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From the Editor

"Begin at the beginning," the king said gravely, "and go on until you come to the end. Then stop" (according to Lewis Carroll in *Alice's Adventures in Wonderland*).

Our journal is seldom swamped with submissions and, like Alice in Wonderland, I'm curious. After all, as the king says, writing is simple. In psychotherapy it is often more helpful to explore what people fail to do than what they actually do. Therefore, I thought I would explore some possible reasons why physicians do not write. According to participants in my recent writing workshop, the primary reason is "not enough time." We can all relate to that. But dare I counsel about balance in life? Other issues include lack of knowledge, skill, and confidence in writing, or lack of mentoring and support. Despite the king's assertions, many physicians just don't know where to start. Or perhaps they believe E. B. White (of Charlotte's Web fame), who claims, "Writing is hard work and bad for the health."

These issues can be remedied with practice and education. Sometimes one needs to "just do it" or "begin at the beginning." Experts often recommend writing ten minutes a day and only editing your work later. But let's consider some good reasons to write. Writing enables us to share our ideas, report on our own research and experience, express our opinions, and generate discussion. Through it we can be intellectually stimulated and psychologically challenged—by both the research and the writing process. We usually gain a sense of accomplishment and, if published, we may even attain a degree of immortality. Just remember, when you "come to the end," to submit your piece to the Medical Psychotherapy Review (MPR).

Fortunately, we have some members who have done this. Volume 23, issue 3 of the MPR features Howard Schneider's regular "Psychopharmacology Corner," which reviews useful and somewhat alarming information on tardive dyskinesia occurring with the use of atypical antipsychotics. (Our other regular column, "Standards in Psychotherapy," will return next issue.) David Murphy presents his promised second part on Neuro-linguistic Programing for depression.

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From the Editor (cont'd)

He shows how "dysfunctional, maladaptive psychological programs" can be modified through techniques such as hypnotherapy, timeline imaging exercises, and resolving depressive identities. In our new column, "Improve your Practice," I summarize the concept of emotional styles—an alternative approach to personality. As a reminder, we welcome submissions to this column on a wide variety of topics. Share your tips with your colleagues.

In our "Art of Psychotherapy" section, Siobhán Conway-Hicks offers a creative reflection on her experience at the recent GPPA/MDPAC annual meeting, including "a chair with a grey chiffon semi-permeable drape, people positioned around the chair. One on knees with chest on chair. Another sitting on ground with a trail of the shroud from the chair held to the throat" (I don't think I was at that workshop). Josée Labrosse also writes about body movements in her whimsical reflection on yoga—with interruptions from a toddler. In "MDPAC Matters," Catherine Low provides updates on the latest MDPAC news, including the rebranding of our organization and peer assessment. Finally, Daniel McBain highlights two MDPAC members, Drs Roy Salole and Mel Borins, who have recently received honours.

As you read, perhaps you too will be inspired to write. Your words are where your heart can connect with the needs of the MDPAC community. This is your journal.

Grace and peace,

Janet Warren

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SCIENTIFIC PSYCHOTHERAPY

Psychopharmacology Corner

Tardive Dyskinesia

Howard Schneider, MD, CGPP, CCFP

ABSTRACT

The emergence of extrapyramidal symptoms (EPS) must be carefully monitored for when antipsychotic medications are being used. There are differences in the incidence of EPS among different antipsychotic agents. While the incidence of tardive dyskinesia is reduced with the use of atypical antipsychotics compared to conventional antipsychotics, it remains significant.

Introduction

As medical psychotherapists, whether we prescribe or not, we are expected to be familiar with current psychopharmacotherapy. Psychopharmacologist Stephen M. Stahl, of the University of California San Diego, trained in Internal Medicine, Neurology, and Psychiatry, as well as obtaining a PhD in Pharmacology. In 2011, Stahl released a case book of patients he has treated. In this column, I will examine one of his cases and highlight its important lessons.

Stahl's rationale for his series of cases is that knowing the science of psychopharmacology is not sufficient to deliver the best care. Many, if not most, patients would not meet the stringent (and, arguably, artificial) criteria of randomized controlled trials and the guidelines that arise from these trials. Thus, as clinicians, we need to become skilled in the *art* of psychopharmacology. To quote Stahl (2011, p. xvii), this requires us "to listen, educate, destigmatize, mix psychotherapy with medications and use intuition to select and combine medications."

In this issue, we will consider Stahl's 25th case, "the young man whose dyskinesia was prompt and not tardive." The patient is a 21-year-old single unemployed (on social security disability) man who comes with his mother to see Dr Stahl.

Before we dive into this case, let's review some terminology:

Term	Definition (Stedman, 1976)
tardive	late, tardy
dyskinesia	difficulty in performing voluntary movement
extrapyramidal motor system	all of the brain structures affecting bodily movement, excluding the motor neurons, the motor cortex and the pyramidal (corticobulbar and corticospinal) tract….
extrapyramidal dyskinesia	movement disorders attributed to pathological states …of the extrapyramidal motor system… generally characterized by insuppressible, stereotyped, automatic movements that cease only during sleep; examples are Parkinson's disease, chorea, athetosis…
parkinsonism	…syndrome…characterized by rhythmical muscular tremors, rigidity of movement, festination, droopy posture and masklike facies
chorea	irregular, spasmodic, involuntary movements of the limbs or facial muscles
athetosis	constant succession of slow, writhing, involuntary movements… of the fingers and hands, and sometimes of the toes and feet
tardive oral dyskinesia	a syndrome marked by involuntary movement of the lips or jaw and other dystonic gesture
dystonia	abnormal tonicity (either hypo- or hyper-) in any of the tissues
torticollis	a contraction, often spasmodic, of the muscles of the neck…the head is drawn to one side
akathisia	motor restlessness and a feeling of muscular quivering

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Tardive Dyskinesia (cont'd)

Past Psychiatric History

- Childhood—no psychiatric history but introverted behavior noted.
- Strange behavior noted at age 17—the patient would branch off tangentially in the middle of a conversation and inappropriately smile, the patient was previously a good student but dropped out of school, the patient believed his mother was practicing voodoo with Hilary Clinton who was talking to his mother via a computer chip in his mother's brain, the patient believed that his mother wanted to poison him, and the patient complained about hearing voices from his favorite professor via a computer chip in his own brain.
- Diagnosis of schizophrenia at age 19—the patient had started yelling, shoving, and slapping; the police were called, the patient was hospitalized, diagnosed with schizophrenia, and prescribed olanzapine 12 mg od with good response.
- Patient went to college, behaved normally, obtained good grades, but then decided to stop his medications. Two months later he was found screaming that his food was poisoned, and he was re-hospitalized. There was a court order to force him to take medications for one week and then the patient was released from hospital.
- After being released, the patient stopped his medication, became violent with screams and threats, and was re-hospitalized. This time he did not seem to respond to olanzapine, and was then tried on aripiprazole and then paliperidone 12 mg od, which gave a better control of the psychotic symptoms.
- Patient developed an increase in anxiety attacks over the next few months and paliperidone was gradually decreased to 3 mg od due to complaints of muscle spasms, tremor, leg twitching, abnormal arm positions, and neck spasms.
- Patient stayed on paliperidone for three months but then stopped it since he felt he was fine now and no longer needed the medication.
- Two days after stopping the medication, the patient's symptoms returned and eventually he was hospitalized again. He was discharged on paliperidone 12mg od and quetiapine 400mg qhs.
- The outpatient psychiatrist then switched the medication to olanzapine 10mg qhs, kept the paliperidone at 12mg od due to persistent positive psychotic symptoms, and added benztropine 0.5mg for a movement disorder, although the latter medication did not result in improvement.

Past Medical History

- Low normal BMI, normal blood pressure, normal routine blood tests including glucose and triglycerides

Intake Medications

- Olanzapine 10mg qhs
- Paliperidone 12mg od
- Benztropine 0.5mg od

Personal History

- Lives at home on social security disability
- Does not have many friends or dates
- Has no outside activities since dropping out of college after one semester
- Has no significant jobs

Family Psychiatric and Medical Relevant History

- Maternal uncle: schizophrenia

Chief Complaint

Patient feels that he has been misdiagnosed with schizophrenia, that his medications do not help him, and that they cause movement problems.

History of Present Illness, Mental Status Examination, Physical Examination

Patient tells Dr. Stahl that he has a computer chip in his brain which is telling him that he was starving in Romania as an infant. The patient does not believe that he could have schizophrenia but rather it is an excuse so his "evil" doctor can give him medications. However, the patient agrees that for the last three years he has had delusions and hallucinations. The patient argues that the medications do not help his symptoms but instead cause movement problems. He denies suicidal ideations.

The patient has torticollis on the right with a stooped posture. He has bizarre dystonic arm postures and finger movements as if he was playing a piano. However, he has no oral, buccal, lingual or facial dyskinesias.

Stahl thinks that the patient obviously suffers from a psychotic illness. With regard to the movement disorder, there are signs of acute extrapyramidal symptoms (EPS) such as the stooped posture, as well as signs seen more often in long-term treatment such as the finger dyskinesias. Although another illness could cause the movement disorders, they began with the paliperidone, so are likely medication related too.

Stahl notes that reducing the medication will probably worsen the psychotic disorder, but if the medication is not changed, the movement disorder will continue or

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Tardive Dyskinesia (cont'd)

worsen. Over the long-term the patient is at risk for tardive dyskinesia or tardive dystonia. The patient should not be switched to a conventional antipsychotic (higher risk of tardive dyskinesia) or risperidone (since paliperidone, which appears to be a main cause of the patient's movement disorder, is the active metabolite of risperidone). Stahl feels high dose monotherapy with an antipsychotic with less risk of movement disorder should be considered. He considers the following medications: quetiapine (may be efficacious), aripiprazole (but the previous lower dose was not effective in the patient and it can cause akathisia), asenapine (can also cause some EPS), iloperidone (reportedly has low incidence of EPS), lurasidone, ziprasidone (patient non-adherent which is an issue since it must be taken twice a day with food), and clozapine (may be the most effective for psychosis in this patient and has the least risk of movement disorder, but is an issue if the patient is not compliant with the periodic laboratory testing required due to risks such as agranulocytosis). Stahl also recommends benzodiazepines to help with sleep and agitation in order to keep the dose of the antipsychotic as low as possible.

Course of Treatment

Stahl sees the patient 12 weeks later, i.e., after the first evaluation. The patient denies that he had any psychosis, refuses any blood tests, and worries about being poisoned. The patient's prescribing doctor did not follow Stahl's recommendations but instead raised the olanzapine to 20mg. The patient's movement disorder persists. His family was told by the prescribing doctor that if they change the paliperidone, then the patient will end up being re-hospitalized, and that there is nothing that can be done for the movement disorder. Stahl spoke with the family and they agree to change to another psychiatrist.

Stahl then sees the patient 24 weeks after the first evaluation. The new doctor had tried olanzapine at 40mg od, which helped the patient's delusions but his movement disorder worsened, and he was more sedated. Paliperidone was then reduced to 3mg od, which caused agitation. The patient was then put on quetiapine-XR 600mg od, paliperidone 3mg od, plus benztropine 0.5 mg od. Delusions were not as well controlled but the movement disorder was a bit better although still an issue, including the torticollis.

Current Medications:

- Quetiapine-XR 600mg od
- Paliperidone 3mg od
- Benztropine 0.5mg od

Stahl considers the options at this point. Clozapine would be the best choice but the patient refuses the periodic blood tests required. Stahl advises to slowly increase the quetiapine-XR to 1000mg od, and then to decrease the paliperidone by 0.5mg od per week over 6 weeks and then stop it. The benztropine dosage is too low but Stahl wants to first wait before stopping the paliperidone to see if raising the benztropine helps. Stahl also recommends monitoring the patient's weight and to obtain fasting triglycerides levels in two months.

Stahl then sees the patient 36 weeks after the first evaluation. The patient's psychosis is better controlled. There is some sedation with the higher dose of quetiapine. The movement disorder persists despite stopping the paliperidone.

Current Medications:

- Quetiapine-XR 900mg od
- Benztropine 0.5mg od

Stahl considers the case again. Unfortunately, it appears that this patient is extremely sensitive to EPS even from second-generation atypical antipsychotics. Clozapine, which was not possible to use due to the patient's non-cooperation, and then quetiapine are probably the best antipsychotic choices for stabilizing this patient's movement disorder. Stahl notes that movement disorders can become permanent. However, it can sometimes take many months for the movement disorder effects of antipsychotics to dissipate, and it is hopeful that there will be improvement in the coming months. The dystonias, including torticollis, worry Stahl since they may represent tardive dystonia, which can become permanent and do not have many good treatment options.

Stahl recommends that if the patient's dystonias do not improve in the coming months, then benztropine at a high dosage should be tried. In addition, local injections of botulinum toxin for the torticollis can be helpful. Stahl also recommends neurological consultation to consider other diagnoses for the movement disorder. He does not see this patient again in consultation, and concludes that he likely had a rapid onset of a movement disorder from the medication, including reversible EPS (rigidity, restlessness/akathisia) and possible permanent tardive dyskinesia/ dystonia (abnormal finger movements, arm postures and torticollis).

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Tardive Dyskinesia (cont'd)

Discussion

The nigrostriatal pathway consists of dopaminergic neurons that go from the substantia nigra to the caudate nucleus and putamen ("dorsal striatum"). Antipsychotics block dopamine D2 receptors in the nigrostriatal pathway, and potentially cause motor adverse effects clinically observed as extrapyramidal symptoms. Long term blocking of the D2 receptors is thought to cause upregulation of the D2 receptors (more receptors) which causes motor adverse effects clinically observed as tardive dyskinesia. Typically, tardive dyskinesia presents as abnormal tongue and face movements (e.g., chewing movements, protruding tongue, facial grimaces) and as jerky extremity movements. The above patient did not have the typical facial movement abnormalities but did have jerky finger movements. In addition, his acute dystonias had become chronic dystonias, with the risk that these would become permanent.

Although the newer second generation atypical antipsychotics have reduced the risk of EPS and tardive dyskinesia, the risks are still non-zero. Paliperidone and risperidone are more likely to cause EPS than other newer choices. Clozapine or quetiapine should be considered where psychosis needs to be controlled and movement disorders appear. There is some evidence that clozapine does not cause EPS and may help improve tardive dyskinesia. There is also evidence that, although acute EPS and chronic tardive dyskinesia are different phenomena, the former may predict a higher incidence of the latter, and therefore treating acute EPS is important.

Work by Woods and colleagues found that the incidence of tardive dyskinesia from atypical antipsychotics was actually close to the incidence from conventional antipsychotics (Woods et al, 2010). They followed 352 patients without evidence of tardive dyskinesia for up to 4 years. The rate of development of tardive dyskinesia in the group taking conventional antipsychotics was 5.6% per year compared to 5.9% per year in the group taking the atypical antipsychotics. This is a higher incidence than other studies have reported. Work by Toronto psychiatrist Gary Remington gives a rate for the development of tardive dyskinesia of approximately 1% per year in patients taking atypical antipsychotics versus approximately 5% per year in patients taking conventional antipsychotics (Remington, 2007).

A number of scales exist to monitor for extrapyramidal symptoms, particularly the development of tardive dyskinesia. These can readily be found in reference books or downloaded and used with patients. The Abnormal Involuntary Movement Scale is a commonly used scale to record the development of tardive dyskinesia (Rush et al, 2007). It contains twelve items evaluating the patient's orofacial movements, extremity and trunk dyskinesia, and global severity, including distress to the patient.

Since the introduction of the atypical antipsychotic agents, their use has, as Alexander and colleagues write, "…grown far beyond substitution for the now infrequently used typical agents. Antipsychotics are increasingly used for conditions where FDA approval and associated clinical evidence is less certain" (Alexander et al, 2011). Antipsychotic medications can be very useful in certain patients, but the emergence of EPS must be carefully monitored, and the use of these medications should be justified by the lack of alternative efficacious treatments.

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Tardive Dyskinesia (cont'd)

Conflict of Interest: None

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Generic Name	**Trade Name**
	(Common, Canadian names where possible)
olanzapine	Zyprexa
aripiprazole	Abilify
paliperidone	Invega
quetiapine	Seroquel
benztropine	Cogentin
risperidone	Risperdal
asenapine	Saphris
iloperidone	Fanapt
lurasidone	Latuda
ziprasidone	Zeldox
clozapine	Clozaril

CLINICAL APPROACHES

Neuro-Linguistic Programming for Depression: Part II

David Murphy, M.B., Ch.B., CGPP

Introduction

Neuro-Linguistic Programming (NLP) is a model of psychotherapy, developed by Richard Bandler and John Grinder (1975a, 1975b), in which it is postulated that humans create language patterns within the nervous system to process sensory information and form psychological programs that drive our behaviour. Using the NLP model, symptoms of depression can be considered as dysfunctional, maladaptive psychological programs that can be modified, through psychotherapy treatment, into functional, constructive programs. In this article, I will expand on the description of NLP from my previous article in this journal (Murphy, 2016) and highlight some of the NLP techniques that can be applied to the treatment of symptoms of depression.

Neuro-Linguistic Programming

NLP postulates that humans encode their sensory (neurological) experiences using language in order to create a reality. That reality is then stored in memory, in the form of a map, and that memory becomes a part of our personal knowledge, experience and wisdom. An example of that coding is the difference between whether or not we like or dislike an individual. We encode if we *like* someone differently than how we encode if we *dislike* someone. The encoding is both a physical (neurological) and an emotional experience and is associated with a language pattern. Whether or not we choose to like an individual is governed by complex psychological programs that involve personal beliefs, values, previous life experiences and generalizations about people and the world around us.

The primary human senses are sight, sound and touch (visual, auditory and kinesthetic). We all tend to rely on one sense more than the other two. Approximately two-thirds of individuals are primarily visual. About twenty percent of individuals rely on their auditory sense. Perhaps 10% of individuals are kinesthetic. Each group will use specific language patterns that reveal that preference. Individuals who are visual may use the phrase, "I see what you mean," to indicate that they understand. Someone who is primarily auditory will say "I hear you." Someone who relies on their kinesthetic senses will say "I've got it." If we are receiving conflicting information from a different sense, we will tend to rely on the information coming from our primary sense. For instance, if I am primarily visual, then I am more likely to rely on the information from other people's body language than on the information from their spoken words.

The psychological programs that govern how we process sensory information and drive our behaviour can be simplified into two categories: *towards pleasure* and *away from pain.* Ideally, we have a balance between those two programs. However, individuals who are driven only by pleasure may have a tendency towards addictions, thrill-seeking, eating disorders, instant gratification and egotistical behaviours. Individuals who are driven only by avoidance of pain may exhibit avoidant behaviour, repetitive breakdown of relationships, addictions, symptoms of depression and symptoms of anxiety.

NLP and Depression

Patients presenting with symptoms of depression who are primarily kinesthetic will use kinesthetic terminology to describe their symptoms. They use expressions such as, "I have this heavy weight on my shoulders" and may present with psychosomatic symptoms such as chronic pain or gastrointestinal symptoms. The patient who is primarily visual may describe the future as "gloomy" and have a pessimistic or hopeless/helpless outlook on life. A patient who relies on the auditory system may hear negative parental messages from the past, such as "you're useless" and have a low self-esteem.

There are many psychological programs that can result in sensory information being encoded as symptoms of depression. For example, negative generalizations about oneself that are part of our sense of identity, such as "I'm a loser" will inevitably lead to repeated failure in life. Events in which the patient has been successful will be deleted from memory or distorted into and encoded as perceived failures. Any success will be demeaned and discarded as unreal or meaningless. The patient may never move out of entry-level jobs. Relationships may break down. Any sensory information which challenges that belief will be deleted or distorted.

A patient who lives life by setting negative outcomes and describing reality in negative terms will present with constant symptoms of depression. Such a patient, when asked to set outcomes for therapy, may respond by

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Neuro-Linguistic Programming (cont'd)

saying, "I don't want to feel miserable anymore; I don't like my job; I don't feel appreciated by my spouse." When asked to describe their state of mind, the same patient may respond with, "I'm not happy—I don't know—my partner is not supportive; I don't feel important." This patient will present with symptoms of depression and derealisation, because he or she is unable to describe or live in a real world.

Growing up, we are all exposed to various role models. In our very young years, our primary role models are our parents. Role modelling from our parents and other important individuals in our life results in beliefs about ourselves and our sense of identity; beliefs about values, beliefs about our capabilities and beliefs about emotional behaviours. We learnt what to feel happy about, what to feel sad about, what to be afraid of, what to be ashamed of and what to be angry about. These programs become encoded psychologically and drive our behaviour, in response to sensory information about our outside world. If our parents are alcoholics, we will be more likely to become involved in an addiction in our adult years. If a parent presents to us a hopeless/helpless view of the world, then we are more likely to feel depressed ourselves as adults.

The NLP Treatment Paradigm

NLP offers an optimistic viewpoint on the treatment of symptoms of depression. The NLP model postulates that depression is caused by learned psychological programs, which result in maladaptive, depressive behaviours. The beliefs that are associated with those psychological programs both distort and delete sensory information, resulting in the patient's reality being encoded with symptoms of depression. Therefore, it is possible to change those psychological programs through psychotherapy treatment, encouraging constructive coping skills and a positive, resourceful, empowered outlook on life. This may result in an improved self-worth and a sense of contentedness.

The NLP model is patient-centred. The therapist is not there to fix the patient. It is up to the patient to set their own specific, positive-focused outcomes for therapy and develop sensory criteria for knowing when those outcomes have been achieved. In other words, what will the patient be able to see, hear and touch/feel when the outcomes for therapy have been achieved? I often use the analogy of an Olympic champion who will realize that he or she has achieved their dream when they feel the sensation of someone draping a gold disc on a ribbon around their neck, see their nation's flag being raised up the middle of three flagpoles, and they hear their national anthem being played. I tell my patients that I am not there to fix them or to tell them what is wrong with them. I will not tell them how to live their life or to tell them what is right or wrong for them. My only role as their therapist is to help them understand what it is that they want and need in life, help them to access their own internal, untapped resources and offer them some tools and resources to help them achieve those outcomes.

NLP makes a number of presuppositions that can be important in the management of symptoms of depression (1975a, 1975b):

1. Behind every behaviour, no matter how destructive it may be, there is a positive intention.
2. Every behaviour is useful in some context.
3. People already have all the resources they need.
4. There is no such thing as failure. There is only feedback.
5. If you aren't getting the response you want, try something different.
6. No one is wrong or broken. People function perfectly to accomplish what they are currently accomplishing.
7. The map is not the territory.

Some Strategies for Treating Depression with the NLP Model

A. Hypnotherapy

Because of Milton Erickson's (1979) influence, hypnotherapy is an NLP tool that is used for treating symptoms of depression. Hypnotherapy can be used for bypassing the part of the mind, the *critical faculty*, that generates the generalizations/distortions/deletions that are contributing to depression. Regression exercises, through hypnotherapy, can help the patient access positive resources from past memories and bring those emotional resources into the present to be incorporated into daily life. If, for instance, symptoms of depression are encoded in the kinesthetic system, then hypnosis can be used to access positive emotional coping skills that have been encoded in the visual or auditory systems. A patient who *feels useless* can be encouraged to *see* times in their lives when they have been productive or *hear* words of praise from a co-worker or employer for a job well done.

B. Timeline Imaging Exercises

We encode our past memories and our future imagination differently. We can all tell the difference between a past memory and an imaginary future, but would be unable to describe how we do that. Usually, there is a difference in

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Neuro-linguistic Programming for Depression (cont'd)

how we visualize those experiences. Images of the past may appear to be behind us and images of an imaginary future may appear to be in front of us. That is where the expression "putting the past behind me" comes from.

One of my patients, a 30-year-old man who had been depressed for many years, encoded his past memories behind him and his imaginary future in front of him. However, there was a period in his mid-teens when he was involved in drugs and gangs. He was deeply ashamed of those events. Those memories had been encoded so that they appeared to be right in front of his face. Unconsciously, he was viewing his future through the filter of these shameful times. He was able to imagine putting the teen memories behind him, filing them away within the chronological order of his past experiences. As he did so, he started to smile for the first time. He continues to smile, his mood improved, and he concluded his psychotherapy treatment shortly after that.

C. Resolving Depressive Identities

Who we are includes many different identities. We are all sons or daughters. Some of us are parents. We may be doctors or psychotherapists. Each identity has a set of guiding beliefs and values that have been encoded over time. Those beliefs influence our capabilities. We will not be able to do something if we do not believe that we are capable. Therefore, beliefs can limit our capabilities. Our capabilities affect the behaviours that we are able to carry out. Those behaviours are carried out in a particular environment.

If symptoms of depression have been encoded as an identity—"I am useless, I'm a loser, I'm a failure, I am an alcoholic, I am a victim, and I am depressed"—then the associated beliefs will limit capabilities and affect behaviour. In this context, mood is a behaviour. Lack of motivation, low energy, hypersomnia, anorexia, and anhedonia are all physical/mental/emotional states that have a strong behavioural component. Changing an identity can be difficult. It can take a long time to create an identity. For example, it takes years of training to become a doctor. Therefore, it is much easier to treat symptoms of depression that are associated with an identity by encouraging change at a different level. An *alcoholic* can be encouraged to attend Alcoholics Anonymous. A *failure* can be encouraged to set up achievable outcomes. A *victim* can be taught to be empowered. It is much easier to treat symptoms of depression than to challenge the belief and identity that *I am* depressed. As the behaviours are practiced, then capabilities change, distorted beliefs are challenged and the identity evolves into something constructive.

Conclusion

NLP is a useful psychotherapeutic model for effecting change in patients who present with symptoms of depression. Many of the NLP treatment strategies are similar to Cognitive-Behavioural Therapy. Both techniques challenge the patient's language that is creating symptoms of depression and offer to teach constructive language patterns. Because NLP was developed by role-modelling Fritz Perls and Milton Erickson, many NLP techniques bear similarity to Gestalt Therapy and include hypnotherapy techniques.

A downside is that NLP has its own jargon, which can sometimes be difficult to comprehend for the patient and for clinicians who are unfamiliar with the model. Criticism has been levelled at the NLP model, because it is also applied by non-medical practitioners in non-clinical scenarios, such as personal growth and business. Despite these concerns, I believe NLP is a helpful therapeutic model. It is capable of quickly challenging core beliefs that have created long-standing symptoms of depression, particularly when hypnotherapy techniques are also applied.

Conflict of Interest: None

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Improve Your Practice

Emotional Styles

E. Janet Warren, MD, BSc, PhD, FCFP

Ever notice how some people recover from trauma with ease? Yet others take years to recover. Some are supremely sensitive to anything we say; others barely listen. Some are highly intuitive; others…a little "clued out." And then there's the clichéd "glass-half-empty" people. We've often attributed these differences to personality—that catch-all term that eludes definition. The term we all know but can't quite describe. The concept we know that does not excuse behavior, but which implies little hope of change.

Well, neuroscientist Richard Davidson (Davidson & Begley, 2012) has an alternative explanation to personality. His work is based on 30 years of research and was inspired by his graduate supervisor, Daniel Goleman (known for his innovations in emotional and social intelligence). Davidson suggests the concept of emotional style, defined as a constant and stable way that people respond to life experiences. Unlike personality, this correlates with specific brain circuits. Unlike personality, people can modify their emotional style (genetic contributions explain 20 to 60 percent). There are six styles and everyone falls somewhere on the spectrum of each. Those at either extreme are more likely to have difficulty coping in life.

1.Resilience: Speed of recovery from adversity

People respond to distress in varying manners. At one extreme, those with too much resilience may appear unfeeling or may lack motivation to make necessary changes. Towards the negative end are those who are miserable for hours after a minor argument. At the extreme negative end are those in whom moderate adversity provokes severe depression.

2. Outlook: Duration of ability to sustain positive emotion

This dimension complements resilience. Those who have a positive outlook on life also tend to be more resilient. They believe the next ten years will be better than the last. If they enjoy a party, the positive mood lasts all night. At extremes, they may deny negative experiences that may lead to growth. On the other end of the scale, those with a negative outlook will avoid social situations. And, even when they have a positive experience, their good mood fades quickly. At extremes, this manifests as depression.

3. **Social Intuition: Ability to perceive social signals**

People who score high on this scale will easily notice subtle emotional cues from another person and may notice themselves responding to someone else's distress based on their own intuition. This is a helpful ability for counsellors, but may lead to burnout. People at the other end of the spectrum are surprised when people express anger. Those with an extreme form of insensitivity often have an autism spectrum disorder.

4. Self-Awareness: Ability to perceive one's own emotions

Those with high self-awareness are very comfortable in their own body, able to express their emotions easily, and able to detect their own heartbeat. At an extreme, they may suffer from panic attacks or hypochondria, and are susceptible to burnout. People with low self-awareness are poor at heeding their body's messages. They're puzzled why someone would ask why they're angry or sad. At extremes, they may have difficulty with relationships and may ignore medical problems.

5. Sensitivity to Context: Ability to regulate emotional response according to circumstances

People at the upper end of this scale are often told that they have good manners. They are sensitive to other's feelings, talk and act differently in public versus in private settings, and easily recognize familiar people and places. Conversely, those at the lower end, are often told that their behaviour is socially inappropriate. They may be too chummy with their boss, they seldom filter what they say, and are usually unaware why people avoid them. Like social intuition, those with extreme insensitivity to context may fall in the autism spectrum.

6. Attention: Ability to focus clearly and easily

We are all familiar with those at the extreme low end of this dimension—usually diagnosed with Attention Deficit Disorder (ADD). However, people with high focusing abilities may be too detail oriented, and have problems seeing the "big picture."

Davidson has devised questions that evaluate people's emotional style on a scale of 1 to 10. Individual personality traits can be viewed as particular combinations of emotional styles. For example, shyness and sociability are part of the social intuition scale, emotionality falls under both the resilience and outlook dimensions, adaptability aligns with sensitivity to context, and impulsivity with attention.

Continued on Page 12

Emotional Styles (cont'd)

Davidson believes that a problem with psychiatric diagnosis is that the "tipping points" are arbitrary; for example, at what point in the attention scale do we diagnose ADD? Furthermore, DSM categories do not conform to how the brain works; for example, outlook is a factor in schizophrenia, mood and anxiety disorders, and addictions.

Davidson offers further detail on how emotional styles influence health, and suggests ways that we can improve our style. These include using visual imagery of good outcomes and practicing gratitude to boost positive outlook, mindfulness to increase self-awareness, and training in reading micro-expressions to increase social intuition.

Davidson's work is intriguing, although his ideas are not entirely new to therapists. We should note that there is overlap among the different dimensions and that the neuroscientific correlations have the same limitations of all neuroimaging research. Nevertheless, I believe consideration of emotional styles is useful for both assessment and treatment of all patients. I find this concept a helpful alternative or addition to traditional psychiatric diagnoses, which can be limiting and potentially judgmental. Instead of focusing on a "problem," I explain to patients that they are at one end of a continuum and can be helped to move a little further along. Attending to all the dimensions of emotional style improves my thoroughness and reminds me to look for areas of strength as well as weakness. Overall, I much prefer the idea of malleable emotional style to that of fixed personality. Give it a try: Davidson's work may improve your practice too!

Conflict of Interest: None

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Janet Warren is a Family Physician who practices psychotherapy part-time in Burlington, ON. She enjoys writing and is editor of the Medical Psychotherapy Review.

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THE ART OF PSYCHOTHERAPY

The MDPAC Conference—A Personal Narrative

Siobhán A. B. Conway-Hicks, MD, CCFP, MS, MA

I was honoured to receive a bursary to attend the MDPAC conference this year and, in return, I offer a reflection on my experience. A photo-essay essay was suggested; however, since I am not comfortable behind a camera, I have written some snap-shots in the spirit of the embodiment concepts of Gestalt and feminist theory. If you attend this travelogue slide-show, maybe your own memories and connections are stirred.

Thursday.
We leave Saskatoon in late evening. I walk home in the small town of Martensville after my last appointment of the day, which is a home visit for family therapy. Brian, Felix (our one-year old son), and I play a pow-wow travelling song on YouTube as we review our checklist and ready ourselves. We fly through the night, catching up with the sun early as we fly east. The sunshine brings the morning towards the west. All three of us sleep in a huddle on the plane.

Early Friday morning.
At a lobby desk, door behind us with bright sun shining in past windows and a revolving door. A staircase tucked close to the desk with carpeting leading down into a dark that is illuminated by electric light, the shamanic cave of transformational work. A smudging ceremony is happening in another part of the hotel. I stand with my partner who holds our son. We are weary after travelling through the night. We do not have a room booked for the right date. The three of us are off down the streets, past City Hall, alongside Osgoode Hall, past the TTC stop on Queen St, with the stroller and two suitcases, through the Sheridan parking lot and into another Hilton close by. Another manager recognizes how full our day has been already. He wishes us a happy day now that we are about to have our room and get back on track. He has supported us to reset and clear the palette, ready to switch from travelling to the day.

Friday morning.
A woman at a lectern. A banner hanging from the lectern with a triangle and three words printed: "mind," "body," and "spirit." Two projection screens in the background and a long dais table. On the screen, photographs.

A lineup at a mic, three people, one speaking into the mic, two behind, bodies leaning towards each other, faces open and smiling. Many large round tables in the background, another mic, all tables full of people seated. The people look engaged, interested, full of vitality, energetically present. Less Reichian body armouring in the musculature around eyes, jaws, shoulders, hips, than typical at an MD conference.

Friday lunch.
A close-up of a white plate, prosciutto draped on top of layers of food. A silver knife tucked underneath a pile of food, a fork balanced on the edge of the plate. In the background, a retired member of the community who has come to take part in the AGM over lunch. A second member with a look of concentration on her face, her nose has energy, as she detects cigarette smoke coming into the conference cave.

A display of books, books laid out on tables, short bookshelves at the back of the table holding more books. People gathered around. One speaking to another. Two holding books and reading. Another reaching out to a book on the table. In the background, another table holding papers, two people seated behind the table.

Friday afternoon.
In the bright sun, and held by the Toronto summer humidity, skin looking moist, two members sitting on a little wrought iron bench. One holds a cigarette, the other holds a teal-green e-cigarette contraption, blowing vapour and a third member leans in towards the vapour. Lush trees full of deep dark green leaves in the background, a car parked on the sidewalk, trunk open with suitcases on the ground of interlocking bricks.

Saturday Morning.
A picture of a notebook, blue lines horizontal across the red page, and a red line vertical. A silver metal spiral, three holes placed along the edge with the spiral. Blue ink writing as disordered as the lines are ordered. Amongst the writing an anarchy symbol, names, telephone numbers, email and website addresses, a proposed script for 40 mg propranolol p.o. one hour prior. A gentle oscillation wave superimposed on a spiky back and forth, with little fainter blue circles drawn at the spiky points and along the wave, with the words "fish oil" circled too. Pages more of cryptic conference graffiti.

Continued on Page 14

The MDPAC Conference—A Personal Narrative (cont'd)

Saturday afternoon.
An elevator, silk prints with oriental patterns of women and traditional floral dress and soothing colours. Four people in the shot, all close together, elevator doors opening, the indicator states in electronic glow that we are twenty stories into the sky.

A chair with a grey chiffon semi-permeable drape, people positioned around the chair. One on knees with chest on chair. Another sitting on ground with a trail of the shroud from the chair held to the throat. Another behind the chair back, various human beings at different distances and postures towards the chair. In the background, a man standing and watching on. Behind him, a projection screen with a PowerPoint displayed.

One week later.
Now, seated with weight on left bum, left elbow on round black dining room table, as hand writes in notebook placed on top of computer. A green large tea mug rests on a white dish with the remnants of plum. On the table a teal green e-cigarette contraption, artwork from last Wednesday's local Community Healing Initiative meeting with MD psychotherapists in the circle. Cell phone, keys, Parle-G crackers crumbled in a pile. Beige dental impressions in a Ziploc baggy. A small blue agenda with a blue elastic. A large, thinner black agenda book. Facing a window with a sliding door to a second floor balcony. Curtains billowing. Vast blue Saskatchewan sky, with scattered fluffy white clouds. Dining table chairs scattered about the room by my one-year old who is off to the park with his Daddy. Bedroom door banging rhythmically in its frame from the cross breeze. The sound of traffic on the highway from Saskatoon to Blaine Lake and farther north. Recalling the spirit work, the body work and the mind work of a gathering of MD Psychotherapists.

Conflict of Interest: none

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Siobhan Conway-Hicks lives in Saskatoon and plans to return to Ontario in the next couple of years. She practices Gestalt Psychotherapy, and was trained by the Gestalt Institute of Toronto.

Sunny Day Salute

Josée Labrosse, MD, MEd

Ahhh, Saturday.
Little Emma is busy playing with her stuffies while daddy holds the fort. Mommy slips into her room to practice yoga.
She is enjoying a really good Cat Stretch. Little Emma pats silently into the room and pounces lightly onto her mom's back.
Emma makes purring sounds as mother slowly arches up, and down, up and down.
"My little kitten, could you please go catch some mice. I want to practice."
Emma pitter pats with a meow out of the room.

Mom is in a Warrior pose. Emma bounds in with a stuffed mouse clenched between her teeth. She crawls under the leg tunnel, circling around before pouncing up to swing on an out-stretched arm.
"Please your Cat-ness, give me some peace and quiet. I am in mighty warrior mode!" Emma marches off, leaving the mouse behind.

Dancer is a beautiful balancing posture.
Emma tiptoes in wearing her ears and tail from the musical they had seen.
She runs and leaps to touch her mommy's hand. "Higher mommy, higher. I'm Mr. Mistoffelees, and I can leap *very* high."
"Mistress M., please leap your way back to the playroom for a while." Mommy notices a slight hissing in her voice.

She re-kindles her inner smile and moves into Full Wheel. Emma skips in singing, slips under the bridge, then scales up her mom's legs to perch on top. "Oooff! Offff! " Mommy coughs, and begins to slowly collapse.
Emma sings merrily: "London Bridge is falling down…"

Mother moves into Tree Pose, but loses her balance as Emma starts to climb up. She decides to do Mountain instead, and stays solid as Emma scales her to perch on her shoulders.
Peace mountain is starting to crumble, so she swings Emma down. "Okay, Em, I'm going to light my candle, say 'Om' and make a wish."

Emma eagerly sits cross-legged across from her mom.
She stretches her arms out straight, rests her hands on her knees with palms up, and closes her eyes.
Mom fondly gazes at Emma. The little one takes a deep breath in…and out, in and out, then says in a clear and solemn voice:
"Let there be love in my heart, and peace in the world, and…

"LET US PLAY!"

Conflict of Interest: None

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Josée Labrosse is a physician-therapist who practices at the River House, an integrative centre in Ottawa. She incorporates mindfulness and reflective practice, connection with nature, and principles of coaching in her work with individuals and organizations.

MDPAC MATTERS

Members In The News

Daniel McBain, MD, CCFP, CGPP

Dr. Roy Salole: Honorary Membership
At the 29th Annual General Meeting of the General Practice Psychotherapy Association held in Toronto on May 28, 2016, now-retired veteran Medical Psychotherapist Dr Roy Salole received, in absentia, an Honorary Membership. In nominating Dr Salole for Honorary Membership, Dr Joan E. Barr praised his years of contribution to the General Practice Psychotherapy Association until he retired in 2009.

Dr Salole took a leadership role in the development of the original Position Paper on the role of Psychotherapy in Medicine in the mid-1990s. At that time, the Ontario Ministry of Health (MOH) was discussing delisting psychotherapy from the General Practice fee schedule. Dr Salole was a leading figure in helping reverse that MOH decision, in large part through the publication of *The Role of Psychotherapy in Primary Care* and *Guidelines for Training in Medical Psychotherapy,* both in 1996. (Those seminal publications were later followed by *Recommendations for Training in Medical Psychotherapy for Non-Psychiatrist Physicians* in 2004.)

Dr Salole was very politically minded, monitoring MOH activities and developing alternatives to the Ministry's often short-sighted positions. Along with several other leading GPPA members, he spearheaded the creation of the OMA Section on GP Psychotherapy, selling the importance of Medical Psychotherapy in his wise and articulate manner. For many of the initial years of the GPP Section, Dr Salole served as its Chair.

As a member of the GPPA Professional Development Committee during the late 1990s, Dr Salole proved an enthusiastic and influential proponent of member education. He was adept at teaching, providing informed content via an effective experiential learning style while creating a supportive learning environment. Between 1998 and 2001, Dr Salole led the new GPPA initiative to provide educational support for members outside the GTA in a series of four-weekend courses held in rural locales. Subsequently, from 2001 to 2009, he was enthusiastic in teaching two of the six *Basic Skills Core Curriculum Courses.* Dr Salole's contributions to the field also included mentoring Medical Psychotherapists, many of whom are practising today.

Dr Barr, in her presentation of Dr Salole's Honorary Membership at the Annual General Meeting, made a moving address, citing her own good fortune in working closely with Dr Salole in the GPPA over close to 20 years. She then went on to propose the following acronym describing some of his outstanding qualities:

ROY SALOLE:
R: Resourceful, Respectful, Rigorous
O: Organized
Y: Yet more words—Wise, Politically astute, Mentor
S: Supervisor, Salient, Serious, Sharing
A: Attuned, Attentive, Accepting, Articulate, Adept
L: Listener, Leader
O: Observant
L: Learning guru
E: Expressive, Enthusiastic, Experienced, Excels, Educator

Past and present members of Medical Psychotherapy Association Canada, along with the innumerable Canadian patients who have achieved greater mental wellbeing through the assistance of a non-Psychiatrist psychotherapist, are all direct or indirect beneficiaries of Dr Salole's devotion to Medical Psychotherapy.

Excellence in Continuing Education Award: Five-Weekend Program in Counselling and Psychotherapy in Family Medicine
This April, the Professional Development Program Awards Committee of the Department of Family and Community Medicine at the University of Toronto honoured the Five-Weekend Program in Counselling and Psychotherapy in Family Medicine with the 2015 - 2016 Professional Development Program Award in the category of *Excellence in Continuing Education.* Sharing the award were Mel Borins, MD MGPPA, Stephen Holzapfel, MD, Vince Poon, MD, Ginny McFarlane, MD, CGPPA, and Ed Bader, Registered Family Therapist. Dr Borins has been Course Director since 1997.

In the mid 1990s a subgroup of The Working with Families Institute of the Department of Family and Community Medicine, University of Toronto, identified the need for training in counselling and psychotherapy skills to both family medicine residents and family physicians in community practice. A working group of Ed Bader, Fred Tudiver, Stephen Holzapfel, Mary Pat Tillmann, and Mel Borins met

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Members in the News (cont'd)

together over many months to design the Five-Weekend Course. The group shared a vision of a skill-based, experiential course, using a small-group, interactive format. Rather than psychiatrist teachers, the Program has always relied on family physicians who understand the challenges faced in primary care.

The course is an eclectic sampler of a variety of psychotherapeutic modalities, with the expectation that physicians identify modalities they find useful, leading them to pursue further training after completing the course. Students encounter solution-focused techniques, cognitive behaviour therapy, mindfulness, relaxation skills, and couples counselling, as well as approaches to sex therapy, addictions, grief counselling, and self-care.

The course takes into account differing learning aptitudes, offering traditional didactic lectures while also honouring visual and auditory styles, ensuring interactive experiential training opportunities, and providing handouts that include key articles. Participants routinely express appreciation for the Program's "hands-on" interactive skill transfer, with small-group practice for immediate feedback. The five blocks of intensive training are supplemented by mentoring sessions between weekends, creating an ongoing longitudinal experience extending from September until June.

Research based on evaluations and questionnaires at three stages—course beginning, course end, and again at six months post-completion—confirms that physicians' confidence and competence increase, that graduating participants offer their patients more counselling and psychotherapy than before taking the course, and that they feel less isolated in their own practices. Of the hundreds of participants to date, many have gone on to be members of the GPPA (now MDPAC).

Award-winning educators Mel Borins, Stephen Holzapfel, Ginny McFarlane, Vince Poon, and Ed Bader all attest that offering the Five-Weekend Program in Counselling and Psychotherapy in Family Medicine has been a rewarding, inspirational experience.

The course will be offered again starting in September, 2017. If you would like further information go to http://www.cpd.utoronto.ca/cpfm/

Conflicts of Interest: None

Contact: doc@danielmcbain.ca

Daniel McBain resides in Kamloops. He has been providing psychotherapy to Ontario patients through Telemedicine since 2010.

(L - R) Ginny McFarlane, MD CGPPA, Ed Bader M.A., Mel Borins, MD, MGP-PA,

Graduating Class of 1999
Front (L - R): Stephen Holzapfel, MD, Ed Bader M.A., Mary Pat Tillmann, MD, Mel Borins, MD, MGPPA

Report from the MDPAC Board of Directors

Catherine Low, MD, MDPAC(C)

Rebranding the Medical Psychotherapy Association Canada

The first Annual General Meeting of the MDPAC (Medical Psychotherapy Association Canada) took place on May 27, 2016 during our annual education conference. This was the place of the unveiling of our new logo. Watch for a brand new look for our Journal in the next issue. Plans to redesign and relaunch our website are currently underway, as well.

The Fifth Annual MDPAC Retreat

This retreat will take place the weekend of November 4–6, 2016 at Geneva Park. The theme is "Strengthening Resilience with Mindfulness and Self Compassion." There may still be spots available for this very popular event. Contact Carol Ford for further details.

Peer Assessment Handbook Review at the CPSO

An Ad Hoc Committee was formed to draft a reply to the CPSO's request for input on the Peer Assessment Handbook that has been undergoing review at the College over the past four years. The committee produced an excellent summary of comments and suggestions made by the membership at large as well as those who posted comments on the Listserv. These comments were used as the basis of a very impactful report authored by Stephen Sutherland, Barbara Kawa, Stephen Fowler, and Muriel van Lierop. The report was submitted to the CPSO on June 17, 2016.

Third Pathway Status at the CPSO

MDPAC will be making a third and final presentation to the CPSO's Education Committee on September 12, 2016 at the CPSO offices in Toronto. The presentation will be made by Andrew Toplack, Stephen Sutherland, and Muriel van Lierop. In this third year the CPSO has asked MDPAC to make a formal re application to be granted ongoing status as the Third Pathway for recording educational credits in order to maintain a licence to practice medicine in Ontario. This report was prepared over the summer by the joint efforts of the members of the CPSO/ CPD Committee, the PDC Committee, and the Membership Committee.

Core Essentials in Primary Care Medical Psychotherapy Committee

The committee plans to offer two four-day intensive courses in the core essentials of medical psychotherapy. The first course will cover approximately 30 hours of Main Pro Plus educational credits and will be held in June 2017 on the campus of U of T's Erindale College. There is a maximum of 30 participants allowed for this course so be sure and sign up soon if you want to attend.

Outside of Ontario Members Meetings

Over the past year, MDPAC has hosted four meetings to address the interests and concerns of our members from outside of Ontario. Three of the meetings took place using the web platform GoToMeeting. They were held on January 11, 2016, March 28, 2016 and June 9, 2016. The fourth meeting was a face-to-face meeting that took place on May 28, 2016 during our annual conference. These meetings were well received and the source of lots of lively discussion. A fifth one is scheduled this fall.

Conflict of Interest: none

Contact: mclow98@gmail.com

Catherine Low, the current chair of the board, has been a member of the GPPA/ MDPAC since 1996 and involved in committee work since 2007. Her medical practice began in Scarborough with an interest in women's health, and continued in Ottawa where work with immigrant women led to her interest in psychotherapy. She currently practices full-time psychotherapy in Ottawa.

MDPAC Theratree Recipient

MDPAC 2016 THERATREE AWARD RECIPIENT

The MDPAC Board of Directors
was pleased to present
the 2016 Theratree Award to
Dr. Helen Newman
at the 2016 MDPAC Conference.

(Left to Right: Dr. Brian McDermid, Dr. Helen Newman, Dr. Catherine Low)

MDPAC ACPMD
MEDICAL PSYCHOTHERAPY ASSOCIATION CANADA
ASSOCIATION CANADIENNE DE PSYCHOTHÉRAPIE MÉDICALE

Medical Psychotherapy Review

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Whom to Contact at the MDPAC

Journal – to submit an article or comments,
e-mail Janet Warren at journal@gppaonline.ca

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

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

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

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

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

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The MDPAC publishes the Medical Psychotherapy Review three times a year. Submissions are accepted up to the following dates:
Spring Issue - February 1
Fall Issue - June 1
Winter Issue - October 1

For letters and articles submitted, the editor reserves the right to edit content for the purpose of clarity. Please submit articles to:
journal@gppaonline.ca

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