Podcast Transcript

Out of Darkness: Symptoms and Treatments for Major Depressive Disorder

Episode 1 – It's an Illness, Not Sadness

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At Colibri Healthcare, we developed this educational content with a genuine approach to bringing attention to mental illness from a healthcare provider's perspective. This podcast series contains content that may be unsettling to some listeners. Each episode involves an in-depth discussion of suicide, depression, and self-harm. We do our best to discuss sensitive topics such as these with discretion and sincerity. Because of the sensitive topic being discussed, we recommend this podcast series for adults only.

Content Warnings: Mentions of Depression, Death, Suicide

Guest

Reg Arthur Williams PhD, RN, BC, FAAN

- Dr. Williams is a professor emeritus in the School of Nursing and Psychiatry, Medical School at University of Michigan.
- He completed his PhD in higher education in 1980 and became the chair in Psychiatric-Mental Health Nursing at University of Michigan, where he taught undergraduate, graduate, and doctoral students
- As a board-certified clinical nurse specialist and nurse practitioner in the state of Michigan, he continues to carry a small caseload of patients who suffer from depression at the University of Michigan Depression Center, where he provides psychotherapy and medication management.
- He has conducted research on depression and was the principal investigator in research funded over a 15-year period by the Department of
- Defense, TriService Nursing Research Program, to examine stress and depression among young men and women in military service
- He has written four books and more than 80 journal publications.

Host

Leana McGuire, BS, RN

- Over 30 years' experience in healthcare
- Teaching experience in leadership development and executive coaching
- Background in content development, visual performance, speaking and podcast hosting

Content Reviewer

Candace Pierce DNP, RN, CNE, COI

- With 15 years in nursing, she has worked at the bedside, in management, and in nursing education
- She has demonstrated expertise and scholarship in innovation and design thinking in healthcare and education and collaborative efforts within and outside of healthcare.
- As the Lead Nurse Planner for Colibri Healthcare, she engages with nurse planners and subject matter experts to assist in developing high-quality, evidence-based continuing education for nurses and other healthcare professionals.

Transcript

CANDACE PIERCE, Reviewer: Hello, I am Dr. Candace Pierce with Colibri Healthcare. We are so glad you are joining us as we dive into the topic of depression. It is estimated that 5% of adults worldwide suffer from depression. In the United States, it is estimated that 21 million adults will have at some point in their life, an episode of major depression. Depression has been around as far back as the 4th century BCE, when Hippocrates identified depression as a physiological disorder. Depression, a very common term, is much more complex than sadness or feeling blue. It is actually considered a leading cause of disability worldwide.

Now let's join into the discussion with our host Leana and our expert Dr. Reg as they discuss the symptoms and treatments for Major Depressive Disorder.

(SOUNDBITE OF MUSIC)

LEANA McGUIRE, Host: Welcome to a special edition podcast with Dr. Reg Williams. Dr. Williams is Professor Emeritus at the School of Nursing and Psychiatry in the Medical School at University of Michigan, and he also serves as a nurse practitioner. Welcome, Dr. Williams

REG ARTHUR WILLIAMS, Guest: Thank you.

McGUIRE: Do you prefer Dr. Reg?

WILLIAMS: The pleasure to be here.

McGUIRE: All good. Good to have you here. Our topic today is depression out of darkness, depression and some latest therapies, which I think is a really, really interesting and intriguing topic. You and I had a conversation offline, and the questions were just bouncing around in my head. So, I'm happy that you're here for everyone to hear. And as you answer some of those for us now, I think we're all familiar with experiencing sadness.

Can you explain to us the difference between feeling the blues or feeling sad with actual depression?

WILLIAMS: Absolute. You know what's interesting about depression and sadness to sort of compare the two, you know, often times when people are feeling sad, they'll say, oh, you know, I'm feeling depressed, but they're actually experiencing sadness. And the easiest way to kind of characterize it is we all feel sad if someone dies

that is close to our family, a loved one of some person that that you've lost an animal that we're very close, that we treasure.

Those kinds of things will oftentimes cause sadness. And that aspect of being feeling down and feeling very sad over a loss, you know, is pretty profound. However, people, when they're feeling sad, can actually pull out of it. And probably a good example is during a wake, you know, people might be talking about their loved one and sitting and laughing, telling, telling stories about the person.

And then 5 minutes later, you're sitting, crying. I mean, that is sadness. And that is not atypical of the grieving process that we all go through. But depression is very different. It's clinical depression where you don't pull yourself out of it. And so, what I oftentimes use as an example that really characterizes, I think, depression is that a person will say to me they feel like they've fallen in a hole, and they can't get out.

And that is so true. If they don't even, they'll oftentimes even use that term, but they'll often describe something that's very similar. And I've seen my role in terms of helping people as if I'm putting a ladder in that hole and helping them climb out. And that's actually, you know, when you combine medication and psychotherapy, that's what I'm doing, is putting that ladder down there and helping them climb out of that hole.

McGUIRE: Wow. That's I love that analogy. That's perfect. So, this depression, when they feel like they're in that hole. Are there ever glimmers of light or they're just literally in there?

WILLIAMS: Oh, there can be glimmers of light. But, you know, for a diagnosis of depression, it has to be the symptoms. And we'll go over those in a moment that they experience. But it's more days than not. More hours than not. And that's typical of, you know, clinical depression.

McGUIRE: Great. What are the incidents of depression in in in the U.S. or, you know, globally? What is what have you got for statistics on depression? I'd love to hear that.

WILLIAMS: Well, you know, it's estimated that about 21 million U.S. adults have at least one major depressive episode in their lifetime. And so, it is it is profound in terms of the number of people that experience depression. And when I talk about this topic, you'd be amazed, Leana, how many people tell me, oh, my goodness, I suffered depression or I've had depression in my past, that kind of thing.

And it is so common to hear the number of people that have suffered depression. And so, it affects a lot a lot of people.

McGUIRE: Sure. And a lot of them that we wouldn't even know about. Right. I mean.

WILLIAMS: Exactly.

McGUIRE: Just the ones we are aware of.

WILLIAMS: Where because a lot of people. Well, one of the things that I think is kind of interesting about what depression does to a person, and it's actually one of the symptoms of depression in terms of what it does, it makes them think that they're weak and that somehow, they should pull themselves out of it so they can go for a period of time convincing themselves, oh, I'm just being weak.

You know, this is not an illness. I'm just I'm just being lazy. Those kinds of terms that they'll often describe their behavior. And in reality, they're suffering depression and it really affects their life and people around them.

McGUIRE: Sure. So, there'll be people listening to this podcast who may be thinking, I don't know anyone that suffers from depression, but you actually may. They're just not being forthcoming.

WILLIAMS: Oh, most often, yes, I. Well, one of the things that I do is often ask students, you know, how many people do they know that have suffered depression and I can assure you that when I've lectured on depression with nursing students as an example, every hand goes up in terms of how much they've seen depression, either in their family or friends or even in themselves.

McGUIRE: Sure. Sure

WILLIAMS: So, it's pretty profound.

McGUIRE: Among other things, the cost of depression can be burdensome on our society. Is that correct?

WILLIAMS: Oh, absolutely. One of the things that that some of the statistics that have been shown in terms of the cost and burden of major depressive disorder is it increased from $236.6 million? I'm sorry, $1,000,000,000 a big B billion in 2010 to $326.2 billion in 2020. So just in that period of time, you can see in a ten-year period how much it has actually increased in the cost.

And the burden is just not only for the person but for companies, for families, you name it. And it is it is a very expensive illness.

McGUIRE: Wow, it just it's not something that I would have thought about after. Off the top is the cost of it. But that is staggering. Now, we talked just briefly about that stigma of being weak. And I know when I think of my father's generation or even my own, I think that that was really prevalent. But what about younger generations?

What about our millennials or nexters, or are they? Do they have the same stigma to the same degree or is it different?

WILLIAMS: You know, the good news is, is that I, I really seen a difference of older generation and their stigmatization of depression as compared to younger people. Younger people are much more willing to be open about their depression, tell their friends, etc. Where during? During my parents' era. Oh, you didn't even mention it. You know, a mental illness was not something.

It was kept in the closet. You know, you threw the key away so that no one knew that kind of thing. And so, the contrast. But unfortunately, there's still a stigmatization. And I think one of the one of the problems with it is that what I described to you earlier about that feeling of feeling weak. And I often tell patients it's kind of a standard statement that goes out there that I've said a number of times to people, you know, you have an illness, not a weakness.

And that is so important that the person recognized that this is an illness. It is not that they are just being weak or being lazy, none of that. Right. And so, it helped that take the stigmatization. When I work with patients, I have a program that I use where it illustrates the brain and the limbic system within the brain and actually go over that with the patient so that they really by the time I'm done with them about it, they truly understand that this is an illness.

No different than any other physiological illness that people suffer. And they really then walk away with the understanding that we're talking about an illness, not a weakness. And I'll tell you, it's really pretty profound. And I always do that with every patient that I do an evaluation on and talking with them about their depression.

McGUIRE: Wow. That's very interesting. But I am glad that that stigma isn't as bad as it was because it really was an issue. Yes. Depending on the generation. So, if depression is left untreated, does it get worse, or do they stay at about the same level? Or how does that transition work? If there is one.

WILLIAMS: Good question and I think it's something to really understand about depression and what it is, is that when you look at depression untreated, that the depression symptoms get more severe as time goes on, they last longer. So, they are they experience depressive symptoms for a longer period of time and the time between episodes. So those periods between the episodes become shorter.

And that's what happens. There is a graph that really depicts this that you really get to understand that over time, with untreated depression, the person really gets to a place where they have more days of being depressed and severely depressed. And this is where you see people that get aged, and they are really in a constant form of depression.

And it's because it's gone untreated. And, you know, earlier generations wouldn't seek treatment. Younger people now are more willing to say, you know, something's wrong, something's not right, that I need help. Where older generations wouldn't do that. And so, it's changed. But, oh, there's still a lot of people that suffer depression and don't seek treatment.

McGUIRE: Well, younger generations are more open to sharing in general. Maybe that's part of the reason. Do you think?

WILLIAMS: Yeah, I think so. I think so. I think that's part of it. I think they have come to realize that holding this all in doesn't do anything and being able to at least tell people, you know, I'm having a hard time here that they're much more willing to reach out for help. I mean, that's the encouraging part.

But, boy, we still got some distance to go before we really get people to seek treatment early. And that that is still a problem.

McGUIRE: Have you seen I'm just curious, in your practice, if you have seen an increase or are aware of more of an increase since COVID since 2020?

WILLIAMS: Oh, yeah. Although what's interesting in terms of your question is, you know, if you look at the statistics on COVID and the increase in depression, you know, especially in younger people, there was about a twofold increase of depression in younger folks, 2 to 3-fold. So, it really did cause younger people to have more depressive symptoms and that was very, very concerning as to what was going on with COVID.

Now, my patients that I treat, I was concerned about that, you know, with having they having to stay at home, you know, not making any contact, etc., were they going to have an increase in depressive symptoms, and they really didn't. But I think what it what I attribute it to is that I was seeing all my patients remotely, so I was seeing them via Zoom, and we were connected.

So, we weren't sitting there with a mask on. You know, I saw them. They saw me. We talked about what they were going through and that support it got them through that period without really any problem. So, I ended up not having to do more for the patient that I was treating when COVID hit, but certainly people started coming in more frequently because of COVID.

So, there was there was an uptick in the number of people seeking treatment because of COVID.

McGUIRE: Interesting. So, I would yes, I would like to talk to you about how this shows up, what are like the symptoms. For example, if someone is not forthcoming, that they're feeling depressed or going through something like this, but, you know, you're assessing a patient as a nurse, what kind of things are going to show up that would indicate that this person may be having a depressive episode?

WILLIAMS: Well, the typical diagnostic criteria for major depressive disorder, see, really comes down to where the person experiences a depressed mood. Mm hmm. And or a loss of interest in pleasure and activities that they normally would gain pleasure in. Sort of anecdotal, what we often referred to as anecdotal. And then they must have at least five more symptoms present, but it has to be during the same two-week period.

So, in other words, this isn't something that, you know, a person experienced. I was had a depressed mood today and I'm fine tomorrow. Now this it goes over a two-week period where they really having more symptoms than not, more days than not, and for more hours they're not. And so that is typical in terms of the other symptoms that often happen with depression.

Major depressive disorder is weight loss or weight gain. They'll experience insomnia and most often insomnia, but on occasion there will be hypersomnia. So, they'll oversleep. I've had a few patients that literally were sleeping, sometimes 14 hours a day because they were hypersomnic. And so that that can happen. Psychomotor agitation or retardation can happen with some people where they literally will describe to you as if they were in slow motion.

You know, you were having a slow-motion picture where they are just literally slowed down, slowed down not only in their motor movement, but slowed down in their thinking that they literally what will happen in that when you see that symptom is they will literally you ask them a question and they'll pause and you're sitting there waiting for them to respond to the question.

That's psychomotor retardation. Boy that is profound when that does occur. Now, not all people get that, but it is a symptom as a criterion for the diagnosis of depression. The other is fatigue or loss of energy. I see that quite frequently with patients with depression that is very common and then feelings of worthlessness or excessive guilt. They feel guilty about everything and just that is so common that I see with patients with depression and then a very frequent one that I see often with people with depression is difficulty in concentration.

They can't focus and they just can't think through something, can't even problem solve. And I could explain that to you from a physiological perspective in the brain as to why that occurs. But in any event, it is one of the one of the diagnostic criteria for depression. And then, of course, the most serious is recurrent thoughts of suicide or death.

They may not talk about, you know, I'm going to kill myself, but they may talk about, you know, they'll say something like, you know, I wish I could just go to sleep and not wake up. And that is some of their thoughts of death and it is pretty profound when they when they experience that. And it's scary.

There are other criteria that sometimes happens, although it's not diagnostic criteria, but I see it very frequently in people with depression, they can experience aggression or anger. Not uncommon to have someone really angry about something that's going on in their life, etc. one that I see very often and again what I'm describing, Leana, are symptoms that are not necessarily they're not diagnostic criteria, but they are very common with people with depression.

So, cynicism they will be very they just they they're upset about anything and everything and very cynical and or if someone criticizes them, oh, my goodness, they'll overreact to it. That is, if, you know, you just cut them at the knees kind of thing. And they're very self-critical. I had one patient that every time she'd talk about her depression, she put up above her forehead an L for loser, you know.

And that's how she criticized herself, that she was just a loser. And it's like, no, you're not. But that's how she sort of viewed herself. The other that I see also so frequently with patients, which is not necessarily a bad trait,

but that can be a trait that really causes them a lot of problems. Is perfectionism. They get very, very perfectionistic about anything and everything.

So whatever job they did wasn't good enough that that's where it comes to haunt them in very, very negative ways they can. Depression is an all-body illness, and so they can have gastrointestinal symptoms, you know, stomachaches, headaches. They have a lower stress threshold when they experience stress, a stress will get to them very, very quickly.

They will over worry, worry about minutia, worry about things. It's not a big deal. But in their mind, they'll sit there and worry about it. I've had some patients that will put on an act. I've had one patient said to me that she was hiding her depression from her friends so she would put on when she'd go to a party or meet with some friends or something.

She told me that she put on an Academy Award performance of how happy she was, etc. but behind that she was in absolute misery. And so, you know, that whole business of putting on an act can happen. What's interesting about that is the people who see it through it the most are people that they themselves have been depressed.

They lost it almost immediately, which is really very interesting. Another one and this this whole thing is part of also treatment in terms of depression is distorted thinking. You'd be amazed of how they will take things and think about it, and it becomes very, very distorted. And we'll talk a little more about that later. Some patients I've had who have infidelity, they may have an affair, or they will have marital conflict.

I've had a number of patients that ended up coming into treatment, not because they thought they were depressed, but because they were having such difficulty in their marriage, and they were getting very down about it. And indeed, they were depressed and that helped them. When we got it treated some patients, not a lot, but some patients will get into risky behaviors.

They'll take chances on things, get it very risky. Or one that I see very often is social withdrawal. They will literally draw away from their friends, not return phone calls, not return emails. They will literally back off. And this becomes a vicious cycle. So, what happens is now remember, guilt gets played in here as well. So, what happens is they don't respond to a friend either by phone call or email.

However, they were connecting with them. Then they wait too long. Then they feel guilty because they didn't do it. Then they say to me, well, I don't even know what to say to the person. I literally in therapy you have had patients where I literally got them on the phone with a friend and helped them talk to the person just to work through that whole thing of withdrawal that they got into.

And so, it is so common. And the last one that sometimes you can see is substance misuse. They will misuse, it can even be over-the-counter meds, but nonetheless they will get into misusing medications and alcohol being one of them, one of the biggest ones, what most people with depression don't realize. They think they feel better when they're drinking, but in reality, it makes their depression worse.

And so, I often have talks with patients that I treat of, look, you know, I know that you think it makes you feel better, but in reality, you don't sleep as well. And secondly, it increases your depressive symptoms. And I could give you examples of patients of where that's happened. But in any event, those are those are not uncommon.

McGUIRE: Yeah, that sounds like a really vicious circle of trying to find relief.

WILLIAMS: Oh, it is worsening.

McGUIRE: I'd just like to ask a couple of questions about a few of these. What can you give me an example of distorted thinking for our listeners?

WILLIAMS: Yeah, there is. There's a whole list. And David Burns wrote a book on this where he outlined Distorted thinking. And it's really quite interesting. An example of one is all or nothing. People with depression get into its either all or it's none of it. And they will literally go to the extremes. While we always know most of the things are somewhere in the middle, it's not all or nothing, but they really do get trapped into that kind of thinking.

So, it gets very distorted and that that example of self-criticism is another one where they will, you know, criticize themselves for just nothing, but yet in their mind, it's like profound. And so that's another element of distorted thinking. So, there's a couple of examples for you.

McGUIRE: Excellent. Okay. And I would think that that putting on an act has I mean, that has got to be physically and emotionally exhausting to do that really.

WILLIAMS: It is.

McGUIRE: Which just exacerbates the problem.

WILLIAMS: You're right on that. It's also true and I've had patients that did that, talked about how exhausted they were by the time they got home because they were trying to show everybody, oh, I'm so happy when in reality they were miserable. And yeah, the patient that I think of just immediately in my mind is a woman that that literally did that.

And she talked about how she literally had to go to bed the minute she got home because she was so tired from trying to just put on this act. So indeed.

McGUIRE: Now for a nurse and assessing a patient in a clinical setting who is unfamiliar with their benchmarks, so to speak, or what their baseline is, some of these symptoms may appear to be just part of that individual's personality. Do you recommend having conversations with families if there's anything that you're not sure about, or if a question arises that you think they might be depressed but they say they're not.

WILLIAMS: You bet. I very often when I'm doing an evaluation on a patient and the family is out there in the waiting room, I always talk with the patient and ask them if it would be okay if I met with the family. Since they're out there waiting for them, they're concerned about what's happened to their family member, etc.

And, and I cannot think of a time yeah, I really can't where a patient said to me, no, no, I'd rather you not talk to my mother, my father, you know, my wife, my husband, that kind of thing. They've always said, Yeah, I've been more than happy, so I'll bring them in, and I will literally give them some of the education that I gave the patient about what's going on in the brain, you know, what's happening, and talk with them about how the depression not only affects that person, but also affects the family.

It isn't just the person only it really is pretty profound of how it happens. Much of those examples that I gave you that are not part of the diagnostic criteria you can well imagine have a real impact on family members. They really do. You know what? When you've got someone who's being rather aggressive or angry all the time, that's not a fun interaction to have with a spouse is an example.

And so, you can see how depression really does affect not only the person but the family too.

McGuire: I think you've really shone a light for us. I mean, not that we weren't aware on some level, but it's really shone a brighter light on the fact that if someone's coming in for a clinical reason and they're displaying symptoms of depression, that we shouldn't just brush that off, that we need to take the time and dig in.

Is that correct?

WILLIAMS: Absolutely correct.

PIERCE: That is all the time we have for Episode 1. But what profound information Dr. Reg has shared through this episode. We know that there are and will be events that occur in life that will cause intense sadness and put us through the phases of grieving. But clinical depression is not being able to pull ourselves out of the dark hole; and as healthcare professionals we need to take the time to further assess when we notice symptoms of depression.

(SOUNDBITE OF MUSIC)

If you or someone you know is struggling with clinical depression, we at Colibri Healthcare encourage you to seek help with a counselor nearest you, or by contacting the National Alliance for Mental Health, also known as NAMI at 1-800-950-6264. If you or someone you know is in an immediate health crisis, you can also seek help by just dialing 988.

I hope you can join us for Episode 2 of this series Out of Darkness: Symptoms and Treatments for Major Depressive Disorder where we will continue the discussion of depression as it relates to suicide ideation and past, current, and future treatments of Major Depressive Disorder.

This is Dr. Candace Pierce for Colibri Healthcare.

(SOUNDBITE OF MUSIC)

Episode 2 – Past, Present, and Future Treatments of Major Depressive Disorder

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McGUIRE: I think you've really shone a light for us. I mean, not that we weren't aware on some level, but it's really shone a brighter light on the fact that if someone's coming in for a clinical reason and they're displaying symptoms of depression, that we shouldn't just brush that off, that we need to take the time and dig in.

Is that correct?

WILLIAMS: Absolutely correct.

(SOUNDBITE OF MUSIC)

PIERCE: Welcome back for episode 2 of our series Out of Darkness Symptoms and Treatments for Major Depressive Disorder. I am Dr. Candace Pierce for Colibri Healthcare

In episode 1, we focused on symptoms within the diagnostic criteria of depression and observed symptoms that are seen in most people suffering with major depressive disorder but that are not necessarily a part of the diagnostic criteria.

In this episode, we are going to discuss-- the how to--for discussing suicidal ideation with patients and the present treatments for depression along with some very interesting possible future treatments.

We are going to rejoin the discussion with our host Leana and our expert Dr. Reg as they continue the discussion on Major Depressive Disorder.

WILLIAMS: Not every nurse is going to necessarily, have a psych background to be able to, you know, evaluate their depressive symptoms and come up with a diagnosis. But what's important is that that nurse be able to say, you know, I'm concerned about what's going on for you and make an appropriate referral. You know, that's what a nurse that is not in psych mental health, as an example, can actually do because of the desire to care for that person and provide them the best health care that they can.

And that's what I believe every nurse should do. I've had nurses say to me, oh, well, you know, when I was in school, I didn't like psych, so now I'm not doing psych. And my response to them is, yes, you are, because if you're going to be an effective practitioner, you're going to do psych. You can't escape it because people come in with all kinds of stresses.

And I've seen some nurses, you know, say, well, you know, I'm in Peds. I don't have to deal with any psych problems. It's like, well, wait a minute, what's going to happen with that mother and father that are freaking out over something of a diagnosis of their child? You're not going to use your psych skills. Yes, you will.

And so, there is where I've really confronted nurses about the importance of build their skill, even though they don't necessarily have to go into psych, but they're going to call on their psych skills throughout their entire career.

McGUIRE: Yes, definitely. I totally agree. And to your point, I think that bringing that point to the open about contacting a psych nurse or doing the referral is key, because I think sometimes that nurses are afraid that they're going to say the wrong thing. But if you bring in someone who knows what to say and how to broach the topic and go from there, then you're then you're fine.

It doesn't have to be you don't have to take on everything as the caregiver. So that's really important to remember those resources.

WILLIAMS: Just to add to that comment, Leana, there is I often tell nurses that you know, don't worry about you're going to say the wrong thing to the person they've already had all the wrong things said to them already anyway. So, you're not going to say something that's so much worse if you care and you are connecting with that person and you've got empathy, guess what?

You are helping that person. And so, I never worry at all that a nurse is going to say some horrible thing to a patient. If they are operating from that perspective of being empathetic and being supportive and being concerned about the welfare of their patient, they're going to be fabulous.

McGUIRE: Excellent, great point. Empathy. Empathy is the key ingredient at all times, empathy and not sympathy, because they you know, people can tell the difference. They can read that right away. Now, this topic, I realize that depression can sometimes sadly lead to suicide attempts or ideation. How often does that occur and how many are actually follow through with it?

WILLIAMS: Well, you know, when you look at yeah, it you know, one of the things that I think is one of the most serious outcomes to depression, of course, is suicide. And it is something that I can tell you as a provider, I take extremely serious I do not ignore it. I make sure that I've evaluated it and I ask the questions that I think every nurse should do when they are wondering, you know, is this person possibly having suicidal thoughts?

But to answer your question, they're probably more than about 47. Yeah, say it right. There are probably are more than about 47,000 patients or people that complete a suicide per year. So, when you think about it, that is

pretty huge. You know, we lost 58,000 people, young men, some women in the Vietnam War. This is not that far from that amount per year.

That was the whole Vietnam War of the 58,000. Think of that happening, almost having that per year with suicide. So that's why suicide is so important to not ignore. And if anything, we need to do everything in our power to make sure that a patient isn't suffering to the point where they are literally, seriously wanting to die. And that is so important.

You know, about 12 million people have serious thoughts about suicide. So that's not uncommon to see that. And that number, about 3.6 million have made a plan. So, they really have an idea in their mind of how they would actually complete suicide. And 1.4 million have attempted. And those are statistics that were put out by the CDC. And so, it is important to recognize that suicide is very serious, and it is not something to ever ignore.

It's the 10th leading cause of death in the US where homicide is 16th. Wow. So, when you just think of that alone, it, it, it is more than homicide. And, you know, we, we, we just think of, you know, how many people are being killed by homicide. It's nothing in terms of comparison. And, you know, many of the statistics on suicide, you really have to think about there probably more because how many single car accidents occur that were considered an accident but in reality, may have been a suicide.

You know, you don't know in terms of how many more really actually died from completing suicide. So, what I always tell people that nurses that work with patients is if you have any question whatsoever, you ask, right, that is so important. But you got to build a rapport with the patient before you just look at them and say, well, are you thinking about killing yourself?

That's not the best way to approach it. So, know that that it is important to assess, and it is something that no nurse should ever, ever ignore.

McGUIRE: No, that absolutely just blew my mind. That comparison with the Vietnam War, it just really drove the point home. It's staggering numbers. I'm curious about the 3.6 million who have made a plan. If someone has made a plan, are they more likely to attempt?

WILLIAMS: Yes. It doesn't mean necessarily that, you know, given that they have a plan that they're going to follow through on it. One of the things, Leana, to keep in mind is when a person is having thoughts of suicide, they're ambivalent. They at one point think, oh, you know, I just I want to I want this over. I want this pain to end.

And so, they then they have thoughts of suicide, but there's another part of them still wants to live. And so that is one thing I recognize when I'm dealing with someone who is suicidal. Now, knock on wood, I have never lost a patient through suicide. Thank goodness it is scary as a practitioner because I certainly don't want any of my patients to ever complete a suicide.

But it is something that I take very seriously, and I evaluate it. And if I determine that they are a suicidal risk, I literally have them go to the emergency room and have it evaluated. In every case that I've done this, the hospital has agreed with my assessment, and they hospitalized the patient because they were that serious.

So, I've always made the right decision in those situations. I never let the person go home when they were that suicidal. And thank goodness for that. But it's serious. And, you know, we'll talk more about suicide for sure. But nonetheless, it is something that as a practitioner, you never want to ignore.

McGUIRE: No. Yes. We will be doing actually a separate podcast on suicide, but this ties in with the depression conversation and it talks about, you know, it ties in with assessing these folks for sure. And what about asking

about suicide? Because I know that some people are afraid that if they mention it, then it will plant an idea in the patient's head.

Is that accurate or should we just let that thought go.

WILLIAMS: Get rid of it? Because it's a myth there. I've never had a patient and I've told many, many nurses to never worry that somehow by you saying, you know, have you thought about suicide in the patient says to you, well, no, but now that you mention it, that's a good idea. I've never had a patient say that.

Believe me, when you ask them the question, you can get a sense of relief in the in the patient that I'm actually letting someone else know of the pain I'm going through. And that in itself is very protective for the person in that sense, not 100%, but it certainly is on the road of literally keeping a person from actually doing harm to themselves.

And so, whether it's an attempt or a completed suicide is what you are really trying to prevent. And that is so important to do. And so, indeed, that's a myth. Never, ever do I have people worry that somehow, you're planting an idea in their head because you really aren't. They thought about that long before you even mentioned that.

McGUIRE: Yeah. Yeah. Okay. And again, we will concentrate more on this topic in a in another podcast episode, but just a few if you could give us a few tips on how to bring up the topic if you're someone who's not comfortable and you're assessing a patient, what are what is some verbiage or approaches that we could use that would be helpful?

WILLIAMS: Okay. I'm pleased to tell you and give you some ideas of how to deal with that, because that's what's important. What I think is also important is to remember that and I use this example with nursing students and said, you remember the first time you ever gave an injection. You know, you were you were sitting there shaking in your boots, oh, good Lord, you know what?

Could I hurt the person? You know, am I going to do this right? You know, kind of thing? Yeah. Well, how did you get better at it? You practiced. You'd get more. Same thing with asking a patient about their suicidal thoughts. The more you do it, the easier it becomes for you. And so you never. You're never uncomfortable, you know?

Initially, yes. Just like you were with that injection. It's no different. But the fact remains is the more you get comfortable in asking the questions and find out, and when you do pick up on a patient that is suicidal, you have you will get accolades like you won't believe. And that's what's important. And it doesn't mean that you then have to do the assessment as to how much of a risk they are.

It's the fact that they're a risk. Get them call in the resources, call in the troops to help you to then deal with this, to get this further evaluated so that that patient wouldn't leave and then actually completed suicide. So that's one point. The first thing I think is so important is to build a rapport with the patient.

You can't just jump in and say, well, you know, are you thinking of killing yourself? Because that is so shocking to the person that they may not really answer you honestly, but if you've built some rapport and you are empathetic with that patient, they will tell you when you ask them. And what I usually recommend is, you know, start out slowly, but make sure that throughout that interview that you are making with the patient that you've asked them the question.

So, it could be things like, you know, how badly are you feeling or how hopeless do you feel? That's a good question to ask a patient. Are you thinking a lot about death or being better off dead? That's it. That's a very

good way to get into this whole thing. But I think what's most important is you are direct, you're open, and you're matter of fact.

And you can ask the person, do they have a plan? And if they do, you know, how serious a plan is this? Now, sometimes I've had patients say, you know, I've thought of it, but I can't do it because, you know, my it would affect my children forever. And that is so true. One of the things that I do with patients is I do talk with them about the fact that, you know, very often when they are very depressed, their feeling is, you know, my family would be better off with me dead.

While I assure them that under no circumstances ever, ever is the family better off with you dead because they're not. They will have to live with it for the rest of their life. And I often talk with patients about that and Leana, I've had patients say to me, oh my goodness, I never thought of it that way because see, they're so focused on the pain that they're in that they're not thinking of the impact.

But that doesn't make it so that all of a sudden now they're no longer suicidal. It just means that it is something that you need to help them to put it in perspective in that sense. And it and it really again, I've had patients that I've done that and that really opened up their thinking in terms of their suicidal thoughts.

What I think is most important to recognize is that when you treat depression, you put a patient on medication and they are having thoughts of suicide and the medication starts to work, they will come back. This is I can't tell how many times this has happened, and the patient has said to me, my goodness, I can't believe I was thinking about suicide a week ago.

I'm not thinking about that now. I'm this just boggles my mind that I was thinking in that way. And that just shows you how much this is an illness, not a weakness. If the medication wasn't doing something, then they wouldn't be saying that. So that's why it's important to recognize it's the treatment and that support that you're providing that can really make the difference of their thinking more about suicide or not.

McGUIRE: Well, that's a perfect segway into my next question, which was about treatment approaches. So how do we approach this from a treatment perspective?

WILLIAMS: Well, the most common treatment for major depressive disorder is usually using a selective serotonin reuptake inhibitor, which is called an SSRI. And that can be things like fluoxetine, which is Prozac, or sertraline, which is Zoloft or citalopram, which is Celexa. Those are just a couple examples of that type of medication that is used as an SSRI.

And they can be very effective. They don't always work perfectly for every person. And so, recognize that. But it is certainly the method that is most often prescribed for major depression. And I've had tremendous luck now, one of the things that I do is I tend to do a genetic test that I use to evaluate how the person metabolizes different psychiatric meds.

So, it provides a report, and it puts it in what are called three zones. There is a green, a yellow zone, and a red zone. The Green Zone are the meds for that for let's say for depression. It would list out the meds that probably the person would have less side effects and may be more effective in treating it.

It is not a not an absolute is not a panacea. But it certainly helps to reduce the, you know, hunting and pecking to try to figure out what's going to work for the patient. So, then a yellow zone is that there may be some side effects, or it may not be as effective for certain people. You know, if they're a smoker, for example, it will sometimes put that med in like a yellow zone.

And then the red zone is where the med would cause more side effects. That really could be troublesome for the person. And so, if you don't know how the patient metabolizes the med, you could put them on the wrong med and. Then they're having all kinds of side effects and then say, oh, I don't like this and stop taking it.

Well, now you're back to zero point and that's not the way to go with treatment. What is important about the side effects of SSRI is the most common side effects are either headaches or nausea and vomiting. Those are the most common. If and what I've found in my own practice is if I really let the patient know about that, they will often come back to me and say, you know, you helped me explain this to me and I found out that I did have a headache, but it only lasted about a day, and I was fine.

And it's, it's it is preparing them for what are going to be the most common side effects of the med versus something where they had no idea and they said, I'm not taking this anymore. And then now what is what is accomplished in that? So that's where I think, again, being very open with a patient about what are the side effects of this med, what are the typical side effects, but every is person different.

So, there's no guarantee that they're going to have a certain side effect. And I've put some patients on some SSRIs, they had no side effect. So, it goes the gamut in terms of it. So, it's amazing in terms of that there are other meds out there that that can be used for depression. But the usual starting place is using an SSRI.

McGUIRE: Well, that's really interesting. And then you combine the medication combined with other treatments.

WILLIAMS: Absolute. What I tell all the patients is that what happens is that you are going to have the most positive outcome when you marry psychotherapy with medication. Because Leana, if medication was it and you were depressed and you came to see me and I'd say Leana, your genetic test shows that you would be most probable effected best by this particular med.

Not this, but it's in your green zone and put you on it and say, you know, we're done. It doesn't work that way. Because one of the things that depression does is it creates that distorted thinking. If the medication would just correct that immediately, well, then that wouldn't that be great. But it doesn't work that way.

So, it's the combination of psychotherapy and medication that helps. Now, what type of psychotherapy? Well, the most common that’s used and has shown in research to be one of the most effective psychotherapy methods to use is cognitive behavioral therapy. And it really is just by its nature of what it's defined as being, is to help a person correct some of their thinking.

And that's where it is really, really, very, very powerful. Now, some clinicians use sort of a cookbook. They'll follow a sort of a manual. I don't I find that I need to adapt my cognitive behavioral strategies that I help a patient learn based on what their what they how they kind of think, what works the best for them, talk with them, give them a strategy.

They go home. I because I'm an educator for all of my career, I often tell patients I guess what I'm giving you homework assignments and I do. And they will go home and try a particular cognitive behavioral strategy and see if it helps. And then they come back and report on it. We adjust it based on what they found that seemed to work better, what didn't work as well, that kind of thing.

And it's amazing of the success I've had. That's what's kept me in this business of just all of what I've done over my career, both in the research, teaching, and clinical work that I've done. So, it's made it fun for me from my, you know, feeling like I've had a very rewarding career.

McGUIRE: Yes, I would think so. Now I'm assuming that there would be some medications. Are there other medications on trial or are they continually trying to improve on treatment for depression?

WILLIAMS: Yeah, in fact, what's happened is that there are a number of clinical trials that are underway as we speak that are starting to show some real positive outcomes to major depressive disorder and so like, for example, Zulresso was a med that was used for postpartum depression, but it required an IV infusion. So, there are some trials of actually trying that with major depressive disorder.

In addition to treating postpartum depression. And so that's one. The other is that there are meds that sometimes are used are what are called atypical antipsychotics that are used to treat depression. But keep in mind, they have some serious side effects that you really do have to monitor and be careful in using. And usually if I'm putting a patient on that, it would be after I have tried different meds that that may have may have not worked as well as we were hoping.

And then there's another class of meds that are that are really called Serotonin and norepinephrine reuptake inhibitors. SNRIs and an example of the drug like that is Effexor. And that is one that is used sometimes as an effective because it deals both with the serotonin in the brain along with norepinephrine. And so, it has sort of a dual purpose in terms of the neurotransmitters in the patient's brain.

There are some meds that are out there. And like I said that they're really trying to test psilocybin is under clinical trial that has magic mushrooms that we often refer to as magic mushrooms or lysergic acid, LSD is under clinical trial and they are showing to be quite effective in treating depression, but they're still under clinical trial.

So, I don't have the option right now of trying one of those meds with a patient. But I have a feeling the next couple of years, those could really be available. And so even methadone has been used for treating opiate addiction but shows some effectiveness for depression. So, what's kind of neat about what I see going on in the research world is that there are some clinical trials where they really are seeing some positive outcomes to major depressive disorder.

So, it's encouraging in that sense.

McGUIRE: It is very encouraging. Other treatments, are there other treatments that they're using? I know that ECT. I remember seeing a treatment of ECT when I was in nursing and you know, from a clinical perspective as a young woman, I thought it was pretty scary. But it is effective, correct?

WILLIAMS: It is. It is. Especially in what is often referred to as persistent depressive disorder. In other words, it's long-term depression that the person has. But often some people referred to as treatment resistant depression. I don't particularly like the term because it makes it sound like the patient is being, you know, sort of being resistant. It's not it's that the med that is going to treat the depression isn't working as well.

And so, it becomes a challenge to figure out what to do. And so persistent depressive disorder is the term. But I think what's important is that sometimes there are treatments out there, and especially when you have someone that has gone through a number of trials of different meds and it isn't working, that ECT can be a possibility.

The other is what is now referred to is repetitive transcranial magnetic stimulation has been shown to be somewhat effective and doesn't create the seizure that ECT does. But remember what happened in in the whole treatment of using ECT was when the movie came out of One Flew Over the Cuckoo's Nest.

McGUIRE: Oh yeah.

WILLIAMS: It depicted ECT as if the patient is on the bed thrashing away, etc. That is not how it actually happens. And one of the things that I always required undergraduate students to do is go and observe ECT, and

they would all the time come back and say, oh my goodness, it is so different than what I was expecting because see, they have the image of what was in One Flew Over the Cuckoo's Nest as what ECT is.

And it's not, not at all. And so, it can be very effective. Ketamine is been shown and now it's been showing some effectiveness with infusion, nasal spray or even pill form and there's pros and cons to each of them. But that ketamine has been shown to be somewhat helpful for treatment resistant depression or persistent depressive disorder. Botulism that's used for, you know, toxin that is that people will get.

And they found that people that needed to get rid of some wrinkles.

McGUIRE: Ahh, yes.

WILLIAMS: Started saying, gee, I don't feel so depressed. And so that was it. And then there's a newer one that is called magnetic seizure therapy, which is an alternate to ECT and that's gaining some use. There's some clinical trials using that. So, there are a number of real interesting treatment possibilities that are coming on the horizon that I think are encouraging.

McGUIRE: Well, that's fantastic information and it is encouraging. I thank you so much for several things. Number one, giving us your expertise, sharing your expertise with us today, helping to demystify some of the myths and things that have been going on about depression, letting us know that it's okay to, you know, tap into the resources and not take this on yourself in a clinical setting, get past our discomfort and have those conversations.

And obviously, by your testimony with those treatments and those conversations combined treatments, you've had success stories, and I'm sure there are many, many out there. So, it's worth us paying attention to our patients for whatever reason they come into the clinical setting. Dr. Williams It is an absolute thrill to spend the last hour with you and to learn more about depression. And again, we'll have another conversation about suicide in a separate podcast. Thank you for joining us.

WILLIAMS: You are certainly welcome. It is my pleasure.

McGuire: We hope you enjoyed this episode on Depression with Dr. Reg Williams. We encourage you to familiarize yourself with the numerous courses available at Elite Learning com to advance your career and we certainly appreciate you listening. This is Leana McGuire for Colibri Healthcare.

(SOUNDBITE OF MUSIC)

PIERCE: We hope you have enjoyed our series Out of Darkness: Symptoms and Treatments for Major Depressive Disorder.

If you or someone you know is struggling with thoughts of taking their life or in an immediate health crisis, please call or text the national suicide prevention lifeline at 988. This line is open 24 hours a day, 7 days a week. And you will be connected to trained counselors who can provide support and resources.

If you or someone you know is struggling with or what you think maybe Major Depressive Disorder, we at Colibri Healthcare encourage you to seek help with a counselor nearest you in person or through telehealth. You can also find more resources through the National Alliance for Mental Health, also known as NAMI at www.nami.org or by calling or texting 1-800-950-6264.

You can keep your learning going by finding additional podcasts and other educational resources on elite learning dot com.

This is Dr. Candace Pierce for Colibri Healthcare.

(SOUNDBITE OF MUSIC)