EPISODE 12

[INTRODUCTION]

[0:00:01] AS: You know battling food and your body doesn't work. You want to love and accept yourself. And because you're insatiable, you want results too. And wouldn't you know, you bring the same intensity to your life, wanting to maximize your time, potential, and experiences you have here on this beautiful and wondrous planet Earth.

Fair warning, it will be a rollercoaster. But for those insatiable, that's your prime time to thrive. We're here to say "YES!" to the hunger of wanting it all. I'm your co-host, Ali Shapiro, a health coach who helps people end the losing battle of dieting and find a truce with food.

[0:00:44] JB: And I'm Juliet Burgh, nutritionist, fitness expert, and a co-owner of Unite Fitness Studio Franchise.

[EPISODE]

[0:00:52] AS: Hello everybody and welcome to Episode 12 of Insatiable. We are here with Dr. Kelly Brogan, the newly author of *A Mind of Your Own*. Juliet and I are so excited today. We have so many questions. I have been following Kelly's work for years and I think it was about, I think it was back in November Kelly?

[0:01:12] KB: Yeah.

[0:01:13] AS: Yeah, she wrote this great article about resilience which Juliet and I are always talking about in the podcast or how resilience is a measure of health and I made a comment on Kelly's blog about how I approach that in my practice and she reached out to me and she was as lovely in person as she is on the page and just super down to earth and also very smart. So we are super excited to have her today.

Before we get to talking about her book and really fascinating information about depression and how it shows up in women, which I know our audience is going to be really, really intrigued by. I want to give you her official bio.

Kelly Brogan MD is a Manhattan based holistic women's health psychiatrist. Author of the book, *A Mind of Your Own* and co-editor of the landmark textbook, *Integrative Therapies for Depression*. She completed her psychiatric training and fellowship at NYU Medical School after graduating from Cornell University Medical College and has a Bs from MIT and systems neuroscience. I love systems.

She is a board certified in psychiatry, psychosomatic medicine and integrative holistic medicine and has specialized in the root cause resolution approach to psychiatric syndromes and symptoms. She's on the broad of GreenMedInfo, Functional Medicine University, Pathways to Family Wellness, NYS Perinatal Association and Fisher Wallace, medical director for Fearless Parent, and board member of the Health Freedom Action and the peer reviewed index journal Alternative Therapies and Healthy Medicine. She is a mother of two.

[0:02:49] JB: Kelly, how do you have time?

[0:02:51] AS: I know, I'm reading this and I'm like, "Oh my God".

[0:02:54] KB: I think it just basically speaks how much debt I have. I think that's mostly what that bio is about.

[0:03:01] AS: Well no, I just feel like what that says to me so is much advocacy and I think what I love about you is your quest for truth and I think that's actually what I want to open up with because your journey is fascinating and you mentioned a little bit in the book but tell us a little bit how you went from super cerebral analytical science, science, science to a new understanding of science and how we access that complexity?

[0:03:26] KB: So it's been, as I've mentioned, it's a parallel process because as much as I am interested in what is going on, on the global sphere in terms of perceptions of health and medicine and really have been for a long time even when I was at MIT, I directed health

conferences and was very interested in the sort of big picture. I always fancy myself as like a minor philosopher of sorts I guess.

I'm just interested in patterns and unfoldment's and my personal process began essentially in my pregnancy which was during my fellowship. At the end of my medical training, I was pregnant with my first and I was at the pinnacle of my masculine energy at that point in my life and when I say that and I know some people are resistant to these reductionist categories, masculine or feminine or, "Gee, what does that even mean?"

For me what that meant and what feels true is that I was coming from a space of seeking to succeed, focused very much on ambition, productivity and I had this driving sense that if I just put enough time, effort and intellect into what I was seeking to master, I'd get there and then I'd have some feeling. Some powerful feeling I was seeking.

I was at the pinnacle of that when I became pregnant and so I approached pregnancy from that space. Where I was like — I'd been on birth control for 12 years because who needs a menstrual cycle, it's a total pain in the ass, right? Of course, that's what I thought and so I basically continued the cycled birth control for almost over a decade. I had a little bit of trouble, my cycle didn't come back after I'd stopped it.

I was like, "I'm going to crack this code," and got myself pregnant and totally unconsciously meaning I wasn't preparing my body or my life scape or my mind scape for pregnancy. It was just something I decided to do like so many women and in my pregnancy, I began to figure out what is the most evidence based way to proceed with this pregnancy?

I've always been a data nut, I always spent a lot of time on pubmed.gov and I began to research it. I've began to research what I could about epidurals and C-section and ultrasounds, certain recommendations, everything spanning from Tylenol to vaccines in pregnancy and I applied that to my experience and it began to create a dissonance for me because what I had been taught in medical school and what I was learning through my research were worlds apart.

So I ended up a natural birth not because I was interested in some transformative experience but because I had convinced myself that that was actually best from a scientific perspective for

this baby and of course, that opened Pandora's box spiritually for me where I came into contact with a part of my primal energy and force that I have never known even existed let alone, didn't know that I was suppressing it actively.

So the following years, basically I began to deconstruct everything I had learned. I spent hundreds of thousands of dollars and blood, sweat and tears putting into my training and I had to learn to let it all go and it was a several year process, probably seven years actually, culminating in my work with my now late mentor, Dr. Nicholas Gonzales who took me the final stretch in the seven months before he died in July to really help me to hold my certainties very lightly.

Certainties from like "gluten is bad for everyone" to "no one should ever take synthetic folic acid" to all of these — the dogma. He helped me to let go of any shred of dogma and I'm happy to talk more about that but it's been a process of surrendering to a different type of approach to health in the body personally and on a professional level.

[0:07:35] AS: So what I hear you saying, which is interesting because you're very big into intuition and everything which I think is so important and that's often when I'm working with my clients is getting them to trust their own experience. But what I love is what you're saying, you don't just discard the intellect but you bring up the intuitive knowing just as strongly because it sounds like in your experience that what you learned in medicine school was one version of science but then there's another version of science out there. Where is that disconnect? I'm very curious myself, like who curated medical education?

[0:08:07] KB: Yes, it's a very important question and the truth is that the question is not just about medical school, right? It's about all of the information that disseminated around elements related to everything from climate change to planetary health and wellness and animal welfare to the chemical industry to the food industry, where do we get our information, how do we get it and who are we trusting as a source of information that encompasses the whole of the truth if there is such a thing?

So in the medical realm, it's very clear that there are, leagues deep I would say, layers of corruption and conflicts of interest. In fact, I just wrote an article about the fact that there's a

movement to change the term from conflicts of interest, which of course means that in decision making around what's best for the health of the population you're being influenced by industry connections, right?

So you are essentially being paid by pharma, but there's a movement to change it from the term conflicts of interest to confluence of interest. "It's just like a co-occurrence. It's not a big deal," but it's subtle little manipulative tools that have allowed for interweaving of systems that really are best kept segregated and the educational system, the clinical practice model and the pharmaceutical industry with the government lording over the entire cohort.

It's become almost one entity and I don't think I realized that to any extent in my training, I remember going out because when I was in medical school being quoted by the pharmaceutical industry was still very big and I went to Nobu and all of these fancy five star restaurant for years and you're such an indentured servant during your training.

That to be taken out to a fancy restaurant or given a pen feels like something you're almost entitled to and you become so nourished by it. It's sad but of course, that's the psychology at work there and I remember saying to a friend, a colleague who is actually very much against these kinds of dinners, I would know if I was being influenced.

I would know if I was prescribing more Risperdal because I was taken out by Janssen Pharmaceuticals last night, come on but of course the data demonstrates just the opposite that in fact, despite the fact that physicians feel that they are impervious to such influence, in fact they absolutely demonstrate in their prescription pad and maybe from something as innocent as an empathic human response that we naturally have with other people who have expectancies of us.

So it's not necessarily a bad quality but it's being put to a rather dangerous use. The pharmaceutical industries is a business. They're beholden to their shareholders and they're doing what they set out to do. They never asserted their mission to be your health wellness and wellbeing. That's not what they're here for. They're here for profit and it only becomes confusing and activating of some deep denial when the government protects those interest over ours because we feel we want to depend on the government.

There has to be somebody looking out, there has to be someone guarding the hen house and so it's almost too much for many people to accept that it could be the fox unfortunately and I understand that because it's quite a scary transition to move through, to understand that all of the information you're getting should be subject to review and should be subject to vetting on another level. So it's a tough thing to wake up to and frankly, most people wake up to it because they've been injured by this conglomeration.

[0:12:06] JB: Now, in your book you talk about you no longer are prescribing medications.

[0:12:10] KB: That's right, yes.

[0:12:12] JB: First of all I'm curious, how did you get into psychiatry, what led you down that medical path?

[0:12:19] KB: So I was a neuroscience major in college and I've always been very interested, again my sort of like interest in the meta picture, I've been very interested in human behavior and I figured out, "Well, we've cracked the code of human behavior. We've totally figured out why people do what they do and what happens when the brain goes awry in its functioning and that's called neuroscience."

So I studied that, and the clinical extension of that of course is psychiatry. I worked a suicide hotline at MIT and MIT is unfortunately notorious for having many completed suicides every year and I worked this hotline and it was supervised by a psychiatrist. So I met with him regularly and I'm just so interested in the curious way that he looked at what many people can't even touch.

This idea of pain so deeply that it causes you to self-extinguish that runs so deep. It's very difficult obviously for many people to engage without any degree of comfort and so, I was very fascinated by that and I went to medical school to become a psychiatrist but along the way, my native feminist inclination bubbled up to the surface and I decided that I wanted to become an obstetrician.

But it only took one clerkship rotation in my third year of medical school to convince me that that's the most miserable profession on the face of the earth and the statistics bear that out and it's quite an ill constructive model for clinical practice. I mean these people are expected to deliver babies, to operate on cancers, to do bread and butter GYN and nowhere in there is a women's health advocate which was of course I was interested in and knowing my patients on a deep level, helping shepherded them through their experience.

So then I learned about a verging specialty called reproductive psychiatry, which was the marriage of the two and so I was one in the early, early crop of those specialist and I specialist in of course, with that unfortunately translates to is specialty in medicating pregnant and breastfeeding woman with psychotropics and by extension, medicating women who struggle with PMS and menopause.

[0:14:28] JB: Got it, which is still so prevalent that I know Ali and I have clients that come to us that are dealing with those issues, having reproductive issues or they're trying to have a child or whatever it may be and they're on medications and they are like, "I don't want to be on these medications anymore because I want to try to have a baby," so that is a really touchy subject for a lot of people.

[0:14:51] AS: Yeah and Kelly, I want you to tell everyone, a lot of people of your patients come at that time in their lives when they want to get off medication. But I think it's really important for us to find depression for people because one of the things that was amazing in your book was I think you used the phrase "people think it's a sad woman at the couch at home at night" and that's not how your clients depression presents in women. So I'd love for you to explain to people, first of all, how are you even defining depression?

[0:15:21] KB: Yes. So first of all, it's very important to me that the take home message be that depression is a symptom, right? So it is not a diagnosis, it is not a heritable disease, it is just an indication of imbalance and so like a fever, it doesn't tell you a whole lot of the source of that imbalance, is it viral, bacterial, fungal, is it none of the above? It just tells you that something is amiss.

I tend to focus, because I feel like it is such a natural point of entry for so many people in our time right now, I tend to focus on healing the body first. But of course, there are many different practitioners and healers out there who focus in healing the spirit first, healing energetic vibrations first. There are other ways to get at it but my bias is to work with the body first because I love the Maslow's hierarchy which is fulfilling these most basic needs.

So that the body experiences a sense of safety and so then, you can start to liberate your thoughts because when you're not preoccupied with your constipation, with your hair falling out, with a sense of constant inner agitation, this is actually what people are calling depression these days. These days, depression is a sense of, often, of simultaneous inner discord like inner disease, right?

So this sense of like, "Something is just off. It's off, it's off." And we call it anxiety but it manifest in many different ways externally but that's at the root and then it's like this layer of disconnection so people feel flat, they feel hopeless, often they feel like largely disconnected from any sense of purpose of motivation, or interest and that could extend to sex, that could extend to anything that resembles food.

So of course, what they end up working towards is the more addictive types of foods that seem to touch on a sense of pleasure or satisfaction so processed food mainly. It looks like a picture of global sickness, right? And actually in the research, that is depression is referred to when we are characterizing it in the animal model, it's called sickness syndrome.

And sickness syndrome refers to an inflammatory state in the body that is actually designed physiologically to slow the body down for recuperation. So you don't have sex, you don't interact with other beings, you stop eating, you conserve resources for healing and that's what depression is depicted as in the animal model and so that really peaked my interest in exploring what is referred to as the inflammatory model of depression.

Now, do I think every case of depression is an instance of inflammation? No. Do I think the vast majority of what we are calling depression as evidence by this evolutionary mismatch at the lifestyles we're living and the lifestyles are genes over millions of years have expected to see? Yeah.

I think that's a big part of what's going on and why one in four women are taking medications as they go into a potential pregnancy. But I always love this idea of, "Oh, I don't want to take any medication during pregnancy." Like, "What's good enough for pregnancy is good enough for you," you know what I mean?

[0:18:48] JB: Yeah.

[0:18:49] AS: Why would you say that?

[0:18:50] KB: It's the dichotomy.

[0:18:51] AS: Or it's like saying women should only take care of themselves if they're procreating.

[0:18:54] KB: Exactly, it's a strange standard but it speaks to some intuitive sense that there is a standard we could hold ourselves to that when we're doing it for someone else like a fetus, we can connect to that but to do it for our own life experience is something we've been conditioned not to engage.

[0:19:14] JB: Are you connecting depression and anxiety kind of simultaneously as the same sickness syndrome or do you separate the two?

[0:19:21] KB: It's a great question. Personally, in my almost a decade of practice in this particular arena, I have never seen a case of self-described depression without a component of agitation or anxiety. So I think they co-occur. Anxiety can be as simple as a sense of vigilance or sense of like, "I need to be doing more, what should I be doing?" And just that running tape or it can manifest as panic attacks or what we call obsessive compulsive disorder.

Specific phobias, it can manifest in many different ways but anxiety, it serves a purpose of course as all bodily expressions and mental expressions do. It's serves a purpose but when it is hyper stimulated because there is such a level of wrongness of that lifestyle, it can obviously eclipse any ability to experience your life.

[0:20:18] JB: And it's amazing how in this era we live in where it's complete instant gratification with everything and people are overworked and they don't take time for themselves. A lot of my clients are on an anxiety medicine simply because they're just so stressed out that it's, like you said, their reoccurring tape and the agitation just gets to be way too much for them and they need that sedative feeling. They can't go on but they're not addressing any of the actual issues. It's just putting a band aid over them.

[0:20:47] KB: 100% so we say in functional medicine it's like if you have a piece of glass stuck in your foot and you just take a Tylenol for it. I mean yeah, who knows? Maybe it will offer you a little bit of relief you might need for six hours but any mentating being would tell you that's a crazy thing to do. It doesn't make any sense. So our model, our entire medical model and again, I don't love to slam psychiatry. I love to slam medicine on the whole in it's conventions.

[0:21:15] JB: People opportunities here.

[0:21:16] KB: Totally, totally. And no, listen. I should say that I have come to a place and Ali and I have discussed this, I have come to a place where I actually do believe that if conventional allopathic medicine feels right to you and it is working for you, go with grace. Do your thing.

[0:21:36] JB: You talk a lot about the belief systems with how much that impacts. So much of your book, as I was reading is a lot about the placebo effect, with a lot of the medications and how powerful that is and it's not the actual medication is doing anything. Sometimes it's doing more harm than good but a lot of it is just belief in, "This is going to help me."

[0:21:55] KB: Right and what we're struggling with now is kind of bull is that culturally and collectively, our beliefs are shifting where I think we're all starting to lose some of the placebo effect that had been offered when some of these drugs first came out because we're all starting to see it like, "We may have been sold a bit of a bill of goods here and there may be more to the story that we don't know."

It is almost collectively, our beliefs are impacting the potential placebo effect of any gain of medication as deliberate now and we see that in the billions of dollars that people spend in

America on supplements and alternative medicine. It's bearing out that there is a bankruptcy in this model that will ultimately be its undoing but as you said, the difference between the allopathic and conventional model and what I'm proposing is that if we are looking at depression and anxiety as an invitation, right? Or as a message, there is a process that has to be engaged of shifting consciousness.

So that's what I'm interested in. I'm not interested in getting your symptoms gone so you can get back to work and functioning in your miserable life that isn't suited for you. That's actually the pharmaceutical model. "Get you back to work," that's the model. This alternative paradigm is really interested in something different. It's moving you through the significance, the message, the meaning of those symptoms so that you can get to a next step, get to a next chapter.

And I have experiences with my patients that are profound. I have patients who end up coming out of the closet, they move to Europe, they quit their job, they adopt a baby, they open up doors to their life experience that were never available to them and certainly never would have been available to them if they were only interested in getting their symptoms gone.

[0:24:00] JB: I think it's the same with what Ali and I do with coaching clients with any type of disordered eating and food issues. It's the same kind of thing Ali, you've seen it right? I've had clients divorce their husbands, I had a client moved to Europe to go to business school when they were a lawyer but they're really interested in entrepreneurship. It's incredible of what healing something like that can do to get to you that next level of like who you truly are, what your sole purpose is.

[0:24:28] AS: Yeah, I mean Kelly, I am such a big picture person too. I love the global aspect and you were saying how you think it's inflammation but some people might say it's spiritual but to me, they're actually not separate.

[0:24:39] KB: That's true.

[0:24:40] AS: Yeah, like the same way that cancer is on the rise. I'm like, "Well, there is also cancer is inflammatory and we have global warming going on," but I think people are very

emotionally inflamed by being out of alignment and when we talked about resilience, one of the points that really stuck out in your book, I actually wrote down page 14.

“A lot of depression and moods are the mind’s interpretation of its own safety and power,” and there’s so much packed in that one sentence but we are talking about this consciousness and these beliefs and I think we were all sold this good bill of goods that we would feel safe if we didn’t have any challenges. If everything went according to plan and I’m a big believer of paradox and Dao De Jing and so real safety comes through, going through uncertainty.

[0:25:27] KB: 100%. It’s like you get what you want when you let go of it. It is that, the power of paradox is very operative in this space. I think there is no room, I was just telling a patient this morning, her father died somewhat suddenly and she’s never missed a day of work in her adult life and she’s struggling with feeling like she needs a couple of days to integrate this experience. There’s just absolutely no room in our society for everything called…

[0:26:00] JB: Grief?

[0:26:01] KB: Grief, of course and in fact, as an aside in the DSM Five, which is the diagnostic manual for psychiatry, the dictionary of disorders, grief has now largely been pathologized if it last more than two weeks.

[0:26:13] AS: What?

[0:26:14] KB: Yes.

[0:26:15] AS: Two weeks for grief?

[0:26:16] KB: Yes like symptomatic grief.

[0:26:19] AS: Oh like it’s linear too.

[0:26:20] JB: Wow.

[0:26:21] KB: It's poetic. It's almost like they're showing their hand. It's like, "You guys have gone too far, if you were just a little more subtle about your intentions, you might be able to pull this off for a little while longer," you know what I mean? But there's no room for everything falling apart and sometimes, people require maybe a phoenix process as Elizabeth Lesser refers to it, an author.

I love that phrase. It's this idea of moving through the fire that is required for you to actually incarnate as your truer self and that is so anathema to our consciousness in this country where the focus is on outsourcing your freedom so that you can feel safe and remaining functional at all cost. So it's the productivity model and it's not just working anymore and that's a good thing that it's not working anymore.

[0:27:17] JB: The more medications that people are on, the more medications that are created, the sicker people are getting so clearly it's not working. We have more psychiatric problems than ever before and more diagnoses than ever before. That always interests me when they come out with new diagnosis after diagnosis after diagnosis with any kind of mental health problem like, "Okay so they just made that one?" I could see they just made that one up because someone has a new phobia so they have X cases, so then they're just like, "Let's write this in, okay".

[0:27:44] KB: Yeah, so in psychiatry, it's a funny thing right? Because unlike other realms of medicine there are no objective test. We don't do brain scans. Some psychiatrist don't even do basic blood work, there is no means beyond just a subjective impression of delivering a diagnosis to a given patient. So the DSM has ballooned since its inception in 1952.

Of course in the 70's they cast out homosexuality, which used to be a diagnosable condition. This is the nature of what we're talking about. Almost all of them, the white men, old white man on the board of the DSM have conflicts of interest and it's just a charade but the most compelling data that I speak about in my book because it was really a turning point for me of awakening is presented by the journalist Robert Whitaker and he wrote a book called *Anatomy of an Epidemic*.

In it, he makes the claim that you just eluded to which is that we have ever escalating “access to treatment”. We have more and more people medicated essentially for psychiatric illness than ever before in the history of time. So why is it that we also have the highest rates of mental health disability ever and that depression is the number one cause of disability globally?

Shouldn’t that those be inversely proportional where more treatment equals less disability? So his entire treatise unfolds to demonstrate that actually it looks like medication is perpetuating and propagating this epidemic of disability, how can that be and the answer is that medication, first of all, we have a keyhole perspective on what these medications are even doing, is a total fallacy that they are fixing anything.

They’re not fixing anything, they’re forcing your body to adapt to a chemical stimulus that in many cases in particularly in the case of antidepressants renders you so dependent physically that in some cases it is not possible to function physiologically off of these medications. That is where I learned through the most challenging process in my clinical career.

I learned through my patients why I needed to put my prescription pad down and it was because when I read this book, I started taking all my patients off of medication with their consent of course, and interest. Again, because so many of my patients are pre-pregnancy, it’s a model population for that type of medication and what happened and what ensued was horrific.

I was basically running like an outpatient rehab center and I had no idea what was going on. Patients are paging me at all hours of the night with the most bizarre neurologic and physiologic symptoms and suicidality and then I started to look into this and then I learned a lot of what I know from other patients, from grassroots movements to raise awareness around the dangers of these medications.

Now, finally as of this past year, there are research groups who are actually putting out data that says and reifies this idea that these medications are addictive, habit forming and cause a very dangerous withdrawal syndrome in many patients.

[0:31:03] AS: That’s one thing I really got from your book Kelly because I had tried antidepressants several before. I eventually did have the same problem, we talked about it. My

primary care doctor was the one prescribing them and then I remember being in her office and being like, “I don’t want these anymore,” and she’s like, “Okay, one second,” and she turns around to this massive book and probably thumbed to Wellbutrin and was like, “You should be able to get off that in four weeks,” and I was like, “Okay.” Looking back now I’m like, she clearly had no context.

[0:31:33] JB: But there is a protocol right? It’s like you’re saying that sometimes people are just shooting in the dark.

[0:31:38] AS: Yeah, we all are and that’s what I know.

[0:31:40] KB: They all are, yeah.

[0:31:41] AS: From the book that I really got is that and it’s so important and you see analogy of if you have glass in foot and then you take a Tylenol, yeah it might help you but also it’s making things worst because you’re hitting that heel with glass in it and I think it’s so important when people — you have to read the book obviously, but to realize that there is cost to medication.

I think a lot of people are like, “Oh I’ll just use this to get by for a year,” or they don’t understand the full consequences and there is a cost. You may need them and Juliet and I both want to hear are you completely against meds or whatever but I think what your book highlights so importantly is that there is a cost and it’s really important to do your due diligence before you decide that this is something for you 100%.

[0:32:30] JB: Yeah and I was going to say to Kelly just like Ali has had her own experience with antidepressants, both my mother and my twin brother are diagnosed bipolar. My mom bipolar and borderline personality disorder and the next one they added onto it.

[0:32:44] KB: Tag it on, yeah.

[0:32:45] JB: They tagged on schizophrenia and then they tagged, then they took it away. Then they put on the BPD. I was like, “Okay, I can’t keep up here.” So anyways, she’s going to be in

her late 50's so since she's dealt with her first episode since she was 19 and then she had a complete remission, wasn't on medication at all until she was about 40.

She claims that the things that restarted her psychosis was she had been prescribed a lot of pseudoephedrine for a head cold sinus infection and the doctor overprescribed her like, "Take this much every hour," and she had a complete psychotic break from pseudoephed., I guess and ever since then, she's just been on medication, in and out of hospitals, can't get off of medications.

On a ton of benzodiazepines which is, as you know, one of the most addicting medications that withdrawal is coming off of folly like heroine, you know? But yes, I think both Ali and I are really curios about that. That someone with maybe that level of psychiatric need when they're dependent of these medications and the withdrawal is so scary, how do you navigate that?

[0:34:02] KB: Yeah. I think a lot of people, and I have plenty of critics out there, but I think a lot of people like to imagine that I have a Madison Avenue practice and I treat only the worried well and women who want to know how many potatoes every week or not or whatever. But in fact, I have patients with diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, OCD, the whole spectrum.

While the vast majority of the patients that I treat have clinical depression, many of whom have been diagnosed with very severe and treatment resistant is a very popular term for when psychiatry bumps up against the wall, it has created for itself, treatment resistant depression. I don't believe that there is a single case of mental illness on the planet today that would not best be served by first doing no harm.

First doing no harm to me looks first like restoring a setting for that patient's lifestyle to unfold in a very different way because I have suicidal patients in my practice etcetera and what do we do about suicide alley? So we lock them in a hospital to watch them. Hey, maybe that sounds such a bad idea, maybe there is something very healing about feeling like people care enough to actually keep an eye on you continuously.

Okay, not so bad then we start them on a medication that we all agree has no mechanistic affect for four to eight weeks, right? So antidepressants, any prescribing psychiatrist will tell you to take that long to "work" and we could have a whole conversation about what working actually means but the truth is, there's not anything urgent going on chemically so sometimes we sedate them.

So we use medications like you said, benzodiazepine is to sedate patients to take them out of the intense anguish that might prompt them to do something impulsive but the problem is the instances of impulsive and violent behavior because that's what everyone is afraid of, right? That someone is going to kill themselves or kill someone else.

The instances of impulsive and violent behavior that have been news making let's say in this country, if you go to the website SSRI stories, you can see the confirmation of this have almost without exception been in patients who have been recently prescribed psychiatric medications or who are tapering off them.

[0:36:33] JB: And we're talking about school shootings.

[0:36:36] KB: Correct. Planes coming down, infanticide, you name it. So it's a lovely idea, it's a lovely idea that there could be such a magic pill that is safe and effective and can take you out of the pain and struggle of your experience. That's a great idea, unfortunately I'm here to tell you that that is not the truth. It just doesn't exist and because it doesn't exists, it doesn't mean that we just take the next best thing which is the reality of what we have.

It means we have to step back and engage the precautionary principle which tells us that examining all of the risk, benefits, and alternatives of what we have available needs to happen with every patient for true and form consent. So there are no exceptions in my practice. I have prescribed in settings of particular postpartum psychosis sedatives.

So Ativan or Klonopin which are benzodiazepines. I use them for their chemical effect so that I can largely keep patients out of the hospital because that would be done in the hospital anyway and you know what? It works the way alcohol works, the way coffee works, the way any drug can have a predictable effect but the difference is that sometimes we tell ourselves a story

which is these drugs are having a healing effect or a corrective effect. But in fact, they are just having a chemical effect.

So in states of "emergency" and I have full cooperation of my patient's families, there's a whole different ethos around my work that I would never recommend anyone to try this. I'll practice if they're not in the same page in terms of beliefs with everyone involved in the patient's care including the patient. I just wrote a case Juliet of acute psychotic mania that was resolved by charcoal. So you know what charcoal is? Charcoal bonds.

[0:38:26] JB: Yeah.

[0:38:27] AS: Yeah. I used it as a diet tool in college.

[0:38:30] KB: So it binds.

[0:38:31] JB: It's a detoxing agent.

[0:38:32] KB: Exactly. Yeah and she had a bariatric surgery and as a result of it developed essentially dysbiosis in her gut that triggered psychotic mania. You could read the case study yourself. It required no psychiatric medications and she was symptom free with this simple intervention. So how can we integrate that into our current model of bipolar disorder which frankly psychiatry comes up really short in explaining anything about in terms of…

[0:39:02] JB: Let me ask you this because I'm curious. Do you believe that she had a pre-disposition to psychosis and something triggered it versus someone else you would have that same bariatric surgery that might not have happened to them because they don't have the same genetic disposition or is it a chemical imbalance? I know you talk a lot about serotonin and I actually was listening to a podcast that you're on that was called the Serotonin Myth and I was like, "Oh I've got to listen to this."

[0:39:30] AS: I think we need to explain too, Kelly if you could, for people listening, I think they're still thinking like, "Oh this is one chemical disorder," like I just need that serotonin.

[0:39:39] JB: Even my brother and mother, we have a chemical imbalance, that's what they tell everybody and that's what they're told. It's just a chemical imbalance. This is what I have to medicate my chemical imbalance for the rest of my life.

[0:39:51] KB: Exactly and you know who taught them that? It's the very pharmaceutical companies that are prescribing and profiting off of the medications for the medical imbalance. So we are one of the two countries in the entire world, New Zealand being the other, that allows for direct to consumer advertising which means that we are taught as civilians about our physiology by the very companies that profit off of our beliefs about our physiology.

It is a very dangerous and perilous thing to allow for and doctors as I have depicted, doctors are also influenced primarily by the science that pharmaceutical companies teach them. So this idea of a chemical imbalance comes from a model of the body that is now completely decimated by new and emerging science around particularly things like the microbiome.

Which is this idea that remote parts of our body are endocrine, hormonal physiology, our brain function for example can possibly be controlled and influenced by what is going on in the ecology of our gut. Those very germs we thought we have to beat into submission with sanitizers and antibiotics and vaccines, right? In fact, the script has been flipped beyond all imagining.

So now, we have the emergence of fields like the one I'm most interested in called psycho-neuro immunology. Sometimes it's called psycho neuroendocrinology, what does that mean? It means all these stuff is related. It's not like brain up, body down anymore the way I learned in my training. So this serotonin myth, this has been exposed by other great thinkers and I learned from them.

People like Joanna Moncrieff and Irving Kirsch, they have been writing about the fact that for six decades, there has been a hunt to validate the pharmaceutical claim that depression has anything to do with serotonin, not like whether it has to do with higher or lower or in between or anything to do with it and in fact, six decades of literature have not come up with a single validated study in human subjects that demonstrates unequivocally that this is what depression is about.

In fact, quite the contrary where I follow a research Andrews at all this group where they've looked and maybe it has to do with high serotonin and of course, there are antidepressants that have been improved. One is called Stablon for example and it's in France that actually increase serotonin. Medications are doing the exact opposite thing or both approved as antidepressants.

So Prozac and Stablon for example and then we have medications like Wellbutrin and then we have the effects of other non-psychiatric medications like thyroid, hormone or blood pressure medications and they all sort of seem to help to the same extent which is about anywhere from 10 to 25% efficacy and of course then there's a whole model that looks at, "Well what does that efficacy is really about?"

That's where this idea of the role of the placebo effect comes in and this guy, Irving Kirsch did brilliant work where he basically unearthed all of the unpublished literature because there is plenty of that that was used to approved antidepressants in terms of licensure and what he found is that 82% of what we are calling the effect of antidepressants is duplicated by placebo. Essentially, they don't work. What I'm trying to say is…

[0:43:23] JB: In a nutshell.

[0:43:24] KB: …they don't work, they're dangerous and they're completely overprescribed.

[0:43:29] JB: We're talking about all drugs, like SSRI's, antidepressants also like mood stabilizing drugs as well and antipsychotics?

[0:43:37] KB: Correct. That why my perspective on it — my book, it's just about antidepressants. My perspective is that this redirect applies and it's not just my perspective. I'm an expert curator so I know tons of smart people and I love what they're up to and I've curated their work. But yes, it applies to every single psychiatric medication period.

[0:43:56] AS: For people listening too, Episode 11, we did a primer for this interview on the gut biome. So episode 11, if you haven't listened to it, go back, I pretty much give a very big overview of it but I think a great visual Kelly, in the book you call it psychobiotics meaning

probiotics, which we talked about in that episode, are this idea that probiotics can have an effect on mental health.

I think when you said it, I'm like, "Wow," to me that dispelled this serotonin method in such a great way because we talked about it in Episode 11 how that gut biome is an ecosystem that you're talking about. So I think that's really important for people to realize that it's not often underneath that, it's this assumption that it's a one for one. One problem when really everything is interconnected.

[0:44:43] KB: Interconnected, yeah. It makes it complicated unfortunately but that's the reality. We can deny it all we want, but that's the reality.

[0:44:49] JB: It is and I think you know that for a lot of people it's overwhelming and what did you say — I know that you require any new patients to take on your 30 day dietary protocol and I think you had said that there are people that don't come until years later because they're not ready because taking on such an extreme change with their nutrition, that can be really overwhelming for somebody. A lot of it is just, it's work. You have to do the work.

[0:45:17] AS: Let everyone know and you'll read in the book but that's your first step, right Kelly? It's looking at someone's nutrition.

[0:45:22] KB: It's my first step because I still have this masculine mind, right? I love outcomes. I'm a totally impatient person and I want change. I want it yesterday for most of my patients. So the biggest needle mover I have found for my population again that I work with which is a variety of folks is the dietary piece and while there are different diets, I have been deeply influenced by folks like Weston Price and of course my mentor Nick Gonzales.

There is certainly not one diet, as you know both of you, for every person but there is a template that I use for depression and anxiety that seems to be a very good fit and there are ancestral explanations for why that might be the case and it's actually rather simple. So here's the deal: This is an opportunity for radical transformation. When you're ready, here's your menu.

If you want to keep continue struggling and living your half baked life, do your thing but the experience that I have with my patients is that they're here, they're reading this material, they're coming to this appointment, they're speaking to folks like you because there is a voice inside them they can no longer ignore and so if I can convey that this is a simple and effective menu that not only will relieve their symptoms but offer them untold unexpected benefits.

You could come in because you're having insomnia and you can't focus at work but then actually as a result of one month of dietary change, you I don't know, have your libido back, your hair is no longer falling out, I keep coming up with that because it's a very common complaint in my patients that a lot of them struggle with thyroid dysfunction. It just unfolds in a way that is so much more abundant than any allopathic model that essentially is just looking at suppressing one symptom and causing potentially 75 side effects while it does that.

[0:47:30] JB: Will this help people if they're on medication or do they need to work with somebody first to wean off of their medication and start, like you were saying, a clean slate and then do the diet?

[0:47:41] KB: I'm so glad you ask that question. I should really lead with this information so that's a very good reminder. This is like media training for me. I'm very glad you asked that. Here's the deal: I have patients who come to me on medication who are interested in coming off it. I have patients who come to me on medication ambivalent of coming off of it. I have patients who never want to take a medication but are symptomatic and then I have patients who are just interested in wellness strategies or whatever.

All of those patients do the same thing, that's when I knew I could write a book because the whole implication of a book is that it's impersonal, right? It's like a template for everyone, but the fact is that no matter what you're coming to me for, you're going to do the same thing and it's going to start with diet. So I do not touch a medication dosage. There's no changes on medication dosage before one to two months of all of this change.

And the change is dietary but it's also the meditation, it's also small amounts of exercise and then it's detoxing the environment, cleaning products, cosmetics, these sorts of things. So I found out the hard way. Remember when I told you I was running that outpatient rehab?

[0:48:53] JB: Yeah.

[0:48:54] KB: That is what it looks like when you just try and take patients off of medication without restoring resiliency to the body. There is a much easier way to do it if you actually restore the patient to the most optimal expression of their physiology and then you try and ease them off. I used compounding pharmacies. Sometimes, I take patients off of medication at 100th of a milligram a month. It can be very complex work and you don't want to go there until you're ready.

[0:49:25] AS: Kelly, you mentioned, I know you have to go, so I am just curious in your book, you mentioned a lot about the environmental stuff which I love. I'm like so about that right now and often, do you think — and I know there is no exact percentages, but do you think nutrition is 50% and then environmentally detoxing?

I know for so long maybe it was because food was my issue. I was like, "I've got to get my diet, my diet, my diet." But now I'm like, "Oh my God, it's the environment, it's the environment." Maybe I just need something to worry about? But I got my Berkey Water Filter, I've over the years cleaned up my makeup, I think about the air pollution, I don't have an organic mattress. I just think about all these stuff and I'm like, "Oh my God." So I'm just curious how you approach that?

[0:50:09] KB: Yes, it's a great question and if you ask 10 holistic practitioners this question, you'd get 10 different answers. I think in my approach, in my model, your intake, you're dietary intake is your deepest connection to the natural world. And it's the one that you have unfortunately the most control over despite the fact that we're losing control over many elements of it.

Environment and exposures can really put you into a fear state because what we're breathing, what we're drinking, what we're exposed to through our skin is a very scary reality. The fact that RoundUp, you know Monsanto's RoundUp, glyphosate is in our air, rain water, it can really activate like helplessness that does not serve our purpose ultimately.

So my approach tends to focus on the very intimate things you can control first and I start with diet. I also start with three minutes of kundalini yoga meditation. It's a very simple breathing exercise every day because we need to ease that stress response because you can eat a perfect diet all day long but if your body is in a fear state, it's not going to do anything for you.

The environmental piece is a process. Like you're describing Ali, I think that's exactly what it should look like where you're at the store one day and you're like, "Oh I can actually make a different choice about this. I never thought about that, about my face lotion."

[0:51:38] JB: I was going to say that…

[0:51:39] KB: Or, "Oh, should I buy organic tampons today instead of not?" It's a process and it ultimately congeals into a lifestyle but we're always learning. I love learning about what different products people have researched and I love a website called I Read Labels For You, Irina Webb runs it and this is all she does all day long. This is not I do all day long so I love the community element of our discussing together like, "How are we approach this together because it's a difficult situation we're in?"

[0:52:05] JB: I mean if you are changing the things you are buying you are then helping the environment. So it's a win-win.

[0:52:11] KB: It's a win-win. It's like I've said before, we've come into this consciousness of connectedness where we have to understand that what's good for the planet, what's good for you is good for me. There's no way around it. If I engage in activities on a daily basis that harm the planet, it is directly blowing back on me.

So listen, if it has come to from a selfish place, then let it. It has to come from what's in my best interest, it turns out that what's in your best interest is exactly the same thing that's in the best interest of the ecosystem at large.

[0:52:44] AS: Yeah I said to Juliet before we started, I loved how you summed that up because I think people think, "Oh my God, there are so many decisions." But the great litmus test is what you talk about in your book, or actually it was on — I listened to a Functional Form podcast you

gave but is it good for me, is it good for the environment? I think about walking, “Okay, walking is good for the environment and good for me.”

[0:53:06] KB: 100%, it’s so simple yeah.

[0:53:08] AS: Yeah, well that’s the irony right? Well Kelly, thank you so much. Everyone, I will have the book again is called, *A Mind of Your Own: What women can do about depression that big Pharma can’t.*

[0:53:21] KB: So I should tell you Ali, it’s funny because we didn’t talk too much about the evolution of my warring stance as an activist but we’ve actually changed the subtitle.

[0:53:31] JB: Oh, okay.

[0:53:32] AS: Oh.

[0:53:33] JB: What’s your new subtitle Kelly?

[0:53:34] KB: *How women can heal their bodies to reclaim their lives*. So it’s basically, a little bit softer.

[0:53:41] AS: What we’re for rather than against.

[0:53:43] KB: Exactly. Listen, I am growing and changing and I can put down my battle ax at some point and the truth is, it’s not anti-pharma. It’s pro information and it’s pro a very different orientation around consciousness and lifestyle. It’s not even available to pharma to think in these terms. So this isn’t about us versus them. It’s really not, and that became more clear to me in the past even a couple of months even in my own personal journey. So anyway, I just thought to throw that in there.

[0:54:13] AS: No, I’m glad you said that. I don’t trust anyone who knows it all and that’s the irony again. The more you learn, the more you realize you don’t know so you just come from

this place of “I’m not sure” and that’s when you really become undogmatic. It’s when you’re like, “I don’t know that’s why.” It’s the only way you can be undogmatic.

[0:54:32] KB: Yes and then you develop a sense of different kind of knowing.

[0:54:36] AS: Yeah.

[0:54:37] JB: So Kelly, how can people get a copy of your book and where can they find out more information about you, where can they connect with you?

[0:54:45] KB: So I actually have on my website which is Kellybroganmd.com, we’ve put together a little bit of an incentivizing opportunity for a bunch of information and there’s downloads for actually “Three things better than Xanax” since we are talking about benzodiazepines and a raffle and stuff like that. We just thought it would be fun around the book’s pre-order because it’s on pre-ordering now through March 15th when it launches and that’s all directly on my website but I obviously, like everyone else, I’m also on social media as well.

[0:55:23] JB: Fabulous and it’s just Kelly Brogan MD everywhere on social media as well?

[0:55:27] KB: You got it.

[0:55:28] JB: Yeah.

[0:55:28] AS: Great. I just thought that you’re really pro-choice. You have come full circle with your feminist. You’re giving people other information, which is giving them different choices and that’s what I love about the book because once people know that they have other choices, there’s freedom just in knowing that.

[0:55:45] KB: It’s so true.

[0:55:46] AS: Yeah. So thank you so much for your time Kelly and everyone get the book. It’s amazing.

[0:55:52] KB: Total pleasure to talk with you both. Thank you so much.

[0:55:56] AS: Thank you.

[0:55:56] JB: Thank you Kelly.

[0:55:57] AS: Take care. Bye.

[END OF INTERVIEW]

[0:56:00] JB: Thank you so much for listening to the insatiable podcast, we hope you enjoy today's episode, you can connect with us on social media, follow me on Twitter and Instagram @julietunite and Ali @alimshapiro, M stands for "Marie". Please feel free to also email us any questions, we would love to hear from all our listeners, you can reach us at ali@alishapiro.com and Juliet@unitefitness.com. We'll see you next time.

[END]