56 - Depression - Diagnosis and Treatment
BioBalance Podcast — Dr. Kathy Maupin and Brett Newcomb
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Dr. Kathy Maupin: Hi, and welcome to BioBalance Healthcast. I'm Dr. Kathy Maupin.

Brett Newcomb: And I'm Brett Newcomb. And today we're going to talk about depression. As Kathy and I have our conversations we discover that there is incredible amounts of overlap between our two fields. And depression is one of those areas that overlaps pretty significantly. In my field when I have somebody come in that presents with all of the symptoms of depression, one of the first things I have learned to do is send them to a doctor. I want them to go to a medical professional, not a psychological professional to be evaluated for a health related causes. My training teaches me that there are two kinds of depression from which people suffer. What we call endogenous depression which is a physical system malfunction, usually having to do with neurotransmitters in the brain and Kathy will speak to those concepts in a minute. And the other is called an exogenous depression which is an externally caused depression, your dog dies, you lose your job, your kid moves a way to college, any number of things that happen that make people depressed. And the way that I understand it is that if you set up an upper range and a lower range for mood swings, emotional changes and fluctuations over the course of the day, everybody fluctuates, we all go up and down, most people don't go above or below a certain point. And if you have clinical depression, you go way below that point. Sometimes you have an exogenous depression and you are seriously depressed but not what we would call clinically depressed.

KM: And tell them what the difference is in that.

BN: The difference is the severity and the duration of the depressive cycle. They don't cycle normally. So you can be knocked off your feet for a few days, maybe even a couple weeks. Not really that much of a concern. But if it becomes a constant problem, an enduring problem, then you start to have what we call clinical depression. Part of the challenge with that is that many physicians now when a patient goes to them and says this happened and I'm depressed they say here take some anti-depressants. So we want to talk about anti depressants. And in another podcast we'll talk about anti-anxieties which are dispensed in a similar way, here's an anti-depressant and anti-anxiety, mix them as you need them.

KM: Part of that, in the defense of physicians, because of the way HMO's managed care has dealt with us, we have a very short amount of time. And an evaluation of depression is multiple hours long conversations with a counselor, psychologist, or psychiatrist. So it takes a lot longer than what we have available in the office. So that's a short cut.

BN: I'm glad you clarified that. I don't mean to be critical but that's just the way that it works.

KM: And it's not a bad idea to see if it works.

BN: And it may be beneficial to take it for a week or so to get you over a hump and then you're alright. But what I wanted to say was sometimes exogenous depression, external events are so impactful that they do become enduring and they lead to an endogenous change. So your neurotransmitters can change because genetically there's an imbalance. Or they can change because some external factor, some compilation of stress or loss over extended period of time.

KM: I kind of like to view it as a genetic weakness to that. If you look at your family history and you either know that in your family there were several that had severe depression or were hospitalized, in the old days that is what they did with patients they were hospitalized or took some other medication.

BN: Alcohol, they were hospitalized for alcoholism because they were depressed.

KM: That's right they were doing something like that to feel better. And it doesn't make you feel better of course; it feels good at the time. So if you look at your family history, that shows a genetic weakness that you might have.

BN: You said something that so many people say. You said they were drinking to feel better. That is not what the data shows, they drink to stop the pain. Drinking doesn't make them feel better. But the loss of the numbness or the hurt makes them feel like they feel better.

KM: Well I didn't really realize I was.

BN: Well nobody cares except people in my field and they'll fight about it forever. So what we want to talk about today are the symptoms of depression, what to do about depression. Sometimes the treatment of depression takes both medicine and therapy. And we want to try to give some people some information that would be useful in considering if they're depressed or if they're with someone who's depressed. One of the problems with people that are depressed is people don't have a lot of patience with them. It's not like an acute problem like you broke your arm and everybody can see it. And they go 'oh you poor baby, you broke your arm'. After a little while nobody has patience with that depression They're like 'damn it get over it I'm tired of this, where's my dinner, how come you haven't cleaned the house. We never go anywhere, we never do anything, and you're a slug'.

KM: Why don't you smile anymore?

BN: You weren't like that when I married you. Did you lie to me? And they get really horrific.

KM: It's true, that's what my patients say to me.

BN: And so if you are the sufferer of the depression you look at that and say I'm helpless because one of the characteristics is I feel hopeless, I feel like there's never going to be another ray of sunshine again I have no energy, I go sit in the corner, and I just am flat and if you're a female you talk to your friends over and over again about how bad you feel but you don't really want a way out, because depression makes you not want a way out. It makes you want to wallow in it. And friends don't have a lot of patience for that either because it makes me feel depressed themselves and no one wants to feel depressed when talking to their friend.

BN: I wrote about that in my latest blog at brettnewcomb.com, the impact on the therapist. I've worked with some people that are really chronically depressed and over time what I began to notice is it was really hard for me to have the energy go in and sit and listen to the same despair. I mean you have to really teach yourself how to handle that.

KM: It's contagious. Actually I've noticed because I've had to do the same thing with OBGYN, we have relationships with our patients and they come in and tell us about how depressed they are and how horrible their life was and for a year they felt terrible. And they tell us everything and then I felt like I was taking on their pain and their depression and then they leave and feel better. It was like they transferred it to me. I'd have to walk out of the room and kind of breathe deeply and try to get that mood off of me because I can't walk in and be depressing to a patient, another patient. That's not fair.

BN: No you can't. So one of the things that happens, and therapists are trained, some patients are so energy negative and needy that they will come in and it's like you are a rechargeable battery and they will plug into your energy and they will absorb it and they will feel better when the leave the session. And then you will notice as soon as they leave that you are depleted and if that consistently happens with the same client then you have learn how to protect yourself from that. You have to learn to filter that process so you can still give them energy but so you can still have some at the end of the session.

KM: And more over just get them out of that cycle of just talking about that. Maybe they do need medicine maybe they need.

BN: Nice segway because we do need to talk about the science of that.

KM: Yes we do need to talk about that because depression, in my world, it can come from hormones, it can come from long term stress which is mediated by a hormone called cortisol and when your cortisol goes up for a long period of time it wears out your neurotransmitters. Serotonin, I'm sure you've heard of these, Serotonin and epinephrine are the two most important in depression and it wears your brain out. So

when you're trying to survive a long term stress and many of us are surviving long term stresses years long in this economy and there are so many other things that are happening that cause us to be chronically stressed. Finally, you run out of neurotransmitters you get depressed and you feel depressed every day, every minute and you just can't get out of it without some help. And that would be medication that would replenish your neurotransmitters. And I also usually use something to decrease the cortisol because that messes your sleep up. If your cortisol is high all the time you wake up at 2:00 in the morning and ruminate and worry and that's usually a cortisol issue. So I use a very low dose of a natural cortisol from animals, an animal cortisol, but it's very low dose and it decreases that big spike in the middle of the night and that helps you sleep.

BN: But it's important that you talk to your physician about your symptoms because one of the frustrating parts about depression is that it manifests in the extremes. And so some people adapt by sleeping all the time. I mean every minute they're not required to function, they're asleep. Some people adapt by not sleeping at all so they report I can't sleep, or I can fall asleep but I can't stay asleep. The same thing happens with food. Some people when they're depressed can not eat and you worry about their survival because they're not eating enough and other people when they're depressed eat all the time. So it isn't that you can say "oh do you have a sleep problem or a food ingestion problem?" You have to look at the duration and the extremity. If you're swinging to the far side to either of those things then you need to talk to your doctor about the fact, I'm doing this help me figure it out.

KM: And how long it's been. It's best to be armored with your history. Go in and say 'okay so it's been 6 months and I can't get out of this mood and here's is what my husband says.'

BN: You need a keeper. You need a keeper to come and say "she's been this way for 4 months" because she's going to go "I have? I have? I don't remember" .

KM: Has it been that long?

BN: Because when that flat affect and depression exists you lose track of time. So sometimes though, you got a patient that comes in, you go through this whole process with them and say I think you need an anti-depressant, try this one, and/or an anti-anxiety. And then that person will call me and say "my doctor gave me this medicine, but I don't want to take it."

KM: Because they're afraid of it, they're afraid they'll be hooked on it forever. But that's not what happens.

BN: Or they're afraid of side effects.

KM: That's true and there are some side effects to these. But in general we can change the brand or type if there is a side effect. And the risk of being hooked on this if you're

only using it for, especially anti-anxiety agents those are the only ones that could be something you could hooked on.

BN: The addictive factor.

KM: Right the anti-depressants don't do that.

BN: But many of the anti-depressants out there have a side effect of reducing libido which makes it a catch 22. Because if you reduce your libido and you're non-responsive, non-aroused, non-sexual, then you're going to have pressure from your partner who suddenly says 'do you not love me anymore, have you found someone else, is there something wrong with me, am I doing something wrong?' which isn't the cause. Or they'll get angry 'you never initiate, you never want', it's a problem. So when I have an individual who's taking one of these anti-depressants, I really talk to them and to the couple about this potential side effect. It doesn't happen immediately it happens over time. It's like, continental drift, plate tectonics. So I talk to them about recognizing the symptom, understanding when it happens somebody has to cognitively process, and it's not the depressed person, has to cognitively process this is the side effect of the depression, this is not a definition of our relationship.

KM: And then the person that's taking the criticism has to realize that their loved one is trying to help them. They're not trying to be more critical and make them feel worse about themselves.

BN: Feel more hopeless. 'I'm trapped. I can't do anything about it.'

KM: You know, most of my patients say I can either have sex or I can be happy. You know that's basically the issue, And now that I deal with women over 40 most of the time, and men over 50, that is a hormonal issue that causes depression.

BN: It is and if you're "having sex or be happy", and so you have sex in order to be safe then what happens is that becomes toxic. And there's a buildup for that because I'm not having sex for intimacy, I'm not having sex for desire, I'm not having sex for release, I'm having sex for safety. And that feels like a form of prostitution or abuse. And so you get resentful and you feel trapped and not understating these things and not finding compensatory strategies that work for your situation really leads to additional problems. And it's part of the ancillary cost of being chronically depressed, clinically depressed. What often happens with the sexual piece of the anti-depressant medicine is the person that's taking the anti-depressant will not feel desire, they won't be conscious of "oh I haven't had sex in awhile" or "oh I want to have sex". Chemically it's just there. So they can however respond, if someone else starts the dance. If their partner comes to them and says "hey I want to be sexual" or however they communicate that, you can respond. But you won't initiate. There's another kicker. Sometimes you can respond but in the middle of the act, boom, it all turns off. And you're like "oh my gosh". It's devastating. So if you don't know that, you don't

understand that, and you don't develop strategies for working around it, you are going to compound the problem.

KM: Being able to have expectations that are realistic is kind of the key to every treatment. No treatment is fun. No treatment is without side effects. No answer to a problem is usually without risk. So all of those things, if you know those things, then you can decide if you want to take that risk or not. Is it important to you to not be depressed?

BN: Well we're back to being an informed consumer. And one of the informed consumer tidbits is that your family, your support personnel, your co-workers, somebody needs to be aware and participate.

KM: Somebody you feel safe with, somebody you don't feel threatened by because if you've always had a relationship with your spouse where they're criticizing everything you do, that's not the person to tell you you're starting to act depressed again.

BN: Maybe a sister, maybe a next door neighbor, maybe even a grown child, somebody that might know.

KM: Best friend.

BN: The problems of depression are many and manifest. Books have been written, we're not going to cover all of that today. But I guess the key points would be know that there can be a physiological component, there can be an emotional stress component, they interweave. For what we call clinical enduring depression, you have to have some kind of intervention. Go talk to a specialist, talk to your physician, talk to a counselor, get some help.

KM: And I'd like to talk about on our next health cast about the hormonal reasons to be depressed and anxious, and that we didn't get to cover today.

BN: Will start with that on the next one.

KM: And so we'll start with that on the next one.

BN: So tune in next time, and thank you for watching today or listening.

KM: And if you have any other questions about our health cast you can go to our website at www.BioBalanceHealth.com or you send us an email at podcast@BioBalanceHealth.com.

BN: And you can find me at www.brettnewcomb.com and my latest blog is about depression and anxiety.