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MEDICAL PSYCHOTHERAPY REVIEW

(Formerly GP Psychotherapist)

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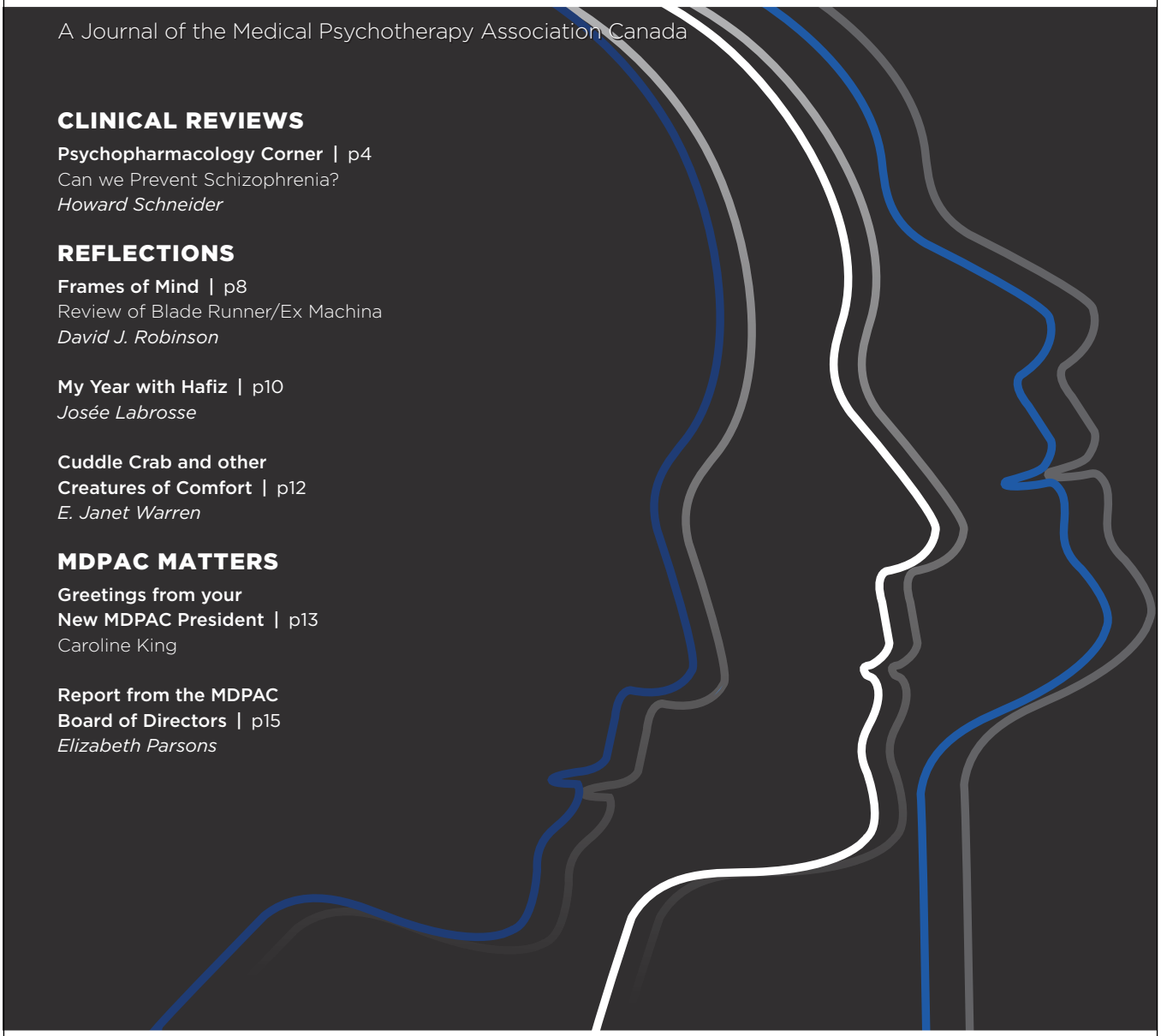

CLINICAL REVIEWS

REFLECTIONS

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"IT WAS MUCH PLEASANTER AT HOME," THOUGHT POOR ALICE, "WHEN ONE WASN'T ALWAYS GROWING LARGER AND SMALLER, AND BEING ORDERED ABOUT BY MICE AND RABBITS. I ALMOST WISH I HADN'T GONE DOWN THE RABBIT-HOLE—AND YET—AND YET..."

Lewis Carroll, Alice's Adventures in Wonderland

Carroll stretches the bounds of reality in his fiction. The world inhabited by Alice is in flux and somewhat ethereal. This classic children's tale has infiltrated our culture. As psychotherapists, sometimes we work to prevent our patients going down the metaphorical rabbit-hole; other times we may encourage it a little. We know that reality is not as straightforward as we would like it to be. Patients we encounter have differing perspectives, unique experiences, yet often eerie commonalities. Psychotherapy takes us beyond the ordinary and forces us to question the nature of reality. I suspect we all strongly refute Francis Crick's provocative proclamation that we are "nothing but a pack of neurons" (he follows Carroll too and Alice's observation that the King, Queen, and attendants are "nothing but a pack of cards"). Human beings are extraordinarily complex. We may be more comfortable with Einstein's assertion that "Reality is merely an illusion, albeit a very persistent one," and we can smile at Robin Williams's quip: "Reality is just a crutch for people who can't handle drugs."

This issue of the Medical Psychotherapy Review touches on issues of reality. Howard Schneider, in "Psychopharmacology Corner," uses a thought experiment to discuss whether or not we can prevent schizophrenia, especially in regard to young people who may be losing their grip on reality. The evidence points to some practical measures we can take. In "Frames of Mind," Dave Robinson reviews two sci-fi movies: *Blade Runner* and *Ex Machina*. Both deal with artificial intelligence and challenge the notion of what it means to be a "real" human. Fiction often offers insight into psychotherapeutic issues. Considering a completely different type of fiction, Josée Labrosse, shares her experience of daily readings with Sufi poet, Hafiz. She reflects that it is a good way to begin her day, and even writes back to the dead poet. On a

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.

more whimsical note, I share a reflection entitled "Cuddle Crab and other Creatures of Comfort." Stuffies are sometimes healthy replacements for realities that are too difficult to handle, and/or provide comfort to those who re-experience such realities.

In more sane and serious matters, we hear from the new MDPAC executive. Caroline King, our new president, introduces herself and her vision in a welcome letter, and Elizabeth Parsons, our new chair of the board, offers a similar introduction as well as reviewing past and future MDPAC activities in her report. She also shares some photographs of the recent MDPAC retreat!

As always, we welcome your participation in this invaluable organization. I trust that this issue of the *Medical Psychotherapy Review* informs, inspires and stimulates as we rejoice in and wrestle with our various realities, in our large and small moments, and our times in and out of rabbit holes...

Grace and peace,
Janet Warren

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Can We Prevent Schizophrenia?

Howard Schneider, MD, MDPAC(C), CCFP

Abstract

It is possible to identify younger individuals who are at an increased risk to develop a psychosis, which often turns out to be schizophrenia. In this article, a review of the literature provides the following recommendations to decrease (or delay) the risk of a transition to psychosis: counselling to avoid the use of cannabis, encouraging physical exercise, interventions to reduce childhood traumas, psychoeducation, social skills training, cognitive remediation, and cognitive behaviour therapy or other psychotherapy. Medications for the sole purpose of preventing a transition do not seem particularly helpful. Further research is needed on prevention, including the development of medications to prevent such a transition.

Let us begin with a thought experiment. You are in the emergency department with a 22-year-old patient with psychosis and agitation, have made a diagnosis of schizophrenia, and are following the guidelines reviewed in the previous issue of the *MDPAC Journal*. You excuse yourself for a moment, enter your time machine, and go back ten years, when the patient was 12 years old and slight pre-psychotic symptoms were starting to manifest, e.g., more disorganized at home and declining grades at school. How do you treat? Can you even treat?

Making Sense of Psychotic Disorders

You need to first make sense of what is really occurring in psychosis, particularly in chronic psychotic disorders such as schizophrenia. Animal models are limited. Although depression and anxiety, and a host of other psychiatric disorders seem to occur in animals, psychotic disorders such as schizophrenia do not seem to. For research purposes, heroic efforts are actually required to induce at best unreliable models of schizophrenia in animals (Jones et al., 2011).

As a next step you can consider clues from theoretical models of psychosis in humans. There are many models—from the dopamine-connectionist models of Cohen and Servan-Schreiber (1992) to the reward processing model of Papanastasiou and colleagues (2018). In the literature it seems that just about any part of the central nervous system, at many levels of representation are implicated, theoretically speaking, in the development of schizophrenia.

You know as a clinician that family history can predict some degree of risk for psychotic disorders such as schizophrenia. However, the search for a "schizophrenia gene" has been disappointing. There have been claims by researchers that the gene, or a gene, for schizophrenia has been discovered, but a detailed consideration of the results are unimpressive. For example, Singh and colleagues (2016) claimed "strongest single gene conclusively implicated in schizophrenia" with regard to their work on the *SETD1A* gene. However, this gene was found in only 10 out of 8000 patients, and 70% of these patients had other learning disabilities. In an evaluation of the genomes of 265,218 patients and 784,643 controls by the Brainstorm Consortium (Anttila et al., 2018), it was actually found that there was considerable genetic overlap between what should be very different DSM disorders of attention-deficit/hyperactivity disorder, bipolar disorder, major depressive disorder and schizophrenia. In contrast, the genetic basis for the neurological disorders they looked at were found to be distinct from each other.

Working Memory

However, subclinical traits of schizophrenia do in fact run in families, so there is some genetic association, but perhaps not the one straightforward gene that would simplify matters. "Working memory" is a short-term memory in the brain where information is not only stored but can be logically manipulated. Working memory is considered to involve verbal and visuospatial working memories. Deficits in both these types of working memories are increased in patients with schizophrenia. However, lower working memory functioning is also found in unaffected relatives of patients with schizophrenia (Zhang et al., 2016).

In patients with a diagnosis of schizophrenia, Lepage and colleagues (2014) showed a strong association between good neurocognitive functioning and a better chance at remission of symptoms. There has been much interest in applying cognitive remediation therapy to patients with schizophrenia to improve cognition including working memory, and hopefully improve their symptoms. Cognitive remediation therapy uses mental exercises to increase cognitive functioning in areas including attention, concentration, working memory, psychomotor speed, and executive functions of planning and problem solving. Mueller and colleagues (2015) performed a one-year randomized controlled

trial (n=156 schizophrenia patients) where the cognitive remediation group showed statistically significant but small improvements in symptomatic and functional outcomes.

Clinical High-Risk State

Given that cognitive remediation can have a small effect in patients with established schizophrenia, the next question would be to ask if it (or any other potential treatments) would have a larger effect in younger patients at risk of schizophrenia before overt symptoms occur. However, to answer this question, you first have to ask if you can actually predict which young individuals are at increased risk for the development of schizophrenia. Work by Fusar-Poli, Borgwardt and colleagues (2013) discuss the "clinical high-risk (HR) state" to characterize persons with *potentially* prodromal psychotic symptoms. The HR state is also called in the literature the "ultra-high-risk state" and the "at-risk mental state." Tools to evaluate an individual for inclusion in the HR group include the Comprehensive Assessment of the At-Risk Mental State (CAARMS), the Structured Interview for Prodromal Syndromes/Scale of Prodromal Symptoms, and the Clinical High-Risk State for Psychosis. In the CAARMS there are inclusion criteria for vulnerability to a risk of psychosis due to a trait (family or history with schizotypal personality history disorder traits plus deterioration in functioning); for risk of psychosis due to a subthreshold psychotic syndrome (i.e., symptoms are not severe or frequent enough to be diagnosed as psychosis); or for risk of psychosis due to a recent history of diagnosed psychotic symptoms that resolved spontaneously within one week.

Cannon and colleagues (2008) followed 291 HR patients for 30 months and found that 35% converted to psychosis. And Fusar-Poli, Bechdolf and colleagues (2013) showed that most such conversions are to a schizophrenic psychosis rather than an affective psychosis. Of interest, a meta-analysis by Giuliano and colleagues (2012) found a wide variety of cognitive deficits in persons with a diagnosis of HR state, generally mild but intermediate between healthy non-HR persons and persons with schizophrenia.

Treating the High-Risk State

What does the evidence show for treatments of individuals in the HR group? Sommer and colleagues (2016) comprehensively reviewed potential interventions in high risk groups for schizophrenia and argued the interventions they suggest are safe and beneficial even if the child would not have transitioned to a psychotic disorder. Mittal and colleagues (2015) consider the ethical and clinical impact of diagnosing a patient with a high-risk syndrome for developing psychosis.

Sommer and colleagues first consider that defects in glutamatergic and gamma-aminobutyric acid (GABA)-ergic function are thought to be involved in cognitive deficits of schizophrenia. Modification of glutamate functioning in patients with established schizophrenia using D-serine NMDA partial agonist has not shown benefit, but Sommer and colleagues argue that it may have advantages if used earlier, based on mice experiments. Interventions with regard to GABA have not been very effective in adult patients with schizophrenia, but a similar argument is made.

There has been some support for choline or N-acetylcysteine (NAC) supplements in animal models of schizophrenia. Although evidence is lacking, Sommer and colleagues argue that omega-3 fatty acids (mildly anti-inflammatory, part of the neuronal cell membrane) and probiotics (can decrease systemic inflammation) may safely be of advantage to children at high risk of developing schizophrenia.

These researchers also note that an abnormal hypothalamic-pituitary-adrenal axis is associated with cognitive and negative symptoms in schizophrenia, and thus reducing stress and increasing resilience should be considered in the HR group. Therapeutic interventions are suggested to reduce bullying and exclusion by peers. Kelleher and colleagues (2013), in a prospective study of over one thousand 13–16-year-olds, found that childhood trauma (physical assault and bullying) predicted psychotic experiences. Of interest, if the trauma stopped, this predicted a decrease in psychotic experiences.

Sommer and colleagues strongly support early interventions to prevent drug abuse. Dragt and colleagues (2010) specifically showed that use of cannabis at an earlier age in HR youth was associated with earlier onset of actual psychotic-like symptoms. Physical exercise is recommended to improve cognition in persons in the HR group. Most studies have considered the benefits of exercise in adults, but Lee and colleagues (2014) found that cognitive functioning was improved in adolescents.

Sommer and colleagues recommend cognitive remediation therapy to improve neu-

continued on page 6 >

ropsychological deficits and note that the effect of this therapy is greater when started at the earliest possible age. Cognitive remediation therapy (CR) should not be confused with cognitive behaviour therapy (CBT). As noted above, CR involves mental exercises to increase cognitive functioning in areas including working memory. Bechdolf and colleagues (2012), in a randomized controlled study of 128 patients (average age mid-twenties) with a possible early prodromal state of psychosis, demonstrated a lower rate of conversion to psychosis with an "integrated psychological intervention" (CBT + group skills training + cognitive remediation + psychoeducation) compared with supportive counselling (3.2% vs 16.9% conversion at 1 year). Similar results, although unfortunately not statistically significant, were found in a recent meta-analysis of published and unpublished interventions to prevent psychosis (2035 patients, average age 20.1 years old) (Davies et al., 2018).

Conclusion

As you near the end of the available evidence for your thought experiment, as a medical psychotherapist, what can you make of the above? You know that there can be a family risk for schizophrenia yet, despite large efforts, no "schizophrenia gene" has been found. As well, in families of patients with diagnosed schizophrenia there are often deficits in working memory in the unaffected relatives. Thus, it would seem that not everyone with a risk of developing schizophrenia necessarily does so. This leads to the question of how you can prevent a young person who is at risk of developing schizophrenia from overtly developing the disorder. While the meta-analysis of Davies and distinguished colleagues (2018) clearly states that there is no evidence to recommend specific interventions for the prevention of psychosis in high risk individuals, they grudgingly note that "integrated psychological approaches could be the target of future replications."

Given that the development of a psychotic disorder such as schizophrenia is devastating to the individual and their family, and given the large numbers to society as a whole, it would seem reasonable that for an individual in the HR group, such as the 12 year-old patient you are with now, there be counselling to avoid the use of cannabis, encouragement of physical exercise, interventions to reduce childhood traumas (e.g., stop bullying), psychoeducation, social skills training, some means of ongoing cognitive remediation, and a trial of CBT and/or other psychotherapy. Further research is needed. For example, is psychosis being delayed rather than actually being prevented? With regard to medication, it is hard to decide if any interventions are worthwhile at this point in time. A risk/benefit argument could be made for taking omega-3 and probiotics. Further research is needed, including future drug discovery efforts targeted to the prevention of the disorder rather than its symptomatic treatment.

Conflict of interest: none.

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

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Blade Runner/Ex Machina

Scott, R. (director) (1982) *Blade Runne*r (motion picture). United States, The Ladd Company.
Garland, A. (director) (2014) *Ex Machina* (motion picture). United Kingdom,Universal Pictures International.

Reviewed by David J. Robinson MD, FRCPC

These two films deal with the theme of artificial life forms and the tribulations they face in integrating with humans. Both films are remarkable cinematic achievements, have gained legions of ardent fans, and warrant being watched more than once. Both films are rife with psychotherapeutic material, with the Oedipal Complex being a strong common element. When humans create something, they most often imbue it with their personality, conflicts, quirks and values. Viewers get ample opportunity in these two films to see the creators of these engineered life forms and to see how they project themselves into their digital children.

Blade Runner is based on the short story "Do Androids Dream of Electric Sheep" by Philip K. Dick. In the 1982 original release, bioengineered humans called replicants are designed for roles in slave labour, the sex trade, or military operations. They are intellectually at least on par with their designers and physically superior to any human. Blade Runners are the detectives who track down and "retire" replicants who return to Earth, where they are forbidden. Since replicants look and behave like humans, specialized detection methods are required to identify them.

Blade Runners use the Voight-Kampff (VK) test, a physical device that measures a variety of bodily functions. A video screen magnifies changes in pupil size to provocative questioning, looking for emotional reactions to contrived situations. There are bellows on the VK machine to analyze pheromone release during the stress of the test. Two administrations of the VK test are shown in *Blade Runner*, which reportedly takes 20–30 cross-referenced questions to determine if the subject is a replicant or a human. In the short story, mention is made that people with schizophrenia were at risk of failing the test given their potentially attenuated emotional responses to stressful situations, and the false-positive result was a risk for Blade Runners.

The Blade Runner assigned to deal with the latest group of renegade replicants is Rick Deckard (Harrison Ford). In his investigation, he is introduced to Rachael (Sean Young), who agrees to take the VK test in front of Eldon Tyrell (Joe Turkel), creator of the company that makes replicants. It takes over 100 questions for Deckard to determine that Rachael is one of the latest versions of replicant, and he is amazed to learn that she doesn't know she isn't human. Her resourcefulness and willingness to assist Deckard create a dissonance that amplifies for the remainder of the movie. Deckard quickly develops feelings for Rachael and switches from being her persecutor to her protector. Sean Young was only 22 when *Blade Runner* was filmed and is astonishing as Rachael, adding nuance and vulnerability to create a timeless, compelling character. The soundtrack created by Vangelis is stellar and accentuates the drama, romance, and intrigue contained in the plot.

Ex Machina was written and directed by Alex Garland. The title stems from deus ex machina (god from the machine), which is both a plot device and a physical device used in classical plays to bring about the resolution of some dilemma. A machine would be used to make actors ascend or descend onto the stage and add an element of wonder to the character. In *Ex Machina*, programmer Caleb (Domhnall Gleeson) ostensibly wins a company contest and is given the chance to spend a week with Nathan (Oscar Isaac), the reclusive genius who created an online search engine and developed it into a mega-corporation. Nathan has been busy working on a secret project that he thinks will be the greatest achievement in history, and he is eager to see how someone naïve to his creation will respond.

After signing an unsettlingly invasive non-disclosure agreement, Caleb is introduced to Ava (Alicia Vikander), who is Nathan's AI android creation housed in the body of a young woman. Ava is clearly an android, having several parts of her body composed of transparent polymer and visible wiring. The evaluation of her AI is to be the Turing Test, named after scientist

Alan Turing. The Turing Test involves an interaction between a human and the subject of the test, and is judged on the naturalness of the responses by the subject. If the human evaluator can be led to believe the subject is human, the test is said to have been passed.

Since Caleb knows Ava is an android, what ensues would be considered a modified Turing Test, where Nathan wants to see if Ava can develop a significant emotional bond with Caleb in the short time they have together. There are several "sessions" of conversations between Ava and Caleb that increasingly show the sophistication of her "programming." Much like Sean Young's performance in *Blade Runner, Ex Machina* works because of Alicia Vikander's outstanding performance. She moves less fluidly than a human due to her servo motors, and because she is still a prototype, more effort has been put into her software than her hardware. She quickly and effectively engages Caleb, who becomes smitten with her, and the question becomes one of *how* they might plan to be together rather than *if.* In contrast to *Blade Runner,* the soundtrack is more of a utilitarian collection and might have benefitted from a love song by Martin Fry/ABC to underscore their burgeoning romance.

The glimpse into the future that these two films provide is both fascinating and troubling. The "programmers" included the capabilities, vanities, and frailties contained in the human genetic code into the code written for these synthetic life forms. While mental health professionals await reliable biomarkers for diagnosing psychiatric conditions, it is interesting to see that identification of androids may be a required future skill—there may be a role for our input into software development. For all the sophisticated programming incorporated into Ava and the replicants, what is it that they yearn for with their synthetic brains? Freedom, equality, respect and a longer life span, and they are just as cunning and ruthless as humans are in the pursuit of their wishes.

It would be fascinating to speak with AI programmers to learn their perspective on what "human nature" encompasses and how various human traits are included or excluded from the code they write. In *Blade Runner,* replicants have a four-year life span to ensure they don't live long enough to organize into a threat to humans, and this possibility is carried into the sequel, *Blade Runner 2049* (released in 2017), which continues many of the themes from the original. In *Ex Machina,* we see a developer/father with palpable pathology, who has programmed his machines to be perfect balances to fill the void in his life, though he treats them with a schizoid indifference that borders on disregard. Humans appear to be unavoidably determined to create androids that may serve us, be our peers, or perhaps even our superiors. If these two movies give us a reasonably accurate view of what our near future holds, our countertransference reactions towards our own creations will be as much of a challenge for our species as are the technological developments.

Conflicts of interest: None.

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My Year with Hafiz

Part 1

Josée Labrosse, MD, MEd

A couple of years ago, my morning habit of reading the newspaper was causing agitation and an urge to address all the woes of the world related to health—which is mostly everything if you recognize anxiety as a common denominator. Any serenity found in sleep, yoga or meditation practice was out the window as my family rose and we prepared to set off into the day's activities. The morning read did not enrich or inspire.

I recalled a tradition I had loved at summer camp and the gentle rhythm it set in motion every day, as 500 varied folk assembled before breakfast in a wooded chapel to hear a "Thought for the Day" offered by a selected youngster or staffer. The thought was posted and sometimes revisited during the day. "Why not do that at home?" I wondered, knowing it would be groan-inducing with family even if I kept it light. Still…better than news-related rants or absent absorption in obsessive hero fantasies.

I had been working with poetry in personal and professional development for a few years and had grown particularly fond of the 14th Century Sufi poet Hafiz, who always surprises and often makes me laugh. So I chose to spend time with him in the mornings, instead of the editors of the Globe and Mail. I also wanted more art and creativity in my life so I committed to taking time to a practice where I become reflective, read a Hafiz poem quietly or aloud, write it out in calligraphy—with a motto of practice not perfection—then have a written chat with the Master and see what happens. It's been the most fun I've ever had with "The Discipline of a Serious Practice."

Whereas many prior commitments have ended after two days straight, I completed the whole year and have mostly kept going! I confess I've had some great conversations with the dead poet, who at times seems very alive to me. Sometimes I'm inspired to respond with a poem of my own, and often try to distil it into a Haiku: 14 syllables max. It helps me find ways to clarify and focus complex emotions and thoughts.

Allow me to share an example with fellow medical psychotherapists. It is from Ladinsky's (2011) April daily contemplations, in which he presents translations rendered by Ralph Waldo Emerson, reworked from earlier translations by Hammer-Purgstall and nicknamed the Hafiz-Hammer-Emerson-Ladinsky work (I contracted this to Haf-Ham- Emer-Lad). It seems that translating Hafiz's work is an elusive art form and subject of controversy among scholars.

In Case Things Really Got Hot

(in Ladinsky, 2011)

She said I could touch her all I wanted,
a beautiful woman I met.

That inspired me to develop
my spirit body more,
which was less intimidated
by time and space,
and had a lot more stamina too…
in case things really got hot!

I thought she would have acted more
surprised and delighted when I finally
kissed her with all my passion,

but the moon was more poised
than I knew.

On reflection, I drafted this reply:

Dear Masters,
Has the time come for men like you to come forth? Shall we post an invitation on the universal dating web? Will YOU respond to it, please? Here's how the ad might read…

Moon Seeking Sun of Man

Divine beauty, moon light, evolving
being seeks worthy mate.

A trained spirit-body
confident, humble, patient, fit
touchstone-ready disciple
of powerful Metta
(One Love, and Kindness)
to transcend time, space and poise,
surprise, delight and co-create
with every look, word, caress and kiss.

Please send resumé along with soul

snapshot to: mydream@wildworld.un

Powerful arrogant fools need not reply. Suitable lovers will be contacted for auditions.

Kindly, Dear Masters Haf-Ham-Emer-Lad, let me know what you think. And also, feel free to visit. Maybe we can practice together.

Love,

Josée. Namasté.

After journaling and writing that, I opened my laptop and the following poem spontaneously opened; this seemed akin to an immediate and playful response from Hafiz himself.

A Mime (in Ladinsky, 2011)

A mime stands upon a gallows for
a crime he did not do. When given
a last chance to speak, he remains
true to his art.

A crowd of hundreds has gathered
to see his last performance, knowing
he will not talk.

The mime takes from the sky the circle
of bright spheres, lays them on a table,
expressing deep love for the companionship and guidance they have given
him for so many years.

He brings the seas before our eyes.
Somehow an emerald fin appears,
splashes. Look, there is turquoise rain.

He removes his heart from his body and
seems to arouse all life on this splendid
earth with such a sacred tenderness;
there for an extraordinary moment,
it looked like someone was giving
birth to the Christ again.

He mounts his soul upon the body of
Freedom. The great breeze comes by.
The sun and moon join hands; they
bow so gracefully that for a moment,
for a moment everyone knows that
God is real. So the tongue fell out
of the mouth of this world for days.

The mime left me speechless. That "Thought for the Day" comingled with others throughout the week. It turned up with a psychiatrist colleague: we were discussing physician health needs when the subject turned to the film The Shape of Water (an acclaimed artsy film featuring love between a speechless mythic sea creature and a wounded woman). They form a wordless bond in colourful imagery that transcends usual human limitations, even violence, and offers healing, hope and poetic justice amid chaos and danger, just as Hafiz now offers my mornings.

The practice offers respite from the chatter of news outlets and various political scandals, health care crises and #MeToo movements. The impact is difficult to describe—yet it is a process that I think is worth experimenting with and experiencing, for any so inclined. I still miss the Globe sometimes, though.

Conflicts of interest: None

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

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Cuddle Crab and Other Creatures of Comfort

E. Janet Warren, MD, PhD, FCFP

Cuddle Crab is a torso-sized stuffie—fuchsia pink with a baby-pink underbelly and, frankly, a kind of creepy grin. But I haven't shared that opinion. And neither have I been bold enough to inquire about its gender, or inspect closely. Cuddle Crab's owner is a young woman who was originally seeing me to process her recovery from an abusive marriage. In her words, once she "found a safe space," memories of childhood sexual abuse emerged. Cuddle Crab, who arrives to sessions hidden in a grocery bag and sits on her lap during therapy, helps her grieve the trauma both during and between sessions.

Now, I've sometimes had people bring in teddy bears or fluffy bunnies but a crab was, well, unexpected. I never cease to be amazed, and to be honest, frequently amused, by the creativity and resilience of my trauma patients. One of my older patients, grieving the loss of her adult daughter, showed me a beautiful tattoo of her daughter's name on her forearm. Another named her anxiety "Violet," after a movie character. Many people share exquisite artwork or poetry.

Regardless of whether one references transitional objects, inner child stuff, internal family systems therapy, somatosensory healing, reconciling the limbic and cortical systems, and likely a few others, people often find comfort in child-like things. Survivors of developmental trauma were robbed of their childhood; recovery can include reclaiming simple play. The new fad of "adult colouring" is a witness to this, although I intensely dislike the marketing associated with this.

I suggested to one patient that she buy herself a doll, after she mentioned that she had never had any as a girl. Next session she arrived with knitted Voodoo and Frankenstein dolls (this last one included a removable skull so that one could take the brains out). Of course, I presented my best therapy poker-face, but thought an image of them would make a good cartoon with the caption: "when psychotherapy takes a wrong turn." A few months later, without discussion or prompts, this woman, now making good progress in her trauma recovery, showed me a picture of her new Barbie doll—sitting on a homemade swing in a blue dress with a miniature unicorn on her lap.

What people wear and bring to therapy can be informative. I have witnessed patients' clothes transition from dark to light colours as they progress. Sadly, one person brought her own box of tissues (our office couldn't possibly supply enough for her grief); another brought a large washcloth, despite the fact that she never shed a tear (but the fear of this was palpable). It's also very informative when someone arrives without their notebooks or usual accoutrements.

As we are all aware, psychotherapy can be draining at times. However, the privilege of sharing in people's pain and recovery is rewarding. I continue to be inspired, as well as amused, by Cuddle Crab and other such creatures.

Conflicts of interest: None

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E. Janet Warren is a Family Physician who practices psychotherapy part time in Burlington, Ontario. She enjoys writing and is current editor of the Medical Psychotherapy Review. The patients referred to in this article have given consent for aspects of their stories to be shared.

Greetings from Your New MDPAC President

Caroline King, MD, FRCPC

Hello fellow MDPAC members! My name is Caroline King and I am honoured to be the 10th president of our organization, having been nominated and chosen by your Board of Directors this past spring 2018, along with the new Board Chair (Elizabeth Parsons) and Treasurer (Alison Arnot).

I have been a member since 2011 and served six years on the Professional Development Committee and one year on both the Outreach Committee (as Chair) and the Board. I believe I am the first president of MDPAC who is a psychiatrist (but don't hold that against me!). Allow me to introduce myself and share some of my story, and my hopes and goals for our organization.

I completed both my undergraduate medical and postgraduate Psychiatry residency training in London, Ontario (University of Western Ontario). After passing my Royal College exams, I returned to the Hamilton area and worked in inpatient and outpatient general adult psychiatry at McMaster University Medical Centre. However my main interest was always psychotherapy; when my daughter was in preschool, I quit hospital and academic psychiatry and pursued training in Jungian Psychology in Toronto. At the same time, I opened my private practice in Dundas, Ontario. I got halfway through the Jungian Analyst Training Program but for various reasons it wasn't working out for me. Around that time, I realized that my practice resembled more of what a GP Psychotherapist does than what a psychiatrist does (i.e., longer-term follow-up, mainly depression and anxiety, some medications, but a lot of psychotherapy). As a solo practitioner, I missed having colleagues, so I joined the then GPPA (now MDPAC) and never regretted that decision. I felt (and still feel) that my values and those of our organization coincide: to promote high quality psychotherapy among physicians in Canada. I've finally found my professional home and my *tribe*.

We've come a long way as a professional medical organization and I try to be mindful of the past, present and future. We have such a pluralistic membership—from long-time members and founders, who are the guardians of our history, to new graduates and residents who are literally the future of our organization. At times it can seem daunting to meet the needs of such a diverse group, and I realize that not everyone will be happy with the Board's and the Executive Members' decisions. Nevertheless, I know the Executive will try to distill things down to our most crucial and important values. To this end, Elizabeth Parsons and I are already starting to plan another Visioning Retreat, perhaps in late 2019. It's hard to believe that the last retreat was seven years ago. So many of the ideas from that year (published in the Spring 2011 issue of the *GP Psychotherapist*) have already come to fruition, including the following:

1 | "…optimi[zing] our use of technology to improve our connections between members."

Our website is now *the* major hub for committee files and documents, as well as the first place that people come to find out about our organization. Also, we have leveraged real-time technology (first through GO TO Meetings and then Zoom) to facilitate distance learning.

2 | "[to] become the authoritative voice of integrative psychotherapy in Canada, and the number one place for physicians practicing psychotherapy, by enabling and fostering the highest levels of self-care, collegiality and connection among our members."

I think we have attained this goal, whether or not we are well known. Although there are other national physician organizations that have members who practice psychotherapy (e.g. Canadian Psychiatric Association, College of Family Physicians of Canada), it's clear that psychotherapy is not the most—or even one of the most—valued skills in these groups. Likewise, while certain university centres in places such as Toronto, Hamilton, Halifax and Montreal may be active in clinical and research psychotherapy, they are not national organizations, and are often led by psychologists. Thus, MDPAC really fills a niche of its own. And of course, self-care, collegiality, and connection among our members are central to our organization, whether through the Fall Retreat, Listserv, or emphasis on CCI.

3 | "To look for opportunities for increased exposure…"

In the last several years, we've done this by exhibiting at two national physician conferences a year. Where we can't exhibit (due to lack of members to staff a booth, or lack of finances), we encourage members to bring MDPAC brochures. Although "hiring a publicist" was put forward as an idea seven years ago (still not likely, due to staff and budget restraints), we've realized that we don't have to reinvent the wheel. By becoming a member of the Canadian Alliance on Mental Illness

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Greetings from Your New MDPAC President | continued

and Mental Health, we can take advantage of its publicity infrastructure as well as its networking relationships with government and other organizations.

Let's keep the momentum of these changes going. As a sneak preview, some of my hopes and goals for a visioning retreat include:

- Increasing membership: I think that our online and in-person educational programs will be the biggest driver of membership in the future.
- Maintaining networks with other physician groups that perform psychotherapy, as well as other mental health organizations.
- Ensuring that our organization is sustainable in the long term, and commits to high standards in psychotherapy education and practice.

In preparation for a retreat, I hope to develop and submit a membership survey in order to get a clearer, more democratic picture of what our members want as well as their needs and goals. Listserv is great, but not always representative of the organization as a whole. I know most surveys only have a return rate of about 30%, but let's aim for 100%! I want everyone to contribute their ideas.

A word about my *leadership style*. I only recently learned that this is a thing, as I took a CMA leadership course this spring. I am *blue/red* which means I am analytical (yeah, survey!), I value standards, and once I decide on a goal or project, I will see it through to completion (that's the red part). I am less strong in imagination and inspiration (*green/yellow*), but am looking forward to working with people who have strengths in these areas. I am taking another CMA course in October entitled *Engaging Others* which I hope will give me more ideas on how to motivate our volunteer base!

I'm writing this during Labour Day weekend, which is like New Year's Eve for many of us. So Happy New Year! Let's make it a good one.

Sincerely,

Caroline King

Report from the MDPAC Board of Directors

Elizabeth Parsons, MD, CCFP, FCFP

This is my first report from the Board of Directors. I am excited to be taking on the job of Chair and to be working with Caroline King as President and Alison Arnot as Treasurer, along with all the members of the board. I want to thank Catherine Low, outgoing Chair, for all her hard work over the past six years on the board (four as Chair) and for making my transition a smooth one.

Allow me to introduce myself. I attended the University of Ottawa for medicine and completed my family practice residency at the Northeastern Ontario Family Medicine program in 1999. My research project in second year was a survey of family practice residents across the country on stress levels and drug and alcohol use. At that time I didn't know that I would eventually practise psychotherapy full time, but my interests certainly pointed in that direction as my electives included palliative care and addictions. My first few years in practice were spent doing short-term locums and in 2002 I started working in student health at Carleton University. During my time there, I became more interested in psychotherapy and by January 2007 I decided to practise psychotherapy exclusively. My psychotherapy training started with CBT and moved on to DBT and mindfulness. Sensorimotor psychotherapy training was a life-changer for me along with Internal Family Systems, which I have recently delved into. My own struggles with mental health issues have had a major influence on my work. I feel strongly that, as physicians who understand the mind/body/spirit connection, we are well placed to bring healing to the medical system itself, especially through our work in the education of our fellow physicians.

Within MDPAC, I have been involved with committee work since 2010, with four years as chair of the Education Committee and five years as chair of the Retreat subcommittee (now a separate committee in its own right). I joined the Education Committee because I wanted to see the return of the Basic Skills Core Curriculum and I'm so pleased that we now have a new Psychotherapy Training Program. It started in June this year with a full complement of participants and an excellent line-up of teachers and topics.

The 31st Annual MDPAC Conference

"Paradigms and Tools for Psychotherapy" took place at the Radisson Admiral Hotel in Toronto, May 25 and 26. There were 134 attendees with 65% of them returning the evaluation forms. Overall the response was positive, with ratings of 4.5/5 or higher for most of the presentations. It was heartening to see a number of younger participants at the conference, many of whom were very active in discussions. The Theratree award was presented to Dr. Harry Zeit, who has been part of the Psychotherapy Training program committee as well as a teacher of two of the modules.

Fall Teleconference Series

When you read this, the teleconference series will already be underway. I'm excited about this series of five presentations on Interpersonal Psychotherapy, which will include applications to adolescent medicine, bipolar disorder and PTSD. You can register online at MDPAC.ca for any or all of the teleconferences so please check them out! You can learn from the comfort of your home at a very reasonable cost and we can thank the Education Committee for making this program available to us.

Outreach at Conferences

MDPAC hosts a booth at two or three conferences each year. This year we have been granted a display table at the St. Paul's Hospital CME Conference for primary care physicians in Vancouver, November 20–23. This is an opportunity to get our name out there and make some connections with physicians from the west coast. If you would like to help out at this conference, please contact Mattie Abell at matabell@shaw.ca. We will also be participating in the Canadian Psychiatric Association Conference, September 27–29, as well as the Family Medicine Forum, November 14–17, both in Toronto.

7th Annual MDPAC Retreat

I have a special fondness for the MDPAC retreat. I was at the 2011 Visioning day and the retreat was something that was crucial to me as a goal for our organization. I can't quite believe that we will be holding the 7th retreat this year and that it has been such a resounding success. "Cultivating Mind-Body Self Care and Renewal: The Hakomi Method" with facilitator Hugh Smiley, assisted by our own George Lewis, will be taking place October 19–21, once again at Geneva Park Lodge near Orillia. I am looking forward to attending this and will share some photographs. (Editor's note: see next page.) It is a wonderful opportu-

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nity to rejuvenate and reconnect with your colleagues in a beautiful and peaceful setting. As of this writing, 18 people have already signed up.

Visioning Plans

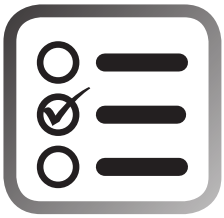
As you will see in our President's message, plans are underway to hold another Visioning Day or retreat in late winter/early spring 2019. Looking back through old issues of the *GP Psychotherapist* I see that we held Visioning Processes in 2000, 2006 and 2011. This regular renewal of our organization's goals is an important part of our growth and change. I strongly encourage you to be part of this process and to help steer the organization in the direction you would like to see it go

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.

OUR 2017 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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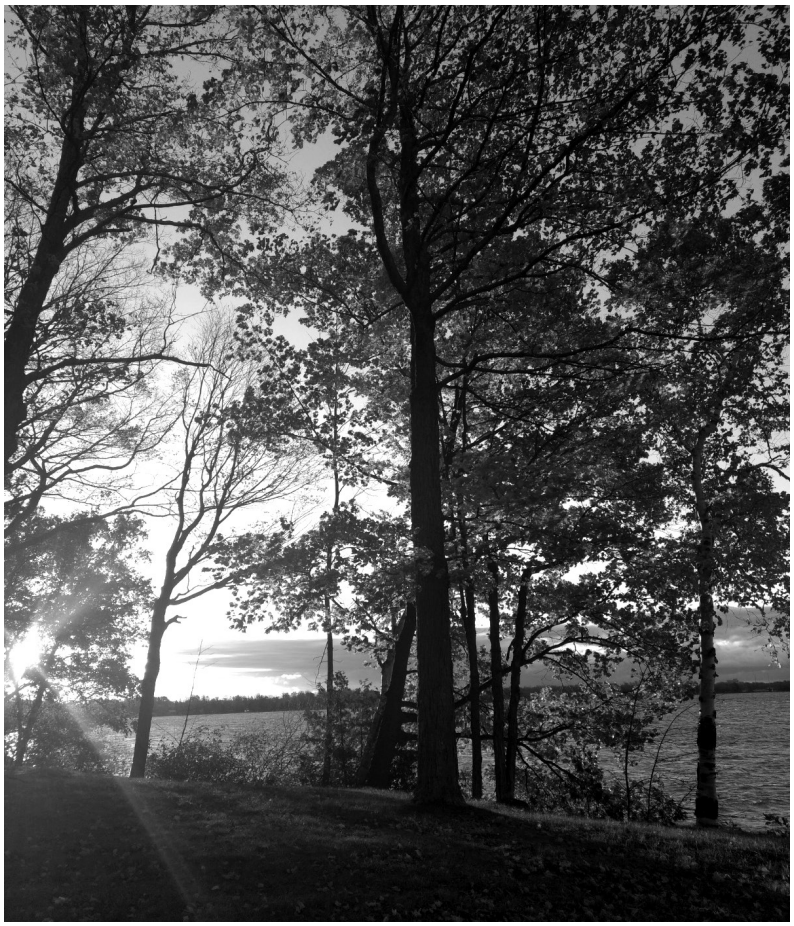
Cultivating Mind-Body Self Care and Renewal: The Hakomi Method



7th Annual MDPAC Retreat at Geneva Park

Facilitators (Top left: L to R) Hugh Smiley and George Lewis with group

L to R: Julie Webb, Linda MacDonald and Beth Ames

L to R: Catherine Low, Cathy Cameron and Karyn Klapecki

THIS COULD BE YOUR ARTICLE

Your Name Here

The Journal Committee needs more submissions!

We are asking the membership to write and share.
We are accepting poems, reflections, case studies and
especially tips to Improve Your Practice.

Do you use a form that you find particularly helpful?
Then please write about it and submit it.

Would you like a free copy of a newly released book?
Offer to write a review of it so we can all be informed.

Do you have a favourite therapeutic style?
Tell us why you like it so we can all improve our practices.

Do you have an opinion (related to mental health care)
that you'd like to share?
Then please, write it down and submit it.

My Poem
Or maybe you are
creative, inspiring you
to write a haiku

Even if you think you are not a good writer,
we have a very experienced editorial committee that will
help you polish your article so that it is ready to publish.

The deadline for the next issue is March 1, 2019.

Please send all submissions to
Janet Warren, editor at journal@gppaonline.ca.

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Search the Membership Directory or contact the MDPAC Office.

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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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