inSocialWork Podcast Series – The Perspectives Approach to Treating Mental Illness

Speaker 1 [00:00:00] Hi, everybody, and welcome back to inSocialWork, I'm Peter Sobota. Helping professionals and students of all stripes are familiar with the various iterations of the DSM, the Diagnostic and Statistical Manual of Mental Disorders, now in its fifth edition. It's pretty much the Bible for the classification and naming of psychiatric disorders here in the United States. And it arguably dictates assessment diagnosis, of course, and the treatment in huge segments of all the helping professions. Full disclosure, my personal copies of the DSM are under a floor lamp in my office, but I'm the host, not the guest. Beyond my own concerns, there are plenty

Speaker 2 [00:00:46] of other popular criticisms

Speaker 1 [00:00:48] of this book and classification system. First and foremost, is that it's largely a disease based, pathology driven worldview and a socially constructed framework that falls way short of the science and the complexity of the human experience. The more cynical takes sight how both the

Speaker 2 [00:01:08] development and the

Speaker 1 [00:01:10] implementation of the DSM drives insurance reimbursements,

Speaker 2 [00:01:14] funding at the

Speaker 1 [00:01:14] governmental level

Speaker 2 [00:01:16] and feeds the pharmaceutical

Speaker 1 [00:01:18] industry to name only a few of the kind of greatest hits. All this said, our interest was piqued when we learned about the work of our guest, Margaret Chisholm, M.D., who likely

Speaker 2 [00:01:29] shares perhaps some of these

Speaker 1 [00:01:31] concerns and whose practice in writing offers an alternative

Speaker 2 [00:01:34] approach to thinking

Speaker 1 [00:01:36] about and treating folks experiencing mental illness. Margaret Chisholm, M.D., is Vice Chair for Education, Psychiatry and Behavioral Sciences and professor of psychiatry and behavioral sciences at Johns Hopkins University School of Medicine. Her latest book, written for consumers, is From Survive to Thrive Living Your Best Life with Mental Illness. Margaret Chisholm. Meg, thanks for joining us and welcome to inSocialWork.

Speaker 3 [00:02:04] Thanks, Peter. I'm really excited to be here. So happy to talk about this work.

Speaker 1 [00:02:09] We're excited to have you. So what I like to do is just begin

Speaker 2 [00:02:14] kind of

Speaker 1 [00:02:14] talking about what I think you're offering an alternative

Speaker 2 [00:02:18] to.

Speaker 1 [00:02:18] And if you do indeed have ambivalence about the labels that are kind of applied by the DSM.

Speaker 3 [00:02:26] Could you talk about that a little bit? So, you know, the DSM has its strengths. You know, it's great

Speaker 2 [00:02:34] for researchers

Speaker 3 [00:02:36] who want to make sure that the signs and symptoms they see that they're

Speaker 2 [00:02:40] studying are the same

Speaker 3 [00:02:42] across different research sites. I would say that it's not a great clinical tool. And in fact, I think it has harmed patients from getting the help they need. So my problem with the DSM is it's a lot of categories and checklists, so it reduces patients to a sliver

Speaker 2 [00:03:03] of who they

Speaker 3 [00:03:04] are

Speaker 2 [00:03:05] as people. And really,

Speaker 3 [00:03:07] the DSM is really focused on diagnosis and not on formulation of

Speaker 2 [00:03:11] patients. And when I

Speaker 3 [00:03:13] say formulation, I mean, thinking

Speaker 2 [00:03:15] about the

Speaker 3 [00:03:16] origins of their problems from all kinds of different sources, not

Speaker 2 [00:03:22] just brain

Speaker 3 [00:03:23] disease sources. And even though the DSM claims to be a theoretical, I'm not saying that these are diseases per se say that categorical approach to

Speaker 2 [00:03:34] classifying patients

Speaker 3 [00:03:36] experiences really lends itself to thinking of them as diseases.

Speaker 1 [00:03:41] Yeah, which seems incredibly limited when you think about the context in which people live their lives

Speaker 2 [00:03:49] and just

Speaker 1 [00:03:50] how unique people

Speaker 2 [00:03:51] are. Person to person

Speaker 1 [00:03:53] really well said. I'm sure we could do an entire podcast swapping ideas about that. But your book Survived to Thrive is written for a lay audience who are experiencing mental

Speaker 2 [00:04:03] illness and is rooted in the

Speaker 1 [00:04:06] perspectives

Speaker 2 [00:04:07] approach to treating mental

Speaker 1 [00:04:08] illness. Could you talk a little bit about this approach? I know it's been around for a while, but I'm not sure everybody is clear about what makes it distinct. And so how this approach is especially different from a DSM driven approach and maybe the other ones that are popular.

Speaker 3 [00:04:25] So the perspectives approach encourages us to consider patients from various

Speaker 2 [00:04:30] vantage points and think

Speaker 3 [00:04:32] about whether or not

Speaker 2 [00:04:33] this problem

Speaker 3 [00:04:35] or set of problems that a patient is bringing

Speaker 2 [00:04:37] to us, if that's best

Speaker 3 [00:04:38] understood or best

Speaker 2 [00:04:40] explained as

Speaker 3 [00:04:41] something that's come upon them, something that they have a disease like schizophrenia

Speaker 2 [00:04:46] or mania, or is this who they

Speaker 3 [00:04:49] are or reflection of who this person is,

Speaker 2 [00:04:52] their affective

Speaker 3 [00:04:54] temperament,

Speaker 2 [00:04:54] their cognitive

Speaker 3 [00:04:56] strength? Or is this problem or a set of. Problems best understood as

Speaker 2 [00:05:02] emerging from something

Speaker 3 [00:05:03] that they're doing, are they restricting their food

Speaker 2 [00:05:06] intake or are they using

Speaker 3 [00:05:07] substances and or is this

Speaker 2 [00:05:10] set of problems really best

Speaker 3 [00:05:12] understood in a meaningful way as as

Speaker 2 [00:05:15] a growing out of experiences

Speaker 3 [00:05:18] that they've

Speaker 2 [00:05:18] encountered and the stories

Speaker 3 [00:05:21] that they're telling

Speaker 2 [00:05:22] themselves or the ways that

Speaker 3 [00:05:23] they've dealt

Speaker 2 [00:05:24] with these problems?

Speaker 3 [00:05:26] So it's a way of formulating the perspectives approach as a way of formulating

Speaker 2 [00:05:30] patients,

Speaker 3 [00:05:31] not just diagnosing them with each perspective. There's an

Speaker 2 [00:05:36] associated kind of aim

Speaker 3 [00:05:38] or goal with the treatment, so it's not formulation at the

Speaker 2 [00:05:42] level of let's understand

Speaker 3 [00:05:43] the problem, but it also is linked to how we're going to solve this problem together.

Speaker 1 [00:05:48] Yeah, I mean, it really strikes me as very person centered and

Speaker 2 [00:05:51] holistic rather than really

Speaker 1 [00:05:53] narrow blinders

Speaker 2 [00:05:55] about what's wrong.

Speaker 1 [00:05:56] Now, feel free to talk to me like I'm 12 when it comes to this because I really don't claim to understand it thoroughly. There are four dimensions or four perspectives that are addressed in the approach. Could you say more about that?

Speaker 3 [00:06:09] Shared their four

Speaker 2 [00:06:10] perspectives? So there's the disease

Speaker 3 [00:06:12] perspective we ask ourselves, Is this something that a patient has? There's three dimensional perspective in which we ask ourselves, Is this something growing out of who the person is? There's the behavior

Speaker 2 [00:06:27] perspective which

Speaker 3 [00:06:29] promises to ask ourselves, Is this

Speaker 2 [00:06:32] problem emerging

Speaker 3 [00:06:34] from something the patient is

Speaker 2 [00:06:35] doing? And then

Speaker 3 [00:06:36] the fourth

Speaker 2 [00:06:37] perspective is the

Speaker 3 [00:06:39] life story perspective. Is this best explained by something that the person has encountered?

Speaker 2 [00:06:45] So is a disease,

Speaker 3 [00:06:47] dimensional behavior and life story. Those are the four perspectives.

Speaker 1 [00:06:52] When you're applying the

Speaker 2 [00:06:53] perspectives, you have these

Speaker 1 [00:06:55] perspectives

Speaker 2 [00:06:56] that kind of

Speaker 1 [00:06:57] provide a

Speaker 2 [00:06:58] framework for what you

Speaker 1 [00:07:00] ask them and what you talk to people about. And so really, it's an assessment

Speaker 2 [00:07:04] approach, but it

Speaker 1 [00:07:05] also is just a wonderful way of just acknowledging that you are more than what's happening to you and that you're living a life in a context and that context matters. And what I'm really interested in hearing more about

Speaker 2 [00:07:19] is the kind of

Speaker 1 [00:07:21] the life story perspective,

Speaker 2 [00:07:22] because when I listen to

Speaker 1 [00:07:24] you, talk

Speaker 2 [00:07:24] about that, what I'm almost

Speaker 1 [00:07:26] hearing is something akin to like a narrative approach. Are there similarities there

Speaker 2 [00:07:31] or or not?

Speaker 3 [00:07:33] So you're right, we're putting a patients problems that they're bringing to us into the context of their life and who they are as a person. And that's actually what I say to patients when

Speaker 2 [00:07:43] they first come. You know, people

Speaker 3 [00:07:45] come with a quote unquote chief complaint. I don't like

Speaker 2 [00:07:47] that term, but they come with a

Speaker 3 [00:07:49] concern

Speaker 2 [00:07:49] or a problem that they want help with

Speaker 3 [00:07:52] their lives, not where they want it to be. Here's what's going on. And what I usually say to a person is, Look, I'm going to ask you a lot of questions. It's going to take probably an hour, at least to get through these questions. I spent two hours with someone

Speaker 2 [00:08:04] on the initial

Speaker 3 [00:08:05] evaluation, at least. Wow. So it's going to I'm going to ask you a lot of questions. I'm going to

Speaker 2 [00:08:09] start with your family history and I'm going to move

Speaker 3 [00:08:12] forward in time because I want to put into context the problem that you're bringing to my attention right now. The thing that's concerning most. I want to put that into the context

Speaker 2 [00:08:22] of who you are as a person and what life

Speaker 3 [00:08:25] experiences you have. And so that's that's the role

Speaker 2 [00:08:29] induction that I give

Speaker 3 [00:08:31] to the patients because oftentimes they've been to other treatment providers who haven't used that same approach. And so they might be startled by all these questions

Speaker 1 [00:08:41] and sometimes maybe even traumatized by some of the people who they've met along the way.

Speaker 2 [00:08:46] I mean, you know,

Speaker 1 [00:08:47] both professionally and personally, I could give you examples of that. So I'm really digging what you're saying here.

Speaker 3 [00:08:52] Well, absolutely. The first question I ask people

Speaker 2 [00:08:55] actually is, have you ever seen

Speaker 3 [00:08:57] a mental health professional

Speaker 2 [00:08:58] before I say

Speaker 3 [00:09:00] that, you know, I want to explore that and I'm going to get into

Speaker 2 [00:09:02] more detail later on in the evaluation about that. But what

Speaker 3 [00:09:06] I really want

Speaker 2 [00:09:07] to let them

Speaker 3 [00:09:08] know is that I may be doing things differently than they've experienced, and this is the

Speaker 2 [00:09:13] reason why I really want

Speaker 3 [00:09:15] to understand them as a person and people are often just so

Speaker 1 [00:09:18] appreciative. Oh, sure, it's transparent. They're a partner, right?

Speaker 3 [00:09:23] And they really want to share their story, and nobody's really asked them about their growing up years or things like that at the initial appointment, especially with the psychiatrist. I would say so. So, so you're absolutely right. Putting the person's problems in the context of who they are as a person is important.

Speaker 2 [00:09:42] The life

Speaker 3 [00:09:42] story perspective

Speaker 2 [00:09:44] is

Speaker 3 [00:09:45] obviously the most personal of perspectives. It involves the setting of a person's life, the sequence of events in their life, and it does have that same arc as a narrative right setting sequence. An outcome, and in part, the outcome is the story that people are telling themselves about these life experiences and how they have dealt with these life experiences.

Speaker 2 [00:10:12] So the

Speaker 3 [00:10:13] goal, if the

Speaker 2 [00:10:14] problem is thought

Speaker 3 [00:10:15] to be emerging primarily from life story

Speaker 2 [00:10:19] perspective or if the problem

Speaker 3 [00:10:20] somebody is bringing us is

Speaker 2 [00:10:22] best understood as

Speaker 3 [00:10:24] having its origin in things that the person has encountered in their life or experiences life experiences, then the goal of treatment for that person is really to understand the story that they're telling themselves and to every script that story collaboratively to one that is more adaptive.

Speaker 2 [00:10:44] Yeah. So do you

Speaker 1 [00:10:45] see the story in kind of like that post-modern tradition where as people tell themselves stories about themselves in

Speaker 2 [00:10:53] their lives, literally

Speaker 1 [00:10:54] what they're doing is creating meaning and truth?

Speaker 3 [00:10:57] Absolutely.

Speaker 2 [00:10:59] Oh, OK. And I want to make

Speaker 3 [00:11:01] it clear

Speaker 2 [00:11:01] that these

Speaker 3 [00:11:03] perspectives or these different explanatory methods

Speaker 2 [00:11:07] are not

Speaker 3 [00:11:08] mutually

Speaker 2 [00:11:09] exclusive.

Speaker 3 [00:11:10] They're interactions between all these aspects of a person's life. So somebody can be experiencing a disease and they can. That's an event, something that

they've encountered in their life to which they're giving meaning. And the way that they react to this event is often an aspect of their personality, too. So these are all interacting with one another. I don't want to say that that somebody who has

Speaker 2 [00:11:40] the disease of schizophrenia is

Speaker 3 [00:11:44] someone that we're going to treat purely as having a disease. We're not going

Speaker 2 [00:11:49] to just remedy them or cure

Speaker 3 [00:11:51] them with

Speaker 2 [00:11:52] medication, but we're also

Speaker 3 [00:11:54] going to want to explore the meaning

Speaker 2 [00:11:56] that that disease

Speaker 3 [00:11:58] had to them. I was that interrupted their life course.

Speaker 2 [00:12:01] And what strengths they have in terms of their temperament

Speaker 3 [00:12:05] and their personality, what strengths they have that have enabled them to cope with that and intrusion into their self?

Speaker 2 [00:12:14] Well, we have been talking very long. But if I

Speaker 1 [00:12:17] ever need a psychiatrist, can I give you a call? Know I'm being sincere. I want to ask you another question about the life story.

Speaker 2 [00:12:26] But I'm just going

Speaker 1 [00:12:26] to ask you this. I know personally and

Speaker 2 [00:12:29] professionally a number of

Speaker 1 [00:12:30] psychiatrists, and

Speaker 2 [00:12:32] I would not dare lump

Speaker 1 [00:12:33] them into any one category because they are very different, folks. But I'm curious, do you ever get grief from your colleagues? Do you get questioned about practicing this way? Because from where I sit, you're challenging some longstanding practices in your field where it is pretty clinical and narrow. At least what I

Speaker 2 [00:12:56] hear, and you do not

Speaker 1 [00:12:58] sound

Speaker 2 [00:12:58] that way whatsoever.

Speaker 3 [00:13:01] Well, thank you.

Speaker 1 [00:13:02] I guess that's a compliment. Yeah, it

Speaker 3 [00:13:04] is. Yeah. Well, I actually feel very privileged to have trained at Johns Hopkins,

Speaker 2 [00:13:10] so

Speaker 3 [00:13:10] I trained there

Speaker 2 [00:13:11] in a group where

Speaker 3 [00:13:13] I guess it starting in the late 80s through the early 90s and already for at least I would say 10 years. This had been

Speaker 2 [00:13:22] the way

Speaker 3 [00:13:24] that psychiatrists have been trained at Hopkins, and they continued to be trained in that. So this is the only psychiatry I really know.

Speaker 1 [00:13:31] Wow. So you're surrounded by like minded

Speaker 3 [00:13:33] folks, at least at our institution, having been trained in this way, has actually kept psychiatry interesting to me. I think I would be very bored with checking signs and symptoms off a list and not really

Speaker 2 [00:13:47] understanding my patients as people. I was trained

Speaker 3 [00:13:51] and continue to train psychiatrists

Speaker 2 [00:13:53] to provide their

Speaker 3 [00:13:54] own psychotherapy for their patients if

Speaker 2 [00:13:56] they wish to do that. Wonderful. I think that's how you get to know

Speaker 3 [00:14:00] people through the psychotherapy, and I find it really limiting. Sometimes, of course, I

Speaker 2 [00:14:05] have patients who

Speaker 3 [00:14:07] are referred to me by psychology or social work colleagues. And you know, I like having that mix and having, you know, some patients that I'm doing psychotherapy with every week and other patients, I'm seeing less

Speaker 2 [00:14:21] frequently and focusing more on medication. But I would say that

Speaker 3 [00:14:26] if I

Speaker 2 [00:14:26] didn't have the

Speaker 3 [00:14:27] ability to really get to know my patients, regardless of why they're coming

Speaker 2 [00:14:31] to me, if I didn't

Speaker 3 [00:14:32] get an opportunity to know them as people, I would find this field to be really boring. So that's the joy of practicing. Psychiatry is getting to

Speaker 2 [00:14:41] know people as

Speaker 3 [00:14:42] individuals and even even for those, quote unquote, medication checked patients. You know, I still see them for a minimum of half an hour because I want to know who they are. I want to know what's been happening in their lives because

Speaker 2 [00:14:54] that's going to be relevant

Speaker 3 [00:14:56] to understanding any symptoms that they might be having. I can't just attribute every symptom somebody has to, you know, the disease of depression that I might be treating them for.

Speaker 2 [00:15:06] Yeah. Well, thank you for

Speaker 1 [00:15:07] even entertaining the comment and the question. I appreciate it, but it's striking. OK, so this is kind of an organized now. Can I circle back to the life

Speaker 2 [00:15:15] story, please? What I

Speaker 1 [00:15:17] know you do from the little bit of research

Speaker 2 [00:15:19] that I've done is that

Speaker 1 [00:15:20] you, when you're working with folks, you offer your patients articulate and you examine the story, you offer people an opportunity to rewrite it. Can you give an example, maybe even a brief one, if possible, if that's

Speaker 2 [00:15:34] even possible of a

Speaker 1 [00:15:36] life story that's been scripted in a way that expands

Speaker 2 [00:15:41] meaning or

Speaker 1 [00:15:42] offers comfort or assistance to a patient?

Speaker 2 [00:15:46] So there are a lot

Speaker 3 [00:15:47] of

Speaker 2 [00:15:47] examples I could give of stories that

Speaker 3 [00:15:50] have

Speaker 2 [00:15:50] shifted and have

Speaker 3 [00:15:51] helped people. So their common sort of stories, a lot of people come to psychotherapy because they're experiencing

Speaker 2 [00:15:58] loss and

Speaker 3 [00:16:00] they might

Speaker 2 [00:16:01] be feeling

Speaker 3 [00:16:02] guilty about the loss. You know, there's survivor's guilt, for instance, or there's feeling like they might have

Speaker 2 [00:16:08] somehow brought this

Speaker 3 [00:16:10] loss on through

Speaker 2 [00:16:11] their their own

Speaker 3 [00:16:12] actions. You know that they're being punished for

Speaker 2 [00:16:14] something or whatnot.

Speaker 3 [00:16:16] So commonly with that kind of script, I might

Speaker 2 [00:16:18] tentatively collaborate

Speaker 3 [00:16:20] with a patient

Speaker 2 [00:16:21] to try

Speaker 3 [00:16:22] to work together to develop

Speaker 2 [00:16:24] a more. More helpful

Speaker 3 [00:16:25] way of looking

Speaker 2 [00:16:27] at that loss, reframing it as

Speaker 3 [00:16:30] perhaps a random act

Speaker 2 [00:16:32] of tragedy or finding some way to to glean

Speaker 3 [00:16:35] meaning from the loss that will help them move forward. I'll give a specific example. It's actually not one of my patients, and I often

Speaker 2 [00:16:43] feel like I don't want to

Speaker 3 [00:16:45] share my patients stories unless they've given me permission to. But this one is as a friend,

Speaker 2 [00:16:50] actually who lost a

Speaker 3 [00:16:51] baby

Speaker 2 [00:16:52] to SIDS. You know, this is

Speaker 3 [00:16:53] somebody who is a

Speaker 2 [00:16:55] colleague, upper

Speaker 3 [00:16:57] middle class

Speaker 2 [00:16:58] educated

Speaker 3 [00:16:58] person who is co-sleeping with her baby.

Speaker 2 [00:17:02] And that is a risk factor for SIDS.

Speaker 3 [00:17:05] Although most of those

Speaker 2 [00:17:06] studies that

Speaker 3 [00:17:07] associate co-sleeping with your infant

Speaker 2 [00:17:10] with SIDS are done

Speaker 3 [00:17:12] with people who are living in impoverished circumstances. And so there are a lot of confounding variables there and those studies, there could be other reasons besides co-sleeping, like

Speaker 2 [00:17:23] nutrition or other problems with quality of the bed.

Speaker 3 [00:17:27] People are sleeping in if they're sleeping in a bed at all things like that. This friend of mine, after she lost her

Speaker 2 [00:17:33] baby, she went to her

Speaker 3 [00:17:34] pediatrician

Speaker 2 [00:17:35] because

Speaker 3 [00:17:36] that's kind of the norm and said, You know, I worry

Speaker 2 [00:17:41] that, you know, this is because

Speaker 3 [00:17:42] of co-sleeping. Did I do this? Did I kill my baby? And that was the story she was telling herself. She was blaming herself for this loss. And this pediatrician said, Yeah, I think so.

Speaker 2 [00:17:54] Now that could

Speaker 3 [00:17:55] be true, but it wasn't helpful. And I can assure you, this woman is never going to sleep with another baby because of that experience, even regardless of what this pediatrician said. Now, if this were my patient and she came

Speaker 2 [00:18:11] to me with this

Speaker 3 [00:18:12] story, I would say, Well, you know, these studies

Speaker 2 [00:18:17] are flawed.

Speaker 3 [00:18:18] And yes, there's no association, but I think you're a wonderful mother. And there are plenty of people that go to sleep with their babies, and this doesn't happen to them. And you know, I think this is one of those random acts of tragedy that we'll just never understand. How are you going to make meaning of this? What can you do to give this

Speaker 2 [00:18:38] loss and this

Speaker 3 [00:18:39] experience some meaning in your life

Speaker 2 [00:18:42] and not only help

Speaker 3 [00:18:43] your self, but maybe even help other people?

Speaker 1 [00:18:46] Yeah, it's really quite compassionate

Speaker 2 [00:18:49] and what I'm

Speaker 1 [00:18:50] hearing, and I just want to check

Speaker 2 [00:18:52] out with you.

Speaker 1 [00:18:53] Once you identified the patient's story, you don't replace the story. It sounds like you build on it, you expand it. So it's not a matter of correction.

Speaker 2 [00:19:04] It's more

Speaker 1 [00:19:05] of elaboration and growth

Speaker 2 [00:19:08] and perspective.

Speaker 1 [00:19:10] Is that fair?

Speaker 3 [00:19:11] I mean, I think people are hard wired to tell themselves stories to explain experiences, and this is known from the work of the neuroscientist Michael Gazzaniga, for instance. So people are hard wired to tell themselves stories,

Speaker 2 [00:19:26] and I'm honoring

Speaker 3 [00:19:27] that story.

Speaker 2 [00:19:28] I understand. And that's what I would say.

Speaker 3 [00:19:31] You know, I noticed that you're kind of framing it this way, and I totally understand

Speaker 2 [00:19:35] that given X,

Speaker 3 [00:19:37] Y and

Speaker 2 [00:19:37] Z. But I'm wondering

Speaker 3 [00:19:40] if there may be another way, or I'm wondering if it might be

Speaker 2 [00:19:44] beneficial to consider this. I mean, again,

Speaker 3 [00:19:47] very tentative honoring the story that someone's telling themselves, but at the same time, opening them up to reflection

Speaker 2 [00:19:55] about

Speaker 3 [00:19:55] other ways of thinking.

Speaker 2 [00:19:57] Yeah, so much like what I'm learning

Speaker 1 [00:20:02] about your approach to clinical work,

Speaker 2 [00:20:04] which seems wonderfully

Speaker 1 [00:20:05] authentic and transparent in your writings, you've also been

Speaker 2 [00:20:11] pretty open that

Speaker 1 [00:20:12] you have suffered life experiences that have been, to say, the absolute least extraordinarily challenging. You have talked about

Speaker 2 [00:20:19] your own experience

Speaker 1 [00:20:21] of postpartum

Speaker 2 [00:20:22] depression and even

Speaker 1 [00:20:23] the suicide

Speaker 2 [00:20:25] of your brother.

Speaker 1 [00:20:26] Of course, to the degree that you're comfortable even talking about this with me and with our listeners.

Speaker 2 [00:20:32] Can you

Speaker 1 [00:20:32] explain how those

Speaker 2 [00:20:33] experiences informed or even

Speaker 1 [00:20:36] were informed by the approach that you're talking with us about today?

Speaker 3 [00:20:41] I have had a long experience with mental illness because my brother became ill around the time I went to college, so I had a lot of family exposure

Speaker 2 [00:20:52] to

Speaker 3 [00:20:52] a psychiatric illness. I had a because when I was in medical school, my first cousin, I had two first cousins,

Speaker 2 [00:21:00] but one of them

Speaker 3 [00:21:02] took his own life when he was in his

Speaker 2 [00:21:03] early 20s. And so I've had a

Speaker 3 [00:21:06] lot of experience prior to going to medical school with psychiatric

Speaker 2 [00:21:10] illness. I had no interest

Speaker 3 [00:21:11] in being a

Speaker 2 [00:21:12] psychiatrist. In fact, I was kind of turned

Speaker 3 [00:21:15] off by my interactions with the mental health professionals once I'd

Speaker 2 [00:21:20] had so, but when I did

Speaker 3 [00:21:23] finally as a medical. All students have required rotations when my last I put it off as long as I could on psychiatric service, I really just love talking to people and hearing people's stories, and I was on a book that was primarily for people with schizophrenia.

Speaker 2 [00:21:42] And so I

Speaker 3 [00:21:43] just found

Speaker 2 [00:21:43] that there was no these were patients

Speaker 3 [00:21:45] that were, for the most part, marginalized, neglected, very ill

Speaker 2 [00:21:49] patients.

Speaker 3 [00:21:50] And I just loved sitting and talking to them and getting to know them as people. I think just showing

Speaker 2 [00:21:56] them kind of human

Speaker 3 [00:21:57] kindness was something that was therapeutic and helpful. So so when I became a psychiatrist, I think my own family experience made me realize that I

wanted to be a different kind of psychiatrist. And then my own interest in other human beings made me realize that I wanted to be a different kind of psychiatrist than someone who was just treating people as diseases more or less. So that was my experience, and I think that helped me. Those experiences helped

Speaker 2 [00:22:28] me become a

Speaker 3 [00:22:30] better psychiatrist. And then after I had completed my training, I had my first child,

Speaker 2 [00:22:36] my own child and developed postpartum

Speaker 3 [00:22:38] depression, which I think also informed my interactions with my patients because I knew what it was like to be on the other

Speaker 2 [00:22:47] side had had

Speaker 3 [00:22:49] known what it was like to be on the other side as a family

Speaker 2 [00:22:52] member. Now knew what it

Speaker 3 [00:22:53] was like to be on the other side as the patient themselves. And so, so all those experiences have caused me

Speaker 2 [00:23:00] to be really

Speaker 3 [00:23:01] aware when I'm with a patient and a family

Speaker 2 [00:23:03] member of how they're

Speaker 3 [00:23:05] experiencing the doctor patient

Speaker 2 [00:23:07] interaction, and it's allowed me to

Speaker 3 [00:23:09] be more compassionate. And then obviously, with my brother's

Speaker 2 [00:23:12] suicide, just

Speaker 3 [00:23:13] deepened the appreciation for my

Speaker 2 [00:23:16] patients who had family members take their own

Speaker 3 [00:23:19] lives.

Speaker 2 [00:23:20] Well, thank you for even talking with

Speaker 1 [00:23:23] us about painful

Speaker 2 [00:23:24] times.

Speaker 1 [00:23:25] But what a fantastic example of what you've been talking about all along. You have a story

Speaker 2 [00:23:31] that yours and

Speaker 1 [00:23:32] it has informed just about every

Speaker 2 [00:23:35] dimension of your life and

Speaker 1 [00:23:37] now your practice in your work. Thank you. It's going to be hard to top that one.

Speaker 2 [00:23:43] But let's see if we can continue

Speaker 1 [00:23:46] just a little bit. You talk about four pathways pathways to happiness and health. Would you like to just talk about those? I mean, that might be a nice add on to the story we've been telling here today.

Speaker 3 [00:24:02] Sure. And it's more hopeful, I think, too. So it's a little confusing because I'm talking about four perspectives and I'm going to shift to talking about four pathways. I'm sorry, the same number I think will have to start with. Yeah, yeah. So I have an interest in not only helping people

Speaker 2 [00:24:21] get over their problems that they

Speaker 3 [00:24:23] first seek help with, but

Speaker 2 [00:24:25] also as a psychiatrist,

Speaker 3 [00:24:26] I feel it's part of

Speaker 2 [00:24:27] my job to help people

Speaker 3 [00:24:29] lead the fullest life possible. And I think this probably comes from my work at the Center for Addiction and Pregnancy. I worked for 10 years

Speaker 2 [00:24:37] with people primarily

Speaker 3 [00:24:39] drug dependent pregnant

Speaker 2 [00:24:40] women. And often it was

Speaker 3 [00:24:42] relatively easy to help them stop

Speaker 2 [00:24:44] using heroin for the most

Speaker 3 [00:24:46] part during their pregnancy, because there were lots of motivators for

Speaker 2 [00:24:50] that. But then once

Speaker 3 [00:24:51] they delivered and had less motivation

Speaker 2 [00:24:56] from outside forces, it sometimes

Speaker 3 [00:24:58] became a challenge to help them sustain their abstinence from drugs. Sure.

Speaker 2 [00:25:05] And so it's always been my

Speaker 3 [00:25:08] interest

Speaker 2 [00:25:09] to think about how I, as a

Speaker 3 [00:25:11] psychiatrist can

Speaker 2 [00:25:12] help them

Speaker 3 [00:25:13] sustain their recovery and

Speaker 2 [00:25:15] actually go on to lead

Speaker 3 [00:25:17] full lives. I've had

Speaker 2 [00:25:18] patients who

Speaker 3 [00:25:20] have been sex workers using I.V. drugs who have gone on to be full professors,

Speaker 2 [00:25:27] so I am very

Speaker 3 [00:25:29] hopeful about the illness of addiction. And so I have thought

Speaker 2 [00:25:35] about what helps people

Speaker 3 [00:25:36] be successful and in the addiction world. It's relatively common

Speaker 2 [00:25:42] to think about

Speaker 3 [00:25:44] the role of family in supporting someone in their recovery, to think

Speaker 2 [00:25:49] about the community, specifically the community

Speaker 3 [00:25:52] of a

Speaker 2 [00:25:53] or an A or the

Speaker 3 [00:25:54] faith community that someone may be from that helps support them through this transition from solo kind of lonely life of

Speaker 2 [00:26:04] addiction to

Speaker 3 [00:26:05] reengaging

Speaker 2 [00:26:06] with

Speaker 3 [00:26:07] family and

Speaker 2 [00:26:08] community as a way

Speaker 3 [00:26:09] of providing

Speaker 2 [00:26:10] these what I would call competing

Speaker 3 [00:26:12] reinforcers,

Speaker 2 [00:26:13] these other positive

Speaker 3 [00:26:14] things in one's life that can

Speaker 2 [00:26:16] compete with the drug

Speaker 3 [00:26:17] addiction. Mm-Hmm. Also, the importance of work is well known in addiction, right?

Speaker 2 [00:26:22] You need to find some way of bringing meaning

Speaker 3 [00:26:26] to your life and purpose and regularity. That work provides some of these, depending

Speaker 2 [00:26:31] on you to show up, to

Speaker 3 [00:26:32] do the job. And also education. Obviously, we encourage women in the center prediction pregnancy to go back to

Speaker 2 [00:26:40] school or to get their GED

Speaker 3 [00:26:42] if they've dropped out of school and

Speaker 2 [00:26:44] didn't want to go further in their education.

Speaker 3 [00:26:47] So those

Speaker 2 [00:26:48] ideas that it's important to

Speaker 3 [00:26:49] have support from family, from your

Speaker 2 [00:26:51] community, to have

Speaker 3 [00:26:53] meaningful work and to have an education

Speaker 2 [00:26:56] that will not only help you get

Speaker 3 [00:26:58] more work or better work or more meaningful

Speaker 2 [00:27:01] work, but an education

Speaker 3 [00:27:02] that would help you enjoy life. So that's sort of common knowledge in the addiction field, but I found it isn't really something that psychiatrists think about otherwise. And certainly health care

Speaker 2 [00:27:14] professionals don't

Speaker 3 [00:27:16] typically think it's their job to start focusing on these

Speaker 2 [00:27:19] topics. And then I

Speaker 3 [00:27:20] became exposed to the work of Tyler Vander Wheal

Speaker 2 [00:27:23] at Harvard, who

Speaker 3 [00:27:25] has developed this model of human flourishing,

Speaker 2 [00:27:28] looking at the

Speaker 3 [00:27:28] various domains of flourishing happiness and life satisfaction,

Speaker 2 [00:27:33] physical and mental health, meaning and

Speaker 3 [00:27:35] purpose, character and

Speaker 2 [00:27:36] virtue, and close social relationships. And he's an

Speaker 3 [00:27:40] epidemiologist who's actually

Speaker 2 [00:27:41] studied these large longitudinal,

Speaker 3 [00:27:45] long term data

Speaker 2 [00:27:46] sets, and he's

Speaker 3 [00:27:47] drawn causal inferences, cause and effect

Speaker 2 [00:27:51] explanations for people who

Speaker 3 [00:27:53] are able to

Speaker 2 [00:27:54] achieve these

Speaker 3 [00:27:55] success in these domains of flourishing, who are finding purpose in their life, who are physically

Speaker 2 [00:28:00] healthy, who have close social

Speaker 3 [00:28:02] relationships, and he's

Speaker 2 [00:28:03] found these pathways to flourish. So the four

Speaker 3 [00:28:06] pathways to flourishing are

Speaker 2 [00:28:08] family, community work and education. No surprise. So I think it's

Speaker 3 [00:28:13] part of our

Speaker 2 [00:28:14] job. I think it's part of my

Speaker 3 [00:28:16] job as a psychiatrist

Speaker 2 [00:28:17] to

Speaker 3 [00:28:18] ask patients

Speaker 2 [00:28:19] about where they are

Speaker 3 [00:28:21] on these pathways. Have they burned all their bridges with their family? Do they

Speaker 2 [00:28:25] need to rebuild

Speaker 3 [00:28:26] those

Speaker 2 [00:28:26] connections, or is it healthy

Speaker 3 [00:28:28] to rebuild those connections? Are they part of any

Speaker 2 [00:28:31] community, whether it's

Speaker 3 [00:28:33] a religious community or another kind of community

Speaker 2 [00:28:37] from which they could draw

Speaker 3 [00:28:38] some support and some meaning? ET cetera, et cetera, so I just I think

Speaker 2 [00:28:43] exploring where our patients

Speaker 3 [00:28:45] are along these pathways to

Speaker 2 [00:28:46] flourishing is

Speaker 3 [00:28:48] essential to helping them

Speaker 2 [00:28:50] flourish once they get

Speaker 3 [00:28:51] over their acute illness or the

Speaker 2 [00:28:54] problems that they came for help with. I think it's

Speaker 3 [00:28:57] really essential for

Speaker 2 [00:28:58] someone to Liverpool life to

Speaker 3 [00:29:01] reflect on where they are on

Speaker 2 [00:29:02] these pathways and for us

Speaker 3 [00:29:04] as health care professionals to support them along these pathways.

Speaker 1 [00:29:08] You are just

Speaker 2 [00:29:09] playing music that excites the

Speaker 1 [00:29:12] ears of social workers. I can just tell you, you know, we like to pride

Speaker 2 [00:29:15] ourselves as and

Speaker 1 [00:29:17] you know, I know this is in our

Speaker 2 [00:29:18] exclusive domain, but we

Speaker 1 [00:29:20] like to pride ourselves as the person in

Speaker 2 [00:29:22] environment people. And, you know,

Speaker 1 [00:29:24] we like to look at the individual in the context of the relationships and then in the context of their larger community and

Speaker 2 [00:29:30] society. And you are

Speaker 1 [00:29:32] just hitting all of the marks with that. And yeah, it's just wonderful to

Speaker 2 [00:29:36] hear it articulated

Speaker 1 [00:29:38] by somebody other than the social worker.

Speaker 2 [00:29:40] Quite frankly, it actually

Speaker 1 [00:29:41] gives me a lot of hope

Speaker 2 [00:29:43] as well. And I

Speaker 1 [00:29:44] also just wanted to back up when you were talking about some of these domains in the

Speaker 2 [00:29:49] Egyptian world. And I've always

Speaker 1 [00:29:51] been amazed that the community reinforcement approach, which includes every one of those things you just talked about as something that needs to be addressed in true recovery, if you will recovery. That not only means that you alter your use of the

Speaker 2 [00:30:05] substance, but you actually

Speaker 1 [00:30:07] had live a meaningful life, which is, you know, no small task to make yourself

Speaker 2 [00:30:14] miserable by cutting yourself off from, you know, a primary

Speaker 1 [00:30:17] relationship with a

Speaker 2 [00:30:18] drug. And I

Speaker 1 [00:30:19] always found it interesting that the community reinforcement approach is one of the most well-researched, evidence based

Speaker 2 [00:30:25] approaches that is

Speaker 1 [00:30:26] barely

Speaker 2 [00:30:27] used in settings

Speaker 1 [00:30:28] that treat addictions throughout the country. So, yeah, thank you for giving voice to that as well. People can't see you, but you're nodding your head. I'm wondering if you just say something?

Speaker 3 [00:30:38] Yeah, no. I mean, I think we're doing research like this at Johns Hopkins, where I am in our department. This is just part and parcel of how we treat

Speaker 2 [00:30:46] addiction is,

Speaker 3 [00:30:48] you know, people have to have a

Speaker 2 [00:30:49] job within a year

Speaker 3 [00:30:50] of being

Speaker 2 [00:30:50] in the program. They have to

Speaker 3 [00:30:52] have a community support person that comes in and that shows up for a group once

Speaker 2 [00:30:57] a week. This is just

Speaker 3 [00:30:59] built

Speaker 2 [00:30:59] into our treatment.

Speaker 3 [00:31:01] I know it doesn't happen everywhere. I've had people

Speaker 2 [00:31:04] come from other treatment

Speaker 3 [00:31:06] facilities or people have wanted to leave our program because of that

Speaker 2 [00:31:10] intensity to go to

Speaker 3 [00:31:11] programs that are less demanding in terms of time and effort. But I do believe that's what it takes to, well, get well and stay well.

Speaker 1 [00:31:22] Well, I mean, I'm nodding in my head for listeners who can't see me, but you know, even all that said, the evidence is actually on your side, you know, so if we're if we're going to be in evidence based, you know, helping profession, it's kind of nice when what we're doing winds up with that. So, yeah, so we are beginning to run. We're getting close to what our time limit is here. And I was going to ask you a little bit about why you thought. A patient should allow, you know, their friends and their family members to talk with their treating physician, you know, as collateral contacts. But you've already answered that before I could get to it. I think you made a very compelling argument. I think that's a wonderful idea. So if I if I could, would I'd. What I'd like to kind of conclude with is kind of like the end of the story here is so what we want are people who feel better, have improved functioning, have meaning and who are happy or to a degree that that's, you know, reasonable for them. So here here's a silly question. How would you? Define recovery. From mental illness. But what what does that look like, if you will, given your perspective?

Speaker 3 [00:32:52] I'm trying to remember I just saw something when we find it. Sure. Take a moment here, which I thought was a really interesting look. I haven't probably don't have it. I think Maya Salivate, who's just written a new book, she wrote Unbroken Brain, I don't know what her new book is called. She had a definition of recovery, which I think was something like being a little better each day. I'm just going to say that. Yeah. So I guess my definition of recovery is. Being a little better person each day and I say person, not just feeling better or, you know, doing better things, but being a better person and the whole idea of thriving and flourishing is it's not necessarily about. What we're doing, although doing things, helps get you to that point. But it's about becoming so I see recovery, I see recovery as an ongoing. There's not an end point, right? I don't think anybody's as well as they can ever be. I think we can all be a little better each day. We can all be have more satisfaction. More. Meaning in our lives. Have. Be practicing more virtues and have closer social relationships every day. I think we're always evolving and in and recovery is is a journey, right? Not a destination.

Speaker 1 [00:34:41] Yeah. So in in in what I hear is you are not a recovering psychiatric. Human community who struggles with some unique aspects of your life. Yeah. Wonderful. Yeah, that is a great place to end, but I can't help myself. I've got to sneak one more thing in here because my curiosity has been piqued here. I read up a little bit about you in Prep for this, and I and I discovered that you I think early on, perhaps even in your undergraduate education, you started out with a very strong interest in the arts and I believe specifically the visual arts. And it sounds like that has not gone away. And obviously, now that we've talked for a bit, at least, I see how that has kind of woven its way into your story, both as a as a professional and as a person, and that you're integrating this perspective, an appreciation or a cultivated cultivation of the of the artistic life into your training of residents in your program?

Speaker 3 [00:36:00] Yes. So my life is I haven't been able to shake the arts. I guess it's my life. Oh, good for you. Yeah. Well, I'm married to an artist, and that's awesome. Yeah. Haven't been able to shake.

Speaker 1 [00:36:13] Yeah, it's getting deeper. Yeah. OK, here we go.

Speaker 3 [00:36:16] No. So so I really see it's very interesting how one's life plays out, so in ways that we can't predict, but I really feel like my life's come full circle. So I was as used as I was. I was a visual arts major in college. I had a film concentration. I'd actually been accepted to graduate school at NYU in cinema studies before I went to medical school, before I made the decision to go to medical school. You know, I hadn't taken many medical school kinds of pre-med kind of classes. So yeah, so I and I didn't really do much with it. In medical school, I had I did one independent elective looking at paintings to kind of see signs and symptoms of various physical illnesses. But aside from that, once I went into my residency and did my psychiatry training and through many years of practicing psychiatry had really no professional. Interest in applying the arts, so in 2015, I went to a health professions educators course at Harvard. It was a yearlong course and there they had a day at the Boston Museum of Fine Arts, where we learned how to. Look at art in a way that was relevant to clinical practice. And I got really interested in the half hour back and and started trying that out with my psychiatry residents. And then the Harvard Macie Institute developed a fellowship for art, museum based health professions education. And I was in that fellowship cohort. I think that was now 2018, 2019. That was the year. And there's been no looking back. So I've now I'm a certified visual thinking strategies facilitator. I'm working my way to be a coach in that program. I have gone back to teach in two successive cohorts of the fellowship. I have grants. Right. I have grants that have supported programs using the arts. In medical education, I'm particularly interested in professional identity formation of medical students. Yeah, I I'm very interested from my work in addictions and with other patients with psychiatric illness. I'm very interested in ensuring that all patients are treated with the respect and dignity that as human beings, we all inherently deserve. And so I've been and most people listening would probably be aware there's a lot of stigma towards people with psychiatric illness and including addiction. And a lot of our patients are not treated very well by the health care system and particularly not treated well by some physicians. And so I'm very interested in helping physicians understand the big questions of what it means to be human. What it means to be a physician and what it means to lead a good life. In an effort to ensure not only that all patients are treated with respect and dignity, but also that the practitioners themselves, the physicians themselves can. Practice self-care that helps their own mental health and also helps them flourish. So I found the arts to be a really great way to explore these big questions that encourages self-reflection, appreciation of multiple perspectives and. Really growth in mindset.

Speaker 1 [00:40:44] Well, one, I'm so glad I asked, I'm I'm smelling a podcast where we just talk about that. So I think this is the place where we drop the mic. Dr Meg Chisholm, thank you so much. It was a pleasure to talk with you. Thanks again for joining us.

Speaker 3 [00:41:02] Thank you so much. It was really fun.

Speaker 1 [00:41:05] Thanks again to our guests, Dr Meg Chisholm. And thanks to the people who help us tell the story on this podcast. That's Steve Sturman, our podcast director. Kate, there's graduate production associate, content editor, research assistant and guest coordinator. And I'm Peter Sloboda. Please check out our new website at In Social Work Board. And please, I implore you to follow us on Twitter and Facebook. Add in social work talk. Check out our new website at in social work at Ord.. And I am imploring you to follow us on Twitter and Facebook at in social work.