Talking to Change: An MI Podcast

Glenn Hinds and Sebastian Kaplan

Episode 56: Motivational Interviewing in Psychiatry, with Antoine Douaihy, MD

Glenn Hinds:

Hello again, everybody, and welcome to Talking To Change: A Motivational Interviewing Podcast. My name is Glenn Hinds, and I'm based in Derry, Northern Ireland. As always, I'm joined by my good friend, Sebastian Kaplan in Winston Salem, North Carolina. Hi Seb.

Sebastian Kaplan:

Hey Glenn, how's it going, man?

Glenn Hinds:

It's doing good. I am doing good, man. Another great episode recorded today with our friend from the MINT world, from Motivational Interviewing and Network of Trainers, Antoine Douaihy, who is a psychiatrist from the University of Pittsburgh. So today, we're exploring the relationship between motivational interviewing in the practice of psychiatry. But in advance of having a chat, before the episode, if you want to just remind people how they can stay in touch.

Sebastian Kaplan:

So, on Twitter, they can use the handle @changetalking. On Facebook, it is Talking to Change. On Instagram, it is Talking to Change podcast. For any direct communication with us, for questions, for episode recommendations, anything like that, you can email us directly at podcast@glennhinds.com.

Glenn Hinds:

Fantastic. And as I say, the episode today was really exploring the relationship between the practice of motivational interviewing in the world of psychiatry. We were very fortunate that Antoine has agreed to do a role play. So, at the end of the episode, about 25 minutes of role play with yourself and Antoine. What was your takeaway from today then, Seb?

Sebastian Kaplan:

Yeah, so I think for me, one was sort of a big picture takeaway. For those who don't know, and I might reference this later in the episode, I'm a psychologist who works in a department of psychiatry here at the Wake Forest University School of Medicine. For most of my career, I have dedicated the work I do, whether it's clinical or educational, to having it some way related to motivational interviewing. I would say it remains a challenge for me to, not so much... Well, the application of motivational interviewing is challenging and difficult to many respects, and something I strive to get better at, but the teaching part of it, in particular teaching MI to medical students and maybe in particular to psychiatry residents, whose training perhaps comes from kind of a different place, let's say, the medical model is something that Antoine references. It's not that MI and the medical

model are in conflict with each other, certainly, but it takes a bit of thinking and creativity on how to marry the two.

It's something that remains a challenge for me. So, it was really great to hear Antoine describe the way in which he uses MI, not just clinically, but the really rich description of his use of MI in teaching context with medical students and with psychiatry residents. Then a specific concept that he mentioned that I found interesting was the idea of the limits of helpfulness and we are and should be helpful to the patients that we work with, certainly, but we can't be all things to all people. And to recognize that there are limits in what we can do in our roles are helpful, not just in the clinical realm and helpful for the patient, but it can also be helpful for us as the provider to recognize that not every outcome falls completely on our shoulders. Those are the two things that kind of stood out to me. How about for you, Glenn?

Glenn Hinds:

That idea of the expert trap, it's almost like that's what Antoine was describing there, but the limits of helpfulness is that we're not responsible for everything that happens in this helping relationship. Certainly, that fits very much with our understanding of the spirit of MI, which is building on the strengths and the talents of the individual themselves. They've made it this far without us. How did they do that? And what can we bring to the party, that can support them achieve whatever it is they're looking to explore for themselves. Building on what you're saying yourself, I'm a social worker by trade and in my own practice over the years, I've worked in mental health and in addictions and multidisciplinary teams where there was this blend of the social model and the medical model.

Most of us will recognize the tension, that professional tension, that can exist in a team where individuals who've been trained in slightly different models of understanding approach their work. And Antoine interestingly explores that idea that motivation interviewing perhaps has its origins, because of its rootedness in psychology, more from a social perspective than from a medical perspective, and his willingness by chance, as it turns out, to be introduced to motivational interviewing and indeed addictions and how the trajectory his life changed in a very positive way.

And just how he has been endeavoring to understand what it was that Miller and Rollnick were first beginning to talk about early eighties, late eighties, and that he's still endeavoring to develop and practice for himself as a psychiatrist, but also, as you say, as an educator for new doctors, whether they stay in psychiatry or go on to more specific or generalized medicine for their future. For him, it's just about being a good listener and being helpful by listening properly or in a more efficient way. It's just that balanced and balancing use of the relationship that he describes, and that's modeled in the short 15, 20-minute role play at the end of this episode, where you are a new patient or a relative new patient to his psychiatric care. So, when we say cheerio to Antoine, you will hear then the opportunity to stay on and listen to your role play, which we'd recommend. But let's get on with the show. Hope you enjoy it.

Sebastian Kaplan:

Well, Antoine, thanks so much for joining us. We're real excited for our conversation today. Maybe you could start with how we often start with our guests, telling little bit yourself, the work that you do, and what we've come to coin, your early MI story.

Antoine Douaihy:

Thank you. Thanks for inviting me. I really appreciate it. Well, it's in a way really, I would say, a fascinating story. My first exposure to MI was back in my first year of residency training in Syracuse, New York. I had a great mentor at that time who was an addiction psychiatrist, Dr. Tinelli. We were supposed to meet for mentorship, he was assigned to me, and it was at the VA. At that time, I was in my first year, starting close to the second year of my residency training in psychiatry. And interestingly enough, he told me, "Okay, well, before we start really our mentoring sessions, I'd like you to read a book." And he handed me the first edition of Motivational Interviewing, which was really, I had no idea what was that about?

Then he said, "Okay, well, I know that you have an elective that is coming up. How about if you would be interested in working with me on the inpatient unit at the VA, which is really an addiction floor. They see a lot of patients who are going through withdrawal. Obviously, a lot of substance use patients, with substance use as well as PTSD." So, I said, "Well, look, I'm not really much interested necessarily in the substance use field. I would really kind of prefer if I can do it in a more of an inpatient setting, that's fine. I can do it probably working with patient with depression, anxiety."

That was my main interest at that time. I was not much interested in addiction and substance use and said, "Look, I know that you don't have much experience. You don't know much about it. At the same time, it would be very kind of a general experience, general exposure to really listening to people's stories and what they are going through. And you're going to see a lot of these patients who have substance use disorder, who experience depression and anxiety. So don't really kind of look at the patient as just a disorder itself, look at the patient as a whole. And I would really encourage you to do that rotation."

I said, "Okay, great. I will try it. It was two weeks." I'll tell you; it was an amazing experience because as I mentioned, I wasn't experienced in terms of knowing much about addiction. And you talking about back in '92 at that time, '92, '93, and even the field of addiction has not evolved much at that time. We had limited kind of treatments. There were a lot of psychosocial treatments that were available, but at that time, also, there hasn't been much in terms of clinical trials. So the one aspect that was so fulfilling for me, and that was really very much also aligned with the time when I started rereading the book and we started the conversations about motivational interviewing, is that how it also fits very clearly with really seeing patients who are struggling with their motivation to change about different behaviors, particularly substance use, or the depression, how to manage their depression.

Also, a lot of the patients that I've seen have a lot of comorbid medical issues. So, you talk about patients with the diabetes, hypertension, heart disease. So we talk about multiple behaviors that they were supposed to really manage and deal with, and really the motivational interviewing approach and learning it at that time and getting a little bit of

an understanding of what it what it's about, using it in a sense as a kind of a road map for the work that I've done, was really fascinating and very fulfilling for me.

It was really kind of a total change in my whole mindset and my whole perspective about psychiatry, but also about my interest in addiction. So, this is how my interest in addiction basically started and then I started building on it. Since then, I have been practicing addiction psychiatry for now 27 years, more than 27 years. I'll tell you; I would really say that the MI has been a big part of my growth professionally, but also personally throughout all these years. Learning it, practicing it, training in it and training practitioners in it and doing even clinical trials, so I have the whole range of experiences with motivational interviewing, particularly with the aspect of, as you know, the issue of the fidelity issue.

Because we hear a lot of people saying, "Well, I do motivational interviewing," and then you see them in action, and then you wonder, what are you referring to exactly? So that does not sound like if it's motivational interviewing. So, this has been my story, and I have really evolved through the whole process as an addiction psychiatrist. I'm very much involved in training medical students, particularly my biggest interest has been medical trainees, specifically medical students. Here at Pitt, we have really integrated motivational interviewing curriculum into the whole aspect of psychiatry … Initially it was a part of the psychiatric curriculum, at the same time I, in a sense, tried to move it away from just really giving it that it's a part of just psychiatry, just moving it more into the behavioral medicine. And the medical school embraced that and that really this has to be more mainstream practice and they've adopted it. We are really now one of the medical schools in the country that really seriously train medical students in motivational interviewing.

Glenn Hinds:

Yeah, what's interesting about what you're saying is the significance of the fact that we're here talking about change and supporting other people change, that in 1992, '93, you had a plan for yourself. And there was a moment, a transition moment where you were invited to think about something differently, and it led you in a completely new trajectory. It sounds like the two things happened alongside of each other. One was that you were introduced to addictions, and there was something about working in the addiction field that captured your attention.

But alongside of that, was the introduction to motivational interviewing and what that offered to you. It was all that, what was significant was that invitation for you to begin by listening to your patients. Your mentor said, "Look, just come here and just practice listening because it'll be helpful wherever you go." It sounds like you've stayed there ever since in that world. So, I guess what I, and I guess other people, are interested in is, what was it about addictions, and more specifically given the podcast that we're on, what was it about motivational interviewing that meant that you married those two things so successfully for this long?

Antoine Douaihy:

Yeah. That's a great question. Initially, I was really terrified because I had no idea, I had no experience whatsoever working with patients in general. It was really my first year and I've done most of what we do in the first year also is medicine, medicine and neurology

and the training in psychiatry. When I look at how much it was really motivational interviewing was so helpful for me, is that it made me think of patient stories from a nonjudgmental, more compassionate, as you mentioned, the whole listening aspect and not feeling that I need to do the work. I've learned a lot from just the listening to the stories that the patient shared with me and, again goes back to what we talk about with MI, is being present with them.

It was a way for me to help me feel more confident too, that, "Look, they're going to be the ones who are going to make the change. You need to walk, to be there to guide them through the whole process." So, in a sense, it gave me from the beginning, that kind of a different perspective of what really the practice of psychiatry was. Which is really in a sense, because I never thought, "Okay, well, wait a second. I know that, in the first edition, as it was more about addictive behaviors." There was nothing much discussed outside that area because there wasn't much obviously evidence based or there wasn't many studies. But at the same time, it was more when I read the preface in the first edition.

In the preface, there was a paragraph that starts with, "A word of informed consent. This approach is likely to change you." I keep going back. This is from 1991. In fact, it did change me. I keep always reflecting when I share my experiences with trainees and practitioners, I keep mentioning this to them and I, as we say, give them that... Bill Miller has talked about it, about the informed consent, getting really kind of a consent from them that we are going to be training you where you might see that approach as potentially transforming you into, not necessarily changing your style, but just giving you that sort of a different perspective on what would be like working with patients and what would be really fulfilling about it. I felt it was really perfect fit with who I am, as a person, which I look at my whole experience for more than now, I've been in Pittsburgh for 22 years and I've trained so many.

I mean, I have on average 25 to 30 medical students that I train every year and I can tell you, 98% of these students felt that the motivational interviewing approached the spirit of it, the way of being with people, the empathic way of being with people was a really perfect natural fit for who they are as people in general, not just how they going to practice medicine. I don't think there has been anything much more fulfilling in my whole career than this. Yeah, I do a lot of clinical work. I see patients, obviously this is also fulfilling. I do clinical trials and I do a lot of dissemination, a lot of training, but that particular aspect, that feeling that I can also share my experience of what I've gone through in terms of my growth in the process of learning and really living it, in a sense, and making it a part of my identity and sharing it. They kind of relate. Majority of the students relates so easily and so quickly.

I'll tell you it happens within few days of working together because most of where I do the work in MI is on the inpatient unit on our addiction floor. This is where the students and the residents work with me for four... Initially we used to be five weeks a rotation, now it's four weeks. So, you're talking about really longitudinal experience, so they get that experience of working with patients and getting the supervision, the coaching, the in vivo coaching, the mentoring and all that. So, in a sense, it becomes really very much integrated into their daily routine of working with patients.

Sebastian Kaplan:

Yeah, yeah. Your passion for MI here, 20, 30, however many years later, is still quite evident. I'm just thinking back to that preface of the book that you cited there, that Miller and Rollnick wrote back in '91, or at least published in '91. Probably began writing it in the late eighties. The idea that, just so you know, this might change you. Right? You reference that for yourself as a young resident working in the VA hospital. For those who don't know what that is, it's a Veteran's Administration hospital, it's a federally funded system here in the US.

But it spoke to you and therefore would likely speak to others. It suggests that the path that they thought they would be on might change because of MI. It kind of speaks a bit to one of the questions I was curious to explore with you, which was in psychiatry, there's something about MI that might feel a bit different that if a psychiatrist, if a resident, were to adopt motivational interviewing as a significant part of their practice, or integrate it into their practice, that's actually something that might be different from what one might traditionally experience in the world of psychiatry.

With that kind of broad brush there, I wonder if you could just speak to why MI might be a shift or a kind of a difference maker in terms of psychiatrist practice.

Antoine Douaihy:

Yes. Thank you for this great reflection you made here. Well, if we think of the field of psychiatry, and it has really obviously evolved over the course of the years, I mean, we're dealing with issues, very commonplace issues in psychiatry. You talk about medication adherence, you talk about management of depression, anxiety, maladaptive coping, any different kind of issues, substance use, I mean all these. Or any kind of behavioral determinants and aspects of patient health. So, it's not really much different than any areas of medicine. In a sense, I think we have that kind of a tendency to stigmatize psychiatry, obviously, because obviously when it comes to the mental health, emotional issues, a lot of people struggle with getting an understanding of what people really go through.

I do strongly believe that MI, as an approach that is using a guiding style in focusing on empowering people, identifying and sensing of their strengths, values, aspirations. And obviously fundamentally, also we'll talk about supporting and promoting the autonomy when it comes to the decision making, as you know now, we talk a lot about shared decision making that becomes very much integrated into the practice of medicine. So, in a sense, I see it as a perfect fit. I see it as a perfect, natural fit into what we do every day. Unfortunately, the practice of psychiatry has not been structured with really integrating MI. Obviously, it's getting better and better now, but traditionally it has not been because all what we... I look back at my own training is that, and particularly as you know, the field of psychiatry or psychiatrists, in a sense, we were not a part of that movement. Let's put it this way. Of the MI movement.

It was more obviously coming from psychologists, social workers. So, we were not really part of that mobilization about how you can integrate MI into psychiatry. Obviously, there are a lot of challenges. We know very well that the image that I talked about little bit earlier, the image of psychiatrist as the diagnostician, I hate to say the word, pill pusher, this is what we are perceived, the prescriber. The language of med checks has basically in a way undermined our powerful role, even in these 10, 15, 20 minutes. As you know,

a lot of the aspects of the brief motivational interventions, the adaptations of MI, can be very much well integrated in that sort of a context.

At the same time, I kind of believe also that it is not the issue, and this is what's been a challenge for me, in the context of the work that I do with patients in psychiatry and training psychiatry residents and practitioners and nurse practitioners who work with patients with psychiatric disorders, is that thinking about it, is, how can we fit it in, in terms of the conversation?

I don't have much time. I don't have the whole half an hour. How can I fit it in? I need to collect data. I need to really come up with a diagnosis. I need to come up with what medications could work, what treatment. Then what ends up happening is that we don't realize that if we approach it from that perspective, we are really losing, in a way, the patient. We are not really improving engagement. We are using some sort of an approach that is not collaborative, that is not really empathic, that is not meeting people where they are. It's in fact, in a sense-

Antoine Douaihy:

... where they are is, in a sense, running the show. We are really here to kind of tell you... Again, we talk about it a lot, in medicine, the righting reflex, which is that sort of an impulse, an urge and desire to fix. And so, it comes across to people that, "Look, all I'm here really for..." And this is unfortunately how patients perceive us. I am here just... "Okay, what are you going to give me? What medication you got to give me? And how long you going to spend time with me here, five, seven minutes?" And so, let's talk about it. And it becomes totally unproductive. And not just really unproductive, I'm talking about my own experience, it leaves you with that kind of a sense of, "What am I really doing here? I mean, really, from a kind of integrity aspect, from an ethical aspect, am I engaging the patient in a way that I know scientifically is an evidence-based that can move the person into really kind making changes after they leave?"

And that is a really big kind of an ethical dilemma, in a sense. And this is where... I have a couple of colleagues now, and friends, who were mentees, basically. And then I mentored them through psychiatry training. Josh Mora, who's in Buffalo, and Dan Cohen, who's here in Pittsburgh. And they use the concept of motivational psychiatry when it comes to really... It's like, we're really trying to integrate it and really present it as really more of how you can really integrate it as really a humanistic, empirically based approach in the field of psychiatry that is really focused a lot on productivity. Focused a lot on how many patients can you see in an hour. Focused a lot on get the data, collect the data, and really, let's move on. And make a diagnosis, tell the patient what the diagnosis is, and tell them what treatments are.

And not necessarily give them a menu of options or treatments. Just tell them that this is what would work for them. So, in a sense, so there is this kind of... I really struggle with that dilemma, in a sense, when trying to really debunk these myths about how MI could be reintegrated. It's like, "No, it is not possible to integrate it. It's just really, this is not for psychiatry. It's really for a clinic where they treat diabetes, where they treat really heart disease." And I think this has been my biggest challenge in the field to really kind of, in a way, get people to see, in a way, because you have to really show them how it works.

You can't just, "We can talk about it." If they are not witnessing and experiencing how it fits in, in these kind of 10, 15-minute sessions, or how the conversation would remain collaborative... am I adherent? And how it could really elicit patients' motivations and perspectives, and work with them to come up with the decision together, they're going to tell you, "Well, no, I don't know how we could really do this in this short period of time," when you're really kind of rushed and you have to document, and you have to really be consumed by a system that has not been really, to begin with, structured to really adopt the MI approach.

Glenn Hinds:

Yeah, so it's almost like you're saying that psychiatry has its own PR issues, within it, in the general world, but also within itself. That there's ideas that they have of itself, and that there's misunderstanding, there's misrepresentations out there. And that it's not that psychiatry didn't want to be part of this process. It was just, they're a bit later to the party than... because at the beginning, as you say, it was psychology and social work. So more from a social model of practice. But in the intervening years, psychiatry has been watching the research coming and going, and it's tweaking some people like yourselves' interest. And they're now asking questions about how and if, can Motivational Interviewing be supportive of us?

And that lovely way you're describing it, that motivational psychiatry, which is... It's almost like you're saying, "Look, you don't have to give up being a psychiatrist. You're not going to become a psychologist. You're not going to become a social worker. You're going to stay a psychiatrist, but this stuff can aid you in what you're doing," which is that opportunity to practice in a more purposeful, and sounds like in a more personally rewarding way. That you're a doctor, you want to be helpful, and you don't want to just be giving people pills. You don't want to be forcing your values on other people. You want to be helpful.

And for you, you have learned, Motivational Interviewing is a vehicle to help you be both a psychiatrist and be genuinely helpful to people who need it, in an egalitarian way that isn't just top down, it's about working with. And I guess one of the things to be curious about, and I imagine there may be psychiatrists or individuals who are considering a career in psychiatry, so how do you do that? And how do you help existing or new psychiatrists begin to consider using MI? What is it you're offering them that catches their attention?

Antoine Douaihy:

Yeah. What I believe has been really fascinating to see is when they start working with patients, when they start their first session, they always call it a culture shock when they see me engaging the patients, using the MI approach, and really having conversation about setting the agenda. Getting the patient's perspective on really what they are struggling with without bombarding them with closed questions, one after another. So, when they start really seeing that, by example, how really that approach and how this whole way of being with the person is about, they start realizing, "Wait a second, it does work."

The patients start really making statements about wanting to engage in treatment. They want to really consider some options of medication that we can recommend. So, what they see in particular, and this is what my model has been... Particularly on the inpatient treatment, we do the rounding and we see the patients all together. And usually, it's the medical student or the resident, psychiatrist resident, or even the addiction psychiatry fellow, would do the session first. They finish their session and I take over, continue my session. And then we can really discuss and give the feedback, the in vivo coaching, to the students. So, what they have seen is really that example of even in a 10, 15-minute, 20-minute session, you can accomplish so much and you can move the process of change. And when they witness this, and without obviously doing it using closed questions and educating, preaching, lecturing. Without these kind, as we call them, roadblocks.

And they notice that if you are really just present with the person, and you are really... And again, we talk about it in MI, and this is one aspect that I want them to always really see, is the equanimity aspect. Being composed there. Being really balanced. Not rushing the person, the patient, and taking the pause aspect of when you reflect, give them a little bit of that kind of really 10, 15, 20 seconds to really process what you said. And that's sort of a pace because they come from really different rotations where they start bombarding patients with closed questions, and then asking, to collect more data. And all really kind of in a way that comes across really... Without intentionally being judgemental. They are not. But it comes across very judgemental, and the patient becomes really frustrated, creates that discord in the relation.

And they wonder, "What is really going on here? I want to know what they are going through." I said, "Well, the way you're doing it. It's not necessarily... Your intention is you want to get the story, get the patient's story and what they're going through. The problem is the way you're doing it is really kind of creating that..." Again, we used to call it resistance. Guys, I avoid that because I keep always really putting in the context of really a discord. You're creating it. The way you're doing it creates that sort of frustration. "And why don't you kind of sit on the other side of this encounter? And I'm going to do this really and bombard you with all these kind of questions to really collect data, and see what it feels like." "Oh, I think I wouldn't like it. Oh, it just would be exhausting, and I wouldn't want to really talk about what I'm really going through."

So, I think, from that kind of a model of really the modeling aspect, the in vivo coaching, it's kind of, in a sense, more of an incorporation of different methods of learning. But I believe there is nothing that really replaces the in vivo coaching. And we talk about really their session, but also, we talk about what's going on with the patients. What sort of an impact did their session have on the patient? How did the patient move? Whether they have been more ambivalent now, after their session with them, or they've been less ambivalent. They are expressing more change talk. Where are they moving?

And help them really kind of, in a sense, do that really functional kind of analysis type that we do obviously in.., but the functional analysis about really the session, how it was navigated and how much genuine they were. How much really, they maintain equanimity. How much they maintained, first and foremost, the spirit of MI. Because they always really struggle initially with, they want to really start with the skills. They want to start with really the open questions, reflection. And really what I see always, and is

missing, is that first and foremost, the spirit. You have to really be present, first and foremost. Anybody can really, in a sense, do reflections or ask a question. It's just really, they notice that that kind of a part sometimes is really missing.

And they build it gradually. And I see it, over the course of one week, two weeks, and the patients give them a lot of the feedback mostly about, "We appreciate you were there listening to me." They don't tell them, "Well, we appreciate that you just prescribed Prozac for me." You know what I mean? But they tell us, "We appreciate you were really just helping me understand what I'm going through." And so, this kind of, in a way, becomes like some sort of an epiphany for these students. "Wait a second, that does work, and I'm going to take it with me." It's not just, "I'm going to practice it doing psychiatry." Let's say, "If I'm not going to do psychiatry, I want to be able to really do it if I'm in surgery, if I'm in family medicine, if I'm in pediatrics." So, they start seeing how it can be applied across. So, the psychiatry example is really kind of, in a way, disseminated into other practices.

Sebastian Kaplan:

I mean, you're really describing nicely an example of an experiential experience over the course of many, many days and weeks. And I think it goes to show the richness of what you're describing, but in some ways, the importance of going beyond maybe more traditional views about how we teach, in medical training programs, right? It's beyond ways in which people might be thinking of how to teach something like Motivational Interviewing, that it has to move outside of a lecture hall or a small classroom. You can't rely solely on PowerPoint slides and little exercises that you might do on a breakout group. You're talking about a multi-week experience with real patients, making real decisions that impact people's lives. And your modeling of the MI spirit and skills, and your observation of residents trying this out for the first time and debriefing right after a conversation with a patient and giving them feedback and having an opportunity to go back and try again, and incorporate that feedback day in, day out, is what you're offering.

And I imagine, from the standpoint of a psychiatry resident... And as I mentioned before we started recording, I've met two people independently who've met you and worked with you and found your work quite impactful. So that's really, really wonderful to hear you describe that. My question is, it's a bit about... And I don't know if I've mentioned it already on the recording, but I've been in a department of psychiatry... as a psychologist, granted, but in a department of psychiatry now for over 15 years... and one of the things that I think I've observed, I guess, in a way that makes MI somewhat challenging, at times, to integrate is some of the language or common terms that we use in psychiatry that describe people or patients, right? I guess I contrast it with how, say, a primary care physician might talk about another patient, right?

So, a doctor might talk about someone's blood pressure or someone's blood glucose level or range of motion, or these kinds of things which are fairly distant from how a person sees themselves, right? It's just the way their blood flows or how their knee feels, or something like that. But in psychiatry, we have these terms like insight, judgment, personality, or other ways to describe people that I think, anyone could recognize, could feel quite offensive. Addict, raging borderline, these sorts of things. And I guess I'm just

wondering your experience as an MI practitioner, and a teacher of MI, in how you either reframe something like calling someone an addict, right?

You already talked a bit about starting to kind of move away from the word resistance. Right? That was one example you've already shared. But even something like insight, right? That's such a common term. "So-and-so lacks insight. So-and-so has poor judgment." And so, it's kind of a long-winded entry into my question, but how do you use some of these common terms in psychiatry, but use them from the standpoint of the MI spirit in a way that's more patient centered?

Antoine Douaihy:

Well, you're making really excellent points here, which has been really what you mentioned about the whole stigma, the challenge of the stigmatizing language that has been ingrained also in our society. And when I'm having conversations with my trainees, I always refer to, "If this were to be somebody with diabetes, how would you approach the fact that they cannot...? They struggle with managing the diabetes. They struggle with really managing checking the blood sugar. How would you really kind of see that? How would you really approach the patient differently than if you were to have a patient with really severe depression and they have a hard time taking their medications consistently? If they have a hard time being activated? What they do to really feel much better, and to isolate that."

And it's really fascinating because initially the response, as you mentioned, Sebastian, is more that kind of a really more concrete. When there is more concrete things to really focus on for trainees, it's easier to really kind of see it as a focus of treatment. Versus when there are some things that are more kind of related to emotional struggles, they really feel like it's just vague. "I don't understand it." And you talked about some of these concepts of insight, which kind of sometimes really drives me nuts because it kind of comes with this whole thing of, when you mention insight, or the patient lacks insight, or has a poor judgment... And I kind of feel immediately too, it kind of drives me nuts because it kind of really conveys some judgment here.

And the judgment comes from the fact that... How about if we understand what they are struggling with instead of just using a label? Because first of all, when you use a label, "Here we go, another..." This is an implicit bias. You're really kind of going from that perspective that if you see them as lacking insight into their behaviors, what are you going to do? Are you going to really inject insight into them so they can really make the change? So, I just reach out, and they said, "No, but I mean, it's just..." "So then how would you want to approach it?" I think the challenge has been, particularly in working with patients with psychotic disorders, is we know very well that the whole damaging labels... And you know that whether the addicts, schizophrenics, I mean, we use, as you said, the raging borderline, all this, clearly invalidating, disengaging. And instead of kind of going into conversations about diagnosis and being the expert there, and really the diagnostician in a way, how about if we have conversation and maintain some sense of humility and some sense of really...?

Again, I talk about the equanimity, some sense of openness. "Well, what is your understanding? I mean, obviously these are your symptoms that you've described, that you've struggled with. What is your understanding, first, of what...?" Because we have a

lot of patients who come tell us, "Well, I am bipolar. I am schizophrenic. I am this and this." And I kind of right away want to react, in a sense, tell them, "Don't play with yourself," but obviously I'm not going to do it this way. I approach it from, "So would it be all right with you if we have a conversation about it, in terms of what do you mean by all these kind of...? They told you these kind of things. They told you that you have a bipolar illness, they told you this. What is really exactly your understanding? We can work here together on figuring out your better understanding." In a sense, using their words to really build on helping them understand better what they're really going through.

And again, what I think about it is that what I'm looking for is just, I want to really kind of try to move away from this whole medicalized system that psychiatry has been... How can I say? Has been paralyzed with. I mean, we've been paralyzed by this whole medicalized, looking at things from always a medicalized thing. And as you know, also the substance use problem has always looked at this chronic disease, chronic relapsing disease, all this kind of terminology that even comes from the National Institute on Drug Abuse. Which I understand you want to define it from that scientific point of view, but when you put it out in a context of working with patients, this is really damaging. This is accusatory. It kind of really demoralizes people.

And again, we're not really saying that we don't want to be honest and open with patients about what they're struggling with. And at the same time, when you really put it this way, it means, "Oh my God, there is no hope for me. I'm not going to ever get better." So, I think that aspect is not taken into consideration. And I really try to always tell them, "Use patient-specific language and guide them from there, with what language they used," and you can really adjust that. I hate to use the word correct, but you can really kind of, in a sense, modify it. You can help them really kind of look at it from a different perspective. I mean, I believe it's a cultural issue, and this is a cultural problem that we have. And we need to kind of, in a sense, bridge that sort of philosophical perception of what patients are really going through, what patients' diagnoses are.

We need to kind of, in a way, integrate it better in terms of really understanding people's experiences instead of just labeling. I mean, yes, you can use it. I mean, obviously the same thing with diabetes, heart disease, hypertension, people would need to know, asthma, whatever they have, the disorder. But we don't want to really kind of, in a sense, focus on the label, on the diagnostic label. In fact, focus more on people's experiences within that kind of medical condition. And then really, otherwise, that what we're doing is basically, in a sense, we're really... Again, I mentioned it earlier, you want to always look on the glass half full, not on the glass half empty. And we can guide that whole process there.

And remember, Bill Miller talks about all the time, in the field of addiction, nobody's perfect. Why would we expect patients who have psychiatric disorders to always perfectly take their medication at the right time? Do whatever they need to do to manage their depression? We do not expect it from people who have diabetes. We do not expect people who have diabetes to really manage their diabetes perfectly well. So, I think we need to really adopt that sort of humility which has been big part of what I help them... The humanistic approach, that is really based on that kind of humility. And really kind of, as we always talk about, the way of being with people and really kind of transposing

yourself into the works to really kind of get a better understanding of what they're going through.

Glenn Hinds:

And the word that jumps out for me is empathy. And just the whole idea that you're encouraging trainees to connect with and use their empathic understanding, first of all of their patient, but also the experience and the patient's concerns and needs, and then the experience of what it's like. What's it like, for this patient, for you to do this when you're with them? And are they finding that helpful?

And part of what also I heard you saying was you're challenging the impact of working with labels. You've been through school, and you've picked up these labels. And it sounds like no one's ever asked you, "What does that mean and how does that look? And now what?" And it was lovely the way you talked about that idea of, "you know, what are you going to do, inject them with insight?" And it was a lovely way of just inviting them to look at things differently. Because it sounds like what you're doing is you're endeavoring to model Motivational Interviewing in your teaching of these students. Whether they stay in addiction psychiatry or go on to medicine somewhere else, what your hope is, take some of this with you if it's going to be useful for you to be the best doctor you can be, because the world needs good doctors, and get on with being a good doctor. And part of it is, use this thing called empathy to help you understand. And even the way you're asking your students permission to find out what they know about anything before you then go on to teach them, so you're using your elicit-provide-elicit in your teaching of your students. And you're modeling trusting their experience. You are the expert, because you're the lead psychiatrist, but you don't start off with, "Right guys, you're going to do it this way." You go, "Right guys, what do you’se think?" And then when you have information that you feel that they need, you offer it to them.

And given the importance of empathy, and even the experience of empathy, allowing ourselves to open up to the empathic experience, what I'm curious about is, given the nature of the people that you're supporting, and particularly the emotional presentations of the people you're coming into contact with, I guess you'll have a lot of fear, a lot of loss, a lot of anxiety, a lot of psychological pain, when you're practicing empathy in that world, what I'm curious about is, how do you maintain your balance and wellbeing, and how do you help your students begin to become conscious of you need to practice being balanced? Because you're working with a lot of people who are out of balance, and if you're not paying attention, you could fall out of balance, and it would feel very normal to you.

Antoine Douaihy:

Yeah. That's excellent point here, about how you maintain your equanimity, in a way, throughout the whole process and really prevent that sort of... And you know now we use a lot of that term of the compassion fatigue, empathy fatigue, as you know, in the context of the pandemic. A few things here, that I always approach... And this is, I believe, what helped me throughout all these years, particularly working with patients with substance abuse, or acute psychotic disorders, is that they come to you with so many intense emotions. They share all this pain that you'll talk about. The emotional pain, the anger,

the depression. I mean, all these intense... Shame, guilt. All these very heavy, loaded emotions.

And one aspect of what I really try to help my trainees see through the whole process is that you're going to experience that sort of exhaustion when you are really working with patients. You're going to be frustrated. They are not going to change. They're not going to really do what you want them to do. They're going to really come back and tell you, "Well, I decided not to. I wanted to stop using it now. I don't want to stop using. I stopped taking my medications. I don't believe I need my medication."

It's going to get you frustrated. It's going to get you into a place where you're going to lose that kind of a sort of empathic skills, or start questioning, "Am I doing it the right way?" So, you start kind of getting into that kind of a... Really, your self-efficacy starts getting shaky here. And one of the things that I found: look, this is a part of really, also, growing here. And if you always think of the patients, they are in charge of their lives. They are the ones who can really make the decisions to change. They are the ones who are going to really do it. And you are a catalyst there. You are a part of that whole process. And if you take away that sort of...

And again, it goes back to taking away that sort of an "expert", that, "I need to really kind of fix this. And the reason they are not doing it: because I did something that is not working." Instead, more helping yourself through the process of also engaging with other colleagues, other peers, to share these experiences. Because they could be isolating. They could be demoralizing. I've gone through this myself. I blew out, lost, some of my empathic spirit, with a lot of patients who keep getting re-hospitalized again, many, many times, or stop taking their medications; they never follow through with any sort of the treatment.

And despite the fact that I believe what I've done is the evidence-based, that should really work, but it didn't really, in a sense, work, it's, I think, helping them at least stay grounded in terms of, also, what they are capable of or not. So, really, when we talk about the equanimity aspect, is that, really, the limits of helpfulness, too, is important to keep in mind. And this is something that, really, they do not experience in other rotations. Because in other rotations, and we've talked about it earlier, is that "There is the blood sugar that is high; we fix that. There is a high blood pressure; we give this medication." There is no real kind of a connection to these sort of challenges that are related to people's experiences, that can be very intense, and then the trainees would feel that they become very much also involved in that. And they need to really figure out a way how they can find, as you mentioned, that sort of a balance. Where, "Let me kind of really regroup myself." And I encourage, and I've talked with a lot of my trainees, about mindfulness meditation. That can be extremely helpful to really regroup and reconnect with yourself. And unfortunately, we do not train much in it, in medicine. But I think one aspect of it is also that I show them, also, my vulnerabilities, too. They see me when I get frustrated, with the certain situations with patients. They see how much I get, really, also, sometimes angry with staff, about the language that is used, on the unit or in the out. They see me as that genuine person that I kind of feel, "I go through similar experiences that you are going through. And that's really fine."

And kind of fascinating because they tend to really want to... In a sense, they try to help me process my own experiences of what I'm going through. Which is really exactly

that whole egalitarian approach. They're like, "I do not claim that I really can..." And that's why I tell them to avoid using, sometimes, words of, "I'm an expert in MI," or "I'm the guru of MI here in the medical-" I say, "No, no, no, please do not really use... That takes away the whole spirit of MI. We do not... There is no... People are more proficient, people practice it; we don't want to be labeled."

Again, that's against what we are really trying to promote, as an approach, a mindset, a heart-set, as Bill and Steve talk about. And it helps a lot, also, with what sort of responsibility they wanted to take, and how to deal with discord situations, in the patients' encounters.

Sebastian Kaplan:

Well, Antoine, we definitely appreciate you sharing your thoughts on maintaining balance. That's such an important question that Glenn asked about. And just some things that stood out: you used the phrase "the limits of helpfulness", and that is such an important concept. It strikes me as, as a reminder, not just to the students and residents that you work with, but all of us, that we can be helpful, but ultimately a patient who is on our unit or in our offices, for however long they may be there, will ultimately live their full lives largely independent of us. And they get to choose how they live, what they do, what they don't do. And we can play a role in that, a catalyst, as you said, but it's not all up to us.

And that recognition, and living that out, is a real keyway for us, working in stressful, challenging roles, to maintain some of that balance. So, what we'd like to do now is start to transition to the end. At least this portion of the episode, we are planning a role-play, as we've been doing lately, to tack onto the end of this. But as we often do, we just want to check in with you, Antoine: see what else is happening for you, whether it's professionally or personally, that's catching your attention, that we could explore with you, just for a couple minutes.

Antoine Douaihy:

Sure. Thanks for asking me. I'll tell you that it's been... I'm going to be really brief, just to give you a sense of where I am now, professionally and personally. So, during these past couple of years of the pandemic, and we're still obviously ongoing, not at a different level; it, in a sense, was a huge wake-up call for me, in terms of really reflecting on where I want to... "Okay, how do I envision my life to be like?"

Obviously, we've, as you know, saw a lot of the challenges with the dealing with the pandemic, the impact of the pandemic, the consequences and all of this, particularly emotional impact. And I've kind of realized more and more that, as much as I love the work that I do, and it's been a big part of my identity, obviously. But there's also the personal aspect of what I would like to pursue as, really, realizing, particularly, that I've experienced a few losses through the whole pandemic, and so kind of, like, "Wait a second. So, what matters to you at this point in time? What do you want to do?"

And honestly, for a couple of years, I wasn't able to go back to France. I ended up going back to France in October, at the time when the Delta was really kind of finishing up, and we got the other one. So, I had this whole three weeks there, and I ended up spending some times in the country, trying to really reflect more, relax more, everything, realizing... Because I'm a city person, obviously. Even though Pittsburgh is not very

cosmopolitan. But it's just, I realized how fascinating it is to see people living a simpler life and being fulfilled and satisfied.

And I never thought that I would enjoy that kind of disconnecting, not being really overstimulated all the time. Even though there is a lot of the cultural aspect that I love, I used, in effect... One of my, early on in my professional life, I was kind of pursuing a dance career, and then I kind of got injured, and I changed my whole really perspective on what I wanted to do. Obviously, it was not possible to continue professionally in the dance world.

And so anyway, here, I've been kind of thinking more and more. My next steps would be, potentially, maybe exploring some kind of options, maybe like being in a remote area somewhere. Whether maybe it's Oregon, like in Willamette Valley or somewhere, where, really, you can really enjoy the precious moment of being around people, and relaxing, and really kind of making your life meaningful in a different way.

So, I'm really, in a way, exploring a little bit of that. Maybe possibly running a bed-and-breakfast place. Having a farm or something. And even though I never have imagined, in my whole life, that I would even think about it this way. But, I mean, I'm seriously thinking about it. I'm just seriously thinking about my next steps, in terms of really finishing up. And I'm not planning on working forever. I feel like I've gained significant fulfillment from the work that I've done, and obviously it's going to be hard to detach eventually.

At the same time, you're going to have to really also see what... Again, we talk about the value system. What matters to you. And, in the context of working with patients, you have to really ask yourself that question too. And really have your values aligned with what your behaviors are, and what you really want to do. So, we'll see where this is going to go. If I... Obviously, I have some ambivalence about it, so I need to really work through it. But we'll figure it out, hopefully.

Glenn Hinds:

Yeah. It's a wonderful way... It's almost like the conversation is a circle in from the beginning, where you began to describe this significant transition moment in your early career, where you were introduced to addiction and motivational interviewing, and it changed everything for you. It sounds like a couple of weeks back home in France, just seeing things from a different perspective, has invited you to consider that maybe it's time to do something different again.

Antoine Douaihy:

Yeah.

Glenn Hinds:

That thought, what both of them have in common, is a sense of purpose for you. A sense of reward for you. A sense of what matters to you. Because staying in touch with yourself, and staying in touch with what lights you up, sounds like what has been rewarding up until this point. And while it brings about some potential concerns, or potential difficulties, it sounds like it's something that you're willing to consider, and in many ways, just noticing

that is for the rest of us to recognize, "This is change. And this is what human beings go through. And, with change, sometimes it's really exciting, and sometimes it's really frightening, and sometimes it's both."

And what you've been describing throughout the episode is just your willingness to remain curious, with that person and that journey for themselves, to discover what's right for them. And sometimes it's been very helpful, what you do. Sometimes they need help from others as well. So, Antoine, we're delighted for you to have come along today, and I have no doubt that there are many people listening that will have questions or want to touch base with you.

And we always ask our guests, if people who are listening want to reach out to you, and make comments or ask questions, is that okay for them to do it? And if it is, what different ways can people get in touch with you?

Antoine Douaihy:

Yeah, would love to hear from people! Yes. Any comments, or questions, reflections, any, and they can reach me via email. And my email is DouaihyA. So, it's DouaihyA@UPMC.edu.

Glenn Hinds:

Fantastic. And we'll add that onto the podcast notes. And just to remind, as we come to the end ourselves, then, I'll say in advance, we will have a role play at the far end of this when we finish this episode. But just to remind people how they may stay in touch with us.

Sebastian Kaplan:

Right. So, on Twitter, it is @ChangeTalking. Facebook is Talking to Change. Instagram, TalkingtoChangePodcast. And any requests or questions or comments to Glenn or me it is podcast@GlennHinds.com.

Glenn Hinds:

Fantastic. So, again, thank you, Antoine for your time, for your sharing your expertise. And thank you, Seb.

Antoine Douaihy:

Thank you.

Sebastian Kaplan:

Thank you, Glenn, and thank you, Antoine.

Antoine Douaihy:

Thank you, guys. Appreciate it. Thank you, Sebastian, for coming today. How have you been doing recently?

Sebastian Kaplan:

Well, I'll tell you. I just can't seem to... just can't seem to relax. I just feel so stressed all the time. Whether it's at work, or at home, or in the car, or laying in bed at night, I just feel like there's a tension that's pressing on me at all times. And yeah. It's just been a really, really tough few weeks here.

Antoine Douaihy:

You've been very much struggling recently, and you've been feeling overwhelmed, but now, as you're describing, your anxiety has been really, very much, in a way, paralyzing you.

Sebastian Kaplan:

Yeah. I mean, it takes a lot to get out of bed in the morning. To go to work. To stay focused. I mean, it just takes every, every bit of energy for me. I've just had these thoughts that are just constantly in my head about things that might go wrong, or just worries about screwing things up. And I don't know. It's just getting harder and harder to just do what I normally would do.

Antoine Douaihy:

You are very much overwhelmed, and you've been trying very hard to really pull yourself out that state of mind. And at the same time, you're really also experiencing, from what you're describing, in addition to that anxiety, that sense of really being unmotivated, and not having much of a drive. And I was wondering how you see that, in a way, going with the anxiety. So, you're describing, in fact, the anxiety part; at the same time, I'm getting a sense that you're also describing some state of being really very much down, and not being able to really function.

Sebastian Kaplan:

Yeah. I guess part of it is, it's just more challenging to do the things I would normally do and trying to turn off all of this worry. And just as, day-in/day-out, week-in/week-out, that I've had to deal with this, it's been... Yeah! It's just no fun. It's just not enjoyable. And life, there is no break to it. And, and yeah, I'm just... I guess "down" would be a word? It's hard to really find enjoyment out of anything anymore.

Antoine Douaihy:

Well, you've been feeling stuck for quite a while now. You that's for, really, a significant period of time. And you're seeing yourself really getting more and more unable to really pull yourself out of that state. And that's kind of obviously creating a lot of confusion for you. A lot of that sense of being demoralized. More and more maybe depressed, even, to a point where you are really kind of can't keep going like that. And as you said, a lot of these thoughts that you've been experiencing are kind of really taking over in a way, and really not letting kind of... And getting in the way of you really functioning.

Sebastian Kaplan:

Yeah. Well, I don't know. I don't know if I'm depressed. I mean, I think depression means you're just kind of crying all the time, and that's not what I do, but I don't know; you're the

doctor, so I guess you might know better than me. But "demoralizing", I guess, is a word that fits. I don't know if "depression" does, though. Again, I'm not crying all day.

Antoine Douaihy:

So, you're obviously wondering what it means to be really depressed. What your experience is, and you can correct me if I'm wrong here, what you're describing is that state of being always very stressed out, having a lot of fulminations. Your thoughts are kind of running and running and running. A lot of racing thoughts. A lot of that anxiety. At the same time, also, you're really having a hard time with your motivation. You are really less and less motivated recently, and you're reaching a kind of a point where, as you said, you're wondering, "What is that state that I'm in?" And you're kind of questioning what it means to be depressed.

Obviously, what you're describing as the experience is mostly, as you said, a confusing experience, and feeling kind of really very much unable to really function, which is really leading you to feeling more helpless. And I was wondering, if it's okay with you, because you're questioning, "Is that depression? Is that? What am I going through here?" And would it be all right with you if we talk a little bit about that part, and maybe you give me some perspective, and you tell me what your thoughts are on that?

Sebastian Kaplan:

Yeah, that sounds like it'd be... Anything you can do to help me feel better. Really.

Antoine Douaihy:

I appreciate it. So, what you're describing is, as you said, is more that kind of a sense of really significant feeling, overwhelmed all the time, and not being able to really also process your thoughts and your emotions. You talked about that. And you talked about really being very much unable to really function as a result of that.

At the same time, when people also experience... And these are what you're describing, are really symptoms of an anxiety disorder. We can figure out together what sort of really particular anxiety, disorder you might have here. And because a lot of people can experience that sense of continuous anxiety that affects their sleep, can affect their thinking, can affect their attention span, concentration, and some people also can have what we call an anxiety attack, or panic attacks. This really kind of a short episode of 3, 4, 5 minutes of really a huge surge of anxiety, where they can't even breathe. They can, they can get overwhelmed. They feel like they're going to die. And this is one thing you're describing.

And the other thing that you have really also described is that state where you are really feeling more unmotivated, not wanting to do the things that you enjoy doing, from what you've been saying, that you typically usually do. So, you lost that sort of an interest. And, and these are really things that kind of are leaning more towards a depressive state. And we know very well, it's not unusual that most people who experience depression or anxiety, they have them together. They come, really, hand in hand. What do you think about my perspective? Obviously, you know yourself the best here.

Sebastian Kaplan:

Well, I guess it's helpful. I didn't know that people who were stressed and anxious were also depressed. And, again, I thought depression meant you were just sad all the time and crying. And, but I guess you mentioned not feeling motivated, and feeling a bit helpless about things, and some of these other things that you referenced, which I would say are true. And so, yeah. I guess I mainly came in focused on my stress level and my nerves that I just can't stand anymore, and hoping I could maybe get some medication for that; but now that you mention it, I guess depression, I suppose, it fit. It could fit, if one can be depressed without, again, without tears and crying and sobbing all day. Then, I guess that fits for me too.

Antoine Douaihy:

Well, you're making a very good point because people have different experiences of depression. So, some people experience depression more as a state of feeling very much down in the dumps, not having much motivation, not having much drive, losing interest in pleasurable things, having difficulty with their sleep, sleeping too much, not sleeping, crying, having difficulty controlling their emotions, having difficulty concentrating, focusing. So, it varies. Every person experiences the depression in different ways. The same thing for anxiety. Your experiences are really unique. At the same time, they kind of fit into this big picture of what we've been describing, whether it's really anxiety and depression. And I think most importantly, as you said here, you just want to do something about it. You cannot keep living like that. This is like a torture for you and you're really totally, as I mentioned before, you come across that you feel totally paralyzed and you cannot really do the thing... You cannot see yourself productive anymore.

And I was kind of wondering also that creates that sense of really helplessness and that sense of hopelessness if you like and as we mentioned, the sense of demoralization. At the same time, you are really open to what could really here do in order to help me figure out what's going on and you brought up the medication piece and there are also other options that we can look at that could be potentially helpful, that we can really explore in addition to the medication. The medication could play a role, obviously, in addressing some of these symptoms and helping you really kind of, in a sense, get more regulated, your emotions getting more under control. What do you think if we can have that explore together here these options, medications option as well as other really what we call therapeutic options like counseling type of options, talk therapy type of options.

Sebastian Kaplan:

Yeah. I've tried talk therapy in the past. I've tried meds in the past. I'm a pretty busy guy. Talking about my feelings isn't really my favorite thing to do. And I can think about it. Honestly, I remember maybe 10 years ago when I was going through my divorce, and I was really stressed and my doctor gave me some Xanax and that seemed to really help me a lot. So, I figured maybe I could come in and... My doctor wasn't really interested. I have a new doctor now and he felt like I should go see you. So, okay, so I agreed to that. And I'm thinking maybe if you could give me some Xanax, because it helped me before, that'd be great.

Antoine Douaihy:

Okay. So just to understand what you've been sharing with me, you've had negative experiences with medications or with therapy, as you said before. You haven't had very good experience. You haven't seen it as really beneficial before.

Sebastian Kaplan:

With the therapy part. Xanax was helpful-

Antoine Douaihy:

The medication,

Sebastian Kaplan:

... but therapy, yeah.

Antoine Douaihy:

Okay. Thanks for clarifying that. And the other aspect that you're really mentioning is that, in terms of in your experience with the Xanax, what specifically you've seen improving when you took that medication?

Sebastian Kaplan:

Well, it felt like this feeling of pressure that I have now, it just felt like within a matter of minutes it just... It was like a valve that kind of released that pressure. And it just helped me to just really relax. It helped me sleep. It-

Antoine Douaihy:

It's like a quick relief. You got that quick-

Sebastian Kaplan:

Quick relief. Yeah.

Antoine Douaihy:

Reducing the anxiety level and feeling more comfortable with yourself.

Sebastian Kaplan:

Yep. That's right.

Antoine Douaihy:

Yeah. And would it be all right with you if we... And I know you said you're really kind of wondering about whether I would be willing prescribe it, whether you would be also open to some really ideas about different options. I mean, the Xanax could be one medication option that can help in terms of really the short-term treatment of the anxiety, which means... Because it does not help prevent the anxiety for the long run. So, as you described it, you described it, really articulated it very well, that it helped you really at that moment to decrease that level of anxiety. So, we could really potentially consider that as

one option at the beginning of treatment that could really help relieve your kind of anxiety symptoms so you can really think more clearly and we can look at also other options that can help for the long run. What are your thoughts on that?

Sebastian Kaplan:

So, you're saying I might need medications for a long time?

Antoine Douaihy:

Well, from what you're describing with your condition, really the chronic course of it and your anxiety, what is more indicated is medication over the long run to really kind of control it and to prevent it from happening again. Because you want to really be able to really live your life without having these bouts of anxiety coming back and affecting your ability to function and obviously leading to really the depression piece that you've talked about. And we can look at options in terms of medication that can work for both for the really that chronic anxiety, as well as really making sure also to really address the depressive symptoms that you're really experiencing. So, we have different options from that perspective.

One aspect that I would like you to think about and tell me what your thoughts are on that is that when you kind of also think more clearly, and I know this is something you mentioned there's some negative experience with the talk therapy. I wonder whether you have received the therapy that would be the mostly helpful for you considering your anxiety symptoms and depressive symptoms. We can look at these options too if you would be willing to do. And we know very well that the combination of both could really potentially kind of really produce better response than just one option versus the other. What do you think?

Sebastian Kaplan:

Look, I'm willing to do anything, I guess. And if there's a medication that helps both with my anxiety and stress level and it sounds like you think I have depression too, if there's a medication for both, I... I'm not a big fan of taking a bunch of pills, so that would be good. And it sounds like you want me to see a therapist again or at least try it. And yeah, I mean, I don't know, but the person I saw before, it was somebody through work and it didn't really feel like-

Antoine Douaihy:

It wasn't a good time.

Sebastian Kaplan:

But he was real busy. He canceled a lot and just really was... It seemed like he forgot who I was each time I went in there. And I don't know, it just didn't really seem like it was useful.

Antoine Douaihy:

Well, you clearly, what you're describing, you didn't feel like he cared much, obviously, I mean, from your experience and you know that to you're really... You didn't feel, as you described it before, you didn't feel comfortable. You struggled with opening up to begin with and that kind of really sort of really... situations you had with that therapist did not make you feel comfortable opening up and learning something from it.

And as you said, this is one attempt that you tried. Obviously, it's going to be up to you to decide whether you would be open to really giving it another try. And obviously, we know very well we can't guarantee how it's going to go. We would hope making sure that if we have some really kind of people that I can think of, therapists, that would be potentially good fit for you with their background and how, in terms of addressing anxiety and depression, and if you would be willing to give it a try, then we can pursue that part too.

Sebastian Kaplan:

Sure. I know I can't keep living like this, so I'd be willing to try. Whatever you think would be helpful, really, I'd be willing to try it.

Antoine Douaihy:

Well, I appreciate your taking my advice. Obviously, it's entirely up to you to decide. And I kind of sense a little bit, and which is not unusual, to be hesitant about, to be ambivalent about it, that it's part of you just wondering, "Is this going to potentially work. I've tried it before." And so, you're in that kind of state of mind where it is not unusual. It's kind of very much normal in fact to kind of wonder and question and... So, it's always entirely up to you. I mean, now your decision is going to be whether you would want to give it a try, you want to give... You want to really try that opportunity, or I'll leave it up to you. We have different ways of doing things here. And you decide what you feel the best way to do it, whether starting with the medication and then doing the therapy or doing them together. So, it's up to you.

Sebastian Kaplan:

It certainly feels like you're listening to what I'm saying. And I am hesitant, I suppose. I came in hoping you'd give me just a prescription for Xanax like I did years ago. And maybe I'm leaving with more than that or in addition to that. But I'm open to it. And like I said, I just can't keep living like this.

Antoine Douaihy:

Well, I appreciate your trusting me here. You have articulated very well what you're really going through. I want to make sure here we're going to work together and do whatever you believe is really the right thing for you to do. I mean, I can give my perspective. You can still really kind of, in a way, disagree, or we can always really brainstorm different options. I want to make sure that we have a good way of really communicating openly with each other. And I would like you to tell me whenever you feel like it's not working out, I'm not really understanding your struggles or just to bring it up and we can figure out together how we can get a better understanding of what you're going through and making

sure the ultimate basically thing that we want to look for here is that's making you feel better so you can get back to functioning better and have a better quality of life.

Sebastian Kaplan:

All right. Well, I appreciate it, doc. I wasn't sure what I'd expect coming in today, but I appreciate you listening and trying to help me.

Antoine Douaihy:

Thank you.

Glenn Hinds:

Right. So that sounds like there's a transition taking place now. And I imagine in real life that conversation may have continued for a little longer and those options... And I think that's the thing what strikes me is that before I asked both of you to debrief that, the overarching piece for me was just your emphasis on the options, choices, reinforcing the client's, patient's autonomy and just the whole thing was about possibilities, that you were the expert, but your expertise wasn't weighing heavy on the process. It was really light touch. You were offering lots of options and ideas and thoughts and just reinforcing, encouraging the patient to decide whatever you going to do, I'll endeavor to support that. And I guess, if it's okay to start, then can we maybe speak first to the patient and just check how was that for you?

Sebastian Kaplan:

Yeah, no, it was really interesting to role play that. I mean, it went from that initial period of me sharing what I was sharing and I'm, of course, in a kind of a real situation, there may be some nuances and details that you'd be exploring that you didn't hear just the interest of time, but it felt like your priority actually wasn't, is it this variant of anxiety or is it this strain of this or that. It was, "What is your experience? And I want to make sure you feel as if I get it and I'm hearing you and I'm capturing it in some way." And then it shifted it.

And you picked up on my sort of passing comment about medication. And it was this opportunity for you, it seemed, to still maintain that reflective stance and that constant effort to understand, but it was like this moment of, and here's something that you're thinking about in a broad sense, something that you'd like to be different, something that you want to do about it, some change that's possible. So, it was really kind of, like you said Glenn, a light touch of it, but definitely helped me go from a place of, alright, this guy gets it and, yeah, let's think about what we're going to do about it.

Glenn Hinds:

So can I just check with... See the experience of being got.

Sebastian Kaplan:

Yeah.

Glenn Hinds:

What was that like for you going in because it sounds like you had an expectation I am going into the psychiatrist, blah, blah.

Sebastian Kaplan:

Yeah, yeah.

Glenn Hinds:

And you got got.

Sebastian Kaplan:

Right. Yeah. Because I had the experience before that I mentioned where I saw a therapist through work and that was clearly not helpful. In fact, it felt kind of not just... Like a waste of time but even worse like the person just didn't care. And then, even just with setting up this appointment, I went to see my doctor and my doctor didn't give me what I wanted, right? My primary care doctor, right? And so, coming into it, there's already this negative experiences in the past, maybe a sense of I'm searching, I'm doing what I need to do to try to get some help here. And so, to feel as if someone is taking the time in a pretty brief interaction, it... Yeah, I mean, it just kind of softens the edge.

It creates an openness in me to fully explore things. We didn't go into much detail about the ins and outs of my life and what's going on. However, if and when, and in a real encounter, there probably would've been questions that are more sensitive in nature, right? Trauma history, substance abuse, current, previous. I briefly mentioned a divorce, right, so there's some things that you would be exploring that are more sensitive in nature. The feeling of being got, I guess, or being understood, as the foundation, really sets up the openness that would come later.

Glenn Hinds:

Right. So, Antoine didn't have to go deep for you to feel understood. What you were offering, he worked with that, and that was really meaningful. And it sounds like, from a strengths-based perspective, it was almost if the foundation is not in place, if they are going to go deep, the foundations are in place. It's almost a paradoxical. He's going to go deep by going up, by building on where he's at. And I guess what I suppose we're curious about then, Antoine, is obviously this was... We had agreed we were going to do role play, but we hadn't agreed that this wasn't scripted. So, what I'm curious about is what was going on behind the curtain when you were in that process? What were you processing and how were you making the decisions you were making because Seb found it really helpful?

Antoine Douaihy:

Sure. Yeah, this is a great question because I always have this kind of a roadmap, right, of where you would want to go. And I think the two things that I would never want to compromise, that would eventually create the discord was partnership and the autonomy support. These have to be reinforced over and over again. So, the question, the challenge

for me was, how can you remain genuine and not kind of in a sense jump to conclusions because he asked about the medication that he wants? Because I could have simply said that from the beginning, "Oh, forget it. I'm not going to prescribe him this."

So, in a sense, when you anticipate the outcome, or when you set the outcome, you're kind of, in a way, destroying the relationship. Because obviously, you're not allowing the patient to really give them their perspective. Jumping right away to making a decision can be... I mean, it's not really kind of MI adherent, right? I mean, that's what I tried really to do as much as I can to really stay MI adherent from the spirit aspect, particularly the partnership supporting autonomy, evoking, and all this kind of...And at the same time, obviously, remaining empathically present with him.

And it did help me because I get that kind of a sense that also, and Sebastian you mentioned that, that you have a hard time opening up. I mean, in a sense, I didn't reflect on it early on. I waited to reflect on it later on in the context of that negative experience that you had with the therapist so to really, in a way, normalize the fact and validate that you experiences were really kind of very totally legitimate and valid because you did not see somebody... You were not present with somebody who has expressed any interest in really understanding what you're really going through.

What makes you kind of feel safe and comfortable to open up? You're not going to do it. You already struggle with that. So, I think I tried to really kind of, which is really always the challenge, I tried to remain as genuine as possible as really sticking to the MI staying adherent with the whole intervention. And again, I still use my expert opinion kind of, but obviously in a way that is more engaging and always really kind of presenting the different options in terms of treatment and based on science, obviously, and really always kind of referring to if...

And obviously, I kind of always needed to remember that the pointing out his ambivalence. That is really crucial because that could be something to go back to because that can kick in anytime. I mean, he's willing at this point in time. He expressed some change talk, I'm willing to give it a try. Yes, we can do it. And at the same time, I shouldn't take it for granted that this ambivalence is not going to kick in at any point in time and he's going to say, "Forget it. I don't want to really do this. I want just that medication." And so, I think that could be also another area to explore a little bit more, to always check on in terms of his ambivalence about engaging in treatment.

Glenn Hinds:

And normalizing is such a significant part of what you're describing, which you were, first of all, normalizing the patient's experience of their own experience. And you were weaving your expertise in in such a gentle way, which was... And you describe this and from our experience or other people, and you describe the generalized and then the more specific anxieties and depressions, and then very significantly you asked, "And what do you think about that?" And you invited the client, the patient to come back to respond to your information rather than simply saying, "This is what you've got to think, and this is what's happening to you."

You went, "This is what we understand. What do you think about that?" And then the normalizing of, this is someone who's struggling. What you were witnessing was really quite normal in your experience, which was, this is somebody struggling, and I don't have

to get angsty and I don't have to get frightened. And I don't have to get too worried about this person's presentation, because this is quite a normal presentation for somebody who has anxiety and depression. And in my experience, there is hope because people have come to me with this experience and over a period of time, whether it be medication in conjunction with good therapy or whatever else, this can be helped and this can be resolved, and you bring that hope with you.

Antoine Douaihy:

Evoking that hope in the therapy.

Sebastian Kaplan:

And there was another thing too, there was no point where you stated an opinion about anxiety or this sort of new idea of depression added to the mix, the medication long term, short term, introduction of therapy. At no point did you offer something without checking with me how that landed, what do I think of that? There was nothing that was like, this is a fact because I'm saying it or because I think it.

Antoine Douaihy:

Right. Thank you. Yeah. I mean, we weren't able to do it. I wonder how much time we spent on that, in that encounter. 10 minutes, 12 minutes but it just really demonstrates that it is really doable. And as you mentioned, also, Sebastian you can really also build on it in the next sessions too. I mean, this is kind of like a work in progress here.

Sebastian Kaplan:

Yeah, yeah, yeah. Not everything has to happen, not every single stone needs to be unturned. There's certain, I guess, more so have-tos. Like, I imagine you would've explored safety and certainly in a first session, that's something that's standard for a psychiatric practice, but-

Antoine Douaihy:

Yeah. That's correct. Yeah.

Sebastian Kaplan:

Yeah, it is also an ongoing process as well. Yeah.

Glenn Hinds:

Well, again, gentlemen, thank you both, first of all, Antoine for your willingness to offer that support and Sebastian, for your willingness to take on the role and to help us to get a better idea of what it was you've been describing in the podcast in action and just that kindness, that spirit of understanding and empathy and desire to understand the patient and for you to be as helpful as you can be. So, thank you again for the podcast in total and the role play Antoine.

Antoine Douaihy:

Thanks for having me.

Sebastian Kaplan:
Thanks so much

Antoine Douaihy:
Take care.

Glenn Hinds:
Take care. All right. Next time.

Antoine Douaihy:
Bye.