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GP psychotherapist

Journal of the General Practice Psychotherapy Association

From the Board – September 2011 • By Muriel J. van Lierop, MBBS, MGPP

The GPPA Annual Educational Conference with the theme of ***Trauma and Attachment – Foundations for a Healing Paradigm*** was held for two days at the end May, 2011. This was very well attended and had registrants from Ontario as well as Saskatchewan, Newfoundland, Alberta, the USA. Seventy percent of the registrants completed an evaluation and of these, seventy-five percent are practising psychotherapy full-time and twenty-five percent are practising psychotherapy part-time in their General or Family Practice. Plans are now underway for the 2012 GPPA Annual Educational Conference.

The GPPA Steering Committee is following-up on the Five-Year Plan for the Strategic Initiatives created at the Strategic Planning and Visioning Meeting of February, 2011. Two new Committees have been formed. The first is the Outreach Committee which includes the concept of establishing a Therapy Web Voice. The second is the Research Committee which is also looking for an established researcher to guide the initiative. Other initiatives have been given to existing committees to develop: ***Online or Telephone Mentoring Initiative + Group Retreat Initiative + To Set Up Local Groups for Study/Personal Growth Initiative*** have been given to the Education Committee, and ***The Streamlining of the Process for Certificant and Mentor Initiative*** has been allocated to Professional Developmental Committee.

The GPPA received an invitation from the College of Physicians and Surgeons of Ontario (CPSO) to participate in the CPSO Preliminary Consultation: Medical Records Policy to give suggestions to up-dating the Patient Encounters Where the Focus is Psychotherapy. The CPSO Medical Records Policy is being reviewed for September 15, 2011. The GPPA Board asked the Guidelines Task Force to help with this request and they developed excellent recommendations very quickly considering the amount of work that was involved.

This newsletter has been renamed the *GP Psychotherapist - Journal of the General Practice Psychotherapy Association* and will soon be up on the website for easy access.

You will receive this just at the time that you will be renewing your membership in the GPPA. We trust that you have entered all your educational activities into our web application which you can reach through the GPPA website. **September 30, 2011 is the end of the 3 year cycle and all required credits need to be entered into the website by October 15, 2011.** Continuing Professional Development (CPD) as it is called by the CPSO - we call it Continuing Education (CE) and Continuing Collegial Interaction (CCI) – is considered very important both by the GPPA and the CPSO. In the future, evidence of having done CPD may be required for the renewal of your medical licence.

Renewal time is also an excellent time to consider joining a GPPA Committee if you are not already a member of one. It is a great way to get to know other members and also obtain CCI credits. If you are an Associate Member consider becoming a Clinical Member so you can join a committee. The list of possibilities is on the last page of the *Journal*.

Inside

From the Editor • *By Howard Schneider MD, CGPP, CCFP*

We start off this issue of the *GP Psychotherapist* with the Theratree 2011 Award, given this year to Dr. Victoria Winterton, in recognition of inspired contributions to the organization in leadership and expertise. We then move on to the Diagnosis and Management of Borderline Personality Disorder. This disorder is thought to have a prevalence of about 4% in the community, and as much as 20% in many clinical psychiatric populations. As medical psychotherapists, regardless of our practice interest, we see and treat these patients.

Borderline Personality Disorder can be approached from substantially divergent angles, from the neuropsychiatric to the psychoanalytical. In this issue's article on the subject we make an attempt to present the diagnosis and management of Borderline Personality Disorder from what can empirically be taken as a mainstream point of view, the lectures presented by Dr. Joel Paris at the 2010 Canadian Psychiatric Association Annual Conference. However, to balance this view, Harry Zeit and Norman Steinhart have written invaluable commentaries on the article and on the subject of Borderline Personality Disorder.

We then continue with a thought-provoking Book Review by psychiatrist and psychotherapist Anne Rose on Joyce's *Termination in Psychotherapy – A Psychodynamic Model of Processes and Outcomes*. As Dr. Rose notes, for the the patient, the termination of psychotherapy can bring a resurgence of the issues that were addressed in the treatment. However, if handled well, termination of psychotherapy can reinforce the positive improvements the patient has achieved.

The issue then moves on with a short article by Victoria Winterton on her recent work in bringing Psychotherapy into the Special Interest or Focussed Practice (SIFP) of the College of Family Physicians of Canada (CFPC). The issue then concludes with its 'Psychopharmacology Corner'. As medical psychotherapists, whether we prescribe or not, we are expected to be familiar with current psychopharmacotherapy. Stephen M.Stahl, the psychopharmcologist's psychopharmcologist, has released a case book of patients he has treated. Where space permits in the *GP Psychotherapist*, I will take one of his cases, and in a compact fashion try to bring out the important lesson to be learned.

Theratree Award 2011

Dr. Victoria Winterton was presented with the Theratree Award at the 2011 GPPA Annual Conference. This award is presented in recognition of inspired contributions to the organization in leadership and expertise. Vicky has served on the Board of Directors of the GPPA since 2005 and provided leadership as President for the years 2007 to 2009. She has served as the Secretary of the GP Psychotherapy Section of the OMA, as past Chair of the Certificant Review Committee of the GPPA, and is currently working to enhance our position with the College of Family Physicians of Canada. As a member of BESTCO, Vicky provides mentorship and training in sexual therapy. We also acknowledge her warmth, humour and insight which have made it all seem effortless, and which we value so much.

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For letters and articles submitted, the editor reserves the right to edit content for the purpose of clarity. Please submit articles to: howard.schneider@gmail.com.

Diagnosis and Management of Borderline Personality Disorder

- *By Howard Schneider[1] MD, CGPP, CCFP, and Robert Tarzwell[2], MD, FRCPC*

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Borderline Personality Disorder can be approached from substantially divergent angles, from the neuropsychiatric to the psychoanalytical. In this article, the diagnosis and management of Borderline Personality Disorder is presented from a mainstream point of view of Dr. Joel Paris, based on a series of lectures presented at the 2010 Canadian Psychiatric Association Annual Conference. The DSM is syndromal and thus permits comorbidities. BPD is often comorbid with depression, which Paris does not find meaningful in view of the low threshold for Major Depressive Disorder criteria. Although BPD unfortunately has a 10% completed suicide rate, patients do continue to improve with age, so that by age 50 years old only 8% of BPD patients still meet the criteria, and have mild symptoms with an average GAF of 63. The most dramatic improvements are in relationships, but many patients still show residual symptoms of dysthymia. The evidence base for psychopharmacological management of BPD is considered weak. All agents tend to primarily reduce impulsivity and no psychopharmacological agent produces remission. SSRIs and low-dose neuroleptics may be the most conservative choices. The best evidence for psychotherapeutic management of BPD is Cognitive Behavioral Therapy (CBT) and Dialectical Behavioral Therapy (DBT).

While Borderline Personality Disorder was described in the 1930s by Adolf Stern in patients who did not do well in psychoanalysis, it was not popularized until the 1960s by Otto Kernberg, and it did not enter the DSM-III until 1980. In the Editorial of the American Journal of Psychiatry two years ago (Kernberg 2009), Dr. Kernberg notes, "we have made tremendous strides in only a few decades, beginning with a theoretical concept in psychoanalysis that was ridiculed by most other psychiatrists, and progressing to a widely recognized clinical entity; from a pejorative label for disliked patients to a carefully defined diagnostic category; from the subject of almost no systematic study to one of the most intensively researched personality disorders…. That is the good news, but there is also much that is not yet good news—questions to be answered and things that we have yet to learn. There is also the residue of professional bias against the diagnosis and, unfortunately, stigma for those who suffer from it, that has hampered progress in the field."

Dr. Kernberg notes that Borderline Personality Disorder has a prevalence of about 4% in the community, and as much as 20% in many clinical psychiatric populations. As medical psychotherapists, regardless of our practice interest, we see and treat these patients.

Despite the progress that Kernberg describes, Borderline Personality Disorder can still be approached from substantially divergent angles, from the neuropsychiatric (eg, Schneider 2011) to the psychoanalytical (eg, Kernberg 2008). In this compact article, we present the diagnosis and management of Borderline Personality Disorder from a very mainstream point of view of Dr. Joel Paris, a psychiatrist from McGill University and currently the Editor of the *Canadian Journal of Psychiatry*. Dr. Paris has extensive experience in the research and treatment of Borderline Personality Disorder (Sadikaj 2010, Paris 2010). This article is based on a series of lectures presented by Dr. Paris at the 2010 Canadian Psychiatric Association Annual Conference.

In 1975 John Gunderson (Gunderson 1975) showed how we could define Borderline Personality Disorder (BPD) in terms of observable features. In 1980 BPD entered the DSM-III and considered impulsive (self-damaging, recurrent suicidal, inappropriate anger), affective (affective instability as opposed to a mood episode, emptiness) and interpersonal criteria (efforts to avoid abandonment, unstable interpersonal relationships, identity disturbance). According to Paris up to half of patients can have transient auditory hallucinations at moments of intense upsets, and indeed in the DSM-IV a ninth criteria concerning such cognition (transient paranoia or dissociation) was added.

The DSM-IV (APA 2000) diagnosis of Borderline Personality Disorder requires 5 out of the 9 following criteria:

1. Frantic efforts to avoid real or imagined abandonment.
2. Pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
3. Unstable self-image or sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging.
5. Recurrent suicidal behavior, gestures or threats, or self-mutilating behavior.
6. Affective instability due to a marked reactivity of mood (lasting a few hours and only rarely more than a few days).

continued on page 4

7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger.
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

Paris notes that the research criteria of BPD involves a diagnostic interview and scoring in the following categories with a 8+/10 cut-off defining a more characteristic group of patients:

-Affective (0-2)
-Cognitive (0-2)
-Impulsive (0-3)
-Relationship (0-3)

At present many patients do not meet the full criteria for BPD but rather fall into the most common personality disorder category – NOS (301.9 Personality Disorder Not Otherwise Specified). In the DSM-V, Paris notes that there will be scoring on trait dimensions for personality disorders, which will help us to conceptualize NOS patients.

The DSM is syndromal and thus favors comorbidities. BPD is often comorbid with depression, which Paris does not find meaningful in view of the low threshold for Major Depressive Disorder criteria. Most BPD patients are 'depressed' at the time of clinical presentation, and indeed, BPD often presents at puberty with dysthymic symptoms. However, the depression in BPD differs from melancholia in that it lacks the classical vegetative features, often it is reactive to environmental stressors, often it manifests as a chronic dysphoria and unfortunately it responds more poorly to antidepressants (Paris 2009).

While Bipolar Disorder (BD) also involves mood swings, in BPD mood swings are very rapid, often a matter of hours, and often in response to the environment. Anger is more prominent in BPD than the 'highs' seen in BD. Mood stabilizers according to Paris have little effect. In Bipolar II Disorder, while mania is not required, the hypomania required must be for at least four days, something which is often not seen in BPD.

The pseudohallucinations of BPD differ from the more chronic paranoid hallucinations seen in schizophrenia. BPD is not a form of Post-Traumatic Stress Disorder. Dr. Paris argues that there is actually a lack of good evidence that stressors cause BPD, and that BPD symptoms are not explained by trauma (Zweig-Frank 2006). Dr. Paris goes on to note that BPD is not, as well, a form of Attention-Deficit Hyperactivity Disorder (ADHD).

The prevalence of BPD varies from less than 1% to 6% of the population, depending on the study. Dr. Paris notes that the prevalence of males equals females, but the males do not seek help as often, and in clinical samples, 80% of patients are female. Most cases of BPD we see are less than 40 years old because BPD peaks in youth and gets better with age.

In twin studies of BPD, about 50% of the variance is accounted for by heritable factors, and indeed, the personality traits of BPD (ie, impulsiveness, affective instability, cognitive abnormalities) are heritable. Environmental factors (we must remember that being in the same family does not necessarily mean the same environment) accounts for the other 50%. Thus Paris notes that the genetics of BPD partly contradicts the idea that parenting so strongly shapes personality.

Although not discussed by Paris, there is a large literature on the various psychological factors that may be responsible for symptoms seen in BPD. For example, Aaronson 2006 at Mount Sinai School of Medicine in New York, has scientifically compared attachment styles of BPD with other disorders.

Serotonin activity is a biological marker to some extent for BPD. Impulsivity is inversely related to serotonin activity. The most common disorders in primary relatives of BPD patients are Substance Abuse and Antisocial Personality Disorder, supporting an impulsive etiology.

Dr. Paris notes that neuroimaging lacks specificity for BPD. However, he notes that in PET scans there is decreased activity in the anterior cingulate gyrus (ACG) and decreased activity in the prefrontal cortex (PFC). In fMRI scans there is increased activity in the amygdalae and decreased activity in the PFC. Indeed, in neuropsychological testing, PFC defects (executive function) are found in BPD patients.

Dr. Paris notes that adverse childhood experiences are retrospective and subject to recall bias – patients remember bad memories because they are depressed. And indeed, there are few prospective studies to see which children go on to develop BDP. Up to 70% of patients with BPD report some form of childhood abuse, but most sexual abuse incidents are of mild severity, ones which do not lead to sequelae in community studies, as opposed to extended, multiple incidents which are better shown to cause damage. Paris notes that it is still a research issue finding the relationship between childhood adversities and BPD development (Zweig-Frank 2006). With regard to other factors, Paris points out that cross-cultural research suggests that BPD appears with modernization and urbanization.

Although BPD unfortunately has a 10% completed suicide rate, patients do continue to improve with age, so that by age 50 years

continued on page 5

old only 8% of BPD patients still meet the criteria, and had mild symptoms with an average GAF of 63. The most dramatic improvements are in relationships, but many patients still show residual symptoms of dysthymia. Nonetheless, only about a third of patients are living with a partner, and over half have no children. Paris notes that BPD actually has a better prognosis than many other mental disorders but don't expect high functional levels.

Despite the improvement with age, the average age of completed suicides is ironically 38 years old -- much older than the patients who we commonly see presenting with suicidal threats. Although females attempt suicide more often, the males complete the suicide more often. Cutting is not suicidal in intent – it functions as a means of emotional regulation. Substance abuse is a predictor of an increased risk for suicide completion. However, the majority of completed suicides occur with first attempts with little warning.

Paris notes that there is no evidence that hospitalization prevents suicide. Hospitalization is indicated for a life-threatening suicide attempt or a psychotic episode. Hospitalization is not indicated for wrist cutting, mild overdoses or chronic suicidal threats. An advantage of day hospital over a hospitalization is that it avoids regression, it is structured and it is evidence-based as to helping BPD patients. To avoid litigation, rather than hospitalize, consider keeping good medical records and document as much as possible, explain one's rationale for management, get consultations and involve the patient's family.

Dr. Paris feels the evidence base for psychopharmacological management of BPD is weak (Paris 2009). He notes that all agents actually were developed for other purposes. Neuroleptics can have an anti-impulsive effect in low doses, as well as their usual dose antipsychotic effects. However, Paris advises to consider the adverse effects before using. SSRIs also have some anti-impulsive effects, and as well can take the edge off low mood. Lithium is not indicated. Valproate, topiramate and lamotrigine have a mild anti-impulsive effect but little effect on mood. Not discussed by Paris, a recent study by Ingenhoven 2010 did meta-analyses of RCTs (randomized controlled trials) of pharmacotherapy for severe personality disorders. Mood stabilizers had little effect on depressed mood, but they did have a large effect on impulsive-behavioral dyscontrol, anger and anxiety.

Benzodiazepines may be useful for short-term use in BPD. However, there is little good evidence-based literature. Try to avoid using the fast acting benzodiazepines which can be addictive. Clonazepam is less addicting.

Paris notes that all agents tend to primarily reduce impulsivity and no psychopharmacological agent produces remission. He notes mood stabilizers, unfortunately, do not stabilize mood in BPD. There is no evidence that augmentation with additional agents leads to remission either. Dr. Paris feels that SSRIs and low-dose neuroleptics are the most conservative choices. He notes the patients usually receive medications, unfortunately, because psychotherapy is unavailable.

Psychotherapy options range from no psychotherapy to long-term intensive psychotherapy. Paris advocates an intermittent psychotherapy. The best evidence for psychotherapeutic management of BPD is Cognitive Behavioral Therapy (CBT) and Dialectical Behavioral Therapy (DBT).

Long-term Dynamic Therapy does not appear to be consistently effective. It is problematic in that it has a lack of structure and a focus on childhood which can be regressive.

In Mentalization-Based Therapy (MBT) there is work on the ability to observe feelings in one's self and in others, which is assumed to be deficient in BPD patients. This psychotherapy is more cognitive than dynamic, and has proven effective in outpatient settings.

Transference Focused Therapy is based on clarifying distortions in the psychotherapeutic relationship. A 2007 study actually showed results comparable to DBT.

In 1987 Linehan introduced Dialectical Behavioral Therapy (Linehan 1987). It has been subjected to controlled studies and has been shown to be superior to 'treatment as usual' as well as treatment by community experts. However, of interest, Paul Links (McMain 2009) found that a *structured* psychotherapeutic program, which did not necessarily have to be DBT, produced equivalent results to a DBT program.

Goals of DBT are to decrease suicidal behaviors, to decrease therapy interfering behaviors, to increase problem solving skills, to learn to recognize when one is upset, to learn distress tolerance and of course to improve emotional regulation. There is a validation to the patient's world, but a 'dialectical' approach is taken towards change.

In open trials (Wenzel 2007) Beck showed the effectiveness of CBT. The "Montreal Approach" is a 12 week group-based CBT program, although there can be up to two years life skills training for chronic cases.

continued on page 6

Another Canadian psychiatrist with an interest in BPD, David Dawson (Dawson 1993) developed and advocated an approach he termed, "Relationship Management," which has been the subject of some encouraging research. The therapist specifically listens to the spoken words of the patient with a view to determining the implicit communication process, since responding in a direct fashion, or using traditional psychotherapeutic approaches is, "fraught with peril."

Paris concludes that there really is not overwhelming evidence that any one particular psychotherapy is dramatically effective for BPD. He advises to avoid therapist burnout by realizing that it is a chronic disorder and not everyone gets better.

Thanks to Dr. Norman Steinhart for helpful comments.

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Comment on "Borderline Personality Disorder" Article

- *By Harry Zeit, MD, DABEM (Diplomate of the American Board of Emergency Medicine)*

"Tell us about that time when you were three months old and you had to sequester your unbearable shame or rage or terror, and then placed your dissociated affect next to your hypothalamus, in the lower right hemisphere, and tell us about how it's been throwing off your future development and your neuroendocrine and immune function ever since. And about how it has epigenetically turned on bipolar affective disorder genes."
--*Harry Zeit, GPPA ListServe 2011*

Psychiatry and Psychotherapy

I recall many years ago reading the reflections of Jeremy Holmes on whether, during an era when the impact of attachment theory on mental health was beginning to be known, psychiatrists and psychotherapists would be able to continue to work comfortably and effectively alongside one another. This point is not lost on McGill psychiatrist Dr Joel Paris, and where better to look at this dilemma than on the great forum of clinical struggle around the treatment of Borderline Personality Disorder (BPD).

Dr Paris is no newcomer to the field of mental health and psychiatry. He has been ploughing through this fertile and unsettled terrain for a great many years, writing prolifically on the subject. He has seen the tension build between psychiatry and psychotherapy over the years, and writes in a way that acknowledges that either side has claimed some ground for themselves while ceding other ground to the other. Courageously, he notes that psychiatry may pay a price for abandoning the teaching of sophisticated therapy training as it has grown to embrace and increasingly rely upon the biological model and psychopharmacology.

In BPD, as described in this issue's article by Schneider and Tarzwell, Dr Paris notes the limited, although certainly important utility of medications. This is a condition where, as noted BPD expert Dr John Gunderson writes "psychosocial interventions remain the primary treatment". As one begins to critically read the work of Paris and Gunderson, there is an understanding that there is a crucial need for psychotherapy in the treatment of BPD, but also that psychotherapy is not necessarily helpful or harmless. Certain types of psychotherapies and certain psychosocial interventions (such as frequent hospitalizations) can be harmful.

Dr Paris proceeds to list the therapies he has found, through review of research, most helpful. These include Marsha Linehan's Dialectical Behavioural Therapy, as well as Mentalization-Based Therapy inspired by the work of U.K. psychoanalyst and researcher Peter Fonagy. He mentions as well transference-focused therapy, a modification of earlier psychoanalytic models that is more geared to the various challenges and pitfalls of treating BPD or complex traumatization.

Revising the Prognosis of BPD

So far so good, and I find myself in general agreement with Dr Paris. But I become more cautious and circumspect when he begins to discuss prognosis. I am reminded of a caution I have heard on and off over the years. Since the DSM diagnosis of BPD rests on meeting a minimum number of diagnostic criteria, remission can be achieved simply by removal of one of those criteria. This certainly does not translate into cure, or even into a permanent improvement in an illness known for its fluctuating course and its burden of suffering on both patient and on those closely involved with the BPD sufferer.

As Fonagy and Bateman note, studies have tended to focus on the removal of those symptoms which are most plastic and most easily removed. They note that "symptoms such as impulsivity and associated self-mutilation and suicidality show dramatic change". These symptoms, like the quasi-psychotic breaks sometimes seen in BPD, make for the flashy displays for which this disorder is renowned. But those symptoms which are most resistant and most likely represent the neural bedrock of the disease, reflecting affective function and regulation, as well as interpersonal functioning, rarely change, *and are rarely the focus of clinical studies.*

A Foot in Two Camps

Eleven years ago, Dr Paris published a book entitled "Myths of Childhood". In an article reviewing this publication the reviewer noted that Dr Paris had quoted the Roman writer Horace, from the first century B.C.

> *Nullius addictus iurare in verba magistri*
> (I am not bound to believe in the word of any master)

At that time, he appeared to be challenging some of the beliefs put forth by various movements, as various as psychoanalytic, feminist and social psychological, concerning the ubiquity of child abuse as a cause of mental illness. In my own reading of a recent interview with Dr Paris, I do not find him quite as adamantly defending the primary influence of heritability as a causal factor in BPD. He seems to equivocate

continued on page 8

some, and to emphasize that very little is known. Is this surprising in a disease for which research funding is almost non-existent[1]?

Yet, at the same time, I see another example of what this reviewer also noted in the earlier work of Dr Paris, a tendency to remain fixed in old paradigms. Can the writer of "Myths of Childhood", so invested in disproving his predecessors, now catch up to the work of contemporary neuroscientists and trauma and attachment experts?

The "New Paradigm"

Allan Schore, the author of *Affect Regulation and the Origin of the Self* continues to offer brilliant descriptions of the pathway to new ways of thinking about psychotherapy, integrating the newest advances of neuroscience into practice. He sums up current thinking in a 2011 webinar, where he discusses how the "emotional transactions between infant and mother imprint themselves into the developing right brain". Pushing back the frontiers of infant research, he notes how the old analytic interest in the oedipal stage (age three to four) is now being supplanted by an interest in the effects of pre-natal environment and the earliest infant development in the first two years of life. The psychoanalytic interest in oedipal emotions such as aggression, sexuality and anxiety has been replaced by current interest in pre-oedipal affects such as rage, shame, disgust and despair. Are these not the primary affects we confront in our daily toils of treating BPD? Schore reminds us that to address these pre-verbal affects, we are challenged to understand and communicate in a manner that pre-dates language and the development of rational verbal and left hemispheric speech.

Ruth Blizard PhD, a noted New York psychologist and writer, has offered that BPD might better be termed *Chronic Relational Trauma Disorder*. She notes "evidence increasingly shows that BPD derives from chronic trauma, neglect and especially, *double-bind relationships* in the family of origin." The hallmark characteristics of borderline personality: affect dysregulation, fear of abandonment, idealization and devaluation, explosive rage and self-mutilation, she notes, can better be understood "as resulting from dissociative fragmentation due to": neuropsychological state changes, disorganized attachment, traumatic re-enactment, post-traumatic magnification of perceived threat and avoidance of overwhelming memories.

So, how important is it that psychiatric researchers such as Paris and Gunderson note, that although physical and sexual abuse are common in BPD, they do not create or invariably accompany the condition (and we may ask the same for similar conditions, such as the also difficult to treat anorexia nervosa)? The current paradigm in psychotherapy appears to be that this kind of "big T" trauma may add another layer to treatment but researchers and clinicians are certainly no longer looking for this kind of trauma as causal. The current focus is on very subtle effects of maternal infant stress and attachment failure, leaving deficits and wounds in an early developing right brain.[2] Looking at mental illness and BPD from this viewpoint, it is no surprise that medications and left brain based therapies will be of limited efficacy and that focus will need to shift to correcting deficits, building skills and gradually enhancing the right brain functions upon which sense of self, affect regulation, mentalization and secure attachment rest.

Implications for Psychiatrists and GP Psychotherapists

Let's return then to the everyday challenges of working with BPD, reminding ourselves of the stormy emotions and the amount of tragic suffering, in both our patients, and sometimes in ourselves. It seems that no matter how much conventional psychiatric and often psychotherapeutic treatment my new BPD patients come in with, my first exposure to their chronic sense of emptiness and primal erupting emotions, reminds me, at a gut level, of what a difficult journey lies ahead.

I find it's generally useful to read books by other BPD sufferers with my patients. Two of my favourites (Van Gelder, Johnson) allow discussion of some of the key features of the condition, such as abandonment anxiety and attraction to the "wrong" partners, while also offering good descriptions of theory and treatment. In *The Buddha & The Borderline: A Memoir*, the author Kiera Van Gelder reminisces after being informed that her first DBT program was not a genuine, accredited program. She expresses her frustration with the system: "The whole system is fucked. I've had my diagnosis for almost half my life and no one told me (about what it means to have BPD) ... I've been on six different medications, and now I discover that the hospital's 'DBT program' is a sham, even as I'm told it's a critical element to helping me get better."

I think what we can take from the literature is, as Dr Paris notes, some psychotherapies are helpful, and some others are harmful. As Fonagy and Bateman note, countertransference reactions can be extremely destructive in treating BPD. What does this imply about the kind of training we receive? For psychiatrists, it demands, as I think is generally accepted, that the treatment of BPD requires multi-disciplinary teams. As Holmes suggested fifteen years ago, this requires excellent communication and co-

continued on page 9

operation between psychiatrists and psychotherapists. For those of us performing psychotherapy, it means – as I think again is generally accepted – that we require sophisticated, carefully supervised training and familiarity with the treatment models that work for BPD. As well, we are expected to embark on the painstaking (and rewarding) personal therapy that allows us to identify and work with our own countertransference reactions.

For the rest of the system, the message is humbling. In my own city of Toronto, as in many other cities, as Dr Paris acknowledges, there just is not access to the kinds of therapy that are known to work. Perhaps that is no surprise to those social researchers who note the stigma of the BPD diagnosis and the disenfranchisement of borderline personality sufferers by the mental health care system, the political systems and the professional colleges through which the political systems exert power on the treating professions.

Epilogue

I've been fortunate to have some humble successes treating BPD and to really learn a great deal from their suffering and from our mutual efforts to work through the core early relational wounds. I've also been fortunate to be exposed to the models that Paris mentions, through notable teachers such as Jon G. Allen and Suzette Boon. I know that, had I relied only on these models, I would have never achieved the progress I did in treatment. Keira Van Gelder, after completing her formal "real" DBT program goes on to do Internal Family Systems therapy, where she begins to identify her various dissociated parts and to integrate them under the guidance of her own developing core Self. In the real world, we will continue to encounter many of our patients, with any diagnosis, to be overladen by "big T trauma". I have found my own training in somatic psychology (through sensorimotor psychotherapy and internal family systems therapy) to have been, ultimately, the tool that has allowed me to work through the most primitive, embodied, frightening and procedural parts of the healing process with my patients.

A new age seems to be dawning on us, where we are informed by structures such as the right and left insulae, and understand that the empathy so crucial to treating conditions such as BPD depend on our own healthy, mindful embodiment (exactly what was lacking in the original caretakers). Unfortunately, clinical research can no longer easily keep up with neuroscientific research, and I know it will be many years before we have meaningful data and how newer trauma and attachment based therapies, more informed by what Daniel Siegel terms the integrated phenomenon of "Mindsight" can be studied. By that time, therapies will continue to evolve as well.

BPD will continue, as Dr Paris knows so well, to challenge all of us, and to encourage us, through our failures, to pursue better treatments and better systems of delivery. Psychiatry, I believe, will not forever be able to live in a divide where the huge impact of social conditions and early relational traumas are denied. Ultimately, they will be called to admit that medications cannot heal all, and perhaps even that competent psychotherapists will never be so common as to make treatment readily available. As long as mainstream psychiatry clings to an old belief in the primacy of genes over environment, we will fail to address the real social and early childhood stressors which leave in their wake illnesses like BPD, antisocial personality disorders and a myriad of other medical and mental health conditions.

[1] In his paper, Gunderson notes that even though BPD is more common than bipolar disorder and vastly more common than schizophrenia, it receives only a tiny fraction of the research funds made available for those conditions.

[2] For instance, in the recently published Trauma and the Avoidant Client, Robert Muller notes: "Attachment-related traumatic experiences, intrafamilial abuse or neglect, and traumatic losses are the primary traumatic stressors considered." He notes in an accompanying footnote that he will not be focussing on big T traumatic experiences arising out of natural calamities.

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Commentary on Schneider Tarzwell *Borderline Personality Disorder* Article: *Review of BPD Reveals a Role for Psychotherapy Research in Elucidating Fundamental Processes of Mental Health*

• *By Norman Steinhart, BSc, MD, CGPP*

Schneider and Tarzwell's review of the diagnosis and management of Borderline Personality Disorder is a useful primer on a deadly (10% suicide rate) psychiatric disorder. However the limits of the utility of the descriptive lists of DSM for diagnosis are best revealed in relation to BPD. Clearly the list reviewed by Schneider shows symptoms and signs that overlap with several other conditions: chronic depression and dysthymia, and bipolar disorder, with reality-perception impairments and paranoid ideation, even hallucinations that resemble keystone symptoms of schizophrenia. What is most interesting, are the areas of functional brain scanning, and psychotherapy that despite very different approaches, converge in their findings and complement each other and show the most promise for advancing treatments of BPD.

One of the most striking omissions from the mainstream approach outlined by Schneider and Tarzwell is the lack of consideration of attachment (Minzenberg, Poole & Vinogradov, 2006) in a disorder that is as much as any other characterized by social difficulties, including unstable and dysfunctional relationships, and polarized and unstable social cognition. The characteristic symptom of BPD, intolerance of being alone and fear of abandonment (Gunderson & John, 1996) and either panic or volcanic anger reactions at perceived threats of rejection clearly relates to anxious insecure attachment patterns. The puzzling pushing away that BPD patients also do to people can be considered a form of avoidant attachment. The emotional dysregulation, if a primary problem, may lead to this strange polarization of behaviours that can be seen as a disordered attempt to adjust the social distance to use others to help regulate dysphoric states. This effort in BPD uniquely continues to overshoot in either direction producing "oscillations of attachment" (Melges et al 1989).

While there may be controversy regarding the role of sexual abuse in development of BPD patients, the way that the person who develops BPD processes these experiences may be the defining aspect. The finding of genetic predispositions to emotional dysregulation could make people vulnerable to even single episodes of such abuse. As well, the effect of non-sexual abuse, such as inconsistent responses, recurring threats of physical punishment, witnessing repeated physical punishment of family members and emotional neglect can be expected to cause major problems for attachment development. Such 'small t' ongoing attachment trauma should be further investigated.

The lack of trust and cooperation that borderline patients show in experimental settings (Unoka, Seres, Aspán, Bódi & Kéri, 2009) supports a specific neuro-developmental problem of abnormal activation of the anterior insula together with the cingulate cortex and the amygdala (Seres, Unoka & Kéri, 2009). The impairments in fronto-orbital networks and executive functioning and their inability to regulate emotions i.e. an under-active fronto-limbic system fits well with the detection of an overactive, i.e. poorly regulated limbic system and associated clinical symptoms. Whether the neuro-cognitive aspects predispose to adult symptoms or are sequelae cannot be determined from current studies. However as we look at the effective treatments for BPD this helps us to see that the improvement of executive regulation of social cognition, behaviour and emotions are critical areas to work with.

Finally as we examine the treatments that have some credibility in improving the function of BPD patients, they all share a focus on utilizing the therapeutic relationship as an integral part of the treatment. The various therapies reviewed in the main article recognize how the opportunity to interact with the patient in a therapeutic way provides a corrective model for their interactions with other people.

Although further testing is needed, these approaches will possibly all improve the mentalizing ability of patients, as well as their reflective ability to understand the intentions of others.

In summary, the fundamental difficulties in developing secure attachment, with poor emotional regulation in response to threats of rejection, criticism and experiences of abandonment emerge from complex genetic-environmental interactions. Modern therapy that acknowledges the importance of counter-transference and patient-clinician interactions as central to improvement, by modeling and teaching mentalizing and reflective skills provide a

continued on page 11

Book Review: Termination in Psychotherapy - A Psychodynamic Model of Processes and Outcomes

by Anthony S. Joyce, William E. Piper, John S. Ogrodniczuk, and Robert H. Klein

- *By Anne Rose, MD, FRCPC*

Review of *Termination in Psychotherapy - A Psychodynamic Model of Processes and Outcomes* by Anthony S. Joyce, William E. Piper, John S. Ogrodniczuk, and Robert H. Klein. For the patient, the termination of psychotherapy can bring a resurgence of the issues that were addressed in the treatment, together with issues around loss and separation. If managed well, termination can reinforce positive changes achieved by the patient (and the converse is also true) . The termination is an opportunity for addressing issues in the therapist-patient relationship. The termination phase can be an opportunity to review the tools available to the patient in an ongoing way after the therapy is done.

Hello all! I'm writing this book review because in 2009 I had a disastrous year where things that could go wrong with my practice did go wrong. This inevitably was followed by a note from the College advising me that I had been "randomly selected" for an audit of my practice. HAH! Like I believe the universe is imbued with such randomness! Next thing, they'll be telling me that dropped toast doesn't differentially land with the buttered side down. No, this was clearly the year that the fates were sending the auditor to enjoy a laugh, possibly some beer, and one hopes a suitable hangover at my expense.

You see, it had been a year of "Toxic Terminations". In one case, an extremely intelligent and articulate patient informed me that I was finishing up with them too quickly yet one to two years too late, another fired me outright, and yet more said "I was wondering how long THIS was going to go on for" and several more said "no, no, no, I can't finish therapy, it's too soon!" I would like to thank all these patients for helping me to learn and improve my practice over time.

I pondered the above situations along with other terminations of therapy that had gone well. Some questions arose:

Question 1: Why is termination so challenging for me?
Question 2: What differentiated the terminations that went well from those that went poorly?
Question 3: How can I improve my practice to better help the clients/ patients?
Question 4: Surely there is a better name for this process than "Termination", perhaps something that doesn't sound like being fired from a job while facing the Mayan Apocalypse?

I found the answer to Question 1 from within myself and upon review of my training. Firstly I have found endings of relationships to be incredibly sad and challenging for me in my personal life, and thus I don't bring a happy countertransference reaction to the situation. Secondly, in residency it's generally the residents who are moved about and may even graduate. Thus rather than a working through a termination of therapy completion at the healthiest point for a given patient, often administrative umm…. terminations (of us) prevailed.

Some answers to Question 2 yielded to reviews of my charts. The ones that went poorly were characterized by poor rapport and therapeutic alliance from the outset, plus no specific discussion of time frame and/or "dose of psychotherapy". The terminations that went well were with patients with whom finishing up therapy was discussed near the outset. These were not all CBT or other short-term psychotherapy cases. Some were medication management with supportive psychotherapy; some were more open-ended purely supportive or psychodynamic processes. But in essentially all that went well,

continued on page 12

Commentary on "Borderline Personality Disorder" Article *(cont'd)*

foundation for treatment of BPD as well as valuable evidence for the underlying disorders of social interactions.

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a rough time frame was at least mentioned at or near the beginning using a technically brilliant sentence like "I wonder if short-term or long term therapy would be more helpful for you" followed by another gem like "some people find easing off gently in terms of frequency of sessions is best when finishing up whereas others find a clear finishing point to be most helpful, still others need periodic support available on a long term basis."

Question 3 led me to try to presage the arrival of the auditor with finding further information on the topic of Termination. The most helpful resource I found was the book "Termination in Psychotherapy" by Joyce *et al*. This is what I learned from the book in a nutshell (yes I really said "nut" and "shell"):

The authors explained in their Preface that time-limited approaches to treatment can and do incorporate a known date of termination from the outset but that rigid adherence to manuals without the therapist maintaining flexibility and creativity may be unproductive. The authors were "struck by the relative scarcity of systematic examinations of termination phenomena". They cite Kramer (1990) and Kupers (1988) as "exceptional and important work in this regard". They also review in a later chapter contributions from psychoanalysis starting with Freud and then elaborating from work of later analysts.

Joyce *et al* outlined some key broad principles in their Introduction and Overview, paraphrased below:

a) For the patient, the termination of psychotherapy can bring a resurgence of the issues that were addressed in the treatment, together with issues around loss and separation
b) If managed well, termination can reinforce positive changes achieved by the patient (and the converse is also true)
c) The termination is an opportunity for addressing issues in the therapist-patient relationship
d) The termination phase can be an opportunity to review the tools available to the patient in an ongoing way after the therapy is done.

I would quibble slightly with their suggestion of "leaving the door open" simply because I work at a very busy clinic wherein it may be wiser to advise the client/patient the relevant re-referral process should significant time have elapsed and they wish to return.

And from their later chapters I would add additional principles:

e) Termination in particular of psychoanalysis may be considered when symptoms have been traced to their origins, and tolerance of anxiety, capacity for enjoyment of positive emotions, object relations, ego strength, reality testing and ability to work are improved and/or managed better. (Summarized from the author's more extensive outline of Firestein 1978).
f) Factors associated with patient qualities (such as Axis II issues, history of trauma and attachment style) , therapist qualities (such as therapist's needs and counter transferences) and treatment approach influence the importance and outcome of therapy, and termination of therapy.
g) "Forced terminations" (ie, therapist initiated termination due to moves, retirement, counter transference issues, etc.) are particularly challenging and need to be handled with considerable sensitivity. Patient-Initiated Premature Terminations are also challenging. Careful patient selection and treatment negotiation as well as preparation, reminders and alliance building help to prevent patient-initiated premature terminations.

So, what is involved in doing termination well? The authors outline a termination phase model. The phases involve reinforcement and consolidation of the treatment process and gains, resolution of issues in the patient-therapist relationship, and preparedness of the patient for maintaining healthy functioning. A respectful attitude and attention to the patient's perceptions and input are critical as is attention to issues of loss and awareness of one's own counter transference. A "good enough" termination may thereby be accomplished.

Question 4 (re: the word Termination) led me to regular use of the attached worksheets on "Therapy Review (Initial)" and "Completion of Psychotherapy" (here appended for your use at your discretion). Please let me know if anyone has seen anything similar and I will be happy to request our editor to add any relevant information and citations to the next edition.

The authors of "Termination in Psychotherapy" have greatly contributed to the development of a general model of the termination of psychotherapy and I highly recommend the book as an excellent resource for therapists!

I must close with the fact that the CPSO auditor declined any and all mood altering substances - even the glitter candy! He passed me on my audit, gave me some helpful suggestions for improving my practice, shook my hand as a gesture of completion and went on his way.

continued on page 13

Psychopharmacology Corner: Failure of Antidepressants • *By Howard Schneider, MD, CGPP, CCFP*

Sheppard Associates, 649 Sheppard Avenue, Toronto, Ontario, Canada M3H 2S4

Major Depression can be recurrent and progressive, with shorter periods of wellness between episodes. There are neuropsychiatric manifestations of disease progression, eg, hippocampal volume loss is greater with longer periods of untreated depression. If patients have 3 or more episodes of depression, then they should be treated indefinitely with antidepressants.

As medical psychotherapists, whether we prescribe or not, we are expected to be familiar with current psychopharmacotherapy. Psychopharmacologist Stephen M. Stahl of the University of California San Diego, trained in Internal Medicine, Neurology and Psychiatry, as well as obtaining a PhD in Pharmacology. Dr. Stahl has just released a case book of patients he has treated (Stahl 2011). Where space permits in the *GP Psychotherapist*, I will take one of his cases, and in a compact fashion try to bring out the important lesson to be learned. For readers more enthusiastic about the subject, I encourage you to purchase this softcover book, and follow along in more detail.

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

In this issue we will consider Stahl's first case – the man whose antidepressants stopped working. A 63 year old man presents to you with the worst depression and anxiety he has ever had in his life.

You take a history:
- 63 year married man x33years with 3 children
- No alcohol or marijuana use
- PMH: hypercholesterolemia but other blood tests normal, atrial fibrillation treated with medication
- FH: mother – depression + alcohol abuse, son –depression, daughter—mild depression, daughter – postpartum depression

Psychiatric history:

-**1st depression** at 42 years old after episode of atrial fibrillation (treated with antiarrhythmic) and death of mother. Rx'd with **sertraline 100mg/d**, resolution of depression within 2 mos, stopped sertraline after 6 mos due to sexual side effects.

-**2nd depression** at 52 years old, unable to function for months. Rx'd **paroxetine** which didn't work, switched to **sertraline 150mg/d** and improved within 2 mos, but again sexual side effects so stopped sertraline after 1 year.

-**3rd depression** at 58 years old. Rx'd **bupropion-SR** to avoid sexual side effects but no improvement at 2 mos so **sertraline** restarted. Two months later there is improvement, but patient stops sertraline a year later.

-**4th depression** at 61 years old. Rx'd **venlafaxine-XR 75-150mg/d**, worked in even less than 2 mos and no sexual dysfunction, but patient still stopped it a year later.

-**5th depression** now at age 63 years old. He has been depressed for over a year (ie, even shorter interval of

continued on page 14

Book Review *(cont'd)*

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Therapy Review (Initial)
Timeframe
Formulation
Transference Prediction (Dynamic)
Goals

Finishing Date (+-taper of frequency)
Missed Sessions (patients who drop out of therapy are out of therapy)

Patients view of change

Will med visits or consults be needed after? Will GP follow up be needed?

Completion of Psychotherapy
Date of Last Session
Reason for Psychotherapy
Diagnosis at start of treatment
Treatment
Progress
Medications at end of treatment
Recommendations of treatment followup
Diagnosis at end of treatment
Brief Mental Status Examination
Suicidal Ideation

wellness this time). Venlafaxine 75mg/d then 150mg/d x 8 weeks but no response this time. **Venlafaxine 375mg/d** x 8weeks but still no effect.

Antidepressants do not seem to be working for this patient anymore. He presents with severe psychomotor retardation, anxiety and suicidal ideas. Thus **4 mos** after treatment has started, the patient is still in a severe depressive state.

Months 5-11 of treatment: **Venlafaxine 375mg/d + dextroamphetamine 20mg/d + buspirone 30mg/d + clonazepam 2mg BID + lorazepam 2mg BID**. This only results in a partial response.
Months 12-15 of treatment: Venlafaxine switched back to sertraline 200mg/d but no improvement.

You are now seeing the patient at **month 15** of treatment. What would you do?

Medications at this point are: **sertraline 200mg/d + dextroamphetamine 20mg/d + buspirone 30mg/d + clonazepam 2mg BID + lorazepam 2mg BID**.

Adding an atypical antipsychotic is a reasonable choice but the patient is concerned about the possible metabolic side effects, so you instead try mirtazapine 15mg HS, stop the lorazepam (no reason to prescribe two different benzodiazepines), stop the buspirone (does not seemed to have helped) and lower the dextroamphetamine to 10mg AM (not clear it has helped). Medications at this point are: **mirtazapine 15mg HS + sertraline 200mg/d + dextroamphetamine 10mg/d + clonazepam 2mg BID**.

At **18 mos** of the treatment regimen, the patient starts to feel better but it is not the same improvement he has had in the past. Thus mirtazapine is increased to 30mg HS and quetiapine 300mg/d is added. Medications at this point are: **quetiapine 300mg/d + mirtazapine 30mg HS + sertraline 200mg/d + dextroamphetamine 10mg/d + clonazepam 2.5mg AM + 1mg HS**.

At **22 mos** there still is no further improvement and patient actually feels quite depressed in the morning. Thus sertraline, mirtazapine and dextroamphetamine are all stopped and washed out for 5 half-lives, ie, 1 week. The patient is then started on a monoamine oxidase inhibitor (MAOI) -- transdermal selegiline 6mg/24hrs. Due to excess sedation the quetiapine was then discontinued. Medications at this point are: **transdermal selegiline 6mg/24hrs + clonazepam 2.5mg AM + 1mg HS**.

At **24 mos** of the treatment regimen, the patient finally feels better.

Stahl notes that Major Depression can be recurrent and disease progression is seen by increasingly shorter periods of wellness between depressive episodes. There are neuropsychiatric manifestations of this progression, eg, hippocampal volume loss is greater with longer periods of untreated depression. If patients have 3 or more episodes of depression, then they should be treated indefinitely with antidepressants, as should have been done in this case. Stahl also notes that more of an effort should have been made to add psychotherapy to the patient's treatment plan.

Although MAOIs are not used as much as they were in the past, they remain important alternatives for treatment resistant depression. The practitioner should be familiar with side effects, diet restrictions, and drug interactions of MAOIs. Transdermal selegiline (Emsam) is available in the USA. Selegiline is an irreversible MAOI. However at transdermal doses of 6mg/day, dietary restrictions need not be as strict as for other MAOIs (Stoll 2009). Other MAOIs, as well as oral selegiline, are available and used in Canada. While as GPPs we may not typically initiate MAOIs, they are an option which may be started by hospital mood disorder clinics we refer our patients to.

Generic Name	Trade Name		Generic Name	Trade Name
	(common, Canadian names where possible)			*(common, Canadian names where possible)*
sertraline	Zoloft		**clonazepam**	Rivotril
paroxetine	Paxil		**lorazepam**	Ativan
bupropion-SR	Wellbutrin-SR		**mirtazapine**	Remeron
venlafaxine-XR	Effexor-XR		**quetiapine**	Seroquel
buspirone	BuSpar *(nb. discontinued 2010)*		**transdermal selegiline**	Emsam *(USA -- Somerset Pharmaceuticals)*
dextroamphetamine	Dexedrine			

Do NOT combine with MAOIs: Risk of Hypertension
decongestants (phenylephrine, ephedrine, pseudoephedrine, phenylpropanolamine)
stimulants (amphetamines, methylphenidate)
NE Reuptake Inhibitor Antidepressants (TCAs, NRIs, SNRIs, NDRIs)
appetite suppressants with NRI (sibutramine, phentermine)

Do NOT combine with MAOIs: Risk of Hyperthermia/Serotonin Syndrome
antidepressants (SSRIs, SNRIs, TCAs especially clomipramine)
cyclobenzaprine, carbamazepine, sibutramine
opioids (dextromethorphan, meperidine, tramadol, methadone, propoxyphene)

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The College of Family Physicians Recognizes Focussed Practices • *By Victoria Winterton, MD, FCFP, MGPP, Bestco cert.*

In September 2007 a meeting was held in Toronto by the College of Family Physicians of Canada (CFPC), to discuss the phenomenon of Focussed Practices within the discipline of Family Medicine. This meeting was attended by a wide variety of Family Physicians who had either a Special Interest or Focussed Practice (SIFP) in a wide variety of areas of medicine – from Sports Medicine to Palliative care. We, I and several other GPPA members, were there to represent SIFP in Psychotherapy.

Over the next couple of years the CFPC moved forward to establish a new Section of the CFPC to represent physicians within the College who had a SIFP practice. In 2010 they had established a framework to allow the establishment of new "Programs" representing the various interests, and invited members to establish "Working Parties" who would then make an application. A structure was established to allow for representation of each of the areas of interest.

In the spring of 2010, with the support of the Board of Directors of the GPPA, Janice Coates and I completed the application, and after submitting the application and a number of supporting documents from the GPPA, and having meetings with the CFPC, GP Psychotherapy was accepted as an SIFP program within the CFPC. For various reasons, we are established as a Sub- Committee of the Mental Health Program, rather than a free standing program.

So what does this mean for GP Psychotherapy? I believe that the establishment of this section will further establish Medical or GP Psychotherapy as a legitimate and valuable area of medical practice. My hope is that we can connect Family Physicians from across the country who are interested in psychotherapy- either as part of a comprehensive care family practice, or as an exclusive Focussed Practice. I hope this will lead to more educational opportunities, more collegial connection, and also more visibility which may lead to a more integrated role in the medical system. Obviously differences in provincial funding currently have a significant impact on the practice of psychotherapy across the country.

And, in a separate but related question – what does this mean for the GPPA? In the process of making the application we were asked to identify "sister organizations" which were already active in this SIFP area. We were able to clearly designate the GPPA as such an organization, and the documentation and significant work we have already done on criteria for Training and Continued Professional Development were well noted. I think the GPPA will benefit from "going national" and the hard work done by so many over the years will be put to good use. We will continue to liaise closely with the GPPA as we move forward.

We have established a committee consisting of myself, Peggy Wilkins of Peterborough, Ontario, and Christina Toplack of Halifax, Nova Scotia. We as a committee will be meeting with the Mental Health Program Committee of the CFPC in November 2011.

In addition, we are going to be presenting at the Family Medicine Forum (the CFPC's annual convention) in Montreal on November 3-5. We will hold a Networking session on the morning of Friday Nov 3, hopefully to begin the process of connecting with other physicians. We are also presenting three educational sessions – the first by Catherine Carmichael on our Guidelines for the Practice of Psychotherapy by Physicians, the second by Pat Rockman and Jose Silveira on "Managing Uncertainty in the Diagnosis of Undifferentiated Mental Health Disorder in Primary Care" and the third by myself on "The Therapeutic Relationship".

This is a new and exciting development for the practice of psychotherapy by physicians. We need and welcome participation by interested physicians.

Whom to Contact at the GPPA

Newsletter – to submit an article or comments, e-mail Howard Schneider at howard.schneider@gmail.com

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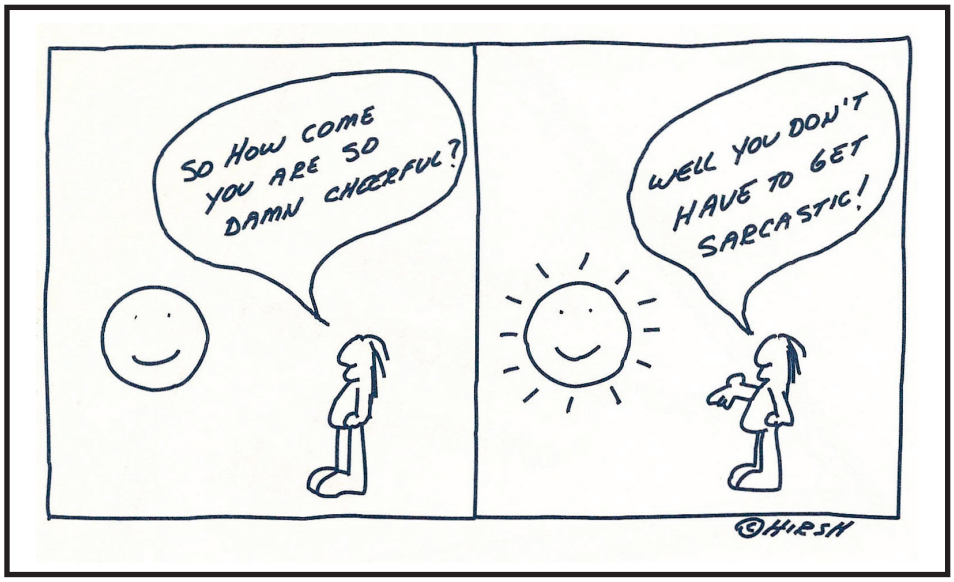

Allan Hirsh is a psychotherapist in North Bay.
This cartoon is from his book
Relax For the Fun of it: A Cartoon and Audio Guide to Releasing Stress.
View at www. allanhirsh.com.

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Committees

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Karyn Klapecki, Larry Nusbaum,
Liaison to the Board – Christena Beintema

Certificant Review Sub-Committee
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Mentor Review Sub-Committee

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Liaison to the Board – Muriel J. van Lierop

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Muriel J. van Lierop, Peggy Wilkins
Liaison to the Board - Jim Brown

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Alison Arnot, Heidi Walk, Lauren Zeilig,
Harry Zeit
Liaison to the Board – Jody Bowle-Evans

Listserv
Marc Gabel, Webmaster
Edward Leyton, Lauren Zeilig
Liaison to the Board - Howard Schneider

Journal
Howard Schneider, Norman Steinhart
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Barbara Whelan
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