Depression in Parkinson's Disease

Melanie M. Brandabur, MD
Clinic Director
The Parkinson's Institute

Over many years of taking care of people with Parkinson's disease, I have met with hundreds of patients, even more if you include the ones I have met at support groups and patient conferences. The vast majority of the patients I have met are optimistic, intelligent people intent on living life to the fullest, despite their diagnosis. During an office visit, when I ask patients if they are depressed, most of them say no. I commonly hear "I get down once in a while, but I can snap myself out of it." However, most studies have found that depression is extremely common in Parkinson's disease, present in up to 90% of patients depending on the type of depression scale that is used.

What accounts for this apparent discrepancy? It is my belief that the problem arises in part from the terminology used. The word "depression" tends to imply a degree of sadness that is overwhelming, perhaps incapacitating, with overt displays of emotion, tears or even suicidal intentions. Most PD patients do not report having anywhere near this degree of emotional upheaval, though of course there are exceptions.

For example, people who have recently been diagnosed with PD or a related condition such as MSA(Multiple Systems Atrophy) may become quite depressed as they struggle to come to terms with the diagnosis and all of the potential implications on their life, work and loved ones. This is a perfectly natural response, though counseling and/or antidepressants may be helpful during this period. Typically, most patients get through this time with amazing strength and resolve as they learn to "fight back" against their PD with exercise, medications, and family support.

For the less acutely depressed group, we probably need a better term, something that means "not as happy as usual, a bit down" to describe the mood of many PD patients. Family members, when asked, frequently tell me that the patient does have some degree of depression, even when the patient does not complain of a mood problem. Of course, this must be differentiated from the motor aspects of PD, which may cause the face to appear less animated even if the person is not actually depressed. Significantly, though, spouses

and adult children may say that the patient no longer does things that he or she used to enjoy, avoids going out and no longer participates in previous activities (clubs, sports, volunteering).

The patient may blame this on the PD itself, even when the symptoms are quite mild, but it often turns out that depression is really to blame. Even when symptoms are more bothersome, some "quality time" with a good physical or occupational therapist can make many of these activities possible again, once the mood disorder is treated and interest returns.

As discussed in a previous issue, anxiety is a frequent companion to depression in PD and is sometimes a bigger problem. Treating both of these symptoms is an important step in improving quality of life for many reasons.

In addition to effects on functions such as appetite and motivation to exercise, both depression and anxiety can cause insomnia and early morning waking. Sleep, vital to everyone for maintaining good health, is especially important in people with PD and other forms of parkinsonism. When patients who report having "good days and bad days" are questioned closely, they often note a strong relationship between a sleepless night and poor motor function the next day.

So how do we treat depression? In an ideal world, I would refer every patient to a well-rounded program that includes individual and family counseling, meditation, stress management, perhaps even a week at a spa, or a yoga retreat in a beautiful setting. The realities of life, insurance, time constraints, and often unwillingness on the part of patient makes most of this holistic approach hard to come by. Moreover, studies have shown that PD can cause changes in the levels of some brain chemicals related to mood, such as serotonin and norepinephrine. Therefore, drugs that restore the balance of these substances to a more normal balance, are often the most effective therapy. Patients are often reluctant to take these drugs, which include SSRIs such as Lexapro (escitalopram) and Paxil (paroxetine), because they have heard negative things about them, but when prescribed appropriately, they usually are safe and effective in people with PD.

Two troubling symptoms that may or may not respond to therapy for depression are fatigue and apathy (loss of motivation). In fact, fatigue is noted by most PD patients whether they have depression or not. Apathy may occur as part of a spectrum of depressive symptoms but may remain after depression has resolved. We work hard to treat these troubling symptoms in our patients. Drugs like Provigil (modafinil) or Ritalin (methylphenidate) help in some cases, but may cause side-effects in others. We have yet to find a solution that works for everyone.

As a patient, the best way to approach these issues is to work with people who know you well to identify mood issues that could be having a negative effect on your overall quality of life. Then, bring them to the attention of your doctor and prepare to be open-minded about possible solutions.

Remember, a positive attitude is one of your most important assets in fighting PD!