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MEDICAL PSYCHOTHERAPY REVIEW

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CLINICAL REVIEWS

REFLECTIONS

MDPAC MATTERS

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MEDICAL PSYCHOTHERAPY ASSOCIATION CANADA
ASSOCIATION CANADIENNE DE PSYCHOTHÉRAPIE MÉDICALE

"MEDICINE IS NOT ONLY A SCIENCE; IT IS ALSO AN ART. IT DOES NOT CONSIST OF COMPOUNDING PILLS AND PLASTERS; IT DEALS WITH THE VERY PROCESSES OF LIFE, WHICH MUST BE UNDERSTOOD BEFORE THEY MAY BE GUIDED."

Paracelsus

Paracelsus, a Swiss physician during the Renaissance period, was perhaps ahead of his time. His comments are especially relevant today as "pills and plasters" have multiplied exponentially and expanded to include things like neurostimulation. Physicians who practice psychotherapy are particularly aware of the importance of the art of medicine and of confronting the "very processes of life." We are in a unique position to provide exceptional care to those afflicted with a large variety of mental ailments. Yet medical psychotherapy continues to be misunderstood and undervalued. Indeed, it is only covered in some provinces and there are threats of delisting or limiting it in others. This is tragic.

Many, if not most, medical psychotherapists have experience in family practice. Therefore, we are uniquely placed to understand our patients through the life cycle and through a comprehensive biopsychosocial perspective. Many psychiatric conditions have physical manifestations that require knowledge of both physiology and psychology. For example, those with Eating Disorders can benefit from nutrition counselling as well as psychodynamic insight. Addictions are another common disorder with complex interacting neurobiological and psychological components. Furthermore, many "medical" conditions, such as chronic pain, have mental components and consequences. Medical psychotherapy is ideal for such conditions.

And, of course, unlike non-physician psychotherapists, physicians can prescribe medication. This, along with lifestyle counselling on nutrition, exercise etc., allows us to treat biological aspects of psychiatric conditions. Our experience and expertise is invaluable in managing patients on multiple medications or who are unresponsive to medication. Of course, not all physicians who practice psychotherapy prescribe medication (and this discussion is ongoing!), but most agree that our knowledge of medications is vital to a comprehensive management of mental ailments.

One of the reasons I find psychotherapy rewarding (well, most of

The MDPAC Mission is to support and encourage quality Medical Psychotherapy by Physicians in Canada and to promote Professional Development through ongoing Education and Collegial Interaction.

the time) is that I can guide people towards deeper and more permanent healing than "pills and plasters" alone. In fact, in many cases, psychotherapy reduces hospitalizations and improves physical health, thus resulting in cost savings for the system. I suspect many of us recognize the limitations of the "medical model" with its focus on biology and chemistry for the management of complex people with complex pasts navigating complex current situations.

In this issue of the *Medical Psychotherapy Review*, as usual, we focus on the "art of medicine." In his column, Howard Schneider reviews the CANMAT guidelines for management of depression. Interestingly, these list psychological treatments before pharmacological ones and recognize the benefits of "evidence-based *therapy relationships*."

Our reflections section contains both a movie and a book review. Dave Robinson discusses a movie about someone with narcissistic personality disorder, giving us a glimpse into the nuances and challenges of dealing with personality disorders. These complex patients are often well managed by medical psychotherapists. Vivian Chow reviews a book on childhood maltreatment, noting that it offers information and guidance for those providing care for adults as well.

One of the few psychiatrists in our association, and current president, Caroline King dispels some myths about psychiatrists and psychotherapy. They do indeed get training and have interest in psychotherapy, but there are multiple factors that limit their ability to do so. This too is tragic.

Finally, Elizabeth Parsons reports on some of the activities of the MDPAC. The work of our organization provides further evidence of the importance and value of medical psychotherapy. For those not yet involved, the invitation is always open!

Grace and peace,
Janet Warren

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CANMAT Guidelines for Major Depressive Disorder

Howard Schneider, MD, MDPAC(C), CCFP

Abstract

The CANMAT Guidelines for Major Depressive Disorder can help guide treatment from an evidenced-based and expert opinion perspective. The guidelines provide different levels of recommendations for a variety of psychotherapies and lists of first-, second- and third-line antidepressant choices. Neurostimulation treatments, complementary and alternative medicine treatments, and treatment in the perinatal, perimenopausal, and late-life period are also discussed.

In this issue's *Psychopharmacology Corner* we will return to basics. Consider a patient in your office with a condition that meets the DSM diagnosis of a mild-to-moderate Major Depressive Disorder, an all-too-common disorder affecting millions of Canadians at some point in their life. Your patient does not have psychosis and there are no significant mixed features. The first session with the patient was largely supportive therapy and allowed you to start to formulate an assessment. The patient is now in your office for the second session. As a medical psychotherapist you have the skills and tools to provide such a community-based patient with some of the most comprehensive treatment our medical system allows. But what should such treatment be?

The Canadian Network for Mood and Anxiety Treatments (CANMAT, 2019) is a non-profit organization that produces evidence-based guidelines for mood and anxiety disorders. We will consider the CANMAT 2016 Guidelines for the Management of Adults with Major Depressive Disorder as a guide towards the initial treatment of our patient with a mild-to-moderate depression (Lam, Kennedy, et al, 2016).

CANMAT: Disease Burden and Principles of Care

The CANMAT 2016 Depression Guidelines consist of six sections. The first section is titled "Disease Burden and Principles of Care" (Lam, McIntosh, et al, 2016). Lam and colleagues note that each year about 5% of the teen and adult population in Canada (i.e., over 1.5 million Canadians) will experience a DSM diagnosed Major Depressive Episode (MDE), with a lifetime prevalence of over 11%. Lam and colleagues note that, despite increased mental health services to the population, the annual prevalence of MDE has not statistically changed—4.8% in 2002 and 4.7% in 2012.

CANMAT: Psychological Treatments

The second section of the guidelines, "Psychological Treatments" (Parikh, et al., 2016), emphasizes the importance the CANMAT group places on this modality of help. In MDEs that are considered low to moderately-severe risk, the decision to use psychological treatments or antidepressant medication can be based on patient preferences and resource availability.

The authors provide recommendations for the psychological treatment of depression (see Table 1). They also acknowledge that the best results in psychological treatments actually come from the use of "evidence-based *therapy relationships*, not just evidenced-based *treatments*."

CANMAT: Pharmacological Treatments

The third section of the guidelines, "Pharmacological Treatments" (Kennedy, et al., 2016), begins with evidence supporting the efficacy of antidepressants in Major Depressive Disorder (MDD) despite some earlier reports to the contrary (e.g., Kirsch, et al., 2008). The section then discusses the principles of pharmacotherapy management:

- Full assessment including suicidality, bipolarity, comorbidity, other medications
- Full assessment of previous treatments attempted
- Discussion with the patient of pharmacologic and non-pharmacologic treatment options, and patient preference with regard to pharmacologic treatment
- Consider lab testing, including lipids, liver function tests, ECGs
- Reassess in less than 2 weeks after starting treatment, and consider follow-up every 2–4 weeks, using validated scales to assess progress

In choosing an initial antidepressant for our patient, the CANMAT guidelines recommend the medications listed in Tables 2, 3, and 4 below, as first-, second-, and third-line choices respectively.

The guidelines note that with regard to choosing a first-line antidepressant "there are no absolutes, and relative differences between medications are small." Thus, the choice is really influenced by the characteristics of the patient's case. For example, if there is concomitant pain, then an antidepressant such as duloxetine could be helpful for both the depression and the pain.

In a network meta-analysis (able to in-

Table 1: Psychological Treatments for Depression

Psychological Treatment (including common abbreviation)	Acute Treatment Recommendation	Maintenance Treatment Recommendation
Cognitive-behavioural therapy (CBT)	First-line	First-line
Interpersonal therapy (IPT)	First-line	Second-line
Behavioural activation (BA)	First-line	Second-line
Mindfulness-based cognitive therapy(MBCT)	Second-line	First-line
Cognitive-behavioural analysis system of psychotherapy (CBASP)	Second-line	Second-line
Problem-solving therapy (PST)	Second-line	Insufficient evidence
Short-term psychodynamic psychotherapy (STPP)	Second-line	Insufficient evidence
Telephone-delivered CBT and IPT	Second-line	Insufficient evidence
Internet- and computer-assisted therapy	Second-line	Insufficient evidence
Long-term psychodynamic psychotherapy(PDT)	Third-line	Third-line
Acceptance and commitment therapy (ACT)	Third-line	Insufficient evidence
Motivational interviewing (MI)	Third-line	Insufficient evidence

directly compare medications against each other) Cipriani and colleagues (2009a, 2009b) found better response rates for escitalopram, mirtazapine, sertraline, and venlafaxine. The guidelines note that, from a population basis, perhaps these modest differences might be clinically significant, but imply that, on an individual basis, the patient's needs must be considered in making decisions regarding medication.

Of interest, a more recent network meta-analysis by Cipriani and colleagues (2018), found the most effective antidepressants to be agomelatine (not available in Canada), amitriptyline, escitalopram, mirtazapine, paroxetine, venlafaxine, and vortioxetine. The least effective antidepressants were fluoxetine, fluvoxamine, reboxetine (not available in Canada), and trazodone. And the most tolerable antidepressants were agomelatine, citalopram, escitalopram, fluoxetine, sertraline, and vortioxetine.

The Florida Best Practice Psychotherapeutic Medication Guidelines for Adults are intended to "provide rational approaches" to clinicians who use psychotherapeutic medications (Florida Medicaid, 2018). The 2017–2018 Florida guidelines recommend an SSRI, an SNRI, vortioxetine, or, to consider bupropion or mirtazapine with regard to initial psychopharmacological treatment.

Returning to the CANMAT guidelines, it is important to consider potential serious adverse effects in each patient. With regard to suicide risk, the guidelines note that large studies have not shown significant differences between various antidepressants. With regard to prolongation of the cardiac QTc interval, which risks arrhythmia, the guidelines note warnings for citalopram, escitalopram, and quetiapine. SSRIs can decrease the aggregation of platelets and, if a patient is also taking a non-steroidal anti-inflammatory medication, the risk of gastrointestinal bleeding is increased.

The authors recommend that if there is not an improvement, defined as a 20–30% reduction of symptoms on a rating scale, by two to four weeks, then the dose should be increased as tolerated before considering

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CANMAT Guidelines for Major Depressive Disorder | continued

Table 2: First-line medication recommendations (only drugs available in Canada are included here)

Generic Name	Brand Name	
bupropion/SR/XL	Wellbutrin/SR/XL	NDRI (Norepinephrine-Dopamine Reuptake Inhibitor)
citalopram	Celexa	SSRI (Selective Serotonin Reuptake Inhibitor)
desvenlafaxine	Pristiq	SNRI (Serotonin-Norepinephrine Reuptake Inhibitor)
duloxetine	Cymbalta	SNRI
escitalopram	Cipralex (USA: Lexapro)	SSRI
fluoxetine	Prozac	SSRI
fluvoxamine	Luvox	SSRI
mirtazapine	Remeron	Alpha2-adrenergic agonist; 5HT2 antagonist
paroxetine	Paxil	SSRI
sertraline	Zoloft	SSRI
venlafaxine/XR	Effexor/XR	SNRI
vortioxetine	Trintellix	S reuptake inhibitor and multiple 5HT effects

Table 3: Second-line medication recommendations; there also seem to be some extraneous lines here

Generic Name	Brand Name	
amitriptyline, clomipramine	generic	TCAs (Tricyclic Antidepressants)
levomilnacipran	Fetzima	SNRI
moclobemide	Manerix	RIMA (Reversible MAO-A Inhibitor)
quetiapine /XR	Seroquel /XR	Atypical antipsychotic
trazodone	Desyrel	S reuptake inhibitor, 5HT2 antagonist
vilazodone	Viibryd	S reuptake inhibitor, 5HT1A partial agonist

Table4: Third-line medication recommendations

Generic Name	Brand Name	
phenelzine	Nardil	Irreversible MAO Inhibitor (MAOI)
tranylcypromine	Parnate	Irreversible MAO Inhibitor (MAOI)

switching the antidepressant. If there is still no significant improvement, then one can switch to another antidepressant or add an adjunctive medication. If there is no significant improvement after another two to four weeks, then consider another trial of a switch or adjunctive medication.

With regard to switching antidepressants, the authors noted that, although there was some evidence supporting a remission advantage in switching an SSRI to an antidepressant in a different class (e.g., bupropion, mirtazapine, venlafaxine) compared to switching to another SSRI, this evidence remains uncertain, and thus the recommendation is to switch to an antidepressant with evidence of better efficacy for some specifier/dimension. For example, if cognitive dys-

function is present, then there is evidence and recommendation for a switch to vortioxetine (the only one the guidelines give a level-1 rating for this purpose), bupropion, duloxetine, SSRIs, or moclobemide.

An adjunctive medication should be considered over switching if the initial antidepressant is well tolerated, there have been already two antidepressant trials, there is some improvement with the initial antidepressant, or there is a pressing need to get a response more quickly. With regard to adding a specific adjunctive medication the first-line recommendations are aripiprazole, quetiapine, or risperidone. Brexpiprazole, olanzapine, and ketamine also have level-1 evidence of efficacy as an adjunctive medication, but are not first-line recommendations. Second-line recommendations for an adjunctive medication are brexpiprazole, bupropion, lithium, mirtazapine, modafinil, olanzapine, and triiodothyronine. Third-line adjunctive recommendations are other antidepressants, other stimulants, TCAs, and ziprasidone.

There is evidence to support continuing an antidepressant for 6–9 months to avoid a relapse. However, there is also evidence, albeit weaker, for patients with recurrent MDD and/or risk factors for recurrence, to be treated for two or more years in order to reduce the risk of recurrence and achieve better psychosocial results. The authors recommend slow tapering when the decision is made to stop the medication.

At the time of writing, use of newer antidepressants such as ketamine have started to emerge in clinical practice. However, we would not begin treatment, for example, of our patient above with mild-to-moderate MDD, with ketamine or its enantiomer esketamine. (The 2019 USA Food and Drug Administration approval of nasal spray esketamine, tradename Spravato, is for treatment-resistant depression.) The CANMAT guidelines remain a relevant tool to help us approach the treatment of our patient.

CANMAT: Neurostimulation Treatments

The fourth section of the guidelines, "Neurostimulation Treatments" (Milev, et al., 2016) considers neurostimulation treatment. Repetitive Transcranial Magnetic Stimulation (rTMS) uses strong magnetic pulses to induce electrical currents in cortical areas. rTMS is actually considered a first-line treatment for MDD if a patient has failed one or more antidepressant trials.

Electroconvulsive Therapy (ECT) electrically induces seizures, with the patient under anaesthesia in countries such as Canada and the USA (Leiknes and colleagues, 2012). ECT actually yields some of the most effective results for treating MDD. However, anaesthesia facilities are required and there are often cognitive adverse effects.

Neurostimulation treatments provide more options for MDD patients. As noted above, rTMS can be a first-line treatment for a patient who has failed one or more antidepressant trials. ECT is a second-line treatment choice for patients with treatment-resistant depression, but can be a first-line choice in certain cases.

CANMAT: Complementary and Alternative Medicine Treatments

The fifth section of the guidelines, "Complementary and Alternative Medicine Treatments" (Ravindran, et al., 2016) notes that up to one-third of patients use Complementary and Alternative Medicine (CAM) treatments. Unfortunately, there is very limited evidence for most CAM treatments.

Light therapy involves 10,000 lux for a half-hour in the early morning. Evidence supports a recommendation of light therapy as a first-line monotherapy for unipolar seasonal depression and as second-line or adjunctive treatment for other MDD. For mild-to-moderate MDD there is a first-line recommendation for exercise. There is a second-line recommendation for yoga and a third-line recommendation for acupuncture.

Evidence exists for the efficacy of St John's Wort and it has a first-line recommendation in mild to moderate MDD. Omega-3 fatty acids are given a second-line recommendation in mild to moderate MDD. SAM-e is also given a second-line recommendation in mild to moderate MDD, albeit only as an adjunctive therapy.

Complementary and alternative treatments provide more options for MDD patients. Exercise, light therapy, St John's wort, omega-3 fatty acids, SAM-e and yoga have first- or second-line recommendations for treating mild to moderate MDD.

CANMAT: Special Populations: Youth, Women, and the Elderly

The sixth section of the guidelines, "Special Populations: Youth, Women and the Elderly" (MacQueen, et al., 2016), considers the treatment of child and adolescent depression, perinatal depression, perimenopausal depression, and late-life depression. In children and youth, the authors give first-line recommendations to CBT or IPT for initial treatment. Second-line recommendations are fluoxetine (level-1 evidence) or escitalopram, sertraline, and citalopram (level-2 evidence).

Perinatal depression includes unipolar MDEs during pregnancy and one year postpartum, and is relatively common—7.5% of women during pregnancy and 6.5% in the first three months postpartum. If the MDEs and more minor depressive disorders are both considered, then about 18% of women will have such a depressive episode during preg-

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nancy and 19% in the first three months postpartum. For mild-to-moderate depression during pregnancy the authors give first-line recommendations for CBT or IPT, and second-line recommendations for citalopram, escitalopram, or sertraline. The first-line recommendations for the treatment of perimenopausal depression are desvenlafaxine (level-1 evidence) or CBT (level-2 evidence).

Late-life depression is considered MDD in patients over 60 years old, but is different than a recurrence of depression in a patient with a history of depression. Late-life depression has a worse prognosis, and there is a hypothesis that cerebrovascular disease is responsible for some late-life depressions, as well that late-life depression may sometimes be prodromal for dementia. The authors recommend as first-line treatment duloxetine, mirtazapine, or nortriptyline (level-1 evidence). Also as first-line treatment but with level-2 evidence are bupropion, citalopram, escitalopram, desvenlafaxine, sertraline, venlafaxine, or vortioxetine.

Discussion

The CANMAT Depression Guidelines are not without criticism. For example, Snelgrove (2017) takes issue with designating a treatment as "first line" on the basis of only two randomized controlled trials (RCTs) with no quality standards that a RCT must meet, including who funded an RCT, although equivalent depression guidelines elsewhere do take these sources of bias into account.

Nonetheless, the CANMAT Depression Guidelines can be a useful resource. Let's return to the patient in your office with a first episode of mild-to-moderate Major Depressive Disorder without psychotic or mixed features. In the history you obtained, the patient had received cognitive behavioural therapy in the months before being referred to your office, but the depression did not improve with therapy. In the family history, the patient's sister has had serious depressions and was treated successfully with sertraline. You discuss treatment options with the patient, and collaboratively decide on a trial of sertraline, a first-line recommendation for MDD, and as well giving a good outcome in a close relative. In addition, you collaboratively agree to a trial of psychotherapy again, lifestyle changes including daily exercise, and will meet every one to two weeks.

Conflict of interest: None

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The Wife

Runge, B. (director) (2017) *The Wife* (motion picture). United States, Sony Pictures Classics.

Reviewed by David J. Robinson MD, FRCPC

Narcissistic personality disorder (NPD) poses a significant set of challenges for psychotherapists. By the time people with this condition come for help, it is usually because of years of interpersonal carnage; they typically present themselves as part of an ultimatum, often issued by a loved one or business partner. One of the aspects of NPD that can make it difficult to apply the diagnosis is deciding if there truly is some aspect of the person's social or occupational functioning that is impaired by his or her modus operandi. Would a diagnosis of NPD still apply if the person was highly accomplished in his or her field? How might a psychotherapist try to address behaviours that have already worked very effectively for someone? Fiction often provides insights into challenging psychiatric conditions.

The Wife is based on the 2004 novel of the same name written by Meg Wolitzer. The film focuses on Joe Castleman (Jonathan Pryce), a former Smith College faculty member who receives a highly anticipated phone call with the news that he has won the 1992 Nobel Prize for Literature. The Swedish-accented voice on the other end of the line lists off accolades for Joe's oeuvre that would be all that any novelist could ever hope to hear. Joe celebrates with his wife Joan (Glenn Close), inviting her on the call. A hint of what follows is shown when it is suggested by the Academy representative that Joan might wish to make herself available to manage the anticipated barrage of media attention.

The movie flips back and forth between many time frames, and viewers get to see the couple's relationship develop. *The Wife* deftly details the manipulations of how a person with NPD manages to extract the enduring support of a devoted spouse while simultaneously robbing the family of a genuine father or husband. Joe is quick to criticize others for any number of small infractions (smoking, crooked ties), but absolves himself of the need to lead by example and eats high-fat foods with impunity despite having significant cardiac issues.

Young Joe (Harry Lloyd) aspires to be a great writer, and secures a job as an instructor at a private women's liberal arts college. He waxes eloquent about the romantic life of a writer: the duty to persist, the agony of countless revisions, and the uncertainty about whether pouring one's heart into the written word will ever get anyone's attention. "A writer needs to write," he exhorts. Joe is a charismatic salesperson for the writing life, and his act intrigues his then-student Joan (Annie Starke, daughter of Glenn Close, plays the younger version of this character). She makes an appointment to discuss her interests. Joan becomes smitten with Joe, who dares to ask if she is free the upcoming weekend…to babysit for him and his wife! Joan accepts, and is so keen in her perception of character and narrative that she writes a short story based on the observations she makes while at Joe's house. The story gets printed in the school newspaper, and importantly, gets digitized for others to read in later years.

Joan attends a reading by a disaffected female writer named Elaine Mozell (Elizabeth McGovern). Elaine pulls her published novel off the shelf where alumni have their works displayed. She asks Joan to listen to the crack of the spine, emphasizing that is the sound a book makes when it is opened for the first time. "A writer," she says "needs to be read." Elaine paints a pessimistic picture of female authors being able to receive recognition, and advises Joan to do something else with her life. This is a pivotal experience in Joan's life. She has the interest in pursuing a career as an author and has the talent, but what Elaine says changes her life. Elaine managed to get a book published, which we are led to believe is an uncommon feat, and it sits unopened on the faculty bookshelf. Joan realizes that what Elaine says about writers needing to be read (vs. Joe's comment about writers needing to write) is true, and she realizes in that moment she has a better chance of her work getting published if it is under a man's name.

Not surprisingly, there is acrimony in the first Castleman marriage and it dissolves, giving Joe and Joan the chance to share their lives. Joan gets a job at a publishing house. Joe writes at home and has lots of big ideas, though staring at a blank page stupefies him. When he writes something, he is so exquisitely sensitive to criticism that he attacks the person offering feedback before it even gets expressed. Joe is so fragile that he crumbles into despair, accusing Joan of saying his work was valueless when he asks her to read something. He projects blame onto Joan for the loss of his job at Smith College (he was dismissed for the affair with her). Joe accuses Joan of stealing from his life by writing her short story about him and his first wife. Joan learns that her husband's self-esteem rests on the anticipated accolades of his future novels. She sees an opportunity to help her insecure husband and find an outlet for her

talent by becoming his writing partner. Joan overhauls a draft of one of Joe's novel and gets it accepted for publication. The joy Joe feels radiates out of him, consigning Joan to become his ghost writer.

Joe's thirst for admiration is unquenchable, and seemingly no amount of success satisfies him. It gets to the point where he sequesters Joan in his office for eight hours per day while he intercepts their children when they come looking for their mother. All the novels become published under Joe's name, while his role in the writing process is later revealed to be just "editing" Joan's work.

Joe believes his own press and behaves like a spoiled artistic genius whose talent must be nurtured at all costs. He has a long string of affairs, hurting Joan deeply, but she endures in the marriage and writing arrangement to keep the family together. Joan finds a creative outlet for her despair in writing novels that are disguised versions of their family dramas. In one scene, she points to one of Joe's "classics" and said it was based on his affair with their third nanny, a point to which he was unaware. At times Joe demonstrates features of an "oblivious" narcissist, while in other scenes he is more of the "hypersensitive" type. If Joan did not have this creative outlet for herself, this would have been a natural point in her marriage to insist that Joe get help.

Joe's relationship with his son is particularly instructive of narcissistic maneuvering. David has endured a lifetime of interference in trying to a have nurturing relationship with at least one parent. Joe keeps putting off finding the time to read a short story that David has written. When Joe finally does have some feedback for David (though it is not clear he's ever read the story), he merely parrots back the feedback that he received about his early work (ironically, that the character development was weak). Joe can't speak for long without using the word "but," and merely wants to send David away to work on a revision. Not even winning the Nobel Prize for Literature can move Joe to give his son any genuine encouragement.

As Joan, Joe, and David head to Stockholm for the award ceremony, the thin threads holding them together are unraveled by unauthorized biographer Nathanial Bone (Christian Slater). Taking the roles of investigative reporter, provocateur, and amateur family therapist, he manages to guide Joan to pull the pin on the grenade that is her suppressed anger. One of Joan's sources of comfort has become alcohol, and over a drink Nathanial tries to recruit her as a source for the upcoming book he's been hired to write about Joe. Nathanial has had the opportunity to read online Joan's short story from her college days, and tells her it is widely known that she is the true talent in the family. Joan had taken considerable care to keep her ghostwriting a secret, and seems genuinely surprised that Nathanial knows about it.

Psychotherapy with narcissistic people often leads to therapists being seen by their patients as employees or extensions of the person's group of supporters. For example, there may be an expectation that a stellar progress report will be given on the person's behalf, or that the therapist is benefitting at least as much from the appointments (by getting to know such a successful person) as the narcissist. One wonders in watching this movie where a psychotherapeutic intervention might have been successful (or even possible) with Joe, possibly after the awards dinner. The film has an ending worthy of one of Joan's novels!

Conflicts of interest: None

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Dave Robinson is a psychiatrist practicing in London, Ontario. He is the author of two books on movies and psychiatry. He notes that narcissistic patients frequently sit in his office chair during therapy sessions.

Helpful Advice from an Unexpected Source

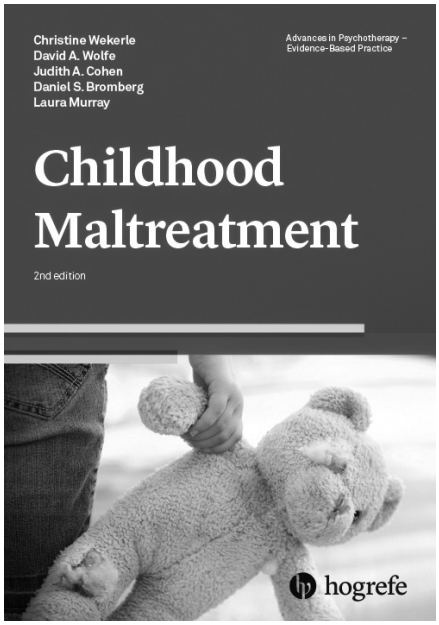
A review of Childhood Maltreatment, 2nd edition
Christine Wekerle, David A. Wolfe, Judith A. Cohen, Daniel S. Bromberg, and Laura Murray. Boston: Hogrefe Publishing, 2019; 99 pp. $41.50

Vivian Chow, MD

As a practitioner of Cognitive Behavioural Therapy (CBT) with an excellent referral system, a good percentage of my patients are pretty straightforward and can be graduated within a reasonable number of sessions. However, in real life, not everyone is straightforward and I'm sure I'm not the only psychotherapist who has long-term patients who take a very long time to be even acceptably functional. The common denominator with all these patients is childhood maltreatment. With this in mind, I was eager to read this book and see what help I could get for my practice.

The lead author, Christine Wekerle, is a clinical psychologist in the department of pediatrics at McMaster University. This book is the fourth in a series on advances in psychotherapy. As I have previous experience with this series of books, I knew that even though the book was short, it would be dense with information. It's best to approach this series as a reference and glean what you need.

It was disappointing to find that this book focusses on treatment of children only. I don't treat children and was starting to wonder if this book would be entirely irrelevant to my practice. I was hoping it would focus, or at least offer practical advice, on treating adults who had suffered from childhood maltreatment. However, I did find that it was quite practical for treating post-traumatic stress disorder (PTSD) in *any* age group. I have recently started seeing a PTSD patient and have been at a loss. This woman in her



30s suffered from a bullying episode (with sexist/racist undertones) in her workplace over a year ago. The cognitive techniques I tried were back firing and she was quite resistant to them.

The main part of this book is divided into 4 sections: Sections 1 and 2 are geared to definitions and theories, Section 3 focusses on diagnosis, and Section 4 is about treatment. Section 5 was a case vignette which I found informative as a quick outline of how the sessions are expected to go. I benefitted most from Section 4 and decided to apply it to my recent PTSD patient.

The treatment section was well organized and gives a very good description of what you should expect to accomplish in each session. There are three phases of treatment and the idea is to spend roughly a third of your sessions in each phase. The first phase, "Stabilization and Skills Building," is further divided into five components: Psychoeducation, Parenting Skills, Relaxation Skills, Affective Modulation Skills, and Cognitive Processing. This was an "aha" moment for me. I usually jump right into cognitive techniques with my patients and immediately see positive results. With my PTSD patient, this led to her becoming quite angry and argumentative. She kept challenging the idea that her thoughts could be distorted because this would somehow imply a "loss of self." She also kept emphasizing the need for "empathy," which of course, I thought I was giving. After reading this section, I realized that I had gone straight to "Cognitive Processing" without following the other components first. During my next appointment with this patient, I went right back to Psychoeducation, which she was very keen on. She had obviously already read a lot about PTSD and wanted to discuss adrenaline and cortisol in the context of stress and hyperawareness. I also just listened and let her express her own theories and how they related to her own situation. She was much more compliant in this session and even smiled and thanked me at the end.

Even though Parenting Skills are not directly relevant in this case, I used examples of parenting as part of psychoeducation, which this patient appreciated. She was al-

ready well versed in Relaxation Skills, but she did appreciate a review of Mindfulness. Now that I have stopped focussing on cognitive techniques, she seems to have quickly developed Affective Modulation Skills. It seemed that focussing on the behavioural aspect of these skills was helpful. For example, self-distraction, finding new goals, reaching out to supports, and using the Relaxation Skills have helped her. If I do any Cognitive Processing with her at all, it will have to be more subtle. I will just be patient and let her recover at her own pace.

The next phase is "Trauma Narrative and Processing." I think it is unnecessary to separate this phase when it comes to treating adults, as adults tend to come to therapy ready to share their story. It's actually an integral part of the whole treatment process.

The third and final phase is "Integration and Consolidation." This is the phase that allows a child to learn to deal with living in an environment where the maltreatment occurred. For an adult, this would be relevant for someone living with an abusive household member, who is willing to change and stop the abuse. This phase is about enhancing the safety of the child by teaching both child and parents Safety Skills and a Safety Plan. With my PTSD patient, because she no longer works in her previous workplace, my goal is to restore her sense of safety in a more general sense.

I am happy to announce that the skills I learned from reading this book have completely changed my last few sessions with my PTSD patient. Her mood and functioning have greatly improved and she is pursuing new life goals.

Childhood maltreatment is a serious issue and has long-term consequences that I see on a regular basis. Ideally it would no longer exist, but the next best thing is to catch it early and treat it. My adult patients who were abused as children repeatedly tell me that the signs were there, but the adults in their life were either oblivious or downplayed them. I think that anyone who deals with children—teachers, coaches, doctors, nurses, etc. —should read this book and keep a copy of the chart on page 30, "Potential Child Maltreatment Red Flags," as a handy reference.

Conflict of Interest: None

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Vivian Chow has been practising Cognitive Behavioural Therapy since 2002. Her practice is in downtown Toronto.

Psychiatry Mythbusters

Caroline King, MD, FRCPC

I've been thinking of writing this article for a while. *Full disclosure:* I am a psychiatrist, but I'm not a huge apologist for psychiatry. To be honest, I think there's a whole lot wrong with psychiatry in North America. However, over my six or seven years of involvement in MDPAC (formerly GPPA), I've often heard many misconceptions about what psychiatrists in Canada do, how they are trained, and what they think about psychotherapy. Below, I hope to dispel a few of the most pervasive myths.

Myth #1:

Psychiatrists don't know much about psychotherapy. They don't get the training in it.

Definitely not true. During my five years of psychiatry residency (1996–2001), there were set requirements for psychotherapy training. We had weekly tutorials over two years, covering topics such as the History of Psychotherapy from Freud onward, Attachment Theory, Object Relations Theory, Transference, and Countertransference. In order to be eligible to write the Royal College Exams in Psychiatry, one had to have completed at least one long psychotherapy case (over 100 hours) and two shorter cases (at least 25 hours each) along with a corresponding number of hours supervision. The long case had to be using some form of Psychodynamic Psychotherapy.

Of course, the availability and quality of teaching really varied across Canada. There were a lot of options in large centers like Toronto and Montreal—less so in smaller centers. I was lucky that in London Ontario, there remained a critical mass of training analysts who survived the "Decade of the Brain" that had gripped Canadian psychiatry programs. A hospital psychiatrist I worked with also strongly recommended I do one of my shorter cases in CBT, which she accurately predicted would be "huge" in the coming years of Psychiatry training and practice.

In the last several years, the Royal College has sought to develop more specific requirements and standardization of psychotherapy training for Psychiatry Residents. The requirements from 2015 (http://www.royalcollege.ca/rcsite/documents/ibd/psychiatry_str_e) are as follows:

1. Longitudinal training "in empirically supported psychotherapeutic approaches…This must involve no less than 32 weeks or 8 months of the PGY2–5 experience [this refers to the didactic, academic half-day seminars—supervision lasts much longer]"
2. "Working knowledge is attained by the resident participating as an observer or co-therapist while proficiency is attained by the resident acting as the primary therapist and engaging in supervision one (1) hour a week."

The specific psychotherapy training objectives (http://www.royalcollege.ca/rcsite/documents/ibd/psychiatry_otr_e) are as follows:

1. "Demonstrate proficiency in assessing suitability for and prescribing and delivering appropriate psychological treatments, including":
   a. Cognitive Behavioural Therapy
   b Family or group therapy, and working knowledge of the other
   c. Psychodynamic therapy
   d. Supportive therapy
2. "Demonstrate working knowledge in assessing suitability for and prescribing and delivering appropriate psychological treatments, including":
   a. Behavioural therapy
   b. Dialectic behaviour therapy
   c Family or group therapy, and proficiency in the other
   d Interpersonal therapies

The objectives of training also include introductory knowledge of Brief Dynamic Psychotherapy, Mindfulness Training, Motivational Interviewing, and Relaxation.

Myth #2:

Psychiatrists aren't interested in doing psychotherapy

This is a more difficult myth to bust. I myself have had a hard time finding psychiatry colleagues who are as passionate about the art and science of psychotherapy as I am. After three years of trying to recruit psychiatrists to MDPAC, I haven't exactly given up, but I think I'm going to have to change my game. Here's what I have learned:

1. Although psychiatry residents receive some solid psychotherapy training in residency, they are not encouraged to pursue it once they are qualified. There are many reasons for this. First of all, most of the jobs for new psychiatrists are hospital based. New graduates usually don't feel confident enough to start a private practice and often have a lot of stu-

dent debt. Hospital-based psychiatry is almost always heavy on emergency and ward consultations, inpatient work, and on-call duties. Even in outpatient clinics, there are often quotas for the number of new patients to be seen and limitations on the number of sessions allowed. A position at a teaching hospital also necessitates an academic appointment. None of this leaves much opportunity for the honing of one's craft or even longer-term follow up of patients.

2. In some centres, psychiatrists are actively persuaded not to do psychotherapy or follow patients long term. This certainly seems to be the case in the city where I work. In Hamilton's predominant Shared-Care model, psychiatrists are urged to act only as consultants: there to make a diagnosis and prescribe treatment. The actual medical treatment is to be carried out by the family doctor and the psychotherapy by a mental health worker associated with the family practice, usually a part-time social worker. I can understand this approach: psychiatrists are seen as a limited resource, and from the outside, it may appear that wait times and length of follow up are directly proportional to each other. Nevertheless, I can't help but feel the baby is being thrown out with the bath water in this situation. Much of the time, patients are not getting quality psychotherapy from the social worker anyway. I've been told that some have caseloads of 70 patients each and are burnt out. I think of some of my own complex trauma patients: In one session, I may revise the diagnosis, review their medications and do psychotherapy. This would necessitate two or three separate appointments at a shared care clinic. One wonders where the time and cost savings are.
3. There are some psychiatrists who are quite dedicated to psychotherapy training and making sure that this remains a core requirement of psychiatry residency. But they are almost always academics in teaching hospitals. Hence, they too are under restrictions as outlined in point #1 above. For three years, I ran the MDPAC booth at the annual Canadian Psychiatric Association conference. Even though our exhibit elicited some interest from a few psychiatrists and provided us with a lot of knowledge and networking opportunities with respect to mental health care at the national level, it didn't translate into increased membership. This past year, I finally figured out why: the psychiatrists who were passionate about psychotherapy already had their own peer support among their teaching colleagues. They didn't seem to need MDPAC.

So where are the community-based psychiatrists, like me, who are doing psychotherapy and pursuing further training? Unfortunately, like the endangered snow leopard, they are few and far between (at least outside of Toronto). Sometimes I feel like doing one of those fundraising commercials: *"Do you care enough, to support this psychiatrist? With just a phone call, you can give her the encouragement to keep practicing. Tell her that the psychotherapy work she does is valued, and not a drain on the public purse. Please, call now."*

Seriously though, at times it does feel like an uphill battle. I get some optimism from supervising and teaching psychodynamic psychotherapy to psychiatry residents. Being a supervisor for the MDPAC Psychotherapy Training Program has also been rewarding. I know there's much interest in psychotherapy among physicians out there, even if hospital and academic systems don't always support it.

Myth #3:

The DSM is the "bible" of psychiatry

Okay, only non-psychiatrists say this. Most religious texts don't change every 7–10 years. The DSM comes out with either a criteria and/or text revision about that often. I was at least lucky enough that the DSM-4 was the main iteration for my entire residency. Many psychiatry residents start learning one version and then have to switch to the subsequent one for their exams. We know it keeps changing. We're not wedded to it.

Furthermore, aside from residents studying for their Royal College Exams, researchers, and clinicians filling out insurance forms, many psychiatrists I know don't keep to DSM diagnostic criteria. For instance, Complex PTSD is a valid diagnostic entity in the ICD-11, but exists nowhere in the DSM. Yet it is a pervasive clinical concept among psychiatrists. There are many other examples.

Conclusion

I hope this paper has highlighted some of the common myths surrounding psychiatry and psychiatrists. Although our first five years of training in residency are highly structured

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and increasingly standardized, there is a lot of heterogeneity among psychiatrists in subsequent practice. Unfortunately, some are seen as "pill-pushers" (a common complaint). But most are steeped in the "biopsychosocial approach" to diagnosing and managing mental health issues in patients. A sadly decreasing few really do have "proficiency" in one or more modalities of psychotherapy. Without mentoring, encouragement, and ongoing supervision, this number is unlikely to grow. Of course, the same could be said for family doctors. I think an organization like MDPAC is well placed to take on this role. Some may say, *"What's the point? If psychiatrists don't want to do psychotherapy, forget them."* I would respond: First, we know it's beneficial for their patients. Second, like it or not, psychiatrists provincially and nationally have the ear of those who direct mental health funding. Therefore, I think it's better to have them on our side and try to influence their decisions regarding psychotherapy.

Conflicts of interest: None

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Caroline King is a psychiatrist in private practice in the Hamilton area and is currently President of the Medical Psychotherapy Association Canada. She admires snow leopards and enjoys spending time with her pets.

Report from the MDPAC Board of Directors

Elizabeth Parsons, MD, CCFP, FCFP

As I write this, snow is falling (yet again) here in Ottawa. We had a taste of spring yesterday and I know that it is on its way soon. I had a brief respite from the winter with a week in south Florida at the end of February, completing my level-1 training in Internal Family Systems. I cannot recommend this training highly enough and the depth of connection and growth that I experienced will stay with me for a long time. Now for some updates from the Board.

Commendation from the CPSO

In February, Muriel van Lierop received a letter from the Education Committee of the CPSO, commending MDPAC on our Continuing Professional Development Program, also known as the 3rd pathway: "The Committee wishes to express their gratitude to you for a thorough report that painted a comprehensive picture of your organization's ongoing efforts to support the continuing professional development of your members. On behalf of the Committee I commend you on your efforts." We have several committees to thank for this, including the CPSO-CPD and Membership committees and the PDC. Well done!

Visioning/Strategic Planning Meeting

This meeting, taking place March 30, is well overdue as our last visioning session was in February 2011. The Board of Directors has worked hard to prepare for this meeting in planning surveys and soliciting input from the members. I am looking forward to seeing how we can implement the new ideas that I am sure will come from this effort.

MDPAC 32nd Annual Conference and AGM

The conference is just around the corner. "Expanding Psychotherapy Horizons" will take place at the Radisson Admiral Hotel in Toronto, May 24 and 25. With plenaries ranging from how diet affects mood to technology and mental health as well as neuroplasticity and consciousness research, there is much here to interest all of us. The conference is also a wonderful opportunity to connect and reconnect with MDPAC colleagues and I look forward to meeting with those from out of town on Thursday evening.

Committee News

You have already seen photos from our last annual retreat. Participants enjoyed connecting with each other and themselves in a body-centred framework. The retreat committee has already been hard at work planning the next retreat. Gaisheda Kheawok of Whispering Song will present a weekend of interactive mindfulness and self-care from a Shamanic energy perspective. This year the retreat will again take place at Geneva Park on the weekend of October 25–27, 2019.

Our first iteration of the MDPAC Psychotherapy Training Program will be completed in April. The feedback regarding this program has been positive and there are already 27 people on the waiting list for the next round. The outreach committee has continued to work to make our presence known by operating the booth for MDPAC at several conferences, including the upcoming Family Medicine Forum in Vancouver October 30–November 2. If you are able to volunteer at the booth, please let Carol Ford know.

The Professional Development Committee is preparing to unveil its new implementation plan for CPD expansion over the next year. This new plan will go into effect in October 2020. Our education committee continues to offer hour-long sessions via the Zoom videoconferencing platform. These sessions will now be recorded and available for a fee; check the website for details.

Changing Scope of Practice

There have been many questions related to the CPSO's "Ensuring Competence: Changing Scope of Practice" policy which was revised in February 2018. The CPSO-CPD committee recently surveyed the membership to gather information regarding members' scope of practice as well as their understanding of this updated policy. There will be new information on the MDPAC website once this review is complete.

Canadian Alliance on Mental Illness and Mental Health (CAMIMH)

MDPAC became a member of this alliance in January 2017 and we have had members participating in the two events that this group sponsors. Upcoming on May 7 is the 17th Annual Champions of Mental Health Awards in Ottawa. MDPAC will be purchasing a table at the event and members who are interested in attending to represent MDPAC can contact Carol Ford.

Psychotherapy Funding

In January we received news about proposed limits on psychotherapy codes and your MDPAC president, Caroline King, has been very busy meeting with members of the Primary Care Mental Health Section of the OMA as well as the Ontario Psychiatric

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Association, the OMA Section on Psychiatry and others. This was all with the view to keep abreast of the information coming from the OMA as well as to form links with other practitioners who are also fighting to keep funding for physician-provided psychotherapy from being reduced.

Although we are a national organization, with the majority of our members practicing in Ontario, we can often be seen to be focusing efforts in Ontario. However, your board of directors have also been looking into the situation in British Colombia, where there is very limited funding for primary care psychotherapy. We want to see more equitable funding across the country.

Keep an eye out for the details of MDPAC's strategic plan that will be released in May. I welcome any feedback you have about this plan or any other ideas you might wish to share.

Conflict of interest: none

Contact: elizabeth@eparsonsmd.ca

Elizabeth Parsons, the current chair of the board, has been a member of the MDPAC since 2007, and involved in committee work since 2010. Her medical practice began in Ottawa where she worked at Carleton University in student health from 2002–2016. She focused her practice on psychotherapy in 2007 and currently engages in full-time medical psychotherapy in private practice in Ottawa.

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