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(Formerly GP Psychotherapist)

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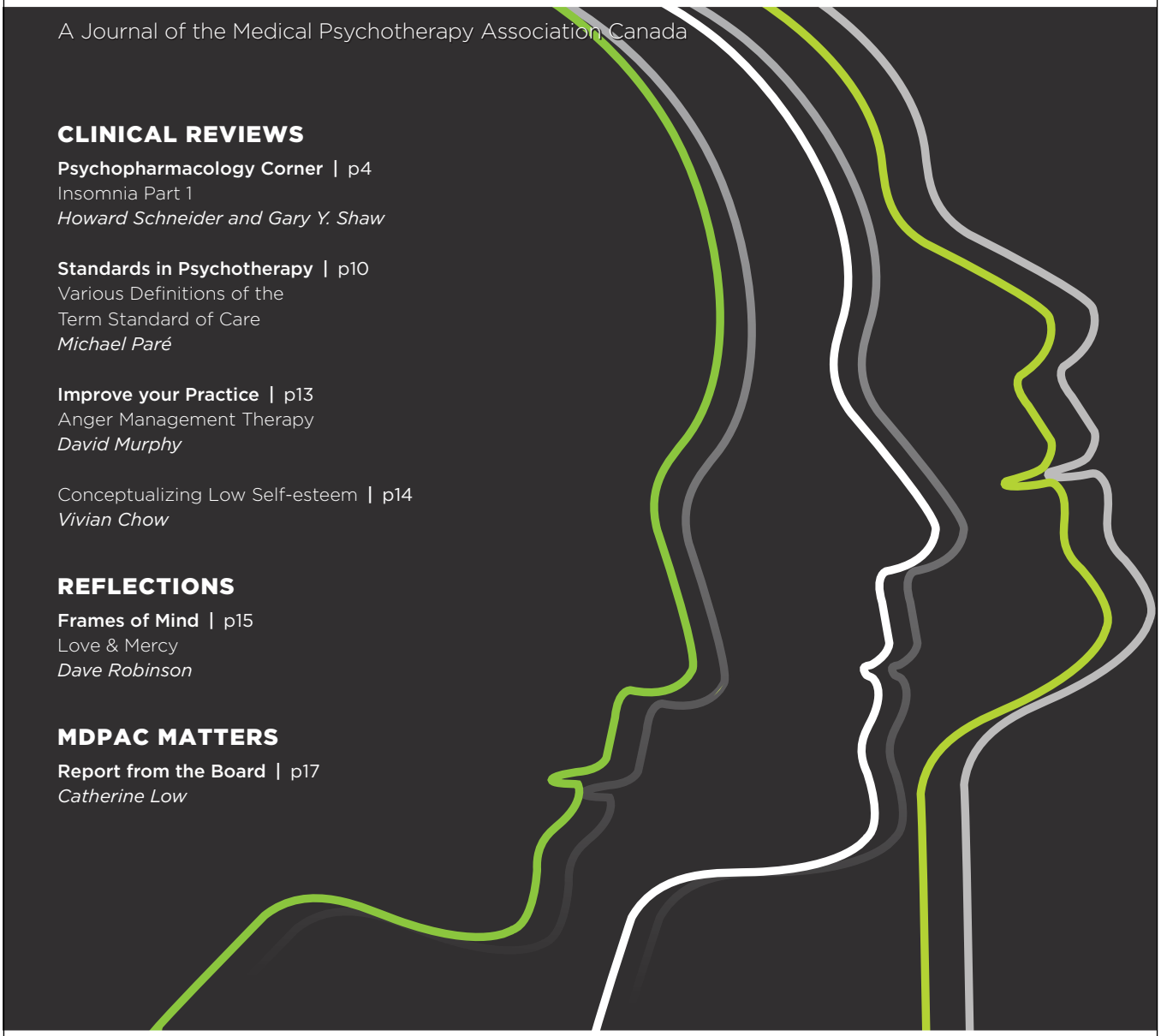

MDPAC ACPMD
MEDICAL PSYCHOTHERAPY ASSOCIATION CANADA
ASSOCIATION CANADIENNE DE PSYCHOTHÉRAPIE MÉDICALE

"THE BEAUTY OF THE UNIVERSE CONSISTS NOT ONLY OF UNITY IN VARIETY, BUT ALSO OF VARIETY IN UNITY."

— Umberto Eco, The Name of the Rose

One of the aspects of the MDPAC that I appreciate is our unity and variety. Because my psychotherapy training has been varied (perhaps scattered is more accurate!)—a conference here, a workshop there, supervision intermittently, a book or 289—I have developed an eclectic approach. I often explain to patients that I deal with issues on the surface (e.g., CBT) and at a deeper level (e.g., patterns of behaviour that are understandable given past trauma). I provide "3 Ps": pharmaceutical treatments, practical ones (think, exercise), and psychological ones. It is nice to know that I am not alone in my approaches, but part of a unified profession that is beautiful in its variety.

As our president has recently argued, medical psychotherapists offer an important service to our patients, which should not be impeded by political motivations. Patients are diverse, often complex, and need a variety of therapies. Brian McDermid has advocated for our profession (which you can read about in Catherine Low's report), arguing that "a one-size-fits-all policy of mental health care" is ineffective both clinically and economically. We need to recognize the limits of science (not all therapies are amenable to "evidence-based" evaluation) and acknowledge the need for a variety of approaches to mental health care.

Our current issue of the Medical Psychotherapy Review reflects Eco's "beauty of the universe." In the "Psychopharmacology Corner," Howard Schneider and Gary Y. Shaw address a common yet complex issue: sleep (interesting trivia—even fruit flies sleep), or specifically, lack thereof. In this first part of a two-part article on insomnia, they examine CBT measures for insomnia, including detailed sleep logs and stimulus control. This approach allows the patient they describe to wean off benzodiazepines. In another example of unity and variety, Michael Paré examines legal and medical understandings of standards

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of care. He points out the diversity and potential ambiguity in these terms and how they can be distinguished from clinical practice guidelines, for example.

In our "Improve your Practice" column, David Murphy outlines his approach to anger management, noting it is the behaviour, not the emotion that is problematic; he discusses crisis intervention, emotional regulation, and dealing with triggers. Vivian Chow examines the common problem of low self-esteem and its relationship to early experiences; she notes that core beliefs often get triggered and thus perpetuate the low self-esteem. These two articles perhaps illustrate how similar problems can have differing presentations.

Finally, in our reflections section, we introduce a new column for movie reviews: Psychiatrist Dave Robinson reviews the movie *Love & Mercy,* about Brian Wilson's struggles with mental illness. We all know patients with fascinating stories, varied but unified. We ourselves have varied but unified approaches to our psychotherapy practices. Let us celebrate the "beauty of the universe."

Grace and peace,
Janet Warren

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Insomnia – Part 1

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

Abstract

Chronic insomnia affects approximately 30% of the adult population, and is associated with multiple health and social problems. Recent guidelines recommend that cognitive behavioral therapy for insomnia (CBT-I) be the initial treatment for chronic insomnia disorder. The first part of this article considers the physiological and psychologic aspects of sleep, as well as details about implementing CBT-I. Generally, CBT-I involves taking a detailed history of sleep behaviours, and then implementing productive changes in sleep hygiene and sleep environment, stimulus control, relaxation training, sleep restriction, and cognitive therapy. The next part of this article will consider the psychopharmacological treatment of insomnia.

A common complaint of many of our patients is an inability to sleep. As noted in previous issues of *Psychopharmacology Corner*, the best treatments require a detailed evaluation and an approach that is much more comprehensive and iterative than the blind prescription of some dosage of some medication taken from a list somewhere. In fact, recent guidelines from the American College of Physicians (Qaseem et al, 2016) recommend a psychological approach—lumped under cognitive behavioural therapy for insomnia (CBT-I)—as the initial treatment for chronic insomnia disorder, with psychopharmacological therapy for those patients where CBT-I alone was unsuccessful.

In the DSM-IV-TR classification (American Psychiatric Association, 2004), "Primary Insomnia" is defined as sleeplessness for at least one month. In the DSM-V classification (American Psychiatric Association, 2013), "Insomnia Disorder" requires a "predominant complaint of dissatisfaction with sleep quantity or quality" at least three nights per week and for at least three months, that cannot be better explained by a secondary cause. Many cases of insomnia that we see in psychotherapy practice are caused by other factors and, obviously, these secondary causes should be treated. However, Yang, Spielman, and Glovinsky (2006, p. 895) note that nonpharmacologic insomnia strategies are helpful for the sleep problems, and argue that "insomnia should be addressed directly even when comorbid with a psychiatric disorder."

Insomnia is very prevalent in the population. Roth (2007) considers several population based studies and observes that approximately 30% of the adult population has trouble falling asleep, trouble maintaining sleep, wakes up too early, or complains of non-restorative sleep. Chronic insomnia is associated with accidents, work absenteeism, poor work performance, lower quality of life and increased general health problems.

Let's consider some background in the area of sleep. Sleep is not unconsciousness, but a state in which there is anabolism in the nervous, musculoskeletal, immune, and other systems. Every investigated vertebrate species requires sleep. Even non-vertebrate fruit flies sleep, with many of the fundamental sleep features which mammals show (Cirelli & Bushey 2008). In mammals, sleep alternates between Rapid Eye Movement (REM) sleep and non-REM (NREM) sleep. The first REM sleep of the night tends to be a short one, perhaps ten minutes long, but during subsequent sleep cycles, which in humans occur each 90 minutes, will tend to be longer. In the final sleep period the REM stage might be as long as an hour. Conversely, towards the latter part of the night the deep stage slow wave sleep periods shorten considerably. Since sleep grows lighter in the latter part of the night, this is when awakenings are more likely to occur, especially when transitioning between sleep stages.

Sleep and wakefulness are regulated by a complex network of structures in the brainstem and forebrain. The approach of Glovinsky and Spielman (2006) greatly simplifies these rhythms into a "Sleep Drive" and an "Alerting Force." The Sleep Drive increases during the day, and then when we sleep, the Sleep Drive resets. The Alerting Force, however, is circadian and follows our internal clocks, and is not significantly affected by how well we slept at night. The Alerting Force starts decreasing a few hours before bedtime, while the Sleep Drive increases, and ideally at bedtime the effect of Sleep Drive exceeds the Alerting Force. During sleep, both physiologic impetuses decrease, but in early morning the Alerting Force starts to increase again while the Sleep Drive is still decreasing, and at wake time the effect of the Alerting Force exceeds the Sleep Drive. During the day, they both increase and the cycle above repeats.

Cognitive behavioural therapy for insomnia (CBT-I) takes into consideration the physiological and psychological aspects of sleep, and strong evidence supports its use for the treatment of insomnia (Brasure et al, 2016). CBT-I involves taking a detailed history of sleep behaviours and then implementing productive changes in sleep hygiene and sleep environment, stimulus control, relaxation training, sleep restriction, and cognitive therapy. Let's consider an example composite case.

ID: 34-year-old male graphic artist, divorced x 3 years, no children.

Past Psychiatric History:

- No psychiatric history endorsed as a teen or in 20s.
- 31 years old: Anxiety, depression, insomnia during divorce from wife (married x 4 years). Treated by family doctor with fluoxetine and clonazepam x 6 months, with some improvement.
- 32 years old: Anxiety and insomnia worsened after losing employment (same company x 8 years) saying position was eliminated when the mid-sized company he was working outsourced his position. He obtained another job, although at a lower salary, in a small company 5 months later, but the anxiety and insomnia did not improve much.
- 33 years old: Family physician referred the patient to a sleep clinic where the patient underwent overnight polysomnography. Sleep specialist reports no sleep apnea or periodic limb movement disorder.

Past Medical History:

- Obesity BMI 31.4.
- Normotensive.
- Hypercholesteremia treated with atorvastatin.
- No blood test results provided with referral.
- No history of smoking, alcohol, or other substance abuse.

Intake Medications:

- Atorvastatin 10 mg od x 2 years.
- Clonazepam 0.5 mg–1.5 mg hs x 2 years.

Family Psychiatric History:

- None

Personal History:

- Father factory worker, mother homemaker.
- 2 older brothers, 1 younger sister.
- Describes happy childhood. No emotional abuse. No physical abuse. No sexual abuse.
- Average performance in elementary and high school. Some close friends. Successfully completed two-year graphics art program at college and has worked most of the time since graduation.
- Met wife at 23 years old, married 27 years old, divorced 31 years old.
- No girlfriend at present.

Chief Complaint:

Tired and apathetic for the last year.

History of Present Illness, Mental Status Examination, Laboratory Tests:

The patient gave a clear history of doing well until about 30-years old, when he started feeling sad and anxious, and having sleep problems (the onset coincided with a breakdown in his marriage). He often would not fall asleep until 3:00 a.m., and then felt exhausted in the morning when his alarm sounded at 7:30 a.m. A few cups of coffee in the morning kept him awake and allowed him to perform at work, but as the year went by he started to feel more depressed, did not take pleasure in many activities, and worried about the future. He saw his family doctor about these symptoms and at 31-years old was treated with fluoxetine 20 mg od and clonazepam 0.5 mg hs. He said he felt better with these medications and was able to sleep through the night.

The patient's divorce went through, and he started to feel much less anxious and less sad. Just before he turned 32, his family doctor stopped the medication. The patient is not sure if the anxiety and depression had gone away completely, but at this time he was feeling okay, though not sleeping perfectly (sometimes taking one to two hours to fall asleep, but sleeping through the night). However, later that year, his company eliminated his position and he needed to find another job. He felt more anxious when this happened, although he says there really wasn't any sadness or apathy at this time. He started worrying more whether he would ever find a good job in graphics art, and started to have trouble sleeping again. It would take two, three, or sometimes four to five hours to fall asleep. Then he got another job in his field, albeit at a smaller company and with a steep salary cut compared to the previous job, and had to wake up in the morning before 7:30 a.m. to get ready for work. His family doctor prescribed clonazepam again; 0.5 mg did not really help but 1.5–2 mg of clonazepam worked to put him to sleep more quickly (although often still taking two hours). He complained of fatigue the next day, and worried he would be fired due to poor performance.

At 33-years old his family doctor was concerned with the patient's sleep problems and so referred him to a sleep clinic. Despite his obesity, no sleep apnea was found on testing, and no specific recommendations were made by the sleep clinic. The patient's family doctor continued the clonazepam before bedtime, and then last month, at 34-years old, referred the patient to a medical psychotherapist.

He presented with a largely normal mental status examination: euthymic, coherent, normal psychomotor movements, grossly normal cognitive function, good

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Insomnia – Part 1 | continued

insight, and no suicidal ideation. The referral from the patient's family doctor describes a normal physical examination apart from obesity. There is mention of high cholesterol but no specific lab tests are available with the referral, and the patient notes that he has not had any blood tests in the last year. The patient agrees to some screening psychiatric tests, screening sleep tests, and lab tests. (Note: All these screening tests are readily found on any Internet search engine, and thus are not reproduced here.)

- Depression screening test HAMD7: 2, not indicative of depression, and questions endorsed actually were related to anxiety symptoms.
- Cognitive screening test MOCA: 28/30. (two mistakes in word recall)
- Epworth Sleepiness Scale: 8, which is interpreted as "Higher Normal Daytime Sleepiness."
- Sleep Logs: Patient to do at home and return with completed logs. The patient was to reduce the clonazepam to 1.0 mg hs prior to doing the logs.
- Lab tests: Normal ECG.
- Lab tests: Normal CBC, glucose, creatinine, ALT, LDL, cholesterol (NB: patient taking atorvastatin), HDL cholesterol, triglycerides, CPK, ferritin, zinc, and TSH.

The patient returned two weeks later with the completed sleep logs. He actually reduced the clonazepam to 0.5 mg hs during this period, saying he "wanted to get off the medication." The patient said he wanted to put the last few years behind him and "get my life back again."

Sleep logs:

- Average time in bed was 9 hours, but with an average awake time of 5 hours (as estimated by the patient on the sleep logs, since he didn't look at his clock until morning)
- On weekdays, the patient was in bed by 10:30 p.m., usually took many hours to fall asleep, and then had to wake up at 7:30 a.m. to get ready for work
- On weekends the patient was in bed at midnight, still took about three hours to fall asleep, and generally slept to about noon, but did not feel the sleep was restorative and still complained about fatigue on weekend days
- Fatigue levels on weekdays started at about 5/10 on Mondays, and climbed to 9/10 by Fridays, and only dropped to about 5/10 on weekends
- Cup of coffee at 8:00 a.m., and then 1 or 2 more cups at noon and again at 2:00 p.m.
- clonazepam only taken at bedtime
- Often a nap at 6pm before making supper, with the patient intentionally setting his alarm for half an hour so he did not nap too long; says he has set the alarm like this for the last year to avoid napping to 11 p.m. and then not being able to sleep at all during then night

The patient meets the criteria for a DSM-V diagnosis of Insomnia Disorder. It is unclear if a diagnosis of a mood disorder or anxiety disorder can be made at this time. A diagnosis of a DSM-V Circadian Rhythm Sleep-Wake Disorder, Delayed Sleep Phase Type is also considered since the patient seems be able to fall asleep by 3:00 a.m., although it is uncertain if this best explains the patient's trouble sleeping. However, delayed sleep phase is often associated with depression and with anxiety disorder, and treatment of these disorders will be considered simultaneously with the treatment of the patient's insomnia.

The possible diagnoses and a plan for treatment are discussed collaboratively with the patient. A non-pharmacological approach will initially be taken. The insomnia symptoms will be treated with CBT-I while the possible residual anxiety and depressive symptoms will be treated with a psychotherapy the therapist is familiar with (in this case, conventional CBT and supportive psychotherapy). Due to the patient's excessive time in bed and the possibility of a circadian rhythm disorder, the sleep restriction component of CBT-I could prove advantageous to the patient. However, since daytime fatigue may result, it is suggested to try this technique later. The patient, however, wants to try it as soon as possible and notes that he has no driver's license, takes the subway to work, and does not do anything dangerous during the daytime. The following treatment plan was made:

1 | Psychotherapy (CBT and supportive psychotherapy) for depression and anxiety.

2 | CBT-I Sleep Hygiene and Environment Improvement:

Changing lifestyle habits can improve sleep in many patients. Similarly, improving the sleep environment can also help with sleep. For this patient, the following was recommended:

- Reduce coffee from four cups to two cups (and then one cup if possible), with the coffee always consumed before noon.
- Do not nap after work, or on the weekend in the late afternoon.
- Join the low-cost gym near his workplace, do half hour of aerobic exercise after work before he comes home.
- Avoid computer use after dinner, dim lights in his apartment in the evening.
- Use light box 10,000 lux x half hour each morning while having coffee shortly after waking up.

• Consider trial of low-cost white noise/soothing sound generator at low volume for the bedroom.
• Turn alarm clock around so he cannot read the display while in bed.
• Set aside a one to two-hour period as a "wind down" period before bed; content still to be determined.
• On weekends, do not sleep past an extra hour more than the weekday waking time.

3 | CBT-I Stimulus Control:

The purpose of stimulus control therapy (Glovinsky & Spielman, 2006) is to retrain and strengthen expectations of being in bed and actually falling asleep. Stimulus control therapy involves a number of the items listed above in Sleep Hygiene, such as setting consistent bed and wake times, including on weekends; avoiding naps, especially in the evening; using the bed only for sleep and sex; encouraging physical exercise, but not in the four to six hours before sleep; avoiding alcohol and caffeine before sleep; and avoiding stress-provoking activities or thoughts before sleep.

If the patient is not able to fall asleep within 20 minutes of bedtime, then he or she should get out of bed, go to another room, and do a gentle, non-stimulating activity, for example, some light reading at a low ambient light. The patient should not return to bed until sleepiness occurs, and then try to fall asleep for 20 minutes. If not successful, the patient repeats the above routine. This technique can also be used if a patient awakens in the middle of the night.

Bright light therapy is a stimulus that can be successfully used to adjust sleep phase. If there is exposure to bright light (outdoor light or an indoor light box producing 10,000 lux for half an hour) shortly after awakening, then this can help the sleep phase shift earlier. If a patient cannot fall asleep habitually until 2:00–3:00 a.m., but really needs to fall asleep by midnight to be awake by 7:30 a.m., the bright light therapy upon awakening can help. Similarly, avoiding blue light such as from a computer later in the evening can prevent shifting the sleep phase later.

4 | CBT-I Relaxation Training:

Although relaxation training techniques are thought mainly to improve the ability to fall asleep easier, Glovinsky and Spielman (2006) note that worry can also affect early morning awakening. An anxious patient can fall asleep at a desired hour due to a high Sleep Drive, and since deep slow-wave sleep occurs at the beginning of the night, the patient will stay asleep; but then awaken later in the night during a lighter phase of sleep.

Relaxation training includes a large set of techniques, some of which most psychotherapists use. Commonly used techniques for sleep improvement are biofeedback, meditation, muscle relaxation, and imagery rehearsal therapy. Paradoxical intention, taken from logotherapy (Frankl, 1959), can greatly reduce a patient's anticipatory anxiety about not being able to fall asleep by avoiding active effort to fall asleep.

5 | CBT-I Sleep Restriction:

Sleep restriction aims to improve sleep by initially restricting sleep. A patient with insomnia may spend a long time in bed, but not sleep during much of this time. The patient becomes anxious about this as well as learning to associate being in bed with frustration and not sleeping. Sleep restriction eliminates the association between bed and frustrated wakefulness.

From this patient's Sleep Logs:
Target Time in Bed = 9 hours – (50% x 5 hours) = 7.5 hours, which is partial sleep restriction. In full sleep restriction target time in bed would be 9-5 = 4 hours. Thus, a target time in bed of seven hours is set, and since the patient has initial insomnia, the 7:30 a.m. wake up time is kept but bedtime is moved to 12:30 a.m.

Thus, the initial sleep restriction plan for this patient is as follows:
- Do not enter bed before 12:30 a.m.
- Wake up by 7:30 a.m. (8:30 a.m. on weekends).
- Do not nap during the day.

6 | CBT-I Cognitive Therapy:

Many patients with insomnia want to fall asleep very much and worry that they won't fall asleep, but this paradoxically contributes to worsening and perpetuating the insomnia. This issue can be addressed with the relaxation techniques described above, but a cognitive approach can also be useful to allow the patient more broadly to question and resolve a number of dysfunctional thoughts and behaviours which initiate, worsen, and perhaps most importantly, perpetuate insomnia. Work by Harvey and colleagues (2007, p. 2491) posits a cognitive model whereby insomnia is maintained by: "1. worry and rumination, 2. attentional bias and monitoring for sleep-related threat, 3. unhelpful beliefs about sleep, 4. misperception of sleep and daytime deficits and 5. the use of safety behaviours that maintain unhelpful beliefs."

In the initial interviews, the patient expressed concern about not sleeping enough and performing poorly the next day and losing his job. This was set as a ther-

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apeutic focus for the following week. The patient was seen one week after treatment was begun. He noted needing to use stimulus control when unable to fall asleep 20 minutes after entering the bed for the first two days, but by the third day he was falling asleep within this period. He reduced his coffee intake from four to two cups, and he drank both shortly after waking and while using the bright light box he had purchased the previous week. The patient resisted the urge to nap, only yielding on one occasion after coming home from work. On the weekend, he set his alarm for 8:30 a.m. and respected it.

The patient was seen two weeks after treatment was begun. There were no naps in the previous week. Other treatments continued. The patient was still using clonazepam 0.5 mg hs. He said he had started to learn how to relax his way into sleep at night instead of making the active efforts he used to make, and he was asleep within 20 minutes each night. One night he had woken up at 4:00 a.m. and couldn't fall back asleep, and so he got out of bed, did some light reading, felt sleepy in about a half hour, and then got back into bed and slept until morning.

The patient was seen three weeks after treatment was begun. He had joined a gym and three days a week walked on the treadmill for a half hour after work. He was going to try to increase to five days a week. Sleep was going well and felt more restorative. He still continued with 0.5 mg clonazepam before bed, two cups of coffee and the bright light box in the morning. Cognitive therapy was directed toward cognitions regarding sleeping enough, keeping and losing jobs, going forward with his life, and improving his work skills.

The patient was seen four weeks after treatment was begun. The above treatment regimen continued. He said he slept well each night and felt restored in the morning. On some mornings, it was not necessary to waken with the alarm. Another 15 minutes would be added to the sleep target time, so that the patient would now go to bed at 12:15 a.m.

Generic Name	Trade Name *(Common, Canadian names where possible)*
clonazepam	Rivtoril *(Klonopin in USA)*
fluoxetine	Prozac

The patient was seen five weeks after treatment was begun. The above regimen continued. The patient said he had fallen asleep every day in the past week within 20 minutes in bed and, on most mornings, he had awoken without the alarm. As well, he felt quite good during the day with no fatigue. He also felt much less anxious about life going forward, and no depressive symptoms were noted. The patient wanted to try to sleep the next week without the clonazepam.

The patient was seen seven weeks after treatment was begun. All the above continued except no clonazepam was taken before bedtime. The patient said on the first two nights and then on the fifth one he had to use the 20-minute stimulus control technique, but he felt good without the clonazepam, actually more alert and alive during the daytime than before, and wanted to continue without it. The patient was euthymic, and increasingly optimistic about his future. Another 15 minutes would be added to the target sleep time. The patient would return, although less frequently, for continued psychotherapy for the anxiety and depression, as well as follow-up for the sleep.

In the next part of this article, we will consider the pharmacological management of insomnia.

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

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Conflicts of interest: none.

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Various Definitions of the Term Standard of Care

Michael Paré, MD, MEd, MSc

Introduction

There are certain important phrases, many that define the quality of our clinical work, that are sometimes believed to be adequately described through alternate expressions. The concepts of "engaged psychotherapeutic relationship," "good boundary maintenance," and "clear record keeping" are wrongly believed to be properly described through such terms as the "standard of care," the "standard of practice," the "standard of conduct" or by the close following of "Best Practices" or "Clinical Practice Guidelines." Additionally, it is falsely believed that these terms are either easily distinguished from each other—by their different aims and definitions—or that they are all synonymous with each other. Yet none of these claims are true, as I intend to demonstrate in this article.

In this paper I focus on the important concept "standard of care" along with its various meanings. In reality, there is no precise medical definition of this phrase, which can make its meaning difficult to pin down when used in the field of medical psychotherapy. In contrast, when used as a legal term, the phrase "standard of care" (SOC) is significantly more established in courts of law.

The legal SOC is usually defined as "the level at which the average, prudent provider in a given community would practice. It is how similarly qualified practitioners would have managed the patient's care under the same or similar circumstances" (Medicine Net, 2016).

In wider medical legal terms, a physician has a duty to exercise the degree of care expected of a minimally competent physician in the same specialty—or focused area of clinical work—and under similar circumstances of care. Currently, the SOC in the legal sense, in a malpractice case, is established through the testimony of physicians who are considered by the courts as experts in the field relating to the specific malpractice case.

I will now distinguish this legal SOC (which I will simply refer to as the SOC) from other terms, such as what I call the proposed standard of care (PSOC), and from clinical practice guidelines (CPGs). Under legal jurisdiction, medical malpractice is considered a specific area within the general domain of negligence. Negligence is generally defined legally as falling below the SOC to which one must conform. A determination of malpractice requires that four conditions be met for the plaintiff to recover any damages. These four conditions are duty, breach of duty, harm and causation. The second condition, breach of duty, is synonymous with a breach of the SOC (Moffett & Moore, 2011).

Most legal action in the medical realm is based on a claim of negligence. The plaintiff, whether it be the patient or the patient's representative, must prove this allegation of negligence on the balance of probabilities. The Trier of Facts (the judge or jury) will then weigh the likelihood of the various contentions.

The following elements must be found for the claim to be successful:

- Duty: The physician owed a "duty of care" to the patient. The courts (usually) say a duty of care only exists when a physician has a doctor-patient relationship with a person (the patient).
- Breach of Duty: There was a breach of the SOC. In determining a violation of the SOC, the courts consider the care and skill that would reasonably have been applied in similar circumstances by a prudent peer colleague; a normally careful practitioner of similar training and clinical experience. This standard is not one of perfection, but rather is minimally acceptable behaviour at a high level of expectation. The courts do not expect flawlessness in the practice of a profession.
- Harm: The patient must show that he/she has suffered harm or injury.
- Causation: There is a causal connection between the physician's action (or inaction) and the negative outcome. The patient must establish that the physician's conduct or omission caused or contributed to the harm or injury sustained.

Patients who have suffered harm may seek compensation. Under Canadian law, in order to receive compensation, the plaintiff (patient) must prove that the defendant was negligent. The defendant may be one or more individuals—physicians, nurses, and others—or else entire institutions, such as clinics and hospitals. Trainees such as resident physicians, and medical students can be named in any law suit, and yet are usually protected from liability due to the fact that they are in training.

To clarify, there are at least two major definitions of "standard of care," one being medical and the other legal. Currently, the proposed definition of medical standard of care (PSOC) is significantly vaguer compared with the officially accepted legal definition. The PSOC can be understood as having a meaning that is roughly equivalent to CPGs. Thus some published PSOC are really proposed sets of ideas of what the SOC might be, or could be, and therefore are more like

CPGs.

An example of this will further clarify the situation. The World Professional Association for Transgender Health (1979) has a 100 page document titled "Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People" and yet they clearly state that these "standards of care are flexible clinical guidelines." I suggest that these proposed standards of care are an example of PSOC and not the legal SOC.

Better ways to possibly refer to PSOC documents would be to use phrases such as, "speculated standards of care" or "suggested standards of care," rather than labeling them boldly and bluntly as "The Standard of Care." Failure to distinguish between the more informal PSOC (and/or CPGs), and the more official, legal SOC can lead to significant confusion.

PSOCs can be developed by any group of like-minded professionals and/or by any physician association as a guide to their members. The label "standard of care" can be ascribed either unintentionally or not with the added significance of the legal SOC designation. Thus, there is a resulting inadvertent (or instead conscious attempt) to provide extra impact and heightened credibility to the point-of-view promulgated by the authors.

PSOCs and CPGs are not equivalent to the legal SOC. The Canadian Medical Protective Association (CMPA) has said that although CPGs may constitute an aspect of an expert's opinion as to the SOC, they are only contributory and never actually define the SOC (CMPA, 2011, March and September). The College of Physicians and Surgeons of Ontario (CPSO) similarly states that CPGs "do not define a standard of care, but may inform the standard of care" (CPSO, 2017).

A medical expert's evidence that a CPG was authoritative and widely accepted at the time in question is only one possible element of the SOC. Regardless of whether the care was in accordance with a CPG, a court will also inquire as to whether the practice was applied prudently. In other words, when deciding whether a physician's care was negligent, a court will weigh the evidence and ascertain the SOC that a similarly qualified physician was expected to follow at the time. As the CMPA (2011, September) has pointed out, CPGs are not equivalent to, and should be distinguished from, the legal Standard of Care applied by the Court. While PSOC and CPGs may be generally respected and therefore bear relevance to considerations in the Court's determination of the Standard of Care, they do not determine, nor were they intended to determine, the legal SOC that the Court will impose on a medical professional. The courts much prefer when there is more direct expert opinion evidence regarding the SOC, i.e., from a peer with reference to the facts of the particular case.

Discussion

What does all this complex medical legal analysis mean to the practicing medical psychotherapist? On one hand, it is extremely practical for a physician to aim to practice at—or above—the legal SOC. On the other hand we can see that giving a precise definition of the important professional expectation for the SOC is not so easily done.

We can say that various PSOC documents (and CPGs) are not necessarily required or usually even involved in a physician being judged as practicing at—or above—the SOC. And yet, seeking to generally follow the guidelines of certain relevant CPGs, and some PSOC documents can be seen as prudent.

1 | As a practitioner, you must clarify to yourself (and possibly others) the type of psychotherapy that you provide. This is because you will ultimately be judged by your peers who also practice the same or similar form of psychotherapy. If you claim to provide a particular type of psychotherapy, you must have adequate knowledge, training, and supervision in the specific type of psychotherapy (and thereby follow—at least to some extent—various PSOC and CPGs). Although PSOC do not define SOC, some PSOC documents can be very useful in helping to guide and educate practitioners as to what is likely to be expected or required of them.

2 | Good examples of these less formal PSOC documents for psychotherapy include the Guidelines for the Practice of Psychotherapy by physician developed by the MDPAC (2010), the professional practice standards developed by the new Transitional College of Regulated Psychotherapists of Ontario (2014), and the standard of care document of the Canadian Counselling and Psychotherapy Association (2015).

Conclusion

We as professionals are always seeking (or should be seeking) to be at or above the legal SOC in our areas of clinical practice. This is the standard required by both the courts and by regulatory tribunals (which

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Various Definitions of the Term Standard of Care | continued

in our case is the CPSO). Among the many ways physicians seek to enhance their abilities and skills is to be involved in reading the literature, attending lectures and workshops, and obtaining individual and group supervision. Clearly following the literature of CPGs and other publicized proposed practices—what I have called PSOC—is a prudent and reasonable practice. Yet care must be utilized in distinguishing various PSOC—which are only proposed or suggested standards—with the SOC, which is the legal standard of care.

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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Anger Management Therapy

David Murphy, M.B., Ch.B., CGPP

Anger and angry behaviour can have a profound impact on both social and occupational functioning, resulting in job loss or involvement with the criminal justice system. Anger itself is not an illness, but occurs with other diagnoses, such as depression, post-traumatic stress disorder, substance abuse or personality disorders. Employers, the legal system or spouses do not care if we are angry. It is angry behaviour, such as physical violence, hurtful and abusive words or threatening behaviour, which will create trouble for the patient. I have found the following approach helpful in my practice.

I divide anger management therapy into three phases. Phase One involves helping patients change destructive, angry behaviours. Phase Two helps them develop emotional regulation skills. Phase Three helps them change triggers for anger, so that they can start to choose when to be angry. I have developed this model over many years of providing anger management therapy to my patients by blending aspects of hypnotherapy, cognitive-behavioural therapy, psychodynamic therapy, solution-focused therapy and pharmacotherapy.

Usually, a patient presents for Anger Management Therapy when there is a crisis. If the patient is in danger of losing a job or a spouse, I have found that medication management may be helpful. I prescribe divalproate (500 mg bid or tid) as a short-term measure, while the patient develops other anger management strategies. One of my patients was on the verge of being fired from his job because he was having temper tantrums and shouting at supervisors. Divalproate helped him to regulate his outbursts, so that he could stop and think before responding. As a result, he was able to modify his behaviour and keep his job, while he worked on specific anger management techniques. Removing substances that can exacerbate anger, such as caffeine, stimulant drugs and alcohol, is important. This is not the time to quit smoking, however, as cigarettes are very effective for quickly regulating angry emotions.

The first phase of therapy is crisis intervention. The focus is on changing behaviours. These straightforward strategies include stop and think, count to ten, breathe, take time-out, and/or walk away. Patients are encouraged to use "I" statements instead of "you" statements when angry, use positive affirmations, and think about the consequences of angry behaviour. It is helpful to be aware of trigger situations so that they can proactively plan. Helping patients be aware of what they will lose from further angry outbursts can prevent destructive behaviours.

In the second phase of therapy, I teach emotional regulation techniques. Simple deep breathing exercises can calm affect. With hypnotherapy, I teach imaging a happy place and help patients access confident and resourceful states of mind and body. They have usually experienced poor role-modelling during childhood. Choosing to model the behaviours of family or friends, who act appropriately when angry, can result in patients acting out healthy behaviours. I like to teach parents to whisper their words to their children, instead of shouting. This can create an instant change in the relationship between parent and child, with the child smiling and responding, and parents finally feeling proud of their parenting skills.

The last phase of anger management therapy involves teaching patients to avoid reacting to old triggers for anger. This can be a natural process that starts unconsciously during phases one and two. Patients might start to notice that situations, which routinely triggered anger and over-reaction in the past, no longer do so. Sessions can focus on reviewing previous anger situations and using imagination to rehearse new, constructive behaviours. Hypnotherapy can be a useful adjunct for practicing new emotional reactions and for anchoring new resources. In this phase, it is appropriate to process any previous psychological trauma that has resulted in unresolved anger and consolidate recovery from substance abuse. Many patients in this phase of therapy start to successfully address their codependent behaviours, for example.

In summary, I have found this three-phase process (educating about defusing crisis situations, affect regulation, and deactivating unconscious triggers for anger) very helpful for patients who struggle with anger management.

David Murphy is a Medical Psychotherapist, whose medical practice is focused on the management of chronic pain, psychological trauma, anger and stress. He provides forensic psychotherapy and pre-sentence reports for sexual and other offenders.

Conflict of interest: none

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Conceptualizing Low Self-Esteem

Vivian Chow, MD

I've always had mixed results with treating low self-esteem. In the hopes of improving my results, I attended a workshop by Melanie Fennell on *Overcoming Low Self-Esteem* in November, 2016. The most valuable thing I learned was how to conceptualize low self-esteem. I find that this new conceptualization really resonates with my patients and makes it clearer what steps need to be taken for them to reach their goals.

Fennell is also the author of *Overcoming Low Self-Esteem* (2016) which is geared for patients but explains the conceptualization in Chapters 2 and 3 and provides a flow chart on page 42 (also provided in the workshop). The top half of the chart is straightforward. The basic concept is that negative (early) Experiences, such as being neglected, bullied or abused, lead to The Bottom Line, which is the self-esteem core belief e.g., "Nobody loves me." Believing in this Bottom Line, the patient then creates Rules for Living, also known as compensatory strategies, such as perfectionism or people pleasing.

This is where things get interesting. The chart then divides into two halves, one focussing on depression and the other focussing on anxiety. Before the split, there is a Trigger Situation. When this Trigger Situation leads to the Rules for Living being broken, this activates and confirms the Bottom Line and causes Depression. When the Trigger Situation leads to the possibility of the Rules for Living being broken, this leads to Anxiety. Both depression and anxiety lead to maladaptive behaviours (such as negative thoughts and avoidance) which reinforce the Bottom Line.

Let me explain this with some examples. I have a young single female patient who has been suffering from depression and anxiety. Her Rules for Living include perfectionism, the need to be liked, and the need to be in "control" of her emotions. When she first started seeing me, she had just broken up with a boyfriend (the Trigger Situation), which resulted in a lot of crying and emotional turmoil. As she had even cried in front of her boyfriend, this broke all her rules and led to a period of depression. She then engaged in the maladaptive behaviour of avoidance, e.g., not seeing friends or going out, which of course, reinforced the Bottom Line that "nobody loves me."

Using this conceptualization helped treat her depression, but she then started to complain of anxiety. Using the model above, this can also be easily explained. My patient got a new boyfriend and became fearful that all of her rules would be broken, especially that he wouldn't like her or that she would become emotional in front of him.

All this serves to emphasize to patients that they need to take a "bottom up" approach in dealing with low self-esteem and the associated depression and/or anxiety. By that I mean that a patient first needs to change maladaptive behaviours, such as avoidance, to stop confirming the Bottom Line. Once the depression or anxiety are improved, then the patient can work on changing dysfunctional Rules for Living to something more functional.

When I presented the cognitive model to my patient, she really liked it and was more willing to do the experiments to show the benefits of not engaging in maladaptive behaviour, which will then allow her to experiment with more functional Rules for Living.

Vivian Chow switched from Family Practice to Psychotherapy in 2002 and focusses on the Cognitive Behavioural Techniques. Her practice is in downtown Toronto.

Conflict of Interest: None reported.

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Frames of Mind: Love & Mercy

Pohald, B. (director/producer) (2014) Love & Mercy (motion picture). United States, Lionsgate.

Reviewed by David J. Robinson MD, FRCPC

Love & Mercy is a 2014 release based on the life of Brian Wilson, lead singer and creative genius behind The Beach Boys. The film stars John Cusack as the 1980s version of Brian Wilson, while Paul Dano plays the 1960s version. Notable other appearances are made by actors Elizabeth Banks and Paul Giamatti. This is a treasure of a film, exploring many aspects of the main character's life. It is not simply a period piece celebrating the saccharine-sweet surfer music of the 1960s. Another movie that looks at the life story of its main character (at three stages) is *Shine,* featuring the life of pianist David Helfgott.

We are introduced to Brian after The Beach Boys have had considerable commercial success, are touring, and are contemplating their next album. Brian has a severe panic attack on a plane after a tour and afterwards becomes phobic of flying. The severity of the attack is muted by the drone of the plane's engines, but the depiction illustrates why many people present to emergency departments fearing myocardial infarctions after suffering their first few panic attacks. Brian opts out of the upcoming tour to Japan and promises to have material for a new album when the group returns. Interestingly, future country star Glen Campbell tours with the group early in his career (but isn't Brian's replacement on the tour that gets underway at the beginning of the film).

Brian begins work on the album that will become *Pet Sounds* (released in 1966), a *tour de force* of musical innovation for its time. His mental health clearly failing as he composes the album, the movie beautifully intertwines the creative process with significant psychiatric symptoms and numerous stressors. Brian has auditory hallucinations that inspire his vision of how the songs should sound, and he struggles to remember them, fearing he'll lose the precious arrangements over time. The band members are divided in their opinions on which musical direction to follow, while Brian receives compliments from a seasoned session player on his originality. The range of the instruments and their orchestration on the song "Good Vibrations" alone is astounding, particularly for the era.

Brian's father (Murry) is an imposing presence reminiscent of Mozart's father as presented in *Amadeus.* During the period of the film, Murry has already been fired by the band and remains embittered, even as Brian respectfully seeks his advice on an early version of the song *God Only Knows.* The physical abuse of Brian by Murry is chillingly described in one scene, and Brian has lost virtually all the hearing in one of ears as a result. In another scene, Brian muses about whether Murry had actually pushed him to create better music.

Brian's use of psychaedelic substances is not strongly emphasized in the film, leaving viewers to speculate on precipitating versus perpetuating factors regarding his mental health. His use of substance in real life is described as significant (Grow, 2016), unlike the depiction in *Love & Mercy,* where it is mentioned by Brian (John Cusack) but not amply demonstrated.

As Brian heads towards a major period of dysfunction—he reports staying in bed for 3 years, famously venturing into Los Angeles in his bathrobe—the family enlists the care of psychologist Dr. Eugene Landy (played by Paul Giamatti). Landy characterizes himself as a "brother from another mother" to Brian, obfuscating his true therapeutic relationship with him. Landy institutes a radical nidotherapy that eventually puts him in absolute control of Brian's life, with the full support of the Wilson family. (Nidotherapy is the virtually complete control over someone's physical and social environment to try to manage persistent symptoms; for more information, see Tyrer & Bajaj, 2005.) Landy arranges, as substitute decision maker (through a psychiatrist colleague not shown in the film) to have Brian's medications prescribed for him, and then—astonishingly—even secures a co-writing credit on Brian's songs! Landy's controversial life story, even as briefly detailed on Wikipedia (n.d.) is worth a read in its own right.

Landy's control over Brian's life begins to erode when Brian purchases a Cadillac from Melinda Ledbetter (Elizabeth Banks)… though for different reasons than you might expect. Her dedication and eventual love for Brian are a testament to hope and inspiring to watch.

There are a plethora of anxiety, mood and psychotic symptoms prominently depicted throughout the movie. Brian's diagnosis in the movie is stated to be "paranoid schizophrenia" by Dr. Landy. This is partially accurate, based on the clear symptoms of psychosis (flat affect, functional decline, paranoid delusions, and auditory hallucinations) that are evident

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Frames of Mind: Love & Mercy | continued

in Brian just after his panic attack on the airplane and continuing afterwards. When we see the 1980s (John Cusack) version, Brian has the social deficits, inappropriate disclosures (boundary deficits), blunted affect, persistent hallucinatory experiences, and negative symptoms associated with a chronic psychotic disorder. However, the portrayal in *Love & Mercy* is not consistent with schizophrenia, and even less so with paranoid schizophrenia (no longer a subtype recognized in the DSM-5). Brian's lack of a conversational filter, directness, and base earnestness as a person endear him both to Melinda and viewers. The scene where Brian locks himself in a Cadillac with Melinda, detailing his brother's death by drowning, and the dinner, where he describes Murry's physical abuse of him, are typical of how someone with a chronic psychotic disorder would communicate such sensitive personal information. Brian states the "facts" in a bland manner that is incongruent with the severity of what he is describing.

In real life, Brian has revealed that his actual diagnosis is schizoaffective disorder, depressed type (Cooper & Friedman, 2009). This is a very reasonable conclusion given the symptoms demonstrated in the movie, especially if we are to exclude substance-induced mood or psychotic disorders from a differential diagnosis.

The Beach Boys, incongruously never popular with real surfers, are as interesting, complex, and talented as any other musical group from the 1960s. Paul McCartney has cited *Pet Sounds* as his favourite album of all time, and an inspiration for Beatles' albums that followed.

Love & Mercy (the title of a song sung by real-life Brian Wilson at the end of the film) is a must-see movie for anyone interested in mental health issues and for music aficionados. The film touches on a vast array of symptoms, songs, and stressors, and is absolutely worthy of its 121-minute runtime. Numerous biographies and other books exist for those interested in more information. Viewers also may be tempted to listen to one of the Beach Boys' compilation albums after seeing the complexity of the music and various characters demonstrated in the film.

On a happy note, Brian's two daughters Wendy and Carnie Wilson, two-thirds of the group Wilson Phillips, clearly have inherited their father's stellar musical skills.

Dave Robinson is a psychiatrist practising in London, Ontario. He has an active interest in psychiatric education and has written two books on movies and psychiatry.

Conflicts of interest: none.

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Report from the MDPAC Board of Directors

Catherine Low, MD, MDPAC(C)

MDPAC President Meets with Mental Health Commission of Canada

At the request of the Mental Health Commission of Canada (MHCC), Dr. Brian McDermid, president of MDPAC, met with Dr. Christopher Canning and two other Senior Policy and Economic Analysts from the MHCC on January 13, 2017.

Brian's presentation emphasized the following key points on behalf of MDPAC:

1 | We are well situated to treat the complex patient as well as to treat complex developmental trauma, addictions, and major mood disorders. We see the need for ongoing support of a range of psychotherapy models emphasizing evidence-based therapies, including psychodynamic and experiential therapies, as well as trauma-informed practices and principles.

2 | We believe the MHCC is likely to encourage providing broad-based support for CBT as a financially prudent manualized psychotherapy intervention to be laid out throughout Canada. Although Brian did not specifically speak to this MHCC policy, he did relay to the senior staff of MHCC what two of the newest and most robust longitudinal country-wide studies of public-purse funded psychotherapy in mental health have to tell us: a one-size-fits-all policy of mental health care was ineffective in approximately half of the cases and was also proven to be economically not sound. Brian hopes that he was able to articulate why he believes that "our marvelous 'big tent' association, representing medical psychotherapists practicing an array of empirically-validated psychotherapy models, is likely the model that the country deserves."

3 | Although we do not necessarily see a benefit now in supporting a country-wide single provider model for CBT across Canada, in British Columbia, where there is virtually no publicly funded mental health, at least within Medicine, this may be an excellent jurisdiction to focus on in the provision of publicly-funded CBT.

4 | We support co-ordinating addiction and psychotherapy services especially with an eye to decreasing turn-style medicine. Brian presented the data suggesting that at least half of all patients presenting with one or both problems have been shown to have complex developmental trauma as the defining early-onset event.

5 | We welcome support from the MHCC in encouraging the College of Family Physicians of Canada to create opportunities for the small numbers of residents who have particular interests in enlarging their scope of practice to include practicing as a Medical Psychotherapist. This may involve encouraging 1–3 residency spaces annually in Mental Health and Psychotherapy either through a 3rd year specialty or through providing some additional training in psychotherapy to those physicians who may need this level of support.

The 30th Annual Conference

The 30th Annual Conference on the MDPAC will be held on May 26–27, 2017 at the Radisson Admiral Hotel in Toronto. The theme will be "Resilience and Recovering from Complex Trauma." Our opening keynote speaker will be Jon G. Allen, PhD, formerly of the Menniger Clinic in Texas. He is the author of the book *Restoring Mentalizing in Attachment Relationships: Treating Trauma with Plain Old Therapy* among others.

The Sixth Annual MDPAC Retreat

I am very pleased to announce that our presenter at this year's retreat will be psychologist Sheri Geller. Sheri works in the area of mindfulness and therapeutic presence and was a very popular presenter at one of our past Annual Conferences. The retreat will be held at the Geneva Conference Centre in Orillia during a weekend in October.

Third Pathway Status at the CPSO

In a letter dated January 26, 2017, Barbara Lent, the Chair of the Education Committee of the CPSO informed Muriel van Lierop that MDPAC has been confirmed as a Third Pathway for tracking CPD activities. This privilege has been granted until September 15, 2019 at which time MDPAC will be asked to make another presentation to the Committee. The letter from the CPSO says in part:

"The Education Committee's final decision was based on your annual reports and presentations to the Committee in 2014, 2015, and September 2016. The Committee continues to be impressed with the dedication with which the Medical Psychotherapy Association Canada (MDPAC) has undertaken the work of becoming our only Third Pathway CPD tracking organization."

Membership in the Canadian Alliance for Mental Illness and Mental Health

In January 2017 the Board of Directors voted to join the Canadian Alliance for Mental Illness and Mental Health, a national organization funded by Bell Let's Talk and the Mental Health Commission of Canada, among others, to raise the profile of mental health concerns throughout Canada. The Alliance

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sponsors two major events a year in the Ottawa area. The next event will be the Fifteenth Annual Champions of Mental Health Awards on May 3, 2017 at the Shaw Centre in Ottawa. Tickets for the gala will be available at a reduced rate for MDPAC members.

Core Essentials in Primary Care Medical Psychotherapy Committee

This committee was unable to reach a consensus as to how best to present a course of this magnitude and the Board of Directors voted in January 2017 to disband the committee and ask the Education Committee to design a blueprint for a future course. Once this blueprint is presented and approved by the Board of Directors, a new committee will be formed to carry out the mandate outlined in the blueprint. This will delay the start of the course by several months but we believe that the results will be worth the wait.

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

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Journal

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

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

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

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

Reasons to Contact the MDPAC Office

1. To notify the office about a 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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The views of individual Authors, Committee and Board Members do not necessarily reflect the official position of the MDPAC.

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