

Depression in People with Parkinson's Disease

By Diane B. Breslow, MSW, LCSW

Depression is the most commonly encountered psychiatric condition in Parkinson's disease. PD patients experience depressive symptoms more than the general population, the elderly population, or non-Parkinsonian control patients with comparable disabilities. In a patient with PD, the depression can be reactive and/or endogenous, i.e. a biochemical consequence of the biochemistry of PD.

Reactive Depression:

Reactive depression is an understandable response to receiving a diagnosis of a chronic, progressive condition. In addition, reactive depression is more likely to occur when:

1. The patient has a close relative or friend who is or was disabled by PD;
2. The patient is already in a major life transition, e.g. retirement, job loss, divorce, illness in the family;
3. The patient's self-esteem is dramatically, negatively affected by tremor, drooling, or the inability to excel in an area of previous competence (such as sports).
4. Further, panic attacks may occur as a result of the immobility and freezing episodes of PD.

Endogenous Depression:

In PD, the degree of endogenous, biochemical depression is not related to age or to the severity of physical symptoms. Endogenous depression can occur at any time during the course of the disease, can last from weeks to months, and can recur. In addition, an endogenous depression may be present (diagnosed or undiagnosed) before any PD symptoms appear. Furthermore, depression may be masked by the symptoms of Parkinson's. When those PD symptoms are relieved by levodopa therapy, the depression may become apparent.

Diagnosis:

It is important to make a differential diagnosis between Depression on the one hand, and, on the other hand, PD symptoms that resemble Depression: an expressionless, immobile, or poker face; a quiet, low or weepy voice; stooped posture; fatigue. In addition, compared to Depression in the general population and in older adults, depression may present differently in people with PD.

PD Depression:

1. Excessive or obsessive fears—of dying, or of not dying and of becoming a burden.
2. Isolation, perhaps due to:
3. Feelings of embarrassment to be seen in public.
4. Panic, precipitated by slowness (bradykinesia), by the inability to move (akinesia), or by the “what if?” anxieties: “What if I can't respond in an emergency?” “What if I won't be able to swallow?”

5. Frequent tiredness.
6. Unwillingness or unmotivated to participate in a normal day's activities, or in one's own daily care.
7. Shift in mood. Perhaps patient doesn't say that he is sad; yet, he becomes irritable, angry, and withdrawn.
8. Weight loss.
9. Sleeplessness.

In order to identify changes and signs that might indicate a diagnosis of depression, a professional can:

1. Administer a depression inventory or scale,
2. Interview the patient in detail,
3. Obtain observations from family members, close friends, and other healthcare providers.

Intervention:

Both PD and Depression can be treated simultaneously. Once properly diagnosed, Depression can be alleviated in a combination of ways:

1. Mental and physical activity, and regular exercise. (If, in the early stages, a patient is not challenged to stay active, she can wallow in self-pity, apathy, or "why me?" and abdicate making an effort).
2. Education and information about PD, in order to dispel myth and misinformation (e.g., the belief that PD = Alzheimer's disease).
3. Setting realistic and achievable goals.
4. Support groups.
5. Yoga, meditation, relaxation.
6. The pursuit of new, personally meaningful, or previously unfulfilled interests, e.g. music, languages, art, astronomy, writing. (In cases where patients have had to stop working, many find that the absence of stress, along with the comfort of a flexible schedule, permits the development of new or latent talents).
7. A positive attitude, and a determination to cope, to grow, to "accommodate without surrendering:" to lead as full a life as one can.
8. Counseling: to accept the realities of the disease, to talk, to grieve, and to feel listened to and understood.
9. Humor and laughter.
10. To love and be loved: Being surrounded and cared for by a loving family; Participating in a support group; Receiving hugs and touch; Sustaining contacts with friends.
11. Anti-depressant medication.
12. Hospitalization.

PD, Depression, and The Family:

A discussion of PD and Depression would not be complete without examining the impact of PD on the patient's family. When one member of a family is ill or disabled, all the subsystems in the family strongly react. The stages of those reactions are:

1. Fear, panic, or disbelief: “I can’t believe this is happening;” “I can’t cope with this.” Many people may speak such words of denial, yet remain capable of doing what they need to do in order to deal with their own feelings and to help their loved one.
2. Anger or rage: wanting to blame someone (a medical provider) or something (genes, a healthcare system, a lab).
3. Guilt: at feeling anger, or about feeling somehow responsible for the illness.
4. Depression.
5. Adaptation, perhaps even Acceptance. No one has to like or understand or even be “at peace” with what happened to them or why. What we hope is that families and patients will see adaptation not as surrender but as successfully meeting a challenge, or more aptly, a series of challenges.

As with the patient, for whom sadness and depression are a normal part of adjusting to PD, so too with the family. With any illness, or disabling or degenerative condition, not only the patient, but also the family, experiences multiple losses, and therefore grief. In PD, with the fluctuation of symptoms, each day can be different or unpredictable. Roles change. Perhaps the spouse who had been less active or taken less initiative now must assume the role of caregiver. Changes occur in a marital couple or family’s images, fantasies, or dreams of their lives and their futures. With an illness, the grieving process is always present, be it latent or active, to a small degree or a large one. Furthermore, grieving is triggered with every new challenge that the disease presents to the patient and therefore to the family.

I strongly advocate PD support groups for caregivers and family members. I know of no better way for patients and their families to gain—“under one roof”—so many benefits:

1. the understanding support of others
2. education and up-to-date information about PD
3. comfort and consolation
4. socialization, and a friend to turn to during the difficult times between group meetings
5. coping suggestions and techniques
6. encouragement and hope.

Those families who are at risk for staying in their depression and having greatest difficulty coping with PD are the ones with a history of poor conflict resolution or unresolved losses; who deny health or safety hazards; who have been either extremely disengaged from one another, or extremely enmeshed; who have poor communication; who mistrust professionals or each other; and who give little nurturance to one another. Families that handle illness have many coping strategies: They call upon each other, friends, and mental health professionals. They utilize all their resources and those provided by hospitals, organizations, agencies, or mental health centers. They have good communication. They understand the disease process and treatment. They work together to maintain a positive overall attitude.

