Personal Perspectives on Major Depressive Disorder (The Medical Mind Podcast)

EPISODE 2

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This episode is the second in a two-part discussion about major depression disorder. We continue the conversation with Dr. Ken Duckworth right where we left off in episode 1.

Peggy Huppert: We were just talking today as a matter of fact about the drinking. I'm really proud of Marty because he hasn't had a drink in nine years. That was really the beginning of his true recovery and being able to live in wellness because it would have been impossible before.

It was that ultimatum that made him go there and he also was just sharing recently that he remembers when he started at Powell, someone said to him, “When you first came here, I kind of wondered what you were doing here,” because he had the attitude that he really didn't need to be there. It was life changing for me too because I went through the spouse program and that was really what I mark as the real true beginning of his recovery.

Ken Duckworth: Dr. Nierenberg, let's talk a little bit about the co-occurrence phenomena of substance use and mood disorders and, obviously Peggy showed tremendous courage and Marty showed a lot of grace in listening to the feedback.

Can you talk a little bit about what the research tells us about co-occurring disorders and mood disorders?

Andy Nierenberg: Sure. A lot of times when people are in distress from having a mood disorder and, that also frequently comes with anxiety, they'll turn to substances, like alcohol, marijuana and other things as a solution, because it gives them some temporary relief. What happens over time, as Marty talked about, is that the solution can end up being part of the problem.

So, they frequently can co-occur, but I think if you put it in the context of, “I'm trying to get some relief here, and this has given me at least some relief.” And then people don't recognize when it morphs into compounding the problem.

Ken Duckworth: What do you find about the different cultures of substance use disorder care and mental health care? I've been impressed at how these are two different approaches and two different worlds. When you have both problems, unless you can solve one of them as Peggy and Marty did together for Marty, it's hard to get them both treated at once. Do you have thoughts about that?

Andy Nierenberg: I think that there have been philosophical differences in the two different worlds. In the substance abuse world, sometimes they discourage people from taking any medications at all for psychiatric problems. That can be a bit of a problem. And then in the mood disorder world, people can say, well, I can't touch your mood disorder unless you take care of this first. Frequently, the truth is somewhere in the middle. You try to take care of both at the same time.

Ken Duckworth: Hm-hmm. Peggy mentioned that transcranial magnetic stimulation made a big impact in Marty's course. Marty, you want to talk a little bit about repetitive transcranial magnetic stimulation and the other treatments that you tried?

Marty Parrish: Yeah, of course. So, I have probably been on more the antidepressants than I care that I can remember. I tried to list them all out and couldn't remember all of them. But starting with the amitriptyline, Elavil, which is a first generation tricyclic, that was my first med back in 1987, worked for me. As many people who have taken those know, it has some serious side effects that eventually you just can't do it. The second generation, I went through a time of trying those, did not really work for me. Then with Prozac and Paxil in particular, Paxil has worked.

The problem is Paxil has, again, its own side effect that was not recognized by research scientist. I'm not gonna knock you guys, but those of us that took it knew it and I am one of those that do the provider training at Des Moines University to the third year students there and I had to share with him that the main reason I got off Paxil was the anorgasm side effect, which is the lack, ability to achieve orgasm.

Marty Parrish: I think that if people were really honest, they might admit that's why they stopped taking them. We have always been persistent and persevered in trying to find a med that would work long term. By the time up until about three years ago, I almost just about given up. I was taking the Paxil and then I would drop it. We tried some other things that didn't work. I don't know if the general public knows, but it takes anywhere from three to six to eight weeks for antidepressants to work.

If you're on one, you got to taper off of that one for three to four weeks before you can start a second one. So, when you start trying to find a new med that works better, you may have two to three months there where you're just suffering. I went through a period where I was out of a job about three years ago and, looking for the right medication and everything and just really about ready to give up. Peggy got to see a real clinical episode of depression: really not getting out of bed, really not getting off the couch, that kind of thing. Really not wanting to do anything. I had heard of TMS before in my research and she did, too through NAMI.

And then, she found out that it was available here locally. I had considered ECT (electroconvulsive therapy) 20 years ago. That's how bad my depression had gotten. But I decided against it because of the memory side effects and other things that came from that. What I learned about TMS is that it was safer and proven effective. I was evaluated for it here in Des Moines. I went through my first treatment three years ago this month, 34 sessions I think it was at the time. I lasted a whole year depressive free until we noticed that I was kind of slipping. Then I had a seven-session booster, a year after.

But for two years now, since that second session I'd been, just basically free of depression. That does not mean I don't have down days. We call them “bad brain days,” and I can have a couple or even three in a row, but I'm still functional. And I recognize it for what it is and what we both do is I alert Peggy and we just monitor it. If it's more than three days, then we're going to get concerned. But so far, that's not happened. So, I've been very pleased with the treatment. I'm not on any antidepressant and haven't been since the TMS sessions.

There are two different types of TMS. There's one that doesn't quite go as far as the magnetic impulses as the other does. I had the deeper of the two therapies. First you've got to be treatment resistant with medications before you even qualify for it. But I was astounded that I've gone this long without a major depressive episode.

Peggy Huppert: It was so life changing that I'll never forget this, that after we left the clinic office that day and they said he was accepted and he could start treatment in three weeks, I was really excited. I said, “Marty, aren't you excited? You got accepted into this. It sounds really promising.” And he said, “yeah, I guess, it's either that, or I'm going to die.”

Just very matter-of-factly.

Ken Duckworth: Andy Nierenberg, I wanted to ask you, how do you think about repetitive transcranial magnetic stimulation in the treatment toolbox? Let's acknowledge, it doesn't work for everybody. No one treatment works for everybody, but clearly had a major impact on Marty. So how do you think about that?

Andy Nierenberg: So, I think RTMS, or repetitive transcranial magnetic stimulation, can always be considered an option, all along the journey of having major depressive disorder. It really is, in some ways, a revolutionary type of treatment that's been around for a while now and continues to evolve. Where, you can rethink major depression as a problem in how areas of the brain are connected to each other, functionally. By using the repetitive transcranial magnetic stimulation, you can shift some of those connections that are related to depression towards a healthier state. It is remarkably safe. You don't need any sort of anesthesia. One side effect it can have is a bit of a headache, cause it can make the muscles in your scalp contract.

But it's a particularly potent and interesting type of intervention. The one thing I will say though, is that it can be a pain in the neck. And the pain of the neck part of it is, people have to go five days a week for six weeks, but there's some new technologies which may actually speed it up.

Ken Duckworth: That's very interesting, we still have so much to learn. People used to use the term “chemical imbalance,” which I always found problematic, but the idea of medications is they are impacting the neural synapses in terms of how neurotransmitters communicate and TMS, as you noted, is more of a connectivity. It's more of a wiring approach. Would you agree with that?

Andy Nierenberg: Yeah. That's one way to think about it, but it's not like a wire that you think about in something electrical because in electrical wiring, the wiring's fixed and what is amazing about our brains is that they're not fixed. You make and break connections all the time. So, it's a dynamic connectome if you will.

Ken Duckworth: Marty, Peggy had mentioned when you learned, you might be eligible for TMS, you said “I'll either get it or I'll be dead.” I think it's important when you're talking about major depression to talk about thoughts of harm, self-harm, or suicide or suicide attempts. I wanted to make sure on a podcast talking about major depression that we took this issue up. What has been your experience in this regard? Was that just one day that you said that offhand, or have you struggled more with your safety?

Marty Parrish: When you are in a state of major depression, the thought of suicide is almost constant or in my case, that's the way I felt it was.

In other words, you have constant negative thoughts. You see no purpose in anything. So what's the point of staying around? So that statement was coming from very deep and from very real point time in my experience. Now I like to claim I've never attempted suicide, but I had a therapist once who said, “When you drive a hundred miles an hour and drive your car off the road, maybe you are trying suicide with the car.”

Ken Duckworth: Did you do that?

Marty Parrish: I did do that. I impaled the car on a post holding up a bridge. How do you survive that? I don't know. We had to have a tow truck come and literally wrench it off the top of the post.

Ken Duckworth: You weren't consciously suicidal, but you were behaving, would you say, recklessly?

Marty Parrish: Absolutely. It is what happened and we have to recognize there's that danger and risk there. As I told the doctors in our last session, sleeping in bed with a loaded handgun because you're just gonna play with the revolver while you're you're drunk and depressed is not such a good idea, either.

These are just reckless behaviors that were part of it.

Ken Duckworth: Do you have any thoughts about how to prevent or address suicidal thinking? It sounds like for you, it was a combination of sobriety and finding the best treatment. You've also mentioned therapists a few times.

Have good therapists been important for you around your safety and your treatment?

Marty Parrish: They have when I found them. I've had therapists that I've worked with and they've been helpful.

The last decade has been the most helpful. A therapist here in Iowa that I saw for several years drew the line with Peggy on the alcohol. For anyone suffering depression, I advise them to continue to look for a therapist. One of the things I found is that when you're depressed, you tend not to have a social support network. I don't care how good a friend you think you have out there or family members. If they've been with you, eventually, they become tired or stressed themselves, and you need that support you get from a professional counselor and therapist.

Ken Duckworth: Marty, I'm interested in your thoughts, what you would advise somebody who's newly diagnosed with major depression and feel somewhat hopeless about their prospects going forward. What advice would you offer them based on your 40-year experience of living through depressive episodes?

Marty Parrish: The first thing is don't give up and don't quit. I've used this before: when I've encountered people with depression, they've asked me, “What do you live for?” And I said, “I lived to see what happens next.” So, I invite people to stick around to see what happens next. And in that same thought, I encouraged them to find help with a medical profession. If they can't get in to see a psychiatrist for four to six months, at least go see a county social worker, someone who is available for counseling and talking. From there, they may be able to go see their local family physician who can at least give them some immediate relief. May not be permanent, but it will at least hold them over until they can get in to see a psychiatrist.

Ken Duckworth: Excellent. Peggy, I wanted to ask you what you would advise the spouse of a person who's diagnosed with major depressive disorder. What advice might you offer them as they take on this journey together?

Peggy Huppert: Well, first of all, recognize it is a journey and that's one of the things that Marty and I always say when we speak together, is that it’s day by day. It is a journey and some days are better than others. It's not happily ever after, but there is light and happiness on the other side.

It's not all unicorns and rainbows, so you have to recognize that there will be bad days and good days, and it is not easy. It's not easy because we're all human, so we're going to get, at times, angry, impatient. “Get up off the couch and do something.” It’s just human nature to feel, “I can't always be the strong one, I want you to carry your weight in the relationship.”

I would not be doing my job and my duty if I didn't recommend NAMI. *Family to Family* is a wonderful resource. There's also family support. It's really helpful to educate yourself. What's really cool about NAMI groups is that you'll think you're the only one who has experienced a particular thing, and you share it, and you see everyone around the table, nodding and or smiling. They're like, “Yeah, yeah, yeah, been there, done that.” Get support, get help, and also work on your own wellness and do the things that make you happy and help you recover.

Ken Duckworth: Great, Peggy. Thank you so much. Dr. Andy Nierenberg, you've been studying depression for the better part of four decades. What advice do you have for people who are newly diagnosed and are struggling with the information?

Andy Nierenberg: I think to realize that the hopelessness that they feel is one of the symptoms of depression and that having hope and as Marty said, curiosity about trying to be open to what happens next, can be extremely helpful. Trying to push through it as much as you can, with as much support as you can get, can also help.

Ken Duckworth: Marty and Peggy, I want to say it was a pleasure to meet you. You're our first married couple on a podcast, and I want to thank you for opening up about the impact on your relationship. I think that was a particularly strong aspect of this conversation. And Andy, thank you as always.

That's all for this episode of The Medical Mind. Look for the first part of this discussion, led by Dr. Duckworth, in the Medical Mind episode list.

Tune in next month for a special series on early psychosis. The mission of SMI Adviser is to advance the use of a person-centered approach to care that ensures people who have serious mental illness find the treatment and support they need. Learn more at SMIAdviser.org.