VIDEO_ Diet Doctor Podcast with Ignacio Cuaranta (Episode 26)

Dr. Bret Scher: Welcome back to the Diet Doctor podcast with Dr. Bret Scher. Today my guest is Dr. Ignacio Cuaranta, he's a psychiatrist from Argentina who is sort of leading the field along with Dr. Georgia Ede and a few just very select psychiatrists who are using low-carb ketogenic nutrition and overall lifestyle interventions to help their patients with mental disorders and psychiatric diseases.

And as we talk about this in this interview psychiatric diseases aren't all that different from body diseases if you want to call it, a lot of it has the same the same baseline the same cause of disorder and the same potential treatment much of which needs to focus on lifestyle. So I really enjoyed this perspective and I think you'll get that from his approach and also how we sort of leading the way in Argentina.

This movement isn't quite as big in Argentina as it is in the United States and in Europe. So he's sort of blazing the path there which I really appreciate. Also this sort of ties in a little bit with the how DietDoctor launched their Spanish website. I wish I could've done this interview in Spanish but my Spanish is not good enough at all. But it's reaching out to a whole new market, a whole different world, this is truly a global event.

So if you want to hear more about this and read the show notes go to DietDoctor.com. Otherwise I hope you enjoy this interview with Dr. Ignacio Cuaranta. Dr. Ignacio Cuaranta, thank you so much for joining me on the DietDoctor podcast.

Dr. Ignacio Cuaranta: Thank you for having me, Bret.

Bret: Yeah, it's my pleasure. Now you came all the way from Argentina here in Florida for the Low-carb USA conference where you are giving two talks really. You are giving one in English and then one-- they're having a special day specifically all in Spanish. And you're giving a talk there as well.

Ignacio: Exactly, two talks, they're going to be about the same but in both languages in order to reach more people and be able to join more people into this world.

Bret: DietDoctor has recently launched their Spanish version of their website as well, so when we were speaking last night and your dad was there, he asked if this interview is going to be in English or Spanish and I said I wish I could do an interview in Spanish but it would've been a very short interview if it was. So I thank you for taking the time to join us today.

So you are a psychiatrist based in Argentina and now you are part of the whole low-carb movement as treating your patients with nutrition for their psychiatric disorders. So let's rewind for a second, go back to your training as you were learning to become a psychiatrist. Was there any discussion about nutrition in any of that training?

Ignacio: There was no discussion whatsoever and this is one of the things that really launched me into doing the investigations myself. Actually one of my core beliefs is that we study function, we study dysfunction, we study anatomy, we study lesions, injuries, but there's no mention whatsoever to how our brain is functioning, what fuel is using... Does it have available fuel? Does it not? Is it permanent fuel or is it transient? So that really is what moves me into studying this.

Bret: My take on psychiatry is, from what I have learned in medical school, was that it really was focused on drug treatment for chemical imbalances and that was really about it. And let's face it, the drugs that are used in psychiatry have some pretty significant side effects. So it's a huge field that even if you can't get people off all their medications to control their psychiatric disease, if you can reduce the medications, you could have a huge impact in terms of daily function and how people feel, right?

Ignacio: Well that's absolutely right. In fact I'm going to have a big mention of what you've just said in the presentations because current practice of psychiatry is excessively pharmaceutical-centric, it has an excessive pharmaceutical-centric view and it disregards many other things we could be doing for our patients. And if you only have one tool, that's the tool you're going to use and really in terms of side effects that's one of the things that pharmaceutical companies haven't been able to reduce much. And when that in fact happened, when there's a drug that doesn't have many side effects, they are usually not as effective.

And let's talk for instance SSRIs that are one of the most available drugs that are used in depression and anxiety, in obsessive-compulsive disorders, in psychotic disorders, for many, many functions, they have a plethora of side effects and adverse effects that are very hard to counteract, and those are drugs that are often very hard to take away from patients. And I think that these strategies that I'm using in my clinical practice can have a huge impact in reducing doses or even avoiding to prescribe a drug altogether.

Bret: Yeah, great point. And it's interesting to think about the scope of the problem because we talk so much about our obesity epidemic and our diabetes epidemic and the epidemic of chronic diseases that have plagued America and Europe and the world really, but when you talk about psychiatric disease it seems like it's fairly similar.

I mean there are estimates that a third of all people will have some mental health condition during their lifetime. The Association of psychiatric diagnoses with reduced mortality and substance abuse problems and decreased quality of life. I mean it's rampant and I don't think it

gets the same attention as you can say the other problems, the diabetes, the body problems rather than the brain problems. Do you think that that's an accurate statement? That it's sort of been not given the attention it deserves?

Ignacio: That's absolutely an accurate statement and in fact psychiatric conditions tend to go underreported. They tend to thus go underdiagnosed, undertreated, thus "chronify". So even when they are properly diagnosed psychiatric medications oftentimes make matters worse. They make a bad problem worse, because most of them have-- one of the most side effect that we see is weight gain.

There is an average of between 2 kg and 17 kg of weight gain over the course of treatment and that's about I think between 4 and 30 pounds of weight gain on average and this severely increases mortality among psychiatric patients and psychiatric drugs are dose-dependent and so if you have a severe condition you will probably need higher doses thus increasing mortality and highly reducing the quality of life and expectation to get better, it really highly limits recovery expectations in this group of patients. And yeah, it is an accurate statement, of course.

Bret: So that's pretty troubling and there's a stigma associated with it; nobody wants to be thought of as crazy or having a mental condition when really it's just another health problem but yet somehow it's got the stigma with it.

Ignacio: But even in patients that maybe don't make the cut to be diagnosed with let's say major depressive disorder or an anxiety disorder, they may have insomnia, they might be overweight, feeling really... with low self-esteem, feeling very sad, having very low levels of energy, having very low levels of motivation, high compulsivity and all those really make your life very miserable because it's like a vicious cycle; it's very hard to get away from it.

Bret: And it's hard to make taking care of yourself a priority when you feel that way - so the rest of your health is going to suffer too. You're not going to exercise, you're not going to eat well, you're not going to take care of yourself so really is sort of a domino effect, isn't it?

Ignacio: It is a domino effect and it is a vicious cycle because most of the those patients, what really troubles me, is that most of them are probably doing very well in other aspects of their lives but they've tried many times to lose weight, to get ahead on their health and they are following the usual guidelines, what the standard of care proposes, and they are doing it following the guidelines perfectly and they don't get better. So after a while they get frustrated and they're probably going to drop out any type of treatment. It is a vicious cycle that really troubles me.

Bret: We focus so much on what people should eat, how they should exercise, how they should sleep and we don't think enough of what's going on in their brain and how they're feeling and how they're responding to things and that's like you said - they may not meet the diagnosis of a

major depressive disorder but how they're thinking and what's happening in the brain function definitely impacts their health regardless.

So walk us through this - so you went through your training, you learned to become a psychiatrist, you started your practice... how did you take the path less traveled, how did you differ from everybody else and start to think, let's look at how nutrition actually affects the function of the brain and see if that's going to help people... How did you make that transition?

Ignacio: Well, let me rewind a little bit. Let us go back to the year 2005. I was in my last year of med school and with a friend, we traveled to Michigan and had an experience at the Beaumont Hospital and then I there decided to do my experience at the weight control center where they prepare patients for bariatric interventions with a kind of a classical approach but it was with meal replacement packets and with controlled calories, but there was a high-protein diet. They got a lot better and then they prepared them for the bariatric surgery.

So, it is kind of like a 14 to 15-year route for me and when the time came to decide what specialty I'd like to go in, I was between psychiatry and endocrinology. Psychiatry kind of like suited me a lot more than endocrinology because there were other aspects that I didn't really care for and really, psychiatry, I have a passion for it, you know.

Really, when I study this type of topics, I get really invested in, and so I decided to go into psychiatry. But you know, inside of me, nutrition was always-- and obesity was always a very important topic for me. So, I kept studying it. Even for myself, for my own health, you know, it's something that doctors sometimes... we will put aside and doctors ourselves are very unhealthy people and that's kind of like a pretty strong statement, you know. And so, I did my residency in psychiatry where I did, you know, I focused on all of the psychiatric large topics but nothing about nutrition.

And, so, after, it was about 2013, I came across the paleo diet, I started doing it myself. And then on year 2004, I travelled to France, I did a 3-month rotation at a psychiatric hospital there in Paris and I kept studying and studying. When I came back my girlfriend got pregnant and she was-- my daughter was born in December 2015. So, I started studying ways to minimalize things in my house. It was pretty, you know, kind of like a, you know, a different path. But I came across the intermittent fasting through a minimalist site.

Bret: Oh, interesting.

Ignacio: So, there ain't more minimalism than, you know, intermittent fasting.

Bret: So, not from a health perspective? Let's try this, you don't have to worry about what you're having for breakfast, you don't have to cook, you don't have to--

Ignacio: That was my first contact with intermittent fasting.

Bret: Yeah.

Ignacio: So, I read Brad Pilon's Eat Stop Eat, that was kind of like a seminal book in intermittent fasting, I read it overnight and the other day was my first 24-hour fast, you know. I just drove into it. I felt so great that I started studying, studying, studying and I came across Dr. Jason Fung's work and I started studying intermittent fasting in a more scientific way, trying to see what there was available in terms of studying and in terms of effects. And lo and behold I wrote to him and I got to be able to travel to Toronto in Canada and did an experience at the Intensive Dietary Management in 2017 April. It was on. I lost, like, myself, like 14 kilos and people was asking me, "What are you doing?", you know, like--

Bret: So, did you go there as a patient of Jason of Dr. Fung's or you went as a practitioner to learn and--?

Ignacio: I learned and observed first and then with an affiliate of an observation program. I had been studying for like over two years at the time, a year and a half, so I kind of like reinforced a lot of the concepts that I had studied, and I started implementing. And the other side of the story is that, as the head of the mood disorders department at the neurological clinic in Rosario, one of the main clinics in Rosario, with a lot of patients coming in all of the time, all of the patients came in to me for the psychiatric assessment.

So I started seeing this very frequent pattern of metabolic disorders among patients. I started seeing all of these compulsivity trades, all of this deterioration in the quality of life and I started asking more about nutritional aspects. So, you know, as a surprise came that they were-- most of them were following the standard diet, you know, with high carbohydrate ingestion without affecting their sleep patterns, you know, with sedentary lifestyles.

So, I started you know, with some patients that were suitable, and I have a very strong patient-to-doctor relationship that is a very important aspect of my practice. I started implementing intermittent fasting and they started getting a lot better but in a matter of days, in a matter of weeks, I was able to start getting people off medication or de-titrating medication, lowering doses, you know, they started getting more energy levels, start feeling better, start telling more people. So, this is how it started.

Bret: Now, you started with intermittent fasting. Was there a low-carb approach as well? Because something that I've found is-- well, the clients that I work with-- intermittent fasting is so much easier when you are eating a low carb, high fat diet and it can actually be fairly challenging for a number of people if they're still following a high carb diet. So, did you have to change the way they were eating first to then impose intermittent fasting? Or did you start with the fasting?

Ignacio: Well, actually, myself, I was doing paleo as I told you before, I was doing paleo before, and then my-- over my paleo diet I added, you know, the intermittent fasting protocols. Among

my patients, what I find is that a 16:8 protocol or a 14:10 for women, but more around 16-hour fast overnight, it is a pretty accessible initial strategy. It helps them a lot to gain perspective, take a little distance from what they are doing, being able to give more thought to their decisions and having to make fewer choices during the day.

Because if you start eating a low carbohydrate diet, a secondary effect is that you starve, you know, reducing your appetite, reducing your carb cravings and reducing your high compulsivity. So, actually my first approach is about implementing intermittent fasting but right now I do it as a combination. I also talk with my patients to reduce, in the first place, sugar or highly limit sugar or try to tell them to avoid sugar altogether, but I am flexible in regards to health and goals, you know.

I try to be coherent with what the chief complaint of the patient is and their goals, and so I try to tell them, okay you're going to have and see a lot of better results if you do this synergistic strategy. Not one or the other, just to lose weight or be in good shape for the summer. My goal with my patients is quality of life, that's what I always talk with them.

Bret: Now, that doesn't seem like a tremendous intervention, you know. it's basically skipping breakfast to start. And you're seeing benefits with whatever psychiatric condition they started with, just that small intervention and you're seeing benefits right away?

Ignacio: Absolutely.

Bret: That's fantastic.

Ignacio: And there is an adjuvant-- and you know that there is more than an adjuvant, an adjacent effect. When they do more intervention. Okay, they skip breakfast and go straight to lunch, you know. Your breakfast will be your lunch time. And they start feeling better already and so, they get excited and they get motivated and say, "What else can I do?"

Bret: Right.

Ignacio: So, it's not only you that is motivated to do whatever you think that your patients should be doing, but they start asking and exploring - and I always stimulate that in my patients. Study for yourself, have an exploratory and growth mindset, try to be progressively incorporating, you know, better aspects of to improve your quality of life.

So, I try not to be dogmatic or rigid in my interventions because, you know, when you are in the clinical practice, face-to-face with patients, you have to be more flexible, you have to be able to talk with different personality traits, different goals, different activity levels, different ages, genders and all of the different types of patients that we see.

Bret: Yeah, well, let's get into the physiology of this a little bit. Because when we're talking about diabetes, when we're talking about obesity, it makes sense why intermittent fasting, why

a low-carb lifestyle, why those have a direct and very meaningful impact. Why does it help psychiatric conditions? Why does it help depression and schizophrenia and anxiety and what is the connection there?

Ignacio: Well, actually, there are different explanations for different conditions. I believe that in anxiety and compulsivity, avoiding the sugars highs and lows with their compensatory mechanism by stimulating the secretion of cortisol, inflammatory cytokines, adrenaline, that you know, puts you in a very vulnerable place, you know, when you are all the time provoking that kind of response in your body. In depression lowering the stress levels altogether, being able, especially in the atypical depression, where it's more, it has more of an overlap with metabolic inflammatory conditions, it's highly linked to hyperinsulinemia and the inability of the brain to use glucose as fuel.

And that's why it's also linked to type 3 diabetes or dementia. It is my hypothesis that it's not only affecting memory and concentration, but it's also affecting behavior, it's also affecting mood. I mean, how would you behave if your brain was not able to use the main fuel that your body is using? If you have already fixed your metabolism to use glucose as energy and your brain is not able to use it efficiently, how are you going to be?

Are you going to be tranquil? Easy? Are you going to be calm or are you going to be excited, desperate, irritable? I mean, it makes a lot of sense for me and this is what I am seeing in the practice, in my everyday practice. So it's not that you have to wait until someone is 60 or 70 to make an intervention, but my proposal is that we should be training metabolic flexibility at an early age, you know. Even though you're not perennially in ketosis but you can you know, be in the outskirts of ketosis daily, doing some types of fasting, training the fasting ability, and being able to use both types of fuel.

Some patients that's more in the psychotic side like schizophrenia, there's studies, very old studies linking gluten, you know, gluten sensitivity to schizophrenia. I recently had the opportunity to talk with a patient that was having hallucinations and really persecutory ideas since she was a child, since after some traumatic event at 5 or 6 years old and she was 34 with continuous hallucinations.

And after she read Dr. David Perlmutter's Grain Brain, she dropped gluten and started doing a ketogenic diet in January, and two or three weeks after that, all the hallucinations were gone. And those are pretty, you know, strong N=1s and experiences and observations, and this is one of the limitations because we try hard in psychiatry to get people to do these types of investigations.

So, what we are seeing at the office is very important because I don't think we should disregard the results that people are seeing, so that sometimes many people are starting to lose weight, but they see secondary effects, "secondary effects" on mood conditions, they start feeling

better, they start seeing more mental clarity, thus, making better decisions if you are able to make. In fact, we are the results of the decisions we take moment to moment to moment. If you start taking better decisions for yourself, that's better outcomes to be expected.

Bret: Yeah, that's a pretty dramatic example that you gave and similar to the example that Dr. Westman published almost ten years ago now. Of the woman who had schizophrenia her entire life since she was 6 years old and in her 70s I think it was, when Dr. Westman started treating her, she started a ketogenic diet and, again, within days, her hallucinations stopped and she was able to come off her medications.

And these dramatic case reports definitely have something behind them. But therein lies part of the problem because right now, we're in a world of anecdotal experience and case reports and not clinical trials and large bodies of clinical research, so it might be a little challenging to say, yes, this works, yes, this should be recommended, because what do we have to back it up? How would you respond when someone asks you that?

Ignacio: Well, actually, that's a great question because I am addressing at my presentation on Sunday, what we should expect and what we should not expect from ketosis and what I like to call the pathways into ketosis. It is not the ketogenic diet or intermittent fasting, or paleo or banting or low carbohydrate diets, but it is what you gain from those strategies and what works for you.

And I think we should not see ketosis or the ketogenic diets or ketogenic pathways as, you know, the panacea, as you know, the end of it all. And the solution for everything is not the panacea for psychiatric conditions and it's not the panacea for major depressive disorders, schizofrenia, bipolar disorders, severe anxiety disorders. But it is and it could be a great co-adjuvant tool to implement, for any psychiatrist or for any clinician or someone working at a primary care and being able to intervene and do prevention.

I mean, how unsafe could it be to prescribe to your patients that they eat real food, that they stop snacking all the time, that they start to talk with them about prioritizing sleep patterns, that they implement any type of stress management, you know, strategy. Those are very safe interventions, and we have a lot of evidence to say that those are safe interventions.

So, what I am proposing is not an excuse to irresponsively dropping medications if you are under treatment, but it is a proposal to widen our views about what we are doing with our patients. Because especially under severe conditions because of what I told before in regards to dependence, the dose dependence of the effects of psychiatric medications, we could really reduce and improve their metabolic profiles even if we are prescribing medications.

And there are also studies regarding the 16:8 protocol and joining, you know, giving the time of the medication at the time of the meal, of meals and, you know, that is a kind of intermittent

fasting protocol. And it really reduces the metabolic derangement of the medications, especially of the anti-psychotic that are very, very tough on insulin levels.

Bret: Yeah, so, it's an interesting point you bring up about how deep you need to go into lifestyle treatment to have a meaningful effect because there's always this question, do you have to be in ketosis to get the effect, is it something about the keones, the metabolic shift, or is a low-carb healthy lifestyle with time restricted eating? So, is that enough to see meaningful change?

And that's also what makes it difficult to study from a scientific standpoint because where do you draw the line? Because there are lots of these studies that show low-carb diets don't work and then they define low-carb diets at 45% carbohydrates. And so, it all depends on how you define it. So, I think that would make it challenging from a psychiatric perspective but what I'm hearing from you is you don't think it's necessarily ketosis.

So, we hear lots of things about how ketones are beneficial for the brain, whether it's in Alzheimer's disease or a traumatic brain injury and people talking about how to use exogenous ketones to boost the beta hydroxybutyrate level to get a bigger effect and bigger penetration into the neurons. And there's studies that ketones decrease oxidation of neurons, there's studies that it increases mitochondrial function in the brain.

So, from your perspective though, is there something beneficial about ketones and ketosis that you think would be helpful for psychiatric patients above and beyond just healthy lifestyle and low-carb?

Ignacio: Well, there has actually been studies that show that actually being in ketosis and their brain running primarily on ketones and beta hydroxybutyrate helps to establish a more homeostatic state on the brain. It avoids what I like to call a more stoic fuel because it avoids this external dependence on constant inputs of energy.

So, I think it's a lot about the energy availability and the energy quality because ketones don't only provide for very large deposits of energy that are very reliable, predictable, thus providing for a brain state in which you have energy predictability, that's fundamental. And then you have neurotrophism that is linked to a higher production of BDNF - brain drive neurotrophic factor.

It strengthens synaptic signaling, helps provide a more physiological environment for the brain. I am a really big fan of Dr. Cunnane's work about brain evolution. He's working also, you know, he's doing a lot of work in relation to dementia. And really, this is not about surviving, this is about thriving.

And what I like to tell, you know, I am focused on prevention and I would like people to know about these types of strategies to start exploring themselves and don't wait until they start

getting severe symptoms to start implementing, because it might be too late and it might not gain functions, lost functions back.

Because when we're talking about the brain, it's really an energy hawk and it needs a constant fuel flow, and ketones provide that. I mean, especially in patients where they are insulin resistant. I love Dr. Naiman's meme, it's the dam concept. I don't know if you are familiar with it.

Bret: No tell me about it.

Ignacio: Hyper insulinemic state, it works like a-- it operates like a dam holding on your energy stores. So, if you are in a constant hyper insulinemic state, you will be preventing or impeding those energy stores to flow. And if you start through fasting and low carbohydrate diet, you can start lowering that hyperinsulinemia, providing this ever-increasing amount of fuel flow.

And this is what I see in the clinical practice because in one week, two weeks, and three weeks after implementing, a well-formulated ketogenic diet and intermittent fasting protocols, patients do start to wake up, do start to feel a lot more focused, more stable, they really reduce cravings and they start feeling more energetic. One of the main chief complaints that the patients have at the office when they come is low energy levels, low initiative.

Seeing that they want to do something that highly differentiates from melancholic depression that they have no motivation to do anything, but they know they see their goal, what they want, they recognize they have everything that they want but they don't have... they just don't have the energy to go with what they want to do. I think if we can rule out all of those patients, we'll keep other conditions that probably don't respond as well to this type of strategies.

Bret: What do you mean that - what kind of conditions wouldn't respond as well?

Ignacio: Because they-- if we follow up on the example that I gave about atypical depression that is more characterized with a metabolic overlap with obesity, leptin resistance, insulin resistance, with personal or a family history of type 2 diabetes and metabolic inflammatory markers.

We also have typical depression, which is melancholic and more related to childhood trauma, it has a later onset, it has a different profile more linked to psychiatric conditions maybe to schizophrenia running in the family, very low appetite levels, with clinophilia, that is like wanting to be in bed all the time.

Bret: So, those won't respond as strongly to nutritional interventions and lifestyle--

Ignacio: Exactly, that's what I've seen and those are very hard or tough patients to work with because there's no motivation. They are usually drawn to the consultation by a family member if they have one and they are isolated. It's a different subtype of depression and I'm going to

talk about that on Sunday and Monday as well, kind of like trying to differentiate what type of patients I propose have the better outcomes with these strategies.

Bret: Yeah, it's interesting to sort of draw the correlation to whether it's diabetes or obesity that not everybody's going to respond the same. But also, it's not a cure, right? We're not talking about a cure, we're talking about either a reversal of symptoms or managing disease or reducing medications just like we can with diabetes, important for people to understand, you don't just start the diet and stop your medication the next day.

That could have some serious adverse consequences. They need to work closely with somebody. But the problem of course becomes finding the person to work with, finding a psychiatrist or even a primary care doctor who's willing to work with them on this. So, you're in Argentina. I don't know much about the medical culture there, but I'd imagine it's-- you sort of stand out from the crowd as a rare breed. Is that the case? Tell me a little more about that.

Ignacio: Well, I do feel like that. This is also-- the demand that I have for my services or what I do in my clinical practice kind of shows what you just said because I have high demand right now and there is a huge subset of patients that really need these types of strategy. I work close with the patient. Because, in addition, obesity and type 2 diabetes tend to mobilize patients to go to a consultation with a nutritionist, with one of the mainstream weight loss professionals.

But they might not, related to what I said before in relation to the under-report of psychiatric conditions, they might not do a consultation with a psychiatrist or a psychologist because the taboo, because of stigma, because they don't recognize or some of the symptoms are harder to recognize and they might not even know that they have depressive symptoms.

They kind of maybe feel that they have low energy, they are overweight, it's all related to that, and they have a reason to think that. But the problem is that they go to the wrong professional and there is a big "Why" because there's-- not all of them, and I'm not saying that everyone that is not doing what I'm doing is wrong, I'm far from that, but I really get very mad when I hear stories from my patients, there is a high rate of verbal abuse about professional abuse with obese patients, and you can see it on live TV, you can see in the Biggest Loser.

We also have our version of the Biggest Loser. It gives me nausea to watch that program. Really, you see people suffering, you see people relapsing all the time, you see people with probably mental conditions or psychological traits. It's really, you know, we have a lot of work to do. And this is part of why I decided to, kind of like expose myself and expose what I'm doing in order to incentivize more psychiatrists to start prescribing or using or at least increasing awareness and observants about this metabolic profile.

Bret: Yeah, so you're really leading the way for Argentina, it sounds like. So, what advice would you give somebody if they want to try getting on a low-carb/ketogenic diet and lowering their medications and their physician just isn't hearing it? What kind of advice can you give?

Ignacio: If they are taking medications, I think we really need to--, it's more from our side what we need to do, we need to really--, I'm launching online consultation in order to be able to help patients so it's not only in Argentina. I can include people that probably want to know how to do it. But I have to work close with a local physician, because if you are taking medication like you said, you need to know personal history, you need to know-- I mean, psychiatric relapse is not a joke and it's very important to be cautious about this.

But I - like I said before - a 16:8-hour protocol is a safe intervention, eating real food is a safe intervention. It's like, that's kind of like weird to say. But improving quality of sleep is a safe intervention. So, really, these are very-- even though it may not sound like it-- these are very conservative interventions. I mean, and I start from there. I always talk with my patients. 16-hour fast is like an anti-seismic structure, I do the same gesturing with my patients. This is a anti-seismic structure, this is where we start from, we are going to move from this.

But it is a structure that is going to give you an ability to better management and to better manage stress in your life, and it's very flexible. So if you wake up one day and you don't follow it, not a big problem, you'll get back on track the moment after you did something you weren't planning to do or to ate something you weren't planning to eat, you drank something you weren't planning to drink.

So, I'm also seeing when you're lowering your compulsivity, I'm also seeing an easier pathway into reducing addictive behaviors, being whatever, alcohol, tabacism, marijuana, cocaine, I'm seeing, you know if you reduce-- and a stressed brain will look for a relief and this is where culture comes in, or your personal history.

Some people rely on food, some people rely on other types of substances or binge watching a TV show or Netflix... and it is one on one work. I'm hoping that more psychiatrists and psychologists jump into this, you know, into this wave and into this movement because it's bringing back the customs that we had 40 to 50 years ago. Really, and intermittent fasting is kind of like a cool name for something we shouldn't stopped doing ever.

Bret: Right, it should just be normal. We shouldn't have names for not eating that way.

Ignacio: Exactly, Dr. Fung says in 60s and 80s that was like normal eating. You know, it's not like fasting, it's not like real fasting.

Bret: Right, and you brought up a good point about addiction because it's hard to address all this if you don't also address addiction which frequently can be carbohydrates and there is some serious debate about whether it's a true addiction or not but, I mean there's certainly a subset of people where it seems like it is a clear addiction and they need to be treated as such. So, do you see the same?

Ignacio: I have many patients that had no problem dropping their smoking addiction, but they are having huge problems dropping sugar or grain addiction. This has to do with... this substance has been so ubiquitous and offered and so socially accepted, and it also has to do with the advance in the development and the design of this food because we have to remember that most of this food-- I mean, when you are carb-addicted, it's not really rice, it's not really potatoes you crave, it's the processing that adds the addictive behavior.

And it's also fructose, so I'm a big follower of Dr. Robert Lustig's work. And really has helped me a lot, the approach that he proposes in The Hacking of the American Mind, his latest book, I really love that book. It really helped me into finding the way between stress, addiction and the ways to, you know, the ways you provide relief. And also, enhancing-- this is very important-- enhancing serotonin pathways. There are many, many natural ways, physiological ways, to enhance your feeling of tranquility.

And it's not just taking an antidepressant, and this brings me back to kind of like a joke that I'm going to tell. It's like most patients-- well not most, but frequently I get at the office the consultations; "Doc, I have low serotonin, I need something to put it up." And this is kind of like you know, this clear example how this monoaminergic imbalance dogma has penetrated the population you know.

Someone is like, I know I have low serotonin, I have to put it back and everything will be normal again. Why don't we address what might have happened, why your serotonin is low in the first place?

Bret: Right, everybody wants a pill to fix their problem.

Ignacio: Exactly, a quick fix, or you know, the silver bullet, like--

Bret: Right, all right, well, let's transition for a second. I find it strange that a low-carb movement isn't bigger in Argentina because Argentinian beef is like the best, right? Tell me about Argentinian beef, is it really that good?

Ignacio: Well, I have conflict of interest I have to declare, because I am always a big proponent in favor on Argentinian meat and this why I tell my patients, you know, we live in the best country, probably the best country in the world to follow these types of diets and sometimes the only intervention that we need to do is remove the bread, remove the potato, and just eat the meat, if you want to eat the meat and put it some side, some vegetable sides and have a good olive oil on your salad, and you'll be great.

And we have this accessible meat, especially the meats that I propose my patients to eat, that are not the lean cuts, that are probably more expensive, but are the cheaper cuts. That's what I eat personally myself. And this is kind of the diet that I follow. I don't only intervene with my

patients, I have a lot of friends that I kind of like supervise their diets and they come to me and they say, "What can I do? I need to do something about my diet."

So, there I go, you know, straight to the source because first of all, cut this everything out and focus on meat, kind of like a carnivore transition diet but not dogmatic. Not like, I had the lettuce, no, you ruined your diet, no, it's not what I propose. But it is a great transition because, they get better, you know. They start feeling better and it's like I said before, they start asking, what else can I do, what else can I add to my life in order to improve it.

Bret: When you come to the United States and you taste the meat here, can you tell a definite difference?

Ignacio: Well, there's definitely a difference in the price. And also, the types of cuts that we prefer, and it has to do in the way we handle the-- how they call, when you have the--

Bret: The carcass?

Ignacio: The carcass, exactly. It is the way that we eat the carcass that makes the cuts different that we have available.

Bret: And what about organ meats? Isn't that much more prevalent in--?

Ignacio: Much more prevalent and this is very sad because most of-- I mean, it is gratifying for me to tell my patients, eat organ meats, because it's like kind of like prohibited by classical nutritionists, you know. They prohibit organ meats. And we have "mocheja", that would be like thyroids, would be like adrenals, and I don't know which other organ "mocheja" is. That it's like gold because it's pure fat, it's very fatty.

And it's very tasty to prepare too with butter, garlic, those are kind of like prohibited in the usual diets. And people-- this is the sad part-- people remove butter, remove organ meats, remove all the fatty cuts, remove olive oil, remove nuts. It's like they remove everything that is healthy because of this caloric-centric view, you know, it's like this eco strategy.

And that's, okay, you want to reduce your calories voluntarily, you will be able to do it maybe for two weeks, three weeks, but you will relapse. I mean, it's like because it's not what our bodies and brain expect from your diet. They start sensing that is, you know, a shortcut. So, most of the time, most often that elicits responses.

And this is important in my practice to address stress levels. Because I don't necessarily suggest a patient going under severe stress to do long fasts, but I go easier, easier with them. And try to of course reduce stress load, improve sleep patterns. I do a lot of emphasis on sleep, maybe you've noticed.

Bret: Yeah.

Ignacio: Because I think it's the first step. Like, I prioritize sleep and movement. If they are overweight, I don't tell them to run, I don't tell them to do CrossFit or functional training. Just go for an easy walk, that's it. But don't go chasing calories. Just think about trying to relieve stress, try to connect with nature, don't take your phone with you, you know. I use a lot of-- I talk a lot about technology addiction in my practice and this is going to be a-- this is a very big problem for future generations.

If you don't address the technology addiction that is the most prevalent... to our cell phones, and nobody forgets their phone when they go out their house. And it's the first thing we do in the morning, the last thing we do at night. And it causes most of chronic sleep deprivation and we all know that this increases insulin resistance you know, and a host of others.

Bret: Right, yeah, great point. And we focus a lot on nutrition, and it is so important prevalent but there are all these other factors that definitely need to be considered, technology being one of them. And you brought up the calorie restriction part and the last thing someone who's battling with depression and medication side effects needs is to feel constantly hungry and be counting calories and just have the stress from that. I mean, hat just seems like a terrible intervention, why would we need anybody to recommend that?

Ignacio: The worst.

Bret: People do recommend them.

Ignacio: They get better for, you know, transiently they feel better because anyone that starts focusing on something, they go to a nutritionist, or a clinic, a medical professional, a medical professional that prescribes the psycho strategy. They might start feeling better for the first couple of days because they are doing something about them, you know, that makes you them feel good. It's also a trap because you eventually fall down on what you are doing, and this will be another frustrating event.

So, picking up what I left before-- this is a very important message that I like to tell in regards to being a psychiatrists and working with these conditions. Many patients come in and they say, I want to lose weight, and I try to talk to them about quality of life and being able to intervene in other aspects of their life and this is what I call really prevention and capitalize all the opportunities of the contact of a the patient with a health professional, you know.

Capitalizing each opportunity because you never know if it is going to be the last opportunity that the patient has or the last time he or she are going to try to get better. You never know that.

Bret: Yeah, very good point.

Ignacio: So, the capitalization of a contact with the sanitary system.

Bret: Yeah, make the most of the intervention because you never know if you're going to get a second chance. Yeah, well, this has been a wonderful discussion and I'm thankful that there are individuals like you taking this message into this whole field of mental and psychiatric conditions because it's not that different but yet for some reason it's been portrayed as being so different so thank you for doing that and for taking the time to be here. If our listeners want to learn more about what you have to say, where can you direct them to go?

Ignacio: Well, I'm very active on Twitter, it's Ignacio, @ignaciocuaranta. I recently launched my web page in Spanish, I have to do a lot of modifications, but I have a guide for intermittent fasting in Spanish on how to start. I'm going to put a lot of information up there, it is ignaciocuaranta.com and also on Facebook I have a page that is called Flexibilidad Metabolica, where I also upload information or interesting articles but mostly on those three sites.

Bret: Very good, Dr. Ignacio Cuaranta, thank you so much, it's been a pleasure.