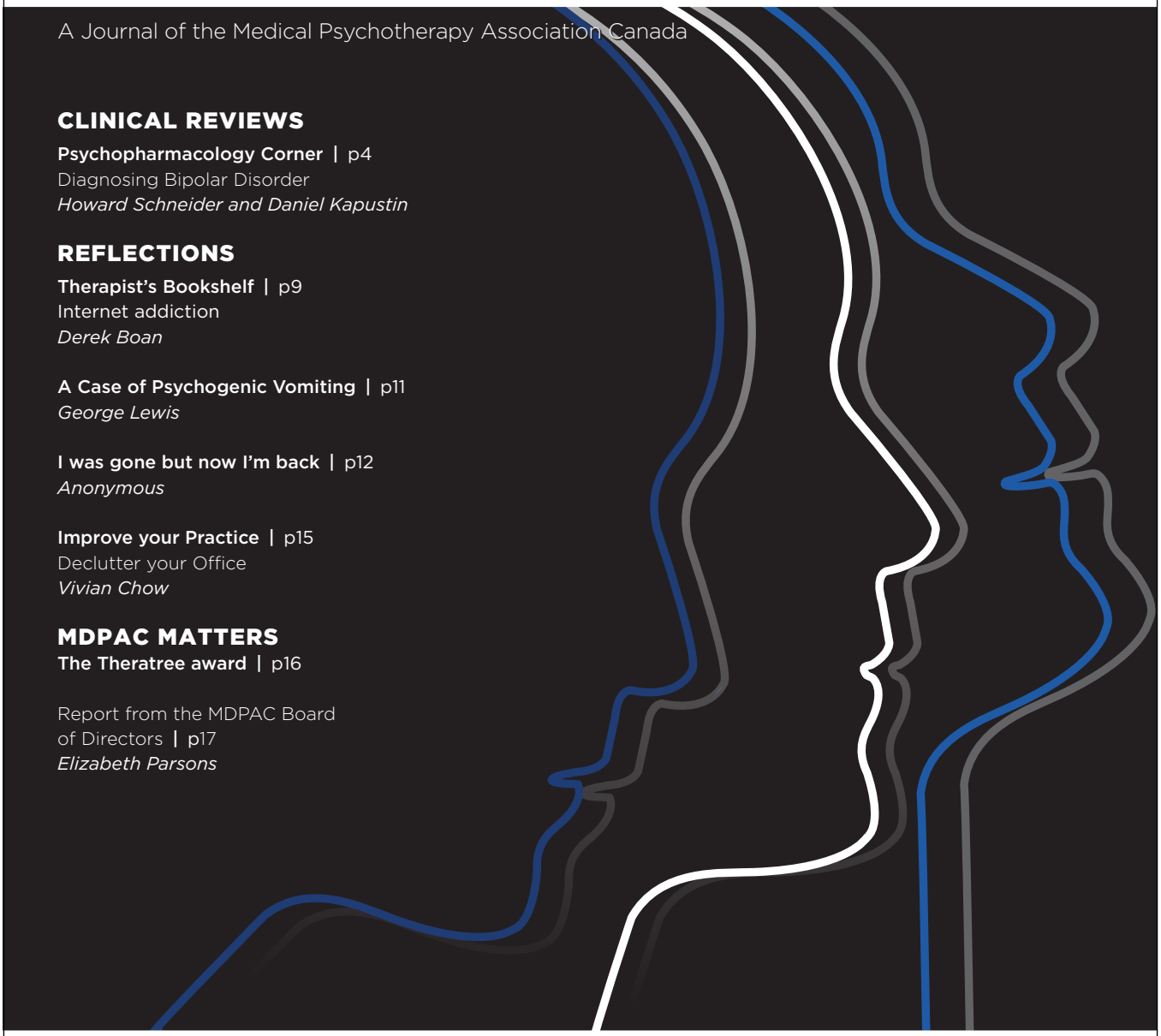
FALL 2019 | VOLUME 26 | 2

MEDICAL PSYCHOTHERAPY REVIEW

A Journal of the Medical Psychotherapy Association Canada



MDPAC ACPMD
MEDICAL PSYCHOTHERAPY ASSOCIATION CANADA
ASSOCIATION CANADIENNE DE PSYCHOTHÉRAPIE MÉDICALE

"WHO CAN SAVE CHILD FROM A BURNING HOUSE WITHOUT TAKING THE RISK OF BEING HURT BY THE FLAMES? WHO CAN LISTEN TO A STORY OF LONELINESS AND DESPAIR WITHOUT TAKING THE RISK OF EXPERIENCING SIMILAR PAINS IN HIS OWN HEART AND EVEN LOSING HIS PRECIOUS PEACE OF MIND? IN SHORT: 'WHO CAN TAKE AWAY SUFFERING WITHOUT ENTERING IT?'"

Henri Nouwen, The Wounded Healer

We've all noted tears welling in our own eyes when we hear stories of tragedy and loss. We've likely also rejoiced with our patients when they overcome obstacles. And we've encountered people who exude such anxiety that it contaminates all within a 100m radius.

The challenges of transference and counter-transference are familiar to all who practice psychotherapy. Finding the balance between healthy empathy and emotional entanglement, between compassion for others and compassion for self, can be difficult. As Nouwen note, empathy is endemic to humanity. But often we are so busy caring for others that we neglect ourselves. I don't need to list the various "self-care" strategies we all utilize, but will mention that I recently joined a MDPAC peer-support group, which I am enjoying immensely. Even if we do not have a difficult case to discuss, we appreciate the opportunity to listen to others and share our experiences.

This issue of the Medical Psychotherapy Review contains some illustrations of self-care and self-compassion. George Lewis shares his personal journey of awakening to emotions and eventually using his experience to help others. A patient of one of our members also writes about his descent into a deep depression, followed by his ascent into "normality." Reflective journaling can be therapeutic to both doctors and patients!

On a lighter and more practical note, our "Improve your Practice" column offers physicians advice for self-care and stress relief. Vivian Chow shares her experience of using the Marie Kondo method for decluttering her home and office.

In our regular column, "Psychopharmacology Corner," Howard Schneider and Daniel Kapustin, discuss the multi-faceted nature of mood disorders. They note that, despite the importance of early identification of bipolar disorder, there are challenges involved in its diagnosis. This issue's "Therapist's Bookshelf" contains a review of

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

Internet Addiction, a new but growing problem. Caution is advised any of us who use the Internet as a self-care tool!

Finally, in "MDPAC Matters," we hear about and from George Neeson, this year's recipient of the Theratree award. In his retirement, he is likely expanding his self-care routines. Elizabeth Parsons, in her "Report from the MDPAC Board," shares some exciting developments for our organization, including MDPAC's vision and mission for the next few years.

May we continue to be encouraged through the experiences of our colleagues and our patients.

Grace and peace,
Janet Warren

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Medical Psychotherapy Review
ISSN 1918-381X

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The MDPAC publishes the 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

Diagnosing Bipolar Disorder

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

Abstract

Diagnosing Bipolar Disorder (BD) is particularly challenging due to the extent of diagnostic overlap and comorbidity with other psychiatric disorders. Notably, distinguishing BD from Major Depressive Disorder (MDD) is a common challenge for clinicians. In addition to having a thorough understanding of the diagnostic criteria for BD, practitioners must carefully assess patients' longitudinal symptom progression, family history, and response to medications when evaluating a potential mood disorder. Early identification of BD is essential to maximize therapeutic efficacy and reduce the rate of unnecessary treatment. In this article, we discuss the utility of implementing clinical strategies such as frequent follow-ups, prodromal symptom assessment, and screening questionnaires when evaluating a potential mood disorder. Ultimately, it is important to observe patients longitudinally to ensure appropriate, evidence-based diagnoses.

Challenges of the Bipolar Disorder Diagnosis

In the last issue's *Psychopharmacology Corner,* we considered the Canadian Network for Mood and Anxiety Treatments (CANMAT) guidelines for mild-to-moderate Major Depressive Disorder (MDD). In this issue the plan was to continue with a review of the CANMAT guidelines for Bipolar Disorder (Yatham et al., 2018). Unfortunately, very few of the pages of these guidelines actually focus on the diagnosis of BD. For the medical psychotherapist, if not actually for most practitioners, the first and largest challenge in treating BD may be accurately identifying the diagnosis, given its overlap with other disorders. Thus, before considering the BD treatment guidelines, we will focus on diagnosing BD in this issue.

Throughout this article, we will refer to the case of Mackenzie, a second-year university student presenting to clinic for the treatment of depression. Mackenzie has had two episodes of depression in the past, first beginning in her late teens. She currently meets the DSM-V criteria for a major depressive episode (MDE). On review of her history, it is found that in her first year of university she was given a prescription for methylphenidate by her school's health and wellness center for concerns of difficulty focusing in class. She is started on an SSRI and will return to the clinic after four weeks.

The diagnosis of BD is particularly challenging and may take years before being recognized clinically. Dagani and colleagues (2017) performed a meta-analysis of 27 studies with 9415 patients, and found that the average interval between the onset of BD symptoms and definitive management for BD was nearly six years. During this time, which in some cases was over a decade, patients essentially suffered without adequate treatment.

It can be challenging to distinguish BD from a variety of other conditions. For example, Fornaro and colleagues (2016) showed on average, that 22% of patients (38% if Bipolar II Disorder is considered) with BD had a comorbid Borderline Personality Disorder (BPD) diagnosis. The significant comorbidity between these two disorders further challenges diagnostic decision-making. Due to the lack of useful biomarkers available at the clinical level, the diagnosis of BD, BPD, as well as other disorders we will discuss below, occurs essentially via a somewhat subjective and overlapping description of the symptoms.

From the viewpoint of physicians, the most challenging differential diagnosis for BD is MDD. If a diagnosis and treatment of Bipolar Disorder is delayed the many years as is typically the case, the patient may receive inappropriate treatments and suffer unnecessary distress. A useful discussion for separating out these two disorders is given in the recent work of Roger McIntyre and colleagues (2019).

Historical and Current Diagnosis of Bipolar Disorder

Mason and colleagues (2016) discuss the historical diagnostic criteria for Bipolar Disorder, from the "Manic-Depressive Insanity" of Dr. Emil Kraepelin over a century ago, to the "Manic-Depression" psychotic disorder of the DSM-I in 1952, the "Manic-Depressive Illness" affective disorder of the DSM-II in 1968, and the modern term "Bipolar Disorder" of the DSM-III in 1980. The DSM-III separated Unipolar Depression and Bipolar Depression as different types of mood disorders. The DSM-III describes Manic Episodes, Depressive Episodes, as well as the possibility of Mixed Episodes. When released in 1994, The DSM-IV further provided more exact diagnostic criteria for Mixed Episodes. The DSM-V's (American Psychiatric Association, 2013) diagnostic criteria for Manic, Hypomanic, and Depressed Episodes remained largely similar although the mood criteria for a Manic Episode required both an elevated/expansive/irritable mood plus increased energy/goal-directed activity. As well, Man-

ic Episodes remained valid if they occurred after administration of an antidepressant, as did Hypomanic Episodes. The Mixed Episode was no longer a separate category but instead it became a specifier ("with mixed features") that could apply to Manic/Hypomanic Episodes or Depressive Episodes.

The DSM is not without criticism. The advent of neuroimaging and genetic data remains to be incorporated into the DSM nosology. Allsopp and colleagues (2019) criticize the symptom overlap of the DSM-V and its failure to adequately include the influence of trauma. While Kraepelin, a century ago, had considered a spectrum of depression and mania, including mixed episodes, the modern DSM-III assumed a more distinct polarity of moods. The concept of a Bipolar Spectrum has been considered seriously for decades (e.g., Akiskal and Pinto, 1999), yet is not adequately handled by the DSM-V. The NIMH Research Domain Criteria (RDoC) is an alternative framework to diagnose equivalent clinical "Bipolar Disorder" pathology, but is not without its own criticism and is not considered valid for clinical use at this time (Garvey et al., 2016). Thus, for now we use the DSM-V in our discussion of BD.

In the DSM-V, if there is a Manic Episode then the diagnosis is Bipolar I Disorder. There could have been many Major Depressive Episodes before the Manic Episode or after the Manic Episode, or similarly Hypomanic Episodes before and after the Manic Episode, but the diagnosis remains Bipolar I Disorder.

For a diagnosis of Bipolar II Disorder there must be at least one (current or past) Hypomanic Episode and at least one (current or past) MDE. If there has ever been a Manic Episode then the diagnosis is Bipolar I Disorder.

The criteria for a Manic Episode are:

A. One week of elevated, expansive or irritable mood plus abnormal, increased energy or goal-directed activity
B. Three of the following changes from normal (four if mood is only irritable):
   1. Increased self-esteem or grandiosity
   2. Decreased need for sleep
   3. Increased talkativeness or pressured speech
   4. Subjective experience of racing thoughts or flight of ideas
   5. Increased distractibility
   6. Increased goal-directed activity or psychomotor agitation
   7. Increased involvement in activities with poor consequences, e.g., foolish investments, unrestrained purchases, sexual indiscretions
C. Impairment in functioning
D. Not attributable to a physiological substance or medical condition, but persistence of a Manic Episode during antidepressant treatment allows the Bipolar I diagnosis

The criteria for a Hypomanic Episode are:

A. Four days of elevated, expansive or irritable mood plus abnormal, increased energy or any activity
B. Three of the following changes from normal (four if mood is only irritable):
   1. Increased self-esteem or grandiosity
   2. Decreased need for sleep
   3. Increased talkativeness or pressured speech
   4. Subjective experience of racing thoughts or flight of ideas
   5. Increased distractibility
   6. Increased goal-directed activity or psychomotor agitation
   7. Increased involvement in activities with poor consequences, e.g., foolish investments, unrestrained purchases, sexual indiscretions
C. Change in functioning
D. Change in mood and functioning are observable by other people
E. No marked impairment in functioning. If there are psychotic features the episode is a Manic Episode
F. Not attributable to a physiological substance or medical condition, but persistence of a Hypomanic Episode during antidepressant treatment allows the Bipolar II diagnosis

The criteria for a Major Depressive Episode (MDE) are:

A. Two weeks with five or more of the following symptoms that must include #1 or #2:
   1. Depressed mood nearly every day
   2. Significantly decreased interest or pleasure in almost all activities
   3. Weight loss or gain >5% or decrease/increase appetite nearly every day
   4. Insomnia/hypersomnia nearly every day
   5. Psychomotor agitation/retardation nearly every day
   6. Fatigue or loss of energy nearly every day
   7. Feelings of worthlessness or inappropriate guilt
   8. Decreased ability to think or concentrate, or indecisiveness nearly every day
   9. Recurrent thoughts of death or suicidal ideations without a plan, or suicidal plan/attempt

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B. Significant distress or impairment
C. Not attributable to physiological substance or medical condition

Strategies to Differentiate Bipolar Disorder from Other Diagnoses

As mentioned above, it can be challenging to differentiate Bipolar Disorder with regard to MDD. McIntyre and colleagues (2019) note that due to the similarities between Depressive Episodes of BD and MDD it may take a decade before the practitioner arrives at the correct diagnosis. However, they present a set of best practices to help the clinician differentiate between BD and MDD, based on an online poll, a focus group, and an expert panel. The online poll respondents actually chose Borderline Personality Disorder, and then MDD and Attention-Deficit/Hyperactivity Disorder (ADHD) as the most challenging to differentiate from Bipolar I Disorder (BP-I). The focus group clinicians echoed the same difficulties, as well as adding to the list: Substance Abuse, undiagnosed Traumatic Brain Injury and Post-Traumatic Stress Disorder (PTSD). These focus group clinicians were also concerned by mood swings, although the expert panel advised that such abrupt changes in mood suggest other disorders such as Borderline Personality Disorder more so than BD.

The online poll respondents were asked that when they see a new patient with a MDE what factors they considered as being most useful to differentiate MDD from BD. There was no majority opinion in what was considered the most useful factor, although 29% chose an "accurate family history," with others choosing "corroborating evidence from family," "clinical presentation," and at 20% "evidence of early age at onset of depressive symptoms." However, the focus group clinicians reported as most useful differentiating factors—clinical presentation, number of episodes and age of episodes, illness severity, sleep history, and grandiosity. While these focus group clinicians were also concerned by psychosis as a factor in predicting a BD diagnosis, the expert panel advised that though psychosis may predict a more complex mood disorder it can occur also in MDD and thus cannot be used by itself to distinguish BD from MDD. The expert panel felt that, unlike the choices of the participants, perhaps the most important factor in predicting a diagnosis of BD is the clinical presentation, followed by family history and corroborating evidence from family members. Dr Zimmerman of the panel felt that since patients who present for BD treatment do so for depressive and anxiety symptoms more so than hypomanic symptoms, a strong history elucidating episodes of mania or hypomania is of importance.

McIntyre and colleagues (2019) note that the lifetime comorbidity of other psychiatric disorders in BP-I ranges from 50% to 70%, further making an accurate diagnosis of BD more difficult. Often, an irritable mood is present in BD, but such a symptom can also present in MDD, Disruptive Mood Dysregulation, Premenstrual Dysphoric Disorder, Generalized Anxiety Disorder, PTSD, Oppositional Defiant Disorder, or Antisocial Personality Disorder.

The expert panel felt that despite constraints on the health care system, the clinician must attempt to spend an adequate amount of time to obtain the fullest history. Indeed, a thorough history is often central to distinguishing between disorders with overlapping symptomatology. For instance, in differentiating between a bipolar and unipolar mood disorder, close attention to several pertinent features may help to raise the clinician's suspicion of bipolarity. These include early age of onset, recurrent depressive episodes, family history of BD, atypical depressive symptoms (e.g. hypersomnia and hyperphagia), and antidepressant-induced mania or rapid cycling. Several patient factors also play a role in the diagnostic algorithm. For example, while the incidence of BD is comparable across sexes, MDD is more prevalent among women. As well, a recent reproductive life event may suggest the presence of a postpartum mood disorder. Clinicians must be careful to also consider secondary medical illness or medication use as potential diagnostic confounders.

When Mackenzie returns to your clinic after four weeks, she also endorses a several week history of hypersomnia preceding her initial presentation; however, states that since beginning antidepressant therapy she feels improvements in her energy and a reduced nightly sleep duration. With a more detailed look at her past medical history you learn that she has noted little benefit in her concentration after initiating methylphenidate. On exam, she appears irritable throughout the encounter and you observe an increased rate of speech. Indeed, Mackenzie's failed ADHD therapy, atypical depressive symptoms, and potential onset of hypomanic symptoms should raise suspicion for BD.

In cases of suspected BD, there are several clinical strategies which may help to further refine the diagnostic inquiry. Patients seeking treatment often present with symptoms of depression and anxiety rather than mania or hypomania. It is therefore essential to screen patients for BD not only at the first visit, but also subsequently if therapeutic response is insufficient. Indeed, while failed response to antidepressant therapy may suggest potential BD, other factors including inadequate dosing or poor adherence must also be taken

into consideration. Additionally, seeing patients more frequently at first, ensuring appropriate gathering of collateral information from relatives, and closely monitoring suicidal ideation and behaviours will all contribute to an evidence-based diagnosis.

Furthermore, the use of clinical screening tools such as the Mood Disorder Questionnaire (MDQ) is encouraged during assessment (Chiu & Chokka, 2011). However, these screens should not be considered proxies for actual diagnosis given their proclivity to produce false positive results as well as missing diagnoses. A close look into the predictive efficacy of the MDQ reveals a positive predictive value of 58% and negative predictive value of 89% (Zimmerman & Galione, 2011).

You have Mackenzie complete the MDQ and you conduct a standardized assessment. This assessment helps you to learn that Mackenzie has had hypomanic episodes in the past, consisting of irritability, pressured speech, and reduced sleep requirements. As a result, you make a diagnosis of Bipolar II Disorder and decide to start her on a mood stabilizer.

Summary

Early and accurate diagnosis is important for clinicians because treatment earlier in disease course is generally more effective. For example, a longitudinal, prospective assessment of 298 patients diagnosed with mood disorders demonstrated that 96% of patients started on lithium within five years of diagnosis had what the authors defined as improvements in rates of acute mood episodes, over a four year follow up (Franchini et al., 1999). The proportion of patients benefitting from such improvements fell to 83% and 49% when therapy was initiated at >5 or >10 years of illness onset, respectively. Though five years may seem ample time to reach a diagnosis, in reality the average interval between onset and management of BD is nearly six years (Dagani et al., 2017). Furthermore, there is evidence to suggest that therapeutic response to lithium declines with successive mood episodes (Swan et al., 1999).

Skjelstad and colleagues (2011) conducted a review of more than 1,500 patients to evaluate prodromal features of BD. While symptoms associated with mania (e.g., elevated mood) appeared to be more promising discriminators, the team concluded that limited data and overall low specificity of these symptoms makes early disease evaluation difficult. Moreover, while repeated episodes of mood dysregulation, accompanied by additional risk factors such as family history may justify an increased clinical suspicion of illness, it is not uncommon that only a longitudinal, retrospective review of a patient's clinical course can make a diagnosis possible. Therefore, there currently remains a clear need to effectively identify patients in the early stages of disease in order to initiate management and mitigate disease burden.

According to Dr Goldberg, it is useful to first "cast a wider net of diagnostic possibilities" and then eliminate diagnoses as more clinical data is obtained. Longitudinal patient evaluation and monitoring illness course through time remains the "great validator" of diagnosis. Ultimately, only a thorough assessment of symptom constellations, patient risk factors, psychosocial context, comorbidity, and longitudinal progression will ensure a holistic, evidence-based differential diagnosis.

Mackenzie returns to clinic two weeks later for follow-up. She says she has been tolerating her new medication quite well and has been feeling like her emotions are back to normal. She endorses being less distractible during her classes and has noticed improved focus when working on her assignments. During your encounter, you observe that she appears less agitated compared to her previous visit and her rate of speech is now normal. You counsel Mackenzie to discontinue her methylphenidate. You book her for follow-up several weeks from now to continue monitoring her progress.

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.

Daniel Kapustin is a fourth-year medical student at the University of Toronto. He has an undergraduate degree in neuroscience and is pursuing a career in psychiatry.

References

Akiskal, H.S. and Pinto, O. (1999). The Evolving Bipolar Spectrum: Prototypes I, II, III, and IV. *Psychiatric Clinics of North America, 22*(3): 1 Sept, pp. 513–534.

Allsopp, K., Read, J., Corcoran, R. & Kinderman, P. (2019). Heterogeneity in psychiatric diagnostic classification. *Psychiatry Research, 279*, pp 1522.

American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition.* Arlington, VA: American Psychiatric Association.

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Chiu, J.F. & Chokka, P.R. (2011). Prevalence of Bipolar Disorder symptoms in Primary Care. *Canadian Family Physician 57*(2): e58–e67.

Dagani, J., Signorini, G., Nielssen, O., et al. (2017). Meta-analysis of the Interval between the Onset and Management of Bipolar Disorder. *The Canadian Journal of Psychiatry, 62*(4), 247–258.

Fornaro, M, Orsolini, L, S.Marini, S., et al. (2016). The prevalence and predictors of bipolar and borderline personality disorders comorbidity: Systematic review and meta-analysis. Journal of *Affective Disorders, 195*, May:105–118.

Franchini, L., Zanardi, R., Smeraldi, E. & Gasperini, M. (1999). Early onset of lithium prophylaxis as a predictor of good long-term outcome. *Eur Arch Psychiatry Clinical Neuroscience*, 249, 227–230.

Garvey, M. Avenevoli, S., and Anderson, K. (2016). The national institute of mental health research domain criteria and clinical research in child and adolescent psychiatry. *Journal American Academy Child and Adolescent Psychiatry, 55*(2): 93–98.

Mason, B. L., Brown, E. S., & Croarkin, P. E. (2016). Historical underpinnings of bipolar disorder diagnostic criteria. Be*havioral sciences*, 6(3), 14. doi:10.3390/bs6030014.

McIntyre, R.S., Zimmerman, M., Goldberg, J.F., et al. (2019). Differential diagnosis of major depressive disorder versus bipolar disorder: current status and best clinical practices. *Journal of Clinical Psychiatry, 80*(3):0518043ah2.

Skjelstad, D.V., Malt, U.F. & Holte, A. (2010). Symptoms and signs of the initial prodrome of bipolar disorder: a systematic review. *Journal of Affective Disorders*, 126, 1–13.

Swann, A.C., Bowden, C.L., Calabrese, J.R., Dilsaver, S.C. & Morris, D.D. (1999). Differential effect of number of previous episodes of affective disorder on response to lithium or divalproex in acute mania. *American Journal of Psychiatry*, 156, 1264-1266.

Yatham, L.N., Kennedy, S.H., Parikh, S.V. et al. (2018). Canadian Network for Mood and Anxiety Treatments (CANMAT) and International Society for Bipolar Disorders (ISBD) 2018 guidelines for the management of patients with bipolar disorder. *Bipolar Disorders*, Mar 1, 2018(2):97–170.

Zimmerman, M. & Galione, J.N. (2011). Screening for bipolar disorder with the Mood Disorders Questionnaire: a review. *Harvard Review Psychiatry*, 19, 219–228.

A Blossoming Worldwide Problem

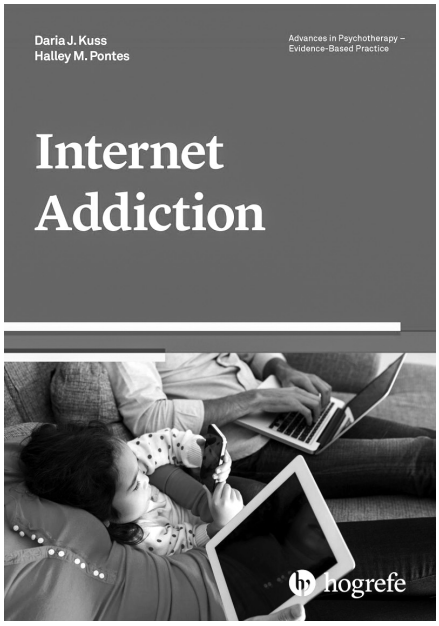
A review of *Internet Addiction*
Daria J. Kuss and Halley M. Pontes. Boston: Hogrefe Publishing Group, 2019, 86 pp. $31.61, paperback

Derek H Boan, MD, CCFP, MSc

This 86-page book, on a topical issue, needed to be written! These two British- based chartered psychologists, Kuss and Pontes, have produced a well-researched, well-organized, concise book about a complex issue that plagues societies around the world. I*nternet Addiction* is divided into four sections: Description, Theories and Model of Internet Addiction, Diagnosis and Treatment Indications, and Treatment.

From a medical psychotherapist viewpoint, I was a bit disappointed that only one case vignette was provided. The case cited in this book involved complex trauma, demonstrating the inherent power of internet addiction, giving users a sense of intrigue, importance, purpose, as well as allowing them to avoid other issues in their lives. The treatment in the case vignette rested on the internet user being given an alternative—a family member willing to spend time with the person and building an emotional relationship, which seemed rather simple.

The first section on Description shows the diversity of the terminology and nomenclature. Although the authors go on to discuss specific behaviours, such as gaming and social networking, the authors have settled on the catch-all term of Internet Addiction. The American Psychiatric Association designated Internet Gaming Disorder (IGD) in the 2013 edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), but only as a tentative mental health disorder, warranting further research. The World Health Organization (WHO) recognized



video-gaming disorder in the ICD-11 International Classification of Diseases. Further discussion of motives and types of Internet Addiction is interesting, especially as related to cybersexual behaviours. The epidemiology is somewhat suspect when one compares prevalence in different countries but uses different population age categories. The prevalence is reviewed with statistics from various countries, indicating a definite global problem. The course and prognosis is thought to be somewhat transient with about half the cases resolving spontaneously over a five-year period. Not surprisingly, comorbidities include Depression and Bipolar Spectrum Disorder, Attention Deficit/Hyperactivity Disorder, Anxiety Disorders, and Personality Disorders. Historically, most of the validated psychometric assessment tools were developed to assess Pathological Gambling. It would have been helpful to have more case vignettes to explore these comorbidities.

The second section summarizes five models: Cognitive-Behavioural, The Syndrome Model, The Components Model, The Neuropsychology-based Model, and The Interaction of Person-Affect-Cognition-Execution Model (I-PACE). Again, it would have been useful to have linked case vignettes to showcase the different models.

The brief two-page section on Diagnosis and Treatment Indications stresses the importance of a thorough psychological assessment. The DSM Structured Clinical Interview for Axis 1 and 2 disorders is promoted, along with a Global Assessment of Function and WHODAS (WHO Disability Assessment Schedule), after using a validated psychometric tool, such as IGD-20 (Internet Gaming Disorder) or IGDS9-SF (International Gaming Disorder Schedule–Short Form), both of which are included in the Appendices.

The final section on Treatment proposes psychological therapy, psychopharmacological therapy and combined treatment, as with most psychiatric problems. CBT (cognitive behaviour therapy for modifying thoughts and behaviours) is most commonly used and the most cost-effective treatment. Depending on the comorbidity, SSRIs, NDRIs, benzodiazepines, antipsychotics, and psychostimulants may prove efficacious in alleviating symptoms and diminish the time spent using technologies. Individual therapy, as known

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A Blossoming Worldwide Problem | continued

previously, relies on the rapport between the client and therapist. Integration of family and significant others is important from an accountability viewpoint, but also for relapse prevention. Group CBT is cost- and time-efficient, suggesting 12–15 sessions, which are nicely outlined in the book.

In conclusion, this book provides an overview to a blossoming worldwide problem and illustrates a foundation upon which to build, in terms of definition, verified assessment tools, comorbidities, and treatment plans. If I were still practicing, I would routinely include a screening tool for internet addiction, while inquiring about substance use and other addictive behaviours, such as gambling and pornography. I found reading *Internet Addiction* to be worthwhile, in terms of understanding the scope of the issue, but it is only the beginning! As a bonus, after reading this book, which is Vol 41 of the series Advances in Psychotherapy – Evidenced-Based Practice, psychologists and other healthcare providers can earn continuing education credits by completing a multiple-choice exam through the National Register of Health Service Psychologists, as approved by the American Psychological Association.

Conflict of Interest: None

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A Case of Psychogenic Vomiting (or my transition from being a Family Doctor to a GP Psychotherapist)

T. George Lewis, MD

"Well Doctor, all your tests are normal—you do not have a medical problem, you have an emotional problem." This was what my somewhat thick-skinned gastroenterologist said to me some 30 years ago.

Prior to this, I had experienced bouts of vomiting….every 15–20 minutes for 24 hours or so. At times I was so weak that I had to go to hospital to get re-hydrated. After one of these admissions, this gastroenterologist was summoned to sort me out, and this was his verdict. Now what? "Well, thank you Doctor, I respect your opinion. I will now go and see an 'emotional' Doctor!"

Luckily, I did find my way to someone who knew about this stuff. Let me back track. I grew up in Ireland, and in retrospect, always had some trouble with my emotions and was considered to be a sensitive child. My father served in World War Two and did not share much about his emotions; he also smoked heavily and used alcohol. Furthermore, my mother was chronically depressed (her own mother passed away when she was six years old) and ten years at a boy's boarding school did not exactly help her develop healthy emotional expression. And so, with that background, I came to Canada in 1974 with a wife and child and my medical degree. And a desire to make a life for myself here.

We entered into life in small-town Ontario. Me as the trusted small-town physician, and my wife with two more children. We were seemingly "The perfect family." But then my father became ill in Ireland. All his years of smoking had caught up with him and now he had his lung cancer. Trying to cope with family life here, looking after a busy practice as well as feeling responsible to my parents in Ireland in their time of need was very stressful. Eventually, my father died. At his funeral, I knew I was in trouble when I felt nothing. Then my wife (who was probably feeling neglected) started to explore other relationships, and that is when my vomiting began.

Ah yes, I have to see an "emotional" doctor. Luckily, I found my way to a physician, since retired, who seemed to know what I needed. He invited me to lie down, do Deep Diaphragmatic Breathing, and then say out loud a clear intention about feeling my feelings. My feet became cold, then started to tremble. The trembling went up my legs to my thighs and then it stopped. With some extra encouragement from the doctor, the trembling started up again and moved through my pelvis into my abdomen and chest and soon, my whole body was vibrating and jumping. Eventually, all the shaking and vibrating cleared and then an amazing peace came over me, which I basked in for the next 30 minutes or so. Soon after, a colleague of mine, who I worked with in the local hospital, was killed in a car accident, and at his funeral, my tears came. What a relief! I knew I was crying for my father and my friend. Later, spontaneous crying would happen, especially if triggered by an Irish song or an old memory.

I learned to embrace all my emotion and all of my pain. By now, my marriage had fallen apart. My kids had moved with their mum out to B.C. and I had fallen apart. I could relate to Job in his hour of need. But then a curious thing happened. I started to write; to write poetry! I started to live and love again. I think I had decided it was okay to be me and that I did want my life after all. Then those things dear to me came back to me. Now, I am married for the 2nd time (25 years!) with three more boys and both of my wives still talk to me. (One of my proudest achievements!)

Of course, as my journey unfolded, I became much more interested in therapy and eventually transitioned into full-time medical psychotherapy. I joined Dr. Michael Paré's clinic to help my patients on their therapeutic journey and have been working in this way for 25 years or so. Now that I am in my 70s, the CPSO wants me to improve my medical records, which I am finding somewhat stressful. However, I like to think I bring something meaningful to my sessions with my patients, which is to do with their unique journeys as well as my own journey.

This is the poem that began my journey:

Death and Birth

To reach down into the depth of my heart
To tear me and myself all apart
To find out what is down there and say~~
Why did I blow myself away?
Why did I let myself go~ and become
a person I did not know?
This is what my pain means to me
It is my labour pain of me about to be!
Welcome T.G.L.

Contact: medclinicbayview@yahoo.ca

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

I Was Gone but I'm Back Again

Anonymous*

I wake up, and immediately wish that I hadn't. The overwhelming feeling of despair isn't the first thought I have, it is just there from the day before. It's like I never slept at all.

There is a constant darkness pushing down on me, it surrounds and invades me. It's the most oppressive feeling I've ever had. I feel trapped.

I'm in a deep, narrow hole like a well. The top of the hole is covered, there is very little light. I'm standing on a small, slippery rock with thick mud up to my waist. If I slip off the rock, I will sink in the mud. I'm desperately clinging to a small strand of hope that I'll get out, but I have no idea how.

I am thinking and moving very slowly.

I endure living for the sake of my family. I tolerate living because I want to see them all again. I miss them horribly.

Every thought I have is sad, anxiety-provoking or both. I try to push everything out of my head, and I will do anything to avoid being alone with my thoughts.

I spend the day waiting to be able to go back to sleep. While I'm awake, I constantly crave distraction from what's going on in my brain—TV and movies give me a distraction for 5–10 minutes at a time. I have no emotional reaction to the stories, and only vaguely care what happens to the characters. I have a lot of trouble following a plotline and remember few details about what happened afterwards. A game on my phone will give me distraction for 10 minutes at a time. I sit alone in the basement for hours at a time watching TV, frozen in place with no interest in moving.

When I hear my family upstairs, some deeply buried part of me wants to join them, but most of the time I just can't do it. People are not a distraction; basic interaction seems impossible and scary.

Just getting through a day is mentally and physically exhausting. I can't nap because that means being alone with my thoughts, and I'm terrified of not being able to sleep at night.

I desperately want to talk to my family, but also just want to be alone. I have things to say, but at the same time I have no idea what I would say if I did talk.

It can take days to figure out how to say something. When I do talk, I usually regret what I say or how I said it. I'm often irritated and harsh with my family and hate myself for it. When they talk to me, I struggle to show that I hear them and that I care, and I hate myself for that too.

I hate the effect I am having on my family. I don't know if I really comprehend how I affect them, I just know it's not good. I hate the fact that I am absent and missing a big and important chunk of my daughters' lives. I hate being an absent husband and father.

I go to watch them in sports or performances, but I'm not really there. I desperately want to find enjoyment, but the emotional response if buried far inside and that makes me sad. I know I'm proud, but can't really feel it, or communicate it. Afterwards I have a poor memory of what happened.

I'm proud of who my daughters have become, but don't know how to tell them. I'm disconnected from the positive feeling of that pride, more just sad that I'm absent. I hate that I'm not the Dad I want to be and hate myself for not being able to help them with their challenges. I'm vaguely aware and thankful that they are being unbelievably patient with me.

I am enormously grateful for my wife's support and patience, and that she somehow picks up the huge amount of slack I create. The gratitude doesn't feel good; I hate myself for what I'm putting her through, and I don't know how she puts up with it. I'm aware though, that her support makes things easier. I'm scared she's going to leave, and really wouldn't blame her.

At the beginning I used to be able to cry, but I can't anymore. Although I feel intense sadness, I'm somehow disconnected from it.

I think it's possible or even likely I will die of a heart attack or blood clot from being so immobile, which seems sad in an abstract way, but I don't seem to really care.

I'm so lonely but have no idea how to change that. I feel completely

isolated. I don't like myself and can't see why anyone would feel any differently about me.

I'm constantly fearful that someone will talk to me, but disappointed when they don't.

I fear being alone with another person, any silence is deafening. Eye contact is terrifying.

The smallest things seem impossible to do. I delay everything until it becomes absolutely necessary, even the basics like going to the bathroom. The only reason I do anything is to try to avoid disappointing my family or people at work.

I have limited interest in basic personal hygiene, and am only sometimes embarrassed by it. I just want it to happen without having to do it, showering seems like a huge, difficult effort. When I do shower, I don't feel refreshed. I have no interest in food, except to fill a void. I'll eat until I feel sick trying to fill the void.

My brain isn't functioning. It does the basics like keeping me breathing and my heart beating, and I'm somewhat surprised it can. My brain is encased in wet concrete that is hardening. Any thought processes with the slightest complexity or need for problem solving seem impossible.

My thoughts are very slow, like fighting through heavy sludge.

I'm paralyzed by uncertainty and fear; I have no confidence in my judgement, even for simple decisions.

I can hear what people are saying, but usually don't really understand what they are telling me. I can understand simple statements, but have a hard time piecing together more than one simple concept or understanding the implications of what is being said. More often than not, I don't remember what people tell me, or that we had a conversation.

Somehow, I desperately want to understand and figure things out, while at the same time I have absolutely no interest.

When at work, I spend most of the time staring at the computer and trying to figure out how to get out of there as soon as possible. I focus on small, simple, necessary tasks. I don't know what else to do, or if I do know of something I could or should do, I can't picture the steps that are needed and can't figure out how to start. I can't remember the details of repeated tasks, and need to relearn them each time. I'm fearful and embarrassed that others know how little I am able to do.

I generally don't remember what happened the day before, or even earlier in the day, everything is in a deep fog.

Irritation with commotion or noise around me is all-consuming. Any noise is too noisy. I feel like I'm made of ice and the noise will shatter the ice. Outdoors is too bright, too cold or too hot, and always too noisy. I can't listen to music, it just sounds like noise and is irritating. I can hear the music but have no emotional response other than irritation and a sadness that I can't connect to it. Hearing people laugh irritates me and makes me sad. People talking around me, and most of their actions, are deeply irritating

I can't imagine talking to people or being in social situations. I have no interest and have all-consuming anxiety they'll see through me and quickly become disinterested or disapproving. It's exhausting to have basic conversations. I'm embarrassed to be who I am.

I occasionally go to things like family gatherings, but only because I know it's important to my wife and to prove to her that I am trying and care about what is important to her. I have no interest in being there other than that, and am consumed by anxiety so strong it is physically painful. All I can think about is how to get out of there.

I believe I am weak for not being able to lift myself out of this. I feel shame and guilt that I'm not doing enough to fix the problem. None of this are things that I can just shake off, they are deeply rooted and they just are who I am. I feel intense sadness, despair, fear and desperation. Not much else. If I smile, I'm faking it.

I'm terrified of the future.

That was my life.

More than 5 years ago, it started with an anxiety that quickly grew

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I Was Gone but I'm Back Again | continued

to be severe and constant. Over time, life spiraled into the depressive state that I've tried to describe. It's bleak, but that doesn't quite capture how horrible life was, or the intensity of the desperation. I don't have the words for an adequate description.

But I'm back now.

I'm back after being very far gone for a long time. The oppressive weight has lifted, and somehow, I've emerged from a dark and desperate state of being.

My brain is working again. I can think, I can feel, and I smile for real. I can see the humour in things, I make jokes, and unbelievably, I can laugh a real laugh.

I can talk to my family. Instead of feeling like I'm on the outside looking in, I know I'm part of the family. I'm capable of engagement, and no longer absent.

I don't push everything away anymore, I take things in, and it feels good.

I can see things that need to be done, and I can think through the steps that need to be taken. I actually want to do things, and I don't question my every thought and move.

Music is deeply meaningful to me again. The first time I chose to listen to music in a very long time I cried, overcome by the enormity of having access to real emotions back.

I still have worries, concerns and irritations but they are no longer all-consuming, and are manageable. They feel normal.

Most incredibly, I can finally feel a sense of calm and peace in quiet times.

I feel a bit fragile and cautious, but that is slowly getting better every week. I know I will be alright. I'm saddened by the tragedy of what I've missed, but it's ok.

I have my life back.

Getting better involved prolonged periods of trial and error with pharmaceuticals and their side effects, talk therapy and naturopathic treatments—all endured with some form of seemingly impossible patience.

If you think you should be able to do it alone, you're wrong. Anyone who implies that you should be able to just "get your act together," "pick yourself up," and "snap out of it" doesn't know what they are talking about.

While I was gone, with my wife's encouragement, I somehow managed to reach out for help. Help from healthcare professionals, and compassion from friends and family. Asking for help was not a sign of weakness, it was a sign of strength and courage.

Wary of the cliché, but without exaggeration, reaching out for help probably saved my life. And I can see now it is a life worth saving.

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* This was written by a patient of Kathie Keefe, a Toronto member of MDPAC who has been practicing psychotherapy and prescribing psychopharmacological medications for about 20 years. She writes:

Over the years there have been a few patients whose depression was resistant to many different medications and combinations thereof. One particular patient developed a retarded or atypical depression secondary to severe anxiety. After many, many trials I referred him to CMHC and a Mood Disorder Clinic in Toronto. They had no further suggestions other than ECT, which he did not want. I then referred him for a series of IV Ketamine treatments; he did improve but the results only lasted for about a week. With persistence on both our parts, his mood improved, but he still lacked motivation, interest and humour—without these he felt like he was just going through the motions of his life. It took four years, but we finally found a combination that helped him: Parnate (MAOI), an atypical antipsychotic, plus a supplement from his naturopath that contained passion flower, St. John's Wort and valerian. It was like a switch had been turned on and he was back to his normal self. We both were surprised and pleased and wondered if the results would hold. They have. I asked him to write about his experience after he felt back to himself again.

Declutter Your Office

Vivian Chow, MD

After being in practice for many years it's hard not to accumulate stuff. Remember the days when we still got freebies from the drug reps? I was starting to feel bogged down by all the clutter in my life, both personally and professionally. With retirement on the horizon and downsizing in my future, I decided to clean out my home. I had a closet and dresser that were overflowing. I thought it was normal to have clothes packed in so tight that it was impossible to remove one item without taking two others with it.

I started by attending a downsizing seminar last winter, and from that seminar I was referred to Marie Kondo's *The Life-Changing Magic of Tidying Up.* I read this book and was so inspired that I immediately read her next book *Spark Joy: An Illustrated Master Class on the Art of Organizing and Tidying Up.* After reading these books, I followed her rules (KonMari method) and cleared out my home, starting with clothes, then books, papers, miscellaneous household items (which she delightfully refers to as "komono"), and lastly sentimental items.

To tidy up your clothes by the KonMari method, you are supposed to collect every item of clothing you own and place them on the floor. Fortunately, I have a king-sized bed, so I used that instead. I'm also a bit embarrassed to admit that I would have needed at least three king-sized beds to fit all the clothes I owned so I had to organize in shifts. The KonMari method does recommend a specific sequence in organizing your clothes, so that's how I was able to divide my stuff. The sorting process is pretty simple: if the item "sparks joy," you keep it, if it doesn't, you discard it. There were bags and bags of donations to the Salvation Army and Value Village. Using her method to organize what I decided to keep, I now have a neat and tidy closet and dresser. As for the rest of the items, basically the shelves and drawers that my husband doesn't access are tidy. Admittedly, I still have CDs, DVDs and sentimental items to go through.

Using this method, I then decided to clean out my office, which fortunately, only involves books, papers, and "komono." Sometimes it's difficult to discard items that you've had for a long time, always thinking "I might need that." But in this digital age, most of our references are available online. Any reference book that I wasn't actively using went into recycling or was donated. I had some books that I knew I would not read again, but that I thought would interest patients. So I set them aside in a special section and have actually given most of them away. In the end, I chose to keep less than 50 percent of my books and my bookshelf looks much tidier.

I still use paper to chart my patient visits so these cannot be discarded. But one of the KonMari rules is to store your items so that they stand vertically (much like books on a bookshelf). Storing objects horizontally makes the objects near the bottom harder to access and can be limitless if piling up from a low height. (Think of those piles of junk in a hoarder's home!) I must admit that I was storing my old charts horizontally and occasionally would need to access a chart near the bottom of a pile. Needless to say, these are now stored vertically and are easier to access.

As a practitioner of cognitive behavioural therapy, I use a lot of handouts for my patients. I've been hanging on to papers on the off chance that I may want to give them to someone. If I haven't used a handout in years, it's not crucial and I can recycle the paper and neaten up my desk. As for the drug company freebies I mentioned before, these fall under the komono category. Not only did I not need these any more, but they also certainly didn't spark joy. These were easy to discard.

Tidying is always a work in progress. It's not about perfection and you can never stop acquiring stuff. But the more organized you are, the less time you waste looking for stuff and the better you feel about yourself. The better you feel, the better you work.

Conflict of Interest: None

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Vivian Chow has a practice in downtown Toronto focussed in Psychotherapy.

References

Kondo, Marie (2014). *The Life-Changing Magic of Tidying Up*. New Yor k: Ten Speed Press.

Kondo, Marie (2016). *Spark Joy: An Illustrated Master Class on the Art of Organizing and Tidying Up.* New York: Ten Speed Press.

The Theratree Award

The Theratree award is a tribute to members of our association who have contributed to the profession, our society of psychotherapists, and the wellbeing of the patients we are honoured to serve. Our recipient this year is such a modest person, that he probably would be fine if his name was not mentioned. But I'll mention it anyway. Dr. George Neeson once said, "What a joy it is to watch broken people often injured as children, heal and start to experience the joy of what each of us can offer to mankind." I think those words speak to what we all aspire in our careers.

I first met George as a peer assessor during the first days of the program. He had had a difficult assessor with little room for understanding the complex Adlerian work he was doing. I was lucky to be next; I assure you neither of us were looking forward to the meeting. What I discovered was a learner, teacher, and therapist. He tells me I peer reviewed him again. I honestly don't remember that, which either speaks to his excellence that I was in awe of, or that he was more adept at hypnosis than he will admit. I learned and found a lifelong friend and colleague.

George Neeson, after a life filled with challenge and achievement, decided 27 years ago to devote himself to Adlerian psychotherapy, leaving behind careers in solo practice, aviation, chemistry and astronomy. He worked early on in the GPPA, being a friend, companion and student of our founder, Terry Burrows. He has served on MDDPAC committees and has inspired us in his deeply meaningful postings on the listserv.

A deeply religious and spiritual person, devoted to continuous learning and teaching his patients, George is now headed into retirement, leading the way many of us will go. In being a beacon for what we can all aspire to, honesty, caring, modesty, living a full and courageous life, we are proud to present him with the 2019 Theratree award.

Marc Gabel, on behalf of the MDPAC board

It was a surprise to me and a great honour to be granted the Theratree Award. I was certainly aware of the award but it had never occurred to me that I would be a recipient. It is a valued award indeed. I am now in the company of Terry Burrows which I would never have thought would occur. Terry was a dear friend indeed and, as the real founder of the organization, he stands head and shoulders above me.

I first drove to Toronto regarding the GPPA on Feb 4, 1994. I never dreamt that it would evolve to the level it has. The real honour needs to go to those hard-working faithful members who have made this happen.

I extend my deep appreciation for the honour of being a medal recipient and as I retire, this sure is a highlight. Thank you to all the membership and keep up the good work.

George Neeson

Report from the MDPAC Board of Directors

Elizabeth Parsons, MD, CCFP, FCFP

The fall is my favourite season: cooler days, cozy sweaters, changing colours and the scent of woodsmoke in the air. It feels more poignant to me this year as we are hearing more and more about the changes in our environment due to climate change, and I can't help but wonder if our seasons will soon be unrecognizable to us. There are calls for medical organizations to declare climate change a health emergency as the Australian Medical Association did on September 2. It certainly is a cause for much anxiety and stress among our patients. Now more than ever I believe the work that we do as individual physicians and as an association is crucial to support our society, and will help us all in the difficulties that lie ahead. Here is some of the important work that your colleagues are doing:

MDPAC's Strategic Plan

On March 30, fifteen members of MDPAC (including six board members) met to develop a strategic plan to guide MDPAC over the next few years. One of the first things that we learned was that strategic planning now only looks 1–2 years into the future, rather than 3–5 years. The pace of things has increased that much over the last ten years. You should have received a summary of the plan in May and the full report is posted on the MDPAC Members homepage. In sum, with a lot of effort, we developed new statements of vision and mission:

- Vision statement: "Enhancing whole-person care by supporting physicians who deliver psychotherapy and mental health care across Canada."
- Mission statement: "To support and advocate for physician-delivered psychotherapy and mental health care."

We also identified eight key strategies and designated the top three to focus on initially.

1. Develop education programs,
2. Develop credentialing and change of scope,
3. Develop public relations, credibility, visibility, and branding.

I will comment further on how we are addressing these strategies in the sections below.

Committee News

The Education Committee continues to develop teleconferences on diverse topics, and these are now available under "MDPAC Events—Webinar Recordings" on the website. The fall retreat is fast approaching. Gaisheda Kheawok of "Whispering Song" will present a weekend of interactive mindfulness and self-care from a Shamanic energy perspective. This year the retreat will again take place at Geneva Park on the weekend of October 25–27, 2019.

In a very unfortunate turn of events, the Psychotherapy Training Program had to be postponed to 2020. Despite over 50 physicians initially indicating interest in participating, only nine had registered as of the end of July, and so the decision was made to postpone the start of the program. Several factors seemed to be related to the lack of enrolment, including the looming threat of changes to psychotherapy funding. This was very disappointing for all involved and I want to again commend the PTP Committee for all their efforts.

MDPAC 32nd Annual Conference and AGM

Our annual conference was generally well-received. The numbers were slightly down this year and the conference committee has already sent out a poll to solicit feedback and suggestions for future conferences. Be sure to make your opinions known!

Canadian Alliance on Mental Illness and Mental Health (CAMIMH)

CAMIMH announced their Faces of Mental Illness for 2019 at the end of July and several MDPAC members were in attendance. We are supporting CAMIMH in their initiatives for mental health parity. Part of this is promoting it on social media. More on that below.

Developing Public Relations

The Board Executive has been working to find a public relations firm to help us with the third strategy in our Strategic Plan. We want this to be a wise long-term investment in the development of our association which will improve membership communication and engagement, and increase our profile among physicians who may be interested in joining us. We also want to develop a core of members with skills in media relations who will be able to respond to events in a timely way.

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Report from the MDPAC Board of Directors | continued

Psychotherapy Funding

As of this writing, there is no new information regarding the funding of psychotherapy by physicians in Ontario. Negotiations are ongoing and it seems we will not hear the results of this until December.

Please be in touch if you have any feedback or questions about the work that your Board of Directors is doing. I encourage you to volunteer for a committee; it's rewarding work, a great way to get to know your colleagues, and gives you CCI credit too!

Conflict of interest: none

Contact: elizabeth@eparsonsmd.ca

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

MDPAC ACPMD

MEDICAL PSYCHOTHERAPY ASSOCIATION CANADA

ASSOCIATION CANADIENNE DE PSYCHOTHÉRAPIE MÉDICALE

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Who to contact at the MDPAC:

Journal

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

Contact a Member

Search the Membership Directory or contact the MDPAC Office.

Listserv:

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

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

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

Reasons to Contact the MDPAC Office:

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

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