Shrink Rap Radio #420, September 11, 2014, A Model for Integrative Mental Health
David Van Nuys, Ph.D., aka "Dr Dave" interviews Rubin Naiman PhD.
(Transcribed from www.ShrinkRapRadio.com by Julie Twomey)

Introduction: My guest today is Rubin Naiman PhD. whom I interviewed previously on episode #302 – *Exploring Mindful Dreaming,* as well as on episode #256 – *Mindful Sleep, Mindful Dreams.* Today, we'll be discussing his model for an integrative approach to mental health. For more information about Dr Naiman please see our show notes for this episode at www.ShrinkRapRadio.com

Now here's the interview.

Dr Dave: Dr Rubin Naiman, welcome back to Shrink Rap Radio.

Rubin Naiman: Thank you very much, I'm happy to be here.

Dr Dave: Well I'm happy to have you back on the show. I think I've had you on twice before speaking about sleep and dreaming and both of those interviews were based on books you've written and today our focus will be a little different and as far as I know you haven't written a book on the topic yet but you have been offering workshops on it – namely a Model for Integrative Mental Health.

Rubin Naiman: Yes.

Dr Dave: And you sent me a PowerPoint deck to kind of give me an idea of what your thinking has been and having gone through that deck I suspect the workshop may be a prelude to another book, would I be right about that?

Rubin Naiman: It's a possibility, (laughs). I've got a couple of other books in the pipeline right now.

Dr Dave: Oh wow. Because the deck that you sent looked like it would make a great outline for a book.

Rubin Naiman: You know that slideshow came – well, if I can share just a little bit of history – the Arizona Center for Integrative Medicine where I'm on the Faculty, directed by Dr Andrew Weil sponsored an initial conference on Integrative Mental Health about four years ago, 2010 and we had a much greater response that we anticipated. So this was an attempt on the part of Dr Weil and the center to expand the focus of integrative medicine and integrative health to basically to Psychotherapists and the response, as I said, was just phenomenal. Subsequently, Dr Weil and I presented at the Networker Conference – a large psychotherapy conference on the east coast I think the next year and he did a keynote address and I did a daylong workshop and again the response was phenomenal. So there's a tremendous amount of thirst, of interest I think on the part of psychotherapists to better understand and actually use integrative approaches and so that's where this slide deck came from and I've been doing that presentation there since and will probably do it in other places as well.

Dr Dave: Yeah, yeah, well that's great. I have a number of psychotherapists that listen to the show and also a lot of psychotherapists in training so you're going to have another audience for your ideas here. Let me start out by asking you – what's the problem that the Integrative Model for Mental Health seeks to address?

Rubin Naiman: Well, in a word it's segregation. You know the word 'Integrative' – the opposite of integrative is segregative and I actually had to look that up some time ago because I started writing it and wasn't even sure if it was a word because I hadn't heard it in speech or I don't think I've read it, but it is a word and our current approach to health in general - mental health in particular - is actually significantly segregative, we split things apart. We certainly split the mind and the body. You know, there are two major camps in healthcare: there are those who take care of the body, of the physical form – we call them physicians and there are those who take care of the mind – we call them psychotherapists. Of course there's a good deal of overlap in the number of these but the basic message is that health is not something that's integrated, it's segregated and we segregate professionals as well and this is a critical issue. We have Mental Health professionals and we have physical – we don't call it that because we think of them as *the* health professionals…

Dr Dave: Right.

Rubin Naiman: …but physicians have been saddled with the ultimate responsibility – the overview of health. So there's a segregation there too and I think there are a lot of smaller ones when we begin to look at specialization and sub-specialization. One example is I have a sub-specialty as you know in sleep and dreams. Part of my approach to that – a large part of my approach, I should say is informed by an integrative approach so when I do an evaluation and a treatment plan around sleeping and dreaming I don't just look at data related to sleep and dreams, you know, *"How many hours are you sleeping? .... What are your behaviours before sleep? ...What are your cognitions around them?",....* and so on. I actually ask about the whole person. I look at all the psychological variables, clinical psychological variables and I look at somatic issues. What's going on in your body? I look at health issues, I look at medications. Historically, I started practice 30+ years ago in California and I have a distinct memory or one of my colleagues who I have to say was a bit on the OCD side - but warning me, in a caring manner, that I might have been crossing the boundary into medical care at the time when I told him I had suggested that a patient have a cup of camomile tea to calm him down before sleep.

Dr Dave: Yeah.

Rubin Naiman: Standards have changed quite a bit, thank God, but in those days – I know in my training and subsequent understanding of clinical psychological ethics we didn't practice medicine without a license and simply suggesting that somebody take something by mouth was iffy.

Dr Dave: Well has that changed? I wasn't aware that that had changed.

Rubin Naiman: It's changed to a degree. I think if you look at APA ethical standards for example, around medications back then we as psychologists weren't even permitted to discuss medications, I mean we could refer out and I know there was a pretty dramatic change some years ago which not only allowed but encouraged us to provide information about psychiatric psychotropic medications which I think is critical because they don't often get sufficient information from prescribing physicians. But it has changed and

most therapists that I talk to today are more open to that. They don't shy away as much as they used to from that classical body/mind gap – which I refer to as the body/mind chasm.

Dr Dave: Yeah, you know and that's an area I'd like to explore with you a little bit because you're a psychologist, I'm a psychologist and as you know historically there was some criticism and cautions and so on about the medical model and now some people are concerned about the medicalization of psychological problems,

Rubin Naiman: Yes.

Dr Dave: …and there are questions of, what's the appropriate level of intervention? Should we be intervening at an educational level? At a medical level? At a molecular level…(Laughs)…. an atomic level? The brain? There are all these kinds of questions, and so, speak to that if you will.

Rubin Naiman: Not to mention a spiritual level.

Dr Dave: Oh, yes, right.

Rubin Naiman: I think the answer that most appropriately we have to step back and ask ourselves, really, what are we trying to do and what is our major concern? - and obviously our major concern is health. It's really difficult to segregate physical health from mental health. Over the years we've seen more and more data showing profound links, inextricable links, for example, between mental psychiatric conditions like depression and heart disease, for example, depression and cancer, anxiety and cancer. Maybe we'll talk a little bit about this interesting parallel between autoimmune diseases and self-recrimination. So, there's this question of dualism which I think many of us are familiar with as a philosophical and sometimes a spiritual question. You know, we have a body and we have a mind and it's not just a spiritual question – it's a question that has some very practical ramifications. So, science - and I think virtually all of us are strong believers in science – science studies matter and manifestations of matter.

Dr Dave: Yes.

The physical world, so health sciences focus on the physical body, on physiology, on biology. Biology is literally the study of life. So science looks at matter but human experience - the human mind is a matter of mind, right, it's not matter. Human experience is psychological; we might say it's spiritual consciousness that we've never really been able to find the link – hard as we try – between the physical and the psychological. We can find links between the physical and behaviour, we can look at the brain and find correlations between neural networks, complex sets of neural networks lighting up that are associated with…. but, you know, we have the old "*This is a correlation, not a cause and effect"*. And so we look at this body/mind issue. The body and the mind are really flip sides of the same coin, ok, and we can make an argument of monism of non-dualism and say yes they are really one but the reality is, in our experience – in your experience, my experience and the experience of the listeners I have this body but my experience of being alive is not physical. Again it's psychological, it's about consciousness, it's spiritual and as much as we want to acknowledge the connectedness, which I think is critical between body and mind I think we have to continue to acknowledge that there are two different ways of looking at life and they are both necessary, they are both essential. There is this old image – it's a little hard to depict vocally but if you imagine a cone, a three-dimensional cone, like an ice cream cone turned upside-down….

Dr Dave: Ok…

Rubin Naiman: …and you shine a light laterally onto a wall, the cone would project an image of a triangle.

Dr Dave: Right.

Rubin Naiman: If you shine a light vertically down on the cone to something below it, it would project the image of a circle. So I think this is one of the ways of understanding body and mind - if who we are as a whole is that cone, we get two very different shapes, two very different reflections, it throws off two very different shadows and we need to honour them both. The problem - so we live in a world where the emphasis has been on the physical and the psychological - and I think many of us, as psychologists understand this - has been valued but it's a second-class citizen in the world of healthcare. Physicians, and I mean

this sort of philosophically, not referring to any particular specialty, physicians run healthcare, and then there's the sense that we as psychologists – if something is not clearly definable physically, physiologically, then the ball goes over into our court. So the presumption behind this is that the mind, that our psychology, that our consciousness is an epiphenomenon, its an expression of the body, the body grows a brain and the brain somehow grows consciousness. But we look at the body as being primary. The alternative to this – and again this is a psycho-spiritual argument – is that we can look at the body as an expression of consciousness and many people would make that argument. I don't think we have to settle that argument, but I do think we have to reconsider the question of primacy and today most of us look at the body as matter, as being what matters, you know physically and I think a very key contribution to this issue here comes from Candace Pert who sadly had passed away this year. She's probably best known for her research at Hopkins that laid the foundation for the development of SSRIs, for which incidentally she subsequently issued a public apology. But Candace did some incredible work towards the end of her life, basically around the theme of looking at the body as the unconscious mind. So, rather than looking at the mind as an expression of the body, looking at the body as an expression of the unconscious mind. So what this does is, it gives us an anchor on the psychological side to begin to build a bridge towards the biological side. There's been an anchor for a long time in biology and medicine and that's the brain, we look at the brain and we can tinker with various neural networks and neurochemicals and so on and say, "Aha, if we do this, we get this impact psychologically". So psychologists need to contribute to closing that gap. There will always be a mind and a body side but we need to close that gap and I think this notion of looking at the body as the unconscious mind is an essential foundation for closing that gap.

Dr Dave: Well, speaking of that gap, what is it that Psychotherapists can do to help heal the body/mind gap?

Rubin Naiman: Great question. You know, I think part of this is a willingness to be courageous, so let me just start by saying that we need to of course operate within the scope of our competence, you know, we're trained in certain things and some of us have more of a background in, say, somatic therapies, body therapies, psychophysiological issues, some of us have less so we want to

stay within the bounds of that. But I think we need to recognise that the people sitting in front of us come in with mental conditions but they also have a body. You know, many years ago there was a great book written for physicians called, *'The Body has a Head'* and it was written by a doc who was very frustrated with the fact that human life was just being reduced to biology and he was reminding doctors that psychology was a factor. We need a book, speaking of books called *'The Head has a Body'*. And so, what Psychotherapists can do is recognise that and there are a number of specific ways in which that can be done. Let me use the example of depression, the World Health Organization is projecting that by 2030 that depression will be the number one health concern in the world, that more people will suffer from depression that any other illness. Now, is it psychological? Is it psychophysiological? You know, it has all kinds of routes and different directions. But we know, we have really hard data now that shows that there are effective psychotherapeutic techniques, the most effective ones in my understanding are Cognitive Behavioural Techniques. But we also know that it's really difficult to successfully treat depression without addressing sleep issues. So I think all therapists – and I've said this before – need some basic background in sleep. We also know that there are a number of nutrients that play a critical role in depression, so any depressed client - client/ patient; this is another issue to talk about – what do we call them? But any depressed individual I see I ask a number of questions about their nutrition. I ask them about their intake of Omega 3 fatty acids. Those fatty acids make up about a third of cell structure in the brain so they're very, very critical to normal functioning. I ask about the intake of B Vitamins; I absolutely focus on Vitamin D, Vitamin D3 because deficiency in all these areas has been shown to lead to depression. And so I think we can't in good faith just do talk therapy, psychotherapy, whatever it is, even if there's a somatic component without throwing a broader net and asking about these other things.

Dr Dave: Now, going back to our earlier conversation about APA, Code of Ethics etc. loosening up and being very careful not to go beyond the scope of legal practice, would a person get into trouble advocating for more Vitamin D3, more B Vitamins and so on? I think in the old days they certainly would have. Has that changed?

Rubin Naiman: Yeah, when you say, "advocating", I think it's a question of how we present this. So, number one, yes we have to be careful. One simple example is that if you have a patient/client

who is on a blood thinner – Coumadin, Warfarin, for example, they need to be cautious about Omega 3 fatty acids – fish oil for example, which also can thin the blood. So I never prescribe and I would not recommend to Psychotherapists, saying *"Hey do this"*. I ask people about it, you know, *"When did you last have a physical? Did they check your Vitamin D levels? Have they checked this? Did your doctor talk to you about Omega 3 fatty acids?"* and then my focus is on the provision of information.

Dr Dave: Ok,

Rubin Naiman: I tell people, you know, we have really strong data showing low levels of Vitamin D - which is an over the counter supplement - are associated with depression. Inevitably at that point my patients are pulling out a pad of paper and they begin to make notes. So, again this isn't a comprehensive treatment but it's a critical part of treatment that's been left out.

Dr Dave: Yeah, and I think in that slide deck that I saw, there was the implication that you feel that Psychotherapists – non medical Psychotherapists, are maybe woefully deficient in their knowledge of the biomedical side of things.

Rubin Naiman: Yeah, yeah, I think so. I think in some ways it's too easy to say, "Well that's a biomedical problem, talk to your Doc about that". Even if they are being treated, for example, for chronic pain it's something we need to consider. So one of the, I think simple and major recommendations I make around Integrative Mental Health is that we need to move from an interdisciplinary to a trans - disciplinary perspective.

Dr Dave: Yeah, what does that mean? What's the difference?

Rubin Naiman: From the time I was quite young the notion of interdisciplinary treatment has been around, you know, many decades now and so this idea that we should integrate, we need to communicate with physicians, with nurses, with nutritionists, with physical therapists. You know, if we're treating somebody that's also getting that kind of treatment we need to communicate. But I think that hasn't worked. I think it's been a step in a very positive direction but a trans disciplinary approach basically says we need to overlap in order to prevent cracks. You know we talk about people falling through the cracks and many do. We really need to

overlap so as a psychologist I need to know a fair amount about biomedicine. I can't just presume that the physician will take care of all of that and physicians need to learn, I think, significantly more about psychology and psychotherapy so it's trans - disciplinary. I think over time, it's something I envision into the future, that our primary identities will shift from being a psychologist or a clinical psychologist or some sort of sub specialty in psychology or medicine. My hope would be that our primary identity would be as Healers, and then our sub specialty might be physician with this or that focus or psychology with this or that focus - that these disciplinary definitions are really in place to serve professionals more than they are to serve our patients.

Dr Dave: Yeah what are the implications for costs of what you're discussing you know, for a long time the physicians were primary as you said, psychologists were secondary, psychology fought for reimbursement and there are limits to what is reimbursable and what is not and still the costs of health care just seem to be spiralling and spiralling and, if you will, more and more camels want to get their nose under the tent, that is, people who consider themselves plying one healing modality or another. I know this is something that you've studied. Talk a little bit about costs and what can be done about those.

Rubin Naiman: You know, around that topic Dr Weil has many time said and written that he thinks that the American Healthcare System – if we can call it a system, will collapse- it is collapsing under its own weight. Yeah, it's a critical issue. Health costs are the primary cause of bankruptcy in the United States. We're seeing a pretty significant rise year after year and I think without any significant benefits. I mean, there are some things we do quite well, emergency medicine as an example. If you've had an accident or having an acute medical condition – a heart attack for example – there's no better place to be than in an emergency room in a good American hospital. But in terms of caring for chronic conditions, certainly in terms of prevention, we really are lagging behind. Part of this I think goes back to the notion that we see matter, we see biology, we see biomedicine as being primary in healthcare and so the focus is on the physical with insufficient regard for the psychological and one of the corollaries of that is we think we can manage our health with physical substances – in other words, with medications. So we are very heavy, heavy handed with medications in our world and a lot of physicians are as

frustrated as people in general and as psychologists are with what many of us believe is an over use, an over dependence on medication, but, you know, it's derived from the contemporary medical model, the belief that we can tweak, we can suppress. Let me just go down a side road here…

Dr Dave: Sure.

Rubin Naiman: If we see the body as being primary and not the mind, we focus on what health psychologists have called disease rather than illness. Disease is the objective measure of being sick, ok, so you can count white blood cells, you can take somebody's temperature, there are numerous ways of quantifying somebody being sick and its objective, it's observable or re-observable. Illness, in health psychology refers to the *subjective* experience of being sick – it's not feeling well, and we've known for many years that the two don't correlate really nicely. So, for example, some years ago data showed that about fifty per cent of people who showed up for out patient physician visits for primary care visits for example, had illness – that they didn't feel well but there was no detectable disease. Now, we could argue that it was prodromal, it was pre clinical, there's something going on that was not yet observable, but I think not – maybe in some cases – I think that this is just a reflection of psychology not being integrated well with biology. There are some cross-cultural medical anthropological studies that look at the occurrence of disease without illness, which I find fascinating. So in other cultures people might have symptoms; in sub cultures, for example, it's not all that uncommon to lose your sight, to actually go legally blind as you age and it's not considered a disease in that culture. There's a classic scene in the Mel Brooks' movie Young Frankenstein, I don't know if you've seen that?

Dr Dave: I've seen it but it's been a long time,

Rubin Naiman: So, Igor, played by Marty Feldman – the Hunchback….

Dr Dave: Yeah,

Rubin Naiman: ….Is hobbling along and the good Doctor Frankenstein says to him, *"I don't mean to boast but I'm a great surgeon and maybe I can do something about your hump"* and he

has this great hunchback and Feldman looks at him with this great big one eye and says, *"What hump?"*

Dr Dave: Right,

Rubin Naiman: It's an example of obvious disease but there was no illness associated with it. So…I'm sort of losing my train of thought…

Dr Dave: That's ok, I've got plenty of questions for you (laughs),

Rubin Naiman: We were talking about cost, I think one of the reasons costs are so high is that we're trying to address everything as if the body is primary and my bias, and maybe it's sort of obvious, is that there's a whole lot more that we can do as psychologists in terms of not just an adjunct in *treating* disease via illness indirectly but also in preventing it.

Dr Dave: One of the things that you suggested - that kind of struck me as strange at first – was you said, *"We should consider an energy medicine framework for thinking about an integrative approach to mental health"*. Tell us what that means.

Rubin Naiman: Yeah, if I may – I think I shared this model with you previously but when I teach about this I refer to something I learned from my mother as a little boy. When I was a boy and if I wasn't feeling well she would always come at me with three questions, always the same three questions and this was her…. My mother was an Eastern European woman, raised in a little village so this was sort of a local folk diagnostic Eastern European Jewish assessment.

Dr Dave: Ok.

Rubin Naiman: She would ask me three questions and the first question was, *"Did you eat?"*

Dr Dave: Right… (Laughs)

Rubin Naiman: You know, classic Jewish mother stuff and if we look at this in broader nutritional terms, it's a question not only about the intake of food and fluids – which, of course, are critical to health - it's a question about everything else we might consume.

So we consume food and fluids but in addition we also consume energy in other ways. We consume vast amounts of information.

Dr Dave: Mm Hmm….

Rubin Naiman: I know that very few people would argue with that today. There's one blogger who suggests that in an average month we consume more information than people did in a lifetime a hundred years ago. Now that's not measurable but it makes the poetic point that I think is critical.

Dr Dave: But the point has also been made in relation to advertising and how many ads we're exposed to in a day and that is measurable and it's fairly astounding.

Rubin Naiman: Yeah, a tremendous amount of information. We also consume light – and this is something people don't think about. But there are light receptors, obviously, in the back of the eye in the retina. There are also light type receptors in other parts of the body, they've been identified behind the knees and I think over time we'll recognise that skin also consumes light and we probably consume other non-visible kinds of electro-magnetic radiation. But we know that light and its absence – darkness – has a profound effect on our health, on circadian rhythms. So, we consume food, we consume information, we consume light and we also consume oxygen.

Dr Dave: Yes.

Rubin Naiman: The point has been made about food, that the irony in our world is that we over-consume food but we are simultaneously under-nourished and of course that is the result of consuming poor quality food, a lot of food without nutrient value – high glycaemic carbs for example. We can make the same point about information – that we consume a lot of, maybe titillating but junk information. I would make the point about light that we over consume light at night in our world, there's no question about that. There's a Buteyko model – which I wont go into in detail- based on the work of a Russian physician that argues that we actually over consume oxygen, we over breathe. So, the point I want to make here is that we can understand health in terms of a flow of energy. All of these things – food and fluids and light and information and oxygen – they all can be translated into energy, and I think we're a bit of an

energy crazy culture today- that there's this uncanny parallel between the global energy crisis, you know, we're running out of energy, and what I think of as personal or individual energy crises, that people often have insufficient energy. And by the way, oil is the number one traded commodity in the world and the number two traded commodity is coffee – and they're both about mediating energy. So, from a psychological standpoint I think many of us crave energy. A lot of new age spirituality looks at energy as an expression of the divine – "*I'm gonna spiritually plug into",* it's almost like there's this power plant in the sky, right ... (both laughs) *"I'm gonna sizzle with divine energy and manifest money and parking spaces and love…"* So, I think there's an over valuation of energy.

Dr Dave: Mm....Hmm…

Rubin Naiman: This is a model that allows us to understand the flow of energy and health, so again, first question*, "What did you eat?"* - What are you consuming? My mother's second question was, *"Did you poop?"* So, we just jump right to the metaphor here.

Dr Dave: Yeah.

Rubin Naiman: If *"Did you eat?"* is about what are you consuming, this is such a critical question. It's a question about what are we able to let go of. So if we are consuming energy, are we able to express it to use it or to dispense with it, to disperse it if we don't need it? I believe this is a very critical issue in understanding sleep disorders, particularly insomnia because we take on more than we need. We take on more energy than we need, we become hyper aroused and it's more than we're able to let go of. I think this consumption of excessive energy is one way of understanding from the psychological, from the mind perspective, chronic inflammation. As we know, as psychotherapists, psychologists we really need to have a better understanding of chronic inflammation, of excessive energy. Chronic inflammation appears to be a factor underlying, underpinning all major illnesses. We see chronic inflammatory conditions behind cardio vascular disease, we see it in neurodegenerative disorders, autoimmune diseases like arthritis, metabolic disorders like diabetes, we see it in cancers, we see chronic inflammation in depression- chronic depression –and in anxiety as well. So, again, when we look closely at it, it can get complicated, you know, the immune system goes awry and it

engages in friendly fire and this causes an inflammatory response. There's actually an interesting cytokine theory now of depression that says that there's a particular immune response that's elevated that results in a slight increase in body temperature, which may or may not qualify as a fever but it's a key factor in depression. So, we can move toward a common language, a language of energy medicine. Now, the term energy medicine is something we use in integrative medicine, we have physicians who are specializing in this area. It's a way of understanding alternative medical systems like homeopathy, traditional Chinese medicine and acupuncture, things like reiki. We need new language, a language that bridges body and mind. But I also think it's a really critical language that psychologists can use, that we can look at, step back and look at the flow of energy in a patient's life, you know, *"What are you consuming, energy wise?"* Maybe in terms of food, maybe in terms of excessive exposure to stimulating information, other things like that, and we can understand that excessive information is associated with chronic inflammation.

Dr Dave: And then, what about the elimination part of it?

Rubin Naiman: Great question. Oh, by the way, my mother's third question was *"Did you sleep?"*

Dr Dave: (Both laugh)

Rubin Naiman: So, I think that's really important, and *"Did you poop?"* - how are you eliminating? So first of all, there's another silent epidemic aside from hypertension and that we hear very little about in our culture – it fascinates me –and that's constipation. I don't have the numbers in front of me but there are millions of people who chronically suffer from constipation. From an energy medicine standpoint, this is associated with a kind of holding, if you will, this is an understanding too and classical sort of psychoanalytic or psychodynamic theory where I'm told in the training that there's a retentiveness. So there's a kind of holding, but that holding can apply not only to the movement of food and fluids through our system but also the movement of various kinds of energy. So there's this question and I think this comes up a whole lot in psychotherapy, a question about '*letting go'*, you know, often in chronic grievous situations for example, people were unable to let go. This notion of '*letting go'* is a key factor in all twelve - step programs, there's so much discussion of the need

to surrender. And I think again, it's languaged differently in different schools of psychotherapy but I think it is addressed in virtually every approach to psychotherapy and so we can focus on – we can look at both excessive consumption and the particular ways in which people engage in that and specifically - as relates to that individual – how we might encourage people to both let go of excessive energy and, I think, even more challenging is to encourage people not to *consume* excessive energy.

Dr Dave: Well, that's very provocative, thought provoking, what you're saying and interesting that you mentioned twelve – step, because I was immediately thinking of, well, maybe addiction itself as a kind of 'hanging on' to something that one needs to be able to let go of. Now a lot of what you're talking about has the implication that lifestyle is involved here, for better or for worse, and so what do we know about how lifestyle affects mental health? We know it impacts our physical health and we're hearing it a lot in the news about obesity in this country and that that's a lifestyle issue. What about our mental health?

Rubin Naiman: Let me back up a step…

Dr Dave: Sure,

Rubin Naiman: So, some years ago, I would say twenty years ago, I went to see my primary care physician who for a long time has no longer been my physician and I had a physical and everything was fine and he was in a hurry as usual and he ran out the door and then came back, he opened the door, he stuck his head in – and I'll never forget – he looked at me and he said*, "Hey, do something about your stress."* At the top of his voice, and then he left.

Dr Dave: (Laughs)

Rubin Naiman: and it was like, I wanted to say, *"Oh my God, of course, brilliant Yes! I will do something about my stress"* What the hell do you mean, do something about your stress? But, you know, in all fairness to him….

Dr Dave: Well, plus his method of delivery sounded like he was pretty stressed in a stressful way of delivering it, (laughs).

Rubin Naiman: In all fairness to Docs – he's got about seven minutes to deal with me, he's got about sixty people to see that day. So we know beyond a doubt that lifestyle is a critical factor in health and illness. Now that's not to say there aren't genetic factors and other things but lifestyle - my sense is perhaps *the* most critical factor, surely the most critical overlooked factor and physicians are getting this now, more than ever but their hands are tied in two ways. Number one, they don't have the time to address lifestyle issue in a meaningful way and number two, they don't know how. They're just not trained in this, now in our program there's a lot of emphasis, for example, on motivational interviewing. It's been fascinating in the twelve or so years I've been teaching at the program I'm always taken by the fact that the Docs who come in to do our fellowship training – the vast majority of them come out with a profound regard for psychology. They get so interested and personal in mind factors and psychological factors and hypnotherapy and motivational interview. They were so hungry for this and I think one of the critical factors in the evolution of Integrative Medicine is from the start, from decades ago; Andy Weil was unusual as a physician in that he had this intense personal regard for psychology, for the mind, for spirit. So I think this is an area, again, where we need a trans - disciplinary approach. As it stands today, we – psychologists, psychotherapists are in an ideal - an essential - position. It's really, I think, incumbent upon us to address lifestyle issues.

Dr Dave: Remind me of motivational interviewing, I actually interviewed somebody about that a long time ago but… how would you characterize the essence of that approach?

Rubin Naiman: It's a set of techniques that evolved originally around dealing with people with addictions, specifically I think with alcoholism. It's a non - patriarchal technique, it doesn't go in and say *"Hi, You're an alcoholic",* or *"You're on twelve – step program"*. It's an approach to interviewing that I think is informed largely by tremendous respect for the client. There are questions about, you know, would you prefer this or prefer that – so it has an old Rogerian client centred focus and there's a good deal of data on it that show it's effective and it can be used in other areas too. So again, rather than in sort of a classical physician manner offering prescriptions, you know- *"Do this, take that"* - it more elicits a positive response than it does impose one.

Dr Dave: Yeah, so it's a non – blaming one that highlights choice and the role of choice for the person – would that be right?

Rubin Naiman: Absolutely, and this reminds me of …one of the key tenets in Integrative Medicine is that healing is seen as a partnership between the professional, the clinician and the patient and in some ways this would seem to be so obvious but it's often not looked at that way, you know, many of us go to the physician, and it's as if we're bringing our car in for body work – we're bringing our body in and they examine that and make recommendations and we get it done but there's that disconnect between body and mind. This is an approach; this is a tenet in integrative medicine that says we really include the patient, the client as a partner in this process, you know, it's non – patriarchal.

Dr Dave: You have some other tenets too that you listed in that presentation. I don't know if you can bring in any of the others off the top of your head?

Rubin Naiman: Yeah, let me translate them into the tenets for Integrative Mental Health if I may…

Dr Dave: Sure,

Rubin Naiman: …Focus on the more important ones. One of them, one very critical one is a belief in endogenous healing and this is something that is key to integrative medicine. You know, there's this question that Don Meichenbaum addressed this many years ago. When we sit down in front of a client or patient there's this unconscious process inside the therapist about, *"Who is this person"*, you know, *"When I look at this individual, am I seeing a biological entity with a complex brain again with neural networks firing or looping or getting stuck? Am I seeing some poor soul who's still engaged in unresolved childhood conflicts and wounds, psychodynamically? Am I seeing a spiritual being?"* And really a lot of that is probably projection – what I believe fundamentally about who I am as a human being is likely what I believe, what I will project on others, whether or not I say that. You know, these old studies going back some years that found that if a patient stuck with a psychotherapist over a period of time, the patient's moral values would come to align with therapist. I think it's profound. I also think there's an unspoken message we give to the people we

work with about our beliefs, about what it means to be human. So, in medicine today the belief is that the body is something that needs to be harnessed and controlled and directed. Essentially, you can't trust it – you need to tweak, you need to apply this medication if you get this symptom. We talk a lot in integrative medicine about symptom suppressive therapies and conventional medicine. One example, a great example is, somebody gets a fever and if it's a child or an adult your Doc might suggest you take an aspirin or acetaminophen and the presumption there is that a fever is a sign of some sort of illness. Well, more technically, the fever may reflect the presence of illness but a fever, per say, is a sign of endogenous healing. It's really the body's response to that and it's so interesting that we really don't make that distinction well. I think this may be as true in psychotherapy, we often fail to distinguish a sign, a serious sign of illness from a sign that the body or mind is trying to heal itself.

Dr Dave: Mm Hmm…

Rubin Naiman: I think a lot of depression – and depression is a broad term, so not all of it – but I think a lot of depression is actually… I think of it as a psychological fever that has a positive benefit. If we listen to our depression – and there have been studies on this too – if you ask depressed people what they really want, is they want to rest, you know, and rest of course is a four letter work in our culture. It's like they want to get off the assembly line, and so I think there's a way of listening to depression. Depressed people also get fatigued. Fatigue, if it is respected is associated with an increase in waking dream, sort of a spontaneous unconscious process. So, of the tenets here, going back to the tenet is regard, a respect for – a deeper regard -for the endogenous healing capacity of the body. In other words, having more faith in ourselves. And I think a lot of people who show up with medical or psychological concerns have lost faith in their own body and their own mind to heal and I believe after doing this work for years that the body and the mind are hell bent on healing and that a big part of healing – again it goes back to this notion – is we need to partner with, not impose or try to force healing on the body, but we need to partner with it.

Dr Dave: Yeah, I've been very interested in Shamanism as an approach within a certain communal context that seems to work to engage that capacity for self-healing.

Rubin Naiman: Yeah, and I really like that communal notion too and one of the issues in integrative medicine is that we expand beyond the body, we recognise that the body has a mind and that the mind typically lives in a social, a cultural setting, an environment and all of that comes to play. My spiritual mentor, Hugh Prather, once wrote that to some small degree, he said, all death is both suicide and murder. And it seems like a shocking statement but I think it's a recognition of our place in a larger system that there are dynamics within us, which will eventually take us down. We will age and we will stop functioning. There are dynamics in the world around us that will wear and tear on us and eventually take us down. I think recognising that both health and illness may manifest in a particular individual but they are really properties of a larger system, this is also another tenet of integrative medicine.

Dr Dave: Yeah, and you know, years back there was a big push for Community Mental Health Centres and I'm under the impression that that movement faltered, yet I have the impression that the idea of community is important in your approach and we were talking about lifestyle and it can be really hard to change your "lifestyle", the things that you do habitually, that you're used to and you're comfortable with and maybe, one of the key things that makes that possible is if you join a community of other people who help to support that.

Rubin Naiman: Yeah, absolutely, I think this is one of the many critical lessons the twelve – step movement, that community is incredibly powerful. It works both ways, you know, there's interesting public health and medical anthropological data that looks at social contagion. So we know, for example, if your neighbour is overweight, it somewhat increases the risk of your being overweight. If your close friends – even if they're hundreds of miles away – are overweight, you have an increased risk of obesity. There are mechanisms at play here that we don't quite understand but they're quite profound socially.

Dr Dave: Yeah. Now earlier we were talking about…. now, I've lost my thought here, but there was something that ties into something that you discussed which is the role or the importance of suffering and so, I believe somewhere in your presentation you…I guess this relates to the self – healing, the endogenous healing, and does

suffering have a role, a positive role? As well, I mean, we hate suffering but is there a flip side to suffering?

Rubin Naiman: I like the distinction offered in some of the Buddhist traditions between pain and suffering and for them, pain is inevitable – it is an inevitable part of life both physical and psychological pain. There are so called '*necessary losses'* right. But suffering results from a kind of clinging to the pain – a holding – a constriction around it. Now, that may be true, for example, I learned years ago from a meditation teacher that most of us when we're walking around – and I do this regularly – we stub our toe in a doorway or somewhere,

Dr Dave: Yeah,

Rubin Naiman: But if you look at that in slow motion, many of us at that point will turn toward the toe and hurl expletives at it, you know, *"Ah, damn!"*

Dr Dave: Yeah,

Rubin Naiman: …and that's a kind of constriction and what this man Stephen Levine used to teach was to embrace in that moment, to embrace the pain compassionately. So you would minimise the suffering in doing that and what I found – at least subjectively - is that it's a lot less disturbing to just experience the pain without projecting all kinds of suffering on it, it's a lot better. So, yes pain is inevitable but suffering, as they say, is optional.

Dr Dave: Maybe related to this is something you discuss as a healthy way of being sick…

Rubin Naiman: Mm hmmm.

Dr Dave: What are you getting at there?

Rubin Naiman: Yeah, so we go back to this distinction between disease versus illness and illness is the subjective experience of being sick, disease is the objective experience. Over the years I've had a handful of patients, some who were quite ill and passed away, some who've been chronically ill – I'm thinking of one or two right now- a young woman I've worked with who's had a chronic auto immune condition, is in and out of a lot of pain but she has this resilience about her, and its not that she doesn't have

pain and sometimes suffering, but, you know, its as if she has a deeply embedded sense that there's something even more important than health in her life. And so this takes me back to something I grew up with – many of us grew up with – you know, with my Jewish mother and all the 'Mishpucha' and there's an old saying – *"You should only be healthy", "You should only be healthy"* I hear this from a lot of people actually. About ten, fifteen years ago I sponsored a conference called '*The Jewish Perspective on Healing – You should only be healthy'....*

Dr Dave: (Laughs)

Rubin Naiman: …and I used to believe that and now I think it's a misunderstanding that our goal is not just to be healthy. You know, being healthy is like having a really good car, ok, you have a vehicle - you body, your mind is a vehicle and it can take you somewhere but it's not an end in and of itself. So there are people who can be sick, who can have disease or illness…again I'm thinking of this one particular individual who has – she has this profound…I'm not sure what word to use…. this passion about life. She has an incredible sense of humour and again this woman is in as much chronic pain as I've ever seen anybody be in and it's a struggle for her but she comes up for air very frequently. She's got a really strong social network… she has an interest in personal artistic expression, so there's something much more important in her life than being sick or being healthy – not that that's unimportant at all – but she uses the vehicle she has, she has a higher purpose if you will. I think that's the essence of being sick in a healthy way. You know, in our world today there's so much emphasis on staying healthy but not enough emphasis on why we should stay healthy, you know, what's the reason for that?

Dr Dave: Someone pointed out – and I don't remember who – that the world is mostly being run by people who don't feel very well.

Rubin Naiman: Yeah, yeah, that's Winston Churchill

Dr Dave: Ok, I thought it might be him but I wasn't sure…

Rubin Naiman: Most of the world's work is done by people who don't feel very well. I was thinking of Joe Campbell who said, basically that it's not that we're so much looking for meaning as we are for experience and I think we're caught in this sort of, *"Body is*

primacy", we're caught in this social definition of what's meaningful – it's meaningful to be healthy. So here's an example; we confuse medical metrics with true experience so a lot of people will – when you ask them about their health – I have patients who do this, they'll come in and they'll bring me their numbers, right…

Dr Dave: Yeah, right….

Rubin Naiman: *"Here's my cholesterol, here's the number of hours I sleep at night",* if they're sick, *"My white count did this…*" and those numbers, somehow, the metrics become meaningful and they're just measures of physical health not of personal experience, and I love that Campbell quote that it's really about finding the experience. That experience is mental, it's psychological, it's psycho-spiritual - it's not about the body and the body may be in good shape or bad shape but people can still have that kind of meaningful experience. They can be healthy.

Dr Dave: Yeah, yeah, and you've said that you don't think that the war metaphor is very helpful, you talk about the war on cancer and the war on AIDS and so on.

Rubin Naiman: Yeah, yeah, this goes back to this faith in endogenous capacity to heal and the partnership and yeah, medicine has become a war. We fight germs, we go to battle with symptoms, we kill germs. In 1972 the US Congress met and literally – these are the terms they used - they declared war against cancer and cancer is a great example because it's a little bit like a medical Vietnam, its really hard to distinguish who the enemy is…

Dr Dave: Mm hmmm…

Rubin Naiman: …and it turns out that over the years, for example, until recent years we believed basically that germs were terrible. I grew up in an era where everybody was afraid of germs and you were spraying and eating and doing things to get rid of germs, and it turns out that these things we call germs, that many if not most of them are actually incredibly beneficial. They make up a big part of who we are, they line our gut, they're critical to our health, our digestion, they create nutrients and so on. So its not so simple and I think we need to stop shooting at anything that moves in a weird way in our body. This is particularly true in my work around sleep, so many people will go to war with their insomnia, with their

sleeplessness and they're firing 'rounds' of alcohol and pot and sleeping pills, you know, it's like *"Dammit, I'm gonna get this thing!"* it's as if it's an enemy. The reality is that so much of what we call disease is really health that's gone awry and I made the point earlier that often we confuse a sign of endogenous healing with a sign of disease. So, one example is that being up in the middle of the night is not necessarily a symptom of insomnia. We are in a world today where this warring attitude has lead many people to believe that if they wake up to pee at night they have insomnia and that fear, in and of itself, can cause them to spin out cognitively, they get anxious, then they cant get back to sleep and then can lead to insomnia. So I really think we need to come at this in a non-violent way. I sometimes think about what I think of as a dialogical therapy between the body and the mind – if the body is the unconscious mind, often what we're trying to help people do around health is open a conversation - you know, create parity and have a conversation between your mind and your body. For many of us it's about controlling the crap out of the body, right and you know "*We're gonna ride this thing, we're gonna ride it into the ground, we're gonna tame it, we're gonna domesticate it, we're gonna make it do what we want, we're gonna push it, we're gonna cut it short on sleep*", we over discipline the body. But I think good therapy, a good integrative approach to psychotherapy is really about a respecting, a deeper respect for the intelligence in the body and creating an open dialogue, a conversation between what's going on in the body and what's going on in the mind.

Dr Dave: You know what, I think that is a great close for today (both laughs). I was going to invite you to say anything else you wanted to say to wrap it up but I think you just gave us a great wrap up.

Rubin Naiman: Thank you.

Dr Dave: Doctor Rubin Naiman, I want to thank you for being my guest again today on Shrink Rap radio and I do expect to have you back more in the future.

Rubin Naiman: It's been my pleasure, thank you very much.