



## **CBT (Cognitive Behavioral Therapy)**

**with Dr. Roseanne Dobkin**

Davis Phinney Foundation

*Note: This is not a flawless, word-for-word transcript, but it's close.*

Melani Dizon (Director of Education and Content, Davis Phinney Foundation):

Hello and welcome everybody. My name is Melani Dizon. I'm the Director of Education and Content at the Davis Phinney Foundation, and I am here today with Dr. Roseanne Dobkin. How are you doing?

Roseanne Dobkin, PhD (Associate Professor of Psychiatry at Robert Wood Johnson Medical School; Rutgers, The State University of New Jersey Location: Piscataway, NJ United States):

Hi, Melani. Doing wonderful. Thank you so much for inviting me to chat with you for a little while this afternoon.

Melani Dizon:

It's great to have you. This is a topic that our community has asked about really frequently, and so I'm excited to talk about it as it relates to Parkinson's. So today we're going to talk about cognitive behavioral therapy and how it can help people with Parkinson's live better. So first, let's just start with who you are, how you got involved in this work, and in particular, how you got involved with working with people with Parkinson's.

Roseanne Dobkin:

Oh, could talk about that all day long. So, Roseanne Dobkin, I am a clinical psychologist and I am a professor of psychiatry at Rutgers University in New Jersey. And my background in training in the clinical psychology field was really targeted around health, psychology, and behavioral medicine. So, I was always very interested in the interface of mental health and medical concerns, and really how to help individuals, you know, who were living with chronic medical conditions, live the best possible life. And prior to starting my actual post-doctoral fellowship followed by a faculty appointment at Rutgers I had worked with different individuals, you know, managing other types of medical conditions, so worked with oncology, cardiac patients a lot of different women's health populations. And when I came to Rutgers at that time back in 2002, we were only the only movement disorder specialty center in the state at the time.

So, fortunately, things, things have changed and resources have improved in the past two decades. But so, we were fielding referrals for movement disorder, specialty consultations from individuals, you know, really across the eastern seaboard. And there was a huge need for

mental health professionals that could assist the movement disorder specialists in the department of neurology, because as we all know, Parkinson's is not just the movement disorder, but the overwhelming, you know, majority of people living with PD also experience pretty significant mental health concerns like depression and anxiety. So, since I was new and I was junior and I was really interested in working with individuals with medical conditions to help optimize their mental health, I was approached to accept some referrals for psychotherapy from the movement disorder specialty clinic. So, I started working with some people with PD and their family members at that point in time.

And I just found the work to be, you know, incredibly rewarding. And as I started to, you know, take a deeper dive into the literature in order to identify resources that would help me to help the Parkinson's community, it became very quickly apparent that nobody at that time, and again, fortunately, things have changed. But, you know, going back 2002 there, there wasn't a huge movement looking at, you know, developing and testing specialized, personalized treatments to target these non-motor symptoms in Parkinson's. There, there was just beginning this would be some research looking at, you know, pharmacological interventions for depression and anxiety. But nobody was looking at behavioral interventions at that point in time. So, I decided, well, what a great opportunity. And I started to develop and pilot test some non-pharmacological interventions in order to best address the needs, the unmet needs of people living with PD as well as their family members.

So that's my very long answer to how I ended up in this space. But I'm just, I'm incredibly passionate about it because these concerns are so common, yet they are underdiagnosed and sub-optimally treated. And when I say sub-optimally treated, I don't mean that unfortunately, you know, we miss a case of depression or anxiety here or there. We're missing upwards of 50% of clinically significant cases of depression and anxiety. And when we don't recognize and we don't treat depression and anxiety appropriately, it compromises all aspects of Parkinson's management. When we do diagnose and we do treat these conditions and we treat them effectively it can really optimize all aspects of PD care and it can really help individuals to live the best possible life.

Melani Dizon:

Okay, this is great. So, I want to get back to that 50% that's there. You're getting missed. But before we do that, can you share a little bit about what is depression? What is anxiety? What is the difference between them, and are they any different for people's Parkinson's versus not their non

Roseanne Dobkin:

Parkinson's? So, so lots of really important questions packed in there. So let me try to take them, you know, one at a time, and then remind me what I missed when I finish. So first I want to just describe and, you know, review some, some of the common symptoms and features of

first depression and then anxiety. So, they are separate psychiatric conditions though they tend to co-occur. So, if an individual is dealing with depression, there's also fairly high likelihood they may also have anxiety as well. So, when we're thinking about depression, we're talking about individuals who are experiencing mood that is not as good as they'd like it to be. And people use many different terms, many different adjectives to describe that, that low mood and how it may present. So, they may feel sad, they may feel low, they may feel blue, but just not quite themselves.

More dysphoric down in addition to feeling sad or down. Usually if an individual is experiencing depression, they've lost their zest, their enthusiasm, and they're not as interested in doing the things they once love to do. And I want to really emphasize that point. Not interested in doing what you used to like to do. I hate to clean my house. I hate to do laundry. I do not like to hold it or put it away, look in my laundry room. That will be proof in the pudding about how much I dislike doing laundry. So that's not really a change for me. But I love going for walks. I love listening to music. I love spending time with my family and with my friends. If I lost my interest in doing those kinds of things that I've always enjoyed, that would be a red flag that maybe I'm feeling depressed.

Depression can also be accompanied by sleep, as well as appetite changes and in a variety of different ways. So, individuals may have a hard time falling asleep, staying asleep, they wake up too early, or maybe they're sleeping all the time. Same with appetite. They may lose their appetite, lose the zaps, the enthusiasm for food or they may overeat a lot of, you know, craving of carbohydrates and those comfort type foods. Concentration can be impacted as well. Individuals may begin to feel very guilty about things, very self-critical, you know, ruminating a lot. They may endorse feelings of helplessness or hopelessness excessive fatigue, you know, above and beyond fatigue that individuals with PD commonly experience. And, you know, very seriously, sometimes individuals may have thoughts that life is not worth living or thinking about trying to hurt themselves in some way.

And of course, any concern like that needs to immediately be brought to the attention of a healthcare provider. So that's really what depression is. But, you know, cardinal features of depression, low mood, loss of interest, anxiety is really defined by feeling nervous worry, apprehension, angst and anxiety can manifest, you know, in many different ways. So, in addition to, you know, the more, you know, emotional symptoms of anxiety, oh, I feel nervous, I feel scared, I'm afraid. You know, there's the cognitive components where you're worrying. You know, you're saying, what if this, what if that, you know, you're expecting bad outcomes, you're making a lot of negative predictions. You know, there can be certainly physical or physiological manifestations of anxiety where you're feeling panicky, your heart's racing, you know, shortness of breath. You may feel dizzy. And, you know, the list of physical symptoms can go on and on.

And then behaviorally, a really key feature of anxiety is avoidance. When people really start to withdraw pull away from the people places and things that really sort of, you know, define the landscape of their day, that can be a sign of anxiety. Because oftentimes in order to manage the anxiety, people just pull back. And if they don't confront those feared situations. And therefore, in the moment, the anxiety feels a bit more under control. But what the avoidance does is it turns the dial down on the anxiety, maybe in the here and now, but then tomorrow and the next day, you know, the anxiety's going to grow and grow. So, I always tell people, you know, avoidance is like miracle growth for anxiety, and we don't want to feed the weeds, so let's not use the miracle grow on the anxiety. So, depression, sadness, anxiety, more worry.

There's a very high rate of comorbidity, meaning that you know, a fair number of individuals, I'm going to say depending on the study, could be as high as 40 or 50% who have depression also have anxiety and vice versa. We also know that the rates of depression and anxiety tend to be significantly higher in people living with Parkinson's versus the general population. And, you know, there are a lot of theories and a lot of explanations, you know, for those differences in prevalence rates. You know, part of it is that there may be shared biology. So, a lot of, you know, the neurochemical changes that characterize the Parkinson's disease process are also implicated in the onset of depression and anxiety. It's possible that depression and anxiety may be the earliest of early signs of Parkinson's for some people.

And again, everybody's Parkinson's is a unique journey from the time it starts, you know, through the entire disease process, you know, for a given individual. But so, but for some, those emotional concerns may be, you know, what shows first, you know, prior to tremor or sleep disturbance. So that's a possibility as well. And then there's, you know, the lifestyle changes and adjustment that go hand-in-hand with living with a chronic medical condition and all the stressors that are associated with living with PD day in and day out, and the way that PD does change the rules of the game, and like the constant adaptation that has to occur in order for an individual to continue to win and to continue to live a good life and how an individual thinks about themselves and the diagnosis and what it means and what it doesn't mean, and their ability to handle things, you know, that, that also plays a role. So, it's a combination of like biological as well as psychosocial factors that drive that higher rate of depression and anxiety in PD, right?

Melani Dizon:

Yeah. So, when you see somebody, you're, are you usually getting a referral from a neurologist or a movement disorder specialist, or how do people find you to be able to work with a neuropsychologist?

Roseanne Dobkin:

So, in my practice, my referrals largely come from my colleagues. In neurology, oftentimes I may get referrals from the community, from support group leaders you know, word of mouth.

But there are many, many ways in which an individual can connect with a licensed mental health professional. You know, certainly asking your movement disorder specialist or your general neurologist for a recommendation, you know, is a really good starting point. Primary care physician can also be a good starting point. I've gotten referrals from physical therapists and from speech therapists and other members of like the PD, you know, interdisciplinary community. So, ask if you're interested in possibly working with a clinical psychologist, you know, or a social worker or, you know, a family therapist and you'd like to receive some counseling. Ask the other members of your personal healthcare team, who do they know, who have they referred to, and who might they recommend you reach out to.

There are also many associations at both the state and county level that keep active referral directories that you can access online. So, you know, as an example, I live in New Jersey. We have a very active New Jersey psychological association. And individuals who are members of that association can pay a very small nominal fee to be listed in the directory of practicing providers. So, if an individual, let's say, had Parkinson's and they were going to this directory to look for a provider, you know, they could go into, you know, the state directory. You can't search by town, but you can search by county. So, you could say, okay, San Jose County, and I want a psychologist, and I want somebody who has the experience, you know, with cognitive behavioral therapy, that'll be, you know, a little check that they can place in the drop-down menu.

And I also want somebody that has experience working with individuals, you know, with chronic medical conditions, and then you can kind of narrow your search. So, you wouldn't be able to be as specific on introductory and say, okay, I want somebody that has expertise with Parkinson's. But you can certainly request information on providers that have expertise in both cognitive behavioral treatment and have interest in experience working with medical populations. And if we can find somebody that matches those criteria, we're probably going to be in pretty good shape. And then in some states, beyond the state level, each county may also maintain its own directory, so you could really try to find somebody closer to home in that way as well.

Melani Dizon:

And this is sort of getting in the weeds, but I want to go back to it. Is this, do you do a lot of telehealth and what is the landscape currently around, you know, clinical psychology and telehealth?

Roseanne Dobkin:

So, that's a great question, and I just, I have to jump on the telehealth bandwagon for a second and just say that I was a huge champion of telehealth long before the pandemic. And I've actually done a couple of larger scale clinical trials looking at the effectiveness of providing cognitive behavioral therapy over the phone audio only, as well as, you know, using web-based



video conferencing. And in those studies, we found amazing results that were comparable to what we found in our in-person face-to-face trials. So, no effectiveness is lost. If treatment is administered via telemedicine, doesn't mean that telemedicine is for everybody. I mean, I have some folks that much prefer to come in in person, and that's fine too. But the overwhelming majority of people seem to really prefer telemedicine and find it convenient. And if there's a silver lining of the pandemic, it's that telemedicine has become you know, much more accessible and reimbursable you know, to the, for the community at large. So, individuals don't have to worry about being forced to pay out of pocket if they want to see a provider via telemedicine because their insurance is covering it.

Melani Dizon:

Yeah. Are there some people that you've never met in person, you've only done telehealth, or do you require an in-person meeting first?

Roseanne Dobkin:

Another excellent question. So, there are some people that I have never met in person, largely because I started working with them during the pandemic individuals that I have an established relationship with, you know, so pre-2020, they were in-person sessions and many, I just continued using telemedicine because of all of the advantages and conveniences associated with that method of treatment delivery. There is a new rule though that just went into effect for mental health services and psychiatric care for those that are being covered by Medicare. And I'm, I'm not a hundred percent sure if it applies to individuals with private commercial insurances, but it definitely applies to Medicare that they're now requiring one in-person visit per year.

Melani Dizon:

Per year, okay. Per year. Good to know. Per year.

Roseanne Dobkin:

Okay.

Melani Dizon:

Okay. Good. All right. Let's get to somebody walks in, but

Roseanne Dobkin:

Actually, I want to make one other one. Their points are so important. I think for the people that might be listening. If you're going to an online directory and you're looking for a provider that you think may be a good fit because of telemedicine, you don't have to necessarily worry if



they're in your town or if they're in your county. I would definitely look for somebody in your state because of licensing laws. But if you find somebody that's, you know, two hours away, but they seem like they've got the background and experience that would be quite beneficial for you, give them a call and see if they can do a telemedicine session.

Melani Dizon:

Yeah. And, you know, one trip, one two-hour trip a year is going to be worth it.

Roseanne Dobkin:

It's worth it.

Melani Dizon:

The right person, therapist. Right. If you find the right person, that's great. Okay. So, somebody is referred to you or they find you, they are wondering, I'm feeling depressed or anxious, what have you, what do you do initially with them?

Roseanne Dobkin:

So, I'm sure everybody listening has also heard the expression, you know, if you've met one person with Parkinson's, you've met one person with Parkinson's, everybody is so different. So, you know, we have to get to know each other, and I need to hear each person's individual story. You know, I'm very, very interested in learning more about, you know, how their Parkinson's first began. Like, what were some of the early symptoms that they first noticed that led to seeking consultation, you know, with the general neurologist or movement disorder specialist, you know, what types of treatments are they receiving? Are those treatments helping, you know, how is their Parkinson's presenting now? You know, what symptoms are under good control? What maybe could be optimized, you know, in terms of the PD treatment regimen? And then I want to know, you know, what depression and anxiety is like for them, or are there other psychiatric concerns that they're dealing with?

You know, maybe they're a military veteran and they also have a history of PTSD, you know, that that's still problematic. Or maybe they're having panic attacks or, you know, they have some phobias. They're afraid to cross bridges, or, you know, to be out in public. They really have to take kind of a comprehensive history and then figure out based on that history, how I'm going to personalize the psychotherapy in order to meet that one person's needs. Because there is no cookie-cutter approach, right? Treatment has to be tailored to meet the unique needs of each person that's sitting with us in the room, either the physical room or the virtual room. It still has to be tailored.

Melani Dizon:

Okay. So then let's talk about cognitive behavioral therapy, what it is particularly, and then what are the signs to you that you think this might be a good avenue to work with someone?

Roseanne Dobkin:

Great, great questions. And I'm hoping to get everybody really interested in cognitive behavioral therapy and just really interested in mental health in general because, you know, even if you feel like you're, you're handling stress, you know, as, as well as could be expected, sometimes it's still nice to have somebody to touch base with a couple of times a year. So, I'm going to just plug the importance of adding a mental health provider to your interdisciplinary PD care team. So, but, going back to cognitive behavioral therapy so CBT is cognitive behavioral therapy. And as the name implies you, it's a type of psychotherapy, a type of talk therapy that really focuses on the thoughts and the behaviors that are related to sort of the onset as well as the maintenance of negative emotional states. You know, like depression or anxiety or panic or fear.

It's very much sort of a coping skills-based approach, very focused on the here and now. Yet of course, we are interested in learning about an individual's history in order to figure out how maybe some of the symptoms developed so we can then figure out how to best treat those symptoms. But it's not like let's say psychoanalysis that often gets, you know, portrayed in movies and TV shows with an individual, you know, laying on the couch and sort of just recalling their past and processing. It's very focused. It's very much about goals and learning new ways to cope with and to manage stress, you know, so as an example, when individuals are, you know, let's say newly diagnosed with Parkinson's, or they are adjusting to changes that occur, you know, in, you know, later stages of the disease, you know, it's not unusual to start thinking and overthinking about things making meaning, trying to interpret you know, what's happening.

And oftentimes, you know, especially if we're dealing with very significant stressors, our thoughts might not be as accurate or as balanced or as healthy as they could be. When we're facing tremendous stress, oftentimes we have a lot of negative thoughts about ourselves, about our world, about the future. Maybe about our level of disability, about our ability to cope effectively with the challenges that the illness may present for us. So, one of the things that we do for the cognitive piece, you know, of cognitive behavioral therapies, we help an individual to try to be more aware of what they're saying to themselves, of how they're interpreting, you know, their lived experience. Because the reality is we're all thinking all the time, and we're all interpreting all of the time. Nobody stops to think about what you're thinking about unless you've got somebody like me that says, what's running through your mind right now?

Or what about that situation in the grocery store was, was so upsetting for you? You know, we're usually sort of just an automatic pilot going, going, going, but oftentimes we're, we're seeing some, some kind of negative things to ourselves saying some negative things about ourselves. Usually, the language that's sort of spinning in our own mind is not nearly as kind or

caring or as compassionate or as balanced as the language that we might use to speak with a loved one or with a close friend. So, we spend a lot of time helping an individual to first of all, recognize what do you say to yourself when you're frustrated, when you're angry, when you're upset, let's press pause, and let's like, look at that thought a little bit more closely and together, let's implement, you know, maybe, maybe one of a variety of techniques.

And let's see if we can figure out if that thought is as true as it feels. Or maybe the thought is guided more by frustration than by the facts of the situation. And if it seems like that thought is maybe being, you know, guided by frustration, guided by anxiety, maybe we can balance it out. Cause if we can change the thought, we can change the emotion and we can change the behavior associated with it. And that's kind of a really core component of cognitive therapy, that it's not the situation per se, it's not the stressful event per se that drives the negative emotional response. Yes, it sets the stage but it's the thought, the meaning, the interpretation of what's happening that is really fueling the fire, you know, with respect to the emotional response that an individual's having as well as what they're doing or not doing.

Right. You know, so an example I like to give, and this has come up a lot there so a friend of mine from the Parkinson's community, Sandy, that I worked with, you know, many years ago, and she had Parkinson's, I want to say about two or three years at the time that we were working together. And, you know, she was still working full-time. You know, she had kids in college, you know, very active and full life, and she had a very sort of high-stress kind of intense job in marketing and advertising. And all of her colleagues knew, and this was long before Parkinson's, if she was racing towards a deadline, like give her personal space, let her work in her bubble, and that's just what she needed. You know, when it was go-time, you know, with respect to deadlines.

So, one day she came into my office and she was just devastated because all her colleagues had gone out to lunch the week before on a Thursday afternoon, and they didn't invite her to go. She was convinced that they didn't invite her to go to the lunch because her Parkinson's symptoms make them uncomfortable. So, she thought that they had come together as a group and decided that she was no longer welcome to join them at social events related to work. So, we spent some time kind of talking about like what exactly happened and what the circumstances, you know, around the lunch were, and then you know, sort of what followed after and following, you know, a 30-minute conversation about this. You know, what we were able to realize together was that they didn't invite her to lunch because they knew she had a deadline. And in the past, she had asked them specifically, please don't invite me to do anything during lunch when, you know, I am racing towards a deadline because it stresses me out. And then I also feel bad because I have to turn down your invitation. But it wasn't until we sort of paused and reviewed all this information together that she was able to recognize maybe there was an alternative explanation other than they don't want to socialize with me because my tremor makes them uncomfortable.

Melani Dizon:

Right. Oh, that's interesting. So, I have a scenario that happens very frequently with our community, and I'm sure you see it on a daily basis, but I'd love to just have a little bit of an example of what you might do, how you might address it. So, somebody with Parkinson's, maybe they've had it for a couple of years and you know, they had a rough time when they got the diagnosis and oh my gosh, my life is over. And then they finally sort of get to the place where like, okay, and they go to a support group and they see their future and this just sends them on a spiral of this future tripping of, oh my gosh, I'm not going to be able to walk, I'm not going to be able to talk, I'm not going to be able to do this, I can't do this anymore. And then it's just, why did I ever go to that support group and this is going to be my future and what do I do? And it's really, the anxiety level just goes through the roof. what are some things that you do in that situation?

Roseanne Dobkin:

And that comes up a lot. So, I, you know, I think it's important of course to kind of talk about how everybody with PD is different. And while in general you know, we know what changes in an individual may experience, you know, at various points along their PD journey. It's not the same for everybody. And there there's so much, you know, individual variability regarding the progression of PD-related symptoms. We also know so much more now than we did 10 or 20 years ago about ways in which individuals can be proactive in their own care and self-care in order to delay the progression of the disease as much as possible. You know, so we spent a lot of time talking about that. How, how can we be empowered? What can we do to manage your symptoms, you know, as effectively as possible?

Because I don't know, I mean, honestly, I don't have the crystal ball. So, I, for 100% sure, can tell you that everybody's different and everybody's on a different trajectory. I can't tell you exactly you know, what your future's going to look like, but I can tell you, and we can spend a lot of time talking about what you can do now to maximize the likelihood of managing this as effectively as possible for a very long time. Like getting a good night's sleep, exercise, exercise, exercise. You know, taking your medication on time every time, you know, pulling every lever that you can reach, utilizing all of the terrific interdisciplinary services that are out there and available even if you feel like maybe, you don't need it. But like physical therapy and speech therapy, keeping your mood under control, you know, managing stress in your life. We know all of these things are so important and yet Parkinson's is progressive, but science is progressive too. And we're going to learn, we are learning so much every day and we're going to continue to learn more and more over time. So, we want to do everything in our power to keep ourselves as healthy as possible today. So, when the next intervention, the next insight comes along, you're going to be able to capitalize on that opportunity.

Melani Dizon:

Great. So, what are some of the symptoms, you know, sort of depression and anxiety fully there, but what are some other symptoms that are sort of down the waterfall from depression and anxiety that cognitive therapy helps with, for example, sleep? Can you give an example of somebody that you've worked with who has Parkinson's? Sleep is a really big issue, which just sort of makes their anxiety and their depression worse. It makes them not exercise because they're too tired, they're not eating well, because they're just searching for a thing to feel good. So how does that work?

Roseanne Dobkin:

Yeah, so cognitive behavioral interventions can be very effective for insomnia that may be a standalone concern or possibly an associated manifestation of depression or anxiety. And both sort of like the cognitive as well as some behavioral interventions can be helpful for sleep. Let me kind of break it down. So, in terms of like what an individual can do, so like the behavioral component, right? Because the B part of CBT is making behavioral changes, you know, responding to stressors in a different way. You know, changing up some routines that are problematic and, you know, helping to establish healthier new routines. So oftentimes when an individual is having trouble sleeping, their entire sleep sort of schedule that gets thrown off. So, they may, they may go to bed, let's say at, you know, 11 o'clock, which is a reasonable bedtime possibly for them, and they're having a hard time falling asleep.

And so, they lay in bed for the next three hours thinking about how horrible it is that they're awake, that they can't sleep. They start catastrophizing about how bad the next day is going to be. They're going to be tired; this is the worst thing in the world. I'm not going to get anything done. So, their mind is spinning and spinning and spinning, and then maybe they eventually fall asleep around 3:00 AM and the alarm goes off at seven. And then rather than kind of getting up and just trying to start the day they roll over and go back to sleep and then they sleep until noon and now, there's there, their sleep schedule's off. So, one important thing to do is to try to establish a pretty consistent sleep-wake schedule and to maintain that schedule, sort of independent of how well you sleep the night before.

So, figuring out what works for you and everybody's a different schedule, different activities, you know, different natural rhythm. So, pick a time that seems reasonable to you as, as a bedtime, you know, 11 o'clock, midnight, 10, whatever the case may be. And aim to get in bed around that time. You know, give or take 30 minutes, and then pick a time that makes sense given your day and the demands on your calendar to wake up each morning. So maybe an individual would aim for going to bed at 10 and being up by 7:00 AM. The goal is to try to stick to that schedule even if you don't get a good night's sleep. Because the idea is even if you, unfortunately, have a poor night's sleep, but you get up at seven the next that evening, it may be easier to get to sleep and then to sleep through the night or to sleep for a longer period of time.

So, try to maintain that schedule and not change your sleep schedule based on how you're sleeping on a given evening. Also, important if you're in bed and you can't sleep, give yourself about 30, 40 minutes to fall asleep, you just can't fall asleep. It's better to get out of bed and go do something someplace else that's not overly activating or stimulating. So maybe read a book in another room or do a crossword puzzle if you're going to, or even if you feel like I have to watch an old movie, get outate bed and go watch it someplace else. And then when you start to feel tired, then go back to bed and give yourself another, you know, 30 minutes or so to try to fall asleep. Because we want to break that association between being in bed and being awake. So, we want to be in bed and be asleep.

If we can't sleep in bed, we want to go someplace else. Now some individuals, you know, who have more advanced PD symptoms, understandably have a difficult time, you know, getting in and out of bed all night long, you know, if they can't sleep. So, in those cases, what I suggest is, you know, after the 20 or 30 minutes that you give yourself to try to fall asleep, if it's not safe or reasonable or feasible to get up, maybe we can do something that is relaxing in bed, but it's something other than trying to force ourself to fall asleep. So maybe we can put on a meditation and we can listen to that on our phone. Or we could listen to an audiobook or we could do some breathing exercises or we could just try to make ourselves comfortable. So, we want to, we want to keep the schedule.

If we can't fall asleep, we want to break that association between being in bed and being awake. So, get up and go do something else or do something that's relaxing in bed. Sometimes excessive napping during the day can also be problematic and can interfere with our sleep at night. I will say that a very strict sleep behaviorist would say no naps. That's not reasonable. Okay. I've spent 20 years working with people with PD. Fatigue is a problem. It's not reasonable or feasible to not nap. But what I will say is, if you're going to nap or if you feel like you need to nap, we want to make it part of the routine to the extent possible. So, trying to schedule the nap about the same time every day. So maybe you take your nap, you know, around 2:00 PM every afternoon and then also try to set an alarm so you're limiting it so you're not sleeping for three hours during the day.

You know, so try to take the nap around the same time, set an alarm so you're up, you know, 60 to 90 minutes later and you know, you're not sleeping for a prolonged period of time. And the last comment I'll make about sleep is when you're in bed and if you're struggling sleeping again, our thoughts, we start to spin and spin and spin and we start to overly interpret what it means that we are awake. We want to pause that negative self-talk. Even if you can't fall asleep, it will be okay. You may be tired the next day, but you'll be able to function. So, we want to talk back to all of those catastrophic thoughts we might be having regarding how horrible it is that we can't fall asleep in that moment. And when you're in bed, try to make yourself comfortable versus force yourself to fall asleep. Cause there's a very big difference if you're sitting there and you're telling yourself, I must fall asleep. Oh my gosh, I have to sleep, I have to sleep, versus how can I make myself comfortable right now? Maybe I'll, I'll grab a different

blanket, maybe I'll change positions. You know, maybe I'll, I'll listen to a meditation or maybe I'll put some soothing music on in the background. Like, how can I just make myself comfortable right now? That's a much easier ask and how can I make myself false?

Melani Dizon:

Right. Yeah, that's excellent. So, who, well first of all, who can provide CBT? Is this psychologist any counselor, or a social worker? It's just people can get specific training in CBT and then any licensed mental health clinician.

Roseanne Dobkin:

So, it could be a clinical psychologist, like myself, could be a clinical social worker could be a licensed professional counselor. And there are so many different types of licensed mental health practitioners and oftentimes it may vary by state as well, but any licensed provider that has the interest and experience and training can most certainly provide CBT. And I also say that there are lots of other types of psychotherapy out there. CBT happens to be my area of research and my passion. It doesn't mean it's the only type of therapy that exists. Right, right. So, I would say any treatment that works for you is a good treatment. Any clinician that you feel comfortable talking to is an excellent provider to work with.

Melani Dizon:

Yeah. How often are you using CBT in conjunction with the person taking a, a, you know, a specific med for depression or anxiety? Or are you trying to say, "Let's try this first. This is a frontline."

Roseanne Dobkin:

It really depends on the situation. It can go either way. So, you know, in my practice, because this is a specialty area of mine the referrals that I get tend to be a bit more complex. So, a lot of the people that I see are also on some type of medication for depression or anxiety and they're not getting, you know, the response that they would like to see or that their family might like to see. So, so we're adding in the therapy to see if we can get a more robust response. But again, I have a very special type of practice at Rutgers because I work so closely. You know, with our movement disorders clinic in a more community-based setting, it could play out in a variety of ways. You know, oftentimes if an individual has, you know, sort of, and I hate to term use the term mild, but you know, when we think about clinical symptoms, we tend to classify them as like mild, moderate or severely mild means.

And again, no symptom is mild because it's distressing and it, and it's causing, you know, discomfort in one's life. But a milder symptom, maybe it fluctuates, you know, it's not there more than half of the time. And yes, it's distressing, but maybe the level of distress associated

with it is like a two or three outate 10 versus, you know, a 5, 6, 7 outate 10. And maybe there's some subtle, you know, hints of impairment in the day-to-day, but, you know, they're not overwhelming. So, in a case like that, we would probably recommend therapy you know, as, as a, as a first approach. If an individual is kind of closer to that, that moderate range where the symptoms are clearly there and they're there a chunk of time and they're really kind of getting in the way with work with a family with school, with leisure activities, we might try, you know, a couple of months of therapy if they don't want to take medication.

But usually, once you hit that mild level, I mean the moderate level we're, we're going to combine viva therapy with the medication. So, sort of fleeting symptoms, they bother us, but we can manage, but we'd like to do better. We're going to start with therapy once symptoms are there, they're pretty distressing and they're pretty impactful. We're probably going to combine the meds with the therapy. And you know, what my research has shown is that it's equally CBT is equally effective kind of when utilized alone or when utilized, you know, in conjunction with antidepressant medication in the Parkinson's population.

Melani Dizon:

Okay. How long, let's say somebody comes in and we're like, okay, we're going to move forward with some CBT, we've identified the issues. How long does it take? And is this something that people tend to come back, you know, every week? Is this like a three-month thing? How, what's do, do you have, do you see people for years with CBT or what do you do?

Roseanne Dobkin:

So, it tends to be shorter term kind of initially. So, in many of the studies that I've done, we've studied like a three to four-month, you know, course of weekly CBT and sort of use those parameters to define acute treatment. So, it could be anywhere from, I don't know, 10 to 16 sessions. And then we typically follow people, you know, monthly for kind of check-ins after that. And then as needed over time. Clinically in my practice when I'm working with somebody new, I like to see them, you know, weekly, if possible, you know, for a three-to-four-month period of time. And then we start to space it out. Because the idea is you learn skills; you learn to approach problems differently you learn to think about things differently and then you can kind of become your own therapist.

You know, that being said, because I've been doing this work for a very long time and Parkinson's is a chronic condition, there are lots of people in my practice that I've worked with for years, if not longer, but maybe I see them four times a year just to kind of, to check in and touch base. So, you know, once we get somebody feeling better, you know, we like to do a tune-up every now and then, but sort of the weekly treatment is usually in the beginning until we can turn the dial down on the distress associated with the depression and the anxiety. So, I would say a good course of CBT would be every week for three to four months and then you start to taper off.

Melani Dizon:

What about group CBT? Is there group CBT?

Roseanne Dobkin:

There are most certainly group approaches to CBT. As well, there are a lot of you know, outpatient practices in the community as well as clinics affiliated with, you know, larger, you know, hospitals and medical centers that may offer group approaches. Probably not necessarily specific to Parkinson's per se, but one may be able to find you know, skills groups that would be very applicable to addressing the concerns that many people with PD are living with. So, an example that comes to mind is, you know, mindfulness, which is, I get this question a lot, well, is mindfulness, CBT, is it not CBT? So, mindfulness is sort of an extension of CBT's. It's a different type of intervention sort of based on the spirit of CBT that can be utilized to help an individual to manage their emotional distress, you know, more effectively. But it uses, you know, slightly different techniques. It doesn't focus so much on, you know, cha directly changing, you know, the content of one's cognitions, but more on responding to those cognitions with a different type of awareness and a less judgmental approach. So, mindfulness is an offshoot of CBT and there are lots of medical centers that offer, you know, mindfulness-based group interventions as well as more traditional CBT interventions as well.

Melani Dizon:

What role do you see care partners or other people who love, you know, their person was Parkinson's playing when their person with Parkinson's is struggling with depression or anxiety or going seeing you doing when they see you?

Roseanne Dobkin:

A huge, huge role. Oftentimes I'll be honest, it's the care partner that maybe encourages their loved one with PD to make the phone call or maybe the care partner makes the phone call to get them connected to treatment. So, you know, they help them to kind of bridge that care gap. And then once the individual with PD is in therapy, I've actually found it helpful. And again, it's going to change case by case. And what I'm about to say is very much dependent on, you know, the type and the nature of the relationship between the care partner and I'm the person with PD, but assuming it's a healthy relationship and that the relationship is strong, what I like to do is either invite the care partner to sit in on a session from time to time just to learn a little bit about sort of the new skills that are being discussed and how they can best support their loved one's application of these new coping skills in the home environment. Sometimes I'll meet with a care partner separately to have that conversation. And sometimes when I'm working with individuals with more advanced PD, the care partner we'll sit in on all the sessions so they can help to facilitate and to help their loved one with PD, you know, sort of re-review and you

know, sort of reinforce them the material both in the session as, as well as at home after the session.

Melani Dizon:

Is there any situation where you've worked with some of PD and you said these, this, that they're just not a right candidate for this, this is just not going to work with them?

Roseanne Dobkin:

There have been situations where I have worked with many individuals, well, I shouldn't say many but a handful of individuals PD or not where I felt like maybe this was not the right treatment approach. You know, so in general, you know, it's kind of funny because I teach a CBT course for a psychiatry resident and like the first class every year, I say every patient's a CBT patient. But the reality is it you have to kind of consider goodness a fit. So, with respect to Parkinson's, if an individual is not necessarily open or ready or motivated to maybe work a little bit outside of their comfort zone, then maybe a different type of therapy, like a more supportive type of therapy to start could potentially be beneficial because CBT is really, really effective.

But it's hard. Like we've had to talk about some themes that can be pretty difficult. Yeah. At times, right? For people to confront and to really grapple with, I mean, people come in and they're putting such negative labels on themselves like they're helpless or they're worthless or they're a failure, or they're not able to contribute, and we really have to, you know, roll up our sleeves and kind of talk about why they believe those things to be true and like why they're not true. And that can be pretty hard work. And it's also important to emphasize that we ask people to kind of do things differently. You know, if you're not exercising, we want an exercise plan. If you're very much withdrawn socially, we want to slowly reconnect with other people. In your world, we want to problem-solve around physical limitations, so you can be more active and more engaged in your day. So, we're not going to really sort of accept a lot of the avoidance and withdrawal behavior that may characterize depression and anxiety. We're going to work together to push past that, and the individual has to be ready to do that.

Melani Dizon:

Yeah. There's the most of the work happens between the sessions, right? Because yes, they just-

Roseanne Dobkin:

That is so, that is such an important point, Mel, and I use this analogy, you know, all the time, if you have a migraine and you know that Advil really helps your migraine and you go up into your bathroom and you open the medicine cabinet and you're staring at the bottle and you know it's

there, but you don't actually take the medicine with a glass of water, you're not going to feel any better. You're still going to have a headache. The same thing applies to CBT. You could understand the model and the importance of what we do or don't do in response to life challenges and the importance of our cognitions. But if we don't actually practice thinking differently applying new coping skills in the face of stress, all of the understanding of the model, and why these strategies are beneficial, it's not going to be very helpful. So, practice is so important because yeah, we can do great work for an hour together every week, but what happens the rest of the time when you're out there living your life? And that's really where change takes place.

Melani Dizon:

Yeah. So is there anything I know this is just such a passionate topic for you, and we have, I know we're going to have so many people watching because this is really important thing for them to learn about. Is there anything that I didn't ask that I should have? Or is there anything you want to leave our community with people who are struggling with some depression and anxiety?

Roseanne Dobkin:

I could talk all day, but I think my, my last comment will be that you know, you are not alone. If your mood is not as good as you would like it to be, if you are experiencing, you know, any of the symptoms of depression or anxiety that I mentioned earlier, these are cardinal core symptoms of Parkinson's. They do not reflect, you know, personality or character flaws. It's not because you know, you're not coping effectively or you're, you're not strong enough. These are cardinal symptoms of the disease and they're also highly treatable. So, if you're feeling anything that's uncomfortable or that you don't like, tell somebody about it. And let's see if some type of treatment, you know, from a medication or talk therapy perspective or potentially both could be beneficial for you. There's no reason to suffer in silence because these symptoms are common.

They're disabling, but they're highly, highly treatable. And if we can identify and treat depression and anxiety can make everything else better. I mean, we know that if an individual is depressed, they're going to be anxious, they're going to experience, you know, an accelerated rate. You know, a physical and cognitive decline associated with Parkinson's over time that they tend to report, you know, lower quality of life, you know, compared to their peers without depression or anxiety. They need more help with self-care. But once we identify and we treat depression and anxiety, all of those negative patterns begin to reverse themselves. He is hard enough to live with, you know, day in and day out. Depression and anxiety can make it that much more challenging. So let, let's remove that burden because again, the goal is to live the best life possible. And when we can treat depression and anxiety and get those symptoms under control, everything else will become that much easier.



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