Laura Roberts (00:15):

So, thank you so much for joining me, Doug. I wanted to introduce you first. We'll be speaking today with Doug Noordsy. He's a professor of psychiatry at the Geisel School of Medicine at Dartmouth. I had the privilege of working with Doug at Stanford where he was a clinical professor and led a number of our really inspiring programs, which we'll get to in just a little bit. So welcome Doug to the Psychiatry Unbound Books podcast with APA Publishing.

Douglas Noordsy (00:46):

Thank you, Laura. It's great to be with you and a pleasure to be able to contribute.

Laura Roberts (00:51):

Yeah. I was so excited to see your Lifestyle Psychiatry book come out. It just turned out beautifully. I hope you're happy with it.

Douglas Noordsy (01:01):

Oh, thank you. Yes, I am very happy with it. It was a labor of love from the beginning and lining up all the contributors and getting to learn from them and reading every chapter three times over. But it was so much fun to create it and I am very happy from the cover to the content. It really came out very nicely.

Laura Roberts (01:26):

Yeah, yeah. Well, let's go back to the very, very beginning where you had the idea of this book. Can you tell me a little bit about what your thinking was and what impact you were hoping a book like this would have?

Douglas Noordsy (01:40):

Yeah, yeah. Well, it really grew organically out of just how I had practiced psychiatry over the years. I found that it was just very natural for me to be thinking about lifestyle in people's lives as I worked with them in helping them to improve their wellbeing and outcomes. I had found it an important part of collaboration and shared decision making with people over time. So often people express frustration with the limitations of the treatments we offer or wanting something more, something maybe they have more ownership of or something that feels more natural. And so, my goal with this book was really to help clinicians to have more tools in their toolbox, but ideally to be able to seamlessly sort of weave lifestyle interventions in with the other components of assessment and treatment that they're thinking about, that it really comes across to the people we serve as an essential component of how we understand the disorders that people experience and how best to help them achieve wellness.

Laura Roberts (03:00):

And as a psychiatrist, have you seen that this approach is meaningful to people and does lead to better health outcomes?

Douglas Noordsy (03:10):

Certainly I would say that from a personal clinical point of view, obviously there's a lot of research looking at the impact of specific lifestyle interventions and specific disorders, but overall I would say that the therapeutic alliance that develops when working with patients and focusing in a holistic way on how to help them to achieve their greatest wellness and really engaging their ownership and responsibility of

the process has been very powerful and meaningful for people. It gives me so many more opportunities when somebody comes into care with some heavy stigma or negative feelings about treatment or past treatment they've had to be able to engage them at a variety of levels wherever they may be prepared to get started.

Laura Roberts (04:05):

You organized the book around several parts. The first part was around just the basis of lifestyle psychiatry. The second was about exercise and prevention and management of psychiatric disorders. The third part had to do with the healthy body/healthy mind, kind of mind-body connection. And then that last section was about inspiring healthy living. Can you describe how you arrived at this particular structure and what you needed to say in each of these different areas?

Douglas Noordsy (04:36):

Yeah, yeah. And as you point out Laura, one of the larger sections is around physical exercise and that's partly my bias. That's an area that I've really had a lot of interest in and follow the literature on. And I wanted to emphasize that in the book but not make it exclusively about exercise. But also that follows the body of literature. There's just more evidence around exercise that's been growing and involving quite a bit, both at the neurobiology of exercise as well as the clinical impact on psychiatric disorders. So I wanted to set up an understanding of lifestyle psychiatry, sort of position it next to lifestyle medicine and really think about how we in psychiatry can be part of the lifestyle medicine movement and education and practice. And thinking from a lifestyle point of view helps to shift our thinking about etiology, about what it means to have a disease, really framing that whole context.

Douglas Noordsy (05:47):

And then I wanted to really give a strong depth of evidence around physical exercise in the common disorders that we treat, so from major depression and anxiety disorders, psychosis, the areas that I think there's more prominent research, cognitive disorders, but then also going into some of the childhood disorders, ADHD and autism spectrum disorders as well as addiction. And then the difficult challenge was... of course, I would've loved to have given just as much space to mind-body practices and nutrition and there's only so much room in a book... and so we ended up having to put those others into single chapters and so then those authors really had the challenge of how to cover the waterfront in terms of the impact of meditation and mindfulness across the whole range of disorders.

Douglas Noordsy (06:49):

But those chapters really came out very nice in terms of giving a higher level evidence on how each of those components of lifestyle contribute to health and wellbeing. And then we really wanted this last section to get a little bit past the data and into the application. So often when I am with colleagues and talking about lifestyle interventions, people express frustration about applicability, that they find it hard to believe that people can make change in lifestyle factors. They see them as somewhat hopeless.

Douglas Noordsy (07:28):

And so I really wanted to spend time on that and both give them the evidence and in fact simple doctor's advice does make a difference in people's lifestyle behaviors, and that what we practice we tend to preach. So as people try out lifestyle interventions in their own lives and in their own health optimization, it helps them to be more effective, but then also just to think some about a vision for how focusing on health and wellness can help to transform healthcare and how we deliver it.

Laura Roberts (08:06):

One of the things that I love about the book is that you include many tables that summarize the current evidence. So actual empirical studies with their findings, and some evaluative comment on the importance of those empirical studies toward this field of lifestyle psychiatry. I do think it's a tremendous strength of the book. It's clear that there are a lot of areas where we need so much more evidence and I would say, for example, that part three, healthy body/healthy mind, I agree. I think each one of those chapters could be its own book. The diet and nutrition, the gut-brain access and microbiome, I mean how could any topic be more interesting to people at this particular time than that? So I think you really integrated the field really well.

Laura Roberts (08:54):

But I did want to commend you for advancing the evidence where it exists, because I think that's a challenge. And you and I talked about it before, even the term lifestyle, I think, has kind of a connotation of being softer and less impactful, less significant. And so I wondered how you would express to our audience your thinking about the phrase lifestyle and the management of lifestyle as we apply our clinical practice of psychiatry?

Douglas Noordsy (09:30):

Right, right. Yeah, and I thought a long time about that term and about the title for the book.

Laura Roberts (09:36):

Yeah, I know you did.

Douglas Noordsy (09:36):

And you and I talked about this because it is such an imprecise term, and I ended up settling on Lifestyle Psychiatry because of the parallel to the well-established term of lifestyle medicine, which even itself overlaps with complimentary medicine, integrative medicine, and other terms. The best alternative would've been wellness psychiatry, but again, that's not terribly precise either. And so I wanted to settle on a term that would have good recognition but inherently with it... I mean, the term lifestyle is really a lay term, it can apply to a lot of other things. I think it carries with it an inherent sense of being a soft area, something that physicians wouldn't necessarily think about or other providers, and that is kind of too easily dismissed even by providers, by patients, that you're asking me to do something that I could get advice at the gym about or that sort of thing.

Douglas Noordsy (10:47):

I felt like it was really important to address it at the level of scientific evidence. And as you said, both pointing out where the evidence is and where it isn't, and the tremendous work that's still left to be done. Again, the goal of this really... I mean, I think that there certainly has been some interest from the lay public about the book but I think that it really is intended to prepare the practitioner to be able to have that evidence driven discussion with the people that they're treating about these interventions in a parallel way to the way we would discuss any other therapy that we might deliver.

Laura Roberts (11:35):

So let's talk about the most radical example, which is treating psychosis with exercise, which I think is fabulous, and actually there is this wonderful database around. But I think that will challenge a lot of

people's thinking about therapeutic interventions and even this very severe condition of different kinds of mental disorders that are characterized by psychotic symptoms. So share with us a little bit about that, and also you could share then a little bit about your wonderful book with Kate Hardy and others on early intervention with psychosis.

Douglas Noordsy (12:09):

Yeah. Well, and as you know this is the other area of my interest, is in treating people with psychosis and particularly early psychosis. People are often surprised when I say that that's where the roots of my interest in lifestyle intervention come from, was my early career work in community mental health and working with young people with substance use disorders and psychosis, are some of our most difficult to treat people. And it really came from thinking about the brain reward system and how substances were sort of particularly drawing young people with psychosis in because of their inherent rewarding qualities and how was I going to help people develop some competitive, some alternate experiences? It really comes from an old concept of community reinforcement. How do other things in a person's life compete with the draw of using substances and the negative consequences of that?

Douglas Noordsy (13:11):

And so, many of my colleagues feel very pessimistic when I talk about using exercise and lifestyle interventions in people with psychosis and feel that the negative symptoms are going to interfere with people's ability to engage. I've found that I've been able to be very successful in this area, and what's so exciting about it is that physical exercise at a neurobiologic level, it's essential, or one of the core impacts is raising levels of brain derived neurotrophic factor and other neurotrophic factors in the brain, which stimulate neuroplasticity and dendritic spine proliferation, increasing brain volume in a way that really tracks the brain volume loss that we see in people with psychosis. And so when we think about it as a potentially very specific and powerful way to reverse some of the volume loss and cognitive loss that we see in psychosis that other tools that we have don't effectively do, it really becomes... your thinking starts to transform towards a very direct and powerful neurobiologic tool for helping to get at some of the underlying neuropathology of the disorder.

Douglas Noordsy (14:36):

And so given that rationale, of course you still have to get people to exercise. But I have found with a very patient iterative process of helping people to set goals, thinking with them about what they experienced when they sampled it, and very often people actually exercise less than the goals they initially set. But I just take a very positive reinforcing approach to talking with them about what they experienced the times that they were able to exercise or times they've exercised in the past, tried to connect to their identity before their illness, really observe the impact on mood symptoms, on anxiety, on cognitive function, on sleep improvement, and really use that experience to help to build a person's perception of when I exercise I feel better. That lasts a while and then it deteriorates and then I need to exercise again in order to sustain that feeling better.

Douglas Noordsy (15:34):

Really bringing attention to the reinforcing effects and also the impact on symptom areas that we otherwise don't do very well at addressing with our psychotherapies and pharmacotherapies, and which are some of the most distressing symptoms for people with psychosis. I mean, continually my patients complain about particularly the cognitive impairments, and imagine knowing you have cognitive ability, but not being able to access it and how frustrating that is for people. So, that becomes powerful in

reinforcing people's movement towards regular exercise. I ended up finding that with a patient iterative consistent approach, checking on adherence, helping people to revise and reset goals, that a majority of my patients were exercising regularly. And large scale studies show that somewhere around 40% of people with schizophrenia do meet physical activity guidelines for adults, and that's usually presented in a pessimistic light that 60% don't, but that 40% do is actually more than I think most clinicians would anticipate.

Douglas Noordsy (16:52):

And with some careful work around that, I find that I can get that to more like 60 or 70% of people getting to a place where they're exercising regularly with support. And of course that's not going to work for everyone, but making it clearly part of the treatment plan, part of the medical recommendation for care, and approaching it as a solution to some of the problems the person may still be struggling with, even with optimal pharmacotherapy and psychotherapy, I think has been very successful.

Laura Roberts (17:31):

Yeah, that's great. And so we're going to just do a little teaser on your book on psychosis with Dr. Hardy and Dr. Ballon, because I hope to actually have a time to visit with all of you about that wonderful book. But it's a special book because of the interdisciplinary approach that you all took. And I don't know if you wanted to say a few words about that other labor of love.

Douglas Noordsy (17:55):

Yes, and it was a labor of love for sure. So Intervening Early in Psychosis is our other book that came out this spring and was a collaboration with the members of the Inspire early psychosis team at Stanford that I was part of during my time there and the others carry on that tradition. And yeah, it was a wonderful collaboration between our team of psychologists and psychiatrists. The subtitle is A Team Approach and we really focused on how this movement in early psychosis intervention across the world has made its way to the United States and has found application in the US healthcare system. And so we incorporate actually a chapter on physical exercise in psychosis in that book, which Laura, you alluded to earlier. But also cover the range from pharmacology and psychotherapies for people with early psychosis and how the things that we're used to using in people with chronic schizophrenia, how those are tailored and applied specifically for people with early psychosis.

Douglas Noordsy (19:15):

But then also having a lived experience perspective, a family perspective and looking at typical complicated issues like diagnosis and assessment in early stages, identifying the clinical high risk syndrome, looking at the impact of substance use and how you distinguish that from persisting psychosis. So again, I'm really happy with how that book came out and the APA Publishing Group was a wonderful support in putting both of the books together. I think that people will find it a really helpful guide for organizing early psychosis services, whether that's a distinct team funded through community mental health intervention or a specialized component of a psychosis service within an academic medical center or a clinical, community mental health center.

Laura Roberts (20:20):

I have to say you have written so much and done so much for our profession, but just to give a couple other examples, you wrote a beautiful chapter in our book on student mental health, you've contributed to the textbook of psycho-pharmacology, the textbook of schizophrenia, integrated treatment for dual

disorders back in 2003. I mean, you've been contributing to the profession throughout your entire career, and I just want to thank you for all of that wonderful work.

Douglas Noordsy (20:49):

Well, thank you. And thank you for your role in inviting me to do a number of those projects. It's been a wonderful collaboration.

Laura Roberts (20:55):

Okay. So Doug, is there anything else that you want to cover or you want to?

Douglas Noordsy (21:02):

I think, again, I would want people to have an opportunity to really dig into the evidence, become a student of lifestyle psychiatry and get to a place where they're comfortable with it so that they can really bring it into practice in a way that's comfortable and genuine. I think that being able to integrate lifestyle psychiatry into the rest of one's practice allows one to practice in a way that has more precision as well as more flexibility and can help people to identify contributors to the onset of their disorder. And the other wonderful part about it is just getting to this nice place with responsibility for illness. When we're prescribing, when a person has to come to me to get a refill, there's an ownership aspect of that never feels satisfying to the customer, to the consumer.

Douglas Noordsy (22:16):

And one of the nice elements of identifying lifestyle interventions that people can choose to implement in their journey towards healing, is that they can take responsibility for that and really explore it and take it as far as they can. And that often then leads to collateral interest. Once a person starts practicing meditation and finds it helpful, then maybe they want to add a nutritional intervention. Maybe they want to really focus on their sleep. As people get comfortable in an intervention, they often want to perfect it by then adding a collateral component and it's nice to see that snowballing.

Laura Roberts (23:03):

Yeah, I like what you're saying but I also like the nonjudgmental piece of it, because a kind of more radical concern I've had is... and I especially see it in the physician wellness movement... there can be a judgemental dimension to this where you're kind of blaming people for not being more, I don't know, physically fit, more nutritionally robust. And so it's this exact framing that you're introducing about taking it as far as the person can, I like that kind of exact language, because what we want to do is support the therapeutic relationship. We want to support the wellbeing of the individual without further stigmatizing or undermining the very people we seek to help.

Laura Roberts (23:53):

So I do think there is an important meta message about continuing to be in this therapeutic stance and accepting people and being not judgmental, and yet supporting them, kind of like motivational interviewing and a lot of the things we've also seen in the addiction space. I don't know if you have observed that, for example, when you're supervising trainees as they're coming up through their training in psychiatry, how to help them find kind of that right sweet spot, where you're not judgemental and you're not blaming and yet you are trying to support people's strengths.

Douglas Noordsy (24:31):

Yeah. Well, right. And I think that can be a problem in pharmacology or psychotherapy as well, that if a person is noncompliant or non-adherent that can often become sort of a judgemental asset or they're not being a good patient, they're not owning their treatment. And that is one of the things I really like about this. I mean, obviously with any mode of intervention we can be monolithic and we can be preachy about it and that just creates distance for people. And I certainly don't think of lifestyle psychiatry as replacing the rest of psychiatry and psychology and the wonderful evidence based things that we do, I see it as giving us more range and more ability to meet people where they are.

Douglas Noordsy (25:22):

And exactly, if I find a person is setting goals with me around lifestyle change, choosing those options, and then struggling to implement them in their life, I mean that's understandable. We've all been there. Right. And so finding a way to both share that with them... of course it's difficult to make changes in one's life, but giving that gentle support and reinforcement. And it's always ultimately the individuals, the ownership is with the individual, it's always their choice, but it may also... when a person comes in, let's say, with trouble sleeping, if all I have to offer is a benzodiazepine or a Z drug or a kind of behavioral intervention that may or may not be immediately available, there's a lot of limits there.

Douglas Noordsy (26:20):

If I then can also talk to them about other ways of approaching insomnia, that meditation has been shown to have equal impact on restoring brain function to sleep, and that we may not be able to control when we fall asleep but we can control when we meditate, that becomes just another option that a person has to explore. I do think that it's very common, especially in working with trainees who haven't developed experience yet to see people struggling with that sort of why aren't people doing what I'm telling them to do, and modeling how to sort of do this in a way that engages the person where they are and connects with what the person brings. I mean some people bring a real attitude about traditional Western medicine approaches and would like to see something that embraces alternative modalities.

Douglas Noordsy (27:21):

Other people may bring a real sadness about an identity they had at one time in their life as maybe an athletic person and that they've lost in their current stage and want to reconnect with. And certainly I've treated a lot of people who had a particular upfront predilection for meditation, for particular nutritional habits that were important to them. And so helping to engage around that and identify how they could use that in a way to help manage their illness can be really powerful for alliance.

Laura Roberts (28:02):

Right, it sounds like it broadens the repertoire of the clinician and it broadens the repertoire of the individual living with a particular condition and that sort of richness that comes with that. Good. Well, I'm so happy that we had a chance to visit together and I look forward to seeing you at the next occasion. I really thank you for everything, Doug, and we miss you here at Stanford for sure.

Douglas Noordsy (28:25):

I miss you all as well. It's hard being away from such a warm, supportive environment.

Speaker 3 (28:40):

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Sanya Virani (29:26):

Hi, everyone. I'm Sanya Virani and I am the host of Finding Our Voice, fresh perspectives in psychiatry. Well, this podcast actually addresses current issues as they pertain to psychiatry, but we have a special focus on amplifying the viewpoints and opinions of our younger groups. Who are they? Resident fellow members and early career psychiatrists. Finding Our Voice is available wherever you get your podcasts from.