.

“Signs and symptoms indicative of nonceliac gluten sensitivity (NCGS), in which classical serum and intestinal findings of CD may be absent, have been frequently reported of late. Clinical manifestations in patients with NCGS are characteristically triggered by gluten and are ameliorated or resolved within days to weeks of commencing a gluten-free diet. Emerging scientific literature contains several reports linking gluten sensitivity states with neuropsychiatric manifestations including autism, schizophrenia, and ataxia.” (Genuis, S., & Lobo R. (2014.)

Gluten Sensitivity Presenting as a Neuropsychiatric Disorder, retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3944951/

We’re skeptical of the patient who comes to us saying they’re on a gluten-free diet, because, when we ask them how they know they’re gluten sensitive, they go silent or give us an answer that we as scientifically-oriented physicians would never accept. In one sense, we are right. There are no laboratory tests which are accepted as diagnostic. But we could be wrong, too. It is now considered diagnostic of NCGS if one completely avoids gluten for a month, experiences relief of any number of symptoms, only to have a return of symptoms after a challenge with a gluten-containing meal. (Genuis and Lobo, 2014)

At this point, you might be thinking: What does this have to do with general practice psychotherapy? Everything, actually, but it’s something so current that we are just beginning to see articles in the medical literature. Furthermore, it’s not a condition one sees once in a lifetime. Rather, it is appearing with greater and great frequency, according to Dr. Joseph Murray of the Mayo Clinic, who notes that gluten induced problems have been doubling in incidence every twenty years, (retrieved from https://www.youtube.com/watch?v=DKwKQ7W9qlM)

Dr. Alessio Fasano at Harvard, who recently assembled a comprehensive review of the subject from a highly-

Art and Art Therapy (cont’d)

course which she found difficult but enjoyed.

I’m not sure if Rumi, the 13th century Persian poet, did art therapy but this quote from his work supports the hypothesis that there is no right or wrong in art therapy and also references the psychotherapeutic relationship.

“Out beyond ideas of wrong-doing and right-doing, there is a field. I’ll meet you there.” — Rumi

Contact: Will Irwin, MD
wirwin@on.aibn.com

Conflict of Interest: None

References:

Gluten Sensitivity (cont’d)

published researcher’s point of view, estimates that non-celiac gluten sensitivity affects as many as 6% of the population. (Fasano, 2014) Others multiply that figure.

As a medical psychotherapist, I found myself working in an integrative medicine clinic in 2005, asked to see patients who were chronically anxious, depressed or suffering from Obsessive Compulsive Disorder (OCD) as a part of a plethora of physical complaints, which generally defied diagnosis or treatment in the mainstream world. Many patients who are anxious somatize, and feel helpless when they do, and if they weren’t coming to our clinic would be among the denizens of emergency rooms (ER). Many of them, if asked, admit to frequently finding themselves rushing to ERs.

In 2005, I was asked to see a different breed of patients who were being newly diagnosed by my colleagues for the first time, who often suffered from autoimmune disorders, and were frequently depressed, or had emotional and mental symptomatology which either defied identification as a particular condition, or else was described by the patient vaguely as “brain fog” - frequently manifesting as the inability to concentrate or remember enough to carry on their usual employment activities.

Out-of-the-Blue Suicidality

While those who are eventually diagnosed with NCGS are almost universally too embarrassed to reveal it in a first contact psychotherapy interview, these patients very frequently describe themselves as feeling “fine”, when, out of nowhere, a strong urge to commit suicide arises. Once one has heard this story a few times, it becomes apparent that this story differs from any other description one hears of relating to suicidal thoughts. This seeming “artifact” may be occurring at the time of a sudden neurotransmitter shift that neuroscientists may eventually demonstrate with PET scans and fMRI’s.

I would like to give you one example from my practice of the typical presentation of a gluten sensitive individual.

Sheldon (not his real name), is a 48 year old father of three, of middle eastern ancestry, who had been off work for about a year from his job as the manager of a government department and an IT specialist, after he found that he could not keep up with changes his department was making in their computer systems. At staff meetings, he found himself zoning out, no longer as sharp as he once was, unable to keep up with schedules. He sees a psychiatrist who had tried several antidepressants with desultory results. He is now on two medications, Cipralex and Wellbutrin, and not feeling any better. In fact, his energy had been sinking and he was so down that he was considering medical retirement. He has had some testing which revealed a mild iron deficiency anemia and some abnormal liver function tests. His wife has recently been diagnosed with Rheumatoid Arthritis and he has a 17 year old daughter who has limped through school, suffering from shyness, and eventually being bullied by other girls. He sees her as withdrawn compared to his other children. Sheldon’s (not his real name) mind was so muddled he had “brain fog.” He continues to be medicated and has no thoughts of medically retiring.

COMMENTARY: Despite the stool testing done in Sheldon’s case, current opinion is that accurate laboratory testing for non-celiac gluten sensitivity does not exist (Guandalini and Fasano, 2012). Instead they would prescribe a one month withdrawal from gluten.
Gluten Sensitivity (cont’d)

followed by a test gluten-containing meal. There should be relief of symptoms (often multiple system symptoms) followed by return of symptoms after the test meal. Clinicians learn to recognize the plethora of symptoms and are assisted in the diagnosis of NCGS by having the patient fill out the form (fig. 1) published by the Gluten Free Society (2014). If the patient scores 5-8 on the form, gluten sensitivity should be entertained, while scores of over 8 almost certainly indicate gluten sensitivity. I find this very helpful in sorting out when to prescribe a gluten-free diet.

Here are some helpful tips for psychotherapists in recognizing and successfully treating patients with gluten sensitivity:

1. Awareness of the condition - A patient presenting to you already taking two antidepressants, and still seeking help should make you strongly suspect gluten sensitivity. Improvement rarely occurs while still on gluten. Another diagnostic clue: Gluten sensitives or their close relatives very often have autoimmune disease. Anecdotally, I see patients who have chronic emotional symptomatology versus candidates for crisis intervention, therefore, every second patient walking through my office door turns out to be gluten sensitive according to the challenge test that is, 50% have symptomatic improvement within a week of going gluten free. NCGS researchers such as Dr. Joseph Murray at the Mayo Clinic believe that NCGS has reached epidemic proportions.

2. Patients feel better emotionally within a week of going gluten free but rarely regain function on their own. Lack of function comes from years of low neurotransmitters. (Pynnönen et al. 2005).

3. Platelet testing in such patients has shown low neurotransmitter levels in 100% of cases according to Dr. Daniel Kalish.

4. Psychotherapy may or may not work immediately, varying from 1 month to 1 year when following a gluten-free diet. Like treating PTSD, it tends not to work at all unless it is intense, like Habib Davanloo’s Intensive Short-Term Dynamic Psychotherapy (ISTDP). Mindfulness-based psychotherapy has been seen to work also.

5. While tests for non-celiac gluten sensitivity are unreliable, testing for malabsorptive complications of non-celiac gluten sensitivity are frequently found, according to the National Foundation for Celiac Awareness. In many cases, therapeutic results (both emotional and functional) depend on treatment of the malabsorptive complications (Strawbridge 2013).

Contact: Dr. Brian Bailey
dr. bailey@acudestress.ca

Conflict of interest: none reported

References


Figure 1: Gluten Sensitivity Checklist. From The Gluten Effect (Petersen ad Petersen 2009)
Book Review

Reviewed by Jennifer Rae, MD

It isn’t hard these days to find articles, blogs, books and seminars on the trendy topic of life-work balance. Indeed, we live today in an era nearly defined by strategies for “stress-management”—from yoga to meditation to mindfulness—in a world where, ironically, we are bombarded by information on how to simplify, streamline and downsize our overburdened lives.

Less well-known, perhaps, is the name Dr. David Posen, a physician-turned-stress expert, who has, for two decades now, spoken-out on the toxic toll stress takes on our health, while offering practical, hands-on strategies for taking back control of our lives.

The homegrown Posen is a Toronto native, having graduated from University of Toronto’s medical school in 1967. He practised as a family doctor for nearly 52 bite-sized chapters to help them review, renew and re-balance their lives.

Posen’s message— that the modern world, and the way we live in it, are making us sick— must have struck a chord; the Little Book is now in its twelfth printing, and has been translated into six languages.

Today, stress-master Posen is back on bookshelves with his latest offering, Is Work Killing You? published nearly a decade after his last book. Having read Posen’s previous “stress-classic,” The Little Book of Stress Relief, I wondered what new message it might hold. Was there much new to say about stress? Were there new tips for managing its presence in our lives? The answers, it seems, are yes and yes. Indeed, Posen’s latest book is a significant departure from his previous works, looking at the larger, macrocosmic, “corporate” causes of stress which impact the lives of so many people.

Is Work Killing You? is a title—and question—that is bound to leap off shelves, and have readers nodding, “Yes, it really is!” with curiosity and even desperation. Just as humorist Scott Adams portrays in his classic comic series, Dilbert, Posen unveils the frustrating culture of North America’s corporate bureaucracy where workers are regularly mismanaged by those higher-up with little vision or training, at enormous cost to their physical and mental health. He zeroes in on what he sees as the three main culprits of workplace stress: Velocity (the speed at which workers are expected to perform), Volume (the sheer load workers are expected to perform) and Abuse in the work environment.

Gluten Sensitivity (cont’d)

Kalish, D., Gluten Sensitivity. retrieved from http://kalishresearch.com/a_gluten.html
Murray, J., retrieved from https://www.youtube.com/watch?v=DKwKQ7W9qlM
National Foundation for Celiac Awareness. Diagnosis of Non-Celiac Gluten Sensitivity; see transcript of Melinda Dennis interview, retrieved from http://www.celiaccentral.org/non-celiac-gluten-sensitivity/testing-and-diagnosis/

Continued on Page 14
I had been seeing a psychoanalyst for about a year when, at the end of November, I announced to him that I was quitting for the holidays. I was sad about the subjects we were discussing and didn’t want to dwell on them during the Christmas season. I promised to start up again in January. He talked me out of it, to my complete lack of surprise. He said we were finally getting somewhere and advised me to sit with my feelings and let them do their work. I went home with a commitment to return at the end of the week.

That night, by pure coincidence, I picked up *The Examined Life* by British psychoanalyst Stephen Grosz. If you haven’t heard of it, this is not a self-help book. *The Examined Life* is a critically acclaimed collection of essays about therapy patients and their struggles, more Chekov than Chopra. What struck me that night, though, was a brief aside by Dr. Grosz in which he includes Charles Dickens’s *A Christmas Carol* on his reading list when he teaches psychotherapy.

I’ve re-read *A Christmas Carol* every December for close to a decade but always enjoyed it as a lighthearted fable

---

**Book Review (cont’d)**

Combining the latest scientific research on stress with extraordinary anecdotes of workplace abuse, Posen details how and why employees regularly “burn out” as a consequence of their work lives. He explores the phenomenon of corporate downsizing, comparing the “costs” to the remaining workers invariably saddled with more work, to the “benefits” enjoyed by managers who save money so there’s more for them to enjoy. And he looks at the trickle-down effect workplace stress has, not just on the individual workers, but on their families, communities and the societies in which they live.

However, there are a few drawbacks to Posen’s latest book. It’s not written, it seemed to me, for just anyone stressed by work (for example, it didn’t have much to offer this stressed-out doctor!) but rather for those working in corporations. So, if you’re one of the many people who don’t work in corporations, yet still struggle with workplace stress, you may not find many solutions here. Furthermore, the title, *Is Work Killing You?* which sounds like an appeal to the beleaguered worker, may be somewhat misleading; to me, the book seems directed less towards workers than towards those who manage workers. Since these managerial folks aren’t the ones stressed, but rather the ones “doing the stressing,” the book may, unfortunately, not end up where it’s needed most – in the hands of management. Because of this, the book and its quintessential question, “Is Work Killing You?” may well leave you convinced, and nodding, “Yes, it really is!” but it may leave you without solutions (short of leaving an anonymous copy on your boss’s desk).

In some ways, this book would have made a good TED (Technology, Entertainment, Design) Talk and one could dream of such books being “required reading” for MBA and human resource programs, as well as for “corporate coaches.” The reference to Canadian statistics—which may limit the book’s international market—is refreshing and appreciated. In all respects, *Is Work Killing You?* is an ambitious and much-needed book, and one which approaches a number of current and interrelated “hot topics” head-on. I would suggest that this important book probably belongs in the Business, rather than Self-Help section, and wonder if it might better have been titled, *Are You Killing Those Who Work For You?* Of course, whether employers would want to consider such a question—or read a book asking it—is quite another matter. On balance, Posen’s latest contribution to the “stress literature” is, I think, an important one, and for those of us whose patients include corporate employees (which is probably most of us), it may offer important insights into the stresses influencing occupational—and overall—health in the early 21st century.

Contact : Jennifer Rae , MD  
jennrae66@gmail.com

Conflict of Interest : None
Christmas Ghosts (cont’d)

about the magic of the season. Dr. Grosz sees more than that. “Dickens teaches us something essential about how people change,” he writes. “Scrooge doesn’t change because he’s frightened – he changes because he’s haunted. Haunting ... makes us alive to some fact of the world, some piece of information, that we’re trying to avoid.” This instantly struck me as the truth. But after re-reading A Christmas Carol again, I can’t help feeling Dr. Grosz only scratches the surface of how Dickens illustrates our relationship with loss at the time of year many people feel it most keenly.

‘He could not hide the light’
I now see, for instance, that Dickens uses the Ghost of Christmas Past to cleverly acknowledge our tendency to avoid the past – and the futility of our trying. The ghost is a smallish entity that emits a powerful light from its head and carries a cap that looks like a candle snuff. While being forced to relive painful moments from his life, Scrooge begs the ghost to stop showing him the abandonment and loneliness he had chosen to forget. “Haunt me no more!” Scrooge cries. He grabs the cap and pulls it down over the spirit. “But though Scrooge pressed it down with all his force, he could not hide the light.” You can’t extinguish the past, Dickens is saying (or put it off to January).

Something else caught my eye for the first time: Revisiting his school days, Scrooge sees his younger self alone in an empty classroom and says, “Poor boy!” Then he cries. Psychoanalysts tell patients that a critical part of coming to terms with the past is letting yourself mourn your losses, something Dickens was clearly getting at.

Dickens also understood something about resentment – how Scrooge’s bitterness over his past separated him from the world. It now occurs to me that Dickens assigned the Ghost of Christmas Present a simple task: that of getting Scrooge out of the house for a change, away from his solitary routine of work, “melancholy dinner in his usual melancholy tavern,” and bed.

Scrooge and the spirit wander through a London alive with “the hopeful promise of the day” on Christmas morning, and travel to a small mining community, and even far out to sea, to witness people sharing kindnesses and love. Most critically, they visit the homes of Scrooge’s clerk, Bob Cratchit, and his nephew, Fred, where Scrooge learns of the degree to which he is present in their lives, contrary to his assumption that they are irrelevant to him and he to them. Both men toast him in his absence. “Who suffers by his ill whims? Himself, always,” Fred says of his uncle’s reclusiveness. “I am sure he loses pleasanter companions than he can find in his own thoughts.”

Dickens tellingly gives the most important job to the Ghost of Christmas Yet to Come: that of moving Scrooge to action. Scrooge at first believes that visions of the pathetic death of an unloved man are merely a warning. “I see, I see. The case of this unhappy man might have been my own. My life tends that way now,” he tells the mute phantom. Scrooge assumes that recognizing his flaws will be enough to alter the course of his life. It is when he suddenly realizes that he is seeing his own lonely death that he resolves to become a better man.

Loss, and happiness
So what is the very first thing Dickens has Scrooge exclaim when he wakes up in his bed, clutching his bedpost and realizing he is still alive after visiting his own grave? “I will live in the Past, the Present and the Future!” The three ghosts have shattered the old miser’s delusion that “you can live a life without loss,” as Dr. Grosz puts it, by refusing to let him look away from his own suffering and the suffering he has caused others.

Dickens then sends Scrooge out into the world on Christmas morning. “He went to church, and walked about the streets, and watched the people hurrying to and fro, and patted children on the head, and questioned beggars, and looked down into the kitchens of houses and up to the windows, and found that everything could yield him pleasure,” Dickens writes. “He had never dreamed that any walk – that anything – could give him so much happiness.”

Ebeneezer Scrooge doesn’t change by suddenly being generous to others, although that is the action he takes to make amends. What really happens is that a sad, lonely man goes for a walk on Christmas Day and sees the world with fresh eyes.

dashboard/follows/

Acknowledgement: thanks to Dr George Lewis, MD for having made the suggestion to include this article for GPPA Members
I practice full time psychotherapy from an office in the basement of my home. It is a quaint and cozy little office but, by the end of the day, I am ready to stretch my legs and get outside. I walk my dogs every day either down by the Bay of Quinte where I live in Belleville or up on the Moira River near Tweed where our cottage is. I always walk in silence but I carry my iPhone in case of emergencies. Never having considered myself a true photographer, I nonetheless will come across a scene that I find awe inspiring and I then snap a photo with my phone. I use the best of these shots as the background on my computer in the office, finding them very soothing and uplifting during the work day.

'Spring on the Bay of Quinte' was taken in April 2014, just after one of the mating pair of swans returned to the marsh beside the Bay.

'Flooding on the Moira River' was taken at our cottage on a misty Monday morning as I was leaving for work. It was a very eerie sight. By Wednesday, the water had risen a further four inches!

'Spring near Tweed' was taken at the end of May on the road into the cottage at the end of my work day. The light coming through the trees and the bright green moss on the rocks were stunningly beautiful.
LETTER TO THE EDITOR

I want to let you and your editorial staff know how much I have enjoyed reading the GPPA Journal over the past several issues. I am always amazed at the breadth and depth of the expertise that is presented by the authors. I see the Journal as a vehicle to not just to gather knowledge but also to generate new ideas and pathways for other members to follow. In particular, Dr. Awad’s article in the Spring 2014 issue provides me not only with information about 'the patient at the centre of evolving care’ but also with ideas for office based research in the field of psychotherapy. This is an area that I am very interested in presently and I wonder if the Journal could include articles about this subject in future issues. I look forward to coming issues of the Journal.

Catherine Low, MD, CGPP

The Editor replies:

On behalf of the editorial staff and the contributing authors, I would like to thank you for your encouraging words. We are always appreciative of articles related to psychotherapy research and welcome all contributions. Our editorial staff looks forward to assisting new contributors by having a component entitled “Author’s Guidelines” available on the GPPA website, to be found in the ‘Journal’ section.

Train to teach mindfulness

Learn to facilitate mindfulness-based cognitive therapy (MBCT) groups at The Centre for Mindfulness Studies in Toronto.

Our expert faculty are health-care professionals with advanced experience and training in mindfulness— including Zindel Segal, a co-founder of the MBCT program.

We offer a specialized certificate program in Applied MBCT Facilitation certified through the University of Toronto.

Save $10!
Use the code MindfulGPPA on any professional development course until Sept. 1.

For more info & to register:
www.mindfulnessstudies.com | (647) 524-6216
When the GPPA Conference Committee assembled its annual presentation on May 23 and 24, 2014 it was the result of a year-long effort which began as soon as the 2013 conference ended.

The first step in planning every conference is to sift through the comments on the feedback forms from the conference that just ended for ways to improve and to collate suggestions for future presenters and topics. The committee then chooses a “theme” which helps to organize the educational content. The intention is to provide CME that is leading-edge, credible, provocative and geared to the stated learning needs of the membership. The committee takes its responsibility to provide high quality CME very seriously since the GPPA has been approved as a “third pathway” by the CPSO for earning educational credits which are mandatory for license renewal. Recent conferences have addressed topics as diverse as the effects of trauma on the developing brain, the impact of attachment, motivational interviewing, mindfulness and neuroplasticity.

Presenters are often selected because committee members have attended past conferences or training sessions that have been helpful to them. Dr. Willem Lammers, who presented at this year’s conference, holds an annual training session in Halifax (http://www.logosynthese.de/docs/logosynthesis.practitioner.pdf) resulting in Board member Dr. Christina Toplack’s Logosynthesis certification. She has found his approach to understanding and managing difficult emotions to be of great benefit to her both personally and professionally.

Howard Eisenberg recommended Dr. Jon Hunter to speak at this year’s conference after attending a half-day workshop that he led in May 2013 for the University Health Network. Dr. Hunter provided an overview of insecure attachment styles and how these manifest as challenging behaviors in the patients we encounter. Once you understand attachment, you have a roadmap to making sense of the behavior which allows you to respond in a helpful way. Those who attended Dr. Hunter’s afternoon workshop had the opportunity to practice linking attachment style to behavior in more complex cases. The keynote and workshop were both highly rated by attendees.

The committee invited Canadian guitarist, Liona Boyd, to speak about her experience of trying to heal from focal dystonia at this year’s conference as a way to understand a patient’s perspective on illness and recovery. Her presentation was well-received by the attendees but we didn’t learn as much as we had hoped about the neuroplastic approach recommended by her therapist, Dr. Joachin Farias (http://www.focaldystonia.net/farias.html). The conference committee is considering an invitation to Dr. Farias to speak at a future conference. He is a world leader in the treatment of dystonia and has recently moved to Toronto, to join the staff at the Movement Disorders Clinic at the University Health Network.

Sometimes speakers are chosen from the GPPA membership at large. In 2012, Dr. Danny Yeung presented a keynote and workshop on Accelerated Experiential Dynamic Therapy and Dr. Alison Arnot presented on the Interpersonal Neurobiology Approach to the treatment of addiction and concurrent disorders.

The honorarium paid to speakers is somewhat modest but nonetheless we have been able feature clinicians of renown such as Harvard psychiatrist and researcher, Dr. Srini Pillay who spoke to us in 2013 about the clinical application of fMRI studies.

Dr. Alison Arnot, the current chair of the Conference Committee, joined the GPPA in 2011. She has a longstanding interest in developing and organizing continuing medical education. She helped to plan the annual CME conference hosted by the Collaborative Mental Health Network when she sat on the steering committee of that organization. It has been an especially rewarding experience to able to contribute to the planning and execution of the GPPA conference as a result of the openness and curiosity of the membership.

Do you as a non-Committee member have in mind a speaker who is experiential and dynamic? If you have a past personal connection with them (i.e. know them personally from attending a previous presentation) that might make them more likely to accept an invitation to speak, the Committee is interested in hearing from you. The sooner the better though. The program is typically finalized by early December, so the application for Mainpro credits can be submitted to the Canadian College of Family Physicians in time for the brochures to be printed.
Standards of Care: Psychotherapy in Primary Care Medicine

Dr. Michael Paré, MD. MSc

I was pleased to be asked to do a series on Standards of Care. This is the first of series of columns on suggested Standards in Psychotherapy in Primary Care Medicine. I hope you enjoy the column and find it interesting.

My overall objective is to open up, and contribute to, an ongoing discussion and development of possible Standards of Care for medical professionals practicing psychotherapy. My interest in this area comes from multiple sources. As someone trained in various forms of psychotherapy (psychoanalytic, interpersonal, and group psychotherapy), I have always sought the true essence of therapy. As a mentor and a trained supervisor in Balint group work, my central interest has been to learn the core skills, roles, and therapeutic interventions needed for competent ethical care. Clearly, I want to know what we must do to be above a minimal standard of practice.

Also, as chair of the Ontario Medical Association (OMA) Section on Primary Care Mental Health, I am seeking – with my colleagues’ assistance – to contribute to efforts to define reasonable standards of care in our chosen area of medicine.

The standard of care is an important concept in psychotherapy as practiced in both the profession of medicine and in other regulated health professions. The standard of care could be described as the qualities and conditions that exist (or should exist) in a particular mental health service that a reasonable and prudent practitioner follows. The standard of care, therefore, guides physicians who provide professional psychotherapy services by specifying and requiring a minimum standard of practice. Thus, it is defined by what our professional peers would do and consequently determined by professional consensus. The standard is based on community and professional practices and evidence. As such, professionals are held to the same expectations as others of the same profession or discipline who hold comparable qualification in similar localities (Zur, 2007).

Although it is of great importance, the standard of care in psychotherapy (except for the proscribed zero tolerance for sexual violations or for gross incompetence) is not easily defined in any exact or precise way. In fact, a standard is always somewhat dynamic in that it changes with circumstances and develops over time. The standard of care is derived from the following sources:
1. Laws or statutes,
2. Professional literature,
3. Teaching Universities,
4. Professional Associations, (for example Guidelines for the Practice of Psychotherapy by Physicians, GPPA 2010, which I will discuss in some detail in future columns),
5. Relevant case law,
6. Professional Regulatory Bodies (in our case, the College of Physicians and Surgeons of Ontario, [CPSO]),
7. Consensus of professionals,
8. Ethical codes of professional associations,
10. When it comes to standards, there is not a completely objective set of rules, ideas, or practices that can be found in any textbook, or even set of textbooks. I will be discussing several sources of standards in future columns. If there are references that have not appeared here, I will likely discuss these various sources of standards eventually.

The true standard is an “ideal” that is somewhat objective and partially subjective. The standard is determined by a variety of factors, such as: the setting in which therapy takes place; the psychotherapeutic modality that is employed; the stage of psychotherapy; the history of the problem; cultural factors; and so on. Of course, patient factors such as chief complaints or presenting problems must also be taken into consideration. But even though the standard is an “ideal”, it is not an ideal of perfection; rather, it is what a regular, prudent and reasonable practitioner would do. Hence, as one of the core ideas of “standard of care”, simply making an error in judgment or making a mistake does not necessarily put a psychotherapist below the standard of care.

It has been suggested by Reid (1998) that the standard of care is essentially determined by what is good for patients. The standard of care, he asserts, “is usually highly correlated with professionally accepted clinical texts, clinical journal articles, clinical training programs, and what real doctors do across the country”.

Counter-intuitively, the standard of care is ultimately determined by the judges, and at times juries, who rely on the testimonies of experts. Often this includes encounters with various experts who provide conflicting testimonies to the court that often attempt to settle the detailed expectations of standards in complex cases. These experts must verbally

Continued on Page 20
combat each other, since opposing parties in civil, administrative, or criminal disputes hire experts for that particular purpose.

Because the standard is a minimum that is based on what is “reasonable”, it is open to considerable interpretation and debate. For example, it is usually expected that psychotherapists have some professional supervision. However, there is a huge difference between someone providing orthodox psychoanalytic therapy a few times a week utilizing a couch, and a family physician providing occasional, intermittent supportive therapy for stress issues a university student might have. The first therapist, providing analytic therapy, would be expected to have a considerable amount of supervision. Yet for the supportive therapy provided by a family doctor there would be fewer, if any, concrete expectations.

Here are a couple of examples illustrating the complexities involved in determining the standard of care in psychotherapy with respect to boundaries:

First, the cases of a home visit with an elderly, bed-ridden male patient who is suffering from dysthymia. This is likely to be seen as well within the accepted standard of care even though the psychotherapy is conducted in the patient’s bedroom.

However, a similar home visit arrangement – by a male physician – seeing a young, able-bodied, female with Borderline Personality Disorder will likely be seen as falling below the standard of care. This is because the situation presents unnecessary opportunities for the relationship to become sexualized. It has been said that, for Regulatory Colleges, where they find evidence of smoke, there is an inference of fire. Because of the important differences between these two scenarios, there is a need for more firm and clear therapeutic boundaries in the latter case.

This column will attempt to shed some light on the illusive and complex nature of the standard of care in medical psychotherapy. I will keep defining the standard of care and outlining its most important elements. For example, in one of the upcoming columns I will explain what the standard of care is not. In order to function within the standard of care, obviously one must first understand it and the complexities that are entailed by the concept. And yet, unfortunately, most psychotherapists have only a very fuzzy understanding of the standard of care (Caudill, 2004).

Contact: Dr. Michael Pare  
michaelpare@rogers.com

Conflict of Interest: none

References:

Looking for a GPPA group for discussion and education?

Go to our Group Supervision” link on the GPPA website, and add your name to the message board by contacting Carol Ford via email at info@gppaonline.ca
When you receive this it will be fall and the leaves in the trees will be changing their colours.

The GPPA Educational Conference
The GPPA’s 27th Annual Educational Conference on Emerging Trends in Psychotherapy was held May 23 – 24, 2014 in Toronto. It was very well attended with 155 registrants and the feedback was very good. A Conference Committee has been set up to plan the next conference.

The Power of Self-Awareness in Therapy
This third GPPA Retreat is planned for the week-end of November 7-9, 2014 at the YMCA in Orillia and the registration is under way. Register soon if you wish to go, as the spaces are filling quickly.

Not-for-Profit Corporations Regulations’ Amendments
Articles of Continuance and the new By-Laws were approved and accepted at the GPPA AGM on May 23. These are being filed and everything should be in order before the deadline in October, 2014.

GPPA Research Initiative
The GPPA’s Research Committee met for the first time on May 26, 2014 with Dr. David Levine as Chair. They reviewed the efforts to date to initiate GPPA private office-based research in collaboration with academic centres. On June 9, GPPA Members were invited by Dr. George Tasca from Ottawa, lead of Psychotherapy Practice Research Network (PPRNet), to a Focus Group meeting at Mount Sinai Hospital with faculty of University of Toronto and other psychotherapists. The main topic of discussion was a review of a survey consisting of more than 750 respondents focusing on their priority of what office-based psychotherapy projects are most important.

Invitation to Present to the College of Physicians and Surgeons of Ontario (CPSO)
The GPPA was invited as a Third Pathway to present to the Education Committee of the CPSO on any challenges there are carrying out that function. Drs. Andrew Toplack and Muriel van Lierop, gave a PowerPoint presentation of the work which the GPPA has done to date. Dr. Barbara Lent, Chair of the Committee, has let us know that they recognize the significant work the GPPA has undertaken to develop systems and processes to support our members who are tracking their CPD through the GPPA. The CPSO will continue to support us in carrying out this responsibility. They also want to work with us, and other CPD trackers, to develop a plan to work with physicians who are not compliant with the CPD requirements.

New Policies and Procedures
1. Recognizing Volunteers
We want all of you who give of your time and energy to the members of the GPPA to know you are appreciated. We list you on the last page of each GP Psychotherapist Journal edition, acknowledging your contribution. We have also developed a Volunteer Recognition Policy. More details about this will follow. We are also looking into how your efforts may be claimed as Continuing Professional Development (CPD) credits

2. Claim Listserv as CCI only
Remember that from October 1, 2014 you can claim the Listserv for CCI credits only. If any member does not belong to the Listserv and would like to, please contact Carol Ford, Association Manager, at info@gppaonline.ca or by telephone at 416.410.6644.

3. Leave of Absence Policy
There are situations in which a GPPA member may not be earning any income for various reasons: maternity leave, care-giving for a sick or elderly relative or the member’s own incapacity. This will affect the member’s ability to attend educational events and so, depending on the length of time off work, there will be consideration given as to the number of educational credits required. The important issue is to let us know as soon as it clear that you cannot work for any reason. We cannot give you consideration if we do not know. See the policy sent to you for details.

4. Audit Policy
The CPSO has asked that we develop an audit procedure so as to be confident that our members are actually performing the educational activities they are claiming. Such a procedure has been developed and everyone has been sent details. Starting October 1, 2014, keep records of attendance and document other details as listed in the policy. Let me know if there is anything you do not understand at vanlierop@rogers.com or telephone number 416-229-1993.

Continued on Page 22
End of the 3-year cycle
The 3-year cycle for entering your educational credits ends on September 30, 2014, just about the time you will be receiving this Journal. All Clinical, Clinical CPSO/CPD, Certificant and Mentor members, check the 3-year summary on the website, the link for which is found just below your list of record entries, to be sure you have entered the required number of credits for this cycle. It is each member’s responsibility to enter the credits. Also be sure to keep all your attendance certificates. The CPSO recommends keeping them for 10 years.

Rewriting of our Web-Application for Recording your Educational Credits
Various modifications are needed for the recording of credits and it has been decided to rewrite the web application that we use for entering credits. The new programme will start with the beginning of the new cycle, October 1, 2014 and it will be more user-friendly, having more capabilities than the present one. The plan is for it to be easier to enter credits and easier for the Membership Committee members to approve them.

Please remember to enter your educational activities for credits as you do them.
at the time with resultant devastating illnesses such as typhoid, diphtheria, polio, tuberculosis, and meningitis. Muriel wanted to give back to her native country and found creative ways in which to do so.

Children and adults were dying due to lack of supplies, medicines, investigations and imaging. Additionally, since the Africans who came to the “western hospital” were brought by their families only as a last resort, there were many for whom interventions would not have helped. She had nightmares for years about the conditions she witnessed.

There are two vignettes that stand out as examples of her ingenuity. Muriel conceived of and put into practice the resterilization of intravenous lines that were then used as nasogastric tubes for starving infants. Now there was a way of securely feeding these children. Additionally, she was aware of how inadequate community knowledge of proper nutrition was. Consequently, Dr. van Lierop organized the nursing staff to go into surrounding areas and disseminate the information. This two-pronged endeavour was quite successful.

When Muriel returned to Toronto, she worked as a family physician for Workers Compensation Board Rehabilitation Hospital – now called the Workers Safety and Insurance Board (WSIB) – for 7 years, in Physical Rehabilitation.

Then she worked at St. John’s Rehabilitation Hospital for 9 years. One of the patients she was caring for was in such a deep depression following dislocation of his total hip replacement. She spent 1 hour with him, just talking and looking at his options. The next day, he was so grateful for the “pep talk” that he asked her if she was a psychiatrist. This was a pivotal moment for Muriel, and with the assistance and support of the GPPA, she began a psychotherapy practice shortly thereafter. It has now been 20 years. Muriel will still do an occasional house call, if necessary, and will visit her patients in hospital, if they so request. The concept of ‘Continuity of Care’ is demonstrated quite clearly by these actions.

Since the year 1998, Muriel has been quite involved with the GPPA, participating in: Finance, Steering, Outreach, Professional Development, Membership, and Retreat Committees. She has been the Treasurer and still holds significant leadership roles within the GPPA - President, Liaison to the OMA Primary Care Mental Health Section, in addition to chairing the committee that works on the implementation of being the Third Pathway called the College of Physicians and Surgeons/Continuing Professional Development (CPSO/CPD) Committee. She is “giving back” to the organization that has helped her through all these years.

Another one of the organizations that Dr. van Lierop contributes her time and energy to is the Ontario Medical Association (OMA). Involved since 2003, she is a delegate to Council as well as being the Tariff Chair for, and holding an Executive position in, the Primary Care Mental Health Section (PCMHS). It was for this latter committee work that Muriel received an Award of Merit at the OMA Annual General Meeting on April 25th, 2014. The Award was inscribed with: “The OMA Section on Primary Care Mental Health is pleased to honour Dr. Muriel van Lierop with an Award of Merit in recognition of her leadership and tireless efforts on behalf of her medical colleagues.”

Dr. Michael Pare, Chair of the PCMHS, detailed the many contributions Dr. van Lierop has made that have led to the recognition of primary care physician psychotherapy in Ontario. Along with Dr. Peggy Wilkins and Dr. Pare, Muriel has served as Tariff Chair for the Section. The Tariff committee is responsible for recommending the remuneration that physicians receive, covering at least 300 categories of medical practice. Muriel along with

---

**Third Annual GPPA Retreat**

**The Power of Self Awareness in Therapy:**

_When you take care of a client, who is taking care of you?_

**Date:** November 7-9, 2014

**Location:** Geneva Park Conference Centre, Orillia

**REGISTRATION:** $625.00 Includes full program fees, single room and all meals.

This weekend retreat and workshop focuses on the energy that flows within, between and among individuals.

To register or for more information, please contact the GPPA Office at info@gppaonline.ca
Whom to Contact at the GPPA

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

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

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

Questions about submitting educational credits – CE/CCI Reporting, or Website CE/CCI System - for submitting CE/CCI credits, contact Muriel J. van Lierop at vanlierop@rogers.com or call 416-229-1993

Reasons to Contact the GPPA Office
1. To join the GPPA
2. Notification of change of address, telephone, fax, or email address.
3. To register for an educational event.
4. To put an ad in the Journal.
5. To request application forms in order to apply for Certificant or Mentor Status.

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