

## Pattern of Depressive Symptoms in Parkinson's Disease

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**Background:** *Depressive symptoms are common in Parkinson's disease (PD); however, it is unclear whether there are specific depressive symptom patterns in patients with PD and comorbid depression (dPD). Objective:* The goal of this study is to examine the frequency and correlates of specific depressive symptoms in PD. **Method:** A sample of 158 individuals with PD completed the self-rated Harvard Department of Psychiatry/National Depression Screening Day Scale (HANDS). By multiple-regression analysis, the authors examined the association between HANDS total and subscale scores and various demographic variables. **Results:** The frequency of depression was 37% (N=58). Patients with a history of depression before PD had significantly more serious depression than those who had no such history. Of those who were more depressed, the most common symptoms of depression endorsed were low energy, difficulty with concentration/making decisions, feeling blue, feeling hopeless, and having poor sleep. **Conclusion:** There is a relatively high prevalence of dPD. Items on the HANDS that discriminated best between depressed and nondepressed subjects with PD included feeling blue, feeling hopeless, feeling worthless, lack of interest, and self-blame. It remains to be defined whether dPD should be understood primarily as a psychological reaction to a physical disability or perceived impending one, or as a direct expression of the neuropathology of PD. (Psychosomatics 2009; 50:448–454)

Parkinson's disease (PD), first described almost two centuries ago (1817) by James Parkinson as the "shaking palsy," is the second most common neurodegenerative disorder, affecting approximately 500,000 individuals in

the United States.<sup>1</sup> Depression is a significant health problem, and is associated with worsened health status across a variety of diseases.<sup>2</sup> Since the 1920s, depression has been reported as a common feature of PD,<sup>3</sup> and, indeed, is the most studied psychiatric disorder in PD patients. Reports of prevalence rates vary, ranging from 7% to 90%, with a general consensus that depression in some form (i.e., either major or non-major depression) appears to occur in approximately 40% of PD patients.<sup>4,5</sup> It can be difficult to diagnose depression accurately in PD patients (dPD), in part because the motor impairments of PD may overlap with common depressive symptoms, such as reduced energy, psychomotor retardation, mental slowing,

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difficulties concentrating, and insomnia.<sup>6</sup> As part of the NINDS/NIMH Work Group on Depression and Parkinson's Disease, Marsh and colleagues<sup>7</sup> reviewed the difficulties of accurately diagnosing depression within the context of PD. Symptoms of PD may mask symptoms of depression, leading to symptoms that cannot be identified. It is also common for clinicians, as well as patients, to discount depressive symptoms when they occur in the presence of a major medical illness such as PD. They endorse an "inclusive" strategy for managing symptom assessment; counting symptoms toward both conditions, not one or the other.<sup>7</sup> In terms of rating scales, there are several from which to choose, depending on the clinical or research goal.<sup>8</sup> Currently, there is no specific dPD scale.

Disabilities due to motor impairments, such as tremor, rigidity, and slowness, dominate the clinical manifestations of PD, but mood changes and even psychoses are being recognized as major sources of disability. Depression may be associated with specific impairments in PD. Weintraub and others<sup>9</sup> found that depression significantly contributes to a PD patient's disability. Norman and colleagues<sup>5</sup> found that depression in PD was associated with more rapid disease progression, cognitive decline, memory difficulties, and functional disability. Yamamoto<sup>3</sup> proposed that depression accounts for about 58.2% of impairment in quality of life (QOL) in PD patients, affecting QOL more than severity of motor disability. Given the co-occurrence of dPD and the impact of dPD, we conducted a cross-sectional study to identify the prevalence and specific symptoms of depression in a cohort of PD patients attending an outpatient clinic. This is an exploratory analysis; we did not have a priori hypotheses, and we were interested in seeing whether we could detect depressive symptom patterns.

## METHOD

We invited 200 consecutive individuals with a research diagnosis of PD, who attended the Massachusetts General Hospital Movement Disorders Unit between March 3, 2004, and June 2, 2005, to complete the Harvard Department of Psychiatry/National Depression Screening Day Scale (HANDS).<sup>10</sup> This study was approved by the Institutional Review Board at MGH. Of the invited patients, 158 completed the questionnaire, and their data were available for analysis. Of the 42 who did not participate, 15 left certain items on the HANDS unanswered, and 19 refused to complete the HANDS. We found no evidence of differences between those who filled out the question-

naires completely and those who did not (see Results section). Because of scheduling conflicts, we were not able to offer the HANDS to eight patients. The HANDS is a 10-item self-report scale, each item of which assesses one of the following symptom areas over the previous 2 weeks: decreased energy, self-blame, appetite, sleep, hopelessness, sadness, interest, feelings of worthlessness, suicidal thoughts, and loss of concentration. Each item is graded on a 0 (normal)-to-3 (severe) scale, with a maximum Depression score of 30; that is, the HANDS Total score or sum of the items. Typically, a score of >9 indicates depression. In order to increase sensitivity while maintaining an acceptable level of specificity, a score of >6 on the HANDS was used to identify depression.

The HANDS scale was selected to detect the presence of depression and identify specific symptoms of depression because it is a brief questionnaire with a high degree of correspondence with DSM-III-R criteria for major depression.<sup>10</sup> Furthermore, the HANDS has been shown to have adequate reliability, as measured by internal consistency; correlation of each item with the total score (minus the item) was moderate-to-high, and its coefficient  $\alpha$  was 0.87.<sup>10</sup> Completion time for the HANDS is approximately 1–3 minutes. For each of the 158 patients, per chart review, we also collected demographic, historical, and clinical data, including age, gender, history of depression or other psychiatric illness before developing PD, presence of dementia, age at PD onset, and PD severity, as judged by the Hoehn and Yahr scale.<sup>11</sup> The Hoehn and Yahr Scale was designed to include the entire range of Parkinson's states. It is a clinician-rated instrument, allocating a 0-to-5 scale to indicate the relative level of disability the patient is experiencing (0: no visible symptoms of PD; to 5: PD symptoms on both sides of the body and unable to walk).<sup>11</sup>

## Data Analyses

With respect to data analysis methods, the distribution of the key dependent variable, the HANDS Total score, was positively skewed in violation of the normality assumptions of some of the significance tests we used. Therefore, where needed, a more normally distributed log-transformation of this score was analyzed first to establish statistical significance of effects. Significant findings were then followed with the same analysis, but with the raw HANDS Total scores, to obtain more interpretable effect estimates (regression coefficients, correlation coefficients, mean differences, etc.). Multiple-regression analyses examined the relation of the HANDS Total to various de-

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