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Inside this issue:

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From the Editor

Happy 2014! Here's hoping that you were all able to spend your holidays in the fashion and manner that suited you best.

As our first edition of the calendar year, we have some exciting concepts and variations for you to review, take into consideration, and be challenged by. For example, you will be introduced, on page 4, to Electronic Counselling by John Yaphe, MD, who has been using this specific modality since 2004. He deftly explains and illustrates how the CARE model has proven to be particularly effective in the e-counselling environment. For those unfamiliar with this model, the C stands for *connect and contain*, the A stands for *assess and affirm*, R stands for *re-orient and reaffirm*, and, finally, the letter E stands for *encourage and empower*. For those physicians who already have direct electronic communications with their patients, you will be fortunate to have a head start in the implementation of this novel intervention.

Schizophrenia is the "disease of the month" in this edition. Dr. Howard Schneider uses the continuum disease model of psychotic and mood disorders, which has schizophrenia at one end of the continuum, while depression is at the other end. In the middle is schizoaffective disorder and the spectrum of Bipolar disorders. As Howard focuses on the "middle" of the continuum, he introduces us to the seminal work of Hagop Akiskal in his column, Psychopharmacology Corner (page 10). A chart allows us to view the definitions of Bipolar ¼, ½, I, 1.5 and so on until Bipolar VI, in a manner quite different from the DSM V.

A different approach is taken by Dr. Anastasia Sky in the newly christened book review section, the Therapist's Bookshelf. With her review of "Psychotherapy is Worth It" (page 13) in general, and schizophrenia in particular , Dr Sky brings forward the evidence and cost effectiveness of psychotherapeutic and psychosocial interventions. Her summary of the value of family interventions versus social skills training will surprise you. We have included a black and white photo of the book and a colour PDF of the cover, for those of you who are visual learners and need to know what the book actually looks like prior to heading to the bookstore or online.

Personal and professional reflection also take centre stage with our contributors in this edition. Drs Parsons and Arnot, both well-known figures in the GPPA , have given us a précis of their recent, unrelated, retreat experiences. Elizabeth Parsons expands on the happenings of the 2nd Annual GPPA Retreat, "The Power of Self-Reflection in Health Care: The Making of a Therapist from Family to Finish" (page 15). Relive the events of the weekend as voiced by participants and by learning about the Satir model, coping stances, family maps and HeartMath.

Continued on Page 2

POSITIONS AVAILABLE

Aspiring authors, researchers and other interested contributors for future issues of GP psychotherapist! Be creative, share your experiences and knowledge. If there is something novel you wish to explore and possibly have published, contact Maria Grande at journal@gppaonline.ca

Smiles

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From the Editor (cont'd)

Alison Arnot and I were both fortunate to have attended the "Mindfulness Retreat for Educators," by Thich Nhat Hanh and the International Plum Village Community, at Brock University, St Catharines, on August 11-16, 2013. Alison offers us a glimpse into her own growth through mindful meditation, beginning many years ago and taking us to the present. We hear about the nuances of a retreat where silence and "being" are the goal. Her article, on page 11, titled "Personal Reflection on the Path to End Suffering," opens us up to acknowledge our own suffering; the fear, pain and uncertainty that is inherent to the practice of medicine.

In the area of office practice we have an opportunity to review the evaluation of depression as per various instruments, as presented by Vivian Chow, MD. Her Cognitive Bytes Column on page 3 provides, in her usual succinct style, practical approaches and resources that are available to us on a day to day basis.

Dr. Jenn Rae (page 6) concludes her 2 part series on Shih Tzu assisted therapy by looking at the origins and diffusion of "Pet Therapy" in the psychotherapeutic arena. Some very interesting history is presented!

The Chair of the GPPA Board of Directors, Dr. Derek Davidson, provides us with his first Report From The Board. Congratulations, Derek! Muriel van Lierop, MD, who has been writing these Reports for the last few years, has taken a well-deserved vacation in Lyon, France.

Still on the lighter side of life, I present you, the reader with a simple, yet playful, challenge. Tell me, Maria Grande (journal@gppaonline.ca), specifically how the Smile Section selection resonates with you….I'll publish your responses! I'm smiling already.

A lotus to you,
Maria Grande

Cognitive Bytes

Measuring Depression *Vivian Chow, MD*

Assuming you have diagnosed your patient with depression, what do you do next? How do you decide how you will tailor therapy? How do you know when your patient is in remission? In order to do that, you need to determine how depressed your patient is. It is important to categorize your patient's depression as mild, moderate or severe. If your patient is suffering from severe depression, using thought records and focussing on the cognitive part of therapy won't work. If you remember my Emotion Wheel[1], this is because the patient is in the "outer ring" where higher cognitive function shuts off. I will tackle treatment of severe depression in a future article.

For now, let's assume your patient is mild or moderately depressed. You would follow the CBT model by starting with a 5-Part Conceptualization[2] to show your patient how his situation, thoughts, moods, behaviours, and physical reactions all influence each other. From week to week you would work on changing his negative automatic thoughts and problem solving.

Ideally, you would be measuring the patient's level of depression at every session. In reality, this is not always practical nor beneficial to the therapeutic alliance. For example, if the patient has had a really bad experience in the week prior to his appointment and obviously looks distressed, he would probably like to focus on that, as opposed to spending time on a depression scale. Also, there is not likely to be any new information from getting a depression score. However, if the patient is amenable to therapy but doesn't show a big change from session to session, it is definitely worthwhile to measure his depression: a) to show the patient how much he is improving; and b) to prove to yourself that you are indeed helping your patient. As a therapist, you have ongoing relationships with your patients. You see them weekly, bi-weekly or monthly, therefore, it's easy to lose track of how much your patient is progressing. A depression rating scale will put you both back on track.

As a CBT practitioner, the gold standard is to use the Beck Depression Inventory (BDI-II). This is a long form that requires permission and a cost to use. As an alternative, you could use the QIDS-SR16 which is freely available (http://www.ids-qids.org/translations/english/QIDS-SR_AU1.0_eng-CA.pdf). However, both of these forms are designed for self-completion by the patient. I, personally, work in a group medical practice with a full waiting room. Even if my patients were to show up early enough to complete this form, they would probably not be comfortable completing it in front of so many other patients. Also, the QIDS-SR16 scoring system is a bit complicated in that not every question contributes to the final score. Another freely available scale which you, the practitioner, would complete is the HAMD-17 (http://healthnet.umassmed.edu/mhealth/HAMD.pdf).

All of the above scales are proven to be effective. However, I find them to be long and tedious. I prefer to spend as little time as possible on the rating and as much time as possible on the therapy. For this reason, I recommend using the HAMD-7 scale (see next page or go to http://www.mdpu.ca/documents/hamd7.pdf), which was modified from the HAMD-17. It's free and readily available and only takes 3 or 4 minutes to administer with just 7 questions to ask. It also has a straightforward scoring system. It has been proven to be as effective as the HAMD-17 in determining remission.

As a clinician, you complete the form yourself thereby eliminating any patient bias.

The highest (worst) score possible is 26 and 3 or less is considered remission. So how do you rate the level of depression? From extrapolation and years of experience, I have personally determined that a score of 4 to 8 corresponds with mild depression, from 9 to 13 corresponds with moderate depression and 14 and over indicates severe depression. There will be some clinician bias so the ranges will probably vary slightly from user to user.

Whatever method you are using, I hope I have emphasized for you how important it is to use rating scales to follow your depressed patients and, if you are not satisfied with your current rating scale, please consider using the HAMD-7. I find that patients are very interested in following their scores and this can help improve their compliance (which is always a good thing).

Conflict of Interest: None reported.

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Continued on Page 4

Cognitive Bytes (cont'd)

CANMAT
Canadian Network for Mood and Anxiety Treatments

7-ITEM HAMILTON RATING SCALE FOR DEPRESSION

HAMD-7

For each item that best characterizes the patient during the past week, write the number in the appropriate score box. Note: when scoring, rater is to combine patient replies with their observations.

Patient ID: _____ **Date:** _____

1. DEPRESSION MOOD (sadness, the blues, weepy) — **SCORE**

Have you been feeling down or depressed this pask week? How often have you felt this way, and for how long?

0. Absent
1. Indicated only on questioning
2. Spontaneously reported verbally
3. Communicated nonverbally (facial expression, Posture, voice, weeping tendency)
4. Patient reports VIRTUALLY ONLY these feeling states in spontaneous verbal and nonverbal communication

Note length of time if Depressed Mood present:
____**# weeks DO NOT ENTER IN COLUMN SCORE**

2. FEELINGS OF GUILT (self-criticism, self-reproach)

In the past week, have you felt guilty about something you've done, or that you've let others down?

0. Absent
1. Self-reproach (letting people down)
2. Ideas of guilt or ruminating about past errors About sinful deeds
3. Present illness is a punishment. Delusions of guilt
4. Hears accusatory or denunciatory voices and/or experiences threatening visual hallucinations

3. INTEREST, PLEASURE, LEVEL OF ACTIVITIES (work and activities)

Are you as productive at work and at home as usual? Have you felt interested in doing the things that usually interest you?

0. No difficulty
1. Fatigue, weakness or thoughts/feelings of Incapacity (related to work, activities, hobbies)
2. Loss of interest (directly reported or indirectly Through listlessness, indecision and vacillation)
3. Decrease in actual time spent in activities or decrease in productivity
4. Stopped working due to current illness

4. TENSION, NERVOUSNESS (psychological anxiety)

Have you been feeling more tense or nervous than usual this past week? Have you been worrying a lot?

0. No difficulty
1. Subjective tension and irritability
2. Worrying about minor matters
3. Apprehensive attitude apparent in face or speech
4. Fears expressed without being questioned

5. PHYSICAL SYMPTOMS OF ANXIETY (somatic anxiety)

In the past week, have you had any of these symptoms?

- GI – dry mouth, gas, indigestion, diarrhea, cramps, belching
- CV – heart palpitations, headaches
- RESP – hyperventilation, sighing
- Having to urinate frequently
- Sweating

Have much have these things been bothering you in the past week?
NOTE: DON'T RATE IF CLEARLY DUE TO MEDICATION
0. Absent 1. Mild 2. Moderate 3. Severe 4. Incapacitating

6. ENERGY LEVEL (somatic symptoms)

How has your energy been this past week? Have you felt tired? Have you had any aches or pains, or felt any heaviness in your limbs, back or head?

0. None
1. Heaviness in limbs, back or head (backache headache, muscle aches; loss of energy and fatigability)
2. Any clear-cut symptoms rates two points

7. SUICIDE (ideation, thoughts, plans, attempts)

Have you thought life is not worth living, or you'd be better off dead? Have you thought of hurting or killing yourself? Have you done anything to hurt yourself?

0. Absent
1. Feels life is not worth living
2. Wishes to be dead (or any thoughts of possible death to self)
3. Suicidal ideas or gestures
4. Attempts at suicide (any serious attempt rates 4 points)

HAMD-7 score ≤3 indicates Full Remission.
HAMD-7 score ≥4 indicates Non/Partial Response. **TOTAL SCORE**

The HAMD-7 Scale was developed by Dr. Roger S. McIntyre, Dr. Michael Bagby, Dr. David Bakish and Dr. Sidney H. Kennedy, University Health Network (UHN), Toronto, Ontario.

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Electronic Counselling:

A New Frontier for GP Psychotherapy

John Yaphe, MD, MCISc

Electronic counselling is a relatively new therapeutic medium that has shown promise in reaching selected populations with good therapeutic effects. It integrates established methods of effective in-person counselling, with the specialized skills needed online. It adds the benefits of asynchronous, accessible, confidential communication under the control of the client. This article describes the format, content, and outcomes of e-counselling. It addresses issues of training and supervision of counsellors. It poses a challenge to counsellors who may wish to expand their therapeutic reach and repertoire of counselling skills to online settings.

Counselling plays a role in every general practice encounter. It can be an intensely therapeutic intervention when well conducted. New technologies have expanded our capacities to counsel our patients and hence to engage in psychotherapy. Electronic counselling is one such technique on the frontier of GP psychotherapy that deserves some attention.

Obtaining my medical degree in the late 1970's, then studying patient-centred care and on-line patient narratives, allowed me to incorporate many fascinating and challenging ideas about counselling and therapy into my family practice.

In 2002, I was exposed for the first time to the notion of electronic counselling (e-counselling) by Cedric Speyer, M.A., M.Ed who had developed this method for Shepell-fgi as part of an Employee and Family Assistance Program (EFAP). He combined his training in both counselling psychology and creative writing to create this pioneering hybrid.

I was initially an e-skeptic. I asked: "How can you counsel effectively when you cannot see, hear or touch the patient? How can you read the non-verbal cues?" I continued this debate with my colleague for two years and observed his progress from the sidelines. My initial questions were answered when my curiosity overcame my resistance and I attempted my first e-counselling case in 2004 for the EFAP program. I would like to share a description of the method, some experiences from the last 9 years of my e-counselling practice, and some challenges for readers regarding possible future directions.

E-Counselling is based on solid principles taken from a variety of therapeutic schools, such as cognitive behavioural therapy and narrative approaches. It relies on facility with *non-local presence*, a term that describes how the counsellor can be in close emotional contact with the client even though they are not physically present in the same location, each writing their reflections and responses at different times (*asynchronous communication*).

Much of the power of the method lies in the freedom given to the client. The blank screen has replaced the therapist's couch and clients are free to project what they like onto the empty space. They may speak without interruption. They can write as much as they like without limitations of time or space, as there are in traditional office visits. They have words to hold onto, as they can save their written offerings and the replies they receive in a file for future reference.

The therapeutic approach of this brand of e-counselling has been described in published articles and chapters in text-books of electronic counselling.[1] The CARE model has proved to be particularly effective in teaching and demonstrating the progress of treatment.

The **C** stands for *connect and contain*. The counsellor says to the patient in the first exchange "Your challenge is human and manageable." **A** stands for *assess and affirm*. After assessing the client's strengths and available resources, we can often say "you've got what it takes to get through this." The **R** stands for *re-orient and reaffirm*. After reframing the client's initial presentation, we are able to say "You are not defined by your life situation." Finally, the letter **E** stands for *encourage and empower*. Before we let go, we say: "Keep going, one step at a time."

This initial four-step model was originally designed to correspond to a four-exchange structure (four back-and-forth letters between client and counsellor). This has been modified over time but the four steps are usually found in some combination in e-counselling transcripts.

The response to e-counselling has been overwhelmingly positive. Clients like the easy access they have to counselling at any time of day or night, on weekends, and on holidays. They enjoy

Continued on Page 6

Electronic Counselling (cont'd)

the privacy and anonymity that writing provides. Many have said: "I could never raise this issue face to face with a counsellor". I have also counselled clients with severe agoraphobia, speech fluency disorders, and post laryngectomy. They would not have attended counselling otherwise.

Clients enjoy the chance to tell their story without interruption. Later, they have the chance to rewrite their story and choose a different ending or a new chapter with the help of the counsellor.

This form of e-counselling contains safeguards to ensure that it reaches those best suited to it and provides safe alternatives to clients who could be better served by other forms of counselling. A screening questionnaire assesses acute suicidal risk, risk of violence, current substance abuse or risk to children. Any positive findings would result in an outreach call and referral to appropriate in-person resources. Counsellors are also directed to take these steps if these issues arise during the course of e-counselling.

Counsellor selection and training is an important issue. Currently all counsellors in my group possess Master's level, or higher, qualifications in counselling psychology or social work. I am required to maintain my medical license through CPSO registration and malpractice insurance coverage through the CMPA. Training involves completion of three to four simulated training cases and close supervision during the initial months of actual practice. This is all done online. Some universities and other private groups offer certificates of competence on the completion of e-counselling training courses but there is currently no statutory licensing body.

Online supervision of e-counsellors is another fascinating aspect of this field.[2] Aside from video or audio recordings made during classic training, this is the only medium where every word 'uttered' (*read:* written) by client and counsellor is available for study during supervision. Much has been written about the parallel process between the provision of clinical supervision and the process of therapy. When the therapist is stuck, the supervisor can often guide the trainee in new directions to help them deal with issues they may find personally challenging. In e-supervision, the trainer can model this behaviour in a supervisory email to the trainee. The trainee can then transfer the lessons learned in supervision to help the client.

Over the past 9 years, I have accumulated a caseload of over 1500 patients. While many of these clients are *"seen"* only once, some have returned for subsequent series of exchanges. The average number of letters shared per case is around 3, exchanged over a period of three to four weeks.

The range of problems assessed resembles the caseload of a GP psychotherapist. Since my clients are all employees (or family members) of companies using this Employee and Family Assistance Program (EFAP), they range in age from 16 to 65. Women predominate among the clients, as in office practice. The issues addressed include feelings of anxiety and depression, couple and relationship issues, childcare issues, elder care and workplace stressors. Currently, I am the only physician on the team of counsellors. Consequently, I receive referrals and cases from other counsellors with a specifically medical flavour. These include patients: with chronic pain; facing challenges of coping with a newly diagnosed acute or chronic illness in themselves or in family members; and, medication related issues, to name a few. The need to maintain contact with the client's usual source of medical care is always stressed, with e-counselling used to identify existing strengths and resources to help with coping, while traditional in-person medical care is ongoing.

Some surprising results have been obtained online. There are situations that are familiar in the office but that might not seem appropriate in the electronic medium at first glance. For example, a mother presented the story of her 7 year-old daughter who experienced undiagnosed chronic abdominal pain and nightmares. Further investigation revealed unresolved grief and conflict in the client following the unexpected death of her mother, the child's grandmother. A few sessions of grief counselling were conducted online with the mother with resolution of the child's symptoms and improvement in the client's general function. A more detailed description of this case is presented in the Irish General Practice College Journal.[3]

Continued on Page 7

Electronic Counselling (cont'd)

Another example of grief work done with a client entirely online was reported in a subsequent case report.[4] A middle aged executive wrote that she felt "alone and disjointed" a year after losing her husband, a close relative, and a close friend. She had difficulty coping with her work and home life. She felt unable to express her grief because of the perceived need to put on a brave face at home for her young children and because of the demands of work. Through e-counselling, she was allowed to express her emotions freely and explore ways to take back control of her life. When she expressed doubts about her progress in counselling, her journey was compared to "flying in a cloud, without visual or tactile clues." She responded to this image with insights of her own. "Your comment about the clouds was so good, I read that over and over and it became so clear to me. That was exactly right, I was all fuzzy and the clarity has arrived and the clarity isn't from anyone, it is from within that it has come, which is really the only place it can." Counselling concluded after four exchanges. The client expressed renewed confidence in her ability to move forward. (Readers are free to contact me at the e-mail address given below if they would like to receive reprints of any of the articles quoted.)

Given the growing volume of email traffic, especially in the in-boxes of family doctors and other therapists, it is puzzling why electronic counselling has not grown faster than observed. There are many reasons for this. One is a basic conservatism or skepticism, as I experienced earlier in my career. Other concerns involve security, confidentiality and malpractice issues. Questions of billing also arise. Increasing interest by regulatory and professional bodies will help solve these questions, as they assure patient safety and set standards of care. A third issue is simply the lack of knowledge that this modality exists and that it works, with many advantages to therapist and client. Various publications have addressed this issue.[5] This article is another pebble tossed in the pond, hoping to find resonance with readers.

I look forward to continuing this dialogue with my colleagues as we push forward on the frontiers of counselling and psychotherapy with the help of new technologies. This journal can be a suitable forum for our efforts.

Conflict of Interest: The author has done e-counselling for an EFAP company since 2004 but has no financial interest in the publication of this article.

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Shih Tzu Assisted Therapy: Part Two

Jenn Rae, MD, CCFP

It had finally come to pass – after more than four decades, at least three of them spent ogling strangers' dogs on the street - I was, at last, a dog owner. You'd think in all those years spent dreaming of, wondering about, and planning for a dog, I'd have given plenty of thought to what owning a dog would be like. You'd think – but you'd be wrong. In fact, dog ownership caught me fairly off-guard. I spent the first weekend with our new family member in a state of unease. There wasn't really anything wrong – Sabrina was a quiet dog, anxious, understandably, in this strange new home. It wasn't that she was any trouble so much as she was "just there." Everywhere I went... there she was. Following me. Staring at me – with her giant, bulging eyes, perpetually worried, wondering, watching. Quietly, but with great determination, she followed me to the kitchen, to the laundry room, even to the bathroom, pushing the door ajar just to keep me in her sights. "What do you want?!" I would ask her furry little face, in exasperated tones. She didn't answer. But soon enough we'd know the truth; this little dog would never ask for much – just the assurance that she never be alone.

This would turn out to be our only challenge with Sabrina – we'd adopted a dog virtually incapable of being alone. In dog-speak (and kid-speak, as well) the proper term is "separation anxiety." In "our-speak," it was a nuisance. It wasn't surprising, I suppose; as a breeding dog, she'd spent her whole life – all five years – in the company of other dogs. Now, there was just us – myself, my husband, Jim, and a pair of disgruntled (though slowly adjusting) cats. Having Sabrina at work with me each day solved much of the problem, since she rarely needed to be alone. Indeed, I wondered if her need for constant companionship might, all by itself, make her an ideal therapy dog.

In researching "therapy dogs," here is what I'd learned:
That a therapy dog's primary job is to provide affection and comfort to people in a variety of settings – specifically, that the dog should allow *unfamiliar* people – strangers – to make physical contact with her, and to enjoy that contact. I learned that the breed of dog was less important than the dog's temperament, which should be friendly, patient, and gentle – even when handled clumsily.

I learned other things, too. That the first known "therapy dog" may have been a stray Yorkshire terrier, abandoned on a battlefield in WWII, where it was adopted by a corporal. The terrier comforted unknown numbers of wounded, convalescing soldiers, under the direction of Dr. Charles Mayo (of Mayo Clinic fame). I learned that therapy dogs were popularized in North America by an American nurse, Elaine Smith, who had worked for a time in England, where she had observed the positive reception enjoyed by a particular hospital chaplain, who visited patients along with his good-natured golden retriever. Finally, I learned what anyone who owns a dog will tell you, and what studies upon studies continue to show, that interacting with animals simply "feels right." The pairing of a human with a pet results in a variety of physiological changes: increasing the bonding hormone oxytocin, and the "feel-good" neurotransmitter dopamine, while lowering cortisol levels, and measurably reducing blood pressure, heart rate, and the general experience we all know as "stress."

As I write this, Sabrina has been "in service" as a therapy dog for more than eighteen months. Somewhat by chance, she proved to have the ideal "therapy temperament" - an ever-gentle, ever-loving nature, which means she seeks out physical contact persistently but politely. She allows children of all ages to physically enjoy her presence. Indeed, she adores kids (we think she sees them as puppies), as one can see from the online photo at http://www.gppaonline.ca/2014Winter.html which shows her convening with young siblings on our office couch. And somehow, she seems to know when her company wouldn't be appreciated – occasionally she gets it wrong and leaps into an unwelcome lap (an event most often followed by a horrified gasp) – but for the most part, she picks up on signals from those who don't like dogs, and gives them their space, and a pass.

For those reading this who currently practice psychotherapy "sans chien," you may find yourself wondering what it would be like to share your workday, and your office, with a dog. I'll see if I can describe it. First of all, it's fun. In a day punctuated by other people's situations and sadness, it can be a welcome relief to share one's working hours with a less-complicated soul. Sabrina reminds me when it's time for lunch. Now, I must make the time to get up and leave the building mid-day. Our noontime walks take us to the Kingston Farmers' Market twice weekly, and, on other days, to the banks of the St. Lawrence River across from our office. Caring for another living being has meant caring for myself as well. I'm less-inclined to work late, work through lunch, or forget to eat - I might not mind, but my dog certainly will!

Continued on Page 9

Shih Tzu Assisted Therapy (cont'd)

Those are just some of the ways her presence is therapeutic for me. With patients, she has a completely different skill-set. In anticipation of each patient, Sabrina situates herself in the waiting room, perched patiently on the back of a stuffed couch, her dark eyes fixed expectantly on the front door. She's often the first thing people see when they arrive at the office - a suddenly animated gargoyle who rises up like a furry Walmart greeter - and she welcomes each person with equal, unbridled enthusiasm and an eager tail-wag, accepting pats and exclamations of her cuteness from those who are fond of dogs, and even from the few who aren't. When patients take a seat on the couch, Sabrina will very often deposit herself in their laps, and will remain there until I head down to my office.

Now and again, though, she doesn't follow me. Consider last Friday. It was later in the day, close to four, and I was feeling glad to be done for the day, for the week. Sabrina and I saw our last patient out. As I checked my messages, Sabrina checked out a late arrival to the office - a young woman sitting very still on the sofa, clutching a tissue, with tears streaming steadily down her face. I did not at the time - nor do I now - know who this woman was, except that she was there for an independent medical assessment, likely on direction from an insurance handler, with a psychiatrist I barely know to see, who rents office space on an irregular basis. I would never know what her tears were about, or what she was feeling that day as she sat on our sofa - anxious? defensive? a sense of foreboding? I watched Sabrina approach her good-naturedly from the floor, staring up at the young woman with a soft and curious look, before gently extending a tentative paw to the woman's knee. In that moment, I saw the woman's face soften, and Sabrina, sensing some subtle shift I could only guess at, leapt confidently up onto the couch. Without missing a beat, she stepped gently into the woman's lap as though she had known this person all her life, and with a series of good-natured grunts, curled herself into a soft and satisfied ball.

I returned to my office to finish paperwork, but Sabrina stayed where she was. When I returned to the waiting room at close to 5 PM, I discovered that she had followed the woman into her appointment - or perhaps been carried in; I never did know - and when she trotted out from the office a short time later, followed by the patient, I noticed that the young woman looked different - more relaxed, it seemed, less-troubled. Perhaps the assessment had simply gone well - there could be a dozen reasons for her brighter demeanour - but before she left, I watched her reach down and fold Sabrina up into her arms, holding the little dog in a brief hug before kissing the top of her blonde head, and depositing her back on the sofa. It was a small, sweet moment, in what had proved to be a year of small moments with Sabrina. Nonetheless, I don't think it's overstating it to say that, in these brief encounters, that little dog was working a kind of quiet, common magic. Somehow - without training, treats, or a single task ever being asked of her - Sabrina was intuiting a kind of wisdom that, for most of us, lies hidden in plain sight. It is the wisdom that lets us know we are all connected - human and animal alike - and reminds us, sometimes profoundly, that the capacity to comfort others, as well as ourselves, transcends talk, and is never much more than an arm's - or a paw's - reach away.

Sabrina will be in attendance at the GPPA's May 2014 Annual Conference in Toronto. She would be very pleased to make your acquaintance.

Conflict of interest: None reported

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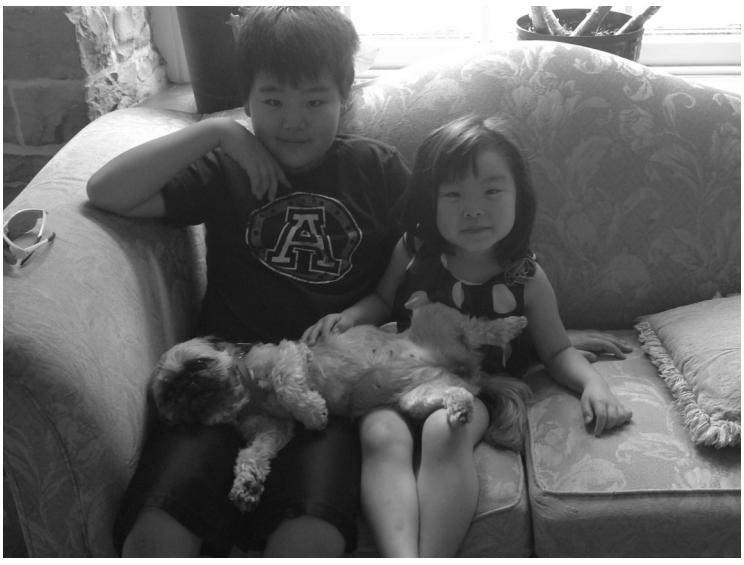

Photo courtesy of Jenn Rae

Psychopharmacology Corner

Schizoaffective Disorder

Howard Schneider MD, CGPP, CCFP

Abstract

In the continuum disease model of psychotic and mood disorders, at one end of the continuum is schizophrenia while at the other end is depression. In the middle is schizoaffective disorder. The diagnosis of schizoaffective disorder can be difficult, and should not distract the clinician from effectively treating the patient.

Introduction

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

In this issue we will consider Stahl's eleventh case – "The young woman whose doctors could not decide whether she has schizophrenia, bipolar disorder or both."

Case Discussion

A 26 year old woman comes to Dr Stahl along with her parents. The woman states that she is perfectly fine and she is at Dr Stahl's office because her parents brought her there.

Past Psychiatric History:

- 20 years old – Anxiety Disorder diagnosed and prescribed diazepam
- 21 years old – Delusions, hallucinations without significant affective symptoms – diagnosis of Schizophrenia. Hospitalized. Haloperidol initiated which was then switched to risperidone. The risperidone did not seem to control her symptoms well enough and so was then switched to olanzapine + escitalopram + clonazepam. The patient was able to function well enough to work as a teacher's aide, but was not able to return to college.
- In the months following, the patient stopped her medications and then had a manic episode, which included psychotic symptoms. The patient had ideas of reference that she was controlled by God and that she was a prophet. Olanzapine and lamotrigine were prescribed.
- The patient gained weight with the olanzapine and so it was switched to ziprasidone, and continued on lamotrigine. However the patient then stopped the ziprasidone and developed again the above manic/psychotic symptoms, and received a diagnosis of Bipolar Disorder.
- The patient was hospitalized for 6 months and her diagnosis was switched to Schizoaffective Disorder. The patient was forced to take medications by legal proceedings. The patient received (combinations are not specified) ziprasidone, lamotrigine, haloperidol, lorazepam, lithium and aripiprazole. Finally the patient was switched to olanzapine plus lamotrigine. However the patient did not respond successfully to this combination either and finally her parents took her home 6 months prior to that visit. The patient at present lives at home with her parents.

Current medications:
Olanzapine 30mg/day
Lamotrigine 400mg/day

There are not many adverse effects to the medications noted, including no weight gain at present. Some gastrointestinal discomfort is noted. However, response to medication has been poor. Her parents complain about ongoing delusions and hallucinations which the medications do not help much. Her parents complain that the patient has been getting worse over the years.

The patient does not use alcohol, marijuana or street drugs. She is a non-smoker with a normal BMI, normal blood pressure, normal glucose and normal triglycerides.

In the family psychiatric history there is a paternal grandmother with a hospitalization for a psychosis and a paternal uncle who is described as "mentally unstable." There is a maternal uncle with a history of paranoia and PTSD.

Continued on Page 11

Psychopharmacology Corner (cont'd)

On examination the patient is tangential and incoherent. There is inappropriate laughter along with irritability. She does not respond to questions, often remaining quiet for 30 seconds after the question, and then continues talking in a psychotic fashion -- "My fiancé is a beautiful butterfly; there are caterpillars in the world. I don't want you talking to my parents. God is talking to me."

Stahl's initial impression is that of a psychosis. He feels the patient is more schizophrenic than schizoaffective and feels that bipolar disorder is doubtful. However there is a history of mood episodes, so perhaps a reasonable working diagnosis would be schizoaffective disorder. Stahl notes that there has been psychosis in this patient with a depressed mood, with a normal mood and with a manic mood, ie, psychosis not driven by the mood.

Stahl obtains plasma drug levels – lamotrigine levels are high, olanzapine levels are within therapeutic range. Thus there is indeed compliance with the medication. At 4 weeks after seeing the patient initially, lamotrigine is lowered from 400mg/day to 200mg/day since there is not much evidence that, in preventing bipolar disorder, 400mg/day is more effective than 200mg/day. However, olanzapine is increased from 30 to 40mg/day.

We see the patient next at 8 weeks after the initial visit. Lowering the lamotrigine may have helped some gastrointestinal symptoms. However, raising the olanzapine did not help the psychotic symptoms. The olanzapine is increased now to 50mg/day.

We see the patient next at 12 weeks. No improvement. The olanzapine is increased now to 60mg/day.

We see the patient next at 16 weeks. Still no improvement with the psychotic symptoms. However, the patient has become more sedated, although no weight gain. The olanzapine is switched to clozapine. Clozapine is an atypical antipsychotic that has FDA approval for treatment-resistant schizophrenia.

We see the patient a month later at 20 weeks. Still no improvement in the patient's psychotic symptoms, but Stahl decides to continue the clozapine and the lamotrigine.

The case ends here, which is somewhat disappointing, as we usually expect super-psychopharmacologist Dr Stahl to find that medication, or combination of medications, that helps to resolve the patient's problems. In reviewing his actions, Stahl wonders if he should have made a more active effort to retrieve the patient's old medical records or speak to physicians who treated her, to get a more accurate analysis of which medications worked or didn't work. Stahl wonders if he should have made more of an effort to try other mood stabilizers in this patient, for example, valproate.

At the end of the case Stahl actually writes: "Chaos is chaos no matter what you call it. There is no such thing as schizoaffective disorder. Long live schizoaffective disorder. The question of diagnosis can distract the clinician and family from efforts to restore function and even attain a symptomatic and functional recovery from a psychotic illness of any kind."

Discussion

Emil Kraeplin (1856—1926) proposed a dichotomous disease model of schizophrenia versus bipolar disorder. He described schizophrenia as a chronic illness that did not remit and with a poor outcome, while he described bipolar disorder as a cyclic illness with restoration of much function between episodes and with a better outcome. However, the continuum disease model proposes that psychotic and mood disorders are both part of a complex spectrum of disorders, with schizophrenia at one end and mood disorder at the other end. Schizoaffective disorder is considered to be in the middle of this spectrum, with both symptoms of psychosis with mania/hypomania or depression.

Supporters of the dichotomous model note that treatments for schizophrenia and bipolar disorder can be different. For example, lithium and anticonvulsants are not very effective in treating schizophrenic symptoms. However, supporters of the continuum model note that second-generation atypical antipsychotics work in nonpsychotic mania and bipolar depression, and even unipolar depression.

Many clinicians accept that patients with bipolar disorder present with a much wider complexity than what the Bipolar I or II diagnoses in the DSM capture, bringing forth the need for a bipolar spectrum. Hagop Akiskal and other workers in the field have proposed the following categories in the bipolar spectrum:

Bipolar ¼	"Not quite bipolar" – unstable form of unipolar depression that responds rapidly to antidepressants but the effect is unsustained, ie, 'poop out'. Unstable mood and can benefit from mood-stabilizers added to their anti-depressants
Bipolar ½	Schizobipolar Disorder or Schizoaf-fective Disorder
Bipolar I	DSM-V diagnosis
Bipolar 1.5	Recurrent hypomania without de-pression. Eventually usually develop a MDE and then diagnosis can change to Bipolar II Disorder. May benefit from mood stabilizers.
Bipolar II	DSM-V diagnosis
Bipolar 2.5	Cyclothymic patients who develop major depressive episodes.
Bipolar III	Patients who develop a hypomanic or manic episode on an antidepres-sant.
Bipolar 3.5	Bipolar Disorder + Substance Abuse
Bipolar IV	Depressive episodes with a pre-existing hyerthymic temperament. These may be optimistic, high-output, successful people for many years but then collapse into a severe depression.
Bipolar V	Depression with mixed hypomania
Bipolar VI	Bipolarity with dementia

Continued on Page 12

Psychopharmacology Corner (cont'd)

Many patients with a diagnosis of unipolar depression may, in fact, have a form of bipolar disorder, ie, they may have an undiagnosed Bipolar II Disorder or they may be elsewhere on the bipolar spectrum. Patients often do not present due to hypomania but due to depression, and so, a bipolar diagnosis is often missed. It is thought that up to half of the patients with a diagnosis of unipolar depression actually have diagnoses on the bipolar spectrum. Such patients usually receive antidepressants alone, which may increase mood cycling, conversion to hypomania, and increase suicidality in younger patients.

In the continuum disease model of psychotic and mood disorders, at one end of the continuum is schizophrenia while at the other end is depression. In the middle is schizoaffective disorder. The diagnostic criteria for Schizoaffective Disorder in the DSM-V are as follows:

A. An uninterrupted period of illness during which there is a major mood episode (major depressive or manic) concurrent with Criterion A of schizophrenia [Criterion A of Schizoprenia – Two or more of the following present for a significant portion of time during a one month period, at least one in criteria 1,2 or 3: 1. Delusions; 2. Hallucinations; 3. Disorganized speech; 4. Grossly disorganized or catatonic behavior; 5. Negative symptoms]
B. Delusions or hallucinations for 2 or more weeks in the absence of a major mood episode at some time
C. Symptoms that meet criteria for a major mood episode are present for the majority of the total duration of the active and residual portions of the illness
D. Not due to the effects of a substance or another medical condition

Negative symptoms may be less severe than those commonly seen in schizophrenia. Schizoaffective disorder may be typically diagnosed in early adulthood, although its onset can be much later in life. It is often hard to diagnose schizoaffective disorder from schizophrenia or from depressive or bipolar disorders with psychotic features. Criterion C is intended to distinguish schizoaffective disorder from schizophrenia. Criterion B is intended to distinguish schizoaffective disorder from a depressive or bipolar disorder with psychotic features.

Results of a large genetic study headed by Dr. Jordan Smoller of Harvard were recently published (Smoller 2013). 364 collaborators in 19 countries looked at single-nucleotide polymorphism (SNP) data for 33,332 patients and 27,888 controls. The patients were diagnosed with schizophrenia, major depressive disorder, bipolar disorder, attention deficit-hyperactivity disorder (ADHD), or autism spectrum disorder. In the patient group, SNPs at four loci showed the same variations. Two of these genes produced proteins that were part of voltage-gated calcium channel subunits in neurons. The results of this genetic analysis suggest that very different psychiatric diagnoses may have more biologically in common than previously suspected. The authors write: "In particular, variation in calcium-channel activity genes seems to have pleiotropic effects on psychopathology. These results provide evidence relevant to the goal of moving beyond descriptive syndromes in psychiatry, and towards a nosology informed by disease cause."

The diagnosis and treatment, and even the existence, of schizoaffective disorder at present is subject to much debate, as Stahl's comments reflect in this case. However, as he also points out, these issues should not distract the clinician from effectively treating the patient.

Conflicts of Interest: None reported.

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Generic Name	Trade Name
	(common, Canadian names where possible)
diazepam	Valium
haloperidol	Haldol
risperidone	Risperdal
olanzapine	Zyprexa
escitalopram	Cipralex (Lexapro in USA)
clonazepam	Rivotril (Klonopin in USA)
lamotrigine	Lamictal
ziprasidone	Zeldox (Geodon in USA)
lorazepam	Ativan
lithium	generic
aripiprazole	Ability
clozapine	Clozaril
valproate	Epival (Depakote in USA)

A Personal Reflection on the Path to End Suffering

or What I Learned About Myself at the "Mindfulness Retreat for Educators"

Thich Nhat Hanh and the International Plum Village Community *Alison Arnot MD*

My first exposure to mindfulness was reading the book "Peace is Every Step" by Zen Buddhist monk Thich Nhat Hanh. I vividly recall his description of himself as a young child, savouring a cookie that his mother had given him. He ate it slowly, bite by bite, lying on his back in the sun. Not doing anything but enjoying the moment. My mother gave it to me in preparation for a trip to Vietnam that was a "gift to self" for my 40th birthday. The trip was organized jointly by the CCFP (Canadian College of Family Physicians) and People to People, a travel agency in the United States. We spent 2 weeks touring the country and had the chance to visit many medical clinics and hospitals. Doctors were so poorly paid in Vietnam at that time, that they needed a second job to earn enough to feed their families. One memory from that trip that still haunts me is the board-like feel of the abdomen of a young man who was recovering from tetanus in a Saigon hospital. My life then was so busy that I rarely considered the present moment. My attention vacillated between the need to finish the next job on my list and my fear of having forgotten to do something of critical importance. I used to wake in the morning in a panic. I was so busy "doing" that there was no time for "being."

It was several years before the busy-ness settled and I had time to think about mindfulness again. I attended a workshop for medical women organized by the Centre for Continuing Education and Professional Development at U of T in 2011 called "Lighten Up." There, I was introduced to Michele Chaban, a social worker, who was instrumental in developing the palliative care program at the Mount Sinai Hospital. She had attended a conference in Montreal in the late 1970's at which Thich Nhat Hanh was a speaker. Michele had discovered meditation to be a helpful way to lessen the suffering of patients, their families and the caregivers who attended them, when death was near. She led our group in a 3 minute guided meditation, the focus of which was our own suffering; the fear, pain and uncertainty that is inherent to the practice of medicine. During those 3 minutes, I started to cry and had trouble stopping. I had been holding way more than 3 minutes of suffering. The experience of attending to and caring about my own suffering was transformative. Michele invited interested participants to join the Applied Mindfulness Meditation (AMM) training program that was being offered through the Factor-Inwentash School of Social work at the University of Toronto. I signed up the following September and completed the 8 module program over the next 2 years.

It was through the communication network of AMM-Mind that I learned of the retreat which Thich Nhat Hanh was leading at Brock University, August 11 to 16, 2013. It was a once in a lifetime opportunity to spend 5 days with the man who first introduced me to mindfulness meditation. How could I not go? My eldest daughter, who is a French immersion teacher, had just been offered a permanent job in Nova Scotia. I asked her to come with me. It would be a rare opportunity for us to spend time together. She moved away 8 years ago to attend university in Halifax and hasn't lived at home since. My relationship with her has been more conflicted than with my other children. I hoped that by sharing this experience with her, I would have the opportunity to bridge the gap that had developed between us.

Thich Nhat Hanh maintains that happy teachers will change the world. His community is actively promoting WAKE UP schools in which mindfulness will be embedded in the curriculum. The intention of the retreat was to "teach teachers" to optimize the conditions for their own happiness in order to assist their students to be happy as well. Children unconsciously recreate the attachment relationships they have with their parents, with their teachers. There is, therefore, an opportunity for teachers to provide developmentally appropriate and repetitive experiences that help children to grow the integrative fibres in their brains that enhance their ability to regulate emotions, which is especially important if their parents have not been able to provide them.

For those who have never attended a retreat, I will briefly review what happened once we got there in the late afternoon on the first day.

After registration and settling into our residence room, we made our way to the cafeteria for supper. Volunteers flanked us as we stood in line with signs that asked us to be silent. Buddhists refer to the practice of not speaking as "'noble silence." It helps to quieten the mind and allow one to better attune to the present moment. We ate with the monks and nuns, who would periodically ring a small gong which was a signal to stop eating and drop into the present moment with our

Continued on Page 14

A Personal Reflection (cont'd)

breath. All 1300 of us later assembled in the gym, which functioned as our meditation hall, for an overview of the week ahead. Thich Nhat Hanh gave a brief Dharma talk but there were problems with the sound system and it was a real struggle to hear him. Dharma is the name given to the study of the Buddha's teaching. I hope I didn't miss anything important! Fortunately, the organizers were able to rectify the sound problem by the next morning.

We arose at sunrise each morning to walk together in silence, which was followed by a guided seated meditation in the gym. A guided meditation is one in which participants are invited to meditate on a specific focus; usually a sensation, feeling, thought or image. After the morning meditation, half the group ate breakfast (in silence) while the others did yoga, qi gong or stick exercises (done standing upright holding a broom handle and, surprisingly, quite challenging). While the other group ate, there was "lazy time," that is to say, "free time." We reconvened in the meditation hall mid-morning for a 2 hour Dharma talk which was given by Thich Nhat Hanh or "Thay" as he is commonly known, which means teacher. We then had a break for lunch. The afternoon program varied from day to day, but included one session of deep relaxation, led by a 75 year old nun who sang to us in English, French and Vietnamese while we lay on our backs and breathed. She ended the session with a demonstration of her technique for curing dizziness. She spun like a whirling dervish then stopped suddenly and looked at her hands which were clasped tightly in front of her. She swore it worked every time. It worked for me too. Who knew?

I had the good fortune of having this same nun, who had been an acolyte for 50 years, as my dharma group leader. Dharma groups consisted of about 20 retreat participants who met over the course of 3 afternoons to discuss their experiences of the retreat and to ask questions about what had been taught in the morning. After supper, we reconvened in the meditation hall for the evening program. When the program ended at 9 pm, we returned to our rooms in noble silence, which lasted until after the dharma talk the next morning.

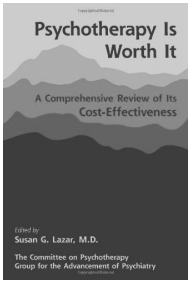
My daughter found it very difficult to sit still and listen for so many hours each day. She has always been more comfortable in movement than stillness and she found it challenging to be confined in such close proximity to so many other people because of her introverted nature. She needs ample solitude for restoration. By the third day she was ready to leave but chose instead to take a break from the program to investigate the teaching resources at the Faculty of Education. This was very wise of her and an important acknowledgement of the need for self care.

What I appreciated most about Thay's approach to meditation is how simple it was. He instructed us to drop into the present moment by acknowledging that we were breathing. "Breathing in, I know that I'm breathing in. Breathing out, I know that I'm breathing out." His monks and nuns sang to us in 3 languages as they welcomed us into the meditation hall each morning. We danced and played in our evening mindfulness workshop. My Dharma group enjoyed a tea ceremony on the 4th day. The retreat gave us the opportunity to return to the rhythm and simplicity of childhood. The experience was both calming and invigorating. I encountered friends from work and the mindfulness training program. I saw some familiar faces from the GPPA as well. As I was waiting for my daughter after one evening program, I chatted with the woman standing next to me, who turned out to be a childhood friend of my sister-in-law. I am always amazed by the connections that exist between fellow participants at mindfulness retreats; proof that there really are only 6 degrees of separation between us and others in the world.

The seated meditation on the 4th morning was the most meaningful experience of the retreat for me. The young nun who led it had an exquisite voice. She sang to us in French that morning, which is something my daughter had been longing for. The theme of the meditation was the relationship to our mothers. The nun invited us to imagine our own mothers as young women full of hope and longing; to see them as their best selves and to forgive them for the things they may have said or done that were hurtful. She asked us to be thankful for their gifts. The tears rolled down my face as I thought of my own mother. She tried to do too much for most of my formative years with very little support from friends or family. She was often tired and irritable. We were encouraged to have compassion for ourselves as well; for wounding our children in turn. I know that in my oft fatigued and depleted state, I have been impatient and angry. My anger terrified my children; the daughter who was there with me in particular. She once told me, after I had cut back my hours, that she hoped I would never return to full-time work so "I wouldn't be mean like I used to be." I prayed that she had made it to the hall in time to experience that sitting meditation because she was still asleep when I left the room to walk that morning. As the meditation ended, I opened my eyes and saw her standing just beyond me in the line waiting to exit. My prayer had been answered.

Therapist's Bookshelf

Psychotherapy is Worth It: A Comprehensive Review of its Cost-Effectiveness



The Committee on Psychotherapy Group for the Advancement of Psychiatry (2010) Washington, DC / London England: American Psychiatric Publishing Inc. Edited by Susan G. Lazar, MD
Reviewed by Anastasia Sky, MD

The book *Psychotherapy is Worth It* has inspired me ever since I discovered it. In my opinion, this book is an important and impactful resource. It significantly supports and recognizes the extent and value of the practice of psychotherapy. I believe the search to find structured evidence and analysis of evidence supporting the health care value and cost-effectiveness of psychotherapy is finally answered by this book.

Over the years, I have repeatedly heard statements such as this: that psychotherapy works, but that few studies exist to show its efficacy and cost-effectiveness; it is also pointed out that such studies are difficult to create to prove outcome. This book succeeds in addressing this complex topic. The book itself is very detailed, and my intention here is to help introduce its structure and content in a simplified manner, as well as to summarize its important conclusions.

So what about evidence for the efficacy and cost-effectiveness of long-term psychotherapies? What about the overall health benefits and cost-effectiveness of psychotherapy for specific diagnostic groups and to health care systems in general? Fortunately, this book also speaks to these and other points.

I believe that we who provide the service of psychotherapy to patients under our health care system would like to know how much we are indeed helping to decrease morbidity and to decrease financial costs. This book collects an impressive array of evidenced-based research and meta-analyses, and contains the critical thoughts and conclusions of a committee of American Psychiatric Association (APA) psychiatrists, trained in a variety of psychotherapies.

The panel of physicians who co-authored and edited the book, include professors of psychiatry from Yale, Harvard, New York University School of Medicine, Georgetown University School of Medicine, George Washington School of Medicine, Weill Cornell College of Medicine, University of California, San Diego Medical School. Many of the contributors are also senior training and supervising psychoanalysts from respected American psychoanalytic institutes.

From the outset, the book's focus is clear, to "discuss the cost effectiveness of psychotherapy and [examine] many aspects of psychotherapeutic interventions for the major psychiatric disorders." Further, it looks to explore "the costs of providing psychotherapy in relationship to the impact of psychotherapy on health and on the costs of psychiatric illnesses and related conditions." In order to do this, the epidemiology of mental illness is explored. Readers are reminded of the World Health Organization's startling statistic from 2008, citing mental health as the leading cause of global-cause disability, and the most important cause of disability worldwide, with substance abuse as the second-leading cause. In fact, the WHO estimates that taken together, neuropsychiatric disorders and substance abuse are "more significant contributors to disease burden worldwide than any other non-

Continued on Page 16

A Personal Reflection (cont'd)

We haven't spoken much to each other about the emotional impact of that meditation, but, for me, a sense of peace has settled where the conflict used to be.

As I write this, I am preparing to attend another mindfulness retreat at Spirit Rock Meditation Centre, a spiritual education and training institution, in California. I have enrolled in a 2 year training program called the Heavenly Messengers, organized by Spirit Rock and the Metta Institute, which trains "midwives to the dying." The "Heavenly Messengers" are ageing, illness and death. They were what the Buddha encountered as he left the cossetted life of his father's estate to explore the world as a young man. As I enter my 57th year, I figure it's time to get a handle on those things since none of us is immune to them. I can't help wonder why all who work in the healing professions aren't offered similar training as a matter of course. We are drowning in suffering; our own as well as our patients, and there is no institutional lifeline. I need to learn how to rescue myself. How about you?

I'll let you know how it is working out.

A lotus, which is a symbol of your Buddha nature, to everyone!

Conflict of Interest: None Reported

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Book Review (cont'd)

communicable diseases such as heart disease and cancer." Prevalence and costs are also discussed, and one can't help but be struck by the numbers, with a US figure dating back from 1985 citing a cost of $273 billion per year. This figure, which includes costs of treatment, law enforcement, reduced productivity and mortality, must certainly be that much greater today, some twenty years on. Despite this, the authors go on to show how mental illness remains both under-diagnosed and under-treated, as well as how psychotherapy, as a treatment modality remains largely unrecognized and under-utilized, despite its proven efficacy and relatively low-cost.

One of the book's strengths lies in its attention to detail. In order to compare relevant studies in a standardized way, the book establishes a clear definition of psychotherapy as "primarily the treatment of one or more patients through the use of psychological processes, primarily mediated through talking, utilizing a therapeutic relationship, and administered by a therapist." As well, the book looks closely at both the "costs" of psychotherapy (as distinguished from "charges"), as well as "cost-effectiveness." Finally, the book establishes a definition for what are considered "positive outcomes" - not just symptomatic relief, but also improved behaviours, increased capacity for improved vocational and social performance and thus, an overall improved quality of life.

As an example, the book's first chapter deals with schizophrenia, looking at psychotherapeutic and psychosocial interventions, along with clinical outcomes and cost-effectiveness. With a prevalence of just 4 per 1,000 persons, schizophrenia's "costs" for a single year (1995) lie in the range of $65 billion; with $19 billion of that deriving from psychiatric treatment expenses, and a further $45 billion deriving from indirect costs associated with illness-related lost productivity.

Next, the chapter summarizes complex data from 22 studies addressing two forms of talk therapy/psychosocial interventions studied with schizophrenic patients and their families. These therapies are referred to as FI's (family interventions), consisting of education, problem solving, and the management of conflict and stress, and SST's (social skills training), which utilize learning theory to improve the patient's interpersonal skills and work competency. The chapter reminds readers that pharmacological agents are indeed effective for treating positive symptoms of schizophrenia such as delusions and hallucinations, thereby reducing relapse rates. However, these agents are much less efficacious against the cognitive and social deficits secondary to the illness itself, either due to chronicity of disease, or due to associated developmental deficits. For these latter symptoms, talk therapies, along with psychosocial interventions appear to have much greater value for schizophrenic patients.

Conclusions of this chapter, based on analysis of the studies, yields the following results: the durability of FI's (family interventions) is both temporary and limited, with benefits diminishing steadily after the treatment ends. However, FI's were shown to decrease patient relapse rates, decrease the need for in-hospital treatment, and improve overall family function. Thus, FI interventions, while not adequate as stand-alone treatments, were nonetheless found to be cost-effective. Additionally, the chapter concludes that schizophrenic patients are able to learn and retain learned skills that improve both social and vocational functioning. Thus, it is concluded that positive changes appear to be more durable in SST's (with patient social skills training) than with FI's (family interventions), while simultaneously magnifying the effectiveness of psycho-pharmacological treatments. The final conclusion and impression of this chapter is that "any effective treatment for schizophrenia, psychosocial therapy or biologic, that reduces relapse rates and days in-hospital will be cost-effective."

Despite the complexities in establishing its definitions, the book does succeed in its ambitious mission. In subsequent chapters, the book summarizes numerous studies and delivers its conclusive message – that psychotherapy is not only cost-effective, but in fact, has vast health-care value. The authors reiterate the need for further large-scale studies to evaluate the cost-effectiveness for specific diagnostic groups of patients, but point to positive conclusions from what limited studies we have, to date. Subsequent chapters are dedicated to evaluating the cost-effectiveness of psychotherapy for a variety of psychiatric conditions, from depression, anxiety, and PTSD to borderline personality disorder and substance abuse. There is also a separate chapter dedicated to the value of psychotherapy for patients with non-psychiatric medical conditions, as well as a chapter focusing on psychotherapy's benefit for children and adolescents.

In summary, this is a reference of enormous value and interest, not only for practitioners of psychotherapy, but for those involved in all aspects of mental health-care. In its pages, we see clearly what we who provide psychotherapy have suspected all along – that there is enormous, perhaps unmatched value in our area of specialty – the psychotherapeutic alliance.

Conflicts of Interest: None reported

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The Power of Self-Reflection in Health Care: The Making of a Therapist from Family to Finish—The Second Annual GPPA Retreat

Elizabeth Parsons, MD

On a blustery weekend at the end of October, 19 people gathered in the lovely natural setting of the Geneva Park Conference Centre near Orillia, Ontario. We were there to attend the second annual retreat of the GPPA. You may remember that last year the topic was "self-care" and that those who attended felt a renewed sense of the importance of looking after their own needs. This time, the topic was "self-reflection" and it was explored mainly from the perspective of the Satir model. Our facilitators were Robin Beardsley, a family physician and experienced Satir teacher, and Susan Ford, MSW, a trauma therapist with a particular interest in resilience among mental health workers. Alison Arnot said after the weekend, "I registered for the second annual GPPA retreat because I wanted to spend time with Robin Beardsley and learn more about the Satir model that we were introduced to at the recent conference. I had no conscious expectations about what might transpire. I left the retreat a changed person, having felt the power of presence and compassion, to heal the childhood wounds that interfere with our ability to connect with one another as people, parents and physicians."

Through various experiential modalities, including the practice of self -compassion, Heartmath and Coping Stances, we began to appreciate a deeper sense of what our own tendencies are in the face of stress and what we might do to increase our awareness in the moment. This, in turn, will allow us to respond rather than react to stressful situations.

The Satir Model[1] is named for Virginia Satir, often referred to as the "Columbus of Family Therapy." She believed that the problem that people present with is often not the true problem, rather it is the way people cope with their problems that causes difficulty. The Coping Stances refer to the ways in which we tend to react when under stress, our automatic responses. She labelled them as "blaming," "placating," "super-reasonable" and "irrelevant/distracted." These stances have physical representations, for example the placating stance consists of kneeling on one knee and reaching up with one hand, with a pleading look on one's face. One aspect of Satir therapy is to take up different combinations of the stances, within a group of three, a triad. We spent some time in each of the stances and noticed how it felt – in our bodies, our emotions and our thoughts – and shared this experience within our triad. After this work with the stances, we worked on our family maps in pairs. These are detailed genograms, from the client's perspective of their family of origin, including adjectives describing each family member, the relationships between family members and what we remember of their coping stances when we were children. From this exercise, I derived some significant new insights about my family of origin and also realized that I have some big questions to ask some of my family members. Whether they are ready or willing to answer them is another story!

Our family maps culminated in one member having the chance to have her family "sculpted." This involved sharing her family's story with us and then choosing members of our group to stand in for members of her family. Family sculpting is the process of placing members of the individual's family (or those they have chosen to stand in for them) in an arrangement that represents their relationships to each other and to the individual. As well, those who take on these roles interact with the individual as the family member that they are representing. Even though the people chosen were playing the part of a person they did not know, it seemed that on some level they were able to resonate with that person's experience and the whole effect was very powerful. Maria Blass, whose family was sculpted, said of the experience, "Robin and Susan were the embodiments of being present. With their skillful guidance and the valuable contributions of the attendees there was a safe environment to work within. I was fortunate to have had the opportunity to sculpt my family, ...at that moment I experienced what I needed, I was not judging, I simply accepted and I trusted in that.... the past was gone and the

Photo courtesy of Jackson Lin

Continued on Page 18

The Power of Self Reflection (cont'd)

future was not there yet, so at that time (at age 16) I got what I needed/was meant to get and I was content with that. The revelation of what unconditional love feels like was empowering. That process of sculpting is an important stepping stone in my personal journey. Through that I am also a better physician."

Each of us shared how this experience touched something in us that related to our own families. It was amazing to see how relevant one person's story was to everyone. One participant, Michael Vesselago, had this to say: "I think it is also of particular interest that while (and perhaps because) the Satir Model is at the same time a powerful approach taken as a whole, which connects cognitive material with underlying experiential and emotional material, elements of it can be taken and used out of context to great and immediate effect. It seems to me that these are especially valuable aspects of the model about which it is worth spreading the word."

During the weekend, we learned some techniques from Heartmath[2]. This approach involves, among other things, techniques to reduce stress and emotional reactivity. An exercise that we learned was called "Inner Ease" and consisted of the following three steps, to be used when you notice that you are feeling overwhelmed for whatever reason :

1. Notice and admit what you are feeling
2. Take a short time-out : breathe a little slower through your heart/chest area (putting your hand on your chest is an option)
3. When you sense a calmness, affirm yourself and commit to maintain a state of ease as you re-engage with your activity.
   Affirming yourself could occur by repeating a short phrase, such as "I can do this" or "I am capable." This exercise requires, of course, that you are aware of what you are feeling in the moment, not always an easy task.

Another exercise was Breathing Compassion. We started with an image of someone or something (like a pet) for whom it was relatively easy to feel compassion. Attending to the breath, with each exhalation, we breathed out compassion towards that being. After a few moments of this, we added to the in-breath, breathing in self-compassion. Many of us found it to be a brief yet very effective way of increasing our levels of mental, emotional, and even physical energy. This is something that could easily be used during a session with a patient or in between sessions. I have already used some of the techniques that I learned at the retreat with some success both in the therapy room and when dealing with my three young children!

Once again, the retreat was a great learning experience at a deep level, both personally and professionally. By the last day, those who attended already had some exciting ideas for next year's retreat. Please contact me at elizabeth@walma.org if you would like to make any suggestions for future retreats or to help out with organizing.

I will leave you with participant Nadine French's eloquent words, "The GPPA weekend retreat was nothing less than inspiring. I now feel a renewed sense of direction, as well as the increased confidence to start that journey in earnest. I am so grateful to the wonderful facilitators who provided a safe, professional yet very relevant personal weekend. And my gratitude is extended to my colleagues who were all willing to share and support. We are on this fantastic journey of self discovery together, patients and doctors alike."

Conflict of Interest : none reported

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References :

1. For those unfamiliar with the Satir model or interested in learning more, please consult http://www.satirpacific.org/index or Virginia Satir's book "The New Peoplemaking"
2. http://www.heartmath.org

Photo courtesy of Julie Webb

Photo courtesy of Kevin Foster

Colour versions of these photos and more are available online at http://www.gppaonline.ca/2014Winter.html

Report from the Board *Derek Davidson, MD*

GPPA Conference

The Annual Conference and Annual General Meeting will again be held in May, on the 23rd & 24th, 2014. The theme will again be "Emerging Trends in Psychotherapy."

Liona Boyd will present a workshop on her recovery from Dystonia. Other workshops will include Pet Therapy, Sex Addiction, & LGBTQ (Lesbian, Gay, Bisexual, Transgender, and Queer) issues. A number of other speakers are being contacted, and an exciting conference is expected.

GPPA as a Third Pathway for the CPSO

A number of new members have joined the GPPA for the opportunity of using the Association as a third pathway. Some applicants have been disappointed that we cannot give them credits for CPD activities not related to mental health. However we are not qualified to accredit educational activities other than those related to mental health and psychotherapy.

5th National Accreditation Conference

Four members of the GPPA were invited to attend this annual conference held by the Royal College of Physicians and Surgeons of Canada (RCPSC) and the College of Family Physicians of Canada (CFPC). The conference was held this year in Ottawa on Oct 7th & 8th.

The GPPA attendees were: Muriel van Lierop, President; Derek Davidson, Board Chair; Caroline King, Professional Development Committee; and William Jacyk, Education Committee.

The major focus of this year's conference was on methods to ensure that biased perspectives, especially from the pharmaceutical and other medically related industries, be limited and their possibility identified by ensuring that speakers at all accredited CPD activities be required to identify for the audience their financial or other connections to industry.

Both colleges, for accrediting CPD activities, have adopted the CanMEDS philosophy which requires that medical professionals be proficient in seven core competencies: medical experts, scholars, health advocates, communicators, collaborators, managers, and professionals. Basically, CanMEDS is a framework to improve patient care. The CanMEDS name is derived from "Canadian Medical Education Directives for Specialists." Educational programmes that promote these competencies effectively will be welcomed.

The GPPA, as a third pathway for accreditation for Ontario physicians, has been invited to send representatives to the 6th National Accreditation Conference which shall be held in Toronto this year.

Some interest exists in other provinces for the GPPA to be a third pathway outside Ontario. This will be explored in the future.

Accreditation Audits

In recognizing the GPPA as a third pathway for educational accreditation, the CPSO has required that the GPPA perform audits on its members to ensure that they have in fact completed the educational activities that they have claimed. Our CPSO/CPD committee is exploring ways and means of satisfying this requirement.

The New Federal Not-for-Profit Corporations Act

The GPPA is a not-for-profit corporation under the Federal Act. Recent changes require that all corporations under the Act must hold their AGM not later than 6 months after the end of the corporation's preceding financial year.

By moving our financial year end to Dec 31st, we will be able to keep our annual conference and AGM in April or May each year. This will not affect our Membership renewal or CE/CCI deadlines.

These and other minor changes to the bylaws must be passed at the next AGM and submitted to the Federal Government by Oct 17, 2014 or our corporation will be "dissolved." The bylaws are being revised by our lawyer, and will be reviewed before presentation at the AGM.

Listserve

We would like to gratefully acknowledge Marc Gabel, the incoming president of the CPSO, for the work he has done managing the Listserve for many years. We would like to thank Carol Ford, who has signed an agreement of confidentiality, for agreeing to manage the technical aspects of our Listserv. Thanks also go to Ted Leyton, who has volunteered to manage any issues that may arise from the postings.

Membership on Board and Committees

Each year the Board and the committees that report to the Board require new members. We are a self—governing organisation and totally dependent on the efforts of our members for survival. We would like to encourage EVERY member of the GPPA to consider volunteering to join a committee, and any member who has served on a committee to volunteer to join the Board. It is by continuous revitalisation of every committee and the Board by new members that we grow and progress.

Our Committees are the following:
Annual Conference, CPSO/CPD, Education, Finance, Journal, Listserv, Membership, Professional Development, Five Year Strategic Visioning, Research.

Please consider joining one of these committees to forward the work of our organization.

Journal of the General Practice Psychotherapy Association

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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
Deborah Wilkes-Whitehall dwilkes@bellnet.ca or call (905) 834-4546

Questions about the 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.

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