INTRO:

[THEME MUSIC]

JOHN
Hello and welcome to The Medical Mind. I'm John Moe. I'm an author and podcast host and I interview people and write about mental health.

KEN
I'm Dr. Ken Duckworth, a psychiatrist and the Chief Medical Officer of NAMI. The Medical Mind is a podcast about mental health treatments and the people who benefit from them. This special episode is co-presented by SMI Adviser, a Clinical Support System for Serious Mental Illness; and by NAMI, the National Alliance on Mental Illness. SMI Adviser is funded by the Substance Abuse and Mental Health Services Administration and administered by the American Psychiatric Association.

JOHN
These podcasts include the real-life experiences of people with mental illness and family members. Some of the content includes discussions of topics such as suicide attempts and may be triggering. To receive 24/7 crisis support, please text "N-A-M-I" to 741741 or call the Suicide and Crisis Lifeline at 988.

John: *[00:01:12]* And Ken, we are making this show in order to maybe demystify mental health a little bit and show just how much of a connection there is between the science of the treatments and the latest discoveries about treatments and regular people just living their daily lives. So we're going to be talking with some experts and we're going to be talking with some regular folks as well. And Ken, I think we are both doing this show for kind of similar reasons. In a lot of ways. This is more than just an occupation and mental health is more than just a hobby, obviously. And it has a pretty personal meaning for me and for you. Tell me a little bit about how you got into mental health in the first place and why. *[00:01:59][47.2]*

Ken: *[00:02:00]* So how do you get a kid who's interested in history, girls and sports to become a psychiatrist? Well, you do it by having the most wonderful parent a boy could imagine who is incredibly ill. When I wrote my essay to become a psychiatrist, it was ignored at every residency program across America and at one program I was told it was a horrible reason to become a psychiatrist.

Wow. The next day, I met a man at the Massachusetts Mental Health Center, where I still work. I'm still on the faculty. And he looked at me and he said, Oh, my God, you know what this is like? You know, just what this is like. You know how helpful you could be to people. I nearly burst into tears. It changed my life. One person affirming my decision one time. Why am I the national? It's a mental illness. A psychiatrist? Well, because I kind of get it. Yeah. And, you know, I've lived some of it in my own little way. And I know, John, this has been important to you, too. *[00:02:56][56.7]*

John: *[00:02:58]* Yeah. I mean, I certainly didn't go the psychiatry route, but. But it's similar in regard to the family connection. My older brother Rick struggled with. We call it today substance use disorder. He was older than me. He found solace in substances, marijuana and on up to eventually methamphetamine. And, you know, kind of lost a lot of things and frankly, developed some psychosis as well. And we never were able to get a grip on what exactly was going on with Rick. He would disappear for long stretches. He would tell us things that that just weren't possibly true. And I always figured there'd be more time for him to get better. He was evidently sober in in the last few years of his life. He volunteered on the Narcotics Anonymous hotline, and he could see the value in anyone's life except his own. And in 2007, he died by suicide in San Diego. I remember a lot of things, but I remember being at his service and just like it had always been, nobody really was talking about what was wrong with him. People were reminiscing, people were sharing memories, and nobody was talking about the pain. Nobody was talking about the issues that he had. And I really wanted to, you know, because that was part of his story. I had this sort of epiphany that, okay, if we talked about it, if he had talked about it to a therapist, he tried it, but he didn't stick with them. If he had stuck with that, if he had reached out to more people, if he had been more open about what was going on and not feeling all the shame that he felt about what was going on, there's a better chance he'd be alive, or at least he'd make it through his most terrible days. You know, and that goes for everybody in society. If we talked about it, more people would stick around more. And if we don't talk about it, then it can only get worse. It can only go in one direction. And I thought, Ha, why in the world are we choosing silence when openness and learning can do so much more? Why did why did we make the dumb decision there? And I thought, well, I didn't have medical school in my future and wasn't a therapist, wasn't a government policymaker. But I thought, well, at least I can talk. I know where some microphones are. I can string us together and I can get other people to open up. And that's where I chose to attack the problem from, you know, in getting to know you over the years, I think even though our jobs are different, our lives are different, I think the intent is very similar. *[00:05:51][173.3]*

Ken: *[00:05:52]* I consider you a brother in the same mission. So we get to the same goal. Like, let's have conversations. Let's learn. Let's learn from each other. Obviously, we took different routes. *[00:06:04][12.1]*

John: *[00:06:06]* It's simple, but it's not easy to talk about. This sometimes requires overcoming historical and cultural stigma and a whole lot of barriers. And, you know, I always say I feel like I'm throwing rocks at a giant, but I got a lot of rocks and I know where to get more rocks. Pretty good answers. *[00:06:25][19.5]*

Ken: *[00:06:25]* To John is what I mean. You've become I've listened to a lot of your podcast. You've made some big dents there. *[00:06:31][5.5]*

John: *[00:06:32]* Yeah, I got a lot of rocks. Well, today we are going to be talking about cognitive behavioral therapy. “We’re going to talk about what this idea actually is. Then we’ll dive deep into the case of how someone used this, what happened, how it worked, how they’ve carried it forward. And finally, a talk with Dr. Kopelovich about how it works from the practitioner’s POV and what that means for mental health treatment everywhere.”

All right. And let's start at the beginning here. Ken, what is CBT? *[00:07:09][37.3]*

[74.5]

Ken: *[00:07:10]* Cognitive behavioral therapy is a kind of psychotherapy. There are many kinds of psychotherapy, but CBT is quite specific, and then it helps people critically examine their thinking and the feelings that follow from it. So the idea is if you are depressed and think you're worthless, you're a loser. A cognitive behavior therapist will help you to critically examine those thoughts and challenge them. Well, is it true that you're a loser, Ken? You know, you did get through the week. You were kind to your neighbor. Your dog is well-fed. In fact, you actually battled through, you know, a difficult week living with the depression. Yes. But I feel like I'm a loser. I feel like I'm worthless. And so, again, the thought is, what is the evidence for that? So it's a critical examination of your thinking process and how it impacts your feelings. When Eric Beck invented this decades and decades ago, it was pretty radical because the field was really looking at people's childhood as the root cause of their mental health challenges, which has a place. But CBT is much more practical coping in the real world now and forward looking. So if you're having really automatic negative thoughts, how do we critique them? How do we challenge them? What is the evidence for them? And that's really the essence of CBT. It's also a shorter-term treatment. Ten weeks, 12 weeks. People come back for boosters. But not every therapist knows

how to do CBT. Just as not every therapist knows how to do any of the dozens of psychotherapies. *[00:08:49][98.2]*

John: *[00:08:51]* And so what does the therapist actually do? Is it an interview question and answer kind of format? *[00:08:57][5.7]*

[103.9]

Ken: *[00:08:57]* It's a conversation with very clear observational skills. First, it's better if you feel safe with the therapist. So hopefully they're kind, engaging, empathic. And the idea is. All right, I'm going to lay out what's going on with you in my mind, as part of my experience of depression, most classically. I see all the negative thoughts that are going through my mind. And the therapist would say, Let's write each of them down. And let's critique them. Is there any evidence that you're a terrible person, Ken? Have you ever committed a crime? Well, no, I actually have never committed a crime. Is there any evidence that you're a terrible person? Ken, isn't it true that you've done your best at work? Well, I have, but the truth is, I still feel terrible. And so this is the idea that cognitive behavioral therapy challenges the psychological dimensions of depression. There may also be a biological route. CBT has been validated in thousands of research studies. It works for people. So it's an interesting novel idea. When it was first developed in the fifties. It is no longer novel. *[00:10:06][68.6]*

John: *[00:10:07]* And what about the use of CBT in psychosis? Because it sounds like a lot of what you're talking about is treatment for depression, for anxiety. Is the treatment of psychosis using CBT a new thing? *[00:10:20][12.9]*

Ken: *[00:10:20]* The Brits brought something to the table. Right. And you know, whether it's scones or warm beer, the Brits bring something different. And some gentlemen, David Kingdon and Doug Turkington, talk to people about their delusions and their voices in the United Kingdom hospitals and realized the same kind of gentle technique where the person talks about their experience. And so what Kingdon and Turkington did is transform a therapy developed in the States primarily for anxiety and depression, and they added it to the concept of psychosis. It's a stroke of genius. If you're in the National Health Service in the UK and you live with an illness that has psychosis as a feature, you can get CBT. B It's much harder to find in America, even as the research has demonstrated that it's effective. There are people like Dr. Sarah Kopelovich that are trying to be the Johnny Appleseed of a very good idea, but they're working uphill, and I'm very sympathetic to them. Her interest in advocacy. Is central to the CBT as a good evidence base. It's respectful, it's cooperative, and it applies a treatment that we know is helpful. *[00:11:41][81.2]*

[94.1]

John: *[00:11:42]* And who are the people that it is most helpful for and why? *[00:11:46][4.1]*

Ken: *[00:11:48]* I think people who find that they feel safe and they have a therapeutic alliance and they're willing to engage in conversation about experiences that many people feel ashamed of. So if you have a delusion which is defined as a fixed, false belief. *[00:12:04][16.8]*

John: *[00:12:06]* And we're going to listen now to an interview that I did with a guy named Johnson. It's not his actual name. It's a name that he asked us to use for the purposes of privacy. And he's someone who's benefited greatly from the practice of CBT. He is actually a patient of Dr. Sarah Kopelovich, who will be talking to in a little while. Let's listen to my conversation with Johnson. *[00:12:29][23.3]*

JOHNSON INTERVIEW

Johnson: [00:01:21] Hi. My name is Johnson. I live in Seattle. Born and raised in Seattle. Uh, I just finished school. I'm applying to jobs, [00:01:32] I went to school for history and engineering [00:01:46] In my free time. I like to spend time outside. I am pretty passionate about the outdoors. I hike, bike, stuff like that. I like to read. [00:01:55] [00:02:06] And that's kind of the skinny on who I am. I'm sure we'll learn more. [00:02:11]

John: [00:02:11] Yeah, well, we'll dive in here a little bit. [00:02:13] [00:02:29] Well, let's start off talking about your mental health history a little bit. When in your life did you first start having mental health issues? [00:02:37] [00:02:38] how did they appear? How did they present? [00:02:40]

Johnson: [00:02:52] nothing really was clear until the summer before my senior year of high school. I was on a school trip and I had a manic episode and that was my first experience. And I was undiagnosed for about a month or two. And then during that summer I went to a local hospital and I was diagnosed with bipolar disorder. [00:03:17]
[00:03:24] so a school trip in a different time zone. Two time zones away from Seattle. So I'd been traveling. It was pretty exciting. I was studying, like, the history of the area and was learning lots of new things. I was stimulated, my

appetite changed, I wasn't sleeping as much. So that's kind of the early signs that something was going wrong. I didn't know what the warning signs were, so I just continued to have high energy, didn't seek help. And then it all came to a head when kind of the thoughts in my head became delusional. I had, like, feelings of grandeur. And I just started making, you know, plans that were unrealistic and unrelated to what I was doing. [00:04:13]

John: [00:04:14] This is all happening on the trip, then. [00:04:16]

Johnson: [00:04:16] On the trip. Yeah. [00:04:18]

John: [00:04:18] Okay. Did people notice? Did people around you say, what's going on? [00:04:23]

Johnson: [00:04:24] Um, I think there was one night they did, and they called the paramedics and they arrived. And then they treated me like I was on meth, so they treated me pretty violently. [00:04:38] [00:04:55] And that was kind of my introduction to a life of mental illness. [00:04:59]

John: [00:05:00] So that happened while you were on the trip. Did you come out of the episode while you were still on the trip or did it last until you got back home? [00:05:08]

Johnson: [00:05:10] It calmed down. I was I remember the flight back with my dad. I was experiencing symptoms. And I had like PTSD from the hospital incident. So I was pretty shaken up and, like I was, you know, in a mixed state for a month or two. And then my parents suggested that I go to a hospital in the Seattle area, and then I was treated. I almost went to the adult unit, which would have been really bad, not terrible, but I was sent to the child ward, which I think was better. So I was treated with a little more kindness. [00:06:09]

John: [00:06:10] So you're home in kind of in a in a in an in-between state for a little while. Was is it a thing where you're always sort of manic or is it kind of, it comes and goes sort of thing at that point? [00:06:22]

Johnson: [00:06:27] Do you know what hypomania is? [00:06:29]00:06:38] Creative, like artists, you know, have really productive periods when they're hypomanic. Business people have really productive periods. They're hypomanic. So you have more energy. You're kind of more lucid. And it's a good feeling. Like, it feels great. Like you're euphoric, but you're still in control. But it was kind

of like that. But also, um, like I was, I was different. And I think my parents recognize that. [00:07:06]

John: [00:07:09] So was it at the hospital in the children's section of it that you were finally diagnosed? [00:07:17]

Johnson: [00:07:17] Yes. [00:07:18]

John: [00:07:34] what were your experiences with therapy early on? [00:07:37]

Johnson: [00:07:48] My team was a psychologist and a psychiatrist. Wonderful people. And it to help people, which is great. Mm hmm. Not just, like, giving them medications every two weeks and switching things. They were really dedicated to my treatment plan. Like I had the A-Team. I was very lucky. Mm hmm. But it was more like, this is your diagnosis. This is what you should expect. Like, here are some strategies for coping. Um. And it was effective at the time. [00:08:26]

John: [00:08:28] So is that how it was when you moved on from. From high school to college? [00:08:32]

Johnson: [00:08:38] When I took a gap year and I did a lot of stuff, you know, like hiking and stuff. And I worked a little bit and traveled and that year I was largely independent from any, you know, like psychological or psychiatric care. [00:08:54] [00:09:14] And so we thought that I was rounding the curve and I had kind of beaten the illness and that nothing won't happen again. And then I went to school in the Midwest. [00:09:27]

John: [00:09:28] And far from home. [00:09:30]

Johnson: [00:09:30] Far from home. Not a lot of psychiatric care in the Midwest. So I didn't have a treating doctor when I was at college. I didn't see the school counselor. I didn't tell anyone of my sports team that I had this diagnosis. I was very quiet about it. It was, you know, stigma and whatnot. And then that first year was fine. I did well in school. I was on two sports teams, and it was good. And then I went home that summer. And I worked construction. And then the following year, I had another manic episode in the fall. [00:10:13]

John: [00:10:14] And what happened with that one? [00:10:15]

Johnson: [00:10:18] Like delusions. More energy. Not sleeping a lot. Paranoid. I fortunately called my mother when it was happening. No, I called my psychiatrist. I was like, I think I feel like if I look at people's eyes, I'm like more powerful or something. And he's like, I think Johnson is having an episode. And so he told my mom, my mom flew out, which I'm really fortunate she could do that. And then. She took me to a hospital in the Midwest and I was there. That was, like, not a great experience. That was an adult ward that time. Hmm. They do things a little differently in the adult ward. [00:11:05]

John: [00:11:18] And then at some point you started to have auditory hallucinations. Was that happening during college as well? [00:11:24]

Johnson: [00:11:28] I probably was and didn't think anything of it. But during my senior year of college, maybe my junior year, and I think I'd always kind of had things like hearing memories of what people's voices sounded like in my head. I definitely had those experiences, but it didn't become a big enough of a problem for me to actually react to it until my senior year of college. And yes, that was 2015. [00:12:06] [00:12:21] So I turned like the stove fan on in my apartment. You know stoves have the fan the vent. [00:12:27]

John: [00:12:27] Overhead fan thing yeah. [00:12:28]

Johnson: [00:12:28] Yeah I turn that on and those noises were really like, distorted, stressful. And I'd hear like, words in the fan that were, like, angry. Or I'd go on a run and I'd hear like an angry thought and a lot of intrusive thoughts. And the auditory hallucinations weren't really affecting me. [00:12:47] [00:14:05] More of a nuisance. Yeah. Like, disorienting. Not like, the fan is taking the voice of Professor So-and-so. And Professor so-and-so is like telling me, you shouldn't be cooking, you should be reading your assignment. [00:14:22] [00:14:35] it was just like. Kind of like shame-based thoughts like, like Johnson is doing this and this or like. Stuff like that. And it was kind of like, whoa, like what just happened? Like, where that sound come from? [00:14:50]

John: [00:14:51] Yeah, like the critical inner voice that a lot of people have was more external [00:14:54]

Johnson: [00:14:57] Yeah, I was like, man, this sucks. Do I have schizophrenia? Maybe I do. Like, that would be terrible. [00:15:05]

John: [00:15:08] We're going to talk about Dr. Kopelovich here. How long had you been kind of in need of psychiatric help before you became a patient of Dr. K? [00:15:20]

Johnson: [00:15:34] since 2009. And I saw her in 2020, I think it was 2020 or 2019. I forget. [00:15:41]

John: [00:15:41] Wow. That's a long time. [00:15:43]

Johnson: [00:15:44] Yeah. [00:15:44]

John: [00:16:08] And then how did you finally find Dr. K? [00:16:10]

Johnson: [00:17:03] I don't remember who referred me to her, maybe one of my parents found her. My psychiatrist or something. And I was super lucky because she's like the best, you know? She's like, really good. [00:17:14]

John: [00:17:14] Yeah. Yeah. What was that first visit with her like? [00:17:17]

Johnson: [00:17:33] Her approach to care is like data driven. And so we might have taken a test where I scored in relation to other metrics for depression, psychotic symptoms, and like whatever. [00:17:48]

John: [00:17:50] What were your first impressions of her? [00:17:52]

Johnson: [00:17:54] Man. She has weird glasses. You know, she does have some eye flair. [00:18:00] [00:18:10] Very, very good with people, very, like, you know, empathetic and present. And I felt like I could be honest with her, and that was really important. [00:18:23]

John: [00:19:05] When you were first exposed to CBT, when you first started working with her in that format, can you remember how you felt about that at first? [00:19:14]

Johnson: [00:19:20] Cognitive Behavioral Therapy for psychosis is hard, it's challenging. You have to put a lot of work in to have the benefit. And it's disorienting and it's kind of like challenging what's in your head. And you hear people like, clickbait news on the Internet. Like, do you have a critic in your head? Do you want to reframe the voices or reframe the conversation in your head? And you read the article and you're like, that's stupid. But like CBTp, it's

like you actually do that. Like, I like I rewrote the script in my head and it's like the, the internal dialog isn't as critical. It's still critical and it's still annoying, but it's like I have the tools to manage it and that's like very empowering. [00:20:05]

John: [00:20:05] You talk about it being a lot of hard work at first, did you have to learn the skills of how to do it because people underestimate this. The mental work that goes into it, the thinking that goes into it can be completely exhausting. What were your first experiences with it? [00:20:26]

Johnson: [00:20:26] I had to be honest about what I was hearing, what the shame was I was trying to fight in my head, and air the thoughts and be honest about it. And so that's hard, to kind of be insightful and to be like, okay, I have this shame about this stuff and it's like really hard to deal with. And then the CBT itself is like shifting the thought, like I'd they'd go on like runs or walks from home and then I have like critical thoughts. I was running like it was really stressful. And so one of the tools I had to do was just in my head, not like out not saying these things out a lot, but like in my head like, I see a tree, I'm walking on pavement, I see a mailbox, there's a bird outside. I see my neighbors. I just had this thought, how does this relate to seeing a tree? And it's really tiring. It's a lot of work. It sounds simple, but it's not. It's really hard [00:21:48]

John: [00:21:50] Does it get easier? Do you build up a muscle almost that makes that a little easier? [00:21:56]

Johnson: [00:21:57] You get more familiar with it. I guess the techniques. [00:22:00] [00:22:07] I'm more used to it now, but I still have like external thought pattern sometimes. Like the Greeks, you know, they talk about external thought patterns as this really insightful thing, it's really helpful to have these experiences and it's right inside with your character or whatever. But in America it's like, no, you're having external thoughts. You're crazy. You say, That's bad, right? I learned just reading about voices. Yeah, it's annoying and it's disorienting, but it's no longer the cudgel was beating me and bringing me down. It's just something that happens. [00:22:55]

John: What elements of your treatment CBTp have been most helpful for you? [00:23:39] [00:23:49]

Johnson: [00:23:53] I'll walk to the mailbox, and for some reason that's been become like a stressful thing. [00:23:59] [00:24:13] I'm thinking, am I offending anyone? I see my car or like I see the mailbox. How does that thought relate to

going to the mailbox? And so I just use it in my daily life to just keep me focused on what I'm doing. But it's annoying. I'll take an exam and I'll be like, okay, how does like that thought relate to thermodynamics or something? And it doesn't, but I still have it and it's annoying. [00:24:51]

John: [00:24:52] I mean, coming out of an academic setting that you've been in, it can often be a really data driven kind of approach. Was that comfortable in some way that you've been in an academic environment? You could use a data approach. [00:25:10]

Johnson: [00:25:14] It's useful. It is useful to look back on the past two years and see where I have been, where I came from, and then how the data has changed and how that maps my experience. I can relate my lived experience with the insight that the data gives. [00:25:37]

John: [00:25:51] We talked a little bit about what's been most helpful. What do you use most often? What keeps coming up the most in your day to day life? [00:25:59]

Johnson: [00:26:02] Just the suite of skills. I don't want to be like, this is the one tool you have to learn from CBTp, and if you have this tool, you'll be sane. Just use all the tools every day and just know what to do. It's like engineering, you have a billion equations, but you need to know which one to use, when. And it's just part of the program. It's like I have a quiver of arrows for CBTp and I pull one out when I need one. [00:26:37]

John: [00:26:37] And how is how is that different from previous treatments that you've gone through? [00:26:44]

Johnson: [00:26:45] When I was in law school out of state--I spent one year out of state and one year in state because I transferred because my symptoms were kind of bad-- I went to a psychologist there, or a social worker, and she didn't talk therapy. She was very nice and like wanted to help me find the root of my problems, my supposed problems, and to make me better. And that was good. And I was like, oh, I have intrusive thoughts. I call them dandelion thoughts. Like I get rid of it, and it grows back, and that's what I labeled them. Dr. K was like, okay, you have these experiences, but I will give you tools to approach them and change the narrative. And so now I'm like in the ring against the thoughts and I can like beat them up and they go away. [00:27:39]

John: [00:34:29] Yeah. What kind of role does your family play in your recovery, in treatment? [00:34:35]

Johnson: [00:34:36] They're really supportive. They listen to me. They help me when I'm having trouble. They're like my support network. [00:34:46]

John: [00:34:47] Yeah. And do you live with your folks then? [00:34:49]

Johnson: [00:34:50] They are my roommates, yes. [00:34:52] [00:35:06] If people ask, I just say, yeah, I have two roommates, I've lived with them for a while. [00:35:09]

John: [00:35:10] They're an older couple. I mean, there must have been a long education process for them too, figuring out everything's going on and how to address it. [00:35:21]

Johnson: [00:35:21] Definitely. It's been an experience for all of us. [00:35:24]

John: [00:35:24] Is it up to you to teach them about it? [00:35:28]

Johnson: [00:35:30] Yeah. My parents have met with Dr. K, and they're familiar with the work I've done with her. I think it's good. I think they could use therapy, but they're reluctant. [00:35:44]

John: [00:35:46] Well, you know, maybe. Maybe we can all be inspired by our kids sometimes. Are there symptoms that are specific to your bipolar disorder that you find that you can manage really effectively with CBTp? [00:36:02]

Johnson: [00:36:21] So I haven't had an episode since being trained in CBTp, so I don't know what I would do if I was manic. Hopefully that never happens again. But with paranoia or minor delusional thinking, it helps for sure. [00:36:39]

John: [00:36:52] Sounds like a lot of it is about teaching yourself how much you are actually in control of, so you're not being swept away, so that you're the one driving the car and you're not in the backseat. [00:37:02]

Johnson: [00:37:03] Totally. [00:37:04] [00:37:35] But what I want most is just to not have any friction and to have the thoughts just kind of roll over me. Just total acceptance and be like, "Johnson's a dumb ass, Johnson's really stupid," and then just have that roll over me like, okay, sure. Not like, "do you have evidence

that Johnson is a dumbass or do you have evidence Johnson is really stupid? But just to be like, okay, interesting. [00:38:03]

John: [00:38:04] Yeah. More of a white noise kind of thing then. [00:38:07]

Johnson: [00:38:07] Yeah. It's like that annoying din in the background. Not like this thing that I have to fight inside because fighting is a lot harder than is accepting. [00:38:16]

John: [00:38:17] Right. Well put. I understand you've recently been diagnosed with Parkinson's. what does that mean for your mental health and your recovery? [00:38:28]

Johnson: [00:38:30] Um, I try not to think about it. I'll think about it when I'm, like, 70 and I'm in a home. Hopefully not. But it's pretty heavy. It's like a terrible diagnosis for someone bipolar because they both affect dopamine pathways in your brain. With bipolar disorder, you get an excess of dopamine, so you start meds to treat that and they can lead to Parkinsonian type symptoms. And then Parkinson's suppresses dopamine and kills the doping receptors in your brain. And so they give you medications to increase your dopamine. So it's kind of like these two opposing things in my brain, these chemical reactions. [00:39:13]

Johnson: [00:39:15] So it's really hard to treat. [00:39:16] [00:39:44] Some of the meds for Parkinson's, I tried them and they made me psychotic, like I was hearing more voices. I had more thinking. And so I was like, I can't do this. I can't be on this medication. Is there anything else? And so fortunately, my neurologist said, There's this other one you can do and it's less likely to cause psychotic symptoms. I'm on that and my tremor is really subdued. I only have low key psychosis right now. Like low level. It's just baseline for my bipolar illness, I think, and it's not affecting it. [00:40:20] [00:40:42] It's kind of like wait and see what happens. I'm just monitoring and checking every six months, and bite my nails. [00:40:48]

John: [00:41:54] In light of receiving this diagnosis, how has the CBT, the CBTp helped you kind of navigate this world? [00:42:04]

Johnson: [00:42:12] One thing I learned in CBTp is focus on the world that you experience, your little circle. Don't worry about the big circle around you. So it's like my little bubble, but I don't like that. I like reading the news being like informed and worrying about what's going on and, but really what you should do

is just worry about your life. Like what you can change or you can affect. Don't worry too much about the other things. And so I'm like, okay, I had this biopsy and it found this protein in my skin that indicates I have Parkinson's with a pretty high accuracy rate. But what can I do about that? Is worrying about it going to make me better? Prevent neurodegeneration? Probably not. So just keep going. [00:43:06]

John: [00:43:06] Yeah. It's about controlling the size of your reality a little bit. [00:43:11]

Johnson: [00:43:11] Yeah. [00:43:11]

John: [00:43:12] If someone listening to this is curious about CBTp and maybe they think that they're a candidate for it, or they at least want to entertain that. What would you want them to know about it? [00:43:25]

Johnson: [00:43:30] It's a really good therapy if you take it seriously. Sometimes I feel like an idiot, like I'm walking down the street and there's a tree, and there's the mailman, and I just heard a crow. And I feel kind of like a dumb ass doing that and it's like, okay, yeah, I get it. Like Johnson, there's stuff in front of you, why do you have to be so silly? It's useful, and it keeps you grounded. It's helpful. They're all good tools in the toolkit. It's not perfect. I still have an atypical mind. [00:44:07]

John: [00:48:00] Well, best of luck to you, and thanks for sharing this. And I think you've helped a lot of people even with this conversation, to learn a lot more than they knew before. So thanks. [00:48:10]

Johnson: [00:48:10] Great. Thank you. [00:48:12]

JohnVOT: *[00:35:14]* Thank you so much to Johnson for providing insight on CBTp and on his own mind. We're going to take a short break. And after the break, Ken is going to be talking with Dr. Sarah Kopelovich. This is the Medical Mind. *[00:35:26][12.4]*

[BREAK]

[REJOIN MUSIC]

Ken: Welcome back to The Medical Mind

Ken: *[00:35:27]* We're going to be chatting with Dr. Sarah Kopelovich, who is a clinical psychologist and leader nationally in the CBTp movement. Dr. Kopelovich is a professor at the University of Washington and cut her teeth on DBT, Dialectical Behavior Therapy, which was developed in Seattle, Washington. She also has an interest in the criminal justice population, and I think the sense of social mission really comes through in our conversation. *[00:35:54][27.3]*

[39.7]

DR KOPELOVICH INTERVIEW

00:18.27
Sarah Kopelovich
So, I am a forensically trained clinical psychologist, which means that I have a license to practice clinical psychology. My passion population is really individuals with severe mental illness who have involvement, either historical or current, with the criminal justice system.
Since joining the faculty at the University of Washington back in 2015, it's really been my mission to enhance access to evidence-based psychological treatments for serious mental illness regardless of where an individual presents for care.

01:49.20
Sarah Kopelovich
And so, a lot of my day-to-day is working with the State, with different State mental health systems, as well as with community behavioral health agencies, inpatient settings, and forensic hospitals, to use evidence-based implementation strategies to adopt psychological treatments like Cognitive Behavioral Therapy for psychosis.

02:05.98
Ken
Fantastic. Do you think some of the resistance is that it had to cross the pond. That is to say, that the Brits developed this? Do you think that's part of the reason it's hard to find here in the states or do you think there are other factors?

02:28.19
Sarah Kopelovich
Well, so I think it's important for people to know that the birthplace of cognitive behavioral therapy is the United States, and the very first patient where cognitive behavioral techniques were applied by Dr. Aaron Beck back in the 1950s was an individual who was at the time a psychiatric inpatient experiencing paranoid and guilt delusions. And so, he later iterated on these techniques and applied them to depressive disorders and for the next several decades as the volume of research came out looking at cognitive behavioral therapy for depression, for anxiety disorders, for chronic pain, Dr. Beck really thought schizophrenia spectrum disorders is really the one area where we just can't apply these techniques, right?

03:23.27
Sarah Kopelovich
These delusions are impervious to reason, so it's not appropriate. It was actually a psychiatrist in the UK by the name of David Kingdon who was working on an inpatient unit. And at the time it was thought, you don't ask a client who's experiencing delusions to talk about those delusions. You certainly would never normalize them. That's really just going to make the matter worse. But he would hear things that he could relate to. So he would say to his patients, you know sometimes I also worry that I'm being watched, or that the government might be trying to know what I'm doing. And what he found was that defenses started to come down. First of all, patients would just sort of take this sigh of relief like oh wow, it's not just me.

04:15.93
Sarah Kopelovich
And they would start to talk more and as they were opening up, he found that he was able to start to ask these curious questions, which in CBT, of course, we call Socratic questions after Socrates, who asked that style when what he was teaching.

04:33.87
Sarah Kopelovich
He began to be able to start to use more cognitive techniques and behavioral techniques and found that folks were getting better even though they were talking about their delusions more. They were starting to question and they were starting to be curious about themselves. He then teamed up with some Doug Turkington and other folks in the United Kingdom to develop CBT into an application for psychotic symptoms. That was in the 1990s. Since the 1990s, we have had an explosion of research and treatment development in this area. So we now have over 50 randomized clinical trials

looking at the application of CBT to psychotic symptoms. We have almost twenty meta-analyses and about five systematic reviews. And what we've seen is that there's good quality evidence that CBT for psychosis is as effective as our frontline medication interventions.
As far as your question about why it's been so challenging to get CBT to really take root in the United States, there are a host of factors that we have to contend with. One is, antipsychotic medications came online and it was just met with such hope, that this was something that was really going to allow us to treat folks in the community, and that this was the silver bullet. And in schizophrenia spectrum care we don't have silver bullets.

06:29.30
Ken
There are no silver bullets. There are tools right? There are tools. Yeah.

06:41.37
Sarah Kopelovich
It's one out of many interventions that work together to help address the challenges that the individuals with psychotic symptoms face and that the families who are supporting them face.

06:54.34
Ken
So it has an American origin. Aaron Beck, Psychiatrist at University of Pennsylvania. He then develops it extensively for anxiety, depression, and related phenomena. It goes across the pond, the Brits pick it up. And of course, it's part of the National Health Service benefit package that you can get CBT for psychosis there. I think it's fantastic what you're doing here in the States. Let's take a transition. What does it look like for the patient who's hearing critical voices? You mentioned delusions.

07:16.40
Sarah Kopelovich
Correct.

07:29.19
Ken
So I have a dim awareness of this strategy. I've never been formally trained, but I've had the benefit of watching you, Kate Hardy, Doug Turkington, and David Kingdon at NAMI conventions. How do you help a person who has very negative voices? "You're worthless, Ken. You should die. You're horrible human being." How might CBT work for someone like me who's hearing intensely negative voices?

07:55.92
Sarah Kopelovich
So the one thing that we do when we're working with someone who experiences voices, and voices that are producing a tremendous amount of distress and impairment, is we start with normalizing.

08:15.85
Sarah Kopelovich
Many people don't know that voice hearing, particularly after a traumatic event, is an incredibly common experience. Most people don't know that in the US alone roughly 22 million people report hearing voices. We think about voices as a very uncommon experience but that's because we don't talk about it. When we start talking, when we start asking the questions, we realize that a lot of folks in adolescence will report hearing voices, after a bereavement, after a death will report hearing voices, after a trauma will report hearing voices, during states of sleep deprivation, if we're under the influence of certain drugs or medications. So first we just start by normalizing the experience. And then we elicit from the individual how they're making sense of that experience. What is the meaning that they're attributing to the voices? And often here we find a big difference between the folks who hear voices where it's an occurrence, but it doesn't interfere with their life or their functioning, versus people who hear voices and it is interfering with quality of life or even life. And it's that attribution that they're making.

09:48.26
Sarah Kopelovich
If you hear that voice that says, “Ken, you're nothing, nobody loves you, you’re a failure,” and you think, “They really got it right about me. They're really credible. They know the real me and I'm just fooling everybody else.” Then you're going to feel quite depressed. You might feel hopeless. You might feel despondent. and as a result you might think about hurting yourself, you would withdraw from other people.

10:17.94
Ken
But the key is, as you've described, is I'm believing the voices not challenging them. That's the linchpin, right? I'm taking this as kind of Gospel way to define myself and your concept Is to use the principles of Cognitive Behavior Therapy to say, Well, what is the evidence that you're a terrible person?

10:43.17
Sarah Kopelovich

That's exactly right. And even before we do that, we can help to facilitate what I call reattribution of voices, right? Which means there's all sorts of reasons why people hear voices. What if they actually don't get it right? What if this is sort of an echo that your mind has created based on things that have been said to you in the past? I wonder have you heard messages like that in the past from someone in your life? The person might say yes, or they might say "No, but I tell myself that and think that about myself." And then we can think about those voices as another form of an intrusive thought. Because here's the really interesting thing about voices, this this comes from the neuroimaging research. When we look at the brain when an individual is hearing voices, there are two really important parts that are lit up. One is the part of the brain that's responsible for receiving speech. That's called Warnke's area. The person is hearing the speech, they're hearing the voice. The other part that's lit up is Broca's area, which is the part of the brain that's responsible for producing speech. So, what that tells us is that this is an internal experience that sounds like it's coming from an external place. So, the person is genuinely hearing it as though it's coming from outside, but it's actually a product of their own mind. And when we share that information, or just in general just sharing alternative models of understanding where voices come from, the person is able to start to adopt a more healthy narrative around the voices, which then primes them for exactly what you just said, which is evaluating. "Well, how often do they get it right? Have they said things in the past that turned out to not be 100% true, and why might that be?"

12:46.48
Ken
"I did help someone once," or "I was nice to a dog." Maybe I don't deserve the worst kind of self-recrimination, right?
I've seen you and your colleagues work, and I've been so impressed that it is just like CBT for a depressed person: don't believe your automatic negative experience. But it's even more sophisticated because you get at some of the other pieces around the commonality. You're reducing the shame of hearing voices. So It's kind of like CBT, next level up, turbo. It's a little more sophisticated.

13:26.85
Sarah Kopelovich
Absolutely.

13:39.10
Ken
Without putting down CBPT, which I think helps millions of people and I'm a big fan of, this is kind of like next level care, isn't it?

13:43.86
Sarah Kopelovich
It is, and what you said is so important. Couple things you said are so important. One is shame. There is a tremendous amount of shame in the experience of having psychosis because we think it doesn't happen to other people, because oftentimes people think, I must be defective. They have all sorts of interpretations and I think it's critical that we target that shame before we can do good CBT and as we're doing good CBT. Doug Turkington has a quote that I've shamelessly stolen: "Normalization is the antidote to shame." And when we can help people understand that psychosis is actually a much more common experience than we realized before, then we can start to address some of that shame and help the person be open to more therapeutic techniques.

14:34.83
Ken
My father had very bad bipolar disorder and periodically became quite psychotic. Unlike a person who has schizophrenia and stable hallucinations, he would have change of state. He was hard to work with when he became impulsive and manic. My guess is optimal care would be working with him as you're treating the mania mostly with biologic treatments, medicines. You're also working with him so that the psychosis was not central to his self-definition. Is that how you would think about it? Because a person with mania has a state change associated with it, right? and I was just interested in your thoughts about that.

15:36.60
Sarah Kopelovich
I think it's critically important that we're providing access to CBT across the care continuum and even outside of the mental health system, because we're always looking for opportunities where the individual is going to be receptive to engaging therapeutically with us, to be able to start to address the shame, and to address the symptoms. I'm working right now with the state of Washington to develop a care continuum model where we would start CBT for psychosis on inpatients. They may still be in an acute state. In that state we may be working very hard on therapeutic engagement, on building trust and rapport, and on building insight not to the diagnosis, but building insight into the value of working with the treatment team. The treatment team is there to serve their interests and goals and, and if they align with us that we can work together. And then to have a supportive transition to outpatient where that care can be resumed once the acute symptoms of mania or psychosis are under better control.

The other piece that I think is absolutely critical to this is working with the families, working with the natural supports because once the person is outpatient, their treatment team may get one hour a week with them. The family has access to them all of those other hours of the week and we know from good quality research that when we engage the families, when we teach them about the disorder, when we teach them about strategies for therapeutic communication, when we teach them about what to say when their loved one is experiencing delusions, hallucinations, disorganization, that we can prevent rehospitalization. We can shorten the duration of hospitalizations if they do need a readmission. Everybody benefits: the system benefits, the individual experiencing the mental illness benefits, and the family benefits.

18:01.83
Ken
So it's a base of normalization and alliance: trust, reducing shame, and therefore the ability to work some of the cognitive belief systems that a person has. It's all kind of based on that.

18:17.46
Sarah Kopelovich
You got it.

18:58.50
Ken
You mentioned family. Let's talk ah about his family. Is what happened with Johnson and his family common or are there aspects of it that are unique?

19:24.45
Sarah Kopelovich
Johnson has an incredibly supportive family. He also has a high achieving family. Both of his parents are professionals. He was hoping to follow in his parents' footsteps. He has is a very close relationship with his sister. I think like a lot of other folks, he experienced his first psychiatric symptoms, aside from some inattention and some social anxiety that he had when he was middle school and high school, he started to experience more mood symptoms and some low level psychotic symptoms in high school that then escalated at college. That trajectory is quite common.

20:15.46
Ken
The classic trajectory. Yeah.

20:21.12
Sarah Kopelovich
He was away for college. He was out of state. He experienced a manic episode for which he was hospitalized. He ended up coming back to his parents' home and living with them and transferring where he was taking his classes. I think his academic achievements-- he was able to graduate college in spite of these disruptions and he was able to go on to graduate school. He then took a break because of his psychotic symptoms, which is the point at which he and I started working together. I think a lot of his achievements were really because he had that supportive family. But the other thing I'll say is that his family had had means. They had the ability to seek out excellent psychiatric care, excellent psychological care. They didn't get all of their care from one place, so I was not practicing in the same setting as his psychiatrist, but we were able to coordinate our care. I'm really passionate about the equitable access to evidence-based care. Your zip code or your socioeconomic status or your race should not be determinants of health.

33:39.84
Ken
How did CBT practices help him keep him from having episodes?

34:17.80
Sarah Kopelovich
One of the things that we find with CBT for psychosis is that we see durability in the effects of the treatment over time. One of the reasons for that is because we work very hard to point out when the individual is starting to feel better by using measures to assess our progress over time, and then to demystify the reason for that progress. We really work hard to make sure that the person is understanding what it is that they are doing that is contributing to the improvement that they're seeing. That really fosters the sense of agency and control and empowerment, right? These are core recovery principles. So what we did very early in the treatment was we started to construct a document called "Making Sense," where we looked at what are the things that are keeping the symptoms going or making them worse? These are called the maintaining or perpetuating factors. And what we learned for Johnson is that when he isolated from other people, when he didn't open up to other people when he was starting to hear voices, when he would start to catastrophize or magnify problems, and when he did something called "self-othering," which was his phrase for comparing himself to other people in a way that always had him coming out on bottom, that those were the things that made symptoms worse. Then we looked at the things that he was doing when he felt at his best. He was journaling, he was exercising, he was working on small goals. Not these Mount Everest goals. He was getting good quality sleep. He was hanging out

with his friends and his family and opening up to them about things getting tough. So right from the get-go, we have a list of things that we know that we need to do to make the symptoms better, and we have a list of things that he's already doing that makes the symptoms better. Then we start to work on those maintaining factors. What we found when we looked at those were, there were all sorts of ways that he was thinking about the voices and about his concern that other people could hear his thoughts that were making the symptoms worse. They were making his mood worse and also bringing on more voice.

We were able to spend a lot of time in the treatment using different strategies to evaluate some of those thoughts he was having. We generated alternative explanations, we actually examined the evidence: how accurate were these thoughts? How helpful were these thoughts? And then we did something that I think was key for him and for a lot of folks, which was constructing a behavioral experiment. We set up and designed together a specific experiment to test this concern that he was having that other people were able to hear his thoughts. And that was huge for really helping him internalize this idea that it was highly improbable that folks were able to hear his thoughts. Once we had all of that done all of that good work and we were seeing he was feeling better, and he was back at school, and he was able to stay in the classroom and attend to what he needed to attend to, and not get pulled away by voices or by these thought broadcasting concerns, then we pulled all of the work that we had done into a wellness plan. We constructed his personal relapse signature: the things that triggered the symptoms, early warning signs of symptoms, and then what he could do if those started to happen. Then we brought mom in and we informed her of that wellness plan so that she could help him. Also, I think it's critical that we're involving family in that wellness planning. They're often able to identify the first indicators of when somebody's becoming more symptomatic, and that's when you want to take action. Not when the symptoms become acute.

21:42.22
Ken
Yeah, so let's talk about that. For people who aren't privileged or have resources, how might you find a therapist who practices CBTp, either through a health plan, a community mental health center, an academic center? How might you approach that if you hear of this idea, perhaps on this podcast, and realize, this might help me? This approach is positive and might be beneficial to my loved one or myself. How might you start that search?

22:11.49
Sarah Kopelovich

Well, here's the good news. Let me start with the good news. It is the case now that you are more likely to find a practitioner who has been trained in CBT for psychosis in a community mental health setting, where they're accepting clients that have a range of different insurances, then you would be to find a practitioner in private practice who's trained in CBT for psychosis. Part of that is because we've had federal and state investments in training the workforce in evidence-based practices. I cannot understate the value of those investments. Most of what I do is supported by philanthropy dollars and State and federal dollars. And that has enabled me to start to build a CBT for psychosis provider network in the pacific northwest. You can go on to my website, my lab's website, which is https://uwspiritlab.org/ and you can see a map of where we've trained providers. And then there are a number of CBT for psychosis trainers who do open enrollment training, so we are seeing more private practitioners getting trained.

28:29.99
Ken
I want to ask a couple other questions. Are there any criticisms of CBTp? Have you heard any critique other than it's not omni-available or paid for?

28:54.24
Sarah Kopelovich
Sure. I think there are a couple of criticisms. Although there is a large body of literature suggesting that CBT for psychosis is effective for delusions, hallucinations, hospitalization, and mood symptoms, there are folks that think that the evidence is being oversold. They think that there's too much hype around CBT for psychosis. When we look at the literature, I would say there's less hype around CBT for psychosis as there is around the atypical antipsychotics, which are really the mainstay of treatment for schizophrenia in in the US. But the effect sizes are the same when we actually look at, not just is it statistically different from treatment as usual, but is it actually clinically significant? We see that the clinical differences are comparable to what we see with medication.

29:52.76
Ken
Nice. So You'd take both/and, right? There's no reason not to take medications *and* CBTp.

30:09.53
Sarah Kopelovich

I would, absolutely. That's the gold standard. I would say both/and should also include family interventions for psychosis, peer support, supported employment and education. We really want to wrap services around the individual and the family system.

31:33.25
Ken
What are your favorite resources for people? Books? Websites?

31:38.11
Sarah Kopelovich
I absolutely adore this series called *The Overcoming Series*. There are two books within that series that focus specifically on psychotic like symptoms. One is called *Overcoming Distressing Voices* and this is a self-help guide using cognitive behavioral techniques. The other is *Overcoming Paranoid and Suspicious Thoughts*.

32:08.75
Sarah Kopelovich
I think these are really fabulous books for folks to start to work through themselves and it really follows a similar trajectory as what you would find in therapist-delivered CBTp, where the person is getting some psychoeducation and then some concrete strategies. The other book that I would recommend for practitioners who are hoping to learn more about CBTp, one of the gold standards, is still Kingdon and Turkington's *Cognitive Therapy of Schizophrenia*. I think they're working on an update to that now.
For family members, there's a fabulous book called, *Back to Life, Back to Normality.* The second volume of *Back to Life, Back to Normality* is actually the foundation of the intervention that I alluded to earlier where we're training family members on high yield cognitive behavioral techniques, so that they can be engaging more therapeutically with their loved ones.

39:02.26
Ken
That's well-said. Sarah, before we stop, is there anything else you want to add to this podcast?

39:18.14
Sarah Kopelovich
What I most want people to know is that CBT for psychosis is effective. This is an intervention that can really change people's lives. I want to dispel of this myth that CBT is not appropriate for individuals with psychotic symptoms or psychotic disorders. What I also want folks to know is that advocacy, whether that's at the hyper-local level, at your

local community mental health agency, or at the federal level, is critical to enhancing access to CBT for psychosis. I cannot emphasize enough how important it is for family members and individuals with lived experience, as well as advocacy organizations, to be talking to administrators and clinicians and policymakers, legislators, and governors about the fact that this is an intervention that we need to make standard of care, because our treatment guidelines say that it should be. Our research says that it's effective. The Substance Abuse and Mental Health Services Administration issued a position statement within the last two years saying that CBT for psychosis should be accessible wherever individuals present for the treatment.

Ken: ***[01:06:18]*** Sarah, this has been a wonderful conversation. I learned a lot from you about CBT. It's so fun to talk about this with an expert who has worked in this for years. I want to thank Dr. Sarah Kopelovich, a professor from the University of Washington, for all the work she does to serve people with cognitive behavioral therapy for psychosis, CBTp, and for her advocacy efforts to make this a treatment that more people can access. *[01:06:34][16.0]*

EPISODE OUTRO:

JOHN: This has been The Medical Mind, a podcast from the National Alliance for Mental Illness.
The mission of SMI Adviser is to advance the use of a person-centered approach to care that ensures people who have serious mental illness find the treatment and support they need. Learn more at SMIadviser.org.
KEN: This podcast is hosted by Dr. Ken Duckworth and John Moe, and it's a production of Poputchik
This episode was produced by Ann Marie Awad (uh-wad) and mixed by John Miller
JOHN: Special thanks to Dr. Sarah Kopelovich (kuh-PELL-uh-vitch) and her patient, Johnson.
To find the rest of NAMI's podcasts and resources, go to NAMI.org, that's N-A-M-I dot O-R-G
JOHN MENTIONS KEN'S BOOK: *You Are Not Alone: The NAMI Guide to Navigating Mental Health* release: September
KEN MENTIONS JOHN'S BOOK: *The Hilarious World of Depression*, out now