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MEDICAL PSYCHOTHERAPY REVIEW

(Formerly GP Psychotherapist)

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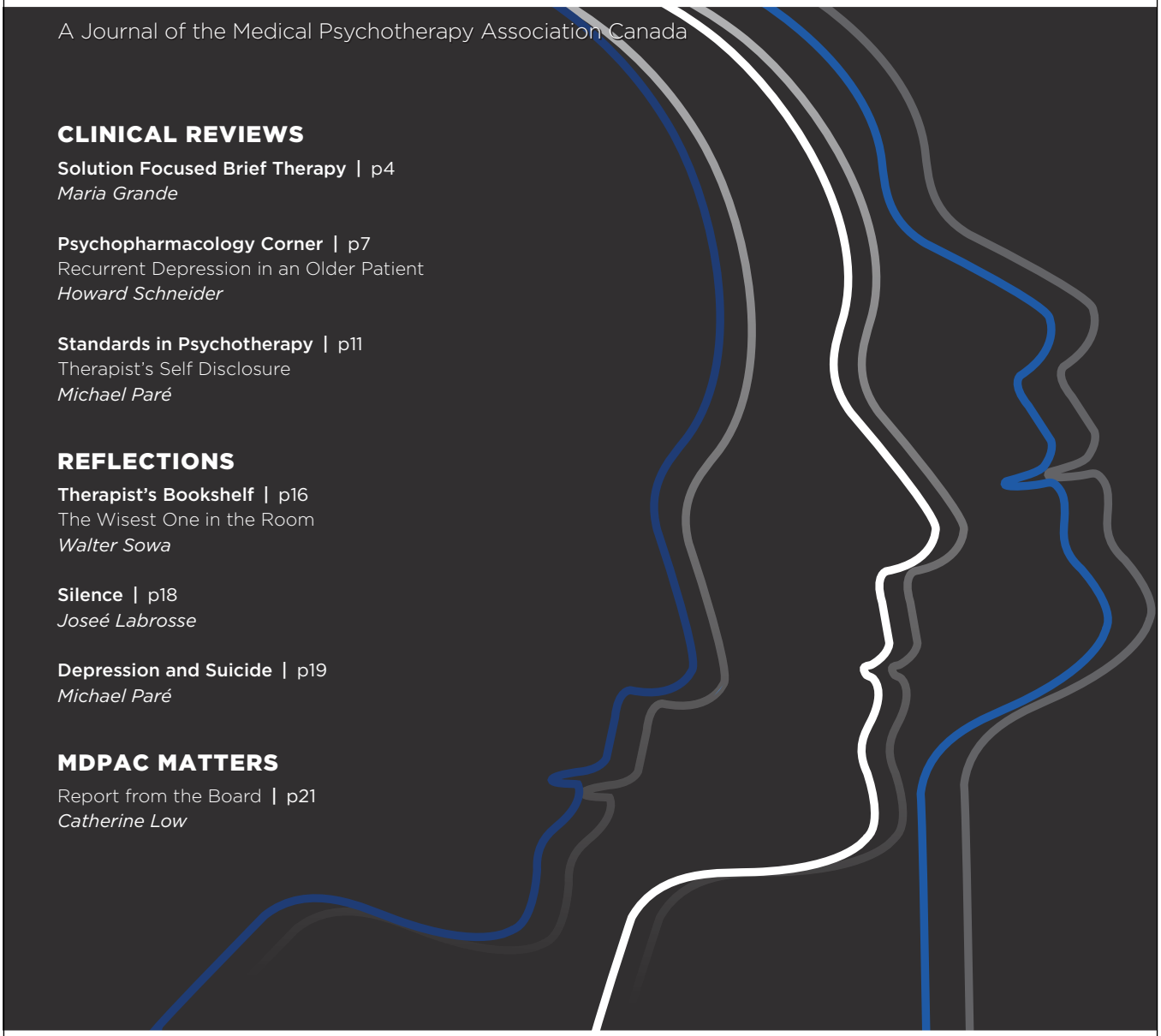

MDPAC ACPMD
MEDICAL PSYCHOTHERAPY ASSOCIATION CANADA
ASSOCIATION CANADIENNE DE PSYCHOTHÉRAPIE MÉDICALE

"WHAT GOOD IS THE WARMTH OF SUMMER, WITHOUT THE COLD OF WINTER TO GIVE IT SWEETNESS"

(John Steinbeck, *Travels with Charley)*

As someone whose highlight of the winter is to travel south, I'm not sure I agree with Steinbeck on a literal level. However, from metaphorical, philosophical and psychotherapeutic perspectives, oppositions and dialectics are essential. We understand and define many aspects of life in relationship to their binary opposition: light/dark, life/death, full/empty, noise/silence. These oppositions are universal. Regardless of the model of therapy we use, dialectics of some sort are always there for us to detect and reflect. We help our patients transition from extremes, finding subtleties of gray or even colour between the black and white. We help illuminate the dark spaces of mood and misunderstanding.

We sometimes intentionally take patients to extremes: What's the worst that could happen? What if a miracle happened? To those who are noisily anxious, we teach silence. To those who are fearfully quiet, we strengthen communication skills and self-esteem. Anthropologists use the term liminal space, albeit in reference to cultural and religious rituals. Its etymology is Latin, meaning threshold. It is a stage of disorientation and ambiguity in a journey towards new identity. It is the necessary space between oppositions. Tensions always need to be balanced—delicately, imperfectly. Indeed, "the comprehensive mind is always dialectical" (Plato, *The Republic*).

Opposite extremes are evident in the current issue of the *Medical Psychotherapy Review:* from suicidal depression to positive-solution-focusing, from talk therapy to the power of silence, from wisdom to inappropriate self-disclosure. Our "clinical reviews" include a summary of Solution Focused Brief Therapy by Maria Grand, inspired by a workshop at the last MDPAC conference. She appreciates its positive slant and provision of new tools for encouraging and challenging patients in their journeys. Howard Schneider, in his regular "Psychopharmacology Corner," discusses the challenges of resistant depression in an older patient, such as finding the delicate balance of medications. Finally, Michael Paré and Laura Dawson, in their column "Standards in Psychotherapy," continue the discussion of therapist self-disclosure, considering the gray areas regarding its appropriateness.

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.

In our "reflections" section, Walter Sowa, a new supporting member, considers human nature and wisdom in his review of *The Wisest One in the Room: How You Can Benefit from Social Psychology's Most Powerful Insights* by Thomas Gilovich and Lee Ross. In a beautiful and thoughtful poem, Josée Labrosse "talks" about how silence "communicates volumes." And Michael Paré reflects upon the blackness of suicide, asking if it involves "colossal courage" or "creepy cowardice." The answer of course is more gray.

Finally, Catherine Low provides her Report from the Board; we can look forward to a new (perhaps colourful?!) website. Speaking of black and white, and gray, and...colour, you'll have noted a new look to our journal. The new cover design, colour logo, and other graphics are the work of our new producer/designer: Eliana (Ellie) Robinson. She has extensive graphic design experience in business and media, having worked on many magazine covers. The journal committee (and all MDPAC members I'm sure) would like to express our appreciation to Carol Ford for her dedication to the *GP Psychotherapist.* After many years of labour on production and design, Carol is retiring from this job. She will, of course, continue to offer support in many other ways.

Returning to our metaphor, we help our patients find truth, balance, contentment...somewhere between the black and the white. We have moved beyond black and white to colour, we have transitioned to a new phase. As always, we welcome "colourful" contributions from members.

Grace and peace,
Janet Warren

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Solution Focused Brief Therapy

Maria Grande, MD, CCFP

The 29th Annual GPPA/MDPAC conference of May 27–28, 2016 was a treasure trove of exciting speakers and topics. One of these was the workshop, "Neuroscience and Solution-Focused Brief Therapy," presented jointly by Dina Bednar, registered marriage and family therapist/registered psychotherapist, and Dr. Ron Warner, Psychologist. I was so inspired by this workshop that I purchased *Learning Solution Focused Therapy: An Illustrated Guide* by Anne Bodmer Lutz, which expanded on the content presented. The presenters used this book as a principal resource, as will I.

Before delving into the details of Solution-Focused Brief Therapy (SFBT), some background and history is in order. It is generally acknowledged that the wife and husband team of Insoo Kim Berg and Steve De Shazer, social workers from Wisconsin, began the movement in the late '70s/early '80s. The philosophy and basis for SFBT, quoted in the workshop, is: "Rather than looking for what is wrong and how to fix it, we tend to look for what is right and how to use it" (Berg & Miller, 1992, p 3).

The first half of the above statement refers indirectly to the more widespread use of Problem Focused Therapy. Problem focused therapy is based on the medical model of elucidating the reason(s) for the patient visit, that is, the presenting problem. In this circumstance, the physician is seen as the expert, who, upon symptom review, begins investigations, makes a presumptive diagnosis, and then recommends a treatment plan.

The latter half of the aforementioned statement, of course, refers to Solution Focused Therapy. This approach, as an offshoot of the Positive Psychology movement, is competency based, rather than failure based. Even more specifically, there is a unifying theme throughout the process that "communicates that the patient's identity exists apart from and beyond symptomatology" (Lutz, 2014, p.x). Resource activation is central to this endeavour.

Resource activation is about focusing "on the healthy parts of a patient's personality" (Gussman & Graw, 2006, p.10) and his/her existing positive coping strategies, some of which may never have been acknowledged. The underlying assumption is that patients are the expert on their own lives; they certainly have had some successful behaviours and outcomes that have allowed them to survive in their environment.

Crucial to the solution-focused therapeutic relationship of provider and seeker is suspension of judgment and preconceived notions relating to the physician's biases and own experiences. In this setting, the "third ear," which hears what is unsaid, should be fully engaged. Listening for survival skills and character strengths in the midst of someone's emotional pain requires one's full attention. Not surprisingly, advice and suggestions are not a component of SFBT.

In support of the above, Dr. Warner and Ms. Bednar proceeded to detail the three experiences that are required simultaneously for optimal learning and to promote a changed environment: a positive emotion; exposure to personally relevant information; and interest, excitement or curiosity. By focusing on these points, using Lutz's vocabulary, and being oriented to a specific concern, therapy can remain brief (up to 20 sessions) and effective.

In the workshop, the therapist's role in SFBT was clarified as:

1 | Accentuating positive behaviours, identifying what has already worked, and therefore being able to do more of those activities.
2 | Co-constructing positive goals whereby there are small, achievable and measurable outcomes, as defined by the individual.
3 | Helping people become aware of their own resources, both internal and external, through directed, standardized, and curiosity-based questions.
4 | Asking questions that promote building unique solutions, using compliments and the person's own words.

The workshop leaders showed video clips of conversations between a therapist and client at different stages of their therapeutic relationship. The most striking component of these vignettes was the language used by the therapist. There was evidence of deep listening, compassion, and curiosity that communicated respect and empathy. Validation of difficulties experienced without exploration of details allowed the conversation to remain solution focused. I was amazed that this possibility existed and could be legitimately used without implying a certain callousness on the therapist's part.

There were opportunities during the workshop to practice some of the techniques, which looked simple but, of course, were not. These short exercises exposed how difficult it could be to stay positive and focused on the future, without being drawn into past negative events and affects. What also became apparent was the tendency of the "therapist" to offer interpretations versus remaining curious and allowing the "patient"

to provide full details of his/her experience, using his/her own vocabulary.

Many times in past therapeutic encounters, I have wondered, "How could I have handled the conversation in a more productive manner?" *Learning Solution Focused Therapy* answers this question extremely well. The required vocabulary, sentence structure, and questioning process were well described in text, charts, case presentations, and links to online video illustrations.

Lutz's book offers many tools for the therapist to use in the form of questions, techniques and comments. These tools can be further subdivided into those directed at specific components of the therapy and those that can be used at any stage of the therapy, i.e., more non-specific.

1 | Specific Components Tools

These are instrumental in establishing the direction of the brief intervention. They are used repeatedly to maintain the focus on solutions rather than problems. There are two main types:

a. The miracle question

The miracle question, originally formulated by Berg and de Shazer (Bednar & Warner, 2016; Lutz, 2014) is a method of questioning that invites the patient to describe, creatively and in detail, how the future would look when the problem is solved. The patient is asked to imagine an ordinary evening with enough detail provided so that the patient has a point of reference to relate to and can adjust to his/her own circumstances. Then the patient is asked to imagine that overnight, the problem has been solved by some miracle. The patient is then asked what that miracle might have been.

While seemingly easy to state, the miracle question requires considerable skill to ask well. The leading statements and question must be asked slowly with close attention to the person's non-verbal communication to ensure that the pace matches the person's ability to follow the question. No matter how skilled the therapist is, there is always the possibility that the patient will answer, "I don't know."

Lutz (2014) has a very interesting paradigm to counter the "I don't know" common response from patients. She suggests the following: "Suppose you did know, what would you be doing?" or in this case "What could the miracle be?"

b. Goal Negotiation

The development of goals that are important to the patient, in terms of their valued relationships, is essential. This is accomplished by the clinician skilfully exploring patients' competencies, success and hopes and dreams for their own future, all in positively framed words. By both agreeing on one vision, patient and therapist can work towards a personally beneficial end to the therapeutic intervention.

2 | Non-specific Tools

The non-specific interventions serve to support the patient's progress with empathy and acknowledgment. There are four main types:

a. Building a Yes-Set

This refers to guiding the conversation to areas in which the therapist and the client both agree illustrate the positives in that person's experiences. The phrase "for you" helps significantly in achieving this goal. For example, "That must be so difficult *for you*," validates the ability of the person to have emotionally survived a difficult situation, whereas "Was it helpful *for you*?" or "How are *you* able to do this?" acknowledges a skill or strength while moving on to have the individual seriously consider and elaborate on that quality being emphasized (Lutz, p. 53).

b. Exception-seeking questions

Proponents of SFBT insist there are always times when the identified problem is less severe or absent for clients. The therapist seeks to encourage the client to identify these occurrences and maximize their frequency. "What happened that was different?" "What did you do that was different?" The goal is for clients to repeat what has worked in the past, and support confidence in taking more and more "baby steps" towards their ideal scenes.

c. Coping questions

Coping questions are designed to garner information about a patient's resources that will have gone unnoticed by them. Even the most hopeless story has within it examples of coping that can be elicited. "I can see how things have been really difficult for you, yet I am impressed that you get up each morning and manage to get the kids off to school. How do you do that?"

By acknowledging difficult experiences, then searching for inner strengths, personal resources necessary to meet ongoing challenges can be elucidated. Repeating this process and having buy-in from patients will enforce a sense of accomplishment which can lead to a more hopeful view of their own life.

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d. Scaling questions

As medical professionals, we are accustomed to using scales to rate pain and mood, for instance. However, SFBT differs from the usual medical model in that the scales are totally subjective. That is to say, the gradient of the scale, between one and ten, is in the patient's control. As a matter of fact, increments of 0.5 can be employed.

Scales are used frequently in multiple scenarios. For example, when someone is overwhelmed by an emotion, a scaling question can help diffuse the intensity by introducing objectivity. Or, when someone has provided a subjective number to answer a specific question, being able to delve further into their solution building skills by asking the following can be very informative: "What makes the number not lower?" "What else makes it not lower?" "What would make it one point higher?"(Lutz, 2014, p. 73).

Lutz's book demonstrates how the recommended approach is flexible enough to allow for variations in application to couples, youth, family, individuals, workplaces, schools, staff, learners, and areas where participation may have been mandated by external agencies, such as courts.

As with any brief therapy, there are limitations to SFBT. Although there are a number of patients in therapy and therapists who report the effectiveness of solution-focused brief therapy, some concerns have, over the years, presented themselves. One major criticism of the modality is that its quick, goal-oriented nature may not allow therapists the necessary time to empathize with what the patient is actually experiencing. As such, patients in SFBT may feel misunderstood or alienated if their therapist is not meeting them on their emotional level.

A second concern is that SFBT seems to simply discard or ignore information deemed important by other treatment modalities. For example, in this type of therapy, a relationship between the problems people face and the changes necessary to solve them is not assumed, and any underlying reasons for maladaptive thoughts and/or behaviours are not explored. Individuals wishing to explore these reasons may find it more helpful to seek a type of therapy that addresses these concerns, though they may do so while also receiving SFBT. SFBT may not be recommended for those who are experiencing severe mental health concerns.

I found the workshop, "Neuroscience and Solution-Focused Brief Therapy," and the book, *Learning Solution Focused Therapy: An Illustrated Guide,* to be very helpful. They provided tools which will enable me to move some of my patients beyond their "stuck" and "I don't know" stage. This included the provision of specific words, tone, and approach necessary to venture into territories that have left me occasionally feeling the same as my patients. Also, in the writing of this article, being able to integrate and write about two diverse information sources and experiences that hold one concept was a significant challenge for me. I hope I have convinced the reader to give SFBT a try.

Maria Grande has been attending GPPA Conferences since 2007. She has been a member of the GPPA/MDPAC since 2008, most recently having served as editor of the GPPA Journal and Chair of the Journal Committee from 2012-2015. This article has served two purposes: one, as a component of the GPPA Conference Bursary requirement; two, as a means to return to writing following a disabling MVA in 2015.

Conflict of Interest: None

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Recommended Resources

Certificate Program in SFBT at U. of Toronto, OISE: http://www.oise.utoronto.ca/cpl/Community/SFBT/index.html

SFBT Organization: http://sfbta.org/

http://www.goodtherapy.org/learn-about-therapy/types/solution-focused-therapy

https://en.wikipedia.org/wiki/Solution_focused_brief_therapy

Recurrent Depression in an Older Patient

Howard Schneider, MD, MDPAC (C), CCFP

Treating depression fully in older patients with comorbid medical problems can greatly increase quality of life. For patients with recurrent depressive episodes, stopping psychiatric medications once depressive symptoms resolve may cause unnecessary relapses. These can lead to further relapses which become increasingly more difficult to treat. In some patients, antidepressant treatment may be indicated for life.

As medical psychotherapists, whether we prescribe or not, we are expected to be familiar with current psychopharmacotherapy. Psychopharmacologist Stephen M. Stahl, of the University of California San Diego, trained in Internal Medicine, Neurology, and Psychiatry, as well as obtaining a PhD in Pharmacology. In 2011, Stahl released a case book of patients he has treated. In this column, I will examine one of his cases and highlight its important lessons.

Stahl's rationale for his series of cases is that knowing the science of psychopharmacology is not sufficient to deliver the best care. Many, if not most, patients would not meet the stringent (and, arguably, artificial) criteria of randomized controlled trials and the guidelines that arise from these trials. Thus, as clinicians, we need to become skilled in the art of psychopharmacology. To quote Stahl (2011, p. xvii), this requires us "to listen, educate, destigmatize, mix psychotherapy with medications and use intuition to select and combine medications."

In this issue we will consider Stahl's 26th case: "The patient whose daughter wouldn't give up." The patient is a 72-year-old woman who lives a few hours away by car, and who is brought by her daughter to see Dr Stahl.

Past Psychiatric History:

- 32 years old: first Major Depressive Episode; treated successfully with a tricyclic antidepressant.
- 45 years old: second Major Depressive Episode precipitated by the death of her husband; not treated, resolved after one year.
- 69 years old: third Major Depressive Episode in which severe anxiety occurred along with the depressive symptoms, unlike the previous episodes. Treated successfully with paroxetine.
- 69 years old: fourth Major Depressive Episode, which occurred after the patient's paroxetine had been stopped after only a few months. Paroxetine worked again but was discontinued again, and yet another relapse occurred.
- 70 years old: fifth Major Depressive Episode; was treated with paroxetine. Stahl's notes are not clear here but apparently treatment was not successful, and the patient was also given olanzapine 5 mg, which helped with anxiety but not depression. Also noted that the patient did not respond to nefazodone or desipramine. Venlafaxine-XR was tried but apparently made the patient more anxious. A trial of seven electroconvulsive therapy treatments were tried but were unsuccessful in helping the depression. In addition, they worsened the patient's memory. Lithium, T3, and perphenazine were also tried unsuccessfully. Treatment was attempted with loxapine and alprazolam, which only provided a small improvement in the depressive episode. A referral was then made to Dr Stahl.
- There is no mention of any hypomanic periods.

Past Medical History:

- Weight, blood pressure, lipids all within normal limits
- Postmenopausal treatment on estrogen/progestin replacement therapy (length of treatment is not specified)
- No history of smoking, alcohol, or other substance abuse

Intake Medications:

- loxapine (dosage not specified)
- alprazolam (dosage not specified)

Personal History:

- widow x 25 years, lives alone
- 2 children and unspecified number of grandchildren

Family Psychiatric History:

- None

Chief Complaint:

Patient continues to suffer from anxiety and depression. Patient's daughter wants another opinion.

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

Stahl notes that the patient comes into his office with Parkinson's disease-like symptoms including a shuffling gait, rigidity, tremor, and masked facies. The patient complains about anxiety, lack of energy, poor sleep, and no interest or pleasure in anything. The patient seems "mentally sharp" but no formal cognitive testing is done at this time.

Stahl thinks that the parkinsonism seen may not be Parkinson's disease but instead related to the loxapine. He does not feel there

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is enough information to consider a dementia etiology right now. The diagnosis made at this point is Major Depressive Disorder, Recurrent with drug-induced parkinsonism.

Stahl stops the loxapine and does not add another antipsychotic to see if the parkinsonism resolves. Mirtazapine is often well tolerated in older patients and thus is started to help with this patient's anxiety and depression.
Current Medications:

- Mirtazapine 15 mg hs → 30 mg hs a few days later
- Alprazolam 0.25 mg tid

Stahl sees the patient four weeks after the first evaluation. Parkinsonism still persists. Stahl notes that up to six months may be required to see if the parkinsonism will reverse, and there is always the possibility that the loxapine had really just made more prominent an existing Parkinson's disease in this patient. Anxiety has worsened with the new medications. Stahl increases the dosages of the current medications.
Current Medications:

- Mirtazapine 45 mg hs
- Alprazolam 0.50 mg tid

The patient did not return for three months (16 weeks after the first evaluation). The parkinsonism had stopped at eight weeks after the first evaluation. Also, the patient is feeling less sad and less anxious on the medications prescribed last visit, and Stahl notes that although this is not remission, it is a good response. However, in the interim the patient broke her hip and had undergone hip replacement surgery. While medications such as mirtazapine and alprazolam can cause sedation and increase the risk of falls, Stahl feels that since the patient is not sedated on examination, it is worthwhile to continue the medications. Stahl also recommends adding venlafaxine to see if that would help the patient achieve remission.
Current Medications:

- Mirtazapine 45mg hs
- Alprazolam 0.50mg tid
- Venlafaxine-XR 37.5 mg à 75 mg od

Stahl sees the patient 24 weeks after the first evaluation. The patient feels much better and Stahl notes, "looks lively, spontaneous." There is much less anxiety. The patient is alert and functioning better; she is playing bridge again.

Stahl sees the patient 36 weeks after the first evaluation. He notes that the patient is now in full remission. She is driving and shopping on her own. The patient is then seen at 48 weeks after the first evaluation, and full remission continues.
Current Medications:

- Mirtazapine 45 mg hs
- Alprazolam 0.50 mg TID
- Venlafaxine-XR 75 mg daily

Stahl does not see the patient until much later, at six years after the first evaluation. She is 77 years old and remains in remission from depression. The patient has had a colon resection for colon carcinoma, which is assumed in complete remission. However, her creatinine clearance has been decreasing and the patient's family physician thinks that perhaps the mirtazapine or venlafaxine are causing renal problems. As well, the patient is booked for surgery for the other hip and the family doctor wants to stop the patient's psychiatric medications and is unsure about restarting them even after surgery. The patient's daughter is concerned about this. Stahl notes that there is still borderline to normal kidney function, and generally neither venlafaxine nor mirtazapine cause renal failure. Stahl recommends obtaining therapeutic drug levels before any of her doctors decide to discontinue the medications, and instead altering dosages based on the levels, if necessary.

Stahl next sees the patient at seven and a half years after the first evaluation. She is now 79 years old. The patient has since had surgery for Stage 1 lung cancer which is assumed "cured." Blood levels were never obtained by the family doctor previously but venlafaxine was still reduced to 37.5 mg od and mirtazapine was reduced to 15 mg od. Unfortunately, there was a relapse of the patient's depression. However, there is normal renal function now. The family physician increased venlafaxine back to 75 mg od and mirtazapine to 45 mg od but it has been two months and no response has occurred. Stahl advises to increase venlafaxine to 150 mg od.
Current Medications:

- Mirtazapine 45 mg hs
- Alprazolam 0.50 mg tid
- Venlafaxine-XR 150 mg od
- hydrocodone-acetaminophen for hip pain

Stahl next sees the patient four weeks later. The patient is still depressed. Stahl advises to increase the venlafaxine further.
Current Medications:

- Mirtazapine 45 mg hs
- Alprazolam 0.50 mg tid
- Venlafaxine-XR 225 mg od
- hydrocodone-acetaminophen for hip pain

Stahl next sees the patient four weeks later; i.e., at eight weeks after the 7.5-year mark. The patient is responding to the medications but is only about "50 percent

better." The hip surgery is pending so no changes in medications are made. Stahl next sees the patient at 16 weeks after the 7.5-year mark. Her depression remains at the same intensity as on the previous visit. Stahl advises increasing venlafaxine further with monitoring of blood pressure. Current Medications:

- Mirtazapine 45 mg hs
- Alprazolam 0.50 mg tid
- Venlafaxine-XR 300 mg od
- hydrocodone-acetaminophen for hip pain

The patient is seen at 20 weeks after the 7.5-year mark. No further improvement is noted. Stahl advises a further increase of the venlafaxine. Current Medications:

- Mirtazapine 45 mg hs
- Alprazolam 0.50 mg tid
- Venlafaxine-XR 375 mg od
- hydrocodone-acetaminophen for hip pain

The patient is seen at 24 weeks after the 7.5-year mark. Her depression is now in remission. Blood pressure remains with normal limits. Current Medications:

- Mirtazapine 45 mg hs
- Venlafaxine-XR 375 mg od
- Alprazolam 0.50 mg tid
- plus, hydrocodone prn for hip pain

The combination of antidepressants chosen by Stahl, venlafaxine plus mirtazapine, synergistically results in increased noradrenergic, serotonergic, and dopaminergic activity, and as a result has earned the nickname of "California rocket fuel." However, to clinicians the clinical effect is what is most important—does the combination improve outcome for the patient? Does the combination result in an intolerable side effect burden for the patient?

Generic Name	Trade Name *(Common, Canadian names where possible)*
paroxetine	Paxil
olanzapine	Zyprexa
nefazodone	Serzone (discontinued in Canada)
desipramine	generic
venlafaxine-XR	Effexor-XR
T3	Cytomel
perphenazine	Trilafon
lithium carbonate	generic
loxapine	generic
alprazolam	Xanax
mirtazapine	Remeron
tranylcypromine	Parnate
fluoxetine	Prozac
bupropion	Wellbutrin

Despite the reality that a very large proportion of patients will fail treatment with antidepressant monotherapy, most of the antidepressant trials in the literature consider the effect of a single medication, with comparatively less evidence available for antidepressant combinations. Fortunately, some solid evidence exists for the venlafaxine-mirtazapine combination. In the large STAR*D trials, which attempted to evaluate the efficacy of various treatments for Major Depressive Disorder, patients who had not reached remission in the three previous trials of medications received tranylcypromine (average dose 36.9 mg od) (n = 58 patients) versus receiving the combination of venlafaxine-XR (average dose 201.3 mg od) plus mirtazapine (average dose 35.7 mg) (n=51). Although the difference is not statistically significant, 6.9% of the tranylcypromine patients achieved remission versus 13.7% of the venlafaxine-mirtazapine patients. However, the venlafaxine-mirtazapine group experienced significantly fewer adverse effects and did not require dietary restrictions (McGrath et al, 2006).

In pioneering work, Pierre Blier and colleagues (2010) at the University of Ottawa initiated treatment for patients with Major Depressive Disorder with either a combination of mirtazapine (30 mg od) plus fluoxetine (20 mg od), mirtazapine plus venlafaxine (225 mg od titrated up), mirtazapine plus bupropion (150 mg od), or monotherapy with fluoxetine (20 mg od). Remission rates were 52% for the mirtazapine-fluoxetine group, 58% for the mirtazapine-venlafaxine group, 46% for the mirtazapine-bupropion and 25% for the fluoxetine monotherapy group. In terms of adverse effects resulting in patients dropping out of the study, the over-

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all rate was 15% and was statistically similar among the four groups. Nonetheless, caution and careful monitoring should always be reserved for such combinations. For example, Houlihan (2004) describes a case of serotonin syndrome from a combination of venlafaxine, mirtazapine and tramadol, albeit after the addition of the last agent.

In considering this case of a patient with recurrent depression, Stahl notes that stopping psychiatric medications once depressive symptoms resolve was not a good strategy over the long-term since the depression had recurred a number of times. As well, repeated relapses can lead to relapses that become increasingly more difficult to treat. There is a "kindling hypothesis" which postulates that previous episodes of depression physically change the brain, and therefore increase the chance that a patient will have a future depressive episode. Stahl notes that hippocampal volume loss increases with depression that is not treated for long periods.

This case illustrates the need to attempt to treat depression fully. If monotherapy antidepressant treatments fail, then combinations of antidepressants should be considered. Care must be exercised to avoid sedation in older patients.

Antidepressants may act to increase trophic factors in the brain. In this patient, as in others with recurrent unipolar depression, antidepressant treatment may be indicated for life.

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.

Conflict of Interest: none

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Therapist Self-Disclosure

Michael Paré, MD, MEd, MSc & Laura A. Dawson, B.A.

The purpose of this article is to help Primary Care Physicians and/or Medical Psychotherapists in Canada become better acquainted with the expectations concerning the standards of psychotherapy in the practice of our focused area of medicine. This is the eighth in an ongoing series of articles that discusses these complex and important topics.

Introduction

Before continuing with the deep discussion of therapist self-disclosure, I want to provide an overview of the scope and extent of this article. My original idea was to outline a range of practical situations in psychotherapy where therapists choose to self-disclose either correctly and therapeutically, and/or incorrectly and counter-therapeutically. Although I do hope to achieve some of the above, I will instead examine some general aspects and definitions of the concept and use of therapist self-disclosure (TSD). My aim is to introduce the complexity and richness of these issues, clarify the definitions, and provide some history of how the concept of TSD developed. I hope to kindle excitement and interest that will lead to ongoing conversation and dialogue. I would like us to examine our beliefs and expectations about the often appropriate use, and the sometimes potential misuse, of TSD (Little, 2009).

Defining Self-Disclosure

As stated in my last article, TSD may be broadly defined as "the revelation of personal rather than professional information about the therapist to the [patient]" (Zur, 2016). But it is impossible to find a fully agreed upon definition of what is included in self-disclosure. There is a wide range of suggestions: from very personal information, to a description of our professional credentials, to the therapist's office decorations. Goldstein (quoted in Sunderani, 2016, p. 8) goes even further when outlining his definition:

> The therapist's conscious verbal or behavioural sharing of thoughts, feelings, attitudes, interests, tastes, experiences or factual information about himself or herself or about significant relationships and activities in the therapist's life. Self-disclosure takes many forms: wearing a wedding band; decorating an office according to personal tastes...talking about how one has solved problems, handled situations, or thought about life; going to events where a patient will be present and/or has invited one[…]where it is impossible not to reveal aspects of one's personal self.

Other commentaries go so far as to warn therapists that revealing their ethnicity, marital status, gender or professional credentials might constitute excessive self-disclosure and should be disclosed with care. Another broad definition is that a therapist's every word and action is TSD. If we take this excessively broad definition seriously, 100% of therapists self-disclose 100% of the time. But this renders the concept useless. I propose that we need to clarify the concept of self-disclosure, or else there is no point in going any further in the discussion.

The table below shows just how diverse the task of classifying TSD is and how little consistency there is in the literature.

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Source	Pizer (1993)	Barnett (1998)	Hill & O'Brien (1999)	Knox & Hill (2002)	Henretty & Levitt (2010)	Farrah (2013), Zur (2016)	Ruddle & Dilks (2015)
Types of Self-Disclosure	• Inescapable • Inadvertent • Deliberate	• Unavoidable • Accidental • Deliberate	• Personal insights • Personal strategies • Feelings • Facts	• Personal insights • Personal strategies • Feelings • Facts • Reassurance/ support • Challenge • Immediacy	• Positive • Negative • More intimate • Less intimate • Self-involving • Self-disclosing	• Unavoidable • Accidental • Deliberate • Inappropriate • Client-initiated	• Reactive • Voluntary • Positive • Negative • Intimacy • Personal information • Similar • Dissimilar

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The classification of different types of self-disclosure is not of academic interest only. If we can delineate the types of TSD more accurately, we may be able to identify those kinds of self-disclosure that are always (or almost always) benign and beneficial, and conversely those that are detrimental, and always to be carefully avoided. Fortunately, many types of self-disclosure are helpful. There are certainly exceptions such as the therapist voicing her or his appreciation of the patient's secondary sexual characteristics (even if genuinely felt), which is rightly deemed entirely inappropriate (and unlawful) and against a standard of professional practice. No Trier of Fact (judge or jury) will be positively impressed by a therapist claiming the need to be entirely honest when responding to a patient's requested verbal reassurance regarding the size and shape of her breasts, for example.

Unfortunately, the hope of any easy delineation and classification of TSD as being positive or instead adverse is very difficult since, in many instances of self-disclosure, even a minor change of wording can have dire consequences.

There are two categories of TSD that I would like to focus on: therapist self-disclosure within a psychotherapy session, often called self-involving (for example, "I can see anger regarding your recent dispute with your son but I sense some hurt feelings too"), and therapist self-disclosure of personal information from outside of the session (for example, "I myself once tried cocaine"). The first category can be split further into two sub-types: professional and personal self-disclosure. To make this distinction, we can look to Stricker and Fisher's (quoted in Zur, 2008, p. 82) definition: "[g]enerally, when therapist disclosure goes beyond the standard professional disclosure of name, credentials, office address, fees, emergency contacts, cancellation policies, etc., it is considered personal self-disclosure." Patients have a right (and maybe even a *need*) to know a therapist's professional information, including his or her credentials and training. Certainly this is a part of informed consent, and therapists should encourage their patients to ask about their professional qualifications. Personal self-disclosure, on the other hand, is not always welcome or needed. To use a simple example: if the patient asks "Doctor do you ever feel stress?" some variations of a possible response spanning from best (and entirely acceptable), to questionable, to unacceptable include:

1) Everyone feels stress at times.
2) Everyone feels stress at times, even myself.
3) Everyone feels stress at times, and right now I'm actually very stressed with you as my patient.
4) Everyone feels stress at times and right now I am feeling horrible and I am about to lose control and become violent.

Self-involving therapist self-disclosure is usually considered a more reasonable type of TSD, since it relates to the therapeutic relationship. Contrast this to therapist self-disclosure of material from outside of the therapeutic session. For example, a therapist says to her patient, "I just got back from the cottage last night." This information has nothing to do with the therapy and may interfere with the therapeutic process and relationship.

Although there are many ways to conceptualize types of self-disclosure, not all types are of equal importance. For example, my choice of office décor such as wall paintings is of lesser concern. The patient's reaction to décor can be used as "grist for the mill." Unless the therapist is practicing the most conservative form of psychoanalytic psychotherapy, it is entirely justified to at least exhibit some individual differences that will presumably be one of the interpersonal themes the patient would be wise to accept as a part of being a fully functioning adult in a free country.

Often it is said that self-disclosure is permissible if it does not hurt or harm the patient. I believe we need to consider more deeply that, although the self-disclosure may not harm the patient, it may still harm the therapy. In fact, a significant amount of TSD might even gratify the patient. It will not lead to a better therapeutic outcome, but may dilute the transference/countertransference towards a friendly relationship rather than a therapy relationship.

All practicing therapists know that the pull towards even some minor self-disclosure is an ever-present temptation, and we all provide some. It is the worst kept secret in psychotherapy that we occasionally self-disclose in the ambiguous task of entering into an intersubjective dyad with a patient with the aim of being in the so-called "zone of helpfulness" (National Council of State Boards of Nursing, 2014). We therapists are tasked with an almost impossible mandate. That zone of helpfulness can be characterized as being composed of two almost diametrically opposed concepts: that we—as entirely committed professionals—should provide safe, regular, standard types of therapy, and simultaneously be natural, spontaneous, and genuine people. What looks like a freewheeling, symmetrical, and fairly unconstrained verbal interchange (and relationship) between two people to the casual observer is, in fact, a lot more (and a lot less).

What on the surface seems simple should be seen as having a significant depth of clinical theory and professional experience.

Wachtel (1993) indicates something similar when he writes that the difficulty of finding the balance of self-disclosure is because of the paradox of the dual nature of the therapeutic enterprise. It is a personal and intimate relationship that deals with matters explored and dealt with in everyday type of interpersonal conversation. It is characterized by respect for the patient's capacities and values and an interest in honestly engaging with all aspects of the patient's experience. "On the other hand, it is a relationship that is professional and limited, and that is by its very nature asymmetric, focusing on the patient's experience in a way that differs from its [minimal] attention to the therapist's needs" (Wachtel, 1993, p. 207).

Strupp and Binder (quoted in Lees, 1999, p. 33) describe this concept of the difficult paradoxical nature of therapy well: "the psychotherapeutic relationship is a highly personal relationship within a highly impersonal framework." The enormous task facing each and every therapist is to find a professionally appropriate yet maximally humane and effective interpersonal stance in their work with patients. This is within the considerable peculiarities and complexities, even paradoxes, and ultimate ineffableness of every therapeutic relationship. Freud's suggestion of psychoanalysis as "the impossible profession" is arguably more widely attributable to psychotherapy in general.

The History of Changes in the Idea of Self-Disclosure

Self-disclosure is an age-old discussion in psychotherapy, dating back to as early as 1912. Early psychoanalysis originally called for neutrality, abstinence, and anonymity from the therapist. This neutrality or "blank screen" was meant to allow patients to freely express their thoughts and feelings and for the therapists to interpret the patient's verbal material (Ruddle & Dilks, 2015). R.I. Simon writes that the therapist strove to "maintain therapist neutrality. Foster psychological separateness of the patient…preserve relative anonymity of the therapist" (quoted in Zur, 2016, p. 514). This idea originates in Freud's early writings: "the doctor should be opaque to his patients, and like a mirror, should show them nothing but what is shown to him" (Freud, 1912, p. 117). The fact that Freud was known to disregard his own writing by gossiping and socializing with his patients is an interesting twist to the story.

Contemporary psychotherapy has rejected the idea of absolutely strict, total neutrality, and anonymity of the therapist partly because it is impossible to achieve and partly for theoretical and evidence-based reasons. In the sixties, the growing humanist movement argued that TSD could be beneficial and therapeutic for the patient. The feminist movement in the seventies and eighties valued self-disclosure because it modeled a more egalitarian relationship between patient and therapist (Zur, 2016).

Tools for Self-Disclosure

So we see that TSD is an ever present and unavoidable aspect of psychotherapy. The "when," "why," "how," and "who" of self-disclosure requires careful forethought. The use of self-disclosure can be considered in the context of keeping good boundaries. We need to highlight the ethical and appropriate use of self-disclosure in psychotherapy. Rather than avoiding any self-disclosure at any cost—out of an excessive fear of violating ethical and regulatory standards—a more thoughtful approach to addressing reasonable self-disclosure is to be sought. In the previous article, I introduced the following case study:

> A medical psychotherapist providing Cognitive Behavioural Therapy (CBT) has been treating a patient for Major Depressive Disorder. The patient tells the physician that lately he has been struggling with alcohol abuse, and asks the psychotherapist if he has ever struggled with substance abuse. The therapist indicates that many people suffering from Major Depressive Disorder have been known to abuse alcohol, and discloses "I, myself, struggled with alcohol abuse in the past." The patient and psychotherapist then discuss some of the difficulties the patient is facing during and after consuming alcohol.
>
> ***Comments:*** This can be characterized as a patient initiated self-disclosure. Nevertheless, the therapist needs to take full responsibility for responding as he did. The therapist, being the professional in charge, controls (or should control) the basic frame and boundaries of the session. As for the present case, the question is why the need for this personal self-disclosure and admission? Is it truly necessary? Was it helpful? Generally, in CBT there is no need to self-disclose at this level. It may not be a significant error but rather a distraction from the real work of the therapy. It could also disturb the patient by lessening his confidence in the therapist, and may cause a reversal in roles so that the patient is somewhat fearful of his or her own self-disclosures.

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> The accompanying emotional expressions may be harmful to the therapist who he now sees as vulnerable. And the patient, to avoid over burdening the possibly wounded healer, may curtail his or her own self-disclosure, and thus decrease the helpfulness of the therapy.

Effective use of self-disclosure is partly based on good use of ethical decision-making, and thoughtful consideration of the many contextual factors involved. Factors that should influence whether self-disclosure is provided include the psychotherapist's motivations, the patient's treatment goals and history, and the psychotherapist's theoretical orientation. Psychotherapists considering the use of significant amounts of self-disclosure with patients need greater guidance on the effective ethical, and clinically appropriate use of self-disclosure.

Farber (2006, p. 153) outlines a series of questions that therapists can ask themselves prior to disclosing:

> Will my disclosure set up expectations for more frequent and intimate disclosures? Will my disclosure be perceived as a reward by my patient, such that subsequent nondisclosure (or less intimate disclosure) will be perceived as withholding or punitive? Will my disclosure be perceived as an implicit communication that there was a better way of doing, saying, or thinking about something? Is this particular disclosure appropriate for this particular patient? Does this disclosure aid in the patient's therapy?

There are a number of issues that are associated when contemplating therapist self-disclosure:

Intent

As with any decision regarding boundary crossings, the decision to self-disclose is based first and foremost on the welfare of the patient. Applying these principles to TSD means that intentional self-disclosure should be patient-focused, clinically driven, and not intended to gratify the therapist's needs. When self-disclosure is not done for clinical/therapeutic purposes, it is to be minimized or avoided. Intentional and deliberate TSD is made under the general moral and ethical principles of Beneficence and Nonmaleficence: therapists intervene in ways that are intended to benefit their clients and avoid harm to them (APA, 2002).

Impact

The intent of the self-disclosure is not the only consideration; the impact of the self-disclosure is equally important. A self-disclosure that was genuinely intended to help could instead—by its impact—still hurt. That does not by itself invalidate this type of disclosure and yet should be used by the therapist as cautionary feedback. It has been said that discretion is the better part of valor, which may be an apt tagline for restraint in self-disclosure.

Ideology

By "ideology," I mean the theory or system of thought of the type of psychotherapy that a therapist follows when practicing. Each type of psychotherapy has its own system of ideas that dictates what behaviour is appropriate or inappropriate. Depending on a therapist's type of therapy, he or she may choose to avoid (or not avoid) most TSD.

Two tools to use when contemplating TSD are Aron's checklist (Appendix A) and the CPSO Maintaining Boundaries (2004) checklist.

In Summary

As we have seen, the definitions of what constitutes self-disclosure are varied and vague. I believe that clarifying this issue is an important first step in this rich and sometimes confusing discussion. This will hopefully clear the way for more meaningful dialogues on the benefits and risks involved in TSD. In the next article, I will provide several practical case studies examples of various TSD.

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Conflict of Interest: none

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Appendix A

Questions for consideration in regard to the "If and When to Self-Disclose" (Adapted from Aron [1996]).

1. For which patients is self-disclosure useful? a) At what point in psychotherapy? b) For what purpose? c) About what topics? d) Under which conditions? e) In what sequence?
2. What conditions should be met first?
3. How is the patient to be prepared for the therapist's self-disclosure?
4. What clues does the patient provide about the appropriateness of self-disclosure?
5. How spontaneous should the therapist's self-disclosures be?
6. Are there certain self-disclosures that should be attempted only after careful reflection?
7. How much affect is appropriate for the therapist to express directly?
8. Are there certain topics that should never be disclosed?
9. What precautions need to be considered to protect the patient from being intruded on by the therapist self-disclosure?
10. How does the therapist evaluate the impact of a self-disclosure?
11. How should the therapist manage the anxiety stirred up in him- or herself following self-disclosure?
12. What are the ethical considerations that need to be considered regarding self-disclosure?

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On Human Nature and Wisdom.

A Review of *The Wisest One in the Room: How You Can Benefit from Social Psychology's Most Powerful Insights*

THOMAS GILOVICH PHD AND LEE ROSS PHD. NEW YORK: FREE PRESS, 2015; 307 PP. $30.60

Walter Sowa, PhD

I read *The Wisest One in the Room* with the same feeling of eye-opening pleasure as I had when I saw my first TV program in colour, after being accustomed to years of black and white images. This book is about the nature of people. It explains how and why we behave, think, feel, make decisions and mistakes, and engage in conflicts. Thomas Gilovich at Cornell and Lee Ross at Stanford provide advice on wisdom backed by real life examples and research findings from the past 40 years. The essence of the book is empathy—respect and kindness for others—and reality.

The authors choose a dictionary definition of wisdom: (1) *knowledge*, or accumulated philosophic or scientific learning; (2) *insight*, or the ability to discern inner qualities and relationships, and (3) *judgment,* or good sense. They provide an illustration of the wisest one in the room through a story from World War II. Supreme Commander Dwight D. Eisenhower and Commander of Operations Bernard Montgomery met with officers on the day before the D-Day invasion. Montgomery gave a masterful address but Eisenhower did not speak. He silently went to each man and shook his hand. He knew their thoughts and feelings. Eisenhower was the wisest one in the room. The lesson is, "You can't be a wise person if you aren't wise about people" (p. 3).

The book is organized into two parts. Part 1 describes five pillars of wisdom and Part 2 applies this wisdom to four situations. The first pillar, *"the objectivity illusion,"* is the conviction that you see things as they really are and those who see things differently are therefore getting something wrong. Such a bias results in mutual misunderstanding and conflict. The second pillar of wisdom, "*the push and pull of situations*," refers to how small or incremental factors in situations can powerfully influence outcomes. People are more malleable than we think. Research by Stanley Milgram in the 1960s showed how a person in authority easily induced two-thirds of the people in a study to administer supposedly increasingly strong electrical shocks to an individual. The people continued with electrocution of the participant in spite of his screaming.

The "*name of the game*" pillar deals with language used to describe a situation. This matters because people respond to their surrounding circumstances not as they are but as they are perceived and interpreted. What a "game" is called is the "game" that people will play. Thus *enhanced interrogation* is used for *torture* in the game of *war*. Only the wisest in the room fully appreciate the extent to which responses are governed by those who control the way particular actions and situations are seen. Meanings are vitally important. The meaning people attach to different actions and circumstances depends on the choices they have available. Other factors determining how people assign meaning include context, habit and experience, motivation, and temporal proximity.

The fourth pillar, "*primacy of behaviour*" is counterintuitive. Many people think that emotions determine behaviour. The opposite is true. *Action leads to belief*, as first hypothesized by William James, and supported by Daryl Bem's Self-perception Theory and Dissonance Reduction Theory. *Rationalization* has a link to evils like the Nazi Holocaust. The lesson: "The wisest in the room recognize that the rationalization of evil, and of inactivity in the face of evil, is as great a threat to humankind as the cruel motives of the perpetrators" (p. 125).

Judgment is impaired by the final filter, the "*keyholes, lenses and filters*" of the mind. These failings include tunnel vision from ideological blindness, preconceptions that make it easy to see some things and hard to see others, and keyhole vision when we see things from a narrow perspective. Restricted vision by lenses includes framing a question in a way that leads people to think in that way. A serious problem is the confirmation bias. We search for confirmatory information for the answer to a question. To determine whether something is true, it is necessary to seek the evidence both for and against.

In part 2, the authors apply these components of wisdom to four situations: catastrophic personal injury, global political conflicts, education, and global climate change. The situation of "*the happiest one*

in the room" is the empirical finding that injured people, through adaptation, in time, come to judge themselves to be happy with life. The second situation, that the authors title, "*Why we don't 'just get along*,'" refers to the Palestinian-Israeli conflict. One strategy is to lower psychological barriers in negotiations. The third challenge involves educating disadvantaged and underperforming students. Employing the positive impact of self-affirmation is one successful intervention. The fourth and toughest problem is coping with Global Climate Change. The authors conclude that the wisest action by humankind is transformative global social movements, such as those that began both Christianity and Islam.

I found this book inspiring and immediately useful, both personally and professionally. I am a scientist and had a Mystical Experience, coincident with a burnout, in 1979 while at work. I have told few people about this powerful spiritual experience. It has led to a passion to follow the teachings of Jesus of Nazareth about relationships to the best of my ability in my life and work. I work towards the survival and growth of a more spiritual United Church of Canada for the 21st Century and beyond. Understanding the wisdom pillar "objectivity illusion," for example, has helped me develop strategies for dealing with church friends and colleagues who oppose my radical plans for change and they become supporters, asking, "What do you want me to do?" The authors' conclusions about developing the wisest global sociological movements modelled on the impact of the monotheistic Abrahamic religions confirm my Mystical Experience.

Many of the concepts, such as self-awareness, recognition of biases, and perspective, are likely familiar to those practicing psychotherapy, but *The Wisest One in the Room* offers a new framework and direction on wisdom. This book is not only for clinicians, but for all who want to be wiser, happier and more successful.

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Conflict of Interest: none

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SILENCE

Josée Labrosse, MD, MEd

Silence.
She's bliss.
She's golden.
Can't enrich her?
Just keep her.

Silence.
She's power
In bids and turnings
Each minute and hour.
Turning toward, she attends, attunes, accepts, allows.
    Kind and loving, she nourishes.
Turning against, she judges, crushes, condemns.
    Stony and cold, she crucifies.
Turning away, she conceals, controls and confuses
    Indifferent or bitter, she alienates.

Silence
Communicates
Volumes.

Conscious, deliberate and discerning, solid or fluid,
We belong and take comfort in her warm embrace.
Deceptive, dishonest, long-suffering she lies,
In disquieting isolation, pain, death or disgrace.

A great cacophony of modern method now poisons
her beauty and form.
(Is anyone home? Charge your phone!
And don't drop it in the toilet.)
No space between the streaming of notes
On the email-skype-facetimebook-twitterchat-linkdin-snapvine.
We dare not whine.
Disturb the bottom line.
Disconnection we all disallow.
What of our bids and turnings now?

Imagine instead:
Two years with her sweetness, in pine-scented woods,
Still lakes, living rivers, roaring seas and soft beaches.
Succulent sun-ripe tomatoes and peaches.
Being Thoreau
To grow
Divine power
In love
With silence.

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Conflict of Interest: None

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Depression and Suicide: A Reflection

Michael Paré, MD

It takes colossal courage, some will say, or it takes creepy cowardice, others will say, to take one's own life in suicide. Life is a gift—many believe from God—that we usually appreciate and savour. Yet, as humans, we all know that life is at times a difficult burden. Most of us usually bear our crosses with grim determination if not with some degree of stoic equanimity. We are only very rarely ecstatically happy and even regular happiness is somewhat elusive, but at least we are often reasonably content. We try to make the most of the good times and survive the bad times. When our mood is low we look forward to better days, which, with much relief, come reasonably soon. Yet for some individuals these better days never come. These unfortunate people are suffering from one of several forms of severe depressive disorder.

Everyone gets the blues now and then, but it is estimated that in Canada greater than 10% of the population will be much more seriously affected and will suffer from Major Depressive Disorder at some time in their life. Sufferers often experience profound feelings of helplessness, confusion, and the extreme pessimism of hopelessness. They may contemplate, attempt, or even complete the act of suicide. As those of us who practice psychotherapy well know, clinical depression is a severely disabling disorder and a genuine medical condition. Unfortunately, due to a lack of knowledge and enduring stigma, many people still believe depression is due to laziness, the result of a bad attitude, or can be explained by moral or emotional weakness.

It is not yet known precisely what causes major depression. Nevertheless, there is a general consensus among experts that a complex combination of ego-damaging past experiences, distorted and self-defeating beliefs, and abnormal brain biological processes are all intimately involved (Ravitz et al, 2013). A theme of significant loss is prominent in many stories of depression: a precious job, a valued marriage, or, more universally, a cherished youthful dream. Undoubtedly, there are also major contributions from biology (including genetic predisposition) and from past and ongoing life experiences (especially interpersonal interactions and relationships).

Depressive Disorders equally affect the poor, the middle class, and the wealthy. Some people naively believe that the superficial trappings of a successful life, such as a good job, social status, prestige, and an expensive car, will immunize and thus protect a person against depression. They are wrong. This is even if "objectively" the person seems to "have it all." For the outwardly successful individual suffering a serious depressive episode, life itself may be experienced as a harrowing affliction beyond adequate depiction. For those fortunate enough not to have suffered this psychological calamity, no description can sufficiently describe this tormenting emotional disorder.

Not only is the depressed person suffering their current misery, but they are also often absolutely convinced there is no end to their eternal pain. Victims of depression are often convinced that life itself will simply be a long journey of constant emotional torture with little respite. The novelist William Styron (1990), of *Sophie's Choice* and *The Confessions of Nat Turner* fame, in his memoir *Darkness Visible,* described his clinical depression as a storm in the brain, and compared it to a kind of emotional drowning or suffocation. His world had turned entirely bleak, all hope had evaporated and a perverse sense of self-loathing grew and completely enveloped him. Alternatively, serious depression may be experienced as the psychological equivalent of physically being set on fire. Unfortunately, the sufferer firmly believes that this metaphorical fire in the body/brain will never cease. Thus the sufferer anticipates the unending agony of body/brain burning for (seemingly) eternity (Paré, 2010). In these extreme cases, the victim of depression may seek to end her or his misery in any way possible. The pain simply becomes too much to bear. When exiting this world by suicide, depressed people sometimes—thankfully rarely—seek to bring loved ones with them with the altruistic intention of saving their loved ones from the certain (in the depressed person's distorted worldview) agony of a hideous world of pure pain. This is an ultimate act of (misguided) love and mercy.

It is this absolute lack of hope, and extremely distorted negative thinking that brings the depressive victim to the point of wanting and then eventually planning their own demise. Some indeed are "successful" at committing suicide. This oxymoronic "successful suicide" has been sometimes replaced with the more accurate and reasonable descriptive term: "completed suicide." Recently it has been suggested that simply saying the patient "died by suicide" is preferable (Olson, 2011).

As with any catastrophe, people look for a likely culprit after a suicide: at whom are we going to point the finger? Who can be blamed

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Depression and Suicide: A Reflection | continued

for the suicide? The honest answer is usually no one. All that we can reasonable say is that ultimately the act of suicide is nobody's fault—not the victim's, not the family's, not the stresses of a new baby, nor the new job, and not even the fickle lover whose heart has grown cold towards our desperate victim. For who has not suffered and survived the ups and downs and turnarounds of romantic love, of school, of work, and of marriage?

The ironic—yet hopeful fact—is that help is usually available even to the most severely depressed and suicidal individual. Yet many will not receive the treatment they need and could benefit from, because the depressive condition is often not recognized or understood by the affected person, their family or even sometimes their family doctor. Studies have shown that many depressed patients go unrecognized as such, even by their family physicians. (Also, the medical system's mental health services are underfunded [Funding for Mental Health, 2015], but that is an issue for another time.)

A variety of psychotherapies and antidepressant medications can be used to treat depressive illnesses. There are many psychotherapists potentially available including psychologists, social workers, and physician psychotherapists. Some people do well with psychotherapy alone, while others respond to antidepressant medication alone. Most people do best with combined treatment: medication to gain relatively quick symptom relief and psychotherapy to learn more about themselves and to develop more effective ways to deal with life's many challenges.

After successful treatment, patients should regain their normal experience of life. Not that so-called "normal life" is always so good. Life is a constant struggle, as Scott Peck (1998) says in his bestselling book *The Road Less Traveled:* "life is difficult." A statement that seems simplistic yet is also profound. We can take his message to mean that, in fact, life is very difficult even when it is going reasonably well. But this level of "difficulty" is infinitely better than the sometimes intolerable psychological pain experienced by a person who is in the grip of a severe depressive mental state with intense suicidality.

So the question remains as to whether a depressed person who chooses to kill themselves is a Herculean hero or instead a vicious villain. They are neither. They are simply a vulnerable, all-too human being suffering from the horrendously distorting influence of a major depressive disorder.

Michael Paré practices psychotherapy in Toronto. He is the Chair of the OMA Section on Primary Care Mental Health and has a particular interest in medico-legal issues of the practice of medicine. Michael has also completed the Osgoode Certificate in Professional Regulation & Discipline in the Ontario Health Care Sector, and the Osgoode Professional Development Certificate in Mental Health Law.

Conflict of Interest: none

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Report from the MDPAC Board of Directors

Catherine Low, MD, MDPAC(C)

New Website: www.mdpac.ca

The Board of Directors has approved the hiring of the firm ExWare to design our new website. This will provide many more features than the previous site including online registration for courses and a separate members-only section for viewing the latest information from the Board of Directors and various committees.

The Fifth Annual MDPAC Retreat

This event was sold out again this year. It took place the weekend of November 4–6, 2016 at Geneva Park in Orillia. The theme was "Strengthening Resilience with Mindfulness and Self Compassion." (See photographs below!)

The 30th Annual Conference

The 30th Annual Conference of the MDPAC is scheduled for May 26–27, 2016 at the Radisson Admiral Hotel in Toronto. The theme is "Resilience and Recovering from Complex Trauma."

Third Pathway Status at the CPSO

MDPAC made a third and final presentation to the CPSO's Education Committee on September 12, 2016 at the CPSO offices in Toronto. The presentation was made by Andrew Toplack, Stephen Sutherland, and Muriel van Lierop. In this year, the CPSO had asked MDPAC to make a formal re-application to be granted ongoing status as the Third Pathway for recording educational credits in order to maintain a licence to practice medicine in Ontario. At the time of

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Photos | Louis Girard

this writing MDPAC has not been officially notified of the outcome of this presentation but the general feeling is that it was well received. It is expected that MDPAC will continue to be recognized as a Third Pathway and that the CPSO will be making specific requests for updates on the progress of our association in the future.

Auditing of members' CE/CCI Credits is underway

For the second year in a row, the Membership Committee is conducting an audit of the educational credits that members have entered for the year ending September 30, 2016. Members are picked at random to be audited. If you receive notification that your name has been selected, please do your best to complete the required documentation in a timely manner. The Membership Committee, like all of our committees, is made up of volunteers from our Association and their time is valuable. This activity is a requirement of the CPSO for us to maintain our status as a Third Pathway for reporting educational credits to the CPSO.

Core Essentials in Primary Care Medical Psychotherapy Committee

The committee will be offering two four-day intensive courses in the core essentials of medical psychotherapy. The first part of the course will cover approximately 20 hours of Main Pro Plus educational credits and will be held June 1–4, 2017 on the campus of U of T's Erindale College. There is a maximum of 30 participants allowed for this course so be sure and sign up soon if you want to attend.

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

MDPAC
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MEDICAL PSYCHOTHERAPY ASSOCIATION CANADA

ASSOCIATION CANADIENNE DE PSYCHOTHÉRAPIE MÉDICALE

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Contact the MDPAC Office directly regarding the following:

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

MDPAC Contacts for Other Inquiries:

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

Submitting CE/CCI Educational Credits:
E-mail Muriel J. van Lierop at vanlierop@rogers.com or call (416) 229-1993

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Be creative, share your experiences and knowledge.

If you have photographs that are your original work and haven't been commercially published, we will begin cataloguing photos to be used in future editions, as appropriate.

In order to meet printing and editing parameters, please check out our Author Guidelines at http://www.gppaonline.ca/Journal.html

If there is something novel you wish to explore and possibly have published, contact Janet Warren at journal@gppaonline.ca

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