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## Practical approaches to promoting brain health

More than once in his Current Psychiatry essays, Henry A. Nasrallah, MD, has stressed the seismic paradigmatic shifts in our understanding of mental illness and brain disease. He has highlighted the critical significance of processes of neurogenesis and neuroinflammation, yet little has been offered to practitioners in terms of practical approaches to promoting the brain health that he encourages.

Two of the most potent modalities for maintaining brain wellness and facilitating ongoing neurogenesis and synaptogenesis are exercise and nutrition—specifically, high-intensity interval training and a diet heavily, if not entirely, plant-based. The neuroprotective capabilities of mindfulness practice and its impact on prefrontal cortical regions also are relevant.

In society at large, it strikes me that physicians have not fared any better than the general population when it comes to maintaining a healthy diet and engaging in physical exercise. I encourage Dr. Nasrallah to continue addressing these themes, and to remind his audience of physicians to "heal thyself."

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## 'Appreciate the editorials'

I appreciate Dr. Nasrallah's editorial on the so-called abdominal brain (Current Psychiatry. 2015;14(5):10-11 [http://bit.ly/1PcxFNP]). Current Psychiatry is a journal with useful reports of advances, reviews, and opinion of research and treatment in our specialty. The selections and editing are always pertinent and thoughtful.

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## A nod to a 'psychiatry great'

In his recent editorial, "Is there only 1 neurobiologic psychiatric disorder, with different clinical expressions?" (Current Psychiatry. 2015;14(7):10-12 [http://bit.ly/1INCvxw]), Dr. Nasrallah presents convincing evidence for such a conclusion. However, he did not mention that a somewhat similar concept was established by one of psychiatry's greats, Karl Menninger, MD, more than 50 years ago. I'm referring to Menninger's *unitary concept of mental illness*, espoused in his book, *The Vital Balance*.[1] Dr. Menninger was, of course, founder of the Menninger Clinic in Topeka, Kansas, which now thrives in Houston, Texas, at Baylor College of Medicine. Like Freud, who predicted that advances in viewing the brain will someday help us understand it better than he could at the time, Dr. Menninger perhaps was ahead of his time in his perspective on mental illness.

We should appreciate Dr. Nasrallah for putting together the research that provides an updated, somewhat revised view of Dr. Menninger's theory.

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**Reference**

1. Menninger K. The vital balance. New York, NY: Viking; 1963.

## Big changes in practice, but none for the better

Dr. Nasrallah's approach to psychiatry, especially to the real problems confronting us, is both professionally astute and realistic.

I have been in practice for more than 60 years and have seen tremendous changes—none for the better—in the intrusion of insurance tyranny and government overregulation. Dr. Nasrallah's comments about obstacles created from the system, regardless of so-called "parity," hit the mark. The insurance companies control everything by setting fees so low and documentation requirements so high that there is little time to focus on the dynamics of the patient population. Unqualified peo-

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ple are deciding whether or not the medications we prescribe will be paid for.

To illustrate what I think of some of the changes, here is what I have observed:

• Electroconvulsive therapy for severe depression has been "rediscovered," but for decades those of us who used it selectively, with good results, were considered to be practicing quackery.

• Dr. Nasrallah's recent article on development of immediate treatment plans for a patient given a diagnosis of schizophrenia (Current Psychiatry. 2015;14(5):32-34,36-40,42 [http://bit.ly/1GLGtrZ]) reminds me of a time when it was thought that you couldn't diagnose schizophrenia until symptoms had been present for 6 months. (Had they ever heard of the work of Eugen Bleuler?)

• At a national meeting 20 years ago, I raised the question of why every other specialty of medicine stressed early diagnosis and treatment but psychiatry did not—and, instead, was doing the opposite. The speaker did not have the courtesy to answer my question.

Keep up the good work! We need people such as Dr. Nasrallah to educate the public about how government and insurance companies are destroying our specialty.

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## This month's quickpoll

Mr. B, age 35, is brought into the emergency room after a car accident that he caused by driving erratically. While taking his history, he has rapid speech and reports not being able to sleep for the last 3 days. Mr. B has a history of major depressive disorder, which has been well controlled with venlafaxine, 225 mg/d, for 7 years, and reports no previous manic episodes. **How would you treat his first manic episode?**

- ☐ Stop velafaxine, initiate quetiapine, 50 mg/d, and titrate to 150 mg/d
- ☐ Stop venlafaxine, initiate lithium, 1,800 mg/d
- ☐ Stop venlafaxine, initiate olanzapine, 6 mg/d, and fluoxetine, 50 mg/d
- ☐ Reduce venlafaxine dosage to 75 mg/d

See **"What to do when your depressed patient develops mania"** *pages 28-32,35-40*

Visit **CurrentPsychiatry.com** to answer the **Quick Poll** and see how your colleagues responded.

## AUGUST POLL RESULTS

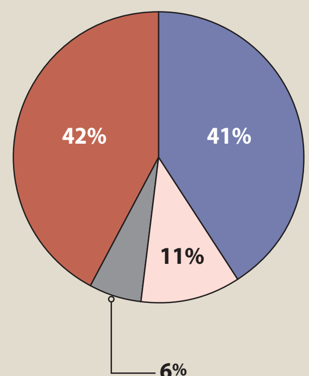
Mr. R, age 18, who has been taking amphetamine/dextroamphetamine, 10 mg/d, twice a day, for attention-deficit/hyperactivity disorder since he was age 10, comes to see you shortly after beginning college asking to refill earlier than usual. He says his symptoms are worse since beginning college and he is finding it difficult to focus in class and keep up with the heavy course work. He says he has been taking an extra 10 mg when he "needs the extra boost." He asks for an early refill and increased dosage. **How do you proceed?**

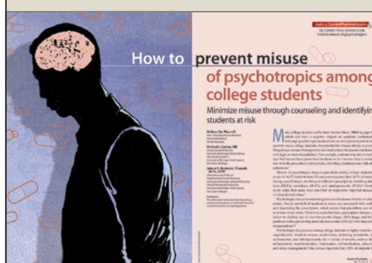
**41%** Switch to an extended release formulation and increase the dosage to 30 mg/d

**11%** Switch to lisdexamfetamine, 30 mg/d

**6%** Prescribe amphetamine/dextroamphetamine, 10 mg, on an as-needed basis

**42%** Tell Mr. R to take his current prescription as prescribed and discuss the dangers of stimulant abuse. Reassess his symptoms at the next visit




SUGGESTED READING:
Tai M, Casher MI, Bostwick JR. Current Psychiatry. 2015;14(8):29-31,43-46.

Data obtained via CurrentPsychiatry.com, August 2015