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MEDICAL PSYCHOTHERAPY REVIEW

A Journal of the Medical Psychotherapy Association Canada

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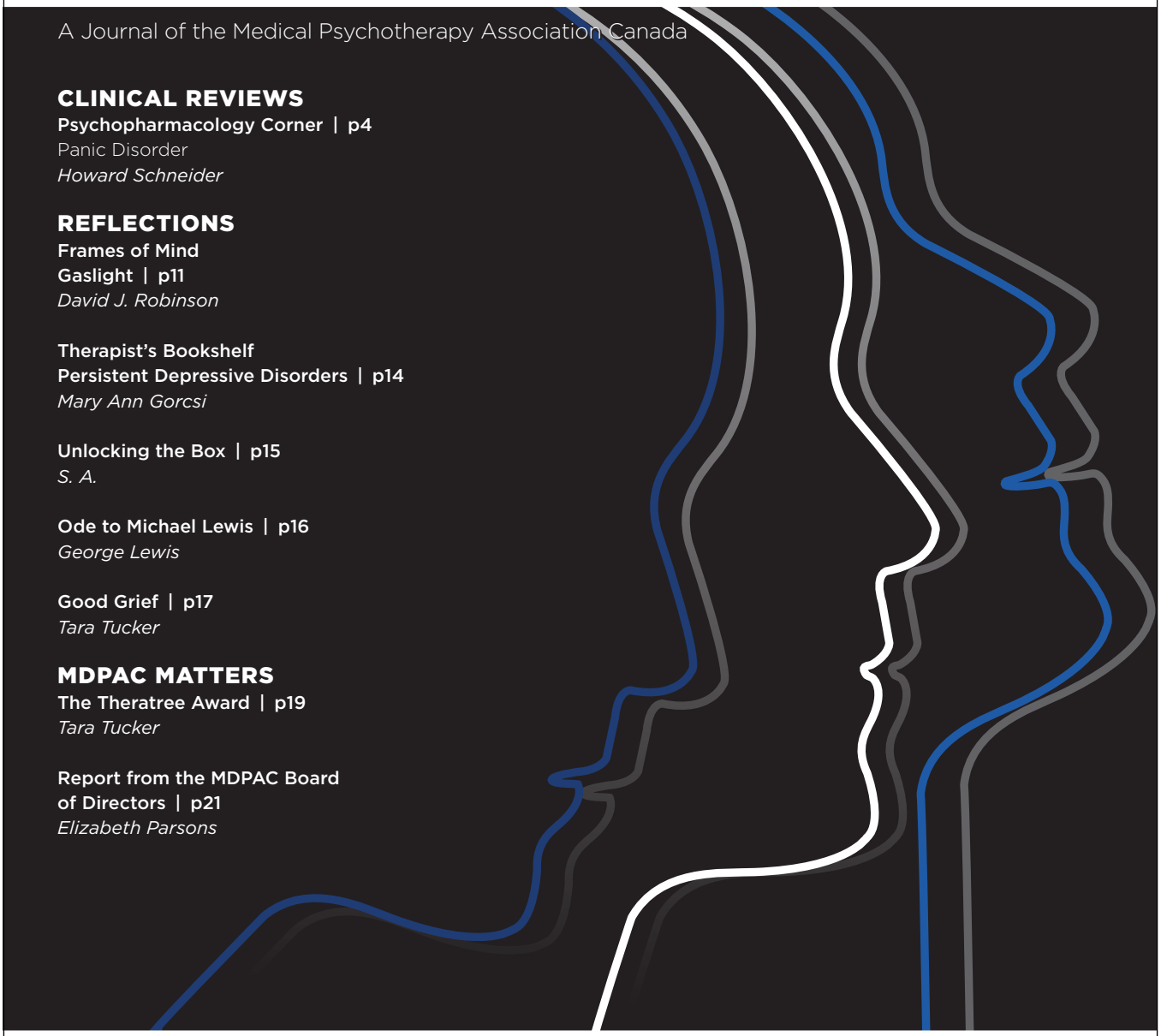

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MEDICAL PSYCHOTHERAPY ASSOCIATION CANADA
ASSOCIATION CANADIENNE DE PSYCHOTHÉRAPIE MÉDICALE

ALL THINGS BY IMMORTAL POWER

NEAR AND FAR

HIDDENLY

TO EACH OTHER LINKED ARE

THAT THOU CANST NOT STIR A FLOWER

WITHOUT THE TROUBLING OF A STAR

Francis Thompson

One of the many "Covid clichés" is "we're all in this together." Like most clichés, it rings true. The pandemic has linked us and separated us simultaneously. We share jokes as well as challenging experiences with friends and colleagues. Some of our patients have found it paradoxically comforting to know that others now understand their isolation. However, most have found their emotional state worsened by isolation and fears about infection. In general, psychotherapists deal with "star troublings" more than "flower stirrings." The linking of all things is evident at the communal level with respect to how easily the novel coronavirus is transmitted as well as through social behaviours, like wearing a mask, that benefit all. It is also postulated to be evident at the subconscious level. Many of us are familiar with the Jungian notion of the collective unconscious. He claims that there is a deep and hidden level of reality that has patterning power and that we are all intuitively attuned to. Such interconnectedness is mind-boggling.

The journal committee has some new connections and a disconnection. We are pleased to welcome Tara Tucker and Jody Bowle-Evans to the team. Tara practices psychotherapy in Ottawa, and also provides palliative care, although her focus is now on therapy. She has contributed two articles to this issue! Jody lives in rural Ontario where she provides psychotherapy full time, having previously devoted half her practice to treating chronic Lyme disease.

We say goodbye to Vivian Chow who is retiring from practice. Vivian has been on our committee since 2011, and we have all appreciated her insight, honesty, and reliability in working to create a publication for the benefit of her MDPAC colleagues. It takes hours and hours to put the journal together. Many of you may remember her column on CBT, which became known as "Cognitive Bytes." We will miss Vivian greatly but wish her well in her future travels.

No doubt her patients will miss her too. In fact, one wrote a poem in honour of her retirement: *Unlocking the Box.* Grief is a common theme

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.

in our practices. George Lewis also shares a poem and story in honour of his deceased brother. The disconnection resulting from COVID-19 is particularly difficult during times of mourning. In *Good Grief: How to Mourn Pandemic Style*, Tara Tucker tells a moving story about how one of her patients coped, and offers suggestions for our practices.

On the topic of disconnection and depression, Mary Ann Gorcsi reviews the book *Persistent Depressive Disorders.* This is the new name for what we previously called dysthymia. Pandemic and panic are sometimes interconnected more than just linguistically. Howard Schneider, in his "Psychopharmacology Corner," reviews the diagnosis of panic disorder (not to be confused with panic attacks) as well as currently recommended pharmaceutical and psychotherapeutic treatments.

In our other regular column, "Frames of Mind," Dave Robinson reviews the classic movie *Gaslight.* This generated a term in psychology to describe the process of manipulating people into believing they are losing their minds. Interestingly, Robinson suggests this may be a part of the fourth wave of COVID-19, in which mental and emotional problems become even more prevalent than they are already.

With respect to MDPAC matters, Tara Tucker interviews Catherine Low, winner of this year's Theratree award, and we learn more about her contributions to MDPAC. Elizabeth Parson's report to the board demonstrates how well our organization has adapted to pandemic uncertainties and realities. Interestingly she ends as I began, with encouragement for us to support each other and "make it through this together."

As always, be sure to check the MDPAC website and your email for up to date information. And, as always, the journal committee welcomes contributions and feedback. We hope you enjoy this issue of the *Medical Psychotherapy Review.*

Grace and peace,
Janet Warren

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EDITOR:
Janet Warren
journal@mdpac.ca

EDITORIAL COMMITTEE:
Vivian Chow, Howard Schneider, Tara Tucker

PRODUCER/DESIGNER:
Eliana Robinson

PUBLISHER:
Medical Psychotherapy Association Canada
312 Oakwood Court
Newmarket, ON L3Y 3C8
Tel: 416-410-6644
Fax: 1-866-328-7974
info@mdpac.ca
www.mdpac.ca

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Panic Disorder

Howard Schneider, MD, MDPAC(C), CCFP

Abstract

Panic attacks are common—the lifetime prevalence is approximately one-quarter of the population. Panic Disorder is diagnosed when panic attacks are recurrent and unexpected. In this article we review diagnosis and treatment of this common disorder. Either combination therapy (psychotherapy plus antidepressant therapy) or psychotherapy alone can be considered a first line treatment for Panic Disorder. Benzodiazepines are considered effective but controversial first-line agents.

David, a 22-year-old single man working as a retail clerk, is referred to you by his family physician: "Anxiety. Requests psychotherapy."

You meet with David and take a history. David's mother and the maternal side of his family have a history of depressions. David describes a happy childhood and adolescence. However, in his last year of high school he describes the features of a Major Depressive Episode. He did not want to take medications, so he bought some self-help books, and adopted a "positive lifestyle"— jogging almost every day, in bed before midnight, no alcohol, no drugs, and yoga classes. He says the depression went away in a few months and has not returned.

Now David has been getting panic attacks for about a year, which are worsening. He describes how last year, the day after breaking up with his girlfriend, while waiting in line at a bank machine, out of nowhere his heart started racing, and he felt short of breath and dizzy. He was certain he was going to die. He ran outside and laid down on the ground. He remembers his body shaking and trying to catch his breath. In about ten minutes the worst was over, but his hands were shaking, and he felt nauseous and exhausted for the rest of the day. He went to his family doctor later that week. An ECG and "lots of blood tests" were done and reportedly normal.

David said he felt better after the doctor visit, but started worrying about having another panic attack. A few weeks passed, but then one day while waiting in line at a fast food restaurant, another panic attack happened. He went outside, tried to look normal, and waited for the symptoms to pass. After this, he started worrying daily about another panic attack. He stopped going anywhere there would be a line, and he was ok for a few months. Then he got another panic attack, this time while at work. His manager called for an ambulance, but he was ok before the ambulance got there.

David said he has been getting one or two panic attacks each month now, and they seem to be more intense. He has started calling in sick for work and started to avoid his friends. He has researched the subject and he asked his family physician to send him for psychotherapy.

Overview and Diagnosis

Panic Disorder is relatively common. The prevalence over a one-year period is 2%–3% of the adolescent and adult population (APA, 2013). The female to male ratio of prevalence is about 2:1. The prevalence tends to decline in older age: 0.7% in adults over 64 years old. The median age of onset is in the early twenties, with onset past the age of 45 years uncommon.

The DSM-5 (APA, 2013) defines Panic Disorder in terms of four criteria (A–D). Under criterion A there must be recurrent unexpected panic attacks where a panic attack is defined as "an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes." A panic attack can occur from a normal, euthymic mental state or it can occur from an anxious state. Under criterion A it should include four or more of the following:

1. Palpitations or increased heart rate
2. Sweating
3. Trembling or shaking
4. Feeling of shortness of breath
5. Feelings of choking
6. Chest pain/discomfort
7. Nausea or abdominal discomfort
8. Feelings of dizziness or light-headedness
9. Feelings of chills or heat
10. Paresthesias (e.g., numbness or tingling)
11. Derealisation (e.g., feeling unreal, detached)
12. Fear of losing control or one's sanity
13. Fear of dying

Criterion B requires that for a month or more after at least one of the panic attacks one of the following occurs:

1. Worry about more panic attacks or their consequences
2. Significant maladaptive change in behavior as a consequence of the attack

Criterion C requires that the panic attack is not due to a medication, a substance, or another medical condition. However, a diagnosis of Panic Disorder can be made comorbid with many medical conditions such as mitral valve prolapse, thyroid disorders, cardiac arrhythmias, dizziness, asthma, COPD, and irritable bowel syndrome.

Criterion D requires that the panic attack is not better explained by a different mental disorder. Panic attacks should not occur only when there is a social situation that the patient fears, as in Social Anxiety Disorder.

They should not occur only due to particular obsessions as in Obsessive-Compulsive Disorder. In these cases, note that panic attacks are not unexpected (as Criterion A requires). However, if unexpected panic attacks are occurring then Panic Disorder can be diagnosed comorbid with other conditions. If agoraphobia also exists and the criteria are fulfilled, then a separate diagnosis of Agoraphobia should be made.

Note that a panic attack, essentially four or more of the thirteen symptoms listed above, is not a diagnosis of Panic Disorder under the DSM-5. Panic Disorder involves recurrent and unexpected panic attacks meeting the criteria above. The prevalence of panic attacks is much greater than the prevalence of Panic Disorder. Katzman and colleagues (2014) give the lifetime prevalence of panic attacks as more than 28% of the population. In contrast, the lifetime prevalence of Panic Disorder is approximately 5%.

You complete the history and examination of David. He does not meet the DSM-V criteria for another anxiety disorder. David notes avoiding lines where there are people waiting around him, but otherwise he does not endorse the criteria for Agoraphobia. The Mental Status Examination is unremarkable – David is euthymic, coherent, non-psychotic, cognitively within normal limits and non-suicidal. Blood tests, including thyroid function, and ECG done by his family doctor are normal. A diagnosis of Panic Disorder is made.

Psychological Treatment: Canadian Clinical Practice Guidelines

The "Canadian clinical practice guidelines for the management of anxiety, posttraumatic stress and obsessive-compulsive disorders" (Guidelines), developed on behalf of the Anxiety Disorders Association of Canada and based on an extensive literature review, provide recommendations with respect to the psychological and psychopharmacological treatment of Panic Disorder (Katzman et al., 2014). CBT is an efficacious treatment (Level 1— two or more RCTs or meta-analysis) for Panic Disorder. The Guidelines note a meta-analysis where techniques and combinations of exposure and cognitive restructuring were most efficacious.

Table 1: Ranking of Psychological Treatments for Short-Term Remission of Panic Disorder

Treatment Name	Relative Score
Supportive Psychotherapy	88
CBT	76
Psychodynamic Therapies	73
Cognitive Training	50
Behavioural Therapy	41
Physiological Therapies (e.g., applied relaxation, breathing retraining, biofeedback)	35
No Treatment Group	25
Wait List Group	13

In addition, less intensive interventions such as self-help books (i.e., "bibliotherapy"), telephone treatment and Internet-based CBT were more effective than control groups receiving relaxation techniques or being on a waitlist for in person CBT. The combination of psychotherapy and psychopharmacology (antidepressants) was more efficacious than either alone in the acute phase.

In follow up studies it appeared that the efficacy of CBT in preventing relapses of Panic Disorder extended to three years. Overall, 93% of patients who received exposure therapy for Panic Disorder were in remission after two years, and after ten years 62% were still in remission. In a Cochrane Review (Furukawa et al., 2007), combined psychotherapy plus antidepressant therapy was more efficacious than antidepressant treatment or psychotherapy alone in treating the acute phase of Panic Disorder. In the maintenance phase, combination treatment was more effective than psychopharmacology alone, and was as effective as psychotherapy alone. In sum, either combination therapy or psychotherapy-alone can be considered a first-line treatment for Panic Disorder.

The Guidelines note that in cases where there is also a comorbid moderate depression, or where there are severe or frequently

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occurring panic attacks, CBT alone may not provide adequate treatment to such patients. Kessler (2006) has shown that in the general population about one quarter of patients with Panic Disorder also have comorbid Agoraphobia (higher percentages are reported in specialized clinic populations) and this comorbidity is associated with Panic Disorder which is more severe.

Psychological Treatment: 2016 Cochrane Meta-Analysis

A Cochrane Database review (Pompoli et al., 2016), considered which psychological therapies are more effective than others in the treatment of Panic Disorder. When the treatments were ranked for short-term remission of Panic Disorder results shown in Table 1 were obtained.

The authors note that the results for Supportive Psychotherapy must be interpreted cautiously since this was connected to the meta-analysis network as a node with a single connection to the network, being compared only with CBT. Psychodynamic psychotherapies were the best tolerated (fewest dropouts) with good results, although more studies would be necessary to better compare its efficacy to CBT. Finally, the evidence does not support behavioural therapy as a replacement to CBT as a first-line therapy for patients with Panic Disorder.

Data was not available for many of the therapies with regard to long-term results, i.e., an average of 12 months after therapy. Analysis of the data available gave the highest long-term effectiveness to CBT followed by psychodynamic psychotherapies.

You discuss starting a course of CBT with David. You collaboratively discuss areas you would work on:

- *Exploration of negative thoughts—in the last two years, David's friends have gone off to college or started good jobs, and he feels left behind, and then his girlfriend left him just before the first full panic attack occurred.*
- *Exploration of misinterpretation of physical symptoms of anxiety, fear and the symptoms he experiences before and during a panic attack.*
- *Exploration of relaxation techniques, possibly re-enrolling in a yoga class which he found helpful the other year.*
- *Exploration of exposure and misinterpretation of situations such as being in line or being at work with customers around him.*
- *Exploration of exposure to certain physical symptoms.*

Pharmacological Treatment: Canadian Clinical Practice Guidelines

Tables 2 and 3 summarize the recommendations of the Canadian Clinical Practice Guidelines (Katzman et al., 2014) for the psychopharmacological treatment of Panic Disorder. Table 2 gives the level of evidence for the various agents, while Table 3 gives what are recommended as a first-line treatment approach versus a second-line or further-line treatment. A first-line treatment recommendation is based on level 1 or level 2 evidence plus clinical support for the efficacy and the safety of the treatment.

SSRIs are first-line agents for the treatment of Panic Disorder. SSRIs showed improvements in patients' panic symptoms, agoraphobia, depressive symptoms and general anxiety symptoms. With respect to SNRIs the Guidelines note that there is evidence for venlafaxine-XR in reducing the severity of panic symptoms.

Diane McIntosh (2019), in her continuing medical education program, pragmatically updated the Canadian Clinical Practice Guidelines for Panic Disorder. Her first-line pharmacotherapy recommendations are:

- *SSRIs:* escitalopram, sertraline, fluoxetine
- *SNRIs:* desvenlafaxine, duloxetine, levomilnacipran
- *Multimodal antidepressants:* vortioxetine, vilazodone

These multimodal antidepressants are not included in the Guidelines' choices for Panic Disorder. Shah and Northcutt (2018) showed statistically fewer panic attacks in patients taking vortioxetine. Currently there is good evidence for the effectiveness of vilazodone in treating Generalized Anxiety Disorder (e.g., Durgam et al., 2016), but less so for Panic Disorder.

TCAs, particularly clomipramine and imipramine, have Level 1 evidence for the treatment of Panic Disorder. However, since TCAs are less tolerated than SSRIs, they are only recommended as second-line agents. Mirtazapine has evidence for efficacy for the treatment of Panic Disorder in some open trials, and is recommended as a second-line agent to consider.

Benzodiazepines are considered as second-line options, but the Guidelines note that they can be considered for short-term treatment of severe agitation or anxiety, as well as at the start of SSRI treatment. However, a number of prominent psychiatric researchers, as part of the International Task Force on Benzodiazepines, note that despite the risks of dependency, benzodiazepines should be more positively considered in the treatment of Panic Disorder (Nardi et al., 2018). Nardi and colleagues (2011) show that at 8 weeks of treatment, 90% of the patients treated with clonazepam versus 82% of the patients treated with paroxetine had cessation of panic attacks. At three years of treatment, the group receiving clonazepam had fewer panic attacks and fewer adverse effects from the medication than the paroxetine group (Nardi et al., 2012).

The Guidelines note that there is some

Table 2: Level of Evidence for Panic Disorder Medications

MEDICATION	LEVEL OF EVIDENCE	MEDICATION	LEVEL OF EVIDENCE
SSRI's		**BENZODIAZEPINES**	
Citalopram	1	Alprazolam	1
Fluoxetine	1	Clonazepam	1
Fluvoxamine	1	Lorazepam	1
Paroxetine	1	Diazepam	1
Sertraline	1	Adjunctive clonazepam	1
Escitalopram	2	Adjunctive alprazolam	3
Paroxetine	2	**ATYPICAL ANTIPSYCHOTICS**	
SNRI's		Risperidone	2
Venlafaxine XR	1	Olanzapine	3
Duloxetine	3	Quetiapine	3
TCA's		Adjunctive aripiprazole	3
Clomipramine	1	Adjunctive olanzapine	3
Imipramine	1	**ANTICONVULSANTS**	
MAOI's and RIMA's		Divalproex	3
Phenelzine	2	Levetiracetam	3
Moclobemide	1 (conflicting data)	Gabapentin	Negative
Tranylcypromine	3	Carbamazepine	Negative
NDRI		**OTHER TREATMENTS**	
Bupropion SR	3 (conflicting data)	Propranolol	Negative
NaSSA		Buspirone	Negative
Mirtazapine	2	Trazadone	Negative

SSRI — selective serotonin reuptake inhibitor; SNRI — serotonin and norepinephrine reuptake inhibitor; TCA — tricyclic antidepressant; MAOI — monoamine oxidase inhibitor; RIMA — reversible inhibitor of monoamine oxidase A; NDRI — norepinephrine dopamine reuptake inhibitor; NaSSA — noradrenergic and specific serotonergic antidepressant

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Table 3: Recommendations for First-, Second- and Third-line Approaches to Psychopharmacological Treatment for Panic Disorder

Recommendation Level	Medications
First-line	citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine, sertraline, venlafaxine XR
Second-line	alprazolam, clomipramine, clonazepam, diazepam, imipramine, lorazepam, mirtazapine (as adjunctive therapy: alprazolam, clonazepam)
Third-line	bupropion SR, divalproex, duloxetine, gabapentin, levetiracetam, moclobemide, olanzapine, phenelzine, quetiapine, risperidone, tranylcypromine (as adjunctive therapy: aripiprazole, divalproex, olanzapine, risperidone)
Not recommended	buspirone, propranolol, trazodone

evidence that atypical antipsychotics (risperidone, olanzapine and quetiapine) may be useful for patients with refractory Panic Disorder. Propranolol has not shown efficacy for treating Panic Disorder and it is not recommended.

They recommend that if the response to a first-line medication is not sufficient to adequately reduce the patient's symptoms, or if there are significant adverse effects, then there should be a switch to another first-line medication. If the second medication attempt is not suzccessful, then a second-line medication can be attempted.

If the patient does not respond to first- or second-line medications, then the Guidelines recommend checking the diagnosis again as well as considering the existence of other comorbid psychiatric diagnoses, including substance abuse, and comorbid medical diagnoses. Third-line approaches to medications for Panic Disorder can then be tried, if appropriate. In studies of maintenance therapy, the Guidelines note evidence for citalopram, fluoxetine, fluvoxamine, paroxetine, moclobemide, clomipramine, imipramine, and venlafaxine.

David attends your office biweekly for CBT and supportive psychotherapy. It is now three months. He says he feels more confident and satisfied about his life and is looking to make plans about his future. The panic attacks are occurring less often, only once in the past month. However, they still are occurring, and he still endorses worrying a large part of his day about the next panic attack, and did not go to work yesterday because of this worry.

You discuss with David a trial of an SSRI. His mother takes sertraline, albeit for depression. Perhaps this medication would help David's remaining panic attacks which are still occurring, and in particular, help with the worry about the panic attacks. David agrees. You prescribe sertraline 25mg, to be taken in the morning. You discuss the possible adverse effects and give a follow up appointment in a week.

The next week David tells you that there were no side effects. Even though it is only a week and the dosage is very low, David thinks he feels calmer inside. You increase the dosage to 50mg AM. You see David next week again, and he reports that he definitely feels "calmer inside," no side effects have occurred, and he agrees with continuing the trial of the medication.

You continue to see David for CBT and supportive psychotherapy, along with continued sertraline. No further panic attacks have occurred, and David continues to become less worried about showing up at work and has even started to see some of his old friends again.

Conclusion

A panic attack, which a relatively high proportion of the population will experience during their lifetime, does not imply a diagnosis of Panic Disorder, which has a much lower, but still significant, lifetime prevalence. To diagnose Panic Disorder under the DSM-5, there must be recurrent and unexpected panic attacks, and the criteria A–D discussed above should be met.

The Cochrane Database and the Guidelines support as a first-line treatment for Panic Disorder, psychotherapy plus antidepressant com-

bination therapy or psychotherapy alone. The International Task Force on Benzodiazepines argues that benzodiazepines should be considered first-line agents for the treatment of Panic Disorder, possibly in combination with an SSRI for the first 6–8 weeks of treatment.

Conflict of Interest: None

Contact: howard.schneider@gmail.com

Howard Schneider started his career performing psychiatric consultations and short-term follow-up care in the emergency department in Laval, Québec. For the past 20 years he has provided care for psychiatry and psychotherapy patients in the community in the Toronto area.

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Generic Name	Trade Name
Alprazolam	Xanax
Aripiprazole	Abilify
Bupropion SR	Wellbutrin SR
Buspirone	BuSpar
Carbamazepine	Tegretol
Citalopram	Celexa
Clomipramine	Anafranil
Clonazepam	Rivotril
Desvenlafaxine	Pristiq
Diazepam	Valium
Divalproex	Epival
Duloxetine	Cymbalta
Escitalopram	Cipralex
Fluoxetine	Prozac
Fluvoxamine	Luvox
Gabapentin	Neurontin
Imipramine	Tofranil
Levetiracetam	Keppra
Levomilnacipran	Fetzima
Lorazepam	Ativan
Mirtazapine	Remeron
Moclobemide	Manerix
Olanzapine	Zyprexa
Paroxetine	Paxil
Phenelzine	Nardil
Propranolol	Inderal
Quetiapine	Seroquel
Risperidone	Risperdal
Sertraline	Zoloft
Tranylcypromine	Parnate
Trazodone	Desyrel
Venlafaxine XR	Effexor XR
Vilazodone	Viibryd
Vortioxetine	Trintellix

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Gaslight

Hornblow Jr., A. (Producer) & Cukor, G. (Director). (1944). Gaslight [Motion Picture]. United States: Metro-Goldwyn Mayer.

Reviewed by David J. Robinson MD, FRCPC

The term gaslighting has been in the popular press recently both with respect to political shenanigans and in reference to compounding the social problems related to COVID-19. To "gaslight" someone (also known as "gaslighting") describes a process where a perpetrator deliberately manipulates events or items to make a victim feel as if he or she is losing his or her faculties, judgement, and even sanity. Furthermore, gaslighting is recognized as an abusive practice, done to wrest control and exert power for self-serving purposes (Porzucki, 2016). The term has gone from a movie title/plot into the vernacular (Urban Dictionary) and is an official entry in established dictionaries (Encyclopedia Britannia), but it is not a formal psychiatric diagnosis. The closest the DSM-5 comes to describing it is the section on "Other Factors That May Need Clinical Attention," which has descriptions for situations involving psychological abuse (APA, 2013). We can trace the development of the term and see how the process remains highly relevant today.

Gaslighting originates from the 1938 play *Gas Light* by British playwright Patrick Hamilton and is set in 1880s London UK. The 1944 release was originally called *The Murder in Thornton Square* in the UK to avoid confusion with the 1940 version. This review discusses the 1944 release.

Paula Alquist (Ingrid Bergman) is the niece of a famous opera singer. We never see her aunt in the movie; she comes to an untimely end just before the first scene (an Easter egg in the opening credits is the shadow on the wall to the right of the sconce that appears to show someone being strangled). Paula was in the house when her aunt was murdered. Traumatized and virtually mute, she is ushered off to Italy to hone her singing skills with Maestro Guardi (Emil Rameau). Despite being the spitting image of her famous aunt, Paula did not inherit her singing abilities, and a decade later we see her mangling Gaetano Donizetti's opera "Lucia Di Lammermoor" (this is another Easter egg because this opera is perhaps best known for its "mad scene" where Lucia goes insane). Despite her operatic shortcomings, Paula has a rather different song in her heart and the Maestro quickly deduces that she is in love. He encourages her to pursue this passion first and return to his tutelage if her journey takes her that way. Her new love is none other than her piano accompanist, Gregory Anton (Charles Boyer). After a whirlwind romance, they marry and he pushes to settle in London UK, where (not) coincidentally, Paula owns the home left to her by her aunt. We know nothing of Paula's background, but this eerily resembles Ingrid Bergman's own history of early and devastating losses, including losing both parents and having to live with her maternal aunts. We also don't know anything of Paula's decade in Italy, but she appears to have no attachments and falls for Gregory's charm and persistence.

Outwardly doting to the point of being uxorious, Gregory begins to take advantage of Paula's uneasiness at being back at the scene of her aunt's unsolved murder. A large painting shows Paula's aunt in an elaborate stage costume, and we see that there is indeed an uncanny resemblance. Gregory arranges to have the portrait hidden in the attic with the diva's other belongings. What superficially appears to be a considerate act actually becomes the first step in a ploy to keep Paula socially isolated. He arranges things to make Paula believe that she has misplaced items with a strong sentimental value, imagines sounds, has visual illusions, and that the household support staff are turning against her. Gregory learns how to control Paula by making continual statements seemingly about caring for her welfare, but then he sharply admonishes her with his commanding baritone when she does something at odds with his master plan. He then quickly apologies and tries to reframe his angry outburst as being a misunderstood aspect of his love for her. Over time, she submits to his unpredictable reproaches, and genuinely begins to doubt her own sanity.

Gregory leaves instructions that all visitors are to be turned away and Paula gets so distraught that she won't even leave the house. He leaves their home every night, ostensibly to go to an office that he rents to work on his musical compositions. What he is actually doing is re-entering their house through the attic to rummage around Paula's aunt's belongings looking for valuable jewels — acquiring them is Gregory's objective in this elaborate ruse.

The term "gaslight" refers specifically in this movie to the dimming down of the gas lamps in the house. When Gregory leaves in the evening, he turns on a lamp that draws from the household supply. Convenient-

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Gaslight | continued

ly, neither of the two staff ever notices the lights dimming, and Paula comes to view it as a harbinger of more unusual experiences (which are the sounds of Gregory rummaging around in the attic, but no one else ever hears this). She is too petrified and on edge to ever make the connection herself. The lights go back to their original brightness when Gregory ends his quest. When he returns to the main part of the house nothing is amiss. but Paula is visibly rattled. He seizes this daily occurrence to further convince her that she is losing her mind.

The situation has many similarities to the plot of the movie Bug (2006) where the more dominant personality Peter Evans (Michael Shannon) induces his partner Agnes White (Ashley Judd) into believing that they are beset by a microbial infestation. This actually has a DSM-5 diagnosis, called *delusional symptoms in partner of individual with delusional disorder* (APA, 2013) and used to be called a shared *psychotic disorder.* One of the key distinguishing factors is that in the delusional disorder there is no clear secondary gain in making the submissive partner manifest the delusional beliefs.

Gaslighting is a technique used for nefarious purposes by dictators, narcissists and psychological abusers of any stripe. A number of books have been published on the topic. Psychologist Stephanie Sarkis (2017) details 11 clear-cut strategies used by gaslighters, and notes that we are all susceptible to these manipulations. However, there are particular qualities that a person may have that would make them more vulnerable to the machinations of a gaslighter. In Paula's case, we can identify the following:

Social Isolation: Paula had no one else to stay with after her aunt was murdered, and seems to have no significant attachments in Italy. She discusses with Gregory other places they might live, indicating that she had no personal reasons to live anywhere.

Lowered Self-Esteem: Despite being a dead ringer for her aunt, she doesn't possess her talent and appears to be supported by her aunt's estate. Many people know who she is, but only in reference to her famous aunt's singing career.

Passive personality: Paula is quick to defer major life decisions to Gregory despite the short time that they have known each other. She lets him assume control of their household affairs even though it is her house. Paula lacks the fortitude to stand up to Gregory when she knows that she didn't do what it is that he accuses her of.

Of these strategies, Gregory's gaslighting gets perpetuated most strongly in this film by social isolation. Paula can't reliably check her perceptions with anyone other than Gregory.

Gaslighting is also speculated to be part of the psychological distress that is predicted to be part of the COVID-19 "fourth wave" that has yet to make its full impact known and may last as long as a generation (Duong, 2020). The original graphic is available online (Tseng, 2020) and was constructed to be theoretical and promote discussion (it is not based on actual data from previous pandemics). The fourth wave refers to the burnout, economic injuries, prolonged stress, psychological trauma and mental illness that occur after the immediate health risks of COVID-19, the diversion of resources from people who get sick from non-COVID-19 causes, and the deferral of preventative care for chronic conditions. The irony of pandemic social isolation is that while restricting one's interactions with others does reduce the exposure to the virus, the risk to one's psychological health worsens, often manifesting as substance misuse, suicide, poor sleep, domestic violence, depression or anxiety (Holt-Lunstad, 2020).

Gaslight, and in particular Ingrid Bergman's spellbinding Academy Award winning portrayal, (the first of three awards she received) are poignant reminders of the vulnerability people have in stressful times, particularly when there is no end in sight to the restrictions imposed by a pandemic.

Conflict of Interest: None

Contact: rapid@psychler.com

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*Dave Robinson is a psychiatrist practicing in London, Ontario. He likes Easter eggs, both cinematic and cho*colate.

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Informative and Easy to Read

A Review of *Persistent Depressive Disorders*

J. Kim Penberthy

Boston: Hogrefe Publishing Group, 2019; 106 pp

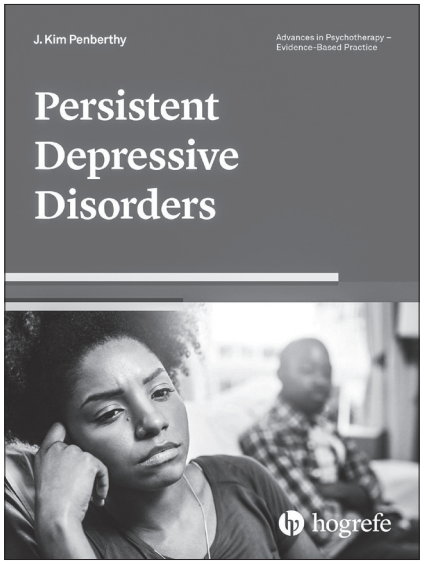
$42.50, paperback

Mary Ann Gorcsi, MD, CCFP, FCFP

Mild but chronic depression is a common problem in our practices. J. Kim Penberthy, a professor of psychiatry and neurobehavioural sciences, has written an excellent book for those who want to do a "deep dive" into the topic of Persistent Depressive Disorders (PDD): Volume 43 of the series on Advances in Psychotherapy—evidence based practices. This diagnosis is new to the DSM 5 and was previously known as dysthymia. As detailed as this topic is, the book is laid out in easy to read chapters for those of us with little time.

First, "Description of Persistent Depressive Disorders" outlines the definition, epidemiology, course and prognosis of PDD. This section also includes useful items, such as rating scales. Chapter Two, "Theories and Models of Persistent Depressive Disorders," outlines biological, psychological, interpersonal, neurophysiological models, and others. This section is a good read for those interested in neurotransmitter hypotheses related to depression. Chapter Three, "Diagnosis and Treatment Indications," addresses topics such as motivation or readiness to change, suicide risk, trauma history, and comorbidities.

The fourth chapter is entitled "Treatment." Penberthy provides general information on drugs used but, being a psychologist, does not emphasise pharmacologic treatment. She mentions common psychotherapeutic modalities, such as CBT and IPT. However, her major emphasis is on a treatment called *Cognitive Behavioural Analysis System of Psychotherapy* (CBASP), which is



Penberthy's area of expertise. A great deal of this chapter is devoted to explaining this model, complete with a breakdown of sessions, and case examples. The author states "CBASP is specifically for early-onset unipolar chronic depression and is especially effective for patients with trauma histories. Primary goals of CBASP are to increase felt emotional safety and perceived functionality in PDD patients" (p. 51) What the author means is that when patients feel safe enough to more fully approach and engage in treatment, they can learn to recognize the interpersonal consequences of their behaviour and begin to make appropriate changes.

The last sections of the book include "Further Reading," which is an appendix of authors' works that were mentioned in the above chapters, "References," and "Tools and Resources." This section is very useful for those who want to learn more about CBASP. There are sample worksheets, and other tools for working through cases using this model.

As a reader of this book, I found it very useful to have major topic points in the side columns listed on each page as a reference. As well, there are a few clinical vignettes to demonstrate brief interactions between the CBASP therapist and the patient.

In conclusion, I found that the topic of pervasive depressive disorders very thoroughly presented. As a new-to-me therapeutic modality, CBASP was also presented in a very clear manner, with many resources for the reader who wishes to pursue the model further. I personally have not used this therapy, however this book outlines the modality clearly and certainly this would be a great place to start in learning to use this model.

Conflict of Interest: None

Contact: magorcsi@sympatico.ca

Mary Ann Gorcsi is a practicing Family Physician in Brantford, Ontario who devotes part of her week to psychotherapy for the patients of her group practice. She is also an assistant clinical professor for McMaster University Family Medicine Postgraduate program, co- teaching Mental Health and Behavioural Sciences to family practice residents, and is the current Chair of the Education Committee for MDPAC.

UNLOCKING THE BOX

*S.A.**

I was sitting in this box alone,
Looking at the disowned throne,
Darkness surrounding outside
Forbidding suffocation inside,
Waiting for some miracle to happen,
My life to be somewhat sharpen,
It felt difficult, it felt sadly,
There were times I went extremely lonely…

I waited for months to get to meet her,
When the time came, I couldn't wait to greet her,
With a torch in her hand, out of nowhere,
Dr. Chow opened the door somewhere,
She smiled and started unlocking the box,
But I refused to untie myself like a caged ox,
She was patient and she was bright,
She lifted me with her spirit and sight,
Trying to show me a better life,
Freeing me from all my rife….

She made me realize, I am beautiful,
And cheered me whenever I felt dreadful,
She was like a slow poison to cure my illness,
She was like that path to my wellness,
Nothing in this world can return her favor,
Her grin is enough to make it always savor,
Neither did she give medicines, nor did she use injections,
Yet this doctor made my life, look like a lovely projection….

Now she is leaving my hands and I don't know where to dwell,
I am scared deep down but I know she has taught me well,
I opened up my heart when I was so helpless,
And slowly she made my life all fearless,
She is the first I remember, when my life is a mayday,
But I promise to surely make you proud someday…

* This was written by a patient of Vivian Chow, chair of the Journal Committee, who has recently retired from medical practice. She writes:

One of the most rewarding aspects of practicing CBT psychotherapy is being able to graduate patients. S.A. was one of the bright lights in my practice. I am further impressed by the fact that English is not S.A's first language.

Ode to Michael F. Lewis

George Lewis, M.D.

When attending my brother's funeral in Wales, his girlfriend at the time said something unkind to me. I was still seething inside when I boarded the plane to fly back to Toronto. I took out my trusty pen and this poem, to honour my brother, just flowed out.

Michael, you brought out the risk-taker in me
Playing it safe – that was not your degree!
Poaching salmon! In the Headmaster's boat!!
Only you and me and Albert would carry this note;
Leaving our bed in the dead of night,
Down to the narrows and away out of sight
To Devinish Island – where the salmon would run,

Oh! What Excitement! Oh! What Fun!!

Paying out the net and then anchoring it
To the dock – And then we would sit
And watch the net "bob" as the salmon hit.
Back in the boat with nets and with fish,
Past the lock-keeper with barely a swish.
Tie up the boat and back up the hill
Into our beds before morning drill.
Tired boys in class that day.
"Not paying attention?" the teacher would say.
And Lewie would grin and gladly agree
For inside he knew what it is like to be free.
He knew what fun he had had that night
And that poaching salmon was a "Bit of all right"
And to use the Headmaster's boat!
Now that is a tale that will always stay afloat.

So Thank-You, my Brother for all that you bring.
Your Joy, your Kindness, and especially your Grin.

My brother and I both went to Portora Royal School in Enniskillen, Northern Ireland. This school was one of six founded by King James I in 1604, to bring up the young men of the land in the traditional way. This was my version of being sent to a residential school, so I have some empathy for my indigenous brethren! Oscar Wilde and Samuel Beckett were both former pupils, along with Henry Francis Lyte of "Abide with Me" fame. The school overlooked the town of Enniskillen and the River Erne, surrounded by mountains on all sides. The summer of 1964 saw a massive run of salmon up the River Erne, right past our school. My brother's best friend Albert was from Donegal and knew all about salmon fishing with drift nets. He persuaded my brother to go out with him in the dead of night and try their luck—in the headmaster's rowing boat no less! The enterprise was successful, except eventually my brother ran out of gas and one night asked me to go with Albert, instead of himself—and thus the seeds of the poem were sown.

My view of therapy is to allow the healthy expression of emotion and learning to surf the wave of emotional intensity when it builds up. It takes a lot of psychic energy to keep emotions under wraps, which depletes life energy and contributes to depression and anxiety. My work in psychotherapy helps me to be me, to "be" with my patients in a healing way, and to write the occasional poem.

Contact: medclinicbayview@yahoo.ca

George Lewis studied medicine in Ireland, and practiced Family Medicine in Woodbridge before focusing his career in medical psychotherapy.

Good Grief: How to Mourn, Pandemic Style

Tara Tucker MD, FRCPC, MEd, SEP

In the midst of this pandemic we are awash with examples of grief. How can we even start to quantify it? Losses abound in so many ways: loss of job, financial security, health, and so many others, as well as the death of a loved one. Whilst some of us will be impacted by the death of a loved one with COVID-19, many more will be impacted by the death of a loved one during COVID-19, from other causes. Healing from death loss requires mourning; however, this pandemic has robbed us of a crucial ingredient in the initiation of mourning: the funeral, or at least the funeral as we have known it. In my Grief Therapy Practice, I have grappled with ways of helping patients mourn, pandemic style. They continue to teach me how best to do this, and here is one example that I would like to share with you.

"Maria" is a patient of mine whose sister "Anna" died of cancer during the pandemic. Despite a difficult relationship through their childhood, recent years have seen the mending of old hurts and a closeness that they could not have imagined. Anna had cancer, and she struggled for the last couple of years with sequelae of the disease and the treatment. She lived in Europe and had not been able to comfortably travel since last year. Maria flew over regularly to support her sister, and to be present for post op recoveries and other milestones in her sister's journey. They shared stories, they laughed and cried together, and they began to learn to live with the reality that Anna would eventually leave her young children behind and Maria would lose her confidante. When COVID-19 struck they were devastated yet again. Maria could no longer travel, and Anna became too fatigued to fully engage in using technology to connect. Anna died in April and Maria was devastated. Not only was she robbed of the precious last few weeks of Anna's life, but now her grief is further accentuated by the inability to attend and partake in a funeral. Maria recognised the added blow of not seeing her sister for the last time, not being present to support her young nephews and not having that final goodbye, and so she came to see me for grief support.

In fact, what Maria was beginning to understand was the importance of funerals in helping us to honour our loved ones and to mourn our losses. Alan Wolfelt (2020), a psychologist at The Center for Loss in Fort Collins, Colorado, describes our need for funerals as an essential step in meeting the needs of mourning. The funeral helps us to accept the reality of the death, and to share stories about our loved ones with others who have also loved this person. As we begin to shift our relationship from one of presence to one of memory, that initial support, both given to others and received, is an important means of launching our mourning. While grief includes the myriad of emotions we feel inside, mourning is the expression of our grief, and it is in the mourning that healing can occur. Hence, the funeral stands as an age-old form of mourning that helps us to embrace the pain of loss and begin the difficult path of reconciling grief.

So, what was Maria, and so many like her, to do? As Dr. Wolfelt (2020) states "it's never too late to have a ceremony, and especially if you weren't able to be with the dying person or the body afterwards, holding several ceremonies is a good idea." Given the restrictions with travel and gathering due to the pandemic, Maria decided to begin with a candle-lighting ceremony with her immediate family and her family overseas via Zoom. The two families set up their respective tables with candles, pictures, and other memorabilia of Anna. They played Anna's favourite piece of music, Maria read a poem, and they each lit a small candle as they shared a favourite story. They said a special prayer (although secular ceremonies are equally powerful) and they finished with another of Anna's favorite pieces of music. There were tears, and there was laughter; there were painful moments, and most of all, there was a profound feeling of support. Maria expressed gratitude in helping her family to understand what to do with their grief, how to express their shared love for Anna between two continents, and to find a meaningful way to honour her, while helping each other to heal. They have already decided that the next ceremony will mark her birthday in September, online of course, and they are beginning to plan what that ceremony may look like.

Finding creative ways of mourning our losses is such an important step in helping us to reconcile the pain of grief. The structure of ceremony and ritual is just one way to launch us on that journey to finding meaning and purpose after one of our precious loved ones has died. Maria has taught me one way to mourn well in this pandemic and I am grateful to be able to

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Good Grief: How to Mourn, Pandemic Style | continued

share that with you. I extend my blessings to Maria and to those who have suffered like her, and to all of you who have endured the pain of loss during this crazy time.

Conflict of Interest: none

Contact: tara.tucker@sympatico.ca

Tara Tucker is a Grief Therapist and Somatic Experiencing Practitioner who works in Ottawa, Ontario. She incorporates the Companioning Model as well as the body-oriented approach of Somatic Experiencing to address the trauma elements of grief.

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The Theratree Award

Tara Tucker MD, FRCPC, MEd, SEP

The Theratree Award is a tribute to a member of the Association who deserves special recognition for their contributions to the profession, to our society of psychotherapists, and to the wellbeing of our patients. I have the honour this year to introduce you to our 2020 Theratree Award winner, Catherine Low. Catherine and I sat down to chat about her life, her career, and what this award means to her, and I offer you the humble and beautiful thoughts that she shared.

Tara: *Tell us a little about yourself, where you grew up, went to medical school, or other interesting tidbits.*

Catherine: I grew up in Scarborough. I was the oldest of five children and my father was an internal medicine specialist at the local hospital there. I decided at the age of 14 that the way to earn respect from people was to become a doctor. After my first six weeks of medical school at McMaster University I wasn't "feeling the love" from the patients or the staff so I seriously considered quitting. But, by then I had already spent two summers working at Scarborough General Hospital, first as an assistant in the nuclear medicine lab doing brain scans and next as a relief worker filling in for vacationing scrub nurses in the operating room, and I was hooked. I loved everything about medicine. So, I hung in there, finished my training and picked up the habit of daily drinking to help me cope along the way. I spent 20 years in family medicine before focusing on psychotherapy. During that time, I watched my patients struggle with physical ailments that were, obviously, even to me, based on

fear, anxiety and childhood traumas. My vision of this got clearer when I finally made the decision to seek help for my drinking and was treated for alcoholism at the Homewood Health Centre in 1991.

Tara: *What influenced your path to a career in psychotherapy?*

Catherine: Doing low risk obstetrics as a young female family doctor I was amazed to find out that many of my patients had unresolved grief related to previous therapeutic abortions and that many of them had never revealed this to anyone including their partners. I watched as this unresolved grief had a predictably adverse outcome on their pregnancy, their labour and delivery and their ability to be emotionally present to their newborn babies. I felt powerless to change these outcomes. After I got sober, I recognized more and more that my patients' coping mechanisms often involved using substances or behaviours in an addictive manner and that these addictions were thwarting all my efforts to treat their presenting complaints such as insomnia, obesity, and depression. My own doctor at the time suggested I look into joining the GPPA and getting some additional training in psychotherapy as a way of managing my practice more effectively. I did this in 1996 and by 1999 I was closing my comprehensive family practice and opening a focused practice in psychotherapy.

Tara: *Who has inspired you in your life and work?*

Catherine: I was inspired professionally by many of the speakers at the GPPA annual conferences. I saw these presentations as "tasters' plates" that allowed me to look further into the types of therapy that interested me. I also learned a tremendous amount from my patients. Bessell van der Kolk's book The Body Keeps the Score was originally recommended to me by a patient and it revolutionized the way I practiced psychotherapy. For years I had been using yoga and meditation in my own healing journey and here was a recognized expert saying that these things were valid ways of treating trauma. From then on I felt empowered to extend my work beyond the realm of "talk therapy" and into the realm of body therapy. I developed skills in SandTray Therapy as a way of helping patients to access their bodies during therapy sessions. This proved to be very enriching both for them and for my work as a therapist.

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The Theratree Award | continued

I was supported emotionally by my supervisors over the years (Daniel Campeau, Mary Helen Garvin and Robin Beardsley), by my own physician and social worker, and by the Peer Support Groups that I joined in Ottawa, Kingston and then Ottawa again when I moved back in 2016. Throughout the past 30 years I have been supported unconditionally by the fellowship of Alcoholics Anonymous which is available literally all around the world. One of the highlights of my life was attending an AA meeting early on a Christmas morning on a beach in Hawaii. It was not hard to find a sense of gratitude for my life that morning!

Tara: *What are your biggest achievements?*

Catherine: Becoming a mother to two beautiful daughters and remaining abstinent from alcohol are the three biggest achievements in my life.

Tara: *What advice would you give for those early in their psychotherapy career*?

Catherine: Get as much support as you can both personally and professionally. Don't go it alone. Don't carry the burdens of your patients alone. The despair and isolation that they bring to you is contagious and you need help to make sure that it doesn't sink you. Also, the more you work on healing your own traumas the more effective and rewarding your professional work will become.

Find something outside your work that brings you joy—dancing, gardening, running, sculpting, yoga—something that focuses your attention away from the sorrows that you hear about at work, and do it with gusto. You don't have to do it well. Just do it with enthusiasm.

Tara: *How did it feel when you were told you won this award?*

Catherine: I felt very proud when it was announced that I had won this award. But what really overwhelmed me was watching the video clips of different people in MDPAC talking about how I had impacted them on an individual level. That made me cry. It was so soothing to hear. Many days I feel powerless when I hear about all the evil in the world. That video reminded me that I can have a positive effect in one person's life and that they in turn can positively impact others and that eventually things will get better. Love is always stronger than hate. We just have to keep putting one foot in front of the other and never give up. Each of us can make a difference. We can make the world a better place than it was because we were born into it and we didn't give up.

Tara: *What career highlights, especially as related to your contributions to GPPA and MDPAC, would you like to share?*

Catherine: The rebranding of the GPPA to MDPAC was one. When the behind the scenes work was done, the week before Christmas 2016, we were quickly approaching a critical deadline. We called a meeting at the OMA offices in Toronto to vote to make this official. And people came! There were some lively discussions around the table but in the end the motion passed unanimously.

Another was the revival of the Basic Skills Core Curriculum course to become the MDPAC Psychotherapy Training Program. Again, there was a lot of behind the scenes work that went into getting this off the ground but it was fully subscribed and very well reviewed the first time we offered it. Congratulations to all the teachers and support staff for making this happen!

And third, the modernization of the MDPAC website and the shift to videoconferencing and distance learning that has allowed us to truly become a nationwide organization. Congratulations to everyone who kept pushing for this!

Tara: *What are your plans for retirement?*

Catherine: I am going to spend as much time as I can outdoors. Gardening, hiking, camping, kayaking and cross-country skiing. The only thing that I regret about my professional career is that I spent most of it indoors. If I had it to do over again, I would tell all my patients to spend more time outdoors. The one good thing about the pandemic, my patients told me, was that they were taking more walks outside and that they were really enjoying it. Nature is the ultimate healer. We were built to heal. We just need the time and the space and the encouragement to help us do this. I believe that we all have the ability to heal.

Congratulations again Catherine! Thank you for your many years of service to your patients and colleagues and for sharing your wisdom and insight with us. May you have many years of happy retirement!

Contact: tara.tucker@sympatico.ca

Website: taratuckermd4grief.ca

Tara Tucker is a Grief Therapist and Somatic Experiencing Practitioner who works in Ottawa, Ontario. She incorporates the Companioning Model as well as the body-oriented approach of Somatic Experiencing to address the trauma elements of grief.

Report from the MDPAC Board of Directors

Elizabeth Parsons, MD, CCFP, MDPAC(C)

Here we are, six months into the pandemic, with no end in sight. The fall is bringing new challenges with a return to school and cooler weather that will keep us inside more and more. I am hearing from my therapist colleagues that they are feeling tired and overwhelmed with the demands for their services. I know that many of us have had a reduction in our income and for those in Ontario who focus on group psychotherapy, you've had to deal with a complete lack of government response to the issue of billing fairly for groups held on platforms other than the Ontario Telemedicine Network. I'm writing this just as two of my three children head back to in-person school and I know many of you are in the same position. The uncertainty is hard to bear at times. I'm glad to have this community of physician therapists to connect with for support.

My work as Chair of the Board of MDPAC has certainly kept me busy with moving everything online. Please read on to hear how your board and committees have been hard at work on your behalf.

MDPAC 33rdAnnual Conference and AGM

As you are no doubt aware, the conference has been postponed until November 6 and 7 and will be offered via Zoom. "Piecing Together the Psychotherapy Puzzle" includes plenaries on Unconscious Cognitive Biases and Somatizing, as well as workshops on Internal Family Systems, Trauma-informed Care Interventions, and an Approach to Sensorimotor Psychotherapy (by our own Dr. Harry Zeit with his partner Irina Dumitrache). Although we won't have the same opportunities to spend time together the way we do at an in-person conference, there will be chances for interaction during the workshops and certainly many interesting topics to learn about. The move to virtual involved a lot of work and I want to thank Liz Alvarez and the Conference Committee, and especially Carol Ford, for making this transition as seamless as possible for our benefit. The conference is accredited for 12 CFPC Mainpro+ credits and we have applied for Royal College MOC credits.

Strategic Plan

We have been working with IMPACT Public Affairs since November 2019 to develop a social media campaign and increase our online profile. In May the Board voted to continue our work with IMPACT for a further six months. We are starting to see an increase in new members and are hopeful that our presence online will draw more participants in to our conferences and educational events. Please consider following and re-tweeting or sharing MDPAC's posts on "Twitter" and "Facebook" to increase our visibility.

We want to keep members updated more regularly on Board decisions and committee work. To that end, starting in early October, we will be posting a brief summary of the monthly Board meeting minutes on the website. You will find these on the "Members Home" page under "Member Updates." We are still interested in setting up a blog on the "Doctors Listen" microsite where members can contribute personal narratives about their work as medical psychotherapists along with other psychotherapy-related topics. Please contact Carol Ford if you are interested in contributing to the blog.

Anti-racism Plan

As a result of the terrible events both in the US and Canada in the spring, and the renewed energy behind the Black Lives Matter movement, MDPAC issued a brief statement in mid-June and I wrote a letter to the membership which was sent June 19. MDPAC continues to be committed to addressing systemic racism as it affects our association. We welcome input from members on what you would like to see our association offer, which might include a group where members could safely explore their own experiences of systemic racism, or educational modules or perhaps a book club. I have been doing a lot of reading on the topic and have joined a small group that is exploring bias from an Internal Family Systems perspective, looking at how our parts have taken on beliefs and shame related to racism. It's deep and rewarding work although also painful and difficult. I believe that it's necessary work for us to heal and move forward as a society that won't keep bringing the wounding from the past to continue causing harm. Just like we work with individuals to help them to heal the wounds of their past, we can begin to heal society's wounds by engaging in this work ourselves.

Fee Increases

You will have seen that the membership fees have increased significantly this year. We sent out an eblast in late July to explain the reason

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for the increases. In case you missed that, I wanted to outline again our reasons for this decision. As I mentioned above, the Board has invested funds in much needed areas which have benefited members: a new website and contract with a public relations firm (IMPACT). Operating expenses continue to rise due to inflation and unexpected expenses have also been incurred from venue cancellations due to the COVID-19 pandemic.

While reviewing the association's finances over the past several years, the Board noted that **membership fees have not been increased in over 10 years.** As such, the Board of Directors has increased the membership fees for all categories of membership for the coming membership year. This increase was being discussed for at least a year before the pandemic. Of note, fee increases for CPSO/CPD members are slightly higher than other categories (30% vs. 20%) to reflect the disproportionate amount of time and funding needing to maintain 3rd pathway status with the CPSO, and the added benefit to members in this category.

The increase in membership dues will help to bring the association's budget closer to a break-even status, so that the Board can continue to sustainably fund initiatives that will benefit our members. In the future, we plan to make membership fee increases smaller and more frequent to reflect changes in expenses over time.

Psychotherapy Funding

We are continuing to communicate closely with the Save OHIP Psychotherapy Coalition to address psychotherapy funding in Ontario. We encourage our Ontario members to support the work that Anastasia Sky is doing.

Additional Committee News

The second iteration of the MDPAC Psychotherapy Training Program has begun this September. We have had so much interest that we have decided to run the program for a second group that will start in November. Both programs are full, which is very exciting. Thank you to all the presenters and supervisors for being available to make this happen! And a big thank you to the committee members who have put in additional work well beyond the original hours they committed to this project.

A reminder that our three-year cycle for continuing education, which was due to end September 30, 2020 has been extended a full year due to the pandemic and the reduction in opportunities to fulfil continuing education requirements.

I know that he has already announced this on the listserv, but I wanted to say that I'm very pleased that Carlos Yu has agreed to take on the role of listserv moderator and Listserv Committee Chair. His experience in running groups will no doubt be valuable in this new position. Welcome, Carlos!

New Members

Welcome to MDPAC! If you have recently joined, you should have been contacted by a Board member, welcoming you to our association. If you haven't heard from anyone yet, please send Carol Ford an email and ask her to put you in touch with a board member. You're also welcome to contact me directly. And please consider joining a committee. I know they will all welcome new members and it's a great way to meet your colleagues and have a voice in our association.

Let's continue to support each other through these stressful and overwhelming times. We can make it through this together—it's a lot easier than doing it alone! May you all be well and safe.

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.

MDPAC ACPMD
MEDICAL PSYCHOTHERAPY ASSOCIATION CANADA
ASSOCIATION CANADIENNE DE PSYCHOTHÉRAPIE MÉDICALE

Contact Person:

Carol Ford, Association Manager
312 Oakwood Court, Newmarket, ON, L3Y 3C8
Tel: 416-410-6644 Fax: 1-866-328-7974
Email: info@mdpac.ca Website: www.mdpac.ca

Who to contact at the MDPAC:

Journal:

to submit an article or comments
Janet Warren at journal@mdpac.ca

Contact a Member

Search the Membership Directory or contact the MDPAC Office.

Listserv:

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

Questions about submitting educational credits, CE/CCI Reporting, or Website CE/CCI System:

Muriel J. van Lierop at murielvanlierop@gmail.com or
416-229-1993

Reasons to Contact the MDPAC Office:

- Notification of change of address, telephone, fax, or email address.
- To register for an educational event.
- To put an ad in the Journal.
- To request application forms in order to apply for Certificant or Mentor Status.

2020 MDPAC BOARD OF DIRECTORS

Caroline King, *President*
(905) 628-5656 | carolineking1066@gmail.com

Elizabeth Parsons, *Chair*
(613) 915-3621 | elizabeth@eparsonsmd.ca

Alison Arnot, *Treasurer*
(905) 813-4402 | 6johnson@rogers.

Margaret Abell
(204) 824-2327 | matabell@shaw.ca

Daniel McBain
(888) 731-0588 | doc@danielmcbain.ca

Marcia Kostenuik
(705) 220-7245 | drmk.barrie@gmail.com

George Lewis
(416) 441-9787 | medclinicbayview@yahoo.ca

Thomas Minde
(613) 842-8187 | drminde2@gmail.com

Stephen Sutherland
(613) 531-3706 | stephenjsutherland@gmail.com

Yves Talbot
(416) 586-4800 | y.talbot@utoronto.ca

James Whyte
(905) 928-7971 | jameswhyte76@gmail.com

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

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MEDICAL PSYCHOTHERAPY ASSOCIATION CANADA
ASSOCIATION CANADIENNE DE PSYCHOTHÉRAPIE MÉDICALE
312 Oakwood Court, Newmarket, ON L3Y 3C8
Tel: 416-410-6644 Fax: 1-866-328-7974
info@mdpac.ca | www.mdpac.ca