Transcript Details

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ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Major Depressive Disorder: The Journey to Diagnosis

Announcer:
You're listening to ReachMD. This medical industry feature, titled "Major Depressive Disorder: The Journey to Diagnosis," is sponsored by Sage Therapeutics and Biogen. Here's your host, Dr. Cole Brown.

Dr. Brown:
Hello and welcome to Changing The Conversation About Mental Health: Patient And Provider Perspectives, a podcast exploring issues related to mental health and ways in which healthcare providers and people living with mental health conditions can work together. This program is sponsored by Sage Therapeutics and Biogen and the participants are being compensated by both companies.

Dr. Brown:
The information you're about to hear is not intended to serve as medical advice or substitute for consultation with a healthcare professional. If you believe you are suffering from symptoms of depression, please contact your medical provider for additional information. I'm your host, Dr. Cole Brown. And in this series of three episodes, we will be exploring the topic of major depressive disorder or MDD. For this series we asked a person living with MDD, Karl Prevost, and Dr. Napoleon Higgins, a psychiatrist who specializes in treating mental health disorders, to share their experiences. For this episode we will discuss major depressive disorder and the journey to diagnosis. So welcome both and let's begin. Karl, I'd like to ask you a question. As a person with MDD, can you describe your MDD symptoms and how long it took you to talk to your healthcare provider about your symptoms?

Karl Prevost:
Sure thing. Thanks, Cole, for that question. My MDD symptoms, I think I started noticing them not too long after I moved to Atlanta for grad school back in 2012. So, it was really in probably spring semester, 2013, where I can remember having these really intense, emotional outbursts. Usually, they were in response to like watching like certain movies or something like that. I would just start crying uncontrollably for no reason. And then it went from like happening in response to like seeing things to just happening just at random moments, just sitting in my living room or while walking around Downtown Atlanta or while sitting in class by myself. And so, I remember having these unpredictable emotional outbursts and talking to one of my professors who happened to be a clinician while she was also, you know, teaching. And it was written off as just that, just having a really intense, emotional response. But it wasn't until my third year in grad school, while on internship where I can remember my symptoms becoming more pronounced and more intense, more compounded.

So, it started with me not wanting to get up out of bed, low levels of motivation, feeling fatigued, oversleeping, under eating. As a result, I was losing weight pretty rapidly because I'm a hard gainer. So, I lost interest in doing things like working out, which was like my, you know, saving grace almost. That was my happy zone. I stopped working out. I remember feeling like a hermit, not wanting to really connect with others, almost like avoiding social interaction, being anxious when I had to leave my apartment. So things like that, and concentration, irritability issues, issues like that with regard like to when I had to like do papers or report write, it became like the most tedious types of tasks simply because I just had trouble focusing on what was in front of me. So yeah, that's when I remember things starting. I didn't really know what it was that was going on.

Dr. Brown:
I really appreciate you sharing that story. When I hear that…you know, when we hear about depression, a lot of times I think we focus on the sadness and the loneliness. I think you speaking about really not being able to work out and really noticing this impact on your daily life is a really important story. And, Dr. Higgins, I'm going to look towards you. As you heard Karl really talk about his initial journey with really being able to understand that he had a diagnosis of depression, how does that speak to you in how you detect and diagnose

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MDD on a daily basis?

Dr Higgins:
Thank you for the question. Realizing that MDD is a very complex diagnosis in that it's important to do screening and making sure that you get a very good history when it comes to looking for the signs and symptoms. Oddly enough, I've found where many individuals don't even realize that they're depressed, that they just come in because something doesn't seem to be correct, or something doesn't seem to be right, or maybe they're missing out on goals and things they want to do in life. And so, trying to make sure that you get a very good history, making sure you ask the right questions, most doctors would use the DSM as a screening tool, and the questions that we ask. And sometimes you may even want to use rating scales to help tease out some of the diagnosis and treatment. But we see that depression is very common and too often people don't come in for the help.

I've understood that many people have just normalized their depression. That they've been depressed so long, and had so much difficulty over time that they don't even know that they're depressed. So, it's hard to get treatment when you don't even realize that you have a problem. So, it's great to see when people show up because normally, when they show up, they've noticed something is going on and somebody's told them something is going on and now they're at the situation where they're looking for help. And as a psychiatrist, I realize that people don't want to see me. You know, so, if you're in the door to see me, that means that something has not gone quite right. It's like people don't want to go see the dentist. People do not want to go see the psychiatrist. So, if you show up to see me, that lets me know that you're in a situation where you need help, and now I have to figure out what's going on in order to do that.

Dr. Brown:
Yeah. It's really critical what you said there, people reaching out for help. And I think another thing I caught in what you said is you know how to ask the right questions. And I'm looking back at you, Karl, when I hear that. Do you feel that the symptoms you described now, you were able to actually describe that to your physician and they heard you or was it a journey for you?

Karl Prevost:
I'm really glad you asked that question. I found myself nodding my head a lot as Dr. Higgins was talking. Honestly, I think I did lack the language around what was going on with me at the time. And honestly, that was tied to a lack of awareness with regards to like my family history around mental health and that sort. So, I actually didn't see my primary care physician until 2016. And when I spoke with him, it was more so in relation to like work burnout or symptoms related to work burnout. And so that's what he attributed it to. But like I said, the symptoms became more and more compounded. And so, I'm like this isn't just me being exhausted, this is something deeper. I just remember, I think, feeling frustrated, feeling like I wasn't being heard, but also frustrated with myself because I couldn't explain what was going on inside of me to someone else. I don't know if that makes sense, but that's exactly how I felt.

Dr. Brown:
Yeah, no, that makes a lot of sense the way that you talk about describing your symptoms. And makes me think, Dr. Higgins, you did mention scales and asking the right questions, but what other ways do you try to get at understanding and getting that differential diagnosis of major depressive disorder and really speaking to elements that maybe the patient themselves can't articulate?

Dr Higgins:
When you're having a conversation with a patient or a client, that is, there are conversations going on on multiple levels. So not only am I listening to the words that you're saying, but I'm also looking at how you're reacting to the questions that I'm asking. So, it's more than one level of conversation inside the room. So many times, I'm trying to read the individual, you know, from their facial expressions, movements, you know, voice inflection, all of that is going into making that clinical diagnosis. And then another issue that we run into and I would say, especially for Black communities, is that as Karl had mentioned, the issue of lacking the language. We don't talk about mental health enough to actually know the language of mental health.

We know when we don't feel bad, we know when somebody's acting out, we know when somebody's angry or they're doing behaviors that seem to be detrimental to their overall health and care. But we don't seem to recognize depression because those are not the conversations that we have on Saturdays. Unlike many other communities where I'll have patients who walk into my office and basically read back to me the DSM of their particular diagnosis. Now, when a person does not communicate that in that particular way, it can easily cause for the diagnosis to be missed because we don't understand the language of the individual. So how are things going? Things are not going well. Well, what's not well? You know I'm tired of work. I'm tired of my job. I don't like the place. I have issues in my home, my family, my wife, my girlfriend, boyfriend, cousin, whoever it might be.

And they're talking in a situation where they're looking at the impact of their mood on themselves and their environment and their interaction with others, but never read out the actual diagnosis of depression. So that's why it takes years of work, understanding, paying attention to people, understanding cultures, understanding men and how we communicate these issues because men don't talk about depression to other men. It's not something that we would typically do. And many times, people are very private, where they don't

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want to communicate that something is wrong to other individuals. That's why it takes that holistic approach in understanding and paying attention and listening on multiple levels to be able to pull off the diagnosis of what we're actually dealing with.

Dr. Brown:
Yeah. And what I'm hearing from you is how being a clinician and being able to listen as part of the story, but there's a societal aspect to it as well, right? Being able to articulate, to be able to have the language to speak to these different disorders. And the question I have for you as we think about brain health is do you think that has impacted physicians in their urgency to treat, you know, patients not really being able to articulate the brain health disorder or are there other issues impacting that?

Dr Higgins:
Well, there are multiple issues that can impact how a person feels. Realizing that when a person tells me that they feel depressed, that's a symptom, that's not a diagnosis. So you know, for example, I spoke to a young lady just recently who was depressed, who was having a lot of trouble in school and then they had poor interest and thoughts of giving up. Well, that was a mix up on her schedule and she was trying to graduate she ended up having to take 24 hours of classes in one semester. Now, she was normally an A student, dean's list, things of that sort, but now she's struggling, and she's never struggled in school her entire life.

Well, that person presents with depression, but my issue is that I don't know if that's depression or not. Who takes 24 hours of school? Of course, you got a job waiting on the other side for January that's depending upon you getting out of school and the mix up was partially her fault, but mostly the school's fault, but now you're in an intense situation. Well, I can't call that depression. I call that you're doing too much, you know, and you're having to do a yeoman's job and trying to pull this through. So medical issues can look like depression. So, screening for diabetes, high blood pressure, thyroid disorder, you know, the impact of issues of trauma in the past. Life throws its curve balls, COVID, the issues of chronic bereavement that we're seeing, where people have had losses of family members, of jobs, of ways of life.

All of these things can go into looking like depression when it truly isn't. The key point to look at when it comes to depression is the impact it has on the individual's lifestyle and your ability to move forward in life. In that you can be depressed, you can be sad, you can have all those issues, but it's not impacting your relationships, your ability to work, your ability to go to school and your ability to grow, it's more than likely not depression. We have to look at the other issues that could be complicating the diagnosis such as other medical conditions, other mental health issues and just the stresses of life. And that's why it takes making sure you take a very good history, listening to the patient and trying to make a clinical decision based upon what you're seeing.

Dr. Brown:
I appreciate you sharing that. And I'm wondering, Karl, as you hear that, is there elements of what Dr. Higgins is saying that resonates with you? Or are there other things you wish you would've shared with him based on this conversation we're having today?

Karl Prevost:
Absolutely. Honestly, I think I was grateful for Dr. Higgins when I met him because he challenged me to be honest with myself and transparent in a way that previous individuals that I had seen, you know, regarding these issues that I was experiencing had not. So, if you remember, it was back in 2016 when I first saw my PCP and discussed these symptoms, but it was in 2013 when I first started noticing them. And then in 2018, it was when I first saw a psychologist about the symptoms that I was experiencing, and this was in Atlanta. But even then, when he arrived at a diagnosis of proposing, you know, MDD, I was resistant, and I think I might have gave some kinda intellectual response related to like the use of language and the power of words and how I didn't want to be labeled as such, because I didn't want to adopt a certain mentality and that sort of thing.

And I think I might have tried the same thing with Dr. Higgins. He wasn't having it though, and it was a really straightforward, transparent conversation. And he challenged me to pretty much let go of the facade that I had learned to adapt or developed in learning to adapt and survive given like my upbringing and where I'm from and that sort of thing. You have to posture yourself a certain way. You have to present yourself a certain way. You can't show weakness. You can't show vulnerability. And so, I would present a certain way and present myself as if things weren't as bad as they actually were. And Dr. Higgins just really challenged me to first be honest with myself, you know, because when we can put a name to what this is that's going on with you, we can do something about it. When we are aware of what it is that's going on with you, when we develop language around what is going on with you, we can then, you know, exercise agency to change it.

Dr. Brown:
Thank you, Karl, for sharing that. Dr. Higgins, how do you tear down those walls? How do you get Karl to where you got him to help really articulate what he was feeling?

Dr Higgins:

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Well, we have to fight the issue of stigma. And stigma and understanding depression and realizing how common depression is. These are not disorders that are strange or odd or lack phenomenon. This occurs on a regular basis. So I tell people that depression is very common. At least one out of five, one out of four people will have a depressive episode in their lifetime, and it happens. It's part of the human experience. And just like any part of the body can be ill, the mind can be ill. It has things that tells you that you're sad, you're depressed, things are not going the right way, they'll never go the right way and that's a chemical change in the mind. And that's treatable through therapy, through medications, through lifestyle changes. And honestly, it requires all of those things.

It's very rare that a person will see me, I write you a prescription one day, and whatever mental health issue you have has now gone away. Another thing is that I'm definitely a truth sayer whether you want to hear it or not, because I think that's the best way to let people know. And the fact is that once it's said, it's out there, people's brains download the information whether they want to or not. And it's like putting an app on the phone, whether you access it or not, at least it's been stated and now you have the opportunity to do something about it. So, it's important to be completely honest with the patient and by being honest, people can appreciate it. So now that they have an idea of what's going on, and now they can do something about it. So, I try to give people information so that they can have command of the diagnosis. And when I'm saying that, I'm referring to, I know what's going on, now I have a plan of what I can do about it.

Dr. Brown:
Thank you, Dr. Higgins, and thank you, Karl. What I'm hearing from both of you is, Karl, for you that this was a tortuous path from really thinking that maybe you were stressed at work to getting a better on understanding of having major depressive disorder and really going from your PCP all the way to Dr. Higgins who's really able to tear down those walls and provide you with the language to help articulate. And from you, Dr. Higgins, what I'm hearing is, through your years of practice, what you've learned to do is not only identify the language but identify different symptoms in patients that are maybe not as evident and sometimes they can't really speak to, right?

So being able to tear down those walls and move past the stigma. But there's still issues that we, you're saying that we need to actually address as a society, right? Whether that's in the African-American community and perspectives around mental health disorders and being afraid to share and discuss them, or if that's in the wider population and clinicians and patients really not seeing depression as something that is as urgent to treat. These are things that I'm hearing from you as some key takeaways. Do you agree with those as key takeaways from this conversation?

Karl Prevost:
Absolutely. I definitely think that also culture plays a role in arriving at an accurate diagnosis and relatability. Dr. Higgins being a Black male, I do think played a factor in him being able to see through, again, the facade that I was presenting, him being able to just tap into or tap beyond what I was saying and/or what I wasn't saying, you know, being able to read between the lines.

Dr Higgins:
Depression is painful. It hurts and it impacts you every day. So the need to be aggressive in treatment and doing all that you can do for the patient, but the patient doing all that they can do for themselves and empowering the individual to fight this depression, to fight this illness, so they can get on the other side of… not that you don't have depression, but the fact is that it's treatable, I can take care of this and I can move forward with whatever else I want to do in my life. But the feelings of depression is very hindering and that's an emergency. That is like having your blood pressure completely out of control, because however your mind is impacts everything that you do in your life. And when you have that depression riding on you, it's like a 2,000-pound gorilla just holding onto your back, and just dragging his feet wherever you go. So, it's important to make sure that we be aggressive in treatment and giving patients the power to get this better.

Dr. Brown:
Thank you Karl Prevost and Dr. Higgins for joining me, this has been a fascinating discussion, and I hope it helps listeners to feel confident about their mental health related discussions. I hope you enjoyed the show today. Please subscribe to ensure you don't miss any of these engaging and informative conversations. For our next discussion in this series, we'll be exploring the impact of major depressive disorder on lives. If you or someone you know is experiencing depression or thoughts of suicide, please seek immediate treatment and/or call the national suicide prevention lifeline at 1-800-273-8255. Please note, the views of the participants discussed on this podcast may not be representative of the views of other providers or individuals living with MDD.

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