Discover The Truth About Psychiatric Medications: Healing from Withdrawal with Dr. Josef Transcript

(Transcripts are generated by AI and may contain errors)

Introduction and guest overview

Hello everyone. Welcome to another episode of Take Back My Brain. I'm your host, Laurie Hammer, and today I'm really excited about this episode because as all of you know, I work with the brain and a lot of people come to me on SSRIs or other psychotropic medications or like, how do I get off of this medication?

And you all know that I use amino acid therapy. I'm happy to work with your doctor and stuff, but sometimes you have to do it another way. And because it can be very difficult, and coming off of all these types of different medications, and I have an expert with me today, Doctor Joseph Witte during and he runs a clinic that is very specific to tapering people off of their mood, medications or psychotropic medications.

And so we're going to dive into that today. All the ins, the outs, the good, the bad and the ugly of it all. And so thank you, Doctor Joseph Joseph, for being here today.

Thanks, Laurie. Glad to be here. Great. Well, where is your clinic? So we work in about nine different states at the moment. I'm trying to physically.

I live in Park City, Utah, but we do the big ones California, New York, Florida, Texas, Pennsylvania, new Jersey, Colorado, Georgia, New Mexico. I may have missed some, but if you want to know where we work exactly, you can go to Taper Clinic KGW.com.

And we have a big US map right on the home page with all of the states we're licensed and awesome and so you can work virtually with people from those states?

Yes. Yeah. Okay. I love I love that. So, how did you get into this? Because it's not your typical. Hey, I just want to open up a tapering clinic for people on medication.

Yeah, yeah. Okay. Well, trigger wanting this. Yeah. I mean, yeah, I guess you've sort of introduced it, but you're going to hear a lot of hot takes on psychiatry that you probably have not heard from your doctor in this explanation.

Why psychiatry and tapering needed a different approach

And so I think very early on from going into psychiatric training, I just realized that it just a lot of things just didn't make sense, like right down to like several things, for instance, like the diagnoses, they're they're not valid medical diagnosis in the sense that other ones, you know, whereas, you know, if you, if, if you're diagnosed with Parkinson's, you know, that there's an underlying biological problem that symptoms that we use in the clinical diagnosis make sense.

And then they sort of stem from the underlying pot that's allergy. But with something just like depression for instance, all of the symptoms that are quite arbitrary that were just voted on by people, there's no underlying, biological problem.

A lot of them have been proposed like a chemical imbalance or, or different problems, but they never really map out. And that's why in psychiatry we don't use any laboratory tests because there's there's nothing that ties the diagnoses together.

And so I didn't like that. I didn't like that the diagnoses, well, were weren't valid in that way. But I'm okay with that. I mean, let's say we just don't know what the underlying cause is.

We could just use them, and it's useful. It's a good way of understanding of of maybe just labeling people who need help. But the other problem I had was that the way we often talked about them was as if there was a well understood biological problem.

We like whether these these were serious medical conditions. And, you know, it was like I, you know, depression is like diabetes and, and you need to go to your doctor to get help.

And so that that felt off to me. And then on top of that, we had a tendency to say the drugs were a lot safer than they were. We I constantly hear people saying, you know, anti-depressants, they're safe and effective.

And but they would leave out all of these caveats, like, yeah, for the two months that we studied them for there was safe and effective media and duration of antidepressant use is two years now.

And we've got something like, I don't know, like 15% of the population taking them. And, and so there were so many ways that I was being taught about what mental illness was and how the drugs worked and how how useful they were.

That didn't sit right with me. And then the more I looked, the more I realized that, that that I actually think most but us so a lot of psychiatrists and I think a lot of doctors are practicing with a model that harms people.

And so I wanted to help people come off this. It's a lot to unpack. So that's that's where I landed. Yeah. Yeah, yeah. If you're going to poke the bear so we might get some good comments.

Yeah, yeah, yeah. You and I understand what you're saying because I was, I was in nursing school and I went to nursing school because I wanted to get into psychiatric nursing, and, because it fascinated me.

And we just had some things in our family. I'm like, that's kind of the route that I want to go. And I got into, like, you know, my psychiatric nursing clinical and I'm like, I am just going to be a pill pusher.

And there really is no solution here for these for these patients other than, you know, we're just put them on this med, we're going to tell them, well, I don't know how long you have to be on it, maybe for life.

And then nothing's really they're there to help them. And it just seemed very arbitrary and not good medical practice to me. So I understand what you're saying.

I went the nutrition route. You went a little bit different route, but, like, I get where you're so kind of poking the bear. Well, I mean, the gosh. And, you know, the more I it's like, marinated in being a psychiatrist in the 21st century, the more I realize that there are a lot of influences out there that push us to look at mental illness in a certain way and treat it in a certain way.

For instance, you know, going going back to depression, which is the the big one, the one that most, that that most people are diagnosed with out of the psychiatric conditions.

It's multifactorial, you know, so it's like, you know, you could have traumatic experiences or you could have, you know, some personality, some personality things that, that, that just make you struggle at work or in your relationships.

And, sure, maybe there is an underlying biological component that people haven't identified yet. You know, that the possibility is there. And we acknowledge these things.

But the reality of how most people are treated today is that they go and see doctors, and they have very short visits. The doctors don't really get to know them very well.

Sometimes they only diagnose them with scales that people fill out in the waiting room, and then they get put on medications and told to come back. And usually they're given a biological explanation for what's going on.

Hey, you know, we don't really know why the depression happens, but maybe it has something to do with some underlying chemical imbalance and the drug safe and effective.

And the reason that people get told that about the psychiatric conditions is pretty much, you know, the way I say it is, it's it's expedient for health care.

It allows people to be treated in short, 15 minute visits where people don't really have to get to know them that well, because that's not scalable. It's expedient.

Well, it's it's good for a drug company, for people to see depression and these problems as biological as they can, prescribed medications for it. And it kind of supports their way of helping people.

And gosh, the the big, the big, you know, ten had a conspiracy thing that I'm going to say now is I also think it's, it's it's helpful politically as well, because I do think a lot of the reasons why people are unhappy come from very valid problems that are happening in the world.

And if you just say, oh my God, depression is on the rise, you know, this, this thing and it's probably biological.

How psychiatric medications work and their long-term effects

You don't have to talk about, I don't know, inequality and the problems of poverty and the tax structure and how like it's, inflation and all of these problems that really actually trickle down to normal people and make them happy.

You just sweep it under the rug and just say, you might have a chemical imbalance. And if it weren't, we got we got something for that. So I think there's a lot of reasons that push us to look at mental illness as biological and fix for the pill, and it's not helpful for people.

It actually makes them sicker in the long run. A lot of them. Yeah. Now. And I see that all the time. So I mean, my demographic that comes into my office, you know, are mainly women and gosh, you know, these meds have been around for, what, since the late 80s, early 90s.

And some of them have been on since the 90s, 2000, you know, so they've been on these medications for a couple of decades. And now, I mean, they feel rotten, right?

They feel like it's it's just everything's just gotten worse. Their hormones are worse. This but this and that, and nobody's checking anything else. They're just leaving them on the medication, you know?

And then we check, you know, the thyroid or their hormone imbalances. And there is an underlying cause that's not related to anxiety, depression. I mean, those imbalances are triggering probably some of that.

And when we fix them and they're off the meds, they feel fantastic. But nobody ever check those things for them to start with. I mean, it's not just a set of arbitrary symptoms that don't mean anything, and then we just give them, I feel like an arbitrary diagnosis.

And so I give a lot of women. My point is that a lot of women that come into the into my office, they're like, I just don't feel like I've been heard, like I still have the same issues I had.

And, I in my life kind of sucks right now. And, you know, it's been 20 years and I really want something different. And it's just it's it makes me really, really sad, that people have to live this way when they're.

There's definitely a better way. Yeah. And you and you raise a good point that that we, we actually have, I think, deteriorated in the quality of care that we give to people coming in and reporting depressive symptoms, because a lot of the times depressive symptoms aren't stemming from some underlying unknown biological problem or even life stressors.

I mean, it can be things like autoimmune problems. It can be diet. I the because I now work in a clinic where we just take people off meds. I mean, I see people all the time who are like, I was on medications for two decades and I had to act.

And then I did a ketogenic anti-inflammatory diet, and I felt better. And now I want to come off my meds because I don't need them and my mood is under control.

And we just, we we and it's not always diet. I just bring it up as an example because it's something that's diminished in the in the medical system is not being real medicine.

A lot of the times. So so I bring that up as it's overlooked. But we see people with sleep apnea that gets overlooked, autoimmune conditions get overlooked, and you treat those things and people go, oh, I'm not depressed.

Well, you never had depression in the first place. You had a medical problem, right? Right. Yeah. And and because you just saw someone for, you know, 15 minutes and they were looking at your cholesterol and your blood pressure and filling out something for your insurance company.

You know, no one ever took the time to really work you up and understand, what was going on. Yeah. And sometimes it's do people get depressed? Anxious? Yes. They do. Like you were talking earlier.

I mean, we just shut the country down for two years. That's going to make people, you know, sad, depressed, anxious, those kind of things. And so a medication doesn't fix that.

You know, there's other things that we that we have to deal with. And I would love for you to talk about, like, the long term side effects of these medications.

It what is it doing to people's bodies, to their mind, to their health in the long run? Yeah, yeah. So let's, let's let's start by talking about what, what the drugs actually do.

And I think I'd like to talk about depression because it's the one that's most relatable to people. But this holds true for schizophrenia and bipolar and and any of the other ones. So, A lot of people were told incorrectly that these drugs were fixing an underlying problem in their brain.

They said depression is due to low serotonin. This Prozac will increase your serotonin and you'll be better. And it's this idea of the condition being like diabetes, where there's this well understood pathological process that we're intervening in with, very, you know, targeted intervention that's going to correct it.

And all of the problems that that that person is having flowed from that pathology, which we can now fix. And you don't even need to think about it. It's just like insulin for diabetes.

You just give it to them and everything's done. Everything's good. Yeah, yeah. That is not how psychiatric drugs work. There's no underlying chemical imbalance.

And so the best way to understand what they do is that they have drug effects just like alcohol or nicotine. And but they're more stable, right. And because these are longer acting drugs, they stay in your system and they and they modify your mood.

These effects can vary in people. But if we were talking about SSRI rise, which is really common, like Prozac and Lexapro, they tend to be mostly mood, mostly numbing and a little bit stimulating as well.

That's the effect. And so, that and that could be very therapeutic if someone is having a high level of anxiety and you just turn the volume down on that, they can actually experience, that is very helpful and therapeutic, and they can improve in their function.

Another drug that people take is Wellbutrin. That's an antidepressant that people find as being more stimulating and motivating and gives you more get up and go.

So all of these drugs, they have a signature drug effect, right? And that's that's what happens. So now when we talk about long term effects, well, one of the, one of the let's, let's say this one, one of the problems with psychiatric drugs is your body and your brain.

But I don't like them. So these neurotransmitter systems like serotonin and then such that then they're not just these tiny chemicals that change our mood and our anxiety.

I mean, they're involved in how our heart beats and how we digest food and even our immune system. And so when you start taking drugs, that throws off those systems, and that's what the drugs do.

They modulate in neurotransmitter systems. You've disrupted numerous physiological processes in your body, and your body doesn't like that. So it sends signals up to the brain to say, hey, we need you to, change the structure of your neurons to adapt to this, to keep us back in balance.

And so over time, multiple things can happen. And I've seen all of this. We have some people who never fully adapt to the drug, and they just get that nice therapeutic drug effect for a long time, and that's just great for them.

I have a lot of people who adapt to them, and the drug just doesn't do anything. After a period of time, they go, I have no idea what this thing is doing anymore.

Maybe I'm having some side effects, but I don't really know. And then for some people, just making them worse, they develop a condition called Todd of dysphoria where they just feel slight and apathetic and they're just like, I don't really know what this is.

It's it just it just feels like a different kind of depression. And, and they genuinely been made worse by the drug. And often that's misdiagnosed. And they get and they get on more things.

And so the when it comes to long term psychiatric drug use, the one thing that I like to tell people is like, you don't know what's going to happen long term because we don't know how your brain is, is going to do on this drug after a long period of time.

So that's the one risk then that it could stop working or it could make you worse in the long run. But the other thing that I think is it's hard to even call it a side effect because it is the drug's effect.

But let's say, for instance, you're taking Prozac and there's something about it that's emotionally constricting. That's just not helping you in one area, in one defined area that's having global effects for you.

And so maybe being emotionally attachment was helpful in your relationships. Maybe it made you more, observant of what's happening with your children or with your spouse.

And now that's been turned down some. And that's having a detrimental effect is how you it's having some collateral damage. Yes, it helped you in one area, but it's also taken away from you and in another.

And so you want to be mindful about how the drug is affecting you globally. And then I mean, there's a whole range of other things, but I'll talk about the most important side effects.

I mean, with anti-depressants, this weight gain as well, that that tends to be an issue. And this is not just a it doesn't just make people crave foods you can't like think yourself out of the way again.

I mean, these drugs change your your basal metabolic rate. So you just accumulate, more weight and, and so they do and they do a number of things there.

But this but there's a couple rare ones which we really worry about this, this SSD, this is uncommon. This is likely to not happen to anyone listening.

But this this is something that I see a lot. Some people develop persistent sexual dysfunction even when they come off the drug. And that is clearly devastating.

That's now recognized by most major health authorities. It's written about in the drug labels. And the other thing that we really worry about with the drugs is something called protracted withdrawal.

And this is a neurological injury that happens when people come off the drugs too quickly. It doesn't happen to to everyone. In fact, it's quite an uncommon thing to happen.

But in a small group of people that come off the medications too quickly, they start to develop neuropathy like burning in their hands and feet here ringing.

And then there's persistent anxiety. And that can be that could be really bad. Yeah. Absolutely. Yeah. So when those things are happening to people like what's the next steps for them to do.

So like with this protective, you know, disorder. What do you do with that? So the good thing about protracted withdrawal is it just gets better over time.

You could consider it to be like, like a nervous system for us. There was something about coming off the drug too quickly that shocked your system. And so time you just you wait it out, and and and the vast majority of people, it goes away completely or near complete.

Completely. But it does. It can take a couple of years and it's really can be quite disabling. And then a lot of people, once that happens, they want to get off the drugs. But you have to do it safely.

And so you have to do this gradual tapers so you can bring the drug out of your system without irritating your nervous system again.

Withdrawal, liquid tapering, and safe dose reductions

Right when I was watching your videos, you do what sounds very unique because I've never heard anybody else do this. You know, as you're tapering, you actually you will even help people to taper with, with drops like you liquefy the medication and do all sorts of amazing things that I have honestly never, never had a doc do with any of my clients over the years.

So can you can you speak to that? Yes. So, so we we sometimes use liquid formulations to type of people because as you get to the lower doses of the drug, they tend to be the it tends to be really hard to get off, without triggering withdrawal.

There's, there's there's something about the way, psychiatric drugs in particular bind to receptors where when you're on very high doses, it's really easy to make large to, to make reductions.

But when you get to low doses, it's like the drug is less sticky. And so if you're at a low dose and you remove a little bit, it can trigger, quite a severe withdrawal, even though it feels like you're only taking away a little, it just it has a big change at the receptor.

And so to get around that, and so what people do sometimes is they try to taper with tablets and they'll get like a pill splitter. And you can only really accurately split a pill into a quarter before it.

It gets a little bit fiddly. But some people will find that even when they drop a quarter of the tablet, especially at the low dose, it causes a flare up of withdrawal symptoms.

And then they kind of get stuck there. Yeah. So what we do is we get the drug and we turn it into, liquid. And then, you know, we use a set concentration and then we start to use syringes.

And there's a lot of precision when you use syringes, because there's all these little markings on the side. And then that allows us to lower the drug, quite precisely, especially at those low ranges.

And that just helps people kind of bust through plateaus. And maybe they stalled out at a low dose, but once they're doing smaller reductions, their body can compensate for the drug being removed.

And so we call that, liquid liquid tapering. Okay. How do you determine how fast a person can taper? I'm assuming it depends on the drug for one, or how long the person has been on the drug.

Yeah. So the other way I do it is it's to prevent, withdrawal. Well, the main thing is to prevent a protracted withdrawal, right. But the other thing is to keep people functioning.

And so I would say when you type of someone, you want them to be having mild withdrawal symptoms because the mild withdrawal symptoms, the tolerable ones, they're they are what is triggering the brain to regrow all the receptors that have kind of down regulated.

That was like saying and how do we know that things are regrowing. Yeah. Yeah. So so we want people to have mild withdrawal symptoms because that's going to trigger that that regrowth.

But it's also going to allow them to maintain their level of functioning. And so what I have people do in my practice is they complete a diary. So after they do a reduction we'll track their symptoms and we make sure that they're only having mild withdrawal symptoms.

And then, and then we just keep on going. And if anything ever goes, if it starts ticking up, it starts to impair that impact their life. We say, okay, we're going to quickly and we cut the write down.

And so each write is completely determined by the person doing the taper. Okay. That makes sense. What's the most difficult class of drugs to come off of?

SSRI is sort of like a Prozac. Lexapro and such the size is 12, so that's like a vaccine. And, you know, caustic. And then, benzodiazepines that those.

So two antidepressants and benzodiazepines are hard. It's not to say that antipsychotics and mood stabilizers, challenging as well, but they just don't seem from my experience, they just don't seem to be as challenging as SSRI is.

And benzos. Yeah. Those are those can be super challenging. Especially. It depends on the one like Prozac. Do you ever do like that Prozac bridge? I've had people use that, like if they're going off save effects or they'll put them on Prozac and then they taper from the Prozac.

Their, I, I've seen a lot of people do that in my practice. We generally try and type of people on the drug that their brain currently is used to. But but that's definitely a strategy that we've seen people use.

And yeah, it can be a useful one and an effective one sometimes. Yeah, I've seen it be effective, not all the time, but I was curious that something you use.

Yeah. So if people are coming off of their meds, their brain is healing. Do you find that people have sort of a level of fear in coming off their medications, or are the people that you're working with they're like, yes, we're ready.

Because I know it's kind of like the unknown. What's it going to be like? Because if you've been on that med for 20 years, what's life going to be like off the medication? And so how do you kind of help people through maybe some of that thought process?

Well, it really a lot of it really depends about why they were on the meds in the first place. I mean, we may have some people who hey, you know, ten years ago I moved down and the doctor just I was depressed and the doctor put me on the meds.

But now I've got a great life, I'm doing well and I have just been refilling it, but I don't really think I'm depressed. And and they're doing pretty good.

That person's usually not that scared about coming off.

Who struggles most with tapering and how to support recovery

They feel well supported that I'm not really sure what are they needed in the first place. And you just go slowly and and they come off. But we had some people who had very legitimate psych, symptoms, you know, they they had trauma histories.

They were on the medications for legitimate reasons and for whatever reason. Now they they can't be on the medication or they've just decided it's not worth it.

And that can be a little daunting because now now you're taking off the medication, but you're also trying to help the person, cope with non-drug, non-drug means.

And, and really, you cannot predict what's going to happen. I mean, some people like, they've just through maturity and the passage of time and the supports that they have, they're able to cope without the meds.

But some people need a lot of support and. Yeah. And you just have to be with them as you slowly wean them off and just see where things lay. I mean, in our program, we like to have people do an anti-inflammatory ketogenic diet and we just try and bolster them up and make them as healthy mentally as possible with non-drug means while they calm down.

But it is unpredictable. And we do have some people who are who under this about coming off. And we just tell them we're in the trenches with them and whatever happens, we'll figure it out with them.

And as they go down and clearly they're coming to you because they want to. So they're ready, which is, you know what? You have to be. So not like you're forcing people off the medication.

So you work a lot with the ketogenic diet as your diet, as you're tapering people. So it's something that we suggest to people just because we've seen, a lot of people have sometimes dramatic improvements with it.

But, but we've also tapered people who can smoke and eat McDonald's all day. And it's still and that still works as well. It so like for some people it will be the thing that makes a huge difference.

But for others it'll just generally make them feel more healthy. And but I recommend that everyone try it, especially if it's unclear where their symptoms are coming from.

Like, it doesn't really make sense that it's anchored in contextual stresses in their life or something else. It's like, hey, maybe it's your diet. And it's it's definitely worth looking into, right?

So have you discovered, like any specific consistent root causes for people? Like do you see a pattern like if somebody you know is on an SSRI, you know, do they have a specific level of toxicity or do they have like women?

Do you see that? Maybe they all have hormone issues. Do you see a pattern of any kind? Let me see. So I work with a lot of people who are on sedatives.

So I, I have people who have, like, work stress and anxieties. I also have a lot of just, I mean, and then I have some really sad cases. I mean, I have people who lose children.

And then in the aftermath of losing kids, they, you know, they they got on meds and then the meds turned on them. I. You know, I this is awful, but I have a lot of women at the moment who will put on sedatives for perimenopausal insomnia.

And then that kind of turned on them. Yeah. And, that's really unfortunate because, you know, there's other hormonal ways that they could have created that they could have got a different route instead of putting them on Xanax.

A and I want to know your thoughts. Why do you think that happens? Because, you know, I have a lot of women that come to me in similar situation, and they're like, they really didn't feel like they're being heard.

They're like, here, just take this med because you're just kind of crazy at this point in time in your life. And it's normal to feel this way. Because it's expedient.

And this is why I think it's done. You know, people come into the office and they go, oh, man, you know, I'm having insomnia. What should I do? And and it takes time to say, well, let me just really understand what's going on.

This is really normal. This is scary. Or maybe even just to do the referral, to hey, go, go and see, hormonal, hormonal, ObGyn someone that might understand that better.

And here's this referral. It's, it's very easy just to say, oh, well, you know, just, just you could take this this this will help. And, you know, see, you light it, you get them out the door and in the 15 minutes, it's just faster.

Yeah, yeah. You know, it's just expedient. Health care isn't always efficient. So. Or it seems efficient, but it's not efficient for the patient. So. Well you know, one of the things that it's so interesting like the incentives because I look at, Medicare reimbursement for psychiatrists and, you so there's different codes for like a 15 minute visit versus like a 25 minute visit versus like a, a visit with psychotherapy.

And, and, you know, I must make a double, like, so if you were to spend an hour as a psychiatrist now meeting with someone and doing psychotherapy as opposed to saying for people and doing, the, you know, med management visits, you'd make half as much.

And so there are incentives baked into insurance reimbursement that, that make doctors and healthcare systems want to see more people in less time. And so there's also that, that going on that.

Right, that that leads to it. Yeah. Yeah. I know my you have to follow the trail of money right. Yeah. Yeah yeah, yeah. Unfortunately if there is, you know, like three things that you would want my listeners to know, what would they be.

Yeah. So the first one is if, you go slowly when you go off medications, don't ever type, faster than, than than you can handle. That will, you know, you want to be functional while you're tapering.

Don't just rip it off and then kind of just grit and bear that that's a bad thing to do. It really shocks your brain. Go and go and go and see someone who spends time with you.

Gosh.

Patient stories, clinic mission, and closing remarks

You know, if you're having a lot of anxiety and depression and you feel like no one ever took the time to hear your life story and look at other, other non-drug ways of helping you, I mean, you might have some psychological things that, that, that, that you could look at and that could be that could be really helpful for you in the long run.

You may have medical problems that people have simply missed. Don't don't don't settle for, someone seeing you in 15 minutes and just say, hey, you know, let's kind of bump the dose that that's not good health care.

And so find someone who spends time with you and. Gosh, I can't think of. I can't think of number three right now. Invest back to me on that one. That's fine.

So yeah, one of your favorite stories you know, of a patient that you've had that you've helped. Or two of them. What's your favorite. Let me see. Okay.

Well, I mean, I, I mean, this isn't representative, but this had this does happen sometimes. I mean, we we've had, you know, we we've had people who've been on meds for like, 15 years and suicidal in and out of hospital, and they change their diet.

Not with us. Before they came to us, they did it on their own. And then they're just they they tell us that I don't need to be on these meds anymore. And they're on multiple antidepressants and antipsychotics.

So we've seen that multiple times, which is just mind blowing. Because you think about the trajectory of someone's life and how how different it would be, you know, chronically mentally ill, in and out of hospital to just healthy, not needing meds.

Their mind is working again and they're ready to go. Those ghost stories, miraculous. But the other really satisfying ones. And this is really nice, just to like, I work with people who have been cognitively destroyed by the drugs, and so they're quite hurt.

And that's quite a grind them. And you just work with them and their families. Sometimes years while they slowly recover. And now and they all do. And that's really rewarding just to have people kind of come back together, regain their health and move on with their lives.

Yeah. Oh that's amazing. Amazing. You're doing such an amazing work. We need we need more of you around the country. So I hopefully you are training other psychiatrists to do the same things that you're doing yourself.

We are we we are training people at the moment, which is, which is great. We're we're we're expanding and we're training people. And I love it. Right.

So if you're listening to this and you're like, oh, I want to, I want to do this work, you know, make sure you contact that yourself here because this is this is so good.

So, this has been a great conversation. I, I admire your work, I respect your work, and I appreciate all that you're doing for the world. And, any parting words you want to leave the audience with?

No, thank. Just just thank you for having me, and I. I love talking about this. If you want to find me, Doctor Yosef on YouTube, but it's spelt in the German way, so it's, Joseph.

And I go by the doctor. Yosef. What type of clinic? We're on all social media platforms. So, if you want to learn more about me, that's where you can find me.

Perfect. I'll. That will be in the show notes to for people to to click on. So, thank you. Thank you very much for being on today. I appreciate it very much.

Thanks for having me. All right. And everybody else, thank you for listening. Make sure you share this podcast because I know you know someone that needs this information.

So make sure you like, subscribe and share and I will see you in the next episode.