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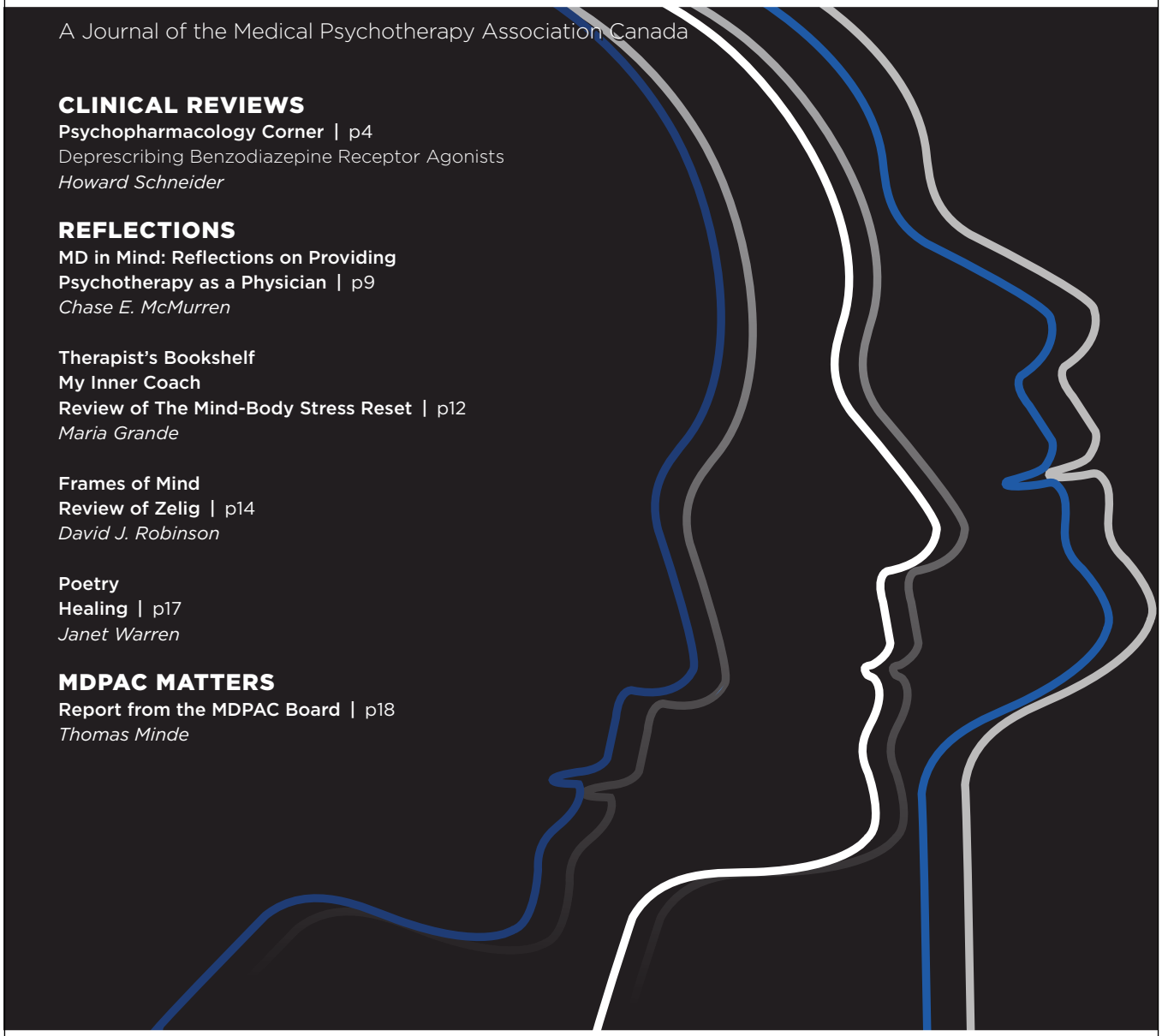

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ALL THE WORLD'S A STAGE, AND ALL THE MEN AND WOMEN MERELY PLAYERS; THEY HAVE THEIR EXITS AND THEIR ENTRANCES, AND ONE MAN IN HIS TIME PLAYS MANY PARTS

Shakespeare, As You Like It

Admittedly, some Shakespearean verses are overquoted, but this one seems appropriate for the current issue of the *Medical Psychotherapy Review.* With the pandemic malignantly lingering, and much of our work continuing virtually, we are perhaps more conscious of being "on stage" than ever before. (The stage being the OTN platform of course.) Also, since we are working from home, we may feel our "exits" are limited.

But the metaphor I want to focus on is "playing many parts." As physicians who practice psychotherapy, we have dual—or multiple—roles and perspectives. These often overlap.

In common with all physicians, we may prescribe medication and give nutritional advice. But uniquely, we may use specific psychotherapeutic techniques and spend more time listening than talking. My poem is about emotional connection and expression, but trust me I deal with cognitions and behaviour as well. As well as counseling, I play a "part" as writer and editor. (You may be relieved to know that I don't care whether patients are grammatically correct or not.)
The varying roles of physicians are discussed by Chase McMurren in his article "MD in Mind." He reflects on some of the differences between practicing "regular" medicine and practicing psychotherapy. In the first, a physician may be primarily a problem solver; in the second, patients are viewed as experts, and the physician walks alongside them. It is always beneficial to reflect on what we do and why we do it. And, as mentioned in previous issues of our journal, whether we "play a part" in prescribing medication or not, all physicians need to be knowledgeable about it. In his column, *Psychopharmacology Corner,* Howard Schneider offers helpful guidance on a very important and timely topic: Deprescribing Benzodiazepine Receptor Agonists. He also suggests that they may not always need to be deprescribed.

And of course, our patients also "play many parts." Indeed, some people coped with trauma by becoming multiple different parts. To

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.

a lesser degree, all of us are a complex blend of mind/brain, cognitions/emotions/behaviour, helpful/harmful, mad/bad/sad etc. These "parts" enter and exit the stage sometimes unpredictably. The movie, Zelig, reviewed by Dave Robinson, offers an extreme example of this. It depicts an intriguing chameleon-like character who, having no sense of self with its dualities, takes on the personas of other people. Robinson also discusses some amusing stereotypes of psychiatrists as portrayed in film.

Another example of dualism relates to the mind/body relationship. In her review of *The Mind-Body Stress Reset,* Maria Grande discusses a topic often mentioned in the pages of this journal. This book offers a helpful approach to improve mental health using somatic techniques. My poem, "Healing," does not address mind/body matters but perhaps speaks to the emotional/cognitive disconnect that is common in trauma sufferers. Without necessarily having conscious intent, these patients often put on an act that all is well. One role of psychotherapists is to help our patients increase their awareness of the different parts they play, as well as when entrances and exits are appropriate.

And, returning to the multiple roles that physicians have, the new chair of the MDPAC board, Thomas Minde, reports on all the parts played by members of our association. There is much good work that is being done, and many educational activities coming up for members who wish to improve their skills "on stage."

Finally, all "players" "have their exits." After six years (and 15 issues) as editor of the MPR, I must now take mine. A big thanks to all who have worked with me as writers and as committee members!

Happy reading—I hope the journal is "as you like it"

Grace and peace,
Janet Warren

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Deprescribing Benzodiazepine Receptor Agonists

Howard Schneider, MD, MDPAC(C), CCFP, FCFP

Abstract

More than one in ten of the Canadian adult population is using prescription benzodiazepines or non-benzodiazepine Z-drugs (benzodiazepine receptor agonists). Usage rates are actually highest in patients over 65 years old, especially for the treatment of insomnia. Use of benzodiazepine receptor agonists in the elderly is associated with a five-fold increase in adverse cognitive effects and large increases in falls. However, in contrast, cognitive behavioral therapy for insomnia (CBT-I) can actually improve sleep more than benzodiazepines or Z-drugs. Thus, this article reviews deprescribing benzodiazepine receptor agonists in one's practice. In addition, another viewpoint is considered, that benzodiazepines can indeed be advantageous agents for some patients, particularly if there is no history of substance abuse and for certain disorders, for example, significant anxiety disorders.

Benzodiazepines can be very Advantageous. Deprescribe Benzodiazepines!

Since the dawn of history, humans have tried to alleviate worries and more generalized anxieties with a myriad of concoctions. In what was considered a new fast-paced era of the steam engine in the 1800s there was widespread "neurasthenia" (anxious mood, fatigue, various physical symptoms; Lee et al, 2017; Conis, 2008). Barbiturates were first synthesized in the early 1900s (Fischer & von Mering, 1903) and soon were being used for anxiety and insomnia related issues. However, barbiturates depressed the brain excessively and carried a high risk of overdose. In the 1950s, Ludwig and Piech (1951) synthesized meprobamate which helped anxiety but did not have as large a risk of CNS depression and overdose as barbiturates did. By 1957, meprobamate, marketed as Miltown, accounted for one third of all prescriptions in the USA (Dokoupil, 2009).

Chlordiazepoxide was the first benzodiazepine synthesized and was marketed in 1960 as Librium. Diazepam, marketed as Valium, appeared in 1963. Benzodiazepines were much safer medications than their predecessors and worked well in alleviating worries and anxiety. Diazepam rapidly became the top prescription in the USA for more than a decade. It even ended up in a Rolling Stones song as "mother's little helper" (Conis, 2008). However, reports of benzodiazepine's addictive potential started emerging. The 1982 film "I'm Dancing as Fast as I Can," depicts a filmmaker's addiction to diazepam. That year, diazepam lost its status as the most prescribed medication (overtaken by the peptic ulcer medication cimetidine).

If we fast forward some four decades to the present, physicians are constantly advised to prescribe benzodiazepines carefully, or even better, to deprescribe them. In 2018, the *Canadian Family Physician* published evidence-based clinical practice guidelines to deprescribe benzodiazepines (Pottie et al., 2018). In 2019, the Centre for Effective Practice, in collaboration with the Government of Ontario, the Ontario College of Family Physicians and the Nurse Practitioners' Association of Ontario released a tool entitled "Managing Benzodiazepine Use in Older Adults" (Centre for Effective Practice, 2019). A 2021 article from the North York General Hospital Family Health Team associated with the University of Toronto described a "pharmacist-led sedative-hypnotic deprescribing in team-based primary care practice" (Lui et al., 2021).

As the title implies, this article reviews deprescribing benzodiazepines and related compounds. However, before we reflexively go down this path, as medical psychotherapists we have the advantage of knowing our patients well. Generally, if it is possible not to prescribe (or deprescribe) benzodiazepines then that is preferable. However, benzodiazepines for certain patients can be advantageous psychopharmacological agents. Thus, before reviewing deprescribing, we will consider possible advantageous uses of benzodiazepines.

Advantageous Use of Benzodiazepines

For the correct patient with low risks of dependency, such as those with a number of anxiety conditions in which symptoms can be debilitating, benzodiazepines can be advantageous. The International Task Force on Benzodiazepines notes 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 eight weeks of treatment, 90% of patients treated with clonazepam had cessation of panic attacks versus 82% of those treated with paroxetine. At three years of treatment, the group receiving clonazepam had fewer panic attacks and fewer adverse medication effects than the paroxetine group (Nardi et al., 2012). Silberman and colleagues (2020) reinforce this point. They

think the field of psychiatry has become biased against benzodiazepines to the point of not following clinical evidence. Further, benzodiazepine abuse tends to occur in patients who are abusing other substances. In a recent editorial, the authors suggest that "we should not deprive our patients of efficacious and well tolerated medications because of historical mishaps, personal and specialty biases…." (Balon et al., 2020, p. 244)

As noted above, it is preferable not to prescribe benzodiazepines. However, if clinicians know their patients well, then benzodiazepines for certain people with debilitating symptoms, such as in the case of panic disorder discussed above, can remain a viable treatment option. This is not the same as chronically prescribing benzodiazepines to a patient with small worries, or to a patient with substance abuse risks. As well, evidence-based first line treatments should still be generally first attempted. For example, in my recent article on panic disorder (Schneider, 2020), the first-line psychopharmacological approach is not a benzodiazepine but rather a number of selective serotonin reuptake inhibitor (SSRI) or serotonin and norepinephrine reuptake inhibitor (SNRI) options.

For patients with very complex cases, the taboo against benzodiazepines may not be appropriate either. Many of the clinical cases reported by Stephen Stahl (2011), some of which were featured in previous *Psychopharmacology Corner* articles, involved treatment with a benzodiazepine, albeit, in combination with other medication classes such as antidepressants and antipsychotics. In all these cases, the patients were well evaluated, and risks versus benefits were considered.

Deprescribing Benzodiazepine Receptor Agonists

Benzodiazepine receptor agonists (BZRA) include the benzodiazepines and the non-benzodiazepine "Z-drugs." The latter include zaleplon, zolpidem, zopiclone, and eszopiclone.

Sarangi and colleagues (2021) note that benzodiazepines were the most abused drugs in the 1970s. They note that as the decades have gone by, the use of benzodiazepines has remained high, with some 13% of the USA adult population using benzodiazepines in 2016. Lui and colleagues (2021) note that in 2019 some 12% of the Canadian adult population used prescription benzodiazepines or Z-drugs.

There are many patients who should not be using benzodiazepine receptor agonists on a chronic basis because these agents do not represent optimal medical care for them. Lui and colleagues (2021) note that benzodiazepine and Z-drug usage rates were highest in patients over 65 years old, and often the agents were being used chronically to treat insomnia. In this elderly group, chronic use of sedative-hypnotic medications correlates with an approximately five-fold (i.e., 500% times original value) increase in cognitive adverse effects and large increases in falls, hip fractures, and hospital admissions from motor vehicle collisions. Therefore, we will focus more on deprescribing benzodiazepine receptor agonists in the elderly, while acknowledging that there are other groups at risk of BZRA adverse effects for whom deprescribing benzodiazepines and Z-drugs should be considered (for example, patients where a psychotherapeutic intervention would be more appropriate, or patients with a history of drug or alcohol abuse where there will be a greater chance of chronic abuse of benzodiazepines) and for whom elements of these strategies can be employed.

The Centre for Effective Practice was created in 2004 as part of the University of Toronto's Department of Family and Community Medicine. As noted above, this organization developed guidelines for managing benzodiazepines in older adults. We will consider this tool ("CEP Guidelines") in detail now.

Like Lui and colleagues (2021), the CEP Guidelines note that all benzodiazepines increase the risks of cognitive impairment, delirium, falls, fractures and motor vehicle accidents in the elderly. They recommend discussing the use of benzodiazepines with all patients 65 years or over, or when a patient presents with new cognitive issues, had a recent fall, notes difficulty driving, is starting to increase use of medication, has another substance abuse issue, or has a possible benzodiazepine abuse disorder.

If it is decided, ideally in a collaborative fashion with the patient, that benzodiazepines no longer are advantageous for the patient, then the patient's benzodiazepines should be tapered. The patient should be made aware that they have control of this process. The goal of discontinuing the benzodiazepine should be discussed but so should a lowest possible dose—a decrease in dosage "is a still a win" (CEP Guidelines).

If the patient has been using the benzodiazepine for less than three weeks, then the CEP Guidelines allow discontinuation without tapering, although the physician should

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be aware of the half life of the benzodiazepine the patient is using and clinical issues specific to the patient. If someone is taking more than the equivalent of 60mg of diazepam daily, or has had serious withdrawal reactions in the past, the CEP Guidelines advise hospitalization during acute tapering.

Scheduled doses are preferred; i.e., establish the dosing interval, rather than prn doses. For patients over 65 years old, a slow taper is recommended. Begin with a 25% reduction in benzodiazepine dosage every two weeks and, as the end of the taper approaches, reduce by 12.5% every two weeks. Discuss the plan with the patient's pharmacist and seek assistance with formulations that will help with the tapering schedule. If withdrawal symptoms become problematic it is okay to maintain a current dose for another two weeks before the next dose reduction. Also, a slower taper rate of 10% every two weeks can be considered. This should also be considered for patients using benzodiazepines for panic disorder.

For patients tapering alprazolam, the CEP Guidelines recommend tapering no more than 0.25mg per week. If patients are taking doses of alprazolam greater than 4mg/day, then the guidelines recommend a slow taper of 0.5mg every 2–3 weeks until at 2mg/day, and then reducing the taper to 0.25mg every 2–3 weeks.

A switch to a long-acting benzodiazepine (e.g., diazepam, clonazepam) can be considered, but the CEP Guidelines note that this is not proven to reduce the incidence of withdrawal symptoms or increase the success rate, although they then note that the long-acting benzodiazepines create fewer rebound symptoms. They recommend that after switching to long-acting benzodiazepines, there should be a delay of two months before tapering begins. Tapering of diazepam should be a maximum of 5mg/week or clonazepam a maximum of 0.25mg/week. Once the dose gets below the equivalent of 20mg diazepam, tapering should be slowed down.

The CEP Guidelines note that other pharmacological agents have limited evidence for helping the tapering success. However, adjunctive cognitive behaviour therapy (CBT) has evidence of helping patients to discontinue benzodiazepines.

Common withdrawal symptoms include rebound anxiety, worsening of panic disorder, rebound insomnia, irritability, sweating, chills, tremors, and dizziness. Severe withdrawal symptoms, such as agitation, confusion, disorientation, delirium, and seizures, generally do not occur with tapering but can occur if a high dosage of benzodiazepines is stopped without tapering or if the patient has risk factors for seizures.

There are no medications approved for the treatment of mild withdrawal symptoms. The first step should be to pause and then slow the taper. However, the CEP Guidelines discuss some off-label solutions. For sweating, the patient should drink enough, and a trial of short term, oxybutynin can be tried. For abdominal cramps with adequate blood pressure, a small dose of clonidine can be tried. For nausea and vomiting, the following are recommended: dimenhydrinate, prochlorperazine, haloperidol (albeit 0.5mg), or metoclopramide. For rebound anxiety disorders, including panic disorder, the CEP Guidelines provide an entire section recommending alternatives to benzodiazepines (also see Schneider, 2020). Pharmacological measures include SSRIs such as escitalopram or sertraline, SNRIs such as venlafaxine ER or duloxetine, or pregabalin. The CEP Guidelines provide lists of nonpharmacological measures: CBT, progressive muscle relaxation, supportive psychotherapy (lower evidence level), or physical activity (lower evidence level).

The CEP Guidelines note that Z-drugs have adverse events very similar to benzodiazepines in older patients—delirium, falls, fractures, daytime sedation, increased motor vehicle accidents, and risk of physical tolerance and dependence. However, Stahl (2017) writing about zopiclone, notes it does not seem to cause as much dependence in patients with no history of substance abuse problems.

The CEP Guidelines recommend tapering Z-drugs by 50% every week until the lowest commercially available dosage is reached. Then the patient should take it every second day, then use it on a prn basis. The last step in the tapering is to stop use completely.

Alternatives to Benzodiazepine Receptor Agonists

The CEP Guidelines provide psychopharmacological alternatives to benzodiazepines or Z-drugs for insomnia. Many of these have been covered in a previous *Psychopharmacology Corner* article (Schneider & Shaw, 2017b). Examples of these alternative medications for sleep, are low dose doxepin and trazodone. However, anticholinergic effects may occur with doxepin as doses are raised, and the total sleep time is only improved by 12 minutes (3mg doxepin dosage). Evidence for trazodone for insomnia is not established. Melatonin only improves sleep total time by 8 minutes, with a decrease in sleep onset latency of 7 minutes on average. However, the risks

of physical tolerance or dependence are minimal with doxepin, trazodone, or melatonin.

The CEP Guidelines do not discuss newer medications such as the orexin receptor antagonist lemborexant, approved for use in Canada in 2021. Rosenberg and colleagues (2019) showed that lemborexant was more efficacious than zolpidem with regard to sleep onset and sleep maintenance. Of particular interest, 45% of the total participants (n=1006) were over 65 years old in this study. Liu (2020) reviews treatments for insomnia and notes that the orexin inhibitors suvorexant and lemborexant may have less risk for the development of dependence.

For insomnia, the CEP Guidelines note that cognitive behavioural therapy for insomnia (CBT-I) is more effective than pharmacological therapy. Schneider and Shaw (2017a) discuss CBT-I in detail and reference Glovinsky and Spielman (2006)—a dated, but readable and actionable reference. Their book *The Insomnia Answer* was intended for a lay readership, so can serve as a modest cost, external reading resource for motivated patients. More recent CBT-I as well as general insomnia resources are included at the end of the CEP Guidelines (2019). Schneider and Shaw (2017a) made the following treatment plan for a hypothetical patient:

Psychotherapy (CBT and supportive psychotherapy) for depression and anxiety.

CBT-I Sleep Hygiene and Environment Improvement

CBT-I Stimulus Control

CBT-I Relaxation Training

CBT-I Sleep Restriction

CBT-I Cognitive Therapy

Conclusion

Some 12% of the Canadian adult population was using prescription benzodiazepines or non-benzodiazepine Z-drugs (both being benzodiazepine receptor agonists) in 2019. Usage rates are actually highest in patients over 65 years old, especially for the treatment of insomnia. Use of benzodiazepine receptor agonists in the elderly is associated with a five-fold increase of adverse cognitive effects, and large increases in injuries. However, CBT-I can actually improve sleep more than benzodiazepines or Z-drugs. Therefore, this article reviewed deprescribing benzodiazepine receptor agonists. In addition, we considered that benzodiazepines can indeed be advantageous agents for some patients.

Conflict of Interest: None

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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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Keeping Our MD in Mind: Reflections on Providing Psychotherapy as a Physician

Chase Everett McMurren, MD, CCFP, MDPAC(C)

It is difficult to hide an "MD" (or equivalent, like MBBS). I recently shared my concerns with a Medical Advisor for the College of Physicians and Surgeons of Ontario about "lumping" medical psychotherapists in with family physicians when it comes to certain policies. In the conversation, the idea that people who receive our care will see us as physicians even if we're not practicing a particular type of medicine arose. It left me wondering how I relate to being a physician who provides psychotherapy.

I often reflect: Do other medical psychotherapists experience their physician status as a blessing or curse? Or neither? A bit of both? When they provide psychotherapy, how aware are they that they're a physician (in addition to being a human witnessing suffering?) How does being a physician shape their way of being and seeing the people they support?

Imagining the varied practices of members of MDPAC fascinates me as I contemplate the variability in style and understanding. How many people/patients do physician-therapists see a day? How long are the sessions? How many MDPAC members rule out "organic etiologies" on their own through physical examination and arranging for "bloodwork"? How many prescribe psychotropic medications? How many physicians see their own therapists, and how often?

The *MDPAC Guidelines for the Practice of Psychotherapy by Physicians* (2017, p. 18) offers several definitions that I've found helpful in reconciling my identities as a doctor. One definition states that "physician psychotherapy is the deliberate establishment by licensed physicians of a professional relationship with patients for the purpose of communication and collaboration to address potential or actual health-impacting problems." This definition is compatible with my evolving understanding that healers don't heal; instead, they support the safe and nourishing context in which a person suffering can heal themselves.

Another definition states:

> Medical psychotherapy always entails continuing medical diagnostic evaluation and responsibility and may be carried out in conjunction with drug and other physical treatments. Medical psychotherapy recognizes that the psychological and physical components of an illness are intertwined and that at any point in the disease process, psychological symptoms may give rise to, substitute for, or run concurrently with physical symptoms and vice versa.

The first part of Katz's definition makes me think twice about my "MD hat" in the role of psychotherapist and how it differs from non-physician colleagues. "Continuing medical diagnostic evaluation and responsibility" seems interventional and perhaps even paternalistic in contrast to some psychotherapeutic modalities that emphasize nonviolence. Rob Fisher, a Hakomi therapist, suggests that

> when a therapist insists on his or her interpretation and causes client resistance, this is an act of therapeutic violence. Imposing an agenda regarding the direction of a session, preferring a feeling over a defense, or giving a client advice are all common acts of therapeutic violence (Fisher, 2002, p. 6).

In my medical training, the goal seemed to be to have enough knowledge and experience to give advice with confidence. In contrast, in my psychotherapy training, the focus landed on being skillfully present without trying to force or finagle a particular feeling or outcome. I am reminded of a quotation by Salvador Minuchin, a psychiatrist who developed a form of family therapy:

> As a physician I was trained to take over, to become a leader, and to take responsibility. As a therapist I also had to learn the language of silence, to learn how to become invisible, to learn how not to intrude and at the same time, to be central. Achieving a centrality that can get people's attention without being so intrusive that you take too much responsibility, is essential in the process of therapy (as quoted by Kurtz, 2018, p. 237).

In each psychotherapeutic modality, the role and stance of the therapist varies, even before we consider the one-of-a-kind quality that each person-as-therapist brings to their practice (and that is before the quality is transformed by the unique impact of the particular person they're supporting!). This has me curious about how our MD (or equivalent designation) shapes how we approach our therapeutic practice and how the people we support see us.

Having an MD after my name is an immense privilege, and I acknowledge that.

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Keeping Our MD in Mind: Reflections on Providing Psychotherapy as a Physician | continued

Increasingly, I have found that exploring the meaning of my MD with people/patients when it comes up has been illuminating and seemingly therapeutic. Some people/patients seem to not realize or recall that I am a physician (despite previous discussion), while others are not bashful in bringing up physical health issues, hoping I might weigh in and save them the hassle of seeing their primary care practitioner.

The reality that a physician providing psychotherapy remains a physician has me wondering how the people we support understand our designation as doctors. At the same time, I am curious about how to navigate the temptation for a Cartesian-like split between medical psychotherapy and other medical care where physical issues are deferred back to primary care practitioners, not unlike a hot potato.

When I consider the intensity and investment involved in psychoanalytic training and many other specialized psychotherapy training programs, part of me is alarmed by the lack of training in psychotherapy physicians receive (in standard medical school and residency programs). Clarifying the scope and skills of a physician providing medical psychotherapy feels increasingly important as funding is threatened.

Earlier this year, I received my designation as a Certificant of the Medical Psychotherapy Association Canada. The process of applying offered some comfort in acknowledging the deliberate efforts I had made to become more skillful in psychotherapy. It also helped me contemplate the unique, perhaps at times contradictory, role we play as both physician and psychotherapist in our work with people seeking support. One way I've begun to embrace and integrate both the biomedical model and a nonviolent way of supporting has been through an updated Memorandum of Understanding that guides a person's orientation to my practice. (Of note, memorandum translates from the Latin as "something to be brought to mind.")

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Carefully, consciously understanding our unique role as physician-psychotherapists can offer space for our own self-discovery and healing and can also reduce the risk of harm that comes from unchecked power dynamics inherent within the doctor-patient frame. I often find myself leaning on the wisdom of Mr. Rogers (2018), and in this case, his belief that "Whatever is mentionable can be more manageable," comes to mind. If we choose to acknowledge our MD and explore its meaning with the people we support, then there is a possibility for reducing unspoken misunderstandings and assumptions. Celebrating the path we've each traveled to find ourselves offering psychotherapy and considering the ways we can both acknowledge and use our status as medical professionals while also mitigating the risks of mistrust and misunderstanding creates an opportunity to support healing in a remarkable way.

Conflict of Interest: None

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My Inner Coach
A review of *The Mind-Body Stress Reset: Somatic Practices to Reduce Overwhelm and Increase Well Being*
Rebekka LaDyne, MS, SEP
New Harbinger publications, Inc., 2020
183 pp; $25.95, soft cover

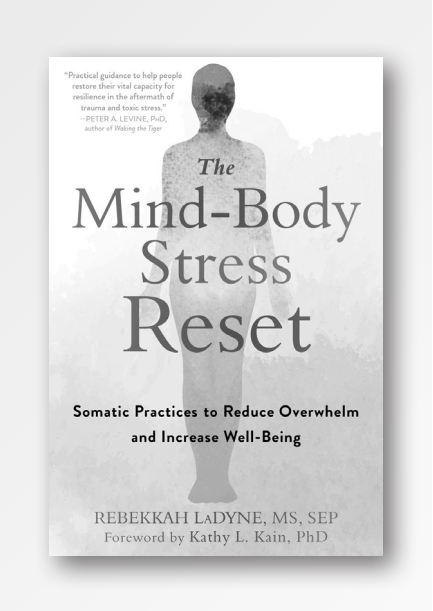
Maria Grande, MD

"Our body records and remembers stress reactions viscerally, while our mind tells the story through words and mental images" (p. 18).

In a recent conversation with Tara Tucker, MD, who has a focused practice in grief and trauma counselling, she mentioned a book that she routinely recommends to her clients: *The Mind-Body Stress Reset*. Given that I have had training in Mindfulness-Based Cognitive Therapy, and have experienced significant trauma, loss and recovery following a 2015 car malfunction, she wondered what my opinion as a psychotherapist and a patient would be of the aforementioned publication.

From the short biography included, the author had practiced, trained and taught within the disciplines of yoga and mindfulness prior to undertaking studies and research into Somatic Experiencing and Wellness. This history informs the language and concepts presented, which were grounded in science and fact. Her approach to recovery from trauma and to homeostasis were new to me. Her easy language and accessible style definitely kept me engaged.

LaDyne's underlying premise is that the mind has dramatic effects on the body via the central nervous system and the patterning of bodily tension. Additionally, her goal of moving the reader from a bodily state of hyper- or hypo-activation,



notably through engaging the autonomic nervous system, into a place of functional activation and self regulation, was a reflection of what I found to be true in my own journey.

Through neuroplasticity, her program is meant to alter neural connectivity by increasing the activity of the soothing frontal lobes on the alarmist primitive brain, changing the road more travelled by rewiring neural pathways. Ongoing practice allows the changes to become primary reactions, superseding the dysfunctional reactions that had become habitual.

A concept which was novel to me was that cognitive approaches focusing on the source of overwhelm in those experiencing anxiety will increase negative thoughts, with a subsequent increase in bodily symptoms, whereas a somatic focus will not. As many of us know, anyone who has a surplus of competing thoughts is not able to be fully present. This can lead to misinterpretation of cues and result in deteriorating or incomprehensible relationships.

Post trauma, this latter situation arose for me on multiple occasions, leading to social isolation and negative impressions of neutral interactions. I can attest to the resulting panic and anxiety states arising when thoughts seemed to increase exponentially amidst the fear of the future, the mourning of the past and the dismaying prospects of the present. By actively engaging in the presented activities, I did find solace and respite from the negativity that had begun to dominate my cognition.

When faced with overwhelm, being able to return to the physical sensation of breath as an anchor to the present can lead to the realization that self regulation is possible. Combined with parasympathetic augmenting movements that are detailed in simple line drawings, the original physical symptoms can diminish. This novel pairing of two commonly used interventions, mindful breathing and yogic

stretches, surprised me and gave credence to the somatic focus being espoused.

Another interesting perspective was the skill of identifying sensations in the body or mind that were either neutral, okay, good enough or pleasant while in the midst of a disturbing sensation. This intervention is more than a distraction—it is meant to bring forth positive emotion and increase vagal tone plus provide another example of self efficacy to the person in distress. This is an example of a stress reset.

LaDyne encourages recognition and celebration of all victories, small, medium and large, on a regular basis; opening ourselves to the joys and beauty that surround us and being grateful in thought and body. Practice becomes habit and forward movement occurs when the negative feedback loops that initially predominated are challenged by the life-affirming acquisition and expansion of positive feedback loops.

As someone who has experienced trauma, this book gives substance to the concepts of moving on and accepting. By recalibrating the acquired baseline reactivity, it becomes possible to overcome chronic distress slowly and surely, bringing into existence an increasingly calm, confident being who deals with stressors objectively.

The Mind-Body Stress Reset guides us to become our own inner coach, knowing when to seek professional help, living fully and weathering the vicissitudes of life, continually returning to optimal functioning. A level of personal resilience is achieved by replacing externally triggered reactions with mindful, internal, and calming cues and then through by ongoing practice. I've experienced this trajectory through my own recovery, increasing my own ability to return to homeostasis.

The whole tone of this book is compassionate, soothing and calming, from the fonts, layout, organization, and tables to the activities, affirmations, illustrations, language, and examples. By combining science with reflection and achievable practices, LaDyne succeeds in providing the tools for managing stress, anxiety, and overwhelm. A bonus for patients are the free downloadable MP3 files, 23 in total, the majority being three to four minutes in duration. In the armamentarium of resources psychotherapists could reference, I would recommend *The Mind-Body Stress Reset*, especially if trauma care is foremost in your practice.

Conflict of Interest: None

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Maria Grande is living in St. Catharines, where she had practised for 23 years in the fields of Mental Health, Physical, Sport and Occupational Rehab before retiring. She was the editor of the GP Psychotherapist (2013-2015), which became the present Medical Psychotherapy Review.

Zelig

Allen, W. (director) (1983) Zelig (motion picture). United States, Jack Rollins & Charles H. Joffee Productions.

Reviewed by David J. Robinson MD, FRCPC

The central character, Leonard Zelig (Woody Allen) for whom the eponymous movie is named, is showcased in a "mockumentary" ostensibly taking place in the 1920s and 30s. What makes this slight, unassuming and self-effacing character the subject of international attention is his ability to morph himself into both behaving and physically resembling the people he is surrounded by. Zelig makes a number of appearances along side famous athletes, dictators, musicians and others (38 in total), and generally a small ruckus ensues when he it is discovered that he doesn't belong, and then Zelig quickly disappears. The blending of Woody Allen (as Zelig) into historical footage was a landmark cinematic achievement at the time, and was over a decade before *Forrest Gump* capitalized on the same special effect.

Zelig cuts between faux historical newsreels and contemporary interviews by actual famous people commenting on the sensation that was Leonard Zelig. The list includes: Susan Sontag, Saul Bellow, Irving Howe, John Morton Blum, and Bruno Bettelheim.

Leonard Zelig becomes known as the "human chameleon" and undergoes remarkable physical alterations, as we later learn, so that he fits in with the group he's surrounded by and doesn't cause any friction by being obviously different. He also picks up on foreign languages and technical jargon in order to do a passable job of furthering the chances of acceptance by the group. We see him transform — among other things — his skin colour, weight and facial hair to blend in with his seamlessly current social group, and he does so in mere minutes.

Eventually, Zelig comes to medical attention and is kept for observation at a prominent New York psychiatric institute. True to form, Zelig starts to look, act and sound like a psychiatrist and in one scene states authoritatively that he is one and enumerates a list of his professional achievements. Senior hospital consultants espouse different views on what the ultimate cause is for Zelig's remarkable ability to transform himself, which

range from neurological to glandular to Mexican food. They similarly endorse a disparate range of treatments to cure Zelig's reptilian-like transformations. Zelig eventually catches the interest of Dr. Eudora Fletcher (Mia Farrow), and she spends an increasing amount of time trying to sort out the enigma that is her famous patient. Though she is junior in the department, she is determined to make a name for herself and takes Zelig to her private estate. She arranges to have her brother hide in a closet to film the entire course of therapy, which become known as the "White Room Sessions."

Dr. Fletcher (named after one of Woody Allen's teachers) is a meek and straight-laced clinician: bespectacled, conservative in her dress, and with her braided hair tightly battened down over the top of her head. Her inexperience shows in her initial approach to Zelig, which just reinforces his assertion that is he a well-known psychiatrist. After some time, she has a brilliant insight and uses an empathic approach to effectively turn the tables on Zelig. If he is such an accomplished psychiatrist, then perhaps he can help her? She confides to the type of insecurities that she thinks Zelig must feel at the outset of his transformations, which include escalating anxiety, a strong wish not to offend or be a burden to others, and that she pretended to have read Moby Dick when she had not (a running gag throughout the movie). Faced with the predicament of now having to effectively try to help himself, Zelig regresses (uttering perhaps the funniest line in a very funny movie). Stripped of his armamentarium of defenses and geographically isolated, he is now ready to engage in treatment with Dr. Fletcher, who also uses hypnosis to excavate the events in Zelig's past that lead to the remarkable ability he has to transform himself.

A more authentic version of Zelig starts to emerge, and with the aid of a (comical) device in which to induce a hypnotic state, his inner world and early experience are explored. The breakthrough is also a huge professional credit to Dr. Fletcher, and the boost in her standing keeps her tied to Zelig for further therapy. However, the two develop strong feelings for one another and a personal relationship develops.

Dr. Glen Gabbard (1999) in his book on movies, *Psychiatry and the Cinema* (co-authored with his brother Krin, a professor of English and Comparative Literature), notes that portrayals of psychiatrists tend to get pigeon-holed into one of three stereotypes: Dr. Wonderful, Dr. Evil or Dr. Dippy. Examples of each might be Sean (Robin Williams) from *Good Will Hunting,* Dr. Hannibal Lecter (Sir Anthony Hopkins) from S*ilence of the Lambs*, and Dr. Leo Marvin (Richard Dreyfuss) from *What About Bob?* Gabbard's book examines the portrayals of psychiatrists in movies and notes that it is as rare to see an accurate depiction as it is a stable mental health professional. Psychiatrists are often part of the means by which directors move plots along, but it is often their shortcomings that get emphasized in movies. Gabbard goes on to note that as bad as male psychiatrists have it in cinematic depictions, female psychiatrists have it worse, generally being portrayed as weak, ineffectual or incomplete people. Many of the portrayals of female psychiatrists in major movies have them developing relationships with their patients. Examples include Dr. Libbie Bowen (Lena Olin) in Mr. Jones, Dr. Susan Lowenstein (Barbra Streisand) in *Prince of Tides*, and Dr. Constance Peterson (Ingrid Bergman) in *Spellbound*. We come to see that Dr. Fletcher struggles with issues of social isolation and prolonged repression. There is a very memorable interview with her mother (portrayed by Jean Trowbridge, in her only major role) that gives a glimpse into the struggles Dr. Fletcher had growing up, and illuminates the fuel that may well propel many overachievers. Dr. Fletcher and Zelig do go on to have a happy life together, but it is a shame this stereotype of female psychiatrists is perpetrated in this movie.

Diagnostically, Zelig would perhaps best be considered a portrayal of a severe form of Avoidant Personality Disorder (APA, 2013). The "nobody who yearns to be a somebody," wishes to fit in at all costs, and will completely subjugate himself to do so. The comedic device in *Zelig* his physical transformation, which can be seen as the ultimate expression of the desire to please others (and spawned several popular song and dances). Still, Zelig comes to attention by finding a way to get close to famous people, so there is a desire for affection and recognition in his guest appearances, which is a central dynamic in Avoidant Personality Disorder. Although the cover art for Zelig shows his name written in several different typefaces (possibly representing different personalities), his portrayal does lack some of the key elements of Dissociative Identity Disorder, although this is a tempting diagnosis to make. Specifically, Zelig does not appear to be distressed by his transformations, and in fact keeps being drawn to situations where his chameleon-like abilities may get him access to famous people. He does not appear to have amnesia for his time around others, though he does claim to not remember certain events in one part of the movie where he has

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been accused of marrying other women and fathering their children.

Zelig is a humorous, but surprisingly insightful, look at what happens when people have an extreme desire to fit in and will sacrifice or minimize what they stand for just to get attention and approval. Considering Woody Allen's long and quite public participation in psychotherapy, *Zelig* is a movie rich in meaning and metaphor. The film is done in black and white…like another famous Woody Allen film. The authenticity of the (supposedly) archival footage was a brilliant technical achievement for the time, and the scenes with Zelig and so many famous historical figures alone justifies watching the movie. The term "zelig moment" (Wordnik, n.d.) has now come to refer to an ordinary person who can change appearance or behaviour to suit the surroundings, or an unimportant person who appears at multiple important events. Furthermore, there is a case report of a Zelig-like syndrome in a person who had fronto-temporal damage due to hypoxia (Conchiglia, 2007), and who would assume different social roles based on changing circumstances. While we are unlikely to ever have a patient in our practices as famous as Woody Allen…or who will get us international acclaim…or lead to their names becoming common parlance, *Zelig* does encourage us to be creative and persistent in our quest to unlock a person's potential.

Conflict of Interest: None

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Dave Robinson is a psychiatrist practicing in London, Ontario. The other Woody Allen movie you are trying to think of is Manhattan.

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HEALING

E. Janet Warren, MD, PhD, FCFP

Carrie worked hard on her colouring homework, perfect and calming,
But emotions don't stay within the lines.
Rachel used sophisticated words and concepts to explain her thoughts and actions,
But feelings are much bigger than words.
Yvonne was confident her pain was buried well in a concrete-reinforced pit,
But it oozed out, red-black slime across her life.
Isabelle built many boxes, labelling them: rage, shame, guilt…,
But the contents escaped, little monsters bouncing around.
Nadine perfectly structured her life—family, work, friends, self-care,
But emotions aren't organized and logical.
Grace sat with her pain: big, noisy, ugly sobs; tears escaping and oozing all over the place.
She healed.

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

Report from the MDPAC Board of Directors

Thomas Minde, MD, CCFP, FCFP, ABIHM

It is a pleasure for me to share some news from your Board and Executive for the first time!

I joined the Board several years ago, and was honoured to be elected to the position of Chair of the Board of MDPAC in May. I would first of all like to thank Dr Elizabeth Parsons for her vision and her tireless work as Chair. She guided us through numerous challenges, and her steady hand has been a major reason that MDPAC has thrived even in such difficult times. On behalf of the Board and all members of MDPAC, I offer her our thanks and gratitude.

Like many of you, the first part of my medical career was spent in a regular family medicine practice, where I enjoyed working in the office as well as doing inpatient and ER work, as well as geriatrics. I spent time in Wakefield, Quebec, as well as in the arctic and in Ottawa. Over time I became more and more convinced of the key role of caring for our minds, as that is where our suffering is experienced. I ended up shifting my practice to psychotherapy exclusively.

It is my belief that as physician psychotherapists we have a tremendous advantage over our therapist colleagues. We get to tend the bodies (and brains) of our patients as well as their minds. This holistic approach is more likely to benefit more patients. It is my hope that MDPAC will continue to be a beacon to spread this good news, and encourage other physicians to engage with their patients' mental health. With this broader more inclusive vision, we are also well-placed to discover and try out emerging trends in the care of mental health. Approaches such as trauma-informed psychotherapy, including somatic aspects, are a natural fit for many of us. It is an exciting time to be a therapist…

MDPAC continues to be busy. We had our recent AGM in May. The Professional Development and Membership Committees have prepared for the roll-out of our new Continuing Professional Development credit tracking program, which has just happened. This is bringing us into the future, using CanMEDs roles as categories. This was required of us by the CPSO and is the current standard in medical education. I am proud to say that in spite of some significant obstacles and unforeseen problems, it has gone well and happened on schedule. The Board is grateful for all the work done by the Professional Development and Membership Committees. In particular, I would like to highlight the dedication and leadership of Drs Stephen Sutherland and Muriel van Lierop, who spearheaded this project.

In the next few months we will be offering our annual Retreat (October 15–17) and our annual Conference (November 5–6). The retreat will be in person, with adjustments having been made due to COVID. The conference will be virtual again this year. Please join us—it is not too late to register! The Psychotherapy Training Program continues to be very popular; we currently have a waiting list of over 80 physicians who wish to register. Our next cohort will begin in January, and we are considering a second cohort later in 2022.

We will also be offering a new project for you and for members of the public: a podcast. On *Doctors Listen*, I interview prominent members of MDPAC to explore a bit under the surface—what makes therapists tick, what are we passionate about, and what do we have to share. Many thanks to IMPACT Public Affairs for helping us to develop and launch this exciting new venture. Stay tuned for an official launch date very soon. Finally, I invite you to enjoy the many webinars that we will be offering; please see the list on the MDPAC website. The Conference and Webinar Committee always seems to find interesting speakers to talk about interesting topics!

If you feel like connecting more deeply with like-minded people, I invite you to join one of our committees. This is a rewarding way to enjoy some collegial time, and to contribute to your organization. It is also an easy way to earn CCI credits. I especially invite any new members to consider this.

I wish you all a delightful autumn, and very much look forward to my work on your behalf.

Conflict of Interest: none

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Thomas Minde, the current chair of the Board, has been a member of MDPAC since 2012 and a member of the Board since 2018. After working in family medicine in Wakefield Quebec and in the arctic, he shifted to practice psychotherapy in Ottawa. He is currently based in Montreal, where he works at CLSC Parc-Extension, a community health centre. He enjoys his teaching at McGill University where he is Assistant Professor in the Department of Family Medicine. His clinical and research interests include cultural issues, spirituality, integrative medicine, and ketamine-assisted psychotherapy.

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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.

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