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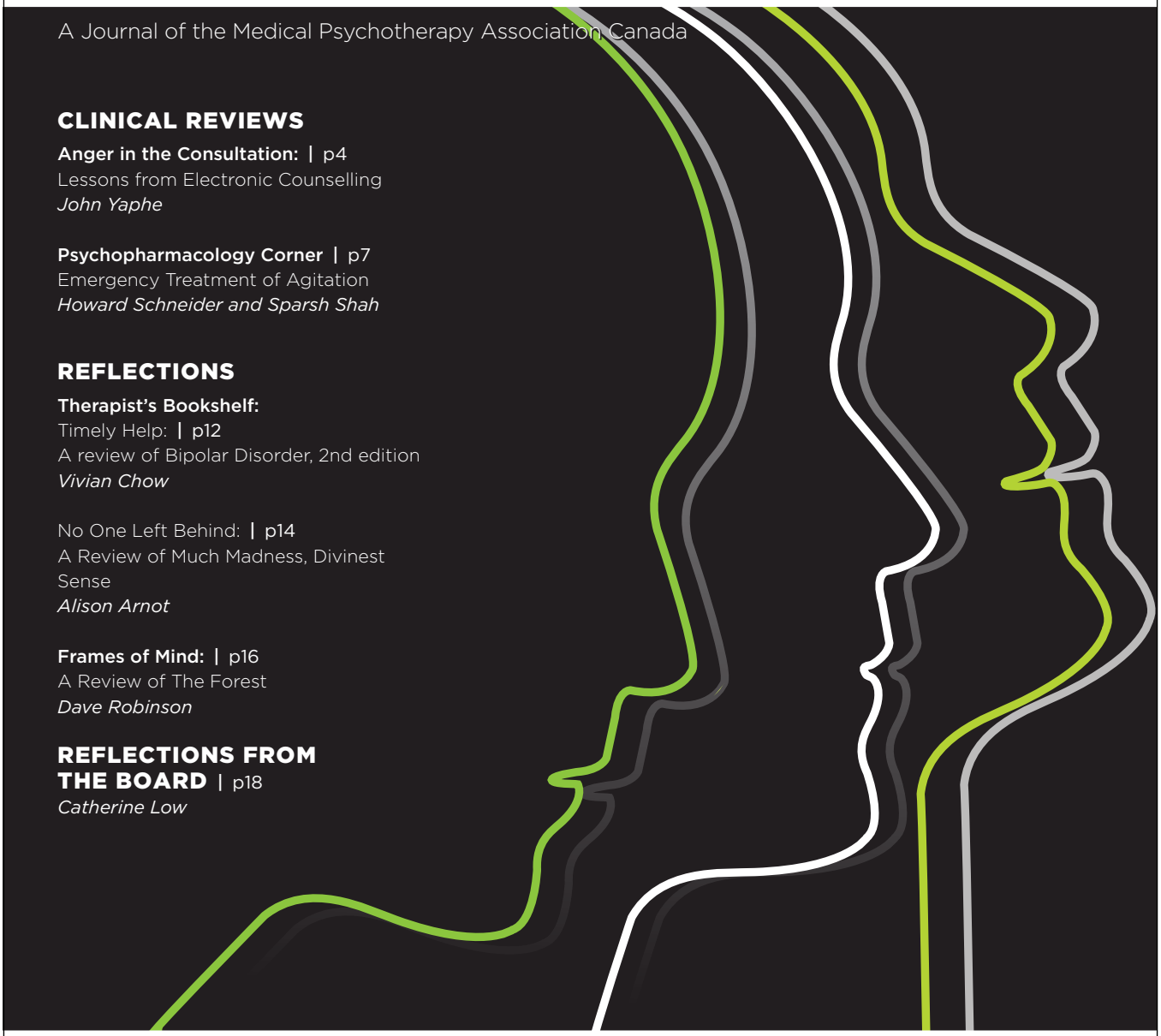
# MEDICAL PSYCHOTHERAPY REVIEW

(Formerly GP Psychotherapist)

A Journal of the Medical Psychotherapy Association Canada





MDPAC ACPMD
MEDICAL PSYCHOTHERAPY ASSOCIATION CANADA
ASSOCIATION CANADIENNE DE PSYCHOTHÉRAPIE MÉDICALE

**DARKNESS SETTLES ON ROOFS AND WALLS, BUT THE SEA, THE SEA IN DARKNESS CALLS; THE LITTLE WAVES WITH THEIR SOFT, WHITE HANDS, EFFACE THE FOOT-PRINTS IN THE SANDS, AND THE TIDE RISES, THE TIDE FALLS.**

*(From "The tide rises, the tide falls," Longfellow)*

Admittedly, and quite unintentionally, this issue is a little dim: anger, agitation, suicide, madness… But this is the territory of medical psychotherapy. The quoted section of Longfellow's poem is dark, but elsewhere it refers to a traveller, and the message is similar to what we help our patients realize: no matter what happens, life goes on. Things go up, things go down, but then they go up again. Darkness and the inevitability of change are both very familiar to medical psychotherapists. We are well aware of the complexities of human minds and lives. We are aware of the lack of psychological knowledge and resources. We share in trauma and tragedy, and grieve with our patients. We journey with people into darkness, and show them the small specks of light.

A reminder about the importance of self-care is perhaps timely here. We need to find ways to lighten our loads and laugh through life. Another well-known seaside story can be encouraging. You encounter hundreds of starfish stranded on the sand, and a solitary man throwing them back into the ocean, one by one. When you express incredulity at the impossibility of his task, he replies, "I may not be able to save them all, but I can help this one."

As mentioned, the topics in this issue of the *Medical Psychotherapy Review* are somewhat bleak. But they all offer insight, strategies for improvement, and the reassurance that our colleagues face similar issues. As the tide rises and falls, the practice of psychotherapy changes too. As does our journal—you are likely aware we are now only publishing two issues a year. However, we continue to endeavour to print quality articles to educate and inspire.

In our clinical review section, John Yaphe, who has contributed to this journal previously, discusses types of anger as expressed in e-counselling. I appreciate his honesty in admitting that not all his

**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.**

cases end successfully. In "Psychopharmacology Corner," Howard Schneider and Sparsh Shah discuss the management of acute agitation, including consensus guidelines on its pharmaceutical management. However, they emphasize that first-line treatment is verbal de-escalation.

Our reflection section includes two book reviews and a movie review. Vivian Chow recommends *Bipolar Disorder* as a handy reference book; in particular the charts and forms in the book that can assist a patient in preventing or mitigating manic or depressive episodes are valuable. Alison Arnot discusses the edited volume of women's stories of mental health: *Much Madness, Divinest Sense*. Many narratives resonated with her own experience; she was saddened by the pain expressed, and angered by the lack of care. Finally, Dave Robinson reviews the suspense movie *The Forest*, and incorporates some discussion of the famous suicide forest in Japan. Art and literature often provide poignant insights into psychological issues. Portraits of how people descend into darkness but come out of it.

This time of year offers many metaphors for the move from darkness to light, death to life. Seeds that have lain dormant over the winter sprout in surprising places, with therapeutic colours. Spring is a time of new life, hope, and promise. Catherine Low's final report reflects this change. She provides a cheerful and encouraging ending to the journal with her reflections on the MDPAC during her time as director of the Board. She speaks for many in her appreciation of those who have contributed to the growth and development of our organization, as well as the collegial support offered by the MDPAC. I echo her encouragement to participate.

Grace and peace,
*Janet Warren*

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# Anger in the consultation:
## Lessons from Electronic Counselling

John Yaphe, MD CM, MClSc

**Abstract**

*Anger in the consultation can be a common but troubling occurrence. Previous approaches have described the "hateful patient" who challenges the therapist with their behaviour. Recent advances in electronic counselling and other forms of online therapy have allowed patients to express their emotions, both positive and negative, in new ways, creating new challenges for counsellors. This article presents case examples of patients who expressed their anger in writing. It looks at the motives for anger in the consultation, including grief, personality disorders, and responses to the impending termination of counselling. It also provides the counsellor's responses and clinical outcomes in an attempt to suggest ways of managing the situation*In

Anger in the consultation can be troubling, but it can also lead to insight and change. I would like to share some of my experiences from electronic counselling in which patients expressed their anger in writing. Two previous articles on electronic counselling in this journal discussed the potential of e-counselling (Yaphe, 2014) and its application in support of patients coping with chronic disease (Yaphe, 2016). The case examples presented here illustrate some reasons for patient anger and suggest approaches that may be helpful in counselling and psychotherapy.

James Groves (1978) explored the concept "hateful patient" forty years ago. He described certain types of challenging patients and the responses they evoke in us; for example, "dependent clingers, entitled demanders, manipulative help-rejecters, and self-destructive deniers" (p. 883). Groves hoped that awareness of these patterns of behaviour by patients could improve the quality of care by helping clinicians resolve problematic relationships.

It can help to remember that anger in the consultation often "is not about you." One revealing case report (Mathiesen, 2012) presents the story of a student who was confronted with patient anger during her training as a counsellor. She came to realize that anger was not personal, that it was an opportunity to enter into the patient's suffering in order to help them, and that it was a reminder to be kind to herself.

A recent study from Israel (Landau et al, 2018) looked at the reasons for dissatisfaction with care in emergency departments that can lead to anger among patients and their families. This has been a cause for concern, since anger can erupt into violence against medical staff. They found that staff attitudes to patients, including a lack of empathy or impatience, along with long waiting times, perceived lack of technical quality of care, and a lack of information provided to patients and their families were triggers for anger. Less severely ill patients expressed more anger than severely ill patients who were grateful for the attention they received.

A study of general practitioners in Norway (Nilsen & Maltrud, 2017) found that anger may be a consequence of denying the request of a patient for tests, treatments, certificates, or other benefits. This is consistent with findings from an earlier study of the ways family doctors cope with conflict in the consultation (Weingarten et al, 2009).

The following case examples of anger refer to grief, personality disorders, and termination of counselling. Clinical details and some wording have been altered to preserve patient anonymity.

### Anger as a stage of grief

Sometimes anger is a stage on the path of grief. We need broad shoulders to help others carry their burdens. Patient A was a 55 year-old woman who requested help in dealing with her feelings following the death of her mother. In reply to the first exchange she expressed anger at the approach chosen.

> Patient A: *I was disappointed with your last response. I don't know what I expected. Did I expect a clue to ending my misery, more affirmation on my mother's care, or more condemnation on my mother's care? I am sick of platitudes: "Her spirit lives on in you. You have the memories." I feel like a child about to have a tantrum. I want my mom. I want to hear her voice. I want to see her.*

The patient's feelings were validated and she was invited to express her grief and her other feelings towards her mother.

> Counsellor: *Thank you for your reply. I accept your anger. I would like to share the feelings it evokes in me with you to see if that helps you to understand your own feelings and move forward. From the intensity of your anger, I understand more of the depth of your grief. You express your love for your mother in this way. But you also*

*express real anger at your mother and at yourself.*

The patient responded with a reappraisal of the source of her feelings and her ways of dealing with them.

Patient *A: One thing is for sure. The anger was not really directed at you. Me, that's where the anger was directed, but as we both know it's easier to throw the anger out there than to direct it inwards.*

### Anger as a recurring pattern in relationships

Patient B was a 50 year-old woman who requested help dealing with feelings of anger at her family of origin and her ex-husband. There was a history of abuse in childhood, abusive intimate relationships as an adult, suicide attempts, and episodes of self-mutilation. She had selected online counselling because of mobility difficulties due to low back pain from a herniated lumbar disc.

This patient had features consistent with borderline personality disorder. Patients may express anger when the image of "the good doctor" shifts into that of "the bad doctor" after a perceived slight. Counselling began with a positive tone. Following initial attempts to witness and contain her suffering, the patient replied with expressions of gratitude.

Patient B: *Thank you—your email and patience were a godsend to me this evening. That feeling of caving into myself is lifting. Can I say thank you enough?*

However, following a delay in receiving a reply from her counsellor, this quickly turned to anger.

Patient B: *I do not trust you at all... You do not have what it takes to be an effective counsellor... You have wasted my time, energy and patience.*

The patient was offered help in finding local counselling resources due to the lack of a therapeutic alliance in e-counselling.

### Anger as a response to perceived rejection

Patients may bear a burden of suffering from old injuries or recent suffering. They may confuse the counsellor or therapist with old aggressors. Anger can be expressed in counselling when patients feel rejected, and/or when the issue of conclusion of counselling is raised.

Patient C was a 27 year-old man who requested help dealing with feelings of anger following the breakup of what he described as an abusive relationship. There was a history of past abuse in childhood. Counselling focussed on exploring the strengths and resources he possessed that allowed him to cope. He was provided with advice on his options including medication, insight oriented therapy, and cognitive therapies. He was given information on how to obtain longer-term guidance after the conclusion of written counselling. When the issue of termination of counselling was raised, in keeping with the short-term nature of the service provided by his employer, he expressed feelings of anger.

Patient C: *This service has changed a lot since I last used it. Now I'm just being told to go look into medication and other services instead of getting the help I need. I did all the work to talk through the underlining issues and it just feels like a quick fix solution or "Here, phone this number." That doesn't help me out at all. I don't want to call someone else, I was wanting to get help here and it's clearly not made for that now, so I think I will end here.*

I responded by acknowledging and validating his feelings and providing him with other options.

*Counsellor: Thank you for your letter with your honest expression of your feelings. I can appreciate the sense of disappointment you experienced regarding the short-term nature of this service. I would like to address the valid points that you made and see if this can help you to find the solutions that you seek. I want to reassure you that your feelings are legitimate, whether they are positive or negative, and you are allowed to experience them and express them fully. E-counselling offers a safe space to do that. I look forward to hearing from you again soon and want to wish you good health and strength as you continue on your way.*

The patient responded to this approach with an apology and a willingness to continue to work on his issues.

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Patient C: *I had time to think it through and realize that this isn't a long-term service, as you said, and the fact that it is even free to me as an employee, I need to apologize for my irrational behaviour towards the service and your help. I should be grateful the service is even offered in the first place and I am genuinely happy to be able to at least get these thoughts and issues out of my head, to someone that can help me to realize and understand some things about myself. So again, I do apologize for my abrupt complaints and negativity towards it.*

Forty years after Groves published his influential paper on "hateful patients," a response appeared with a plea for an "ethic of love" (Gunderman & Gunderman, 2017). This can serve as an antidote to the strong feelings stirred up by these patients in their caregivers. It is hoped that the case examples presented here reflect in part their humanistic view. Perhaps they may stimulate further debate and discussion on the meaning of these central experiences in counselling and psychotherapy.

**Conflict of interest:** None.

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## References

Groves, J.E. (1978). Taking care of the hateful patient. *New England Journal of Medicine 298:* 883–7.

Gunderman, R.B. & Gunderman, P.R. (2017). Forty years since "Taking Care of the Hateful Patient," *AMA Journal of Ethics. 19*(4):369–373.

Landau, S.F., Bendalak, J., Amitay, G., & Marcus, O. (2018). Factors related to negative feelings experienced by emergency department patients and accompanying persons: an Israeli study. *Israeli Journal of Health Policy Research 7*(1):1–9.

Mathiesen, A.M. (2012). Counseling the "angry patient": a defining moment of changing focus from myself to the patient. *Journal of Genetic Counseling 21*(2):209–10.

Nilsen, S. & Malterud, K. (2017). What happens when the doctor denies a patient's request? A qualitative interview study among general practitioners in Norway. *Scandinavian Journal of Primary Health Care 35*(2):201–207.

Weingarten, M.A., Guttman, N., Abramovitch, H., Margalit, R.S, Roter, D., Ziv, A., Yaphe, J. & Borkan, J.M. (2010). An anatomy of conflicts in primary care encounters: a multimethod study. *Family Practice 27*:93–100.

Yaphe, J. (2014). Electronic counselling: A new frontier for GP Psychotherapy. *GP Psychotherapist 21*(1): 5–7.

Yaphe, J. (2016). Electronic counselling for patients facing chronic disease. *GP Psychotherapist 23*(1): 6–9.

# Emergency Treatment of Agitation

Howard Schneider, MD, MDPAC(C), CCFP and Sparsh Shah, HBA

**Abstract**

*Acute agitation can be a common presentation in mental health practices, particularly in institutions. Verbal de-escalation is always the first-line option; however, when that fails, pharmacotherapy is indicated. This article outlines an evidence-based approach to management of the acutely agitated patient, which involves establishing the provisional diagnosis, and then basing pharmacotherapy on that diagnosis and patient-specific factors.*

A significant number of patients present to the Emergency Departments of hospitals with mental health crises. Zun (2016) notes that in the USA 45% of all patients who present to Emergency have a mental illness, and that 10% of all patients presenting do so to receive psychiatric care. Patients with agitation are common in the acute-care setting (Boudreaux et al, 2009), and take the immediate attention of the mental health team. While many medical psychotherapists work in office settings, some do or will work in institutions. As well, agitation does occasionally present in varying degrees to the medical psychotherapist's office. Gottlieb and colleagues (2018) note that almost three quarters of physicians will be threatened in the workplace and almost one half will be a victim of violence at some point in their career. Yet they also found that nearly two thirds of physicians have had little or no formal training in managing agitated patients. This article reviews the current literature and practice guidelines around managing acutely agitated patients. Let's consider a case:

*A 28-year old patient, John, presents to the Emergency Department quite agitated, moving around and unable to take a seat in the waiting room. John is there voluntarily, says he wants help, and is accompanied by a friend, who is quite helpful to staff.*

## Non-Pharmacological Approach to the Acutely Agitated Patient

It is important to ensure that a treatable acute medical cause has been ruled out when faced with what appears to be a mental health emergency. The current standard of care (Balan, 2018, pp. 105–116) is a quick focused history, physical exam, and basic laboratory tests. However, the possible etiologies for what may seem like similar neuropsychiatric symptoms may be quite diverse and not picked up in the medical screening exam and testing. As well, comorbid medical problems may interact with mental issues to create a large exacerbation in behaviour resulting in the emergency visit. Hall and colleagues (1981) looked at 100 patients who had been medically screened prior to emergency psychiatric evaluation and admission to hospital. They found that 46% of the patients had an undiagnosed medical illness that was the major cause of the admission or significantly exacerbated its likelihood. As a result, they recommend a much more extensive laboratory workup. Although many mental health emergencies are associated with overdoses, toxicological issues may slip through preliminary medical screening, depending on presentations, tests ordered or available, quantities taken, and the patient's phase of poisoning.

*One of the emergency physicians along with a nurse, obtain a quick history. John has had, his friend thinks, bipolar disorder in the past, but he has not been taking any of his medications for the last year. His friend does not think he took any substances recently. A quick physical exam is within normal limits, and a set of screening blood tests are drawn. The doctor asks John if he can produce a urine specimen but John is getting more agitated and the mental health team is called: you, a psychiatric nurse and a social worker are on duty at this time.*

The first intervention for treating agitation should almost always be nonpharmacological, i.e., verbal intervention and de-escalation. Work by Richmond and colleagues (2012) provides guidelines for a more tolerant approach to the agitated patient, which can often obviate the need for restraints and involuntary parenteral medication. A three-step approach is advocated. First, try to verbally engage the patient. Second, attempt to form a collaborative relationship with the patient, trying to work with the patient to help him/her. Patients often want to ventilate to someone who appears interested in them. Third, "verbally de-escalate" the patient from agitation to a calmer state. The physician or other health care worker should avoid coercive speech or behavior so as to prevent escalation of the agitation. Personal space should always be maintained. If there are multiple health care workers, then only one should be speaking and should "keep it simple." Set clear limits but not in a provocative way.

*You greet John and ask him if he can*

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*take a seat so the two of you can talk. John smiles at you and then becomes angry, shouting that everything is going to hell, that we all are going to die. He starts pacing back and forth between the walls of the room you are in. You ask John if you can help him. You ask if everything is going fast in his head and if you can help this. You tell him you want to help him. He calms down and seems to appreciate the interest. But then he yells at you that's it too late, nothing can be done, and he takes an empty chair and throws it at the wall.*

## Pharmacological Approach to the Acutely Agitated Patient

If medication is still required to treat the agitation, it is useful to follow the consensus recommendations of the workgroup of the American Association for Emergency Psychiatry (Wilson et al, 2012). A provisional diagnosis should be made, as best as the circumstances allow, since this will influence which medication to use. Patients should not be overmedicated so that a more accurate diagnostic assessment can be made. Medication does not necessarily have to be administered by injection; in many cases, if circumstances permit or particularly in an outpatient setting such as the medical psychotherapist's office, an oral route (preferably a fast-dissolving tablet) can be psychologically beneficial to the patient.

The consensus recommendations consider using three classes of medications to treat agitation: first-generation antipsychotics (FGAs), second-generation antipsychotics (SGAs), and benzodiazepines. We will consider each class briefly, and then consider the consensus recommendations. The reader is directed to Stahl (2013; 2017) for more detailed information about the medications.

Haloperidol, a dopamine 2 antagonist FGA, is effective and relatively safe for treating agitation in the Emergency Department but, as discussed below, it is no longer the first-line treatment in many cases. Haloperidol often creates disturbing extrapyramidal side effects (EPS). In contrast, most SGAs cause fewer EPS while being effective in treating agitation. Thus, where an antipsychotic is required for the treatment of agitation, the consensus recommendations (Wilson et al, 2012) favour SGAs in most cases.

Although not part of the consensus recommendations, a novel *inhaled* form of the conventional antipsychotic loxapine is approved for acute treatment of agitation associated with schizophrenia or bipolar I disorder. Work by Roncero and colleagues (2017) has found that inhaled loxapine works effectively for agitation in intoxicated patients as well. However, inhaled loxapine can cause severe respiratory distress and so its use at present is limited.

Most SGAs appear to be as effective in reducing agitation as haloperidol, with the advantage of having rates of dystonia that are a fraction of what occurs with haloperidol. Work by MacDonald and colleagues (2012) shows that intramuscular olanzapine was actually more effective than intramuscular haloperidol in controlling acute agitation in the Emergency Department. Studies are lacking in comparing the SGAs against each other in the treatment of agitation, but indirect evidence suggests that aripiprazole is less effective than other SGAs for acute agitation. As well, quetiapine can frequently cause orthostatic hypotension if patients are somewhat volume depleted, which sometimes occurs with agitated patients presenting to the Emergency Department. Other SGAs, such as lurasidone and asenapine, had not been adequately tested for treatment of agitation at the time of the consensus recommendations. Clozapine is only approved for treatment-resistant schizophrenia. Thus, the consensus recommendations do not recommend as first-line SGA choices aripiprazole, quetiapine, lurasidone, asenapine, or clozapine. Although not part of the consensus guidelines, work by Allen and colleagues (2017) has since found lurasidone effective in reducing agitation in patients with schizophrenia.

Benzodiazepines have been used for decades for effective treatment of agitation. However, if the cause of the agitation is psychosis, then antipsychotics are more effective. As well, if parenteral benzodiazepines are used, the patient should be monitored for hypotension and respiratory depression. If there are conditions where antipsychotics are contraindicated, then other strategies including the use of benzodiazepines should be considered.

If a patient presents with agitation, and non-pharmacological strategies have not been successful in calming the patient, then the consensus recommendations for the following provisional diagnoses are as follows:

### Agitation associated with psychosis due to a psychiatric disorder:

- 1st line: Oral SGAs; e.g., risperidone 2 mg, olanzapine 5–10 mg, plus benzodiazepine, e.g., lorazepam 1–2 mg if the antipsychotic is not sufficient to control symptoms
- 2nd line: Oral FGA with benzodiazepine, e.g., haloperidol 2–10 mg + lorazepam 1–2 mg

- 3rd line: Parenteral SGA, e.g., olanzapine 10 mg im, ziprasidone 10–20 mg im
- 4th line: Parenteral FGA, e.g., haloperidol 2–10 mg im + lorazepam 1–2 mg im

### Agitation associated with CNS depressant (e.g., ethanol) *intoxication:*

- 1st line: Oral FGA, e.g., haloperidol 2–10 mg
- 2nd line: Parenteral FGA, e.g., haloperidol 2–10 mg im
- Haloperidol is recommended because of safety evidence accumulated over the decades, but SGAs, such as olanzapine and risperidone, will also work.

### Agitation associated with CNS-stimulant intoxication or CNS depressant (e.g., ethanol, benzodiazepine) *withdrawal:*

- 1st line: Oral benzodiazepines, e.g., lorazepam 1–2 mg, chlordiazepoxide 50 mg, or diazepam 5–10 mg
- 2nd line: Parenteral benzodiazepines, e.g., lorazepam 1–2 mg im/iv
- It is noted that some amphetamine users develop psychotic symptoms, and in such a case, an antipsychotic can be added to the benzodiazepine.

### Agitation associated with delirium (and ruled-out withdrawal from ethanol, benzodiazepine):

- 1st line: Oral SGAs e.g., risperidone 2 mg, olanzapine 5–10 mg
- 2nd line: Oral low-dose FGA, e.g., haloperidol <3 mg (EPS risk is higher in patients with delirium)
- 3rd line: Parenteral SGA, e.g., olanzapine 10 mg im, ziprasidone 10–20 mg im
- 4th line: Parenteral low-dose FGA, e.g., haloperidol <3 mg im or cautiously iv
- Benzodiazepines are avoided in the treatment of agitation associated with delirium, as they can worsen delirium.
- Delirium is common in elderly patients and those in the intensive care unit.
- Note that the first step to consider is to treat the underlying medical cause.

### Uncertain or extremely complex agitation *without* overt psychosis or delirium:

- 1st line: Oral benzodiazepines, e.g., lorazepam 1–2 mg, chlordiazepoxide 50 mg, or diazepam 5–10 mg
- 2nd line: Parenteral benzodiazepines, e.g., lorazepam 1–2 mg im/iv

### Uncertain or extremely complex agitation *with* overt psychosis:

- 1st line: Oral SGAs, e.g., risperidone 2 mg, olanzapine 5–10 mg, plus lorazepam 1–2 mg if the antipsychotic is not sufficient to control symptoms
- 2nd line: Oral FGA with benzodiazepine, e.g., haloperidol 2–10 mg + lorazepam 1–2 mg
- 3rd line: Parenteral SGA, e.g., olanzapine 10 mg IM, ziprasidone 10–20 mg im
- 4th line: Parenteral FGA, e.g., haloperidol 2–10 mg IM + lorazepam 1–2 mg im

Treating agitation in the elderly is somewhat controversial and beyond the scope of this article. Indeed, many antipsychotics have black box warnings (although *not* contraindications) against use in elderly patients.

### Agitation Associated with Cannabis

Bui and colleagues (2015) discuss management of cannabis psychosis and agitation. From a medical point of view, ECG QTc interval and electrolytes should be monitored, along with any respiratory symptoms particularly if marijuana was smoked with contaminating substances. Bui and colleagues describe a case where cannabis psychosis and agitation were successfully treated with risperidone 0.5 mg po q6h and lorazepam 1 mg po q6h. Indeed, as Arendt and colleagues (2005) show, some half of these patients will go on to be diagnosed with schizophrenia, so antipsychotic treatment is appropriate.

*After John threw the chair at the wall, you felt an urge to get the orderly to hold down the patient and to ask the nurse to prepare an injection of haloperidol and lorazepam. However, instead, you ask John, "Is it okay if we give you a pill, an antipsychotic, to slow down the ideas in your head and make you feel better?" John nods. Since the provisional diagnosis is "agitation associated with a psychiatric disorder," you follow the first-line recommendations of the consensus guidelines and ask the nurse to give John a 5 mg olanzapine fast-dissolving tablet and a 2 mg lorazepam fast-dissolving tablet. You ask John to voluntarily take the medications and he readily complies. You explain it will take a few minutes to start working, but he will start feeling better. Actually, John calms down almost immediately after your explanation, and a half-hour later, he is almost fully compliant and calm with the psychiatric nurse, and he agrees to an observation period in the emergency department.*

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**Emergency Treatment of Agitation** | continued

## Conclusion

This article outlines current evidence-based practice guidelines to manage the acutely agitated patient. Verbal de-escalation and performing the appropriate investigations for underlying medical causes are important first steps. Haloperidol is rarely a first-line treatment any longer. Patients presenting with agitation can have several different presentations, etiologies, risk factors, and co-morbidities, all of which inform the provisional diagnosis and subsequent medical management of the patient. Management should not end with simply treating the agitation; it should always consider patient specific factors, with the goal of stabilizing the patient to identify and treat the underlying cause of the agitation.

**Conflicts of interest:** None.

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| Generic Name | Trade Name *(Common, Canadian names where possible)* |
|---|---|
| aripiprazole | Abilify |
| asenapine | Saphris |
| benztropine | Cogentin |
| chlordiazepoxide | Librax (*Librium in USA*) |
| chlorpromazine | Largactil (*Thorazine in USA*) |
| clozapine | Clozaril |
| diazepam | Valium |
| haloperidol | Haldol |
| lorazepam | Ativan |
| loxapine inhalation | Adasuve in USA |
| lurasidone | Latuda |
| olanzapine | Zyprexa |
| quetiapine | Seroquel |
| risperidone | Risperdal |
| ziprasidone | Zeldox (*Geodon in USA*) |

## References

Allen, M.H., Citrome, L., Pikalov, A., et al (2017). Efficacy of lurasidone in the treatment of agitation. *General Hospital Psychiatry, Jul* (47): 75–82.

Arendt, M., Rosenberg, R., Foldager, L. et al (2005). Cannabis-induced psychosis and subsequent schizophrenia-spectrum disorders: follow-up study of 535 incident cases. *British Journal of Psychiatry, Dec* (187): 510–515.

Balan, Y., Murrell, K. and Lentz, C. (2018). *Big Book of Emergency Department Psychiatry: A Guide to Patient Centred Operational Improvement.* New York, NY: CRC Press.

Boudreaux, E.D., Allen, M.H., Claassen, C. et al (2009). The Psychiatric Emergency Research Collaboration-01. *General Hospital Psychiatry 31(6): 515–522.*

Bui, Q. M., Simpson, S., Nordstrom, K. (2015). Psychiatric and Medical Management of Marijuana Intoxication in the Emergency Department. *Western Journal of Emergency Medicine, 16*(3): 414–417.

Gottlieb, M., Long, B., and Koyfman, A. (2018). Approach to the Agitated Emergency Department Patient. *The Journal of Emergency Medicine* Jan 29; epub: 10.1016/j.jemermed.2017.12.049.

Hall, R.C., Gardner, E.R., Popkin, M.K. et al (1981). Unrecognized physical illness prompting psychiatric admission: a prospective study. *American Journal of Psychiatry, 138*(5): 629–635.

MacDonald, K., Wilson, M., Minassian, A. et al (2012). A naturalistic study of intramuscular haloperidol versus intramuscular olanzapine for the management of acute agitation. *Journal of Clinical Psychopharmacology, 32*(3): 317–322.

Richmond, J.S., Berlin, J.S., Fishkind, A .B. et al (2012). Verbal De-escalation of the Agitated Patient: Consensus Statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup. *Western Journal of Emergency Medicine, 13*(1): 17–25.

Roncero, C., Ros-Cucurull, E., Palma-Alvarez, R.F. et al (2017). Inhaled Loxapine for Agitation in Intoxicated Patients: A Case Series. *Clinical Neuropsychopharmacology, 40*(6), 281–285.

Stahl, S.M., (2013). *Stahl's Essential Psychopharmacology: Neuroscientific Basis and Practical Applications 4th* ed. New York, NY: Cambridge University Press.

Stahl, S.M. (2017). *Prescriber's guide: Stahl's Essential Psychopharmacology 6th ed.* New York, NY: Cambridge University Press.

Wilson, M.P., Pepper, D., Currier, G.W., Holloman Jr., G.H. and Feifel, D. (2012). The Psychopharmacology of Agitation: Consensus Statement of the American Association for Emergency Psychiatry Project BETA Psychopharmacology Workgroup. *Western Journal of Emergency Medicine, 13*(1): 26-34.

Zun, L. (2016). Care of Psychiatric Patients: The Challenge to Emergency Physicians. *Western Journal of Emergency Medicine 17*(2): 173-176.

# Timely Help

## A review of *Bipolar Disorder, 2nd edition*

Robert P. Reiser, M.D. et al. Boston: Hogrefe Publishing, 2017; 108 pp. $39.95

Vivian Chow, MD

Full disclosure here: The publisher of this book approached the *MPR* about having this book reviewed. I jumped at the chance because I wanted to learn more about treating bipolar disorder and thought that, at only 108 pages, it would be a quick read. I couldn't have been more wrong. Though this book is short, it is really dense and dry. I picked up this book thinking I could whiz through it and get some tips for treating my bipolar patients. Instead, I found that, without context, the book lacked relevance. After several false starts, I finally found a very good reason to persevere and finish reading this book.

At the time of my initial reading early last year, all of my bipolar patients were stable and responding really well to atypical anti-psychotics. Their sessions with me involved helping them problem solve current issues and maintain a euthymic state by reviewing cognitive behavioural therapy (CBT) techniques. But then last fall I started seeing a rapid-cycling bipolar patient—it was he who provided the motivation to read this book to the end. This was my first experience in a long time with an unstable bipolar patient, and certainly my first experience with a rapid-cycler. This 40-ish male, off work on disability, had suffered from a concussion 2 years previously, which triggered the rapid-cycling.

The book is divided into 4 main sections. The first section, entitled "Description," basically explains how to make the diagnosis and gives background information about the illness. The second and third sections,

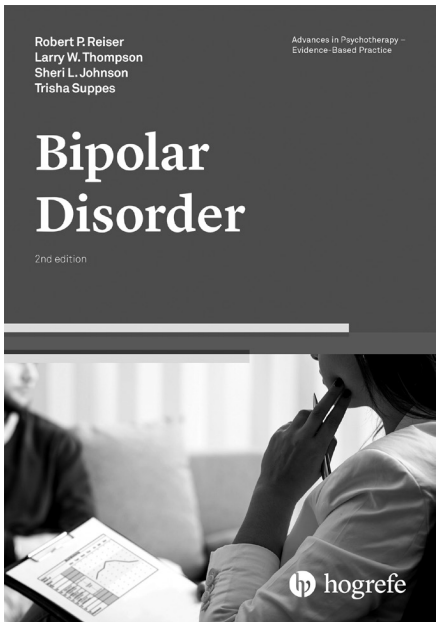


Image courtesy of Hogrefe Publishers

"Theories and Models of Bipolar Disorder" and "Diagnosis and Treatment Indications," are brief and explain the styles of psychotherapy that can be used and how to determine which treatment style to use. As my patient already had a Family Doctor and a Psychiatrist managing his medications, the first two sections were not necessary for my care of him and the third section only helped re-inforce the benefits of CBT. The fourth and last section is "Treatment," which I found the most useful.

The Treatment section is practical and, as stated above, follows a CBT approach. I have been able to incorporate some of the suggestions from this book into my own practice. The treatment is divided into three sections: "The Initial Phase of Treatment," "The Middle Phase of Treatment," and "The Final Phase."

The Initial Phase focusses on establishing a rapport with the patient by being collaborative. This involves setting goals and making agendas at every session and stressing the importance of doing homework. I have seen my new patient several times and have established a therapeutic alliance. I could be a bit stricter with sticking to an agenda, but he has been compliant with doing his homework.

The Middle Phase involves skill building. The first skill is to monitor mood, thoughts, and behaviours to help the patient be more self-aware and hopefully to be able to take action before episodes become severe. Also, with more self-awareness, if the patient is unable to prevent a severe episode, he or she could engage in techniques to mitigate the episode. In the case of my patient, we have started using the charts to monitor and identify symptoms of early, middle, and late depression and mania. Using this information, we will work our way into the cognitive and behavioural components of therapy, and try to help my patient reduce the negative impacts of his illness.

The cognitive part of the therapy is pretty straight-forward and involves using thought records to help with cognitive restructuring. The behavioural part of the therapy emphasizes maintaining social contact, keeping a regular sleep schedule, and generally engaging in helpful behaviours.

The Final Phase is about "maintaining

treatment gains." It will be some time before I reach this stage with my patient, but I am looking forward to helping him remember his skills, identify triggers, use his coping techniques, and be able to recognize and deal with early warning signs.

What I find most helpful is the Appendix at the end of this book. CBT involves a lot of paperwork, but as much as I like using forms and charts, I don't want to inundate my patients with useless ones. I really appreciate practical, helpful forms, and I find that *Bipolar Disorder* provides them. I have been using the Mood Chart and Identifying Signs chart with some success. I am about to start using the activity forms.

I think this book works best as a reference book. I would recommend it to all psychotherapists and any health professional that treats bipolar patients.

**Conflicts of interest:** None.

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

# No One Left Behind

## A review of *Much Madness, Divinest Sense: Women's Stories of Mental Health and Health Care*

Edited by Nili Kaplan-Myrth MD, CCFP, PhD and Lori Hanson MSc, PhD

Lawrencetown Beach, Nova Scotia: Pottersfield Press 2017; 224pp; $17.15

Alison Arnot, MD, MDPAC, FCFP

I volunteered to review this book in April, 2017 when it was first released from the publisher. I was intrigued by the title, which I did not recognize as the modified first line of an Emily Dickinson (1890) poem. It reads as follows:

> *Much Madness is divinest Sense –*
> *To a discerning Eye –*
> *Much Sense – the starkest Madness –*
> *'Tis the Majority*
> *In this, as all, prevail –*
> *Assent – and you are sane –*
> *Demur – and you're straightaway dangerous –*
> *And handled with a Chain*

The book was born from Dr. Kaplan-Myrth's frustration at the lack of support for women who were struggling with complex mental health needs. Realizing that many women who most needed help were unable to access it through conventional psychiatric care delivery models, she put out a call for women to share their stories and break the silence about "the polluted, heart-wrenching, stigmatized, messy subject that is mental illness" (p. 14). The story tellers are given the opportunity to speak their truth without interruption or evaluation. There is no attempt to fit them into diagnostic categories or to pathologize behaviour that can be understood as a legitimate response to difficult circumstances. The stories stand on their own merit and each writer is a wise teacher.

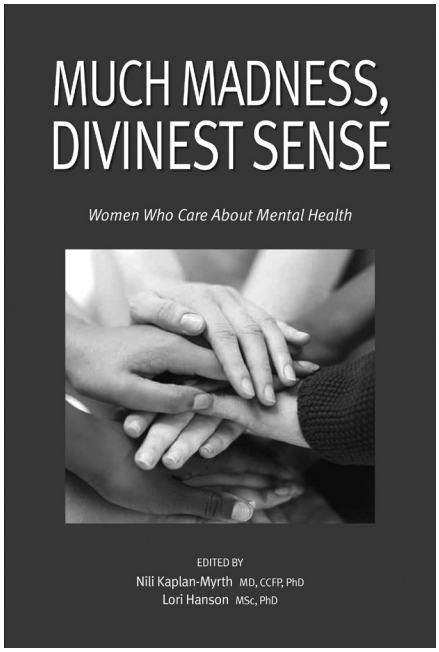


Image courtesy of Pottersfield Press

I heard the truth of my own experience spoken in the stories told by health care professionals. They bravely addressed the negative impact of prolonged toxic stress, workaholism, relentless people-pleasing, and difficulty admitting vulnerability. My heart was broken by stories of loss and isolation. It was warmed by stories of love and connection. I was deeply angered by stories that documented lack of care due to stigma and systemic discrimination.

Section Three of the book is entitled "Care for (a) Change." It is a call to action. Each author offers solutions for transforming the health care of women. Two essays address the (lack of) mental health care for indigenous people in the correctional system. Julie Strong, a family doctor in Nova Scotia, shares her perspective on the mental health system after 35 years of medical practice. She notes that many of her patients have developed anxiety and depression as a result of childhood trauma that has gone unrecognized and untreated. While medication can be helpful, what her patients really need is access to long-term psychotherapy services. She bravely shares the self-care strategies she engages in so she can continue to serve her patients with compassion. Other authors challenge the role of the pharmaceutical industry and the medical model of mental illness as presented in the DSM. We read persuasive arguments for access to trauma-informed maternity and child care, and also for removing the systemic barriers to safe housing, nutritious food, and support services that single mothers face in Newfoundland.

The women who contributed to this book help us to understand the importance of personalized, longitudinal care that honours their needs for safety and connection over the lifespan. It is just this kind of care that we, as medical psychotherapists, are trained to provide.

Read it to remember why you were called to do the work you do. Read it to have your passion for your work rekindled. Read it to understand the ongoing need for self-care. Read it so you can be the change you want to see in the world.

**Conflict of interest:** None

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*Alison Arnot is a medical psychotherapist with a focused practise in substance use and concurrent disorders. She works in Mississauga, Ontario. She is currently learning about the IFS approach to psychotherapy. She has been an active member of MDPAC since 2011 and currently sits on the Board of Directors.*

**Reference**

Dickinson, Emily (1890). *Much madness is divinest sense.* Public domain.

# The Forest

Zada, J. (director) (2016) *The Forest* (motion picture). United States, Gramercy Pictures.

David J. Robinson MD, FRCPC

Aokigahara is a thirty square-kilometer forest, northwest of Mount Fuji, Japan. It is widely known as "The Suicide Forest" and often ranked as the second most common spot in the world for completed suicides, next to the Golden Gate Bridge in San Francisco. (Of interest to Canadians, Toronto's Prince Edward Viaduct, also known as the Bloor Viaduct, is routinely listed in the top five sites worldwide.)

The forest grows on magnetic, volcanic rock and the tortuous tree roots are above ground in many places. The trees are densely packed and block the wind, creating an eerie silence accentuated by sparse wildlife. Due to the high iron content of the soil, many electronic devices are ineffective and compasses spin without yielding any helpful information. Japanese myth and lore add to the mystique of Aokigahara, and it is said that *yurei* (mournful or vengeful spirits of the deceased) haunt the forest. *Ubasute*, the historical practice of leaving infirm or elderly relatives to perish in the forest likely contributes to the unsettled feeling many people get there.

Aokigahara is a popular destination, with marked trails and caves. There are many signs in the forest deterring visitors from leaving the trails, and others that provide positive messages designed to make potentially suicidal visitors reconsider their fate. Those who do not are able to hide very effectively and are not often found alive. Bodies typically are removed only once per year to provide a formal burial and official notification of next of kin. Hanging is the most popular method in Aokigahara, with images of the deceased and their abandoned possessions readily available on the Internet. What better setting for a suspense film?

*The Forest* stars Natalie Dormer primarily as Sara Price, but also as her identical twin, Jess. Despite their shared genetics, they have turned out to be quite different people, with Sara being the more stable of the two. We become aware of Jess when she disappears from her teaching job. Sara has a habit of coming to her sister's aid. She learns that Jess had taken her class to visit Aokigahara and hasn't been seen since. We learn that Jess has attempted suicide before, raising the concern that she succumbed to the lure of the forest. Sara meets up with Aiden (Taylor Kinney) who agrees to help her search the forest in exchange for learning about her past and being able to write about her hunt for Jess.

Sara recounts the death of her parents, but changes major details. She and Jess were orphaned at an early age, but not because of the drunk driver that Sara tells Aiden about. Her father shot her mother and then took his own life while the girls were in the house. Jess saw what happened, while Sara's eyes were shielded by her grandmother's hand. This difference becomes the defining moment in the divergence of their lives.

Sara is warned not to go into the forest, not to leave the trail, and not to stay overnight, but she disregards all of this advice. She is told the *yurei* will peer into her soul, see her sadness, and amplify it to the point where she becomes suicidal. Perhaps this is what happened to Jess, but viewers are not really shown what led to her prolonged stay in Aokigahara.

Jess's potential for suicide is ratcheted up when we learn that her favourite poet is Sara Teasdale, who took her life with an overdose in 1933 after having experienced several significant losses. Jess took her favourite collection of Sara Teasdale's poetry with her into the forest, the book having been given to her by her sister Sara. As Sara explores the forest, things predictably start to go awry. She finds Jess's tent, which the guide tells her is a clear sign of ambivalence regarding suicide. The people who take tents are there to contemplate their lives, so Sara insists on staying overnight in the hope of finding Jess.

Sara begins to have auditory and visual hallucinations. Are there real people in the forest who have valuable information about Jess, or is she succumbing to the tricks of the *yurei*? Is the forest a dangerous place for a seemingly stable person who harbours a tragic past? Is she delirious from an infection? Is Aiden drugging her with the food he provides her? Events go from bad to worse, with Sara not being able to trust her own senses, let alone Aiden or any of the information she obtains. She gets injured and disoriented, becoming increasingly psychotic the longer she stays in the forest.

The Forest is an excellent "descent into madness" depiction, showing what can happen to seemingly stable people under the wrong circumstances. However, it was not a critical nor a financial success, since like Sara, the plot seems to unravel as the movie progresses. It is part suspense, part horror, part psychological study but it doesn't provide a satisfying treatment of any one of these themes. However, one possible inter-

pretation, which makes the film far more intriguing, is that there is no twin but instead a dual nature to the main character. Sara is the more stable, predictable version, with Jess emerging at times of stress or to undermine periods of progress. The strange events in Aokigahara cause Sara/Jess to unravel to the point where she re-experiences the original trauma of seeing her deceased parents and is in a better position to deal with it, fusing the rift that is within her and emerging with a single identity.

A 21-minute documentary can be found on YouTube under the title "Suicide Forest in Japan," which features Japanese geologist Azusa Hayano, who regularly goes into the forest to counsel those who have wandered off the path. This documentary is filled with sympathetic insights, accurate information and footage of the actual forest.

Despite the shortcomings in *The Forest's* plot development, it is a fascinating introduction to an actual place, a credible portrayal of psychosis, and an excellent springboard for discussing various factors related to suicide, particularly from a viewpoint of other cultures.

**Conflicts of interest:** None

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

# Report from the MDPAC Board of Directors

Catherine Low, MD, MDPAC(C)

This will be my final Report from the Board of Directors; my term comes to an end at the AGM in May 2018. I am very grateful for the six years that I have served on the Board. The opportunity to volunteer came into my life when I was feeling particularly isolated and in need of support in both my professional and personal lives. At the beginning of my first year on the Board, I was diagnosed with breast cancer. In my third year, I went through a marriage break up. In my fourth year, I went through the upheaval of moving both my home and my practice from Belleville to Ottawa.

Throughout these changes, members of MDPAC were there to support me. They encouraged me by their words as well as their actions, whether it was a quick phone call to ask how I was doing or the offer of a hug or the gift of cooking me supper. As a result, I learned a lot about the strength we have in this community and how fortunate we are to have this association. I can't imagine practising psychotherapy without the support of colleagues who understand how demanding it is to do the work that I do.

As I leave the Board of Directors I know that I will continue to find that support through the MDPAC Ottawa Peer Supervision Group. I will also stay involved in the work of the association by joining the Outreach Committee. I am looking forward to representing MDPAC at future events here in Ottawa, both as a volunteer at the MDPAC booth at the Canadian Psychiatric Association annual conferences and also as the MDPAC representative to the Canadian Alliance for Mental Illness and Mental Health.

Having seen how far we have come, I am excited to see how MDPAC will evolve over the coming years. I recall the days of Roy Salole and the establishment of the OMA section for Primary Care Mental Health (then called the Section for GP Psychotherapy). Then there were the days of Lynn Marshal and members of her Professional Development Committee, who established the document "Guidelines for Psychotherapy by Physicians." Then the days of Muriel van Lierop and Howard Schneider approaching the CPSO for the first time about becoming the Third Pathway. After that came the Visioning Weekend in 2011 (Toronto), when Ted Leyton, Elizabeth Parsons and others met to establish a five-year plan for our association. Elizabeth then went on to establish the MDPAC Annual Retreat, which has become a sold-out success and is now entering its seventh year. There has also been the establishment of Outreach Committee booths at the national conferences of both the College of Family Physicians Canada and the Canadian Psychiatric Association.

More recently, I have seen the days of Brian McDermid and the push to rebrand the association in 2015. Then there was the establishment of the new website with an online members' directory and online access to local groups for peer support and supervision. Most recently, there has been the re-emergence of the Basic Skills Core Curriculum in the form of the MDPAC Psychotherapy Training Program. Coming up are the results of four years of work by Caroline King, Stephen Sutherland, and the other members of the Professional Development Committee to establish expanded guidelines for our CPD that keep us up to date with those of the Royal College and the College of Family Physicians.

In the midst of all these changes, we have started using internet technology in the form of Zoom to offer distance learning to members across the nation. We have also recently reached out to link with other national organizations such as the Canadian Group Psychotherapy Association and the Canadian Alliance for Mental Illness and Mental Health in order to raise our national profile.

All of these activities will result in an increased visibility for MDPAC as well as for all physicians who include psychotherapy as a part of their practice. As an active and growing association, we will continue to provide support for self-care activities among our members through the Listserv and our Annual Retreat to ensure that we stay healthy and are not in danger of harming those whom we seek to help.

It has been an honour to witness all these changes and as I say goodbye, I would encourage everyone to get involved with MDPAC at some level beyond simply paying their dues. This association has so much to offer each of you and, as with everything in life, the more you put into it, the more benefits you will reap.

**Conflict of interest:** None

**Contact:** mclow98@gmail.com

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*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 low-risk obstetrics, and continued in Ottawa where work with immigrant women and patients recovering from addictions led to her interest in psychotherapy. She currently practises full-time medical psychotherapy in Ottawa.*

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