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John Moe: A note to listeners: this episode contains mention of suicide.

You and I, we're friends, right? We hang out about once a week or so, depending on your schedule. Because I'm always standing by, ready to go. I'm not ready to listen, really. I don't do that. At least not in the normal way. No, I do most of the talking. And then I bring in guests, and they do some of the talking. But really, we're friends, you and me. And I am going somewhere with this. Okay, most friendships don't have one person saying the name of a show, but one is often glad when a friend is here. So, in that spirit, it's *Depresh Mode*. I'm John Moe. I'm glad you're here.

Transition: Spirited acoustic guitar.

John Moe: And one thing that friends do is they tell you when they ran across something cool or interesting, and they want to tell you about it. You know, I just saw this really great movie, or I went to a restaurant you might like. Friend recommendations. Well, I'm doing that this week as your friend. In a little bit, I'm going to tell you about this cool thing I saw on Facebook—therapy for bands, like music groups. How does that work? Who does it? What do people gain from that? We're going to talk about that. But first something cool I saw on television: a two-part documentary called *One South: Portrait of a Psych Unit*. It's now airing on HBO, or Max, or however one accesses HBO content.

It's a profile of patients at Zucker Hillside Hospital in Queens, New York, which has an inpatient psychiatric unit dedicated to college age patients in states of crisis. It's one of the only such facilities in the country. And this documentary is really interesting, because—for a variety of reasons—one doesn't often see what really happens behind the doors of an inpatient facility. I mean, sure, there are depictions of it in movies and TV shows, and these places are often portrayed as being really horrible. And I think a lot of that is done for dramatic effect. So, it's easy to find the idea of inpatient care really scary. This documentary, *One South*, provides access to some of the patients, tells their stories, depicts their struggles and their wins. And yeah, it's sometimes scary, but there's way more to it than that.

Here's a bit of the trailer.

Clip:

> **Music:** Melancholy orchestral music.
>
> **Speaker 1:** I think I was ruminating on having a plan and acting on it for a really long time.
>
> *(Scene change.)*
>
> **Speaker 2:** We have like a situation.

Speaker 3: A situation, okay.

Speaker 4: I think we need more people.

(Scene change.)

Speaker 5: The goal here is to have them find those reasons for living. How am I going to find meaning out of this pain?

(Scene change.)

Speaker 6: Oftentimes, our patients have gone through trauma and feel a deep sense of shame. Shame tells us that we have to hide our true selves.

(Music becomes more hopeful.)

Telling your story, it's a really freeing experience.

(Scene change.)

Speaker 7: I want to know what you're feeling.

Speaker 8: Pretty anxious.

Speaker 9: It feels almost like I'm choking.

Speaker 10: Like a horrible panic.

John Moe: Lindsay Megrue and Alexandra Shiva are the directors of the documentary *One South*. Lindsay Megrue and Alexandra Shiva, welcome to *Depresh Mode*.

Lindsay Megrue: Thank you so much.

Alexandra Shiva: Thank you. Thanks for having us.

John Moe: Let's set the stage here. What is Northwell Zucker Hillside Hospital in Queens? What is this place?

Lindsay Megrue: It's an inpatient psychiatric unit that specializes in treating young people, and specifically college students.

John Moe: I understand it's one of the only or the only facility with this focus on this age group. Is that right?

Alexandra Shiva: Well, it is one of the only facilities with this age group that takes insurance in the country. And it is, I think, one of the very, very few that focus on this age group and put them together in this way at all.

John Moe: And why are they doing it? Why is nobody else doing it? Why is this such an unusual thing? And why is this the focus of this organization?

Lindsay Megrue: That's a good question. I mean, I don't know why more people aren't doing it. And I think hopefully this film will be a bit of a call to action that will show that these units, this type of programming can be really successful and helpful. I know that there's some talks right now in Massachusetts to have a similar program with all of the colleges up there in the Boston area. So, hopefully this will be a model that people look into replicating.

John Moe: Let's talk a little bit about what went into making this documentary. Where did the idea come from, and why did you choose it?

Alexandra Shiva: Well, we had actually—we had done other work on mental health in the past, and we really wanted to understand the inpatient part of the experience—

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—for people who were struggling with mental health and who were seeking help, and to demystify that. We knew that there was a lot of stigma still around the idea of being in an inpatient psychiatric hospital and what that entails. And there were—we really wanted to show that, you know, it is not what people think. There is tremendous hope involved. There are a lot of people who are doing incredible work. And I just—to destigmatize and demystify that process.

John Moe: How did you go about selecting this hospital to focus on, and how did you go about kind of getting the permission, getting all the access that you had?

Lindsay Megrue: Yeah, we—you know, we started researching and were looking at various programs. And the uniqueness of this program struck us, especially because it was focused on young people. And there's a lot of evidence that early intervention leads to better outcomes. And so, we knew that by focusing on young people, there would be a more hopeful quality to the film. And that was important to us. We're both moms, so we were sort of more interested in young people and their perspective. But it was really the uniqueness of this program that attracted us.

And Northwell, they're great collaborators. They, you know, really see the value, I think, in educating the public on the work they do. So, they'd participated in other films. So, they sort of already had an understanding of what it would mean to have a film crew in the hospital, so that they could probably more quickly put into place processes that would allow filming to

happen in a safe way. You know, they sort of already had ideas about consent procedures and how to do all of that.

So, they were very open to filming right away. But it did take a long time. And I think we really hit it off with Dr. Laura Braider, who's head of the program. I think she saw our past work and knew that we were a film team that she could trust, that we had done work in this area. We had done work with participants who were in challenging moments of their life, and we would have the sensitivity and ethics to handle difficult subject matter. So, I think we started from a mutual place of trust and a lot of conversations about how it would work.

John Moe: A lot of the patients that we get to meet in the documentary have been through some really serious things. There's suicide attempts, there's drug overdoses, there's circumstances and actions that have led them to be there. Did you have to—or did you choose to talk them into being part of the documentary? I mean, it's very revealing. They really give over a lot of themselves. Like, were they eager to participate in something like this?

Lindsay Megrue: I think so. I mean, we had conversations early on where we were like, "Is anyone going to agree to this?"

Alexandra Shiva: Yeah. We were really surprised.

Lindsay Megrue: Yeah. But you know, we didn't have to—we couldn't talk anyone into it, because we couldn't even talk—like, because of HIPAA, you know, the hospital handled the whole consent procedure. So, the team made a clinical decision about who could participate, who had capacity to consent, who would filming actually be maybe beneficial for even as part of their treatment. And then we met the patients who were interested. So, anyone who had any reservations or maybe wasn't in a good enough place to consent, we didn't meet.

Alexandra Shiva: And there were also a number of patients that wanted to participate that were not considered eligible to participate. So, we never knew about them. We never… that was it. They were not—the providers did not believe that they could consent, and therefore it was not an option.

John Moe: And so, I understand that you weren't the ones doing the screening and evaluating the consent, but do you know what those criteria were to determine whether they were in a position to consent or not?

Alexandra Shiva: Well, I think that—I know that Northwell had a very comprehensive consent process, and they would determine the appropriateness of each participation, and they would discuss that with the entire team. The exact criteria, I think, is more clinical that I understand, but it was very carefully thought through. Obviously, a patient who is having a manic episode is not someone who could consent. Someone who is experiencing psychosis is not someone who could consent.

John Moe: How does someone end up in this facility? Because there's very much a feeling of people coming and going, new arrivals, people being sent home. How does someone end up there as a patient?

Alexandra Shiva: Well, that's what's really interesting about this program is that it's a partnership with 97—I think they have 97 or 98—colleges in participation with them.

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So, one of the ways that people come is that someone will walk into their college wellness center or health center and say, “I'm having a hard time. This is what’s going on,” and at that point, there’ll be a determination if maybe Zucker Hillside is some place that would be helpful for them. Or if they're in an acute situation, they will then make a determination. They will call, and then there's an entire process that goes into getting them from their school to the hospital in a way that does not then make it difficult to go back.

So, if it's sort of days of ambulances showing up at someone's dorm, it takes all of that out of the equation, so that there is a much more thoughtful process in which someone then is admitted. There's also you don't have to be in college. You can also be college age to also be admitted. There are people who are admitted involuntarily. Those are—we had no—that is also probably not a criteria for consent. So, we did not have patients who were at the time—

Lindsay Megrue: And some of our patients would come through the emergency room, or there's a crisis center. So, they wouldn't necessarily come right from their college. So there's a couple of different ways. But you have to be in acute crisis. That I think is the defining…

John Moe: Yeah. It seems like there was always an overdose or a suicide attempt. Is that what you mean by acute crisis?

Alexandra Shiva: Well, those are the patients that we were filming. The unit is comprised of—20% of the unit are people who are having either a first break or psychosis, about 20% of the unit are having a manic episode. And then 60% of the unit would sort of fall into either some sort of suicidal depression—you know, ideation or attempt, major depressive disorder, not able to function and needing acute care.

John Moe: You get a little bit of a glimpse for what life is like in there, but you've seen obviously many, many more hours than what showed up in the final documentary. How would you describe to somebody else who's unfamiliar with the place what life is like inside this facility—just the day-to-day life for some of the people that you profile?

Lindsay Megrue: Well, it was surprising to me, because I had a very kind of old school idea of what inpatient care looked like. You know, *One Flew Over the Cuckoo’s Nest* was, I think, the thing. And then the day is pretty structured. There's a very kind of—it's all about routine and schedule, which we don't go too much into in the film. But you know, they have a morning meeting, then there are groups, then there's individual counseling, mealtime, free time, activities. But it's a lot of structured time.

So, you'll see that in the film in terms of some of the group therapy sessions, which are primarily dialectical behavioral therapy based, DBT. So, we show that in the film. And then there is some unstructured time, where you see a lot of the patients kind of coming together to

hang out. And that was perhaps, you know, one of our biggest takeaways is just how important community was to the healing process.

The film sort of follows the trajectory of a stay. You know, we start the film with an intake, and it sort of progresses all the way through discharge and leaving the hospital. But there comes a point when patients start to really come out of their shell and connect with one another. And that's sort of towards the tail end of when they're getting ready to leave. And it's kind of finally finding someone who you can relate to, who you connect to, and you're like, “Oh, wait, I'm not the only one who feels like this.” That was a big “aha” moment for a lot of patients, that they weren't alone in these feelings. So, we see a lot of those types of kind of unstructured moments of just connecting.

John Moe: Do you feel like you saw or that you depicted in the documentary, some of those transitions, some of those breakthroughs that occurred for these people?

Alexandra Shiva: I do.

Lindsay Megrue: Yeah, definitely.

Alexandra Shiva: I think we saw a real change in Sara that was incredible. So, she's one of the patient participants. And she really was connecting—she began to really connect with everyone, all of the peers, and was then doing everyone's makeup. Had an incredible breakthrough in a Zoom therapy session with her family, with her therapist next to her, which I thought was incredible and really prepared her to be able to go home.

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I think from the unit she was able to say things she couldn't say or articulate things that she had not been able to articulate before. So, I feel like there was a lot of hope in her story. And then also Evan. There's another one of the participants. There was a scene where he was punched in the head on the unit by another patient. And then there were three providers who were actually trying to help him get to something deeper and really work with him to understand. And Dr. Braider was one of them.

And she basically sort of helped him get to a place where he was able to talk about if he could tell anyone what was going on for him right before he had attempted, what would it be? And that kind of was—it was a big breakthrough for him, I think, to be able to talk about that.

John Moe: One of the patients compares it to prison. And one of the employees of the hospital mentions that, you know, it's one of the only two places you could get locked up is prison or a psychiatric hospital. Did that occur to you as well, either of you, that this—prison-like, as a facility?

Lindsay Megrue: I mean, it certainly doesn't look that way. But yes. I mean, I think Dr. Yan makes that point, which is really fascinating that there really are only two places where you're held against your will. Right? And so, for one of those settings to be a hospital and a healing facility I think is very complex. I mean, none of our patients were there involuntary. So, the

film doesn't go too much into that issue. But I think that was one thing that we saw the staff struggle with, this idea of how do you respect patient's autonomy? There's so much I think real care and consideration that goes into that, but then also how do you keep someone safe? And I think that's something they really struggle with.

Transition: Spirited acoustic guitar.

John Moe: More with Lindsay Megrue and Alexandra Shiva in just a moment. And after that, a look at therapy for rock bands.

Transition: Gentle acoustic guitar.

John Moe: Talking with Lindsay Megrue and Alexandra Shiva, directors of the documentary *One South: A Portrait of a Psych Unit*. In the documentary, the clinicians at the facility employ Dialectical Behavioral Therapy, or DBT. DBT is a form of talk therapy designed for people who experience very intense emotions. I like this description of DBT from the Cleveland Clinic. Quote, “Dialectical means combining opposite ideas. DBT focuses on helping people accept the reality of their lives and their behaviors as well as helping them learn to change their lives, including their unhelpful behaviors,” unquote.

DBT was originally developed to help patients with borderline personality disorder, but it has been effective in treating depression, anxiety, suicidality, PTSD, eating disorders, and substance use disorder.

Lindsay Megrue: But I think the important thing for people to know is that it's really life skills and that it actually is the kind of thing that I think everyone could benefit from. So, we hope that people watching the film—whether they're struggling in their life or not—will get something out of watching it. Because these skills are, I think, are really helpful. Like, we found—you know, our crew would joke like, “Ooh, we're getting free DBT. Like, let's do mindfulness on the way home from the shoot.” *(Chuckles.)* You know, they're great things to be able to kind of reset.

Alexandra Shiva: Radical acceptance. Something went wrong. Okay, let's practice radical acceptance.

John Moe: *(Chuckles.)* Probably in shooting a documentary like this, there was some things that went wrong that needed radically accepting. Why was that the main technique being used in this facility, DBT?

Lindsay Megrue: I think that it—again, you know, we're not clinicians, but my understanding is that it's been shown as one of the most effective treatment—particularly for people who are dealing with suicidal ideation, suicidal feelings. That it is one of the most effective treatment modalities.

Alexandra Shiva: It also is very useful. It has been shown to show—to really change behavior around personality disorders as well.

John Moe: What kinds of things were people—*(chuckles dryly)* I hate to use prison terminology—in for? Was it… I mean, you mentioned the people with schizoaffective disorder or psychosis aren't really featured in the film. But did you notice—did it tend to be the same sorts of things that people were in for?

Lindsay Megrue: Yeah, I mean, a lot of our patients were dealing with depression, anxiety, major depressive disorder, borderline personality, suicidal ideation.

Alexandra Shiva: And then the patients who were having—we have a couple of patient participants in the film who are there because they're bipolar, and they were able to consent once they were stabilized. But mainly, if someone's in the middle of an acute manic episode, that's not something that we could ever film.

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And nor would the hospital have put a person in that situation. And also, the same with schizoaffective. So, it is a very specific view, even within the experience of being on the unit. If that makes sense. We're showing you a slice of what the experience is.

John Moe: Right, right. And as you say, the documentary follows the intake and being there. And then there's a depiction of people who—I don't want to say get to leave, but meet the criteria where they move on. What is the criteria at this facility that needs to be met for someone to check out?

Alexandra Shiva: Well, I don't know if it's—I'm not sure exactly what the criteria is. The average stay is usually 7 to 10 days. Some people definitely stay longer. There were people that we were filming that were there for a couple of weeks. Because it is an acute facility, it's just the beginning of the work. So, I think that as soon as they feel like someone is safe enough to be outside, to start doing that work outside—they're not just being let out in back into school or back at home without a safety net and resources, right? So, they're set up with an outpatient program. They are—it can be a partial program or a daily program. Whatever that is, it's staged.

So—and I think there's always a parent, some parent involvement too, to make sure that the person is resolving some of those issues enough that they can then go home to be with their family, if that's where they're going. So, that's the most we can tell you. Because we would hear in these team meetings, people talking about, “We think she's ready to go home. She's making good progress.” If they were on medication, the medication is working. They are more stable. There was that kind of criteria, and I think there's a lot of pressure too just in the American healthcare system—which we do touch on in the film. The idea that even though this is covered by insurance and maybe they could stay—they could benefit from being there for two more weeks, really there is a pressure in all healthcare in this country to sort of get people better and get them out.

But they're doing it as safely and responsibly as they possibly can and setting them up for success.

John Moe: So, is it as much art as it is science? Kind of people who've been in this business for a long time just using their wisdom saying, "I got a feeling this is going to be okay"?

Lindsay Megrue: I like—I think that's a nice way of putting it. 'Cause I think that—maybe I'm curious what the doctors would say, but I think that they'd like that though. *(Chuckles.)* It's an art and a science.

John Moe: The numbers for this demographic, in terms of mental health problems, have been scary for a while and are only getting scarier—in terms of their being either more people with these problems or more knowledge being found out about all the people who've had all these problems all along. Either way, it results in more patients and more demand for mental health services. Is that reflected in the hospital's approach? Is there kind of an awareness that, you know, there's more of these heading down the assembly line all the time?

Alexandra Shiva: I think they're very aware of the changing landscape, and they're trying to keep up with that need.

Lindsay Megrue: I wouldn't know sort of hospital policy, but at least on the unit and on our experience—I mean, there was a constant talk about the number of beds and how many people are in the ER and are people in other units that need to be transferred. There's a constant awareness sort of the number of people on the unit at all times.

John Moe: What did you observe as documentarians coming into this facility as something that was—that's wrong with the American mental health care system or something that is going well with what these people are doing?

Alexandra Shiva: Well, I think what they're doing is incredible. And we were really impressed by the dedication of all of the staff there. And I think, ideally, there's a call to action, which is we really wish there were more of these units available where they take insurance, and people can come and get the help that they need. It's the way we would hope that things are run.

Lindsay Megrue: Yeah, because it's a college program, there's this holistic approach. There are other elements that I imagine are pretty rare. You know, you see in the film, there's one girl who had an issue with her school, and her GPA tanked because of it. And she couldn't sort of get it resolved on her own. And one of the staff members helped her resolve that.

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They also, you know, help people figure out how to take a leave of absence or how to get extensions from your professors, like all sorts of logistical things that would weigh on your mind. So that they can kind of—the program takes that off their plate, so that they can focus more on their recovery. Which I think is really, really successful.

So, anytime we can have this more holistic approach to all of the elements of someone's lives, it seems like that really sets them up for success. We did spend a lot of time hanging out in the social worker's office with them. Not as much got into the film, but they're incredibly

dedicated. And to see how many phone calls they would make to try to find programs and try to find spots and try to find therapists and try to find doctors that are going to take the right insurance—that's incredibly complicated. And you know, it can delay people's treatment. You know, they can't get—they can't be released until a treatment plan is in place. But if you can't find them a spot in a partial program, what are you supposed to do? So, just that aspect of it—you know, there's so much room for improvement in our healthcare system to make that easier.

Alexandra Shiva: One thing that I was really struck by was that—and other people that we showed the film to who were in the mental health profession said that they didn't—in programs that they worked in, they didn't have the same kind of staff support. Which we thought was really unusual too, the way that they would do the DBT, because they were teaching DBT, that they would support each other in a particular way and talk about—even talking about burnout apparently doesn't happen.

One of our advisors had worked at Bellevue and said, "I never—we never talked about burnout. Ever." So. At the time. That was many years ago, but so the idea that's even part of that process, to Lindsay's point, is very holistic and unique.

John Moe: *One South: Portrait of a Psych Unit* is available on Max. It is made by HBO, and it was made by Lindsay Megrue and Alexandra Shiva. Thank you so much for joining us.

Alexandra Shiva: Thank you so much for having us.

Lindsay Megrue: Thank you, this was great.

Transition: Spirited acoustic guitar.

John Moe: Just ahead, therapy for bands—like, music groups—and what we can all learn from it, even if you can't play a wicked guitar solo.

Transition: Gentle acoustic guitar.

John Moe: So, I was on Facebook a while back, getting caught up with lives of people I haven't spoken to since junior high, comparing myself to others, looking at ads based on websites I have visited and feeling deeply surveilled. And I came across a post by a friend of mine, Sarah Souder Johnson. She's a clinician, a therapist here in the Twin Cities, and cofounder and board president of Dissonance, an organization dedicated to advancing mental health awareness in the arts.

And she posted about something that was really interesting to me and I hadn't thought of much before. Sarah Souder Johnson, welcome to *Depresh Mode*.

Sarah Souder Johnson: Hi, John. Thank you for having me.

John Moe: Tell me about the work you are doing with bands, with musical groups.

Sarah Souder Johnson: Yeah! So, this is an interesting topic to me and one that very much combines my professional and personal interests. Working with bands in therapy is something I love to do, because it's a whole lot like an extension of what I do with families. Bands act a lot like families. So, when an ensemble is struggling, it's often much like how a family struggles.

John Moe: Oh, okay. In what way are they the same, and in what ways do they diverge?

Sarah Souder Johnson: Sure. Well, they're really similar, because a family and a band are both a unit of individuals connected by something. They have something in common, whether that's biology or choice, interests. And so, families and bands have that in common. They also all have rules and roles. Both of those are present in both families and bands. And then I would say there's just sort of an appreciation for one another. And there also with that comes conflict. Anytime you have a group of people, you're going to have some interpersonal dynamics that aren't always fun.

John Moe: In what way does appreciation breed conflict?

Sarah Souder Johnson: *(Sighs.)* I guess I don't mean that appreciation leads to conflict, but that they're often—

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They often coexist.

John Moe: Oh, okay. Gotcha. Okay.

Sarah Souder Johnson: When you have close interpersonal relationships, you're likely to have some conflict at some point.

John Moe: So, what situation do bands come to you in? Is it like you're taking too many guitar solos?

(They chuckle.)

Or you're not singing on key, or your lyrics suck? Or what is it?

Sarah Souder Johnson: You know, it's usually not about the actual creation of the music or the performance much at all. It's much more to do with their interpersonal dynamics. Very frequently I find that somebody in the band—individual's or multiple individuals'—own personal mental health and various life circumstances are kind of trickling into the band itself.

So, sometimes an individual—or more than one of them—is needing more help than they're getting in their own lives, and it's affecting the whole ensemble. So, that's one way that I see bands show up. Frequently, they are having conflict. Sometimes around money and very

frequently around division of labor, and then scheduling. Those are sort of the three big things that conflict seems to exist around. So, it's not usually the music at all.

John Moe: Hm. Interesting. And so, what kind of work do you do with them? Do you just apply family therapy to the band? Or what exactly do you do?

Sarah Souder Johnson: You know, I do. I do often apply family therapy to bands. Certain theories and specific modalities of therapy that work well with families can also be effective with bands. But it's really about looking at the dyads. So, let's say you have an ensemble of four band members that come in for therapy. Within that, there are dyads between each—every two people within the band. So, we might work all together as a group, or we might identify, hey, this seems to be between these two individuals. This is really the crux of a problem here.

We might isolate that dyad and just do a session or a part of a session with the two of them to try and work through some of that and understand their own dynamic one-on-one and how it affects the whole group.

John Moe: Do you ever have that moment—like a John Gottman kind of thing, where you just know, "Oh, this band is not going to make it. These people are going to break up"?

Sarah Souder Johnson: I wouldn't say it's as cut and dry as that. I appreciate the Gottmans and their theories around that and the ability to forecast. And it can be pretty effective, because it's very similar in some regards. If you're not turning toward one another, if you're not understanding one another, if you're not noticing bids for attention from one another in <u>any</u> relationship—and certainly in a band, when you are trying to, you know, live out your passions together and make a life in music together. It's a very creative endeavor and with that comes vulnerability.

So, I don't see dynamics necessarily where I say, "Oh, they're never going to make it. This is pointless." But there are certainly indicators of success that's likely. It's kind of like assigning a prognosis, you know. What might happen here with this group if they don't turn toward one another more and make room for their relationships so that they can then meet their goals as a band?

John Moe: I think a lot of people, even if they aren't in a band—and of course, my advice is that everybody should be in a band, and if you can't find a band, that the government should assign one to you. But a lot of us—

Sarah Souder Johnson: *(Laughs.)* I thought you were gonna say everyone should be in therapy.

John Moe: Well.

Sarah Souder Johnson: But you know, I kind of like both of those.

John Moe: I think it's a recipe for a really healthy life to do both. But I think a lot of people find themselves in these group dynamics working closely together—whether it's in a family, whether it's in a band, whether it's in a group of coworkers, whether it's a very tightly knit social group of friends—it's sort of a human instinct. We gravitate towards groups. It's probably really primal.

What are some really common sources of conflict and common and accessible ways to address those sources of conflict that kind of transcend what kind of group you're talking about that you might apply to a band?

Sarah Souder Johnson: So, one of the big ones is that division of labor. That's one of the big things that comes in.

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Now, when you think about any group, you're working with individuals' own sense of, first of all, personality and their background and upbringing about how they do things, how they live their own lives. And then when you get a group that has a lot of tasks to do, it's kind of like your classic school project. Is there going to be one person that wants to take over and "I'll just do it for everybody and get it done" in that way? Which can breed resentment both directions. Or you know, is it like everybody has these ideas, and no one is executing? Because executive functioning is also in the room for each of those individuals.

So, we're looking at, in therapy, what is—you know, just getting really clear on who's doing what, and is that clear to one another? Has that been clearly assigned, communicated, and then accepted? You know, is somebody saying, "Yes, I'll be accountable to that"?

Another thing I might do with a band that I would do with a family is something like how you might use something as simple as a chart on your refrigerator for a family to get chores done around the house. A band likely needs a similar mechanism for keeping track of their tasks. So, that can help, because it looks at people's strengths. I always want to lean on strengths first and foremost instead of dwelling on the deficits that people might be—are likely pointing out when they first come into therapy. It's a lot of, "He doesn't do this, they're not doing that." And it can be really frustrating when you're at odds in therapy.

So, start with the strengths. What is everyone bringing to the table? And then we're likely going to need to put some sort of system in place for that task management. So, clear communication, conflict resolution, looking at roles and responsibilities. And then how are we actually, again, being accountable to those things? Those are all pieces that I see very similarly between family organizations and task completion at home and in an ensemble like a band.

John Moe: Is there usually a lot of conflict between the lead guitarist and the lead singer? 'Cause I've seen that in a lot of bands.

Sarah Souder Johnson: *(Laughs.)* There's a lot of ego in the room frequently, I will say. Yeah. And so, that's—you know, part of that is looking at, well, what does that even mean?

You know, we say ego, and it's—is it aloofness? Is it in some cases actually, you know, a difficulty with self-esteem? Or is there actual—you know, is there anything going on that's really an unhealthy, rude, or harsh dynamic with other members? Something that's putting others down? But yeah, I do see that, John, sometimes. I find that the people who are most front and center in the band are likely the most extroverted, the most likely to speak their mind and what they want and kind of jump on, "Well, I'll do this. I'll do that." And it doesn't mean they're going to do everything, but they're likely to speak up more than others.

So, part of my role as a therapist is making sure everybody has a space in that session to talk, to share their point of view. And I'm always looking for that. Again, the individual circumstances and strengths and how to let people really shine in therapy so that everybody gets to be heard and understood.

John Moe: Yeah. I mean, it does sound like group dynamic therapy with instruments. *(Chuckles.)*

(Sarah agrees.)

But I wonder, too—like, a lot of bands break up more frequently and after a shorter duration than, say, a family would break up. I mean, the Beatles weren't together all that long, and they've talked about how stunned they were that actually they stayed together as long as they did. Because bands are—you know, people come and go. Is that kind of looseness of, you know, "this could end at any time, or somebody could leave, and we'd get a new bass player", is that kind of looseness and disposability an obstacle in dealing with those group dynamics?

Sarah Souder Johnson: *(Beat.)* That's a really interesting question. I suppose… I'm trying to think back on my own personal experience working with ensembles. And that has come into play, but it's more in the opposite direction as a threat, frequently. "We can get rid of you. You're replaceable." That kind of thing. Which is a horrible position to be in, you know, if you're the person receiving that kind of news. But there—

[00:40:00]

I think that there's a vulnerability to a band that you're talking about that we do have to always address in therapy. And that, again, goes back to, you know, what are your interpersonal dynamics? I can't say that enough, how important that piece is. Are you even aware of how you are affecting other people and vice versa?

So, in band therapy frequently, I will teach a lot about emotional intelligence and the different facets of that and how that shows up, you know, in each individual. If some people are really good at, say, tending to their own emotions and awareness and regulating while others are really focused on other awareness and relational management, you need both of those. Ideally, you can do all four of those really well. But in most bands, that's not the case. And so, there is this sort of tiptoeing around feelings or just, you know, kind of yelling at each other and like a really unhealthy way of managing those sorts of conflicts that might come up. And that can really feel like threats to the group.

John Moe: Is there a difference in the receptiveness of a band, according to what kind of music that they're making? Like, is a wind ensemble better about receiving therapy than a punk band? Or does it make no difference?

Sarah Souder Johnson: I have actually only ever worked with kind of popular music groups, let's say. So, bands that you may find in a recording studio. I find that there's a fair amount of defensiveness in the "classical" music. And I use classical in quotes, meaning—you know, like I was trained in that growing up, in college and things. And while it's a beautiful art form and very rigorous and whatnot, I don't find that it's as personal. And so, the bands that I've worked with are the ones who are, you know, trying—they might come in because they're about to go on a tour. Or frequently. It's really great when a group comes in before they go into the studio together to work on a big project.

Let's work some of these things out before you go and spend intensive amounts of money and time together.

John Moe: Do you think it improves the music to go to therapy and work on these things?

Sarah Souder Johnson: I've heard it's—I've heard it really does. Yeah. I've gotten really good feedback. Like, you know, "We would have been lost without this, or this helped so much going into this." Because therapy doesn't have to happen in a crisis. It can be preventive. It can be because you really want to take care and nurture your relationships and your band. It doesn't have to be because there's some big problem.

John Moe: Sarah Souder Johnson is a clinician, a therapist in the Twin Cities. She is at Sentier Psychotherapy in St. Paul. You can look that up. We'll have a link on our show page. Sarah, thanks.

Music: "Building Wings" by Rhett Miller, an up-tempo acoustic guitar song. The music continues quietly under the dialogue.

Sarah Souder Johnson: Thank you so much, John. I really appreciate a chance to talk about this important topic.

(Beat.)

John Moe: Our program relies on your dollars. We exist because people donate to the show. And I think people donate to the show because they know that it's going out there in the world and making a difference. And people donate because they feel understood, and people donate because they recognize that's the way we have a show. We want to keep having a show. We want you to help us. If you've already given, thank you. If not, it's easy. Just go to MaximumFun.org/join. Find a level that works for you, and then select *Depresh Mode* from the list of programs that are displayed. Be sure to hit subscribe, give us five stars, write rave reviews. That helps get the show out into the world. We're on a mission, folks. We're trying to help people out in the world. We need your help.

Speaking of help, the 988 Suicide and Crisis Lifeline can be reached in the United States and Canada by calling or texting 988. It's free. It's available 24/7.

Our Instagram is @DepreshPod. Our Twitter is @DepreshPod. Our *Depresh Mode* newsletter is available on Substack. Search that up. I'm on Twitter and Instagram, @JohnMoe. Be sure to join our Preshies group on Facebook. Just search up Preshies on Facebook. It's a lot of great people getting together, talking about their experiences, sharing mental health advice and tips. Everyone talking about, "Hey, this worked for me. Maybe it can work for you.." And people talking about what they heard on the show as well.

Hi, credits listeners. I recently went to a restaurant, an outdoor restaurant right near a waterfall. It's beautiful here in the Twin Cities. And I hadn't been there for many, many years. And the reason I didn't go is because I always thought, well, it's so crowded. I'm not going to go, because I don't want to wait in that long of a line. And I went, and it wasn't that long of a line. It was fine. And I realized I could have just waited in lines all this time and had food right next to a waterfall.

[00:45:00]

It was fine. The lesson here, sometimes it's fine! *Depresh Mode* is made possible by your contributions. Our production team includes Raghu Manavalan, Kevin Ferguson, and me. We get help in our booking from Mara Davis. Rhett Miller wrote and performed our theme song, "Building Wings".

Depresh Mode is a production of Maximum Fun and Poputchik. I'm John Moe. Bye now.

Music: "Building Wings" by Rhett Miller.

I'm always falling off of cliffs, now

Building wings on the way down

I am figuring things out

Building wings, building wings, building wings

No one knows the reason

Maybe there's no reason

I just keep believing

No one knows the answer

Maybe there's no answer

I just keep on dancing

James: This is James from Seattle, and you look amazing in that.

Transition: Cheerful ukulele chord.

Speaker 1: Maximum Fun.

Speaker 2: A worker-owned network.

Speaker 3: Of artist owned shows.

Speaker 4: Supported—

Speaker 5: —directly—

Speaker 6: —by you!