



Live Well Today Webinar Series

Depression, Mood, and Anxiety and Parkinson's with Dr. Joanne Hamilton

Davis Phinney Foundation

Note: This is not a flawless, word-for-word transcript, but it's close.

Melani Dizon (Director of Education, Davis Phinney Foundation):

Hello and welcome everybody. My name is Melani Dizon. I'm the Director of education at the Davis Phinney Foundation, and I'm thrilled to be here today with Dr. Joanne Hamilton. Hi, Joanne. How are You?

Joanne Hamilton, PhD, ABPP-CN (Director of neuropsychology at Advanced Neurobehavioral Health of Southern California, and resident neuropsychologist in the Department of Neurology at the Scripps Health in San Diego):

I'm great. How are you doing today?

Melani Dizon:

I'm doing well. I'm doing well. So today we get to talk about a topic that is probably the most requested topic that we get, the most complicated, the most frustrating for people living with Parkinson's. So, I'm really excited to explore this with you and to help people understand that there are things that they can do if they have experience with mood disorders or just even bad moods in general. So first I'd like to just talk a little bit about you and what you do and how you got into this work, especially working with people with Parkinson's.

Joanne Hamilton:

Oh, sure. Well, I went into graduate school to become a neuropsychologist and worked primarily in research with neurodegenerative conditions of which Parkinson's is one. And a lot of my research early on was in the non-motor symptoms of Parkinson's, which is most of the people who are trying to manage it, understand to be one of the most challenging aspects of the disorder. It's difficult, especially because, unlike the motor signs, other people around them can't see it. And so, I think for a very long time, it was underappreciated by healthcare providers. And when I moved into clinical practice from research, that was one of the areas that I really wanted to focus on to help people understand that Parkinson's is such a complex disorder and affects every part of a person's life.

Melani Dizon:

Yeah. So, let's talk a little bit about, to just level set. Can you talk a little bit about what's the difference between, you know, having a bad day, being in a bad mood versus a true mood disorder?

Joanne Hamilton:

Absolutely. So, let's just start by normalizing an occasional bad mood. I don't think that you could find a person in the entire world who hasn't had a bad day. And so, when we talk about conditions like major depressive, major depressive disorder, or generalized anxiety disorder, what we're talking about is a sad mood that's persistent wherein a person is feeling down, irritable numb for day after day after day, weeks on end. And in addition to that, a low mood can also be an intense loss of pleasure. The inability to feel good about the things that used to make them feel good, and the inability to experience joy the way they once did, and those are the hallmark features of a major depressive disorder. And the key there is that it's persistent. It doesn't come up and down the way, you would normally experience a bad day with generalized anxiety disorder, which is another very common condition in Parkinson's.

What you find is a state of unrest, agitation, unease, worry that lasts again week after week after week without, without a lot of break. And so, the way that we distinguish a disorder is that we say that those mood states have become so predominant and persistent that they begin to interfere with your ability to do your day-to-day activities. So they begin to interfere with your ability to get yourself up and out of bed and dressed and, and showered and, and start the day, or it interferes with your sleep or your appetite to such an extent that you may, you may have highs or lows on both of those, you know, sleeping too much because you're down, sleeping too little because you're anxious sleeping or eating too much because you're an emotional eater or, or eating too little because your stomach is always so sour and upset that there's no appetite. So, it's really important that we distinguish that because we don't want to pathologize what is normal. You know, all of us feel grief, all of us feel upset when, when something bad happens. But if it's, if it's gotten to the point where you just can't get out of that mood, then that's the time to start to reach out for help.

Melani Dizon:

Yeah. So, I think the interesting thing is a lot of times with people with Parkinson's, certainly, and we'll talk about this a little bit later, but certainly, you know, some years into their Parkinson's, they will be able to look back and say, oh, I was officially diagnosed, but I feel like I had symptoms a lot longer, or, you know, a lot earlier. And there was a lot of depression and anxiety around that. But for a lot of people, they get the diagnosis and that triggers, you know, an incredible amount of sadness and grief and no, you know, very similar to death or something where, you know, this is a, they can look at it and say, this is situational depression, this is something happened, and I don't feel good. But because they can see a clear trigger and it's like, of course, I'm upset, they don't go get help because they think, oh, this is like, of course, I'm going to feel sad, but nothing can happen.

Like, I can't do anything about it. And I think like what you're saying there is that we can normalize that. And whether that is because you just found out something, you know, that you got, you got Parkinson's, and so you're just having all of these emotional reactions to that diagnosis, or you've just been feeling this sort of low-grade level of depression or anxiety that people say as a non-motor symptom of Parkinson's, you still can get in both of them treated. Like it doesn't really matter where it's originating, or why it started, but if it is going on, you can get treatment.

Joanne Hamilton:

Absolutely. So, you know, kind of along those lines, we are now recognizing that depression and anxiety are probably some of the first signs that there is a change in the brain. So, let's start, let's unwrap that for a second. It's important for, for people both with, you know, living with Parkinson's, but also their, their care partners, their loved ones, to understand that the same neurotransmitters, so the same neurochemicals that are affecting a person's movement, their tremor, the way they walk also are, are those same chemicals that modulate a person's mood. And so even though it's different systems of the brain, those chemicals are, are vital for moderating mood and, and some aspects of thinking. So, what we're finding now is that sometimes a decade before the motor signs the tremor, the stiffness, the rigidity the gate changes start to occur. A person who didn't have any previous history of anxiety or any previous history of depression starts to note themselves feeling very low or very internally agitated. And of course, you know, we chalk that up to everything under the sun. You know, a midlife crisis works kind of tough, whatever it may be.

We know now that early signs those early changes in mood are likely related to a shift in the neurotransmitters that will eventually begin to affect movement as well. So that's the start, kind of this mood condition. Then of course, once you receive a diagnosis of Parkinson's, there will be all kinds of emotions that come up. I mean, I'm never made a person that says, Yay. Great. so, unless

Melani Dizon:

They were told they have; they think it's something a million times worse, and then they-

Joanne Hamilton:

Yeah, well, there you go. So then you might get a little bit of a relief boost that, oh, thank God it's not this, it's just Parkinson's. Right? Until you realize how challenging it becomes to manage just Parkinson's. So, the point there is that once that diagnosis comes, of course, there's going to be a natural response, a natural reaction. That natural reaction could be anything from, you know, okay, well, I put my head down on the learn everything there is about this disorder and I'm going to beat it. You know, I'm going to live well with Parkinson's, and that's fantastic. You know, there's still going to be that period of adjustment. And then some people are going to

put their heads down and that's the way they're going to, they're going to handle it because that's just their personality style. And other people are going to start to feel really scared and worried, and the what ifs are going to start to pop up.

And if that period of time is fairly short, you know, we can call it an adjustment to a normal typical adjustment to a difficult diagnosis. But for others, you know, the mood, it stays low, the anxiety stays high. And regardless, at that point, if it begins to affect your daily functioning, begins to affect your social interactions, your ability to work your ability to take care of yourself, then 100%, whether it was a symptom of the, a sign of the disease itself or reaction to it, treatment is available. And that's when we say, Okay, now it's time to really start talking to your physicians talking to your mental health providers about what do we do, you know because this is one more symptom that we just need to manage.

Melani Dizon:

Right. Okay. So, let's dive into the differences between depression and anxiety and the various different ways that it might show up for people.

Joanne Hamilton:

Sure, absolutely. So, let's just start off by understanding that sometimes our diagnoses are the best we can do, right? So, there are diagnostic criteria for depression. There are diagnostic criteria for anxiety disorders, but in the real world, very often these things are going to commingle. So, let's just start with what we were, what we're going to call major depressive disorder. So, this is a situation where you have a sad, low down, blue, depressed mood for day after day after day after day. And along with that, you may also feel a loss of pleasure, a loss of interest in the things that you used to love to do so that it's tough to even imagine getting together with family because eh, who cares. You know, along with those two features often will come feeling as if you are less worthy.

So, a negative self-impression can be self-blame. It could be a lot of guilt about things that, eh, you know, probably you don't need to feel guilty about a great deal of pessimism or hopelessness. It might affect some people physically. So, you might see appetite changes, sleep changes, either too much or too little of both. You might experience irritability, you know, just really short-tempered and rumination and cer-. And for some people, they'll begin to develop signs or symptoms or thoughts of suicide. So, the idea is that their life is no longer worth living, or that they are now a burden to their family and would be better off, and everyone, frankly, would be better off they if they were dead. And I tell people very often that those thoughts of suicide while horrifying to loved ones are pretty common.

It is actually fairly rare for me to find someone who hasn't at least had those thoughts from time to time. And let's be honest, living with Parkinson's can be very challenging. It can be exhausting. And, and so it is not uncommon for me to hear people say, Yeah, you know,

sometimes I wake up in the morning and I think, gosh, I just wish I was dead. Okay. So, I think it's important, really important to realize that those are not uncommon thoughts. When we begin to worry about suicide with major depressive disorder is when a person's having those thoughts pretty persistently, you know, it's very difficult to shake them. And in addition, that person is beginning to make plans for how they would do it is beginning to think through what they would need to do to be prepared for suicide. You know, giving away their belongings, beginning to write their notes, their wills, and such. That's the point where suicide becomes a very real concern for, for physicians is when we are realizing this is, this is something this person is really starting to plan out. So clearly, you know, major depressive disorder is a very dangerous condition and needs to be taken seriously. Anxiety,

Melani Dizon:

Can we go back to that real quick?

Joanne Hamilton:

Sure, of course.

Melani Dizon:

So, let's say that, you know, it's normal people who hear this and they say, Oh, okay, it's normal. My person with Parkinson's might say that you know, what do you, what is your suggestion to a care partner in that situation where it hasn't quite reached that level where we're like, Okay, I know this something needs to happen here. But they might make a comment here or there. What, what is, what do they say to that? I mean, I know that it's terrifying for a care partner, right? But what do you, what, what is that something for that care partner to say to their person's Parkinson's?

Joanne Hamilton:

Well, I would recommend have sitting down, you know, in a quiet time and engaging in that conversation. You know, let's talk about that thing that you just said this morning. You know, tell me a little bit more. What is it that, what is it that you're thinking about right now? You know, are you, do you have a plan? You know, do you understand how much, how much you are loved and how valuable you are in this family? And understand that depression is a tricky disease, and it can really alter your perception. And so it may be that that person doesn't, doesn't have that realization anymore because depression is tricking them into thinking, thinking the worst about themselves. So, I always recommend to anyone, regardless of Parkinson's or not Parkinson's. If you hear a loved one say, you know, maybe I'm just better off dead, or maybe you're better off if I'm dead, engage.

You know, don't just, don't just let that comment go. Really sit down and talk about what that means to that person. You know, was it that the person woke up and just was really feeling down for that minute and that thought has gone? Or are these thoughts starting to become persistent? And, and, and I think regardless, frankly when that, when those statements start to be made regardless, reach out to your doctor, and say, hey, listen, you know, I don't know if this is serious or this is not serious, but my loved one is saying these things. So that, so that a professional can sit down and really start to unpack what does that mean, you know, and all, and if the concern is even slightly there, that this is something more than just a passing thought reach out for help. You know, there, there's now a national crisis number for suicide. I want to say it's 980.

Melani Dizon:

We're going to, we're, we'll put that up.

Joanne Hamilton:

Oh, we've got that. Okay, perfect. There's a national number for that now. So, if it, even a little bit concerned that that's a statement that is not made just in passing, make that call because there is help that's out there.

Melani Dizon:

Yeah. Great. Okay. Anxiety.

Joanne Hamilton:

Yes. So, anxiety is experienced differently for people. So, anxiety can very often come at this, come with depression, but anxiety tends to be these, these ruminative worries. And we've all, you know, this morning I woke up at 10 to five because I have a ton of stuff that has to be done. And my brain was like, ah, okay. Stress, right? All of us have experienced it, but anxiety and it is a disorder, when it's persistent, it won't go away. And it's become so significant that you really can't think of a lot of other things. Like every time you start one project, a flood of worry about another project hits you and you can feel it internally. So, a lot of my, my folks with Parkinson's will tell me about the sensation they have inside of them, that their insides are anxious, and that may be internal trimmer, or it may be that their body just can't regulate that sort of anxiety as well anymore.

It'll affect sleep, it'll affect appetite. It can cause a lot of physical symptoms. And that's important. Some people will really experience a lot of physical symptoms from anxiety. They'll have an upset stomach, they'll talk about headaches, they'll talk about neck pain. They'll experience it as general fatigue or feeling unwell. So don't, don't misunderstand the word anxiety to mean just an emotional sense of worry. Many people will experience that physically.

And so, I think it is important when a, when someone starts to describe these physical symptoms, again, to reach out to the doctor because maybe it is a physical ailment, but it could also just be that that person's, that person's anxiety system is overloading them. Some folks will describe what ends up being more of a panic. You know, your heart is racing, your breath is short blood pressure is spiking.

These can all be symptoms of anxiety. And people end up in the emergency department with heart attack fears. And when they run all the tests, what it ends up being is this person's fight or flight system is off the chart and causing irregularity in the heartbeat. And so, I think sometimes we forget that anxiety, that the systems are all interconnected. You can't just say, oh, this is just anxiety. This is just depression. No, anxiety and depression are going to affect the entire body, the entire physiology. And many people will experience both of those things physically, not just through their mood.

Melani Dizon:

Okay. So, let's talk a little bit about treatment. Yeah. Treatment. I'd like, I'd like, because a lot of people, you know, have both I'd like to get into sort of what people do if you have both, but let's take each one individually for now.

Joanne Hamilton:

Yeah, absolutely. So, the first step is to let someone know that you're experiencing these feelings. The next time you go in to see your neurologist, after they're done figuring out how severe your movement is, let them know that you've been, you've been battling a mood that is interfering with your wellbeing. Let them know if you're feeling sad, let them know if you're feeling anxious. Let them know in whatever words you can muster what the experience is that will help your doctor better understand what the line of treatment will be. If your physician, your neurologist is comfortable, they might prescribe an antidepressant, then some antidepressants are better at treating the depression. And some antidepressants are better at managing the anxiety. And some are both. And so, some neurologists are very comfortable prescribing these. And others will tell you know, I feel much better if you work with a specialist would prescribe these types of drugs.

And that type of specialist is a psychiatrist. And so sometimes your neurologist will refer you to another doctor who's a psychiatrist who can help manage those kinds of medicines. In addition, if it is available or there, it's a possibility. Many physicians will refer for psychotherapy. And that's usually now conducted by psychologist or another mental health professional, like a licensed clinical social worker or a therapist. And the difference there is those professionals are not going to manage medications. Hopefully, they'll work closely with the doctor who is but they'll, they'll work on coping strategies to help reduce the amount of anxiety that you're experiencing from the situation and to help improve your, your mood through behavioral activation techniques. Helping you see situations in a more objective fashion. So, the medicine



is going to deal with the physiology of the depression and anxiety and the psychotherapy is going to deal with how you're coping with the situation. That's perhaps making it worse.

Melani Dizon:

Right.

Joanne Hamilton:

And that team is important.

Melani Dizon:

Yeah. So, I know that this is going to be a question that people have. So, let's say you do go to your doctor, and you know, your MDs or neurologist or maybe even your just care physician. Absolutely. A person who's doing your care, and they do not feel like this is just not their area. Yeah. And they want to refer out what are the types of options for people like, you know, they're, that they're like, how do I, how do I know? Like, I know they can go to you, right? They can go to a clinical neuropsychologist. Yeah. Right. And they can look for them in their area, but if they're not there, who else can help determine that? Is this a, something else a social worker can do, a licensed clinical counselor can do? Or what options do people have?

Joanne Hamilton:

So absolutely. So, the psych, so medications in, I think every state, but maybe two must be prescribed by a physician. So, an MD, DO, nurse practitioner. someone who has someone who has that medical background in training, the reason that's so important is because these medications are going to interact potentially with other medications you're taking. So, you want to work with someone who knows all of your clinical syndromes in addition to Parkinson's.

So, the medication is prescribed by your physicians. The psychotherapy can be done by licensed clinical. So social workers, therapists, psychologists, Ph.D., or PsyD, it's real. Mental health right now in America is very, very challenging. Covid made it was already challenging before covid and Covid has added 10 trillion times the challenges because frankly, you are not alone. If you're feeling depressed and anxious right now I would bet 90% of the people around you right now at this second are feeling the same. So, we're having a hard time meeting the demand that said, there's some good resources that are nationwide that can be helpful. I, and this is not a plug, there's others. Absolutely. It's just the one I tend to use. There's a, there's a platform called Psychology today.com, and I've found this helpful because you can enter in your insurance type, the type of therapy you're looking for, and the issue.

So, you can click the little button for depression and chronic illness, and it'll pop up the practitioners in your area that might be able to help with that. And they have a little bio, and

you can read through them, and you can see, you know, how think that person might kind of fit my needs or that person doesn't seem quite right for me. And that's a good start. And the other good start is to talk to your primary care doctor and ask your primary care doctor, do you know, is there a system around? And then another option is to look on the back of your insurance card, and there'll be a number there that says behavioral medicine. Call that number and ask them to send you a list of all the people in your area that manage that are in that network. And then unfortunately, and we don't have much better way to do this, you have to start calling and let that person know the issue that's going on. You know, I've got a chronic illness and I see, and I've got some major depression. And then you'll work through that system. And that's how I would say start, you know, unfortunately, mental healthcare is not quite as, as easy to get into as, as medical healthcare, because for a very long time we haven't realized how important it is.

Melani Dizon:

Yeah. And now we're like, oh, it's, yeah, it's important and everybody needs it. Right?

Joanne Hamilton:

Oh, we are behind the eight ball.

Melani Dizon:

Right. Where does apathy fit into this?

Joanne Hamilton:

No, that's a really great question. So, I'll have this discussion with most of my folks. When people are depressed, they can lose their motivation. They don't feel like getting up and doing things. And when they do something that would normally have been enjoyable, there's just no sense of pleasure there. It doesn't like, eh, you know, got together, didn't get together, doesn't matter. Went golfing didn't go golfing, doesn't matter, you know, saw a great movie. Right? That's motivation. Apathy is a little bit different in the sense that we recognize apathy to be a consequence of changes within the brain related to some of these neurological conditions. And apathy occurs not just in Parkinson's, it encourages on others, but with apathy, an individual doesn't seem to have the emotional signal that they should get up and do something. So, it's a little different than just being unmotivated.

It is actually more of a neurological syndrome very often controlled by the frontal lobes of the brain. And those, the frontal lobe functioning tends to be impacted by Parkinson's because of the circuits that run that dopamine system. So, with apathy, what I usually recommend to loved ones and to care partners is apathy prevents an individual from getting that signal, hey, I should get up and go for a walk. Hey, I should get up and take a shower, or, hey, I should get up and go out with my friends or make a phone call to arrange a lunch date if the care partner does it for

them. Or if it becomes routine, very often the apathy can be overcome. And when the individuals doing the things they love to do, they still experience that emotional flavor of joy. So, with apathy, I recommend more of a behavioral activation with the care partner.

You know, hey, at eight o'clock is when we go for our walk and the care partner partners up, and at eight o'clock off you go for the walk. And once the individuals in have overcome that inertia, the walk is awesome. And they'll tell me, oh my, I love that. I love that. And the care partner oftentimes will get frustrated, well, if you love that, why don't you do that? Not realizing that there's not really a signal that says, hey, this is something I could do. So, with apathy loved ones tend to be really important because they're the ones that are going to help push over that bit of inertia to get the behavior started. And once the behavior is started, then it is enjoyed. And it is pleasurable very, very often.

Melani Dizon:

That's a really interesting distinction that it's not you do it and then you still don't care.

Joanne Hamilton:

No. Right.

Melani Dizon:

So, you still, it's, that's a very different way to look at it. And yeah, I think that that idea of scheduling it, so it's just, here we go, this is what we do on Tuesdays, we do this on Wednesdays we do this. Yep. I think a lot of, you know, just so many people during the pandemic had to get rid of that schedule, right? They had to get rid of, like, I go boxing on Monday, Wednesday, Friday, I go to cycling on this day. And, and when that gets taken away, it's, it does so many things, not just the social piece that you're missing out or the exercise piece, but just,

Joanne Hamilton:

Oh, it's caused, it's caused such tremendous change and disease progression in, I'm going to say all of our patients. . . And the reason I think is, you know, I know I'm preaching to the choir, but exercise is medicine for Parkinson's. It's not

Melani Dizon:

Just, you talked a little bit about the nonpharmacological, so yeah, exercise, let's go for That.

Joanne Hamilton:

Exercise is going to be always the first thing that's going to come out of my mouth. And the reason for that is there are, there are very solid studies that demonstrate that for everybody, not just folks who are managing Parkinson's for everybody, physical activity improves mood. It stimulates the types of neurotransmitters, it stimulates the types of hormones that are necessary for, for bringing up an individual's mood and bringing down an individual's anxiety. If you do nothing else, if you say, I'm not going to a doctor, no one can drag me to a psychologist, I'm just not doing it. If you do nothing else, if you will schedule a 30-minute piece of exercise in your day that raises your heart rate up your mood will very, very likely with all probability in proof. And not only will your mood improve, but your ability to move will improve, improve, which by definition is going to improve your mood.

So, exercise is always the first thing that's going to come out of my mouth. The second thing that's going to come out of my mouth is socialization. We know that for individuals who are isolated disease progression is faster. And it is sometimes very hard for, for folks who are managing Parkinson's to get into a social setting. It's anxiety provoking. Other people tend to talk too fast. They can't keep up with a flow of conversation. They may have voice problems, and it becomes frustrating after a while to have someone say, What, what? Can't hear you? What? So, manage that socialization the same way you're going to manage the rest of your, your symptoms in, in little boxes, right? So rather than go out with a big group, you know, 10 people go out with two, but schedule that so that at least two, three times a week you have some sort of a social outing. If you don't have anyone in your life right now, join a support group. You that at least is checking in once, twice a month. Get yourself involved with a senior program, with the Humane Society, with a boys or girls club, so that at least a couple times a week you are out and speaking to other people and relating to other people that socialization matters. You know, the other thing, oh, go ahead.

Melani Dizon:

Oh, no, it was like when you, when you I was going to bring this up before, but you had said, you know, the Humane Society or something like that, you know, if part of, part of what is missing for a lot of people who get diagnosed with Parkinson's, you know, obviously the longer they get it, they might not be able to work. They might not have been able to do any of those things. And so, you know, missing that meaning purpose can be such a big deal, right? So, if you can tack your socialization onto something that feels meaningful to you, then you get sort of a double bang for your buck, right?

Joanne Hamilton:

A hundred percent. I say to everyone, Listen, you know, you've been a productive person your entire life and maybe that productivity is going to look different. But when you're involved in a charitable organization, Humane Society is, you know, any of the animal societies are ideal because no animal cares that they couldn't hear your voice, right? None.

Melani Dizon:

They're pure love.

Joanne Hamilton:

Pure love, pure respect. I mean, you know, pure adoration, pure physical contact, just the touching matters. And then you have purpose too. And so, for me, volunteer work in whatever that looks like, you know, that may look like at the library, restocking books that may look like, you know, taking, taking horses out for a walk. It may look like taking dogs out for a walk. It may be like, you know, volunteering at a Boys and Girls center and just sitting and reading with children. There's, there's many ways to feel purpose in your life, and that purposeful expression is helpful for mood.

Melani Dizon:

That's great. That's great. One of the questions that we had last time when we talked, I definitely want to make sure I address it, was this idea that we're talking about talk therapy. We're talking about medication and talk therapy and that there are a lot of people could really benefit from that combination, but some people have a really hard time just physically talking. So, they it hurts to, they can't project, they can't get to the words that they want. They, they don't have the voice. What are some things that they can do? How can they benefit from talk therapy if they really struggle to talk?

Joanne Hamilton:

And, and that, you know, we have to be realistic with, with this. And I tell people a lot of times, this can be helpful, but sometimes when the disease has progressed in a way that this is not so difficult that it's almost more anxiety provoking to involve yourself with it, then we need to look at other ways. So, it's, I will very often sit with, with somebody and just, and just watch them, right? And just, and just be, be with them and let them do the best they can. But let you know in our system there is insurance and they're going to pay for it, and then there's some point they're not going to pay for it because that's not useful anymore in their minds. So, then I recommend, let's think about, let's meet a person who's managing Parkinson's where they are touch, healing.

Touch is incredibly important. So it may be that at that point the person can't speak well enough to engage in psychotherapy, but they certainly can engage in massage, right? They can be, they can have some of that anxiety released physically. They might be able to express their emotions through art, through painting, and know we don't need it to be a masterpiece. You know, and it may not be perfectly detailed, but painting to express the emotion is an important part. Sometimes it's as simple as once a week going out for a walk or sitting at the beach and meditating with the waves, coming in and out with someone who you love. It could be as

simple as that. There could be no words at all. And I think that that is, I think that needs to be recognized that there will, there could come a time for some folks where their voice just won't allow them to participate.

And it's difficult for many therapists to be the only one talking. So, at that point, at that point, looking towards other means for reducing anxiety, improving mood. And it may be through nature, it may be through paint, it may be through art, it may be through pottery and sculpture. You know, having that sense of getting out emotions just by me, like playing with that clay. And it may simply be sitting and watching the birds go by and meditating during those times. There's there are some really impressive phone apps at this point that can be very helpful. They, they're, they cost very, very little, and they can help a person who may not be able to speak and interact, decrease their anxiety level. One that I found in this, again, not trying to play up anything, but one that I found that very helpful for folks with Parkinson's is something called balance.

The reason that it's helpful in my mind, and I've been using it now for this year, is there are visual cues on the phone to help with, with monitoring, breathing or with focusing attention on something other than the scary ruminative thoughts. And it's very easy to sort of get lost in, in the designs that are shown on the screen. There are a number of others. This is just one I've been playing with this year. And so that's another really low-cost way that you can get involved in, in a type of psychotherapy called mindfulness.

Melani Dizon:

So, we said earlier that there are, you know, medications that treat depression, medications that are better to treat anxiety, and then some that do both. what, I guess what you have, I just feel like people will say, oh, I don't want to take another medication. And they're like, oh, I'm taking one for depression and anxiety and my Parkinson's meds. What, you know, what has been your experience with what's, what's working with people?

Joanne Hamilton:

Well, so I can't, so it's out of my scope to really give medication advice for this, but what I would say is the discussion with your physician needs to center on reminding them if they've forgotten that you're on this whole list of medications and you really don't want them kind of off playing each other you know, Lexapro, some of those medications as Talopram is Lexapro I'm noticing a, you know, quite a lot of folks are doing pretty well with

Melani Dizon:

That it's sort of treating both

Joanne Hamilton:

Treating both, yeah. And talking to your doctor about those, those types of medications by giving them very specific indications of what the problem is. So, talking to them about the fact that you're sad and irritable or you're just irritable helps them then tune in, Okay, well we would probably want to try this class over this class. Talking to them about your other concerns, you know, weight gain weight loss sexual functions. is also really important because certain drugs are going to have a different side effect profile. Sometimes folks from, from different generations are more comfortable talking about, so these things than others, just realize that your, your doctors are not embarrassed when you bring up some really important pieces of your relationship. You know, if you're on a medication that's no longer allowing you to be intimate, that's a discussion you need to have with your doctor.

Now what I will tell people about meds, and I feel pretty comfortable saying this realize that most of the meds that you're going to take for your mood have to build up a potency in your system. So, you're not going to take it on day one, and day two feel like a million bucks. In fact, for some folks, they'll experience more side effects in that first week. What I encourage people to do is, unless the side effect is intolerable or dangerous, and by dangerous, I mean, you know, you're, you're having a change in your blood pressure or, or you're starting to feel dizzy, like so much dizzy that you're starting to fall, that's definitely a call to the, your physician. If it's, if it's not intolerable, you know, okay, I've got a little bit of a dry mouth, or I seem, like, my sleep might have been disrupted last night.

If you can stick with that medication for three to four weeks, that allows you to truly give it a good trial as to whether or not it's going to work for my patients. What I find becomes more challenging is when they try something, it doesn't work in two days, they stop it, you know, now their physician has tried something else, it's not going to work in two days. So, they stop it. And now we really don't know what does work and what doesn't work because it never got up into the full level of potency so that we can determine if it's effective. Yeah. And the good thing is that usually with these drugs, the side effects are kind of worse at the beginning. And then as the drug begins to take effect, the side effects where begin to go away. So, if you can tolerate it I really suggest just see if you can stick with it there.

Melani Dizon:

Yeah. And also, you know, maybe just like track it, you know, track it notice like, oh, and it might feel like, oh gosh, it's not working. Whether you look back a week and you're like, oh, okay, maybe, maybe it is, you know, getting

Joanne Hamilton:

A little, a hundred percent

Melani Dizon:



Right. So

Joanne Hamilton:

A hundred percent there's actually some really nice downloadable like you can go online and just download, you know, a mood monitors and you, it could be as simplistic as, as a happy face on this side and a sad face on this side, and you just sort of mark a line in between. Yeah. You know, and, and then at the end of that three weeks you can say, oh, wow, you know what? Look at this, this first week, most of my days were really very close to this sad and happy face. And, and now they're kind of in the middle. And every once in a while they're actually closer to happy. That's effective.

Melani Dizon:

Yeah, absolutely. Well, I am so grateful that you sat down with us again today, and really appreciate it. I know that everyone's going to love this conversation and will make sure to share with the recording and the transcript and all that stuff with everybody. But again, thank you so much for doing this and we always love having you.

Joanne Hamilton:

Oh, fantastic. My pleasure. And I just was, I just want to remind everyone, let me just make sure I have the right number about the Suicide Crisis number, because that is something that's new to America, really, and it's a nation nationwide number. It's 9 88. And I tell every person because just because you don't have Parkinson's doesn't mean you have these don't have these thoughts. Right. So nowadays, 9 88, if you are worried, that's the number I would re-, you know, call.

Melani Dizon:

So, people can literally go on their phone and click nine eighty-eight.

Joanne Hamilton:

Yeah. It works just like 9 1 1.

Melani Dizon:

That's brilliant. Okay. Definitely. I'll share that for sure. Well, thank you so much, Joanne.

Joanne Hamilton:

It was great to see you.

