Integrative Pediatrics: A New Path for Autism, ADHD, and Chronic Illness Transcript

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Introduction and podcast welcome

Typically, the person that is most affected is the one who's kind of really trying to break free in some ways from this kind intergenerational pattern.

And it's not easy. I recently spoke to Dr. Adele LaFran and she says one of the first things she does with families is also then to dump this whole like parent shaming, like parents feeling shame about like, oh, it is all the mom's fault or it all parents' fault.

That's actually not what this is about either. So she's like, that's the first thing she tries to bet to bed is that this not even what we're talking about, but we are looking at everything that is in play that caused the kid, the adult, whatever, to have this type of mental health expression.

Welcome to the Two Curies in the Podcast. I'm Dr. Ali Ahmed. And I am Dr Surya Rapan. In this podcast, we are asking the unasked questions. We're physicians applying the lens of narrative medicine, exploring integrative practices and psychedelic treatment and health.

Together with our guests, We weave new learnings through stories, expertise and the sciences. Let's dive in. Hello and welcome to the Two Curious MDs podcast.

You're here today with me, Dr. Surya and Dr Aliyah Ahmed and today we're both interviewing Dr Leila Contractor. Welcome Leilah. Leilah is a double board certified integrative child adolescent and adult psychiatrist with a practice in Irvine, California.

Dr. Contractoru2019s background and integrative psychiatry journey

She specializes in trauma, learning challenges, ADHD, autism, and post-injury recovery in athletes. She's also known for her work with ketamine and other psychedelics and her focus on holistic treatments and cutting edge psychiatry to maximize wellness.

Some key aspects that we're going to go over today is your integrative approach using a holistic collaborative care model. You work closely with therapists and other practitioners to address the root cause of challenges.

Now you specialize in trauma, learning challenges, ADHD, autism, and post-injury recovery in athletes. And as we've gotten to know you, we know that you emphasize listening to your patients and validating their concerns, drawing on your ancestral influences on you approach.

And we're really going to get to that as well. Welcome, Leila, to the Two Curious MDs podcast. Thanks for having me, guys. I just love hearing your background.

It really speaks volumes about who you are as a person. And I'm curious to know about the layering, the richness of your experience and how you've kind of come together from this traditional way of psychiatry to this integrative and even the psychedelic healing aspects of the type of care that you provide.

What inspired you to do this? evolution in your clinical path. I think like many people my own personal journey really brought about this transformation and so I had been working for Kaiser for a number of years which is super helpful as far as seeing the sheer volume of patients that I was seeing and what I kept seeing time and again.

So I'd come there with some pretty significant training in working with people who are suicidal and trauma. And so

as soon as I got there, I started getting all these patients who had experienced terrible traumas in their life.

But I kept telling the staff, medicine does not, our medication, like the dirty secret in psychiatry is medication. really doesn't treat trauma. Like you truly need therapy, as in traditional medications.

I'm not talking about ketamine and psychedelics, of course. So that started kind of this process of trying to get more support, more help. for patients and then as things went along, I had a pretty, you know, a patient burden that was, people had experienced significant traumas and I got physically really ill and couldn't work for over two and a half years and nobody could really figure out what was going on with me.

They could see that I was having clearly some pretty significant neurological problems. I met some great doctors. I meet some awful doctors along my journey.

And one day I posted on Physician Mommy Group on Facebook, like everything. All my labs, all my imaging, and quietly I was getting direct messages from integrative medicine doctors that are like, look, you're probably not going to find your answers through a traditional meta set.

I met some amazing people who just really led me then to Dr. Kelly McCann, who's here locally. And I begrudgingly went. I went there, I meet her after waiting months to see her, and I thought it was crap.

It was like way too expensive. Then I kept getting progressively worse to the point where I actually couldn't really get out of bed. And one day one of these women said, I don't know how much worse this could get.

Why don' you just try the herbal thing that she's recommending? Like, what do you have to lose? And I'm like, she is right. And so I tried it and it worked.

It actually halted the progression of the process that was going on. And so that had my attention. That's how I got into getting interested into integrative medicine.

I kind of slowly started finding my way back to health. It was in that process then I started becoming curious for my own patients, like how could my patients be helped.

So I went and did a year-long fellowship in integrate of psychiatry. And so that started my interest to finding other ways, because what I kept seeing time and again, too, is our medicine.

And again I'm not, I feel like I have a balance. There's definitely a place for traditional medications where people need help and support, and yet it truly doesn't often address kind of the root of what's going on, what made somebody unwell.

in the first place. And I often also started seeing that being unwell isn't necessarily an illness. It can be your body screaming that something drastically has to change or something needs to be different.

So that's how I started like that path, and then I felt like I couldn't practice in the way I wanted to at Kaiser, so I started my own private practice with the hopes of offering these type of healing modalities to my patients.

It's quite a journey to go from the work that you did and were doing at the time, the recognition of that idea of trauma, that trauma-informed process, right, addressing that, which is often not discussed in, you know, in conventional treatments, like to the source of a condition, and then your own journey, which sounded like you had to really take time out and investigate and, you know, become really much more aware.

And, even presenting this out of frustration on Facebook, I can't even imagine what that process must have felt like, to kind of really dispel this, out there and receiving the answers that sometimes we need to have when we think out-of-the-box, right?

When you have to step out Usual mindset and I know we met at the integrative medicine psychiatry conference

and that was really impressed by Your voice your journey you've described yourself in your in Your work as a good girl to a wild woman healer and i'm very curious about that.

I think you said that But what is what does that transformation mean to you? going from this usual way of doing things to this really out-of-the-box, really stepping out of the zone and that transformation.

How do you take that as you engage with it in your practice now for yourself as well as for your patients? I mean, to be fair, so my family is from India.

And so I was always, and I had been, you know, pursuing yoga. My uncle was a homeopath in London. I'm always open to other modalities of treatment.

Trauma, medication limits, and the move to private practice

I always look to other cultures and modalities for healing, because I don't think any one field of medicine has a monopoly, per se, in healing. But what I really came to see is, especially when we look at antidepressants, there's a curious phenomenon in training that we would see, is that there are these women in domestic violence shelters, really, obviously, very unsafe situations.

they would come there kind of motivated to leave, highly depressed and anxious as anybody would be fleeing a situation like that. We'd start on an antidepressants and you'd started seeing the motivation to lead these dangerous situations.

You know, psychiatrically they were less depressed. And yet I couldn't help but wonder like, was this a real, were we doing these women a service? by actually containing the trauma, containing their mood symptoms, only to have them return to what we would know would be a very unsafe environment and untenable, not just for them but for their children.

And so this is what started me to even see with my own patients There's a phrase that, so after I did the year-long training with integrative psychiatry, I then did Dr.

Gabor-Mattei's year long training in compassion inquiry, which is his type of psychotherapy. And I've really come to see that I think in medicine we go where we really try to help people with their suffering and their pain and minimizing it.

I come see, that's not always helpful. It's that we want people to suffer. But there is a gift or there can be a give in helping people walk through their suffering and finding meaning in that.

Because what I saw with what was happening with these women was this is not what i wanted my antidepressants to do. I wanted it to empower them and help them to move and oftentimes it does.

I'm giving kind of a more general picture, but sometimes we have to be able to hold our patients, and you guys do this so well right through this kind trial by fire, ring of fire.

Whatever you want to call it, to come out on the other side much more empowered and much being able find their voice. And that isn't always the easiest way through it.

It isn' t for everybody. I think there is something to say that sometimes it isn t the right place or the time. to be able to move through this. Like, I don't think I could have gone through what I went through while I was, you know, pregnant with my kids or even honestly while i was in med school.

This, taking two and a half years off during medical school wouldn't have really worked that well. Yeah, I find that there's a moment of timing that I've started to realize is the body somehow carries it until, you know, carries the trauma until a time where it's actually safe enough or circumstances push us to the wall enough to kind of break it down.

And I typically see this as like people are like, oh no, I had a happy childhood. Everything was fine. I struggled to get my career on the way and now everything is fine, why is it now happening?

There's something happening underlying in our psyche that says, okay, you can handle this now. There is some sort of inner knowing. Do you think that's that something you see?

Yeah, definitely. And I think I'm talking about women, but in my practice, I started seeing this with men too. Again, in their 40s, can typically not always come from a background that could have been very traumatic, But they had a lot of resilience, and they were holding it all together, And all of a sudden, like the bottom, tends to fall out and they're not functioning and it's like your body just can't hold this anymore.

Yeah. And to recognize that as a portal, like you said, it's a ring of fire. It's an opening. How do you frame this for your patients? I know you've moved now from symptom management to a deeper soul level healing.

So how do even address this aspect? It depends on people's circumstances. I have people, you know, if you come in you're, excuse me, sorry. No, wrong, please.

Sorry. We'll have to delete that part out of our podcast. That's a good thing about recordings. Let me do any care of it. I'll be right back. Oh, right.

Yeah. She left. No, it's fine. Ethically speaking, I really need to assess where people are at, right? So if you have a family and people to support, and I have people coming in, so I've a lot of people come in saying they want to work with psychedelics.

I think ethically, I often have to assess, like, what is appropriate? So somebody who may come in, again, family, they have all these employees under them, you know, other financial commitments, that, and you can see that the bottom has fallen out for them.

That may not be an appropriate time. to do psychedelics. And so for people like that, I will still use conventional treatment, but while supporting them and normalizing really the process that they're going through, have a lot of relationships with various therapists.

So connecting them with the right therapist, just make sure that the therapist is helping them support. If they don't want to have therapist then it's something that I work with them And so in a case like that, I will start them in antidepressants.

I can't let them have the bottom fall out, them sell off their company, move to Mexico. And, you know, that's just like not an option. Those are some of the patients that I have.

Once they're in place where there's much more stability, an insight into what's going on, okay, then that's the time to bring in. And that is the beauty of ketamine.

That my patients can still be on an antidepressant and access those type of medicines. But I also actually get a lot of young adults. who are financially resourced.

And in those cases, I would have to say, you know, still connect them with therapists if they don't already have one, or they work with me. In those case, s I help them walk through that.

Then we do psychedelic work. But I'm having an interesting rash of young adults, too, who I think are really have an inner knowing that medication is not the way to go.

That medication cover up what's coming out for them and needs to come out from them. And I find this really interesting. I have some who are be like, man, you really need to get on something.

Like you are not able to function. They're like nope. like they want to work through this. they wanna work though

what has been coming up for that. and I actually think that's you're able do that and if you in a place to do.

That's actually in the long run, the way out. Yeah. I love how this is reframing for us that psychedelics don't just need to be for the treatment resistant cohort, right?

Like that's what we're seeing the research being done on is treatment-resistant. You've burned out on every medication, but now I'm hearing from you that maybe there is a place, if somebody is supported, has the right story around it, it has a right construct around And it won't be too destabilizing that you don't have to try the medications, maybe do the psychedelic healing.

And now we're seeing that there are young adults who really are feeling like they don' want to go on conventional medications.

Scapegoating, family systems, and validating patients

a space here for them. Yeah, and so I came from a background of, I mean I worked at a clinic with Dr. David Brunt with suicidal adolescents. Dr Brant has done a lot of the pioneering research in suicidality in teens.

And what I saw repeatedly is what we call in psychiatry treatment resistant depression. And again, I wanna preface this with I have another colleague, Dr.

Lisa Pan, who's doing phenomenal psychogenomic work and feel truly treatment-resistant. Like people are not making enough serotonin. People have really significant deficits in their ability to produce neurotransmitters that we need to even just survive.

So I'm not talking about those people. I'm talking about what I see are like the 95 plus percent rest that we are labeling as treatment resistant depression.

It is not, it is trauma. Like these people like every story and that's what the gift that Kaiser gave me is just seeing like all these People failing one, two, three, however many psychiatric medications is because our meds are not meant to treat trauma They don't.

And these are the young adults that I'm talking about. It's not that they're, again, even treatment resistant. They're just, our meds don' t treat trauma.

Our conventional medications don t. They can help contain trauma, they can kind of help calm things down. Certainly, we all could use that at different points in time, and I certainly access psychiatric med for those reasons.

But really, I've come to see that treatment resistant depression, we see it's all, it is all trauma. And by the time you get to your third antidepressant, you're abutting at like 13%. That's actually worse than placebo.

True. You mentioned that the STAR-D trial, I mean, that definitely demonstrates that. I want to interject here because you said something earlier, which I thought was very important.

We talked about gobromate, and you're talking about trauma. And what he, you know, trauma isn't what happened to you, it happened, what is what happen after, right?

What was not, provided the resourcing, the support around that active trauma. And in adolescence and young adults, most of trauma occurs really early in life.

Then we see the filtration of that effect later in adulthood, which to me surprised me when in my own practice, like as a pediatrician, I'm like, oh my God, all these things were happening.

at that time that this child was being seen. And we're now seeing the effect of that in adult. But back to this idea of trauma and the work of Garbamate as you described in your training as the compassionate inquiry, providing that

place of safety in you care.

How do you first, how do get to that, in that compassionate in inquiry lens, in your practice to really help facilitate that root cause? What is that approach that you provide in the interactions you have with your young adults or these challenging, complex patients who have come to you now after being trying so many things?

Yeah, so I think, you know, I'm going to step back just a little bit. We often think of trauma as like this one big event, like one that happened and what I saw at Kaiser and when I'm actually really seeing here in my private practice is really what is more like, you know, death by a thousand cuts.

And it's really probably more pervasive than we think is like this real trauma of neglect. And it's often unintentional. We have parents who are doing their best.

Parents are often struggling with their own trauma and the way that they see things. And so I mean, I've worked in some pretty, you know, places that have a lot of economic and housing instability.

You know I was in Pittsburgh. I worked and places with government subsidized housing. Same thing in Philadelphia. Actually same thing. Worked in East LA.

South Central kind of Compton catchment area at Kaiser. And I would have to tell you, the type of neglect that I see amongst the wealthy is probably the worst I've ever seen.

I only say this because it can be just as impactful, if not worse, than the big thing that happens, a big horrible thing happens. It's often missed, and again, it's subtle, especially in people who are financially resource.

What could you have possibly wanted? You had nannies, you had roof over your head. You went to the best schools possible. What was there? But it's almost worse because it can be covered up.

And I think that's what I'm seeing more and more. It's not the big egregious stuff, and it could be too. that as well. So the most important thing I feel I can offer patients is just being seen.

And that sounds very simple or silly or almost too good to be true. But that's what people need to validated and seen for what they've been through because this is the message that they're getting, right?

Even to themselves. I do it to myself. I felt like my story couldn't compare to anything I'd heard time and again from all my patients and the horrific things that they had to endure.

But really, people being seen and having their story validated, which is what's amazing about the narrative work that both of you do. is so important and I can't emphasize it enough.

So the first thing is really listening, spending that time. My evals tend to be 90 minutes and then even as we keep going, remembering what people have to say about what they've had to go, showing the discrepancy really between what the feel is nothing and yet how is it impacting their ability So one of the first things you can do is just really validate and listen to people's stories as simple as it sounds.

And I think that in so many ways is kind of, the most effective tool. Yeah, we call it the radical listening aspect, just kind of really just being present in that space.

And we've talked about this in narrative medicine, that third space between the patient and the provider or the healer. There's that 3rd space, which is also just as valuable because you're unfolding, the patients is kind revealing, and then there's this understanding of that.

processing that's happening while that is happening. While somebody is revealing their story and you're attentive to it, you can attend to even the language, the tone, that pause between the words.

And that itself is so revealing and opens up again that that third space. You're talking about relational healing here, right? You were talking healing through relationship, but also how that attachment that they didn't receive when they were younger.

I have to recognize that as pediatricians, we've seen kids going through all of this, and now as we're practicing with adults, I've had a real shakeup in my worldview.

as to exactly how pervasive and prevalent this is amongst adults, and it's not addressed. These are some of the patterns that people only realize when it comes out when they have their own kids, for example, And they're trying to reach back into their attachment, they are like, wait a second, it re-triggers.

So really just becoming aware that these things can be dormant until they get triggered by circumstances in our lives and just come all the way out. And we don't have language for it.

We don' have stability. Sometimes patients come and they're so afraid of revealing that. They're so ashamed, guilty. There's a story about what kind of child they were.

You were attention seeking. you were this, you are that. And I'd even had patients, like you said, in that higher resourced socioeconomic strata where child protective services actually went into the house.

But because of the power differential that existed, they we're not able to do anything. You know, so I absolutely want to label that and also just recognize that social media is playing into that.

You're absolutely right. Like when, when you have a well-resourced kind of child adolescent growing into a young adult in a very, you know kind, of in, a situation like that, they can be made to feel like the scapegoat.

There's something wrong with them because they're not fitting into that matrix and what's wrong with you, you know, so there's so many multiple layers that we can uncover in this third space and really having the patience and allowing that to come through.

So I'm just, I wanted to add that in there. Yeah, and that actually is a dynamic that I see time and time again, that exactly we're seeing that many of my patients are the scapegoat because they're the ones challenging kind of the family structure in some ways by calling out what wasn't there for them.

And this is where mental health is actually, no, she's got that polar.

Relational healing, attachment, and diagnosis as weaponization

She's by, you know, she's always been like, or this is just like what could you possibly want? Like you had everything, I gave you everything like and they are scapegoated and the are made to feel like.

And I think this where Phil Wolfson's work really, we talk about using it just for adolescents where the adolescent is the messenger for the family system but frankly I see this you can be talking about young adults, you're going to be taking about adults.

Typically, the person that is most affected is the one who's kind of really trying to break free in some ways from this kind intergenerational pattern, and it's not easy.

I recently spoke to Dr. Adele LaFron, she says one of the first things she does with families is also then to dump this whole like parent shaming, like parents feeling shame about like, oh, it's all the mom's fault, or it all parents' fault.

That's actually not what this is about either. So she's like that's the first thing she tries to put to bed is that this not even what we're talking about, but we are looking at everything that is in play that caused the kid, the adult, whatever to have this type of mental health expression.

Yeah, I'm really understanding your diagnosis, right? I just want to put in a word. Even diagnosis can be a way of weaponizing mental health. Yeah. Right, and we're kind of getting in the midst of that and saying, I see what's happening here, all the different ways that we could get into this space and do the wrong thing, but let's talk about what it takes to do right thing.

And we are asking this child, young adult, adolescent to really, one, be the scapegoat, feel everything, being impacted by the story that they're broken, And now, as providers, we're kind of like, well, let's heal you enough so you can understand that there's nothing wrong with you, that you actually are kind the carrier of all the dysfunction that's been under wraps, nobody's talked about, Nobody wants to address, has just taken us as normal.

And that is a really difficult job. I have to say, you know, thank you for bringing in Adele LaFrance because, emotionally focused therapy, it needs compassion.

It needs so many skills that you have bring to the fore. And it also seems like you don't have one modality. You've reached out to really facilitate a deeper kind of understanding of all these different modalities, the emotional.

you know, healing approach, the narrative approach the compassionate inquiry approach and the conventional approach as needed, trauma-based somatic approach.

That this fascinates me how that opens up the view of psychiatry in general, right? Because the few of conventional psychiaty right now still remains based on DSM-5 criteria, everything is labeled and categorized And symptoms are considered diseases, which I find very funny because every most psychiatric illnesses are based on a symptomology.

It's not like, you know, it's based. You have ADHD, your labeled as such, and that's the stamp that gets placed in the chart. And that home, everything is geared toward that way of.

seeing the lens of that patient. And it's ironic that we're talking about this and we've been in the conventional space and now seeing that where do you take this way of thinking to the bigger venues, right?

We're not treating patients, we are treating symptoms that are a manifestation of something else. So where do you take that? How do take this forward?

What do feel is impactful for our audience to know, to recognize, appreciate? That's a big question. To your point, is somebody who is, I'm going to go back to the domestic violence survivor, Is depression really an abnormal response to what that individual, The something that I see a lot is the depression I've seen in adolescence is a a of, you know, what Dr.

Monte talks about is misattunement. You see these kids, and again, well-meaning parents, but really not being able to kind of reflect back to the kid in a way that that kid needs.

And that is really hard if your primary caregivers are not able on an emotional level. And I'm not just talking, I think when people hear that, they think, oh, like overindulging, that's not it.

I mean, you can kind of have a parent who comes from a really authoritative background, That's Not Good or Bad. That can be actually really helpful for certain kids, and studies show that actually some kids need that.

but you'd have a kid who just really needs to be seen and held and validated. And if the parent doesn't have that skill set for numerous reasons, I see that causing depression.

Is that really pathologic or is that just like, the kids nervous system is not getting kind of what it means. But I think, you know, psychiatry actually means healing of the soul.

And I With psychiatry, and I think healing of the soul doesn't mean just providing medications, which is really what psychiatries been relegated to. In the past, actually, if we look at psychoanalysis, not that I necessarily

psychoanalyze, but only psychiatrists were able to do it.

It then became expanded to other therapists, But really, it's whatever it takes. And it may not be just medicine. It usually isn't just medication. I think that's why psychiatry has to be open to all the different things.

One of the biggest referrals I use of being a child and adult psychiatrist is referring to OT. We have plenty of science on the cerebellum. Cerebellums hold 70% of our neurons in our brain.

I won't go down that path, I kind of talk a lot about that. But that is one of the most impactful things I can provide for parents whose kids have ADHD and autism.

There are other things that we really need to look at, even at a neuroscientific level, like what can we do to support that? What can we do to support the emotional elements?

And then with trauma, really, what are the most impactful things we can do? The most impactful thing I can is make sure that this family system is as healthy as it can be to help support this kid.

And you guys are pediatricians, so I'm preaching in the choir, but really the majority of the work I do is with the parents. And this is why I even started seeing adults again, is because the more trauma work I did, the I realized it's the parents who need kind of the support and the help.

And oftentimes, that parents are doing things in the most well-intentioned way, but the parent are grieving over kind what's happening with their kid and feeling out of control, or especially in I still remember this case where the mom, every time she came in, was crying.

The girl had had horrific abuse, which the Mom really, truly didn't seem to know about. She had really trusted these caregivers. And finally one day I asked, I was like, can you tell your daughter what…

So the daughter kept feeling she couldn't share this painful information, and she wasn't. And so I asked the mom, can you tell her what's behind your tears?

And she's like, I'm so angry that the people that I trusted to care for my kids did this. And you could see this is what the girl needed to hear. It's not that her mom couldn't handle it.

It was that the mom was so horribly traumatized herself that she had put this poor kid in harm's way. But that's what's like helps people heal. It's not my medication.

it's Not even me. I mean, at the most I might see my patients twice a month. Like, I'm not doing anything special, but what can I do to create an environment that continues to help with the healing and perpetuate the heal?

I mean, this is what we're all doing, right?

Spiritual emergence and crisis across the lifespan

Helping our patients have an enviornment where the, the heeling continues for them. And I think this where, unfortunately, psychiatrists just being relegated as just dispensing pills is sending a very kind of dangerous message is pathologizing our patients, right?

Identifying them as the patient and the one who's well, and even the overly like reductionistic idea of like biological psychiatry. I totally believe in the biology and in our science of psychiatr and that is not the only thing that's going on for people.

Yeah. Thank you for describing that. That's so beautifully put as we try to hold the both end, right? We've all trained in Western science, in just the categorization, the diagnosis, and the medication.

And that's been really well done. Well, there's all this other stuff. It feels kind of nebulous. The more we can kind define it, bring it down itself to a science.

I think what you're talking about is connection. We're taking about relational healing. You know, treating that as a system, a family as system that moves together.

And I love working like that, as the pediatrician, because I mean as pediatric hospitalist, we would see that in every room we walked in. There was kind of this complex that you see happening, and you can kind say, well, actually the identified patient is not the one sitting in the bed.

It's actually the one that, you know, is crying in the corner or really seems to have a lot of anger come up and can't seem to handle it. And how do we deal with that?

And I know time and time again, we go through situations in healthcare system where that's exactly what's happening is there's the story that the audio and the video of the store are not matching up.

As physicians sometimes we're kind of like, well, what is the gap there? Like you're looking at a movie and the mouths are moving, but the wrong sounds are coming up.

I love this. Let's switch a little bit about thinking about spiritual emergence or spiritual crisis. Because I think that's one of the things that really, when we're in the healthcare system and it's happening, it is really hard to get that kind of perspective on it, that holistic perspective.

So how do you describe that? Let's say I'm a resident, I am training in psychiatry and I've been trained to do the HAL doll, do this, the restraints and this is how I do it.

How can I to it differently and what can learn about this process that my patient is going through that may help everybody in that system recognize what's happening?

So I think, you know, everything starts, I mean, again, as people practice narrative medicine, it starts with a story like what is the story of what's going on and why is there a spiritual emergency or emergence?

What are the conditions that has now brought this to light? And do we know what age group it mostly happens in? What's the gender? Like, what do know from just the science of it?

Who does this happen to and what is spiritual emergence or spiritual crisis? Though I would have to tell you I'm actually not, I mean, be honest, not familiar with what the research shows.

I can tell, you clinically, like doing this for 20 years, it can really happen at any age. So I see adolescents, and again, call it the bottom falling out, but it's really a place of deep emotional crisis where the person tends to question almost everything Where the reality of how much they've had to carry really comes to light for them.

And it can, you know, in the West, we term it as like, she's having like a mental breakdown, right? That would be. But truly, I think there comes a point where the body can't carry this.

The body, the soul cannot carry this anymore. I think Western medicine and culture has really compartmentalized and separated the mind and the body. But if you look at other traditions, like the Chippewa tradition in Peru, they believe that trauma affects the mine body and soul.

the way they see it is that oftentimes in these like spiritual crises or spiritual emergencies the soul becomes so distraught that it leaves the body and so much of shipibo healing is around creating the conditions for the sole to come back home.

And so what so again the first thing that I do is I want to know the store what is the story what has happened what's occurred and often as much information as we can get from other family members, partners.

And sometimes that's available and sometimes it isn't. Sometimes we see this happening in very, you know, even in teens, it comes to a point where they realize that their family system is either not working for them or you see it's often in parentified teens.

The teens who've had to actually be the parent for everybody. And then I mentioned the people are, you know, what I see more classically for women is around the time of perimenopause.

There can be a real shift medically, like because, the actual physically what's going on. but it's also looking at midlife, like we call it a mid-life crisis, but this is kind of where we're at with it.

And so I don't think it actually, there is more prevalence as far as, I think is just more recognized, as I women tend to access mental health more, and actually that's problematic.

because it really men need this just as much and there's just so much more stigma and shame that they actually have that's so many more barriers for them to access.

I don't think there is a particular time and for some people it comes much later in life depending on they may have something that, they have a kid who is now challenging the status quo, challenging that culture and it now all of their perfectly constructed, you know, schema of their life is now falling apart.

And they're having to look at the choices they made that has now led to whatever the big event might be, whether it's a kid who's, you know, homosexual, a kids who is divorcing, who has decided to leave their church.

follow a different faith. I mean, there can be many things that shake this up or choose a career path that they really didn't see for their kid. But there are gonna be so many different things, that bring along the spiritual emergency, which I really just see as kind of, it's a reckoning point.

Thank you for walking us through that term as well as the application and examples of how that shows up at different points in people's lives. And I'm also very, very curious about the intersectionality that we have that was shared at this moment.

You talked about your Indian heritage past, and I am very because we talk about transgenerational experiences showing up through our DNA that then manifests sometimes as that break, that nervous breakdown that can happen generations later, right?

Where is that trauma? And just being some South Asia, all three of us here today, the identity of ourselves, but in the context of mystical practices, right?

Indigenous practices. We have our own. I know I have out our our faith that talks about your spiritual connection to your body. You know, wash your hands and you know clean your hand, clean hand hygiene before you pray.

No, it's about washing your hands and spending time and blessing the water and taking that in and then making intention as you stand up before you meditate or pray.

These things, and if you do this three, five times or whatever times a day, your body will feel good, you'll feel grounded, but really you're supposed to do it because it's a requirement.

You can see the language around this belief of, and I see this so much in patients as well, where we're asking about that, your spiritual practice, what is it that you believe and how does that come into your life or does it or not?

And tell us more about yourself in this context of who you are with the transgenerational experiences that you may have and bringing the aspect of spirituality forward in your practice.

Yes, so my family is from India, but in India they would call us Parsis. So my religious faith is Zoroastrian. Zorastrionism was the largest faith around the time of Jesus' birth.

It probably came around at the same time as Judaism, possibly earlier. has contributed to the beliefs of actually heaven and hell, good and evil, a judgment day, and a final resurrection.

So many scholars who study world religions will study interactionism because a lot of those concepts which now seem like, oh, there's nothing new or kind of quite new for the time.

My ancestors came from Iran 1300 years ago and were facing religious persecution because they were the religion in Iran prior to Islam. And so my ancestors left Iran and came to India for religious asylum.

And so in India, they call us Parsis, which just means Persian. I bring this up as now there's probably about 300,000 of us worldwide, maybe a little more.

Ancestry, epigenetics, and South Asian historical trauma

UNESCO has called us a tribe, not even a religion, and it's pretty much a dwindling faith. These things are important as far as, you know, I brought a lot of my own history, especially when I work with Jewish families.

or Armenian families, right? Other families that have experienced genocide because there is, I mean, this is now scientifically been proven, epigenetics.

So the idea that certain genes under certain circumstances actually get turned on and then are passed down. The research with Holocaust survivors bears the status of Holocaust survivor.

So their children have actually much higher rates of PTSD despite the fact that they actually never experienced the Holocaust. And I'd have to say that bears out even in grandchildren when you see it can manifest as like panic disorders and anxiety, but this generalized anxiety when your very culture being has been threatened for millennia, centuries.

And that's important to know because that informs my practice. So, you know, I do ask. I have a lot of patients who go to Jewish school, and it's very important to understand these things because that is the kind of underlay for what their presentation is coming up as.

So my own religious faith apparently had psychedelics. We had something that was called Homa, Hindus had Soma which was also a psychedelic thing. I actually see this very much part and parcel of continuing this heritage of mine which very much kind of informs how I practice.

I think we know that prayer, belief in God, believe in spiritual, it doesn't even have to be in that, right? Having a spiritual practice is actually very protective.

and very meaningful and gives people purpose. And again, it doesn't necessarily have to be that you believe in God. I mean, there's plenty of, you know, atheists, Buddhists who have that, but it's really an anchor, can be really in anchor for people.

But understanding people's histories are really important and in psychedelic practices or shamanic practice, your ancestors are very much a part of the work that's done and they're very present with you.

There is less of a separation of who's living here And who's like, let's say in the spirit world or in heaven or whatever you would want to call it. And oftentimes your ancestors are there to help and support you during these times.

Sorry, there's a very, I feel like that's very confunded. There's just like a lot I have to cover, but. These are really important psychiatric considerations.

And again, with my Armenian families, so it's my Jewish families. It doesn't even have to be that your ancestors went through a Holocaust. Every group of people, I'm very sensitive to my Muslim patients who come because

there's so much ostracization, especially after 9-11.

that they have faced, which has caused them to feel isolated or that have to explain themselves or feel like they, you know, unfortunately, like, they feel that the have be the ones that say, look, all Muslims are out like this.

That's a very heavy burden for anybody to carry. And so these things are just really important for us to understand, especially because we live in the third largest country in world that truly has every culture and every religious faith under it.

And these things are really important. I thought that was great. Oh, I love how you was like, absolutely late at that. It's like a big question. it is a, it's a great question and I want to bring it up because it, is something again, not in conventional medicine, but in the integrative way of thinking, and they call it a way thinking because its a kind of pulling in and bringing together something to make it more holistically seen, right?

And using all these different modalities that are available, both with the respect of the Eastern indigenous practices that have been practiced for centuries.

And why not bring that in to, even to the conventional space? Because that's what's real, that what people are, you know, experiencing. and have experienced transgenerationally.

And I just wanted to call out the aspect that we're all three Asian, from the South Asian continent and with a different story of conflict, of relational distress and crisis, and now coming to America, which is the other.

Well, the 20th century in South Asia has really been about fracturing, right? Like a fractured of the great continent, subcontinent of India into three pieces.

And now we're seeing how these traumas of fractures, like historical fracture, post-colonial borders drawn between, for example, India, Pakistan, and Bangladesh, are still simmering under the subculture, right, the culture.

And it's erupting, you know, and these are stories that because of the way, I mean, they're both nuclear powers. It's strange that we speak the same language in Indian Pakistan.

There's just a different script. We share similar cultural narratives and roots and history and practices and all of that. and beliefs and ideas. Yeah.

And there's been such a great synchronization of a lot of between Hindu and Muslim culture, for example, right? Over the course of time. Yet here we are separated by a border with the story and now we're at the brink of that trauma that's unprocessed being activated in ways that are just making us more divided.

And I want to point this out. And this is not brought up enough. You know, partition, you know which was the separate really when I feel artificial separation of India and Pakistan is one of the unwritten genocides.

Over one million people were murdered. in a very short period of time and nobody talks enough about that and how traumatic it was and many people have been displaced because of that.

And then the betrayal of neighbors turning against neighbors. This is really important because I don't care what part of South Asia you're from, everybody was affected by it.

My grandfather was very much a part the Quit India movement. And I don't think this is what he had envisioned. My great uncle was Gandhi's physician and like, everybody like has a story and now we're left with this and a world that doesn't seem to understand how awful.

it wasn't, it feels like, I feel like nobody, nobody's really won. Yeah. And that is with this trauma, a trauma that's not even recognized by the rest of the world.

I would even say not stories, right? These untold stories that are trapped in our bodies. and I, feel, like you know, one of, the for example, downstream consequences has been, for, example how we treat this idea of arranged marriage, you know, keeping the girls safe, just how dangerous the world became in the post-partition world really established the mores that were passed on.

Like, oh, don't marry outside of your small, safe community. Don't risk too much because taking a risk after you've gone through something like that is something your neurobiology cannot do.

So it leads to greater protectionism. And if it goes unrealized, it really can, as we've seen over two, three generations, determine just the stories that we tell about ourselves and what happened then.

And there's all these uncold stories of what really happened. I mean, in Bangladesh, we have genocide in 1971, you know, nine months worth, three million people.

And if you look at the rate of how much, how many people were lost, it was actually higher than the Holocaust at some points. But we don't talk about it.

You know, it's just what is talked about, what has revealed, but what it actually acknowledged. And I feel like that's what we're doing when we talk about the soul retrieving work, like when our ancestors are here and they're asking to be acknowledged, you know.

They are present in our bodies and our souls. I fee like in psychedelic work this is what's coming through. very powerfully. I almost feel like my heart is clutching right now because there's just this way of talking about it and being seen and heard that we can talk about outside of being the victim story.

Right? I remember when I went to Pakistan to study, I was so struck by the fact that I had grown up in Dubai within a Bengali culture. And I told a certain story about 1971. It's called The Disturbance.

And then when I went to Pakistan, they were told a different story about it. And I was just like sitting there with these two, you know, competing stories about the same piece of history and realizing like, oh, the truth is somewhere there.

Because we don't communicate about, because we do not share language about and we've been told in a certain way, that's all we carry. But when you meet people from other places and you share their stories, it's like it becomes really real.

And we're all trying to make this real, you know, make our histories real because they're real in our bodies. I don't want to talk forever. I love this conversation because you're right, I can feel the healing of having this kind of dialogue among something that we've carried in our body.

It was with my moment of stillness on my death anniversary of my father. And I had this moment. Just had to, just sat there and I was so sad. You know, write down, I had to grab a piece of paper and I just started to write.

Personal healing practices and the role of psychedelics

And I felt like there was a portal that opened right on his death anniversary at that same moment, you know possibly because it was 12, 24 hours away from me and distance-wise he was in Pakistan and he died very prematurely.

But it this portal of tell my story, right down my father's story. He was on a train. in the partition. He was nine years old, migrating from India to Pakistan, nine-years-old.

And my father carried this story that was the cause of his death. Now I could see it. I couldn't even see until I had to write it down in what he told me.

about what happened and what he witnessed and the effect that it had all in his life of distrust, of anger, rage that showed up as diabetes, heart, you know, depression, and sadly, a lot of other things.

And so, but that revealing of that experience, however it was perceived or that existed, it shows up. And as I'm talking about this, my heart is fluttering because it's feeling lifted and heard and felt.

And I want to just hold that heart and say, yeah, thank you for listening to this. This is what happens when we talk about being seen with patients as well as with ourselves.

Our work is also with our selves. And my question, I guess, is how do you do your own healing? What are the integrative practices that you provide and recommend, too, for yourself as well as for your patients?

So for myself, you know, lean into my own faith. I've adopted other practices from other cultures. You know? I do meditate. So every morning I get up, which is, actually you don't inhale it into your lungs, but it's an idea that you're communicating with God, and the message, your messages, you prayers, wishes are being taken up to Spirit or God or whatever.

And then I do hape, which another kind of sacred tobacco, then go work out. So I'll meditate with that. My story with psychedelics came because I actually developed what I realized in part of my journey on my own is I was like, the only thing left unturned I felt was I wonder if my antidepressant is making me sick.

so I abruptly stopped it and my symptoms improved. And so yeah, it's kind of like dark humor that a psychiatrist who I cannot take stimulants, I get such bad side effects.

So I don't have a way to really treat my ADHD conventionally and I can't. Now on multiple antidepressants I've developed autoimmune reactions. Some look like lupus, and this actually caused what people thought I had ALS, people though I'd MS, they thought that I was Santa Gravis, I did none of that.

And so what I left with was all the trauma I've been covering up, not intentionally, and that was kind of my, you know, whatever you could call it, spiritual emergence.

You know I started studying integrative medicine, psychiatry, i did Gabor's course, And I became a Gabor Maté groupie and I started following him at all these like conferences.

And, I had actually met him during my course and he was the first person who I'd say, nailed my shit in 10 minutes. I've been in and out of therapy like half my life, being someone who's in psychiatry and like, I was like, how did this guy figure it out?

So he was, like call me, read my book, call. And anyways, by then I signed up for his course, but he. Was in San Diego talking about, and that I didn't know anything about it.

It was psychedelic assisted psychotherapy conference. And I went there and I couldn't believe the scientific evidence for this. So the first psychedelic I did was actually ayahuasca.

I didn't research anything about it. It sounds like from what Gabor said it's going to work. Like I have nothing to lose. And so I know right out of all the ones to try first.

So, so much of now my personal work revolves around working with ayahuasca, working psilocybin, and leaning on these because I'm, I mean, pretty much conventional medicines are now completely off the table for me.

But the that is how I know for my patients that doesn't mean that that's for that. So if somebody comes to me wanting to work with psychedelics, that a whole thing and then we open up.

But I don't lead with that because I do believe it's calling. And if that something that people want to do, but usually I really try to tap in on what are my, you know, everybody has strengths.

There's a reason somebody has moved forward, is resilient enough to be standing there in my office or be in office. What are their strengths? And that is the way I work into what can be of resource to these people.

whether they're a kid or an adult. And so as far as involving those for my patients, it's not necessarily something that I will prescribe per se, but working with them on what are they already doing, because they are already that's brought them this far.

And again, encouraging practices, but I also find like, in our space, everyone's quick to say like everyone needs to meditate. Have you ever tried to ask like a trauma survivor to mediate?

No, they don't want to sit still. They don t want t be still, They d n't wanna be stuck with their thoughts because typically what that would mean is they have to also be there with thier pain.

And one of the many difficulties with trauma is that the way most of us will survive it is by checking out in any way shape or form. And so I don't prescribe people to meditate or do that, but really working on what are they already doing that's meaningful to them.

and that could be of a resource, and it could even be just sports. It could hang out with their friends, it can be hiking, whatever they're already doing, then we kind of build on that.

And then if they ask more questions about what else could I do, we work on it. This is really within the framework of what works for them, their life, what's already meaningful for that, I love that.

I loved how you're kind of calling the soul back into the body. Just like in the shipibo, you know, just what works for you, what calls to you? What does your soul love?

And I want to hear a little bit about how do you feel like ketamine is, as a dissociative in this trauma work? How does it work, What's it doing for people?

So, the way I see, you know, all psychedelic work, but even, including ketamine, yes, ketamine is not, although it's found in mushrooms, right? Like, there's not a bloody mushroom that makes it.

Yes. So it is totally artificial or, made in the lab. But what I say psychedelics doing, and again, it has to be the right time and place, Right? There has be some level of stability.

that a client or a patient has, because our job is also not to destabilize an already fragile situation. So a lot of times when people come to me wanting to just take it out, again, we already talked about, first thing is assessment.

What's the safety? What are their resources that are there? Often, I mean, my approach is a little unconventional. I often will work with people for several months.

to get them the type of stability that they need before working with it if that's the appropriate way to go. And what I see psychedelics including ketamine do is really bring to the surface what it is that needs to be worked in.

So I had, you know, a client who had an unfortunately severe history of abuse, including physical abuse. And so often, when he underwent this, what came up was like, kept asking, am I dying?

And I thought, oh no, he's having uncomfortable feelings. As you know, the psychedelics, I think people are painting this as this panacea, but the work can be very uncomfortable.

So right, it brings out kind of the trauma that needs to be dealt with and your body feels like can't be done with, and it has to titrated. You know, we often talk about this window of tolerance and with trauma and what Simeo is what you are also talking about our window tolerance, our ability to tolerate distress shrinks because your body wants to make sure it's keeping you safe and it keeps it narrow and keeps guarded.

Ketamine, trauma processing, and rapid suicidality relief

So even with this psychedelic work, it's very important to titrate or start low, very slow, so you're not shocking the system. You know, I think in the US, we have a very white-knuckled approach.

Blast through it. And this isn't helpful. It actually can be counterproductive. And so it brings up the trauma, but it helps us metabolize it in a way that we weren't able to.

Like, especially if you're younger and send this patient's case, because he thought he was going to die, right? When he is being abused, he had thought, and this is what was coming out.

But this is a chance to change the narrative, to changed the story, right? So with this work and this particular client, like, you know, he asked for his hand to be held, saying that you are safe.

You are okay. It's not happening. But helping them stay with it, this what helps people process. So it brings out the trauma, it helps us metabolize it and on the other side is you know, growth, insight, empowerment, expansion.

That's the idea, but it is not often comfortable and it isn't always appropriate. Like people have to have some sort of stability to be able to do it.

And that's one way that I use ketamine, right? To help people metabolize the trauma and be about to come out the other side recently, actually, an ayahuasca retreat that I went to, so my own abuse came up.

And, you know, they say they call ayhuascas she but she was basically like, You were alone with this when this happened. Do not be alone again, go get somebody.

So I did and it's literally like the helper was there witnessing my pain. witnessing, I was crying, and yet I felt pretty good the next day and that's what needed to happen, right?

Trauma keeps us frozen. It keeps as perpetually frozen in where the event happened, we get stuck with flashbacks. What we don't appreciate enough is our nervous system gets stuck as if the trauma is happening.

And this is what we see in anxiety disorders or generalized anxiety or panic disorders. It is a nervous that is stuck. Right, literally we loop, we play, and we keep replaying.

If we are somebody who is checked out, We continue to be checked-out. And Dr. Mate talks about this in his kind of unconventional look at ADHD. I'd have to tell you, like they say, 25% people who have PTSD would meet criteria for ADHD, I would tell it's 100%, not one of my patients does not meet the criteria of ADHD And so the work of the psychedelics is really to get us, and it doesn't nine just psychedelic, therapy, un-stock from the trauma so we can move forward.

Because what we know what trauma does is it actually keeps us developmentally stunted at the point of where the drama occurred. So this is like the really important work that psychedelcs can really do for us.

I think there's another approach with ketamine, which is another bigger conversation, but I also use it for rapid deescalation of suicidality. And in those cases, I we're not waiting for stability, we are creating the stability for the patient around.

But when there is suicidality involved and we need to rapidly deescalate that, ketamine is super helpful. And I think that needs to open up a bigger discussion of what are we doing with adolescents?

This, in my opinion, and it's, I know, very unconventional and seems This should be a first line. Is it really helpful to keep an adolescent on antidepressants or do I rapidly deescalate the depression, the suicidality, and get them into family and individual therapy so they can do the work?

Because as you know, patients who are severely depressed, they're not really able to access therapy in a way that's meaningful or helpful to them. So I know there's a lot of information, but these are the two ways that I use, you now, ketamine, a kind of watchful, waitful approach when we really want to address trauma.

And then when there is really severe suicidality, we're now waiting. We need to jump in and get people better, faster, and then continue to resource them and rally around them.

Yeah, absolutely beautifully put. And thank you so much for holding it all and describing the complexity and clarifying all that is, you know, coming into the soul retrieval work of psychiatry, right?

I love that. I'm going to just carry that with me and how beautifully you've been able to bring in all the different threads and then apply it to the here and now.

that there's nuance. There's a lot to learn. We're still figuring it out. But there are clear signs that, there is a way forward specifically for, you know, people who are in distress in this way.

So thank you so much for just encapsulating all of that. I really appreciate this conversation. Thank you. Thank you for teaching us again to curious MDs where we ask those unasked questions.

It's really about really poking at the bear, maybe just kind of understanding, really looking at things from different points of view. I think it really brings audience so much richness to the answers that they're seeking and we're learning as we go too as physicians.

And we need to keep that in the forefront because that learning mindset is really where neuro-classicity occurs. Thank you for being here, Leila. It's a beautiful conversation.

I hope to have it again and again, and We challenge you to ask us those unasked questions that you're curious about in your medical practice, condition, health and wellness.

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