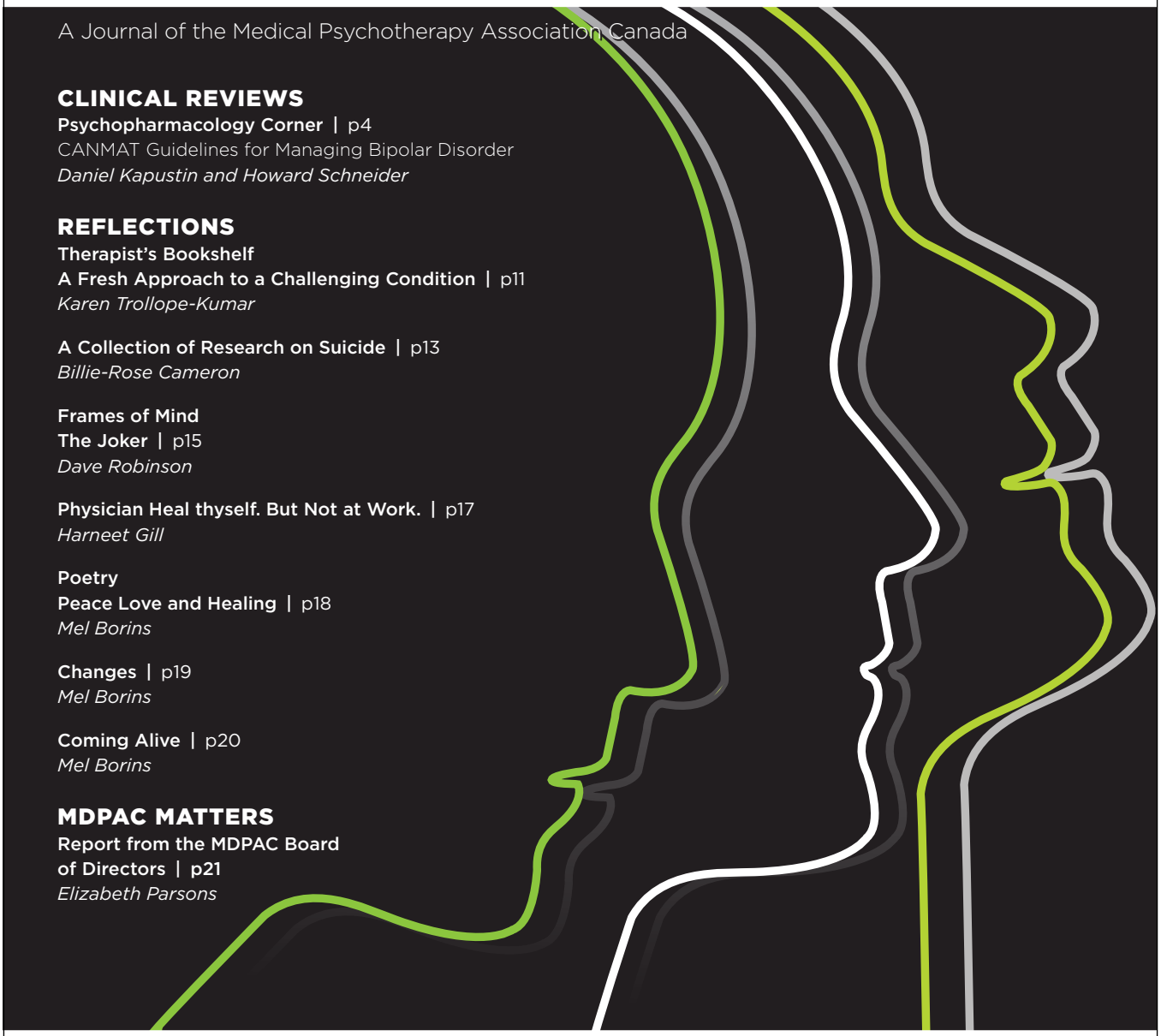
SPRING 2020 | VOLUME 27 | 1

MEDICAL PSYCHOTHERAPY REVIEW

A Journal of the Medical Psychotherapy Association Canada



MDPAC ACPMD
MEDICAL PSYCHOTHERAPY ASSOCIATION CANADA
ASSOCIATION CANADIENNE DE PSYCHOTHÉRAPIE MÉDICALE

"SOMETIMES EVEN TO LIVE IS AN ACT OF COURAGE."
Lucius Annaeus Seneca

I write this during the COVID-19 pandemic. A time when death has inconveniently come out of its dusty corner to mock us from newsfeeds. A time when the mental fragility already present in our patients is magnified. A time when the issues that we hear daily behind the closed doors of our psychotherapy offices walk freely in society, wearing placards. Fear, uncertainty, anxiety, isolation, loneliness, grief. Individual and societal concerns interconnect, local and global are on the same page. Existential questions resurface and don't go away with 20 seconds of hand washing. Fortunately, there are always opportunities to find diamonds in the dust.

And there are opportunities for humanity's holier side to show. Despite *facebook* platitudes and toilet-paper humour, pandemics are a time when courage, compassion, and resiliency have the chance to take centre stage. The Italians who cheer from balconies. The tireless physicians who die while caring for others. Governments and associations who make quick, big decisions. Neighbours who check in on each other. And, of course, medical psychotherapists who offer the gift of non-anxious presence. Who rapidly learn how to conduct virtual therapy.

The informative and reflective articles in this issue of the *Medical Psychotherapy Review* were written well before the coronavirus crisis. Yet they are always relevant, a witness to both the suffering and resiliency in ourselves and our patients. It is always interesting how independently written articles overlap and intertwine in their themes.

In our "Psychopharmacology Corner," Howard Schneider and Daniel Kapustin continue their discussion on the CANMAT guidelines for mood disorders; this time considering the management of Bipolar Disorder. With a clinical vignette to illustrate, this article is readable and informative for all mental health practitioners.

This issue has two book reviews, both on timely topics. Karen Trollope-Kumar gives us a nice summary of a new approach to managing

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.

anorexia, and Billie-Rose Cameron provides an overview of current research on suicide. Seneca's quote is apt when it comes to preventing self-inflicted death. Dave Robinson reviews the popular recent movie, *The Joker*. A good illustration of the effects of childhood trauma, and the psychopathology of a villain.

In a personal reflection, *Harneet Gill* bravely shares her story as a medical student coping with PTSD. Interestingly, she includes a quote from *The Joker.* Mel Borins offers up three poems: one is inspired by Bernie Siegel's work on peace, love, and healing, another is about the challenges of change, and the third addresses recovery from trauma. These are particularly timely during the current global crisis.

In MDPAC matters, we did have a comprehensive update by the Professional Development Committee on the new Continuing Professional Development program but, because of the pandemic, this has been delayed a year. However, Elizabeth Parsons provides a summary of other MDPAC activities in her report from the board, including the ongoing strategic plan. Note that given all the recent changes, information at the time of printing may no longer be valid. Please refer to the website and eblasts for up to date information.

Mental health problems are epidemic, if not pandemic. The one to two deaths by suicide every minute reflect bigger societal issues. To live often requires courage, and to give requires resiliency and selflessness. Colleagues, be reminded of the important work we do. Have courage to give courage to those in need of it. The reader will have more information and stories about the COVID-19 pandemic than I currently do. We trust that the trajectory is positive, and that we all have learned from and contributed something to this global crisis. Similarly, we hope that MDPAC members will learn something from this issue of the *Medical Psychotherapy Review.*

Grace and peace,
Janet Warren

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Medical Psychotherapy Review
ISSN 1918-381X

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The MDPAC publishes the Medical Psychotherapy Review twice a year. Submissions are accepted up to the following dates:
Spring Issue - Mar 1
Fall Issue - Sept 1

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

CANMAT Guidelines for Managing Bipolar Disorder

Daniel Kapustin, BSc and Howard Schneider, MD, MDPAC(C), CCFP

Abstract

In 2018, the CANMAT Guidelines for Bipolar Disorder (BD) were updated to incorporate recent advances in pharmacological and psychological management strategies. These guidelines provide recommendations for first-, second-, and third-line BD treatments, with consideration of the efficacy, safety, and tolerability of therapy across each phase of illness.

In last issue's *Psychopharmacology Corner,* we discussed the diagnosis of Bipolar Disorder (BD). In this issue, we will review the CANMAT 2018 Guidelines for the Management of Patients with Bipolar Disorder (Yatham et al., 2018).

Throughout this article we will follow the case of Michael, a 24-year-old student who has suffered from three major depressive episodes (MDE) over the past five years. Michael was started on sertraline by his family doctor and has been taking this appropriately for the past 12 months. He now presents to your office, alongside his mother, with concerns that this medication has not been working well for him.

Michael describes feeling unmotivated, worthless, and "low" for several weeks. His mother adds that he has been significantly more talkative than usual, he has not been sleeping much, and he has made several "impulsive" purchases recently. She is worried because Michael developed mania about five years ago. At that time, he was seen by a psychiatrist and diagnosed with Bipolar I Disorder. Michael recalls being prescribed quetiapine at the time but mentions he did not tolerate it well. Since then, Michael's family doctor has been taking care of his mood disorder.

Michael scores 13 on the 7-Item Hamilton Depression Rating Scale (HAMD-7), with scores between 12–20 indicating moderate depressive symptoms. There is no suicidal ideation or planning. You recognize that Michael meets the criteria for a Bipolar I Disorder, current episode depressed with mixed features.

You request a copy of the chart from the psychiatrist Michael saw some five years ago, but this will take some time to receive. You refer Michael to a tertiary center for another opinion, but it may take about six months until he is seen. Agreeing with the previous psychiatrist's opinion concerning an underlying bipolarity to Michael's illness, you contemplate starting the patient on a mood stabilizing medication. But which agent will you choose?

CANMAT: Foundations of Management

The CANMAT 2018 Bipolar Disorder Guidelines consist of seven actionable sections, most of which apply to Bipolar I Disorder. The first is "Foundations of Management." Here, Yatham and colleagues highlight that

Table 1: Psychological Treatment for BD

Type of Therapy	Acute Treatment	Maintenance Treatment
Psychoeducation (PE)	First-line (Level 2)	Insufficient evidence
Cognitive behavioral therapy (CBT)	Second-line (Level 2)	Second-line (Level 2)
Family-focused therapy (FFT)	Second-line (Level 2)	Second-line (Level 2)
Interpersonal and social rhythm therapy (IPSRT)	Third-line (Level 2)	Third-line (Level 2)
Peer support	Third-line (Level 2)	Insufficient evidence
Cognitive and functional remediation	Insufficient evidence	Insufficient evidence
Dialectical behavioral therapy (DBT)	Insufficient evidence	Insufficient evidence
Family/caregiver interventions	Insufficient evidence	Insufficient evidence
Mindfulness-based cognitive therapy (MBCT)	Insufficient evidence	Insufficient evidence
Online interventions	Insufficient evidence	Insufficient evidence

Table 2: Pharmacological Management of Acute Bipolar Mania

	Level of evidence				
		Maintenance			
First-line: Monotherapy	Acute mania	Prevention of any mood episode	Prevention of mania	Prevention of depression	Acute depression
Lithium (Li)	1	1	1	1	2
Quetiapine	1	1	1	1	1
Divalproex(DVP)	1	1	3	2	2
Asenapine	1	2	2	2	no data
Aripiprazole	1	2	2	no data	negative
Paliperidone (>6mg)	1	2	2	no data	no data
Risperidone	1	4	4	no data	no data

	Level of evidence				
		Maintenance			
First-line: Combination	Acute mania	Prevention of any mood episode	Prevention of mania	Prevention of depression	Acute depression
Quetiapine + Li/DVP	1	1	1	1	(no data)
Aripiprazole + Li/DVP	2	2	2	no data	4
Risperidone + Li/DVP	1	4	4	no data	4
Asenapine + Li/DVP	1	4	4	no data	4

the lifetime prevalence of BD in Canada is approximately 2.4% (i.e., just under a million Canadians). They note that patients with BD experience substantial functional impairment, often suffering from symptoms for up to half of their lives (Judd et al., 2008) with the greatest degree of impairment attributed to the depressive phase of illness (Van Rheenen & Rossell, 2014).

The authors emphasize the value of psychological treatments in the management of BD. However, there is a paucity of data exploring the efficacy of these approaches and previously conducted trials have demonstrated mixed results, as shown in Table 1.

CANMAT: Acute Management of Bipolar Mania

The subsequent section, "Acute Management of Bipolar Mania," begins with a summary of the diagnostic criteria for a manic episode, which we discussed in last issue's *Psychopharmacology Corner* (Schneider and Kapustin, 2019).

This section then discusses the principles of treating mania-associated agitation. Managing agitation was also discussed in a previous *Psychopharmacology Corner* (Schneider and Shah, 2018), although the CANMAT guidelines provide a more targeted approach to Bipolar Disorder specifically.

The authors then review pharmacological approaches to the management of acute mania, as per Table 2.

CANMAT: Acute Management of Bipolar Depression

The next section of the guidelines, "Acute Management of Bipolar Depression" con-

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CANMAT Guidelines for Managing Bipolar Disorder | continued

siders management of the depressive phase of BD. The authors start by outlining the criteria for a major depressive episode (MDE), which was discussed in the most recent *Psychopharmacology Corner* (Schneider and Kapustin, 2019).

Depressive polarity is frequently the most pervasive and debilitating phase of illness, with over 70% of suicide attempts and deaths occurring during this period (Tondo et al., 2016). Therefore, these episodes should be treated aggressively.

Importantly, other than psychoeducation, there are no first-line psychosocial treatments for Bipolar Disorder or its associated mood episodes. Thus, psychopharmacological strategies must be considered. Recommendations are presented in Table 3.

Hu, Mansur, and McIntyre (2014) suggest that atypical antipsychotics, in combination with a mood stabilizer, are the most effective agents for mixed mood presentations in BD. The CANMAT Guidelines give level-1 evidence for the use of quetiapine in acute depression, acute mania, and prevention of future mood episodes. Hu and colleagues (2014) note that patients with mixed presentations often have poor response to medication, and combination therapies should be considered.

Michael is one such patient. You discuss possible medication choices with him and his mother. You counsel Michael that switching from an antidepressant monotherapy (sertraline) to medications with mood stabilizing properties could offer significant benefit for his symptoms both in the short term and long run. You propose treatment with quetiapine plus divalproex (or lithium), in addition to regular psychotherapy with yourself, and discuss the possible adverse effects from these medications.

Michael refuses treatment. He tells you that while he doesn't mind the sertraline his family doctor is currently prescribing, he remembers that taking quetiapine several years ago made him feel "drugged." He has started to make some progress in university and doesn't want to have to drop out again. Additionally, his mother is concerned about the possible metabolic syndrome associated with the medications, explaining that "there is already enough diabetes in the family." His mother also dislikes lithium saying she knows people on it who "never got better."

Table 3: Pharmacological Management of Acute Bipolar Depression

	Level of evidence				
		Maintenance			
First-line	Acute depression	Prevention of any mood episode	Prevention of depression	Prevention of mania	Acute mania
Quetiapine	1	1	1	1	1
Lurasidone + Li/DVP	1	3	3	4	no data
Lithium	2	1	1	1	1
Lamotrigine	2	1	1	2	negative
Lurasidone	2	4	4	4	no data
Lamotrigine (adjunct)	2	4	4	4	negative

	Level of evidence				
		Maintenance			
Second-line	Acute depression	Prevention of any mood episode	Prevention of depression	Prevention of mania	Acute mania
Divalproex	2	1	2	3	1
SSRIs/bupropion (adj)	1	no data	4	no data	no data
ECT	4	4	4	4	3
Olanzapine-fluoxetine	2	no data	no data	no data	no data

Table 4: Maintenance Therapy for BD

	Level of evidence				
	Maintenance				
First-line	Prevention of any mood episode	Prevention of depression	Prevention of mania	Depres-sion	Mania
Lithium	1	1	1	2	1
Quetiapine	1	1	1	1	1
Divalproex	1	2	3	2	1
Lamotrigine	1	1	2	1	negative
Asenapine	2	2	2	no data	1
Quetiapine + Li/DVP	1	1	1	4	1
Aripiprazole+ Li/DVP	2	no data	2	4	2
Aripiprazole	2	no data	2	negative	1

McIntyre and colleagues (2018) note that mixed features are not uncommon in patients with mood disorders, but unfortunately research into treatment options for these presentations is limited. In general, antidepressants should not be used and the use of second-generation antipsychotics, divalproex, and ECT is supported.

In other research, McIntyre and colleagues (2015) found lurasidone to be effective in the treatment of Bipolar Depression with mixed features. Similarly, in reviewing treatment recommendations for mixed feature episodes, Rosenblat and McIntyre (2017) describe lurasidone as the only second-generation antipsychotic monotherapy shown to be effective for MDD with mixed features. Stahl (2017) notes that while lurasidone is not officially approved for mania, almost all atypical antipsychotics which have been approved for schizophrenia treatment (which lurasidone has been) are effective in the treatment of manic symptoms. However, this must be tempered by case reports of a temporal relationship between lurasidone treatment and the development of mania in patients with Bipolar Depression (Goyal, 2017).

The evidence for lurasidone as a maintenance therapy, however, is incomplete. Ghaemi (2018) writes that there is a lack of evidence for the efficacy of antipsychotics, in general, in preventing future mood episodes. Ghaemi argues that one of the four "true" mood stabilizers (lithium, divalproex, carbamazepine, or lamotrigine) should be used. With regard to lurasidone, Stahl (2017) notes that in the event of partial response, augmentation of lurasidone with divalproex, lamotrigine, other mood-stabilizing anticonvulsants, lithium, or benzodiazepines should be considered. Work by Citrome and colleagues (2014) showed that lurasidone gave a more favorable "likelihood of being helped or harmed" compared to treatment with quetiapine or with olanzapine-fluoxetine combination.

You discuss a trial of lurasidone with Michael and his mother, explaining that it is generally well-tolerated without the risks of as much sedation (particularly with evening dosing) or metabolic syndrome. However, you review its possible adverse effects including akathisia. You also discuss the advantages and risks of the addition of a mood stabilizer. You discuss the use of lamotrigine as a mood stabilizer, reviewing its adverse effects, but, noting that it is generally well tolerated. You also highlight the risks of inadequate treatment by diverging from the guidelines (as noted above Michael has refused treatment with quetiapine, divalproex or lithium). Michael agrees to this plan, alongside a course of supportive and possibly cognitive psychotherapy, with frequent follow up to assess the effect of the medication.

A trial of lurasidone 20mg PM with food is started, along with a gradual tapering of the sertraline. Although larger doses of lurasidone are used in schizophrenia, smaller doses may be effective for BD. Informed verbal consent is obtained regarding the risks and the benefits of treatment. You order baseline lab results that show normal CBC, glucose, HbA1c, lipids, liver, kidney and thyroid function, as well as a normal

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ECG. Blood pressure in your office is within normal limits. There are no tremors noted on exam. You weigh Michael and calculate a BMI of 24.5.

Six days later, Michael returns to your office. He says he is starting to feel better with the new medication, i.e., the lurasidone. He is sleeping better. Thoughts in his mind have slowed down and he said he was able to study effectively for a few hours yesterday. He feels more optimistic about the future.

CANMAT: Maintenance Therapy for Bipolar Disorder

The next section of the guidelines, "Maintenance Therapy for Bipolar Disorder," emphasizes the importance of providing maintenance therapy to patients with BD to prevent future mood episodes. Indeed, effective maintenance therapy has been associated with a reversal of BD-associated cognitive impairment and a preservation of neuroplasticity (Kozicky et al., 2014). The CANMAT authors highlight the importance of therapy adherence, and propose the following hierarchy of first-line treatments, as listed in Table 4.

You continue to see Michael on a weekly basis. He is taking Lurasidone 20mg PO PM with food and does not report any adverse effects. His weight has remained stable and his pants size remains unchanged. Therapy consists of psychoeducation and supportive therapy, although you are starting to introduce some cognitive elements into the sessions. Michael is doing better, his studies at university continue to go well, and his sleeping has improved. He presents with a largely normal mental status examination. At the one-month mark, he scores 3 on the HAMD-7 and no longer endorses hypomanic symptoms.

Despite his success, you collaboratively discuss the need to add a mood stabilizer. You address the potential benefits and adverse effects of lamotrigine, as well as the risks of inadequate treatment. Michael agrees to a trial of lamotrigine added to lurasidone. You give him a prescription for lurasidone 20mg PO PM plus lamotrigine 25mg PO HS. You plan to slowly increase the lamotrigine over the next two months until a target dosage of 200mg PO HS is reached.

You continue to see Michael on a biweekly basis at first, and then a monthly basis. After a few months he reaches the target dose of lurasidone 20mg PO PM and lamotrigine 200mg PO HS. No adverse effect from either medication is reported. Michael's mood has remained euthymic, and mental status examination has been normal on his visits. He is sleeping well and has done well on his last set of university exams. You continue to provide supportive psychotherapy.

Table 5: Pharmacological maintenance management of BD Type 2

Recommendation	Evidence level
First-line	
Quetiapine	Level 1
Lithium	Level 2
Lamotrigine	Level 2
Second-line	
Venlafaxine	Level 2

CANMAT: Bipolar II Disorder

The next section of the guidelines, "Bipolar II Disorder" (BDII) begins by describing the criteria for hypomania, discussed in the previous *Psychopharmacology Corner (*Schneider and Kapustin, 2019). While hypomanic symptoms are less severe than mania, clinicians must be careful to avoid perceiving this illness as a less severe form of BD. Indeed, both the degree of psychosocial impairment and the amount of time spent being symptomatic is comparable to patients with BDI (Kupka et al., 2007).

While there is limited data evaluating pharmacotherapeutic efficacy in BDII, the CANMAT authors recommend that hypomanic episodes, when sufficiently frequent or impairing, be managed similarly to mania. For the management of BDII Depression, the authors recommend quetiapine be used as a first-line treatment, with second-line options including lithium, lamotrigine, sertraline or venlafaxine (for non-mixed depressions), as well as ECT (refractory patients). Finally, they propose recommendations for maintenance therapy in BDII, as presented in Table 5.

CANMAT: Specific Populations

The next section of the guidelines, "Specific Populations" considers the treatment of BD perinatally, in children and adolescents, and in the elderly. Perinatally, approximately 86% of women with BD who stop treatment (versus 37% who continue treatment) will experience a mood episode during pregnancy (Viguera et al., 2007).

In children and youth, the authors give

first-line recommendations for lithium (level 1), risperidone (level 1), aripiprazole, asenapine, and quetiapine for mania. The first-line recommendation for bipolar depression in this group is lurasidone.

The authors further recognize that the management of late-life BD is a key challenge in Canada given our aging population. They recommend that treatments effective in the general adult population are appropriate to use in the geriatric setting, with additional consideration given to medication safety and tolerability.

CANMAT: Safety and Tolerability of Pharmacotherapy

The final actionable section of the guidelines, "Safety and tolerability of pharmacotherapy," discusses the most notable concerns for medication side effects in BD. Considering the importance of medication compliance in BD, counselling around potential adverse events is essential with all patients. The authors highlight several medications, particularly lithium, carbamazepine, divalproex, clozapine, and quetiapine as commonly used agents with important safety and tolerability considerations. Predominant side effects with these psychotropic options include weight gain, sedation, extrapyramidal symptoms, renal toxicity (i.e., lithium), and QT prolongation.

Discussion

The CANMAT Guidelines for Bipolar Disorder are not without criticism. For example, in several clinical contexts (e.g. considering pharmacological management options for patients with BDII) there is limited randomized controlled data to support provided recommendations. Nonetheless, the CANMAT Guidelines serve as a useful resource and a strong framework for clinical decision-making.

In the case of Michael presented above, the CANMAT Guidelines serve as a starting point for evidence-based treatment, but often must be applied taking into account the needs of the patient. A strong psychotherapeutic relationship is essential for such a case, so that the effectiveness of medications chosen can be assessed and changed in a collaborative, adherent-producing manner if needed.

Conflict of Interest: None

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

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A Fresh Approach to a Challenging Condition

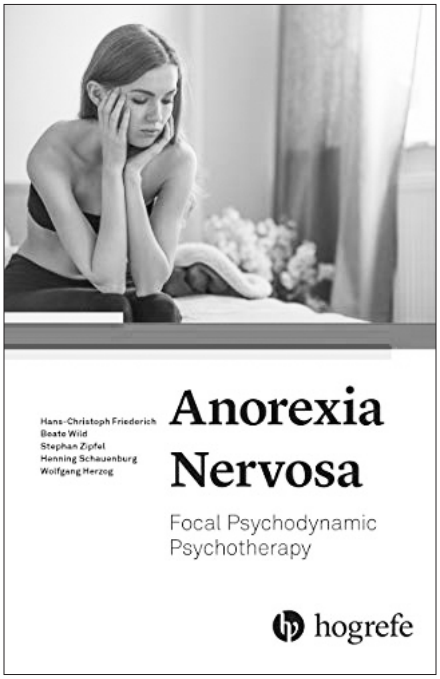
A review of *Anorexia Nervosa: Focal Psychodynamic Psychotherapy* Hans-Cristof Friedrich, Beate Wild, Steven Zipfel, Henning Schauenburg, and Wolfgang Herzog. Boston: Hogrefe Publishing Group, 2019. 109 pages, $38.00, paperback

Karen Trollope-Kumar, MD, PhD, CCFP

Anorexia nervosa is the most lethal of all mental illnesses, with the mortality rate in excess of 16%. Anorexia disproportionately affects young women, although people of all ages and gender identities can suffer from the condition.

The authors of this book have both research and clinical expertise in the treatment of anorexia and are leading experts in brief psychodynamic psychotherapy. The authors describe the design and the results of the landmark ANTOP study in this book. This trial, done by Zipfel et al in 2014, provided evidence for the efficacy of brief psychodynamic psychotherapy in anorexia treatment. This was the first large-scale, randomized controlled trial assessing different psychotherapeutic approaches to the treatment of anorexia.

In the first chapter, the authors review the definition and epidemiology of anorexia as well as the diagnostic approach to the patient. Subsequently, they describe a psychodynamic understanding of anorexia, illustrating how both intrapsychic and interpersonal dynamics are involved. The clinician assesses these dynamics and then formulates an operationalized psychodynamic diagnosis (OPD-2), which shapes the treatment approach. Therapy is divided into three phases. For the first four weeks, the clinician works on creating a therapeutic alliance and defining a focus. In the second phase, clinician and patient work together to uncover the psychodynamics of the identified focus, and in the final phase the clinician assists the patient to strengthen autonomy and responsibility. Throughout the book, the authors provide many clinical vignettes to illustrate their points. Each phase of the treatment is clearly described. In the appendix, nutrition guidelines are given as well as a weight-curve document.



Psychodynamic psychotherapy for eating disorders is not commonly used in North America. For most practitioners, cognitive behaviour therapy would be the therapeutic approach to treat anorexia. Dialectical behaviour therapy is gaining in popularity as a treatment modality, and family based therapy is often used in pediatric populations. However, North American practitioners will find this book an informative description of another evidence-based therapeutic modality.

I have used insights from this book to provide a fresh approach when treating a patient with anorexia who has not responded to other forms of treatment. Cognitive Behavioural Therapy for Eating Disorders (CBT-E) is the standard psychotherapeutic approach used in North America—however, many patients with anorexia have already been through CBT treatment, and are reluctant to continue with this approach. The psychodynamic approach has a particular focus on building the therapeutic alliance in the early stages of treatment. One of my patients with moderately severe anorexia described a recent hospital admission where she felt stressed by the rapid re-feeding protocol. This resulted in a breakdown of trust between her and her clinical team. She discharged herself and refuses to consider re-admission. She and I have managed to create a therapeutic alliance over a period of several weeks, and she is making slow but steady progress.

The authors refer to their book as a manual for psychodynamic psychotherapy. However, the book reads more like a descriptive text about an approach rather than a how-to manual. More guidance on specific ways to conduct the therapy, as

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well as suggestions for handouts and homework assignments would have been useful. The appendix could also be more detailed, with additional practical material.

Overall, this book represents a fascinating introduction to a therapeutic modality that many North American clinicians have never studied. The evidence arising from the ANTOP study further underscores the relevance of this type of therapy in the treatment of anorexia nervosa. This book would be a valuable resource for any clinician who treats this complex disorder.

Conflict of Interest: None

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Karen Trollope-Kumar is a family physician with a particular interest in eating disorders. She works as the Medical Director of Body Brave, a charitable organization in Hamilton, Ontario that is focused on support and low-intensity treatment of people struggling with food, weight and body image issues. She co-leads therapeutic groups, both in-person and online, and also does some individual psychotherapy for people on waiting lists for intensive treatment. She has recently completed a research project on the learning needs of family physicians and trainees about eating disorders.

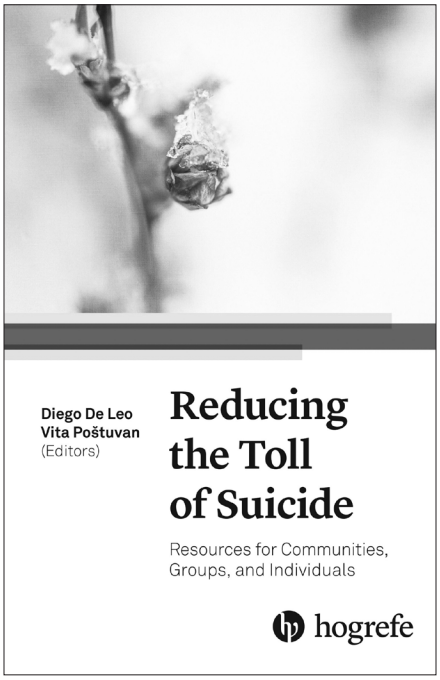
A Collection of Research on Suicide

A Review of *Reducing the Toll of Suicide, Resources for Communities Groups and Individuals* Diego De Leo, Vita Poštuvan (Editors). Toronto: Hogrefe Publishing 2020; 219 pp. $48.79, paperback

Billie-Rose Cameron, MD

"Reducing the Toll of Suicide" is a 219-page book spanning a wide range of topics, including risk factors for suicide, psychotherapy for suicide, groups at risk, community roles including media, technological programs, community intervention and responses to the bereaved, models of understanding suicide, and finally issues related to suicide research. It is edited by experts on suicide prevention, Diego De Leo and Vita Poštuvan. Dr. De Leo is an Italian psychiatrist and director of the Australian Institute for Suicide Research and Prevention, has contributed to the World Health organization Centre on Research and Training for Suicide Prevention and is Head of the Slovene Centre for Suicide Research. Vita Poštuvan, the second editor, is the Deputy Head of the Slovene Centre for Suicide Research. This book results from an initiative of the Slovene Institute conferences on Intuition, Imagination and Innovation in Suicidology. It is an ambitious undertaking, but it ultimately falls short of complete success despite the experienced editors and contributors.

Suicide is a very important worldwide concern; the World Health Organization estimates that every 40 seconds a person dies by suicide. It is clearly a subject that every clinician would want to have the latest information. As a new learner in psychotherapy, I also look for those books that have practical information that can be applied to helping patients. Although this book presents an expansive review of suicide, it is not fully complete or cohesive despite the editors' efforts to organize, in large part because it is the disparate work of multiple authors. Moreover, much of the book is heavily weighted in research with less focus on information that can be used in a practice setting. The most problematic parts of the book are based on PhD research theses, and these in particular tend to be poorly edited, with spelling errors and tables that are too small to be legible, or figures that are too poorly labelled to be fully understood. There is a distinct divide between those chapters and other parts of the book which provide interesting research in a clear fashion.



The following are some of the highlights that might make this a worthwhile read if one is selective and depending on one's goals. Chapter One, "Assessing suicide in older adults" written by the lead editor Dr. De Leo is comprehensive and looks at known risk factors and the limited understanding of protective factors. Clinical evaluation and assessment scales are discussed. Given the deadliness of suicide in older adults this is a very useful read. Chapter Three, "Long term perspectives on Suicide Risk of Youth" is an interesting examination of suicide ideation, self harm and those at risk for multiple attempts of suicide. Although well written, this is clearly aimed more at researchers than at clinicians. Chapter Seven, which deals with the Papageno effect, is fascinating given the impact media can have on suicidality; and this ties in nicely with Chapter Eight, "Ethical guidelines for Technology Based Suicide Prevention Programs." This chapter could be helpful for clinicians looking to develop mobile phone applications and content or even evaluating content that they might recommend to patients. Chapter Eleven, "Status of the Integrated Motivational-Volitional Model of Suicidal Behaviour," is an excellent look at a model of suicide behaviour and its supporting research. Finally, the last chapter "What is Different about Suicidology?" looks at the challenges of

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A Collection of Research on Suicide | continued

research on this topic. Suicide is unique in that direct research on the population affected is impossible and indirect research can be hampered by the sensitivity of the problem. The most interesting concept of this chapter is that of safety and self care of researchers. When dealing with participants who are experiencing distress, the researcher's well-being must be protected. This is, of course, relevant to clinicians who deal with this same patient population and deserves to be a focus for us all.

In summary, this was a difficult publication to review, since it is more a compilation of short works, by different authors, of varying quality, and some of the better chapters would likely be more useful to the researcher than the clinician.

Conflict of Interest: None

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Joker

Phillips, T. (director) (2019) *Joker* (motion picture). United States, Warner Brothers.

Reviewed by David J. Robinson MD, FRCPC

Batman defends Gotham City from many villains in the DC comic book lexicon. In the original TV series that ran from 1966–1968, there were 120 episodes featuring 37 villains, with Joker widely regarded as the caped crusader's arch nemesis (and often seen as Batman's alter ego). Cesar Romero was the original Joker on the TV series. Heath Ledger won an Academy Award for Best Actor in a Supporting Role for his portrayal of Joker in 2008's *The Dark Knight*, and Joaquin Phoenix won the 2020 Academy Award for Best Actor in a Leading Role for Joker (a stand-alone film that takes place in a different "comicverse" than *The Dark Knight*).

Joker's real name is Arthur Fleck. Prior to his transformation, Arthur is a clown for hire who dotes on his mother and aspires to be a stand-up comic. His penetrating laugh gets him noticed as an audience member on a variety show, and the host singles Arthur out to answer some personal questions. Arthur reveals that he always tries to put on a happy face and that his mother told him he was put on earth to spread "joy and laughter." He keeps a notebook with him that serves as a repository for his thoughts and observations about life, and that he hopes will germinate into material for his stand-up routine. How does such a seemingly sweet person and dedicated son go on to repeatedly terrorize Gotham City?

The citizens of Gotham grow increasingly restless as they weather a garbage strike. The city is also in the midst of a mayoral campaign, with the leading candidate being the unsympathetic Thomas Wayne, Batman's father. Arthur is viciously assaulted by a gang after they steal the sign he's holding to advertise a sale. Arthur's employer considers the explanation of events to be too far fetched, and the cost of the sign gets deducted from Arthur's pay. A co-worker provides Arthur with a handgun for protection, and he becomes so overwhelmed by the sense of power it gives him that he fires it in his home. The pistol becomes his constant companion, and it unfortunately falls out of his costume when he does a show for hospitalized children. He loses his job, being unable to convince his boss that the gun was part of his act. Arthur then becomes a vigilante killer of three belligerent Wall Street traders after they harass a female subway rider. This is just the spark that the population of Gotham City needs to ignite their civil unrest, and mayhem ensues. The Gotham City police cannot contain the uprising, and Batman is still a child at this time. What will it take to stop Joker? A different superhero? An even bigger supervillain? How about a caring therapist?!

The movie is an excellent example of what can happen when essential supports aren't available. Arthur has an indifferent social services worker who stares blankly back at him when he reveals that at his core, he isn't really sure he even exists. She tells Arthur the funding for his program will be cut, and it is unclear how he will be able to continue getting his prescriptions. He angrily confronts her, accusing her of never really listening to him. His rage escalates when a support cheque for his mother is late. Arthur learns that Thomas Wayne might actually be his father. Arthur's mother shows him a photograph as evidence that she had an affair with Thomas Wayne with a caption saying that a "TW" loved her smile. Arthur seeks out Wayne to discuss the matter with him, but is rebuffed and belittled. Wayne suspects Arthur is there to try to get money from him, but all Arthur says that he wants is some warmth and humanity. Arthur never knew who his father was and is shocked to hear from Wayne that he was adopted, which runs counter to what his mother had always said. Wayne goes on to say that while Arthur's mother was once an employee, they never had a relationship. Wayne describes her as delusional and that she ended up as an inpatient at Arkham Asylum, Gotham's psychiatric hospital. Incensed by the accusation, Arthur investigates, wrestling his mother's chart from the clerk in the records department. Frantically reading it in a stairwell, he learns that he was repeatedly subjected to negligence and abuse as a child, and that his father is truly unknown. Having lost faith in his mother, Arthur's life unravels further and he sets a series of events in motion that put Gotham City in the same state of turmoil and chaos that he feels inside. In the riots that ensue, Thomas Wayne and his wife are murdered outside a theatre, initiating the transformation of Bruce Wayne into Batman. One of the many intriguing aspects of the film is that viewers cannot trust Joker to be a reliable narrator. Some events may have actually taken place, some may only be his imagination. It could also be that the entire movie is a flight of fantasy that Joker has while he is in Arkham Asylum. In the one-

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shot graphic novel called *The Killing Joke*, Joker says "If I am going to have a past, I prefer it to be multiple choice." Joaquin Phoenix said that his conceptualization of the character continued to evolve during production, even to the last day of filming. He was drawn to play the character because of Arthur's yearning for warmth, love and compassion.

There is much speculation as to which diagnosis or diagnoses Joker might have. He has been treated at the Arkham Asylum (details unknown) and has received prescription medication (unfortunately with fictitious medications on the label), so psychiatrists there ostensibly think something significant is going on with him. The list of speculative diagnoses consists of: Major Depressive Disorder, Schizophrenia, Schizoaffective Disorder, Bipolar Disorder, Post-Traumatic Stress Disorder, Dissociative Identity Disorder, a Learning Disorder, and Schizotypal Personality Disorder. Another intriguing possibility is that of pseudobulbar affect (most likely from head injuries sustained as a child) leading to gelastic seizures. Arthur does seem to have "emotional incontinence" with regard to his laughing fits—they occur at the most inopportune times and he even carries a laminated card with him to inform people that his laughing fits are caused by a medical condition. Arthur's laugh does have an involuntary, almost painful quality. His facial features are incongruous to his laugh during his fits, and he looks more as if he is trying to cry. After his transformation into Joker, he has a more genuine laugh.

There are many hidden gems in this movie! The name of the comedy club where Arthur has his debut is called Pogo's. Pogo the Clown was serial killer John Wayne Gacy's stage name when he was a professional clown. The 0.38 caliber revolver that Arthur is given is the same model used by Cesar Romero in the Batman TV show. Joker is an homage to other films, most notably *Taxi Driver* (1976), *Raging Bull* (1980), and *King of Comedy* (1982). The murder of the Wall Street traders eerily resembles the 1984 shooting by vigilante Bernhardt Goetz.

Viewers need not be Batman fans to appreciate this movie. It is an extraordinary presentation and fully deserves the accolades and awards it has received. *Joker* leaves us with a lingering consideration for psychotherapy… Arthur sums up his existence by saying, "I used to think my life was a tragedy, but now I realize it's a comedy." A similar sentiment was apparently expressed by Charlie Chaplin who said, "Life is a tragedy when seen in close-up, but a comedy in long-shot."

Conflict of Interest: None

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Dave Robinson is a psychiatrist practicing in London, Ontario. He sat in the original Batmobile in 1968 when it was on tour in Winnipeg. His wife Jennifer is a pharmacist who once had the pleasure of assisting Adam West in her frontier apothecary in Edmonton.

Physician, Heal Thyself. But Not at Work.

Harneet Gill, MD

The 2019 movie, *Joker,* in which Arthur Fleck is revealed to have suffered significant trauma in childhood leading to severe mental disturbance, is a shocking look at what tragedy can result when our wounded are rejected by society. My favourite scene showed a note in his journal that poignantly sums up what life is like for those of us who live with a similar reality: "The worst part about having a mental illness is people expect you to behave as if you don't."

As a resident family physician with complex post-traumatic stress disorder, I have never found any setting in which this holds more true than in my own medical education.

My residency program often states it is striving to end the stigma and surprisingly high prevalence of mental illness, suicidality, and burnout among its learners. We have workshops on treating trauma and suicidality, access to free counselling, resident wellness committees, and a physician advisor to support us. Yet the reality on the front lines, in the day-to-day practice of medical training within this educational system, can feel like a war zone for someone with mental illness, and especially a history of trauma.

Dr. Terri Aldred (Doctors of BC, 2018), an Indigenous family physician who has been open about the fact that she has been affected by intergenerational and personal trauma, said in an interview that she also felt isolated and often traumatized by the Western approach to medical education and "had a lot of trauma in medical school. But it actually made me very compassionate to health care professionals because I could see that they didn't mean to be culturally insensitive. They were just burnt out and tired and so ill themselves that they couldn't help it."

Throughout my medical education, I have been repeatedly criticized by my preceptors based on judgments and assumptions about me because I don't conform in the hidden culture of medicine. I scored in the 95th percentile on my medical entrance exam and have been nominated for outstanding performance in family medicine and psychiatry but, as a naturally quiet and introverted person also managing the shame, fear and mistrust that accompany complex trauma, I often face prejudice in evaluations. I'm called a poor team member whenever I don't appear enthusiastic enough, but it's never mentioned that the learners who do appear enthusiastic are often faking it because they need good evaluations and letters of reference.

One of the paradoxical gifts of growing up with trauma and addiction is that I have a deep capacity for empathy. On the wards, I use my gift for making people feel seen, heard and understood so that time with my patients and fellow learners is deeply rewarding. But in my first six months of residency, I have worked with many physicians who have criticized me unkindly, made me feel powerless and unheard, and given me countless messages that I'm not good enough. Going to work requires constant self-protection and coping strategies to deal with the re-traumatization coming from my "mentors."

Part of my role as a doctor-in-training is to advocate for those who are vulnerable, and people with mental illness are some of the most vulnerable in society. This includes me, but I never anticipated how much I would need to defend myself against my own profession. In recovery, I follow a lifestyle of self-care so I do things like focus on my breath during down time at work, and I don't allow myself to be bullied by "pimping." But after working with me for two days, one cardiologist observed my self-care behaviours and decided there was something wrong with me. Instead of talking to me and giving me a chance to explain or adjust, he expressed vaguely worded concerns about my wellness and patient safety to my program directors. I was immediately taken out of clinical duties despite my assertions that my GP and I had no concerns about my wellness, and was forced to prove my medical fitness to return to work, a process which took nearly three months. Throughout the process, I was made to feel powerless, unheard, untrusted, and left to worry about what I had done wrong and whether I had harmed one of my patients, while being told this was not punishment, but protection.

Paternalism, prejudice and discrimination remain alive and well in medicine. But with our society's increasing burden of mental illness, how can medical professionals hope to provide solutions when they aren't able to tolerate the differences that go along with mental illness, or even with self-care, in their own ranks?

Conflict of Interest: none

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Harneet Gill is in her first year of residency in Family Medicine in Victoria, BC. She is planning to practice Integrative Medicine including group and individual psychotherapy, and is currently pursuing certification in Mindfulness-Based Cognitive Therapy.

Reference

Doctors of BC (2018). Dr Terri Aldred, Supporting holistic, culturally sensitive, inclusive care. Retrieved from https://www.doctorsofbc.ca/news/dr-terri-aldred-doctors-making-difference

PEACE LOVE AND HEALING

Mel Borins M.D

Love is the healing gift of our soul,
Unselfish acceptance, becoming truly whole,
Love breathes joy and love breathes hope,
Love breathes endless possibilities,
Love connects us all, fills our lives with harmony.

A newborn takes her first breath, and screams out her first cry,
An old man sighs deeply, says goodbye and closes his eyes.
Lifecycles ever turning, spinning round and round,
No one lives forever, we are all spirit bound.

We have all made mistakes and have scars deep inside,
The ones we love have hurt us, we feel shame we try to hide,
Forgiveness is the answer, to heal our soul,
Share your pain with others, forgive and let go.

To heal is to restore, sickness into health,
Each one of us is special, celebrate your true self,
Medicine can help you, and healers show you the way,
Your body, mind and spirit, growing more whole each day.

Believe in your power, to transform the path you're on,
You have the potential to take charge and become strong,
Miracles still happen, no time to hesitate,
Believe in your power, it's not too late.

This song was inspired by Dr. Bernie Siegel who I brought to Toronto on numerous occasions to give lectures and workshops. The song is featured on https://www.youtube.com/watch?v=zwcK9Duu6Co

CHANGES

Mel Borins M.D.

My eyes were closed and I was hurting,
Head in the sand, wishing for a change,
The road I'm on is a dead end,
I need to make a change

Time to shed my old skin,
Spread my wings and leave my cocoon,
Break out of the chains, wrapped around my brain
It's time to make a change.

Open my eyes, so confused,
So many paths, don't know which way to turn.
Time to let go,
I got to make a change.

I began to crawl on my hands and knees,
Tried to stand, but just fell down,
Finally, stood on my own two feet again.

It felt so good to walk again.
Took tiny steps, winding path,
Lost in a fog, hard to see ahead.
Three steps forward, two steps back,
Felt like giving up, but I pushed on.
Came to a bridge, old and dangerous,
I crossed it anyways, darkness fell.

Climbed round and round and round the endless mountain,
So many guides, helped me find my way.
Climbed to the top, victorious,
Fist in the air, my head held high.

The only change I ever made, is the change inside my heart.
First step to make a change, is to dream a brand new start.
Change is so difficult, all begins by letting go,
Reach out and trust, stick your neck out.

Sunshine on a rainy day, rainbow lights the sky.
Trees and flowers everywhere, birds waving as they fly.
Change is so difficult, all begins with one small step.
Have faith and trust, stick your neck out.

This was inspired by a training week at the Bayer Institute of Health Care Communication to learn how to present the workshop "Choices and Changes." As part of the homework I wrote a 3- part poem which summarized some of the concepts of the process of Change in psychotherapy. The songs can be found at: https://melborins.bandcamp.com/track/changes-part-one-head-in-the-sand; https://melborins.bandcamp.com/track/changes-part-two-on-the-path; https://melborins.bandcamp.com/track/changes-part-three-victorious; https://www.youtube.com/watch?v=M430TSi2dJU'

COMING ALIVE

Mel Borins M.D.

Tried to run, I've been trying to hide,
Pressure in my chest, feelings bursting inside,
Neck stiff and tight, elastic band round my brain,
So out of control, feels like I'm going insane.

Went to the doctor, here's what she said,
"You've been living inside your head,
You have to let go, or you won't grow.
You need to forgive, so you can live."

I started to cry, scenes flooding my mind,
Images so vivid,
It was like it was happening again, just like the first time.
I cried the tears, felt the pain,
Went through the hurts, again and again.

A voice started talking to me,
Saying, "It's all right,
You're still alive, the sun is shining outside.
The worst is over, you've survived,
The worst is over, you're alive."

Coming alive, I can feel me,
Finally free, I can feel me.

This song was inspired by a psychotherapy patient who worked through a traumatic experience of the past. It can be heard at: https://melborins.bandcamp.com/album/songs-of-healing

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Mel Borins is a family physician and Associate Professor in the Faculty of Medicine at the University of Toronto. He is author of Go Away Just for the Health of it and Possibilities—The Pronoic Photosongbook. Dr. Borins is a mentor with MDPAC and organized the first three all-day Psychotherapy Conferences for the GPPA from 1987 to 1989.

Report from the MDPAC Board of Directors

Elizabeth Parsons, MD, CCFP, FCFP

In early January, I remember hearing a lot of discussion about how the coming year was going to be a special one. I'm sure no one was predicting we would be experiencing a pandemic. How this will affect our practices is yet to be seen, however disruptions to our lives and our patients' lives are certain. I imagine that this topic will come into our work more and more. It may mean conducting sessions by phone or video and cancellations of groups and trainings. Once again, as with the climate crisis, our work is crucial in helping others make sense of the world and of our place in it. I wonder how things will be six months from now when I write my next report. For now I will report on MDPAC's current activities.

MDPAC 33rdAnnual Conference and AGM

Unfortunately, the pandemic has forced a change of plan. The conference is being rescheduled to November 6 and 7 at the Radisson Admiral, Toronto. "Piecing Together the Psychotherapy Puzzle" includes plenaries on Unconscious Cognitive Biases and Somatizing, as well as workshops on Internal Family Systems, Trauma-informed Care Interventions, and an Approach to Sensorimotor Psychotherapy (by our own Dr. Harry Zeit). The conference is a wonderful opportunity to connect and reconnect with MDPAC colleagues as well as learning some new skills, and getting a taste of that therapeutic approach that you've been wondering about.

The Annual General Meeting must be held within 6 months of the end of the previous year, so we are planning to hold it virtually. We are looking at an evening meeting, possibly May 20. These plans are subject to change, so please look for updates by email, on the website, and on social media.

Strategic Plan

The Strategic Plan came about from the Visioning Day that the Board held in March 2019. From this we came up with a list of strategies. For the past six months we have focused our efforts on *Strategy #3: to develop public relations, credibility, visibility, and branding.* In October, having reviewed several proposals, the Board voted to hire the public relations firm IMPACT to assist us with strategy #3. Their work thus far has included setting up Facebook and Twitter accounts for MDPAC as well as a microsite that will shortly be linked on our website. We have recently started to target advertisements online for MDPAC directed at physicians, which we hope will generate some interest and awareness (and some new members) in our organization. The microsite will include a blog section where members can contribute personal narratives about their work as medical psychotherapists. Please contact Carol Ford at info@mdpac.ca if you are interested in contributing to the blog.

There are two other main strategies as part of the strategic plan: *#1 – develop educational programs and #2 – develop credentialing and change of scope.* The Board is looking for Champions for these two strategies. Please contact Carol Ford if you'd like to get involved in anything related to the Strategic Plan. We need energetic and creative input and leadership to continue to develop and promote our vision for medical psychotherapy.

Committee News

PTeR: for MDPAC members, we were able to secure 100 spots for asynchronous training in the McMaster Psychotherapy Treatment and e-Resource, an online introductory training program that incorporates readings, videos, quizzes and "virtual training" in various modes of psychotherapy. Unfortunately, our educational license only runs from October 2019 to October 2020, after which time our special price of $50 per person runs out. Fifty MDPAC members have signed up for this program, so spots are still available. However, you would only have a few months to complete the program.

The second run of the MDPAC Psychotherapy Training Program is set to begin this September. We would like to get the word out so please tell your physician colleagues about it. I'm looking forward to teaching the fourth module along with Robin Beardsley. Further information can be found on MDPAC's website.

The Professional Development Committee is continuing with its new implementation plan for the CPD expansion. The internal launch took place November 23 at the OMA offices, and participants were able to give feedback that will help improve the system. This has been deferred a year and there will be a detailed article on the new program in next year's spring issue of the *Medical Psychotherapy Review.* There has been some concern about some members not keeping up with the required CE/CCI credits, particularly for those in Ontario using MDPAC as the pathway for recording the credits required to maintain our licensing. Our three year cycle is ending September 30, 2020 and this time,

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Report from the MDPAC Board of Directors | continued

due to the implementation of the new tracking system, it may not be possible to migrate credits from one cycle to the next the way it was with the old system. For this reason it is imperative that you complete and record your credits prior to September 30.

Please check the website for Education Committee offerings. There have been recent sessions on legal issues and mental health, group treatment for addictions, and advances in neuroscience and novel treatments of PTSD. These are hour-long sessions via Zoom that are recorded and available for a fee.

Psychotherapy Funding

As our Ontario members know, the past year has held uncertainty regarding the decision to limit psychotherapy codes. As of this writing, we are still waiting to hear the final decision, supposedly on April 1st. Ontario physicians did receive an increase in fee codes for psychotherapy as well as an increase in the premium for those billing more than 50% psychotherapy codes.

Board member Mattie Abell has been working to build connections with physicians in British Columbia who are interested in being able to provide psychotherapy. Currently, family physicians in BC are only able to bill twice a year per patient for psychotherapy. Please contact Mattie if you would like to help with this initiative.

Thank you to all those who are working so hard to protect and promote physician-delivered psychotherapy. I am proud to be a member of MDPAC and to work with such dedicated colleagues. May you and your loved ones be well and let's continue to support one another through these very uncertain times.

Conflict of Interest: none

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

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Journal:

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

Contact a Member

Search the Membership Directory or contact the MDPAC Office.

Listserv:

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

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

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

Reasons to Contact the MDPAC Office:

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

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

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