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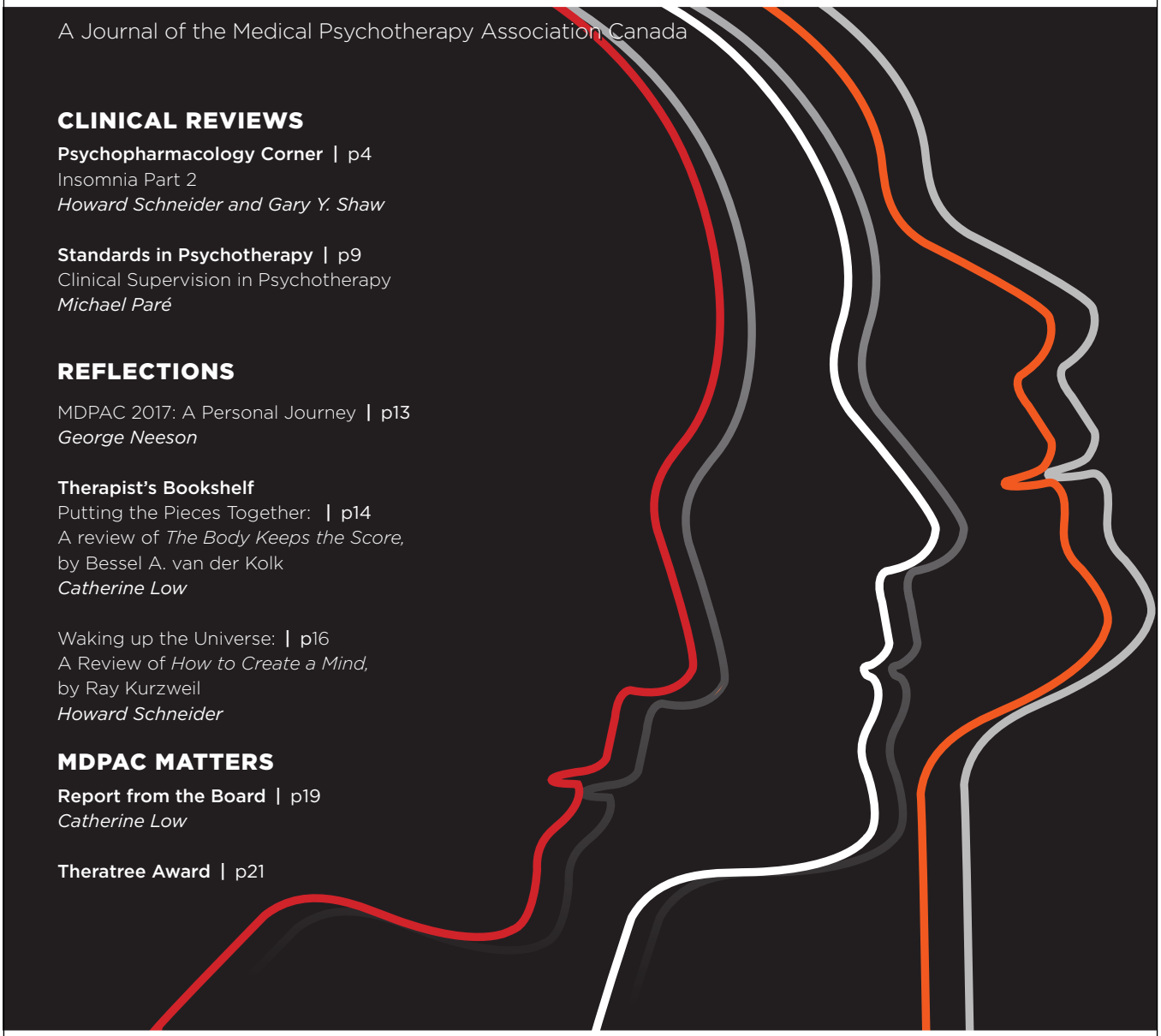
MEDICAL PSYCHOTHERAPY REVIEW

(Formerly GP Psychotherapist)

A Journal of the Medical Psychotherapy Association Canada



CLINICAL REVIEWS

REFLECTIONS

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"THE IMPORTANT THING IS NOT TO STOP QUESTIONING; CURIOSITY HAS ITS OWN REASON FOR EXISTING. ONE CANNOT HELP BUT BE IN AWE WHEN CONTEMPLATING THE MYSTERIES OF ETERNITY, OF LIFE, OF THE MARVELOUS STRUCTURE OF REALITY. IT IS ENOUGH IF ONE TRIES MERELY TO COMPREHEND A LITTLE OF THE MYSTERY EVERY DAY. NEVER LOSE A HOLY CURIOSITY."
— Albert Einstein

I have previously referred to the "greyness" of psychotherapy and the varieties of therapeutic approaches. Another angle on this is mystery. No matter how many techniques we learn, no matter how much we learn about brain changes in mental illness and the effects of psycho-pharmaceuticals, no matter how much supervision we receive, no matter how many conferences we attend, books we read...we will never have all the answers. There is always an element of mystery. Science and rationality have limits. Einstein refers to mysteries of reality and eternity, but I think the psychological structure and function of humans is even more mysterious. I continue to marvel and learn from the people who share their journey with me.

Patients often request, "tell me what to do" or "give me three steps to follow"; I usually respond with an empathetic smile. Few of us like ambiguity and mystery. But rather than being disillusioned, I believe we should rejoice in mystery and simultaneously continue to question, seeking to draw closer, a little bit each day.

The *Medical Psychotherapy Review* is one way we can draw a little closer. In this issue our own Howard Schneider features prominently and we congratulate him on receiving the Theratree award at the recent MDPAC conference. His dedication is exemplary. Fellow longtime member and bursary-recipient George Neeson shares his experience of reconnecting with colleagues at this conference. These two members demonstrate that our organization is not just about information exchange but also about non-tangible things like collegiality. Our chair of the board Catherine Low echoes this view in her report, which documents several ways the MDPAC is working to improve our organization, seeking to draw closer, a little bit each day.

In our clinical review section, Michael Paré writes about supervision in his column "Standards in Psychotherapy." He also notes the

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.

importance of relationships; supervision has an educational component but also includes mentorship, and the sharing of experience, wisdom, and perhaps mystery. In his "Psychopharmacology Corner," Howard, along with co-author Gary Shaw, continues the discussion of insomnia. Sleep, that essential period when we lose consciousness, continues to be a mystery on many levels. However, it is so essential that some require pharmaceutical treatment and this article provides a helpful summary.

Howard also reflects on a fascinating topic—artificial intelligence—in his book review of Ray Kurzweil's *How to Create a Mind: The Secret of Human Thought Revealed*. Despite the confidence reflected in this title, it is clear that there is more to humans than intelligence, and I believe there will always be a mysterious element to the mind. Howard notes that "we can perform logical operations that AI researchers at the time of this writing still have trouble duplicating." In another book review—Bessel van der Kolk's *The Body Keeps the Score*—Catherine Low reflects on how our bodies mysteriously remember and can process trauma. She notes that sometimes too much talking can get in the way of that healing.

Finally, on a practical note, thanks to those who completed the survey; we appreciate the affirmation, and continuously strive for improvement, a little bit each day. See a summary of the results on p. 22. Stay tuned for potential changes. We invite feedback, submissions and participation in the journal committee.

As we navigate the mysteries of human brains, minds, bodies and relationships, let us never lose a holy curiosity.

Grace and peace,
Janet Warren

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Insomnia – Part 2

Howard Schneider, MD, MDPAC(C), CCFP and Gary Y. Shaw, MD, FACS, ABSM (Candidate)

Abstract

This second article on insomnia considers its psychopharmacological treatment. The insomnia must be treated in the context of the patient's overall physical and mental health concerns.

In "Insomnia – Part 1" we considered cognitive behavioural therapy for insomnia (CBT-I) as the initial treatment for chronic insomnia disorder. As noted, insomnia is very prevalent in the population, and is associated with accidents, poor work performance, lower quality of life and increased general health problems.

Psychopharmacologist Stephen M. Stahl (2011, p. xvii), of the University of California San Diego, has said that to become skilled in the art of psychopharmacology, we need "to listen, educate, destigmatize, mix psychotherapy with medications and use intuition to select and combine medications." In this article, rather than mechanically list medications which can be used for insomnia, we will consider some of the possible psychopharmacological treatments for insomnia in the context of a real-life patient with complex mental health needs, Stahl's 11th new case (Stahl & Schwartz, 2016). A 42-year-old single woman comes to Dr Stahl with a chief complaint of "depression and interpersonal stress."

Past Psychiatric History:

- Child: "horribly abused" (details not given)
- Teen to 32-years old: addicted to alcohol and narcotics
- 32–42 years old: sober; attending Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) daily
- Post-Traumatic Stress Disorder (PTSD) symptoms: nightmares, flashbacks, panic attacks
- Chronic Dysthymia with occasional full Major Depressive Episodes with no hospitalizations
- Chronic Borderline Personality Disorder (BPD) traits of affective liability, emptiness, and dissociative events but no suicidal gestures
- Paroxetine and another time nortriptyline helped no more than moderately with symptoms in past

Past Medical History

- Overweight (weight not specified)
- Coronary Artery Disease, Type 2 Diabetes, Chronic Obstructive Pulmonary Disease, Hyperlipidemia, Gastroesophageal Reflux Disease, hypertension, glaucoma

Intake Psychiatric Medications

- paroxetine 40 mg od

Intake Medical Medications

- exenatide (incretin mimetic), metformin (biguanide), glipizide (sulfonylurea), ramipril (angiotensin-converting enzyme inhibitor), salbutamol (beta-2 agonist), fluticasone/ salmeterol (corticosteroid/ beta-adrenoreceptor agonist), latanoprost (ocular anti-hypertensive), ezetimibe (decreases cholesterol absorption), pravastatin (statin), pantoprazole (proton pump inhibitor)

Family Psychiatric History:

- mother and aunts (maternal not specified): Major Depressive Disorder
- many members of extended family: Substance Use Disorder
- mother: Generalized Anxiety Disorder
- siblings: possible Attention Deficit Hyperactivity Disorder

Chief Complaint, History of Present Illness, Mental Status Examination, Physical Examination:

The patient has been compliant with her family physician's advice with respect to medical problems, compliant with her AA/NA meetings, and compliant with using the paroxetine for a few years to treat her depression. However, the patient complains that the PTSD symptoms still make her depressed and anxious and she requests help. The patient says that the full depression she occasionally experiences is caused by worsening of PTSD symptoms or stressful situations with others. The patient also says that she can't sleep well and this is a large problem for her.

Stahl notes that additional specialized psychotherapy is not available in her community, but at least there is supportive care from her AA/NA sponsors. Stahl changes paroxetine to paroxetine-CR slow-release preparation and adds bupropion-XL.

Current Psychiatric Medications:

- paroxetine-CR 50 mg od
- bupropion-XL titrated up to 450 mg od

The patient's depressive symptoms improve but the PTSD and the insomnia symptoms remain issues for the patient. Stahl decides to add tiagabine (an antiepileptic selective GABA reuptake inhibitor) since it is not addictive and can help reduce anxiety.

Current Psychiatric Medications:

- paroxetine-CR 50 mg od
- bupropion-XL 450 mg od
- tiagabine 16 mg od

On follow-up at about a year's time since Stahl first saw the patient, her depressive symptoms remain controlled, but intrusive PTSD events and affective instability symptoms are worse. Also, the patient complains about visual hallucinations just as she is falling asleep, i.e., hypnagogic hallucinations. A sleep study is ordered and shows obstructive sleep apnea. A continuous positive airway pressure machine is prescribed and used by the patient, but the hypnagogic hallucinations persist. Stahl considers using an atypical antipsychotic for the limited hallucinations and mood symptoms, but is concerned about possibly worsening her metabolic syndrome.

The patient is seen at two years' time since Stahl first saw her. She has relapsed and all symptoms have returned. The tiagabine and paroxetine have been discontinued for unspecified reasons and the patient is only using bupropion. Escitalopram is added to help with the depressive and PTSD symptoms, and a very low dose of quetiapine is given to help with sleep, as well as possibly to help with the depressive, PTSD and affective instability symptoms. Stahl hopes that the low dose of quetiapine will not significantly worsen any metabolic issues. The patient responds well to these changes with improvement in depressive and PTSD symptoms. The hypnagogic hallucinations are still bothersome, however. The quetiapine is raised to 100 mg and the hypnogogic hallucinations resolve.

Current Psychiatric Medications:

- escitalopram 20 mg od
- bupropion-XL 450 mg od
- quetiapine 100 mg hs

Follow up a month later showed generally good results but occurrences of affective instability including anger during AA and NA meetings was putting the patient at risk of a lapse into substance abuse again. Thus, an additional 25 mg of quetiapine was added during the daytime. Clinically, the patient's mood lability diminished greatly and other symptoms remained under control.

The patient is seen again at follow up appointments to the 5-year point since her first visit with Stahl. She is doing very well and her symptoms are largely controlled. The patient titrates the total quetiapine 50–150 mg per day as needed for increased nightmares and hypnagogic hallucinations. There is no worsening of her metabolic syndrome. Occasionally her insomnia worsened and the patient would take ramelteon 8 mg HS (melatonin receptor agonist) during these periods.

Current Psychiatric Medications:

- escitalopram 20 mg od
- bupropion XL 450 mg od
- quetiapine 50–150 mg/total per day prn
- ramelteon 8 mg hs during periods of worsening insomnia prn

Discussion

Given the history of trauma, Borderline Personality Disorder, PTSD and Substance Abuse Disorder, and that the patient's depressive symptoms seem secondary to exacerbations in these conditions, many medical psychotherapists may first approach this patient from a psychotherapeutic point of view. However, psychopharmacological treatment can be helpful, and Stahl, to his credit, notes that beyond the supportive therapy the patient receives from her AA and NA sponsors, additional specialized psychotherapy is not available to her. Paris (2009) notes that selective serotonin reuptake inhibitor (SSRI) antidepressants have some anti-impulsive effects in patients with BPD, as well as taking the edge off low mood. Work by Ingenhoven and colleagues (2010) showed that in these patients, mood stabilizers had little effect on depressed mood, but they did have a large effect on impulsive-behavioral dyscontrol, anger and anxiety. Stahl notes that some SSRI antidepressants (paroxetine and sertraline) have been FDA approved for treating PTSD. He notes some evidence of atypical antipsychotics and antiepileptics being helpful in PTSD. However, the use of sedatives is more controversial due to higher addiction rates in vulnerable patients.

The patient achieved a much better improvement in her symptoms after Stahl addressed the sleep issues. Ordering a sleep study was very reasonable given the obesity and bothersome hypnagogic hallucinations. Careful addition of quetiapine despite the patient's metabolic syndrome turned out to be helpful with regard to the patient's insomnia, nightmares, hypnagogic hallucinations and daytime mood labilities. Quetiapine, although thought of in terms of being a "dopamine blocker," also blocks histamine 1 receptors, which helps to treat initial insomnia by lowering the activity of the wakefulness center (tuberomammillary nucleus) and increasing the activity of the sleep cen-

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ter (ventrolateral preoptic area). Quetiapine also blocks serotonin 2A receptors which results in a deeper continued sleep. Ramelteon stimulates melatonin receptors in the suprachiasmatic nucleus which is thought to help maintain the circadian rhythms required for a normal sleep-wake cycle (Stahl, 2014). Ramelteon does not worsen sleep apnea, does not appear to cause abuse, and does not generally cause rebound insomnia.

The quetiapine and occasional ramelteon worked well for this patient's insomnia. Let's briefly consider some other psychopharmacological options. Benzodiazepines can help with insomnia but there is a risk of dependence, particularly in this patient who is struggling hard to remain sober. Similarly, "Z-drugs," such as zopiclone, can help with insomnia but also have a risk of dependence. The tricyclic antidepressant doxepin has little risk of dependence, increases total sleep time and could have been an option for this patient. At antidepressant dosages, typically between 75–300 mg per day, doxepin can prolong cardiac QTc (of concern if other medications are being taken which also prolong QTc) and worsen metabolic syndrome. However, much lower and potentially safer dosages of doxepin may be efficacious for treating insomnia. Trazodone, a serotonin antagonist and reuptake inhibitor, can help with both sleep and depression, and there is little risk of dependence. While many agents used for insomnia can actually worsen sleep architecture, or at best are neutral, trazodone improves deep stage sleep (Ware & Pittard, 1990). The dosage of trazodone for treatment of depression is typically 150–600 mg per day, but for treatment of insomnia doses 25–100 mg at bedtime are usually sufficient. Mirtazapine, a noradrenaline and specific serotonergic agent, can help with both depression and insomnia. However, weight gain is a common adverse effect, and would be problematic for this patient. A variety of over-the-counter medications and supplements are marketed for insomnia, although evidence is somewhat lacking. However, studies have been done on the use of melatonin, and a meta-analysis by Ferracioli-Oda and colleagues (2013) shows it to have a modest benefit in falling asleep faster and improving overall sleep quality, while not causing dependence.

Many clinicians would like to have an organized list of pharmacotherapy options to select from to treat patients. Rather than provide a list of every possible medication that can be used to help with insomnia (some of them discussed above), we include an evidence-based table prepared by the Centre for Effective Practice (2017) (see Table 1).[1]

This article has reviewed pharmacological treatment for insomnia to supplement the previous one on psychotherapy. Patients seen for medical psychotherapy may have insomnia as well as complex mental health needs. The insomnia must be treated in the context of the patient's overall physical and mental health concerns.

Howard Schneider started his career performing psychiatric consultations and short-term follow-up care in the emergency department in Laval, Québec. For the past 18 years he has provided care for psychiatry and psychotherapy patients in the community in the Toronto area.

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Conflicts of interest: none.

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[1] Reprinted with Permission from Centre for Effective Practice. (January 2017). Management of Chronic Insomnia: Ontario, Toronto: Centre for Effective Practice.

TABLE 1

Name	Notes	Usual Dose
Z-drugs		
Zopiclone	Indicated for insomnia Risk of dependence Metallic aftertaste	3.75-7.5 mg (max 5.0 mg in elderly or kidney/liver disease)
Zolpidem	Indicated for insomnia Risk of dependence Risk daytime drowsiness, dizziness, amnesia, nausea, headache, falls	5-10 mg
Antidepressants		
Doxepin	3-6 mg low doses work with regard to total sleep time Risk of delayed absorption if take within 3 hours of a meal Minimal risk of dependence Anticholinergic effects with higher doses	3-6 mg tablets 10-50 mg capsules
Trazodone	Indicated for depression with only limited evidence for insomnia Minimal risk of dependence Low anticholinergic activity Risk of orthostatic hypotension, rare priapism	25-150 mg
L-Tryptophan	Indicated as an adjunct for affective disorders with conflicting evidence for insomnia Risk of serotonin syndrome with SSRI, MAOIs Risk dry mouth, drowsiness, dizziness, GI upset	500 mg-2 g
Benzodiazepines		
Temazepam	Indicated for insomnia Risk of dependence Low-moderate risk of morning hangover due to intermediate half-life Risk of dizziness, confusion, falls/fracture – avoid in elderly	15-30 mg
Over the Counter		
Melatonin	Modest decrease in sleep onset latency and increase in total sleep time, and sleep quality No apparent dependence Purity concerns of various formulations Risk of fatigue, headache, dizziness, irritability, abdominal cramps	0.5-5 mg (usual 1-3 mg)
Valerian Root	Limited evidence for insomnia Purity concerns Risk of dizziness, nausea, headache, upset stomach, rare hepatotoxicity	--

Insomnia – Part 2 | continued

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Generic Name	**Trade Name** *(Common, Canadian names where possible)*
bupropion-XL	Wellbutrin-XL
doxepin	Sinequan, generic
escitalopram	Cipralex (Lexapro in USA)
L-tryptophan	Tryptan
mirtazapine	Remeron
melatonin	generic over-the-counter
nortriptyline	Aventyl, generic
paroxetine	Paxil
quetiapine	Seroquel
ramelteon	Rozerem (not available Canada at time of writing)
sertraline	Zoloft
temazepam	Restoril
tiagabine	Gabitril (not available Canada at time of writing)
trazodone	Desyrel, generic
valerian root	various formulations over-the-counter
zolpidem	Sublinox (Ambien in USA)
zopiclone	Imovane

Clinical Supervision in Psychotherapy

Michael Paré, MD, MEd, MSc

The purpose of this article is to help Primary Care Physicians and/or Physicians providing medical psychotherapy in Canada become better acquainted with expectations concerning the standards of psychotherapy in the practice of our focused area of medicine.

Introduction

The simplest definition of supervision is that of a process or activity where supervisees review and reflect on their work with a senior peer in order to practise psychotherapy better. Supervisees or practitioners present their actual therapy practices to supervisors, who help review what happened in session to derive learning from the experience. Supervision fosters better quality service provision. Two overarching functions of supervision are as follows:

- Fostering the supervisee's development as a psychotherapist.
- Helping to ensure patient welfare by acting as a gatekeeper for the profession(s) (Shepard, n.d.).

The professional supervisor's main roles include those of a teacher, an evaluator, a consultant, and a mentor (Shepard & Martin, 2012). Nevertheless, as will be outlined in more detail later, not all supervision includes every one of these elements.

This piece will offer an outline of my personal experience, both as a supervisee and as a supervisor of psychotherapy. Additionally, I will explain my ideas concerning the link between supervision and the Standard of Care (SOC) within the current practice of medical psychotherapy.

There will be insufficient space to review the massive and growing field of clinical supervision (Smith, 2009; Carroll, 2007). In fact, it is the expansion of the various methods, styles, and theories in the burgeoning literature of supervision that at times is indifferent to supervision's usefulness as an adjunct to the practice of psychotherapy.

What are the benefits of supervision?

Carroll (2007), quoting Lane and Corrie (2006, p.19), summarizes some of the benefits of supervision:

- It offers protection to clients (cases are reviewed).
- It offers a reflective space to practitioners (insights for improvement).
- It helps practitioners identify their strengths and weaknesses.
- It enables learning from peers.
- It offers the opportunity to keep up to date with professional developments.
- It alerts practitioners to ethical or professional issues in their work and creates ethical watchfulness.
- It provides a forum to consider and hold the tensions that emerge from the needs of various stakeholders in the supervisee's work (the organization, the patients, the professions).
- It offers a "third-person" perspective (feedback) from the supervisor, who is not part of the therapist-patient system.
- It creates a forum of accountability for those to whom the practitioner is accountable (organization, patient, profession, etc.).
- It updates practitioners of psychotherapy about the best in innovation, insights, and research in their chosen area of work.

It is ultimately for the benefit of the patient.

Over the years, I have undergone several hundred hours of supervision in various types of psychotherapy (interpersonal therapy, group psychotherapy, and psychoanalytic psychotherapy)—even now, I continue to receive personal ongoing supervision as I expand my own provision of psychotherapy supervision. My supervisees include diverse groups: family practice residents, GPs and FPs who provide medical psychotherapy, and student candidates for the new College of Registered Psychotherapists of Ontario (CRPO).

Simply put, good supervision helps us provide good psychotherapy to our patients. And yet, not only does supervision help us relax and better enjoy our psychotherapeutic work, supervision also allows us to appreciate what we are doing well and also helps us discern areas where we might do things somewhat differently. Supervision is particularly useful with difficult doctor-patient situations, as well as in situations involving complex transference and countertransference issues.

Unfortunately, these days it is difficult to obtain supervision, partly because there is a relative dearth of supervisors. This situation likely results from many complex factors. However, I believe that at least one reason for this relative scarcity of available supervisors is that the role of supervisor has been exaggerated and idealized beyond the reasonable attainment of a regular experienced, competent professional psychotherapist. There is a tendency in the professional literature for authors to swing back and forth between an accurate "description" of supervision and its various elements, and an idealized "prescription" of supervision and of what the various

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elements of supervision ought to be.

How is supervision regulated?

A "description" of supervision endeavours to be objective and generally presents the current situation realistically, while on the other hand a "prescription" concerning supervision is often somewhat more subjective, future-oriented, and idealized. The prescriptive stance of what ought to be frequently highlights many highly laudable ideals and expectations about supervision and supervisors. Nevertheless, at times the commentary sounds—at least to me—consumed with perfectionism (a common problem in medical culture). I get the sense that certain commenters argue that if a supervisor is not entirely benign, caring, empathic, balanced, non-judgmental (and yet apparently adequately "judging" in their required "gate-keeper" role), as well as enlightened, well-trained and, well-organized, he or she will function well below the reasonable standard for professional supervisors. Some writers go on to imply that the consequence of sub-standard supervision will be irremediable damage to the supervisee and severe trauma to the patient. This may be overstated, but I do believe this is the gist of the dire warnings about supervision. If I had begun by reading some of these ominous depictions, I would not likely have ventured into supervision in the first place.

In stark contrast to the images above, the CRPO (2014)—a fairly new regulatory college in Ontario—simply defines the required characteristics of supervisors as follows:

- Must be a professional in good standing of a Regulatory College whose members can provide psychotherapy (in Ontario this includes the College of Nurses of Ontario, the College of Occupational Therapists of Ontario, the College of Physicians and Surgeons of Ontario, the College of Psychologists of Ontario, and the Ontario College of Social Workers and Social Service Workers)
- Has extensive clinical experience, generally five years or more, in the practice of psychotherapy
- Has demonstrated competence in providing clinical supervision.

Note that the CRPO—a regulatory College that enforces a reasonable Standard of Care of the profession of Regulated Psychotherapy—is not particularly demanding regarding the credentials or training of an acceptable supervisor.

By contrast, the expectations for medical psychotherapy supervisors for the Medical Psychotherapy Association Canada (MDPAC) are more demanding. I paraphrase (and somewhat simplify) from the recent MDPAC document *Criteria for MDPAC-Approved Supervisor Status* (n.d.), issued by MDPAC and approved by the Board.

- Must be a professional in good standing of a Regulatory College whose members can provide psychotherapy (in Ontario this includes the College of Nurses of Ontario, the College of Occupational Therapists of Ontario, the College of Physicians and Surgeons of Ontario, the College of Psychologists of Ontario, and the Ontario College of Social Workers and Social Service Workers)
- Must have extensive clinical experience, generally five years or more, in the practice of psychotherapy
- Must have demonstrated competence in providing clinical supervision (e.g., an academic teaching appointment or supervision experience documented in a curriculum vitae)
- Must have minimum psychotherapy training, as follows:
  - either formal comprehensive psychotherapy training in at least one recognized discipline and 2000 hours minimum psychotherapy experience, or 8000 hours paid psychotherapy with submission of individual training history
  - demonstrated competence in providing clinical supervision, or evidence of training in clinical supervision
  - 50 hours minimum personal growth work (personal psychotherapy and/or courses that include an experiential element)

The fact that the CRPO and MDPAC have different expectations and requirements for their supervisors is entirely fair and acceptable in terms of their own membership. Yet these requirements do not define what is expected in the wider field of psychotherapy, where expectations may be more or less demanding between professional associations and professional regulatory colleges.

My understanding is that for the regulatory colleges of professions that include the clinical provision of psychotherapy in Canada there is usually no current requirement for supervision in psychotherapy after the professional license has been granted. Thus, the SOC for at least some simple forms of psychotherapy does not appear to require any ongoing supervision. On the other hand, for practitioners seeking to change their Scope of Practice and for certain remedial undertakings, some Colleges (for example the CPSO) do—at times—require mandated supervision. Also, although supervision may not be an official requirement, I consider it reasonable and prudent, especially for prac-

titioners of more specialized types of psychotherapy, such as Cognitive Behavioural Psychotherapy or Interpersonal Psychotherapy. It may be that practicing certain types of psychotherapy without any previous or ongoing supervision might be considered misleading and below the standard since for most psychotherapists supervision is an essential and required component of their initial training.

What are the different types of supervision?

When contemplating supervision, along with its theory, practices, and all aspects of the professional delivery of adequate and helpful supervision to students and to peers, a quote keeps coming to my mind: "*A rose is a rose, is a rose, is a rose.*" This was penned by noted American writer Gertrude Stein (1922). I will not get into a literary analysis of what this quote might mean except to say that its superficial reading differs fundamentally from my view of supervision. I would say that the following: *"Supervision is not supervision, is not supervision, is not supervision."* Another way to express my point is that although we use the same word (supervision), we are sometimes—often, in fact—referring to a number of different professional activities that, although similar, sometimes differ fundamentally in terms of goals, aims, and interpersonal dynamics. Thus, depending on the actual type of supervision that is provided, the weights of the various roles of any supervisor in the teaching process will actually change quite appreciably, sometimes even essentially.

I believe that supervision can be divided into three different types, or perhaps levels, that emphasize different goals and aims. They may overlap and may be short or long term.

- **Peer Consultation.** This type is like a colleague helping a colleague and need not be very intense in terms of credentialing and supervision experience. The key point here is that there is no current requirement for ongoing supervision from our Regulatory Colleges. Since ongoing supervision is not required, it is difficult to motivate its subscription or implementation. And yet—from a clinical point of view—supervision is helpful and useful. As is generally accepted, and as the saying goes, two heads are better than one. Supervision has clearly been found to be helpful to practitioners. Participants usually experience supervision as supportive, reassuring, and interesting. This is the type of supervision that most of us are familiar with. This is supervision from a more experienced psychotherapist for the benefit of a less experienced psychotherapist (offered in various formats; e.g., group, individual).
- **Initial Professional Licensure.** Professional Psychotherapy training programs or university Professional degrees always have a requirement of several hundred hours of supervision in their supervisees' clinical practicum program, in order for the student to graduate with his or her degree or credential.
- **Regulatory Supervision,** which includes Remedial Supervision and supervision related to a change of scope of practice. The first is a process related to a perceived or identified lack in the physician's practice and mandated by such authorities as the CPSO; it is concerned with evaluation and gate-keeping. The change of scope of practice is a process of educational re-orientation of a fully licensed professional towards a new area of practice that the professional chooses voluntarily to provide. For this clinical area of practice the regulatory authority believes the physician has insufficient previous clinical experience and education. The Change of Scope of Practice is educational and yet there is an evaluative and gate-keeping aspect to the supervision.

Conclusion

The role of psychotherapy supervision is critical to the process of educating and "making" psychotherapists. Supervision has a long history, and is well situated within the tradition of professional apprenticeship training. Because of the central, critical place of psychotherapy supervision in psychotherapy education, more supervision of the various types outlined here is highly recommended.

Yet the reality is that we need more supervisors; there is a definite lack in the area of psychotherapy. At this point, it seems that a modestly talented supervisor may be better than no supervisor at all. And it seems more than reasonable to move forward with tentative plans to develop an independent ad-hoc supervisors training program.

Conflicts of interest: none.

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MDPAC 2017: A Personal Journey

George Neeson, MD

I attended this year's MDPAC conference after several years' absence, with gracious encouragement from Catherine Low, and a bursary from the MDPAC. I recall that many years ago, I drove to Toronto as often as twice a month to meet with early founders of the GPPA, Terry Burrows, Jaga Iwanoski, Roy Salole and others over about a two-year period. Terry had this vision and dream of (what we then called) GPs doing competent psychotherapy. His excitement and vision were infectious, but way back then I had my doubts about whether or not we could "pull it off." I was glad to invest, but had no idea how it might turn out.

Many years later I can see that it all turned out very well indeed. I was thrilled, even astounded by what I experienced in the hotel and the conference rooms during this year's conference. I was delighted to see Roy Salole after all these years. Most of my contemporaries from early GPPA years were not in attendance. Yet I was astonished by the folks who were present, and in such large numbers.

For any who have not attended the conference, ever or recently, the content was deep and carefully presented by extremely expert psychologists and therapists. The detail of the presentations I attended was beyond what I had imagined. And I assure you that I came with high expectations.

I also took great pleasure from meal and break times. It was wonderful to connect with so many people whose names I had seen on listserv. Suddenly there was a human face for the name attached to the posting I had read. I confess that I had dreamt of meeting Harry (Zeit) based on his comments. It was such a pleasure to see him in person on day two of the conference.

It is my nature not to like crowds, yet I never felt crowded during the conference. The shared enthusiasm from people dedicated to helping others with emotional difficulties through psychotherapy was so pervasive. It was moving to watch and experience.

Many current members have not known or met the original founders of our MDPAC (GPPA). I dare say that I am certain they (the founders) would be delighted with what I saw and heard at the conference. Though I am no longer young, I am encouraged that the future of mental health care is in good and caring hands with current members of the MDPAC.

For past, present and future: let us keep the faith. Clearly, there is more to do. I dared to invest with dreamers "way back when." Witnessing how far that has come, I encourage all to dream dreams about our future. Let the Board and members know what you need and envision. Participate. Contribute. Engage. Drive to Toronto if need be, or engage electronically. Our organization started with ordinary "GPs" who had a dream. That dream lives on in the MDPAC and there is so much more to come.

To all who laboured so many hours to make this conference happen, I send my sincere thanks. As health permits I look forward to next year. Once more I send my heartfelt thanks for a conference that exceeded my expectations, which were very high at the outset.

George Neeson received his MD from the University of Toronto in 1962. He practiced general medicine for a few years but, after moving to a remote northern area, became interested in mental health. He has a certificate in Classical Adlerian Depth Psychology.

Conflict of Interest: none

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Putting the Pieces Together

A review of *The Body Keeps the Score: Brain, Mind and Body in the Healing of Trauma*

Bessel A. van der Kolk, M.D. New York: Penguin Books, 2015; 464 pp
$24 or $15.99 Kobo ebook

Catherine M. Low, MD, MDPAC(C)

I had been experiencing a split between the way I was treating myself and the way I was treating my patients over the past few years and this book helped me to heal this split. In my personal journey I have been focusing less on talk therapy and more on body work. This began about 10 years ago when I started doing yoga. It started out slowly and it took a few years before I saw significant shifts start to happen. One of the "aha" moments that led me to make some big changes in my life was recognizing that the only time my soul felt truly nurtured was during the hour or two of yoga that I did every week. I then decided that I wanted more of this. That sent me on a journey to try meditation courses, yoga retreats, a daily walking practice and eventually a daily morning meditation practice. It worked. I got happier. More content. More grateful.

So why was I still emphasising cognitive interventions in my work with patients? Daily journaling, letter writing, endless repetitions of the wrongs that had been done to them in the past. Why wasn't I letting them in on my secret? The secret is *The Body Keeps the Score*. I came upon this book after exploring several others including *Quantum Healing* by Deepak Chopra (1989) and *When the Body Says No* by Gabor Maté (2003). I then made a slight detour to read *Jitterbug Perfume* by Tom Robbins (1984) which, although a work of fiction, turned out to be pretty much en pointe. So, when a patient suggested that I read this latest book by Bessel van der Kolk, I got truly excited. I skimmed the table of contents and the index and started imagining that this could put all the pieces together for me. It did.

The book is basically the author's walk through of all the things he has learned about the dos and don'ts of treating victims of trauma over the course of his career. The personal anecdotes were just as fascinating as the results of the studies he discussed. The book starts with his first job at the Boston Veterans Administration Clinic in 1978 and continues up to the present. At the end of the book he outlines a proposed definition of Complex Developmental Trauma in children and adolescents for discussion and hopefully for inclusion in some future version of the DSM. The definition has several sections which outline the exposure, the affective and physiological dysregulation, the self and relational dysregulation, the PTSD spectrum symptoms and the functional impairments that these patients present with. The book has a chapter on each of the different methods of healing the body that the author has explored thus far including the drama program that helped his son overcome chronic fatigue syndrome. He touches on many modalities including narrative therapy, eye movement desensitization and reprocessing, yoga, internal family systems (IFS) and neurofeedback. Many of these methods were things I had already tried on myself and found useful and here they were being discussed by a well-respected psychiatrist and researcher. I was excited and things in my office began to change.

I started recommending many of these modalities to my patients and, much to my surprise, they actually started doing them. I suggested to one person, who had a regular practice of working out at the gym as a way of managing stress, that she add a yoga class to her routine. The next week she reported that at the end of her first class, while lying quietly in the final meditation pose, she asked herself: "What did I possibly do to deserve this and how can I get more of it?" This was the beginning of her ability to feel some compassion for herself. She moved very quickly in therapy after that to connect with and heal her traumatized inner child, who she had previously buried deep in my sand tray and told me, "We are never going there."

I then wanted to learn more about Internal Family Systems therapy in order to make better use of the Sand Tray in my office so I took an online course with Dr. Richard Schwartz offered through Professional Education Systems Inc. This consolidated some of the teachings I had received in IFS from Dr. Harry Zeit at the 2015 MDPAC Retreat in Orillia. I started making more use of the Sand Tray in my office and I learned a lot as I watched people embody their inner families through the use of the figurines in the tray. I have now started reading one of the books recommended as further reading at the end of the book. This book is *Overcoming Trauma Through Yoga: Reclaiming your Body* by David

Emerson and Elizabeth Hopper (2011) and has an introduction written by Bessel van der Kolk. It is meant as a guide for patients, therapists and yoga studios that want to offer trauma-informed yoga to their clients. It includes a step-by-step description of the different yoga postures that can be used with patients while they are seated in your office and a description of the effects that each posture has on the CNS. I haven't started to implement this in my office yet, but I know that it is only a matter of time.

One of the key points that I took away from The Body Keeps the Score was that people can heal from trauma without talking about it and that sometimes too much talking can get in the way of that healing. I had understood that intuitively for some time before reading this book but van der Kolk helped me to understand both at a neurobiological and experiential level why this is true. This book can be read at the level of a textbook or at the level of a self-help book. I believe that both therapists and patients will benefit from reading it and I highly recommend it as a great jumping off point to explore further many of the concepts and modalities that are covered.

Catherine Low practices medical psychotherapy in a special interest focused practice in Ottawa, Ontario. She practices Satir and IFS therapy with the aid of a Sand Tray. Catherine has been an active member of MDPAC for the past 10 years and is in the process of starting a monthly peer support group for MDPAC members in the Ottawa area.

Conflict of interest: none

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Waking Up the Universe

A Review of *How to Create a Mind: The Secret of Human Thought Revealed* Ray Kurzweil. New York, NY: Viking Press, 2012; 336pp.

Howard Schneider, MD, MDPAC(C), CCFP

To many, Ray Kurzweil is a genius. He invented the first flatbed scanner, the first reading machine for the blind, one of the first voice recognition systems that eventually became Siri in Apple products, and even the first acoustically-equivalent electronic musical instruments. All these products made heavy use of artificial intelligence techniques, particularly pattern recognition. *The Wall Street Journal* (Bulkeley, 1989) called Kurzweil a "restless genius." In 2011, Kurzweil was featured on the cover of Time Magazine. In *How to Create a Mind,* Kurzweil describes his "Pattern Recognition Theory of Mind," which shows both how the brain thinks as well as how we can create powerful digital versions of the brain. Wow. The reviews of this book were brutal, however. For example, New York University Professor Gary Marcus (2012) describes Kurzweil's ideas as "dubious" and, using a quote of another critic, implies that Kurzweil is a "huckster." From cover of Time to "huckster"—what's going on here?

Kurzweil was an inventor in the 1980s and transitioned to a futurist in the 1990s. He showed that information technology had been improving *exponentially* as the years went by, and thus logically would continue to do so (Kurzweil, 1990). Many of Kurzweil's predictions came true, e.g., a computer beat the world's best chess player before the year 2000. He anticipated that technological change would become so rapid in the coming decades that when an artificial superintelligence (exceeding the most gifted humans in most fields) was reached, this would trigger even more rapid growth, and by 2045 a "technological singularity" would occur and continue to improve at a rate and form incomprehensible to humans (Kurzweil, 2005). Kurzweil also started writing books on living longer (Kurzweil, 1993) as well as practising what he preached (e.g., taking 150 vitamins a day) so that he could "hold out long enough for the inventions of robots that will keep humans alive" (*Daily Mail,* 2013).

In *How to Create a Mind,* unfortunately, rather than clearly presenting and *justifying* his hypothesis on a theory of mind, Kurzweil takes the reader on a computer science/artificial intelligence/neuroscience/transcendence odyssey, albeit one well written and interesting for the lay person. How to actually create a mind, as the title promises, is disappointingly tucked away at the end of the seventh chapter, rather than featured more prominently in this work. Instead, Kurzweil describes how we can build a digital brain that will become exponentially more intelligent, merge with humans, and finally go out to other planets, and transcend our galaxy, "waking up the universe" (Kurzweil, 2012, p. 282).

While much of this is beyond my scope of expertise, I would like to review some of Kurzweil's ideas that are relevant to the practice of psychotherapy. In Chapters 3 and 4, he uses thought experiments from previous chapters combined with neuroscience research to explain his Pattern Recognition Theory of Mind (PRTM). In Hebbian neuroscience/machine-learning, the basic unit is the neuron, but Kurzweil has chosen as the basic unit a collection of approximately 100 neurons that he calls a "pattern recognizer." There are 600 of these per cortical column, and thus approximately 300 million pattern recognizers in our neocortex. Synaptic connections within a pattern recognizer are stable but it is the synaptic connections between different pattern recognizers that change with learning. As medical psychotherapists, it might be useful to think about what interventions we use that affect the operation of the pattern recognizers themselves (i.e., assuming this is indeed how the brain actually works) versus the connections of one pattern recognizer to another.

In PRTM, when recognition of a particular pattern of inputs is detected by a pattern recognizer, it sends a signal to a pattern recognizer one level above. That level of pattern recognizer, when recognizing a particular pattern of its inputs, in turn sends a signal to the level above, and so on. (A level is not above or below another one *physically*, but only organizationally by virtue of the connections it has.) For example, the retina signals input into the lowest level of pattern recognizers that could, for example, detect various line shapes. The next level or two of pattern recognizers could detect various shapes made by different lines. The next level could detect alphabetic letters made from the previous level of various shapes. Up another level or two, for example, the word "apple" or "pear" can be recognized. An es-

Ray Kurzweil (68 years old), Feb 20, 2016, Cambridge, MA, USA (photograph by H. Schneider)

sential feature of PRTM is that not only is information travelling upwards in the hierarchy, but feedback is also travelling downwards. The level above is continually hypothesizing what pattern it should see and is sending excitatory and inhibitory signals to the levels below to help or hinder them from triggering a signal. Thus, if the level above hypothesizes that the letter "A" should be seen it will send signals down the hierarchy, making it easier for the lower level pattern recognizers for the visual components of the letter "A" to be triggered. As psychotherapists, we can appreciate how the brain using PRTM is not recognizing an absolute reality but recognizing what it wants to see.

I like Kurzweil's Pattern Recognition Theory of Mind—except for the prefrontal cortex (more on that below)—it seems to explain in a plausible way how the brain might function. However, what is lacking in Kurzweil's book is recognition that much of the work on PRTM actually has been done by others. The key feature of information not only flowing upwards but going backwards to lower levels (i.e., expectations of lower levels to detect certain patterns), has been discussed by many workers in the field, and was the focus of research very similar to Kurzweil's model by Jeff Hawkins and George Dileep a decade earlier (Hawkins & Blakeslee, 2004).

I object to the fact that PRTM tends to treat the prefrontal cortex much as the rest of brain, other than noting that frontal lobes are large in humans. However, human brains do much more than mere pattern matching. Our prefrontal cortex creates a small but almost magical working memory where, in conjunction with the rest of the brain, we can perform logical operations that AI researchers at the time of this writing still have trouble duplicating (to wit, the common-sense logic of a school-age child).

In Chapter 7, Kurzweil finally describes his strategy to "create a mind," essentially pasting a PRTM network together with other modules that do critical thinking, conventional computing, and so on. In the following chapter, he discusses simulating a human mind.

Are the critics still as harsh on Kurzweil's ideas as they were when this book came out? It is hard to say. However, in 2015 an-

other writer proposed a useful improvement to Kurzweil's theories (du Castel, 2015), adding pattern activation and better consistency checking, as well as metaphor generation. Professor Marcus, after criticizing Kurzweil, went on to found a company that used ideas somewhat similar to those of Kurzweil (Metz, 2016). Kurzweil, at 64 years old, was offered a position of Director of Engineering at Google (Ungerleider, 2012), where at the time of this writing he continues to work on actually building the digital brain he presented in his book. And yes, he is still taking his vitamins (Brodwin, 2016).

Howard Schneider is a medical psychotherapist in Toronto.

Conflict of Interest: none

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Report from the MDPAC Board of Directors

Catherine Low, MD, MDPAC(C)

I feel privileged to hold the position of Chair of the Board of Directors of MDPAC this year. This position has allowed me to witness much change and growth both in the organization as a whole and in the individuals who have come together as volunteers to help us evolve and change with the times. I know that I too have grown as a person as a result of my involvement in MDPAC. What follows is a brief summary of the activities going on within your association. I urge you to take the time to find out what is happening and to find a way to get involved that helps to further your own professional and personal goals.

MDPAC President Meets with the Coalition of Ontario Psychiatrists

The Coalition is a formal partnership of the Ontario Psychiatric Association and the Section on Psychiatry of the Ontario Medical Association, representing 1900 psychiatrists in Ontario. They hosted a roundtable, "Improving access to psychotherapy in Ontario," in Toronto on June 28 and Brian McDermid, in his role as President of MDPAC, was invited to participate. In his report to the Board following the meeting Brian emphasized the following:

> I believe many of the representatives at this meeting deeply cared about where we are headed. With some clarifications and reassurances, many attendees, representatives of professional associations including MDPAC, will likely want to support public funding for structured psychotherapy services for individuals with mild to moderate mood disorders and/or addictions; these psychotherapy experiences aim to enhance personal motivation, helping patients achieve healthier goals, and improving their emotional regulation. We could support this initiative, as an experimental and demonstration project, to be later expanded upon by providing public funding for less structured psychotherapy of varying duration and intensity at some time in the future. These latter services would better address the needs of patients with more serious mental health problems including those with dual diagnoses, and/or a history of complex developmental trauma (C-PTSD) and/or PTSD.

The 30th Annual Conference

The 30th Annual Conference of the MDPAC was held on May 26–27, 2017 at the Radisson Admiral Hotel in Toronto. The theme was "Resilience and Recovering from Complex Trauma." Our opening keynote speaker, Dr. Jon G. Allen of the Menninger Clinic in Texas was a big hit; many people stated that they could have listened to him speak for an entire day. Howard Schneider received the Theratree award (see next page). The conference itself was very well received and many of the attendees remarked that is was the best conference they had attended in years.

The Sixth Annual MDPAC Retreat

Registration is now almost full for the sixth annual MDPAC retreat happening in Orillia. Psychologist Sheri Geller will be our presenter this year. She works in the area of mindfulness and therapeutic presence and was a very popular presenter at one of our past Annual Conferences. The retreat will be held at the Geneva Conference Centre in Orillia during the weekend of October 27–29, 2017.

Local Groups of MDPAC for Peer Supervision

There are a number of groups operating in the Toronto area and one in the Kingston area. There is a now group in Alberta hosted by Joan Sametz via GoToMeeting. There is a new group starting in Ottawa in September hosted by Catherine Low. Please contact Carol Ford for further information if you wish to join one of these groups.

Community of Practice in Mental Health Program Committee at the CFPC

It was announced on June 1, 2017 that this committee, along with the other COPs at the College will be reorganized later this year to reduce costs. The restructured committee would consist of two members, a chair and vice chair, with other people being asked to join on a per project basis. Vicky Winterton, who has represented physicians with a special-interest focused practice (SIFP) in psychotherapy on this committee for the past six years, has written to express her concern that this pared-down committee would not allow for a designated representative from a SIFP. Mary Ann Gorcsi sits on the current committee as the representative from MDPAC and her position would also be removed under this pared down committee structure. Vicky has written to the College of Family Physicians of Canada to suggest that the mandate for the new committee specify that the position of vice chair be filled by a physician with a SIFP. One of the issues which Vicky has raised at the committee over the years is the need for the College to develop a Certificate of Added Competency (CAC) in Mental Health and Psychotherapy. There are

continued on page 20>

no plans at present for the College to take action on this request.

Membership in the CAMIMH

The Board of Directors of Canadian Alliance on Mental Illness and Mental Health (CAMIMH) met in May 2017 in Ottawa and voted in favour of accepting MDPAC as the 17th member of the alliance. CAMIMH is a national non-profit organization funded by Bell Let's Talk and the Mental Health Commission of Canada, among others. It was established in 1998 to raise the profile of mental health concerns throughout Canada. At our Board meeting on June 22, 2017, Catherine Low was appointed to be the MDPAC representative to the Board of Directors of CAMIMH. The Alliance sponsors two major events a year in the Ottawa area. The next event, Mental Illness Awareness Week, will be taking place on Parliament Hill in October in conjunction with their Faces of Mental Illness Campaign.

Core Essentials in Primary Care Medical Psychotherapy Subcommittee

The Education Committee has revitalized this subcommittee and is finalizing plans for a new course to provide training in psychotherapy for physicians. The first module of this course will be offered in June 2018 at the Geneva Conference Centre in Orillia.

Board Policy on Psychotherapy Supervision

In preparation for the expanded categories of CPD being developed by the Professional Development Committee, the Board of Directors approved two policies outlining the qualifications necessary in order for a professional to act as a supervisor for an MDPAC member. The policies were circulated by e-blast this spring and are available for viewing on the new website. It will be up to the MDPAC member receiving the supervision to provide proof that their supervisor meets the requirements outlined in the policies.

Please don't hesitate to contact me if you see a way that you can contribute and benefit at the same time by getting involved in some of the activities mentioned above. I would be so pleased to hear from you.

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

Conflict of interest: none

Contact: mclow98@gmail.com

Theratree Award 2017

I am pleased to announce the winner of this year's Theratree Award and I am sure that all of you will agree that the Board made an excellent choice this year.

Dr. Howard Schneider joined MDPAC (known then as the GPPA) in September 2006 and became a Certificant member in November 2008. Since that time he has contributed in a multiplicity of ways to the growth of our association. He took on the role of Editor of the Newsletter and helped it evolve into the Journal that we have today. He continues to sit on the Journal Committee and contributes articles to the Psychopharmacology Corner in the Journal on a regular basis.

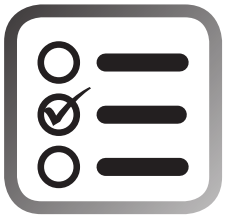
He has presented workshops on psychopharmacology at two of our annual conferences; in 2012 and 2013. He has published numerous articles in various journals over the years on the subject of SPECT scanning in the diagnosis and treatment of serious mental illness.

Howard has served on the Board of Directors of MDPAC and was the Chair of the Board in the year that the association first explored the idea of applying to be the Third pathway for reporting educational credits to the CPSO. Muriel van Lierop still talks about the early days of going to the CPSO offices for the very first time and how thankful she was to have Howard by her side as they waited to be allowed to pass into the hallowed halls (via a restricted access elevator, as I recall).

Howard has witnessed and been an important part of the evolution of our association into the vibrant and relevant organization that it is today. I would like to ask everyone to give a round of applause and

congratulations to Dr. Howard Schneider the winner of MDPAC's Theratree Award for 2017.

OUR READERSHIP SURVEY: Summary of Results



Of the 31 respondents, about 84% had read at least part of the issue. The majority had read the main articles. Of particular interest to us was which categories of articles readers wanted more or less of. The categories were Psychopharmacology Corner, Standards in Psychotherapy, Improve Your Practice, Reflections, and Book/Film Reviews. The majority of respondents wanted the same amount of articles per each category except for Improve Your Practice articles of which 56% of readers wanted to see more.

Thanks to all those who participated!

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Journal

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

Contact a Member

Search the Membership Directory or contact the MDPAC Office.

Listserv

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

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

contact Muriel J. van Lierop at vanlierop@rogers.com or call 416-229-1993

Reasons to Contact the MDPAC Office

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

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