

An anatomical illustration of the human head and neck in profile, facing right. The brain is shown in a semi-transparent yellow and orange color, with a dense network of red and orange fibers representing the nervous system. The spinal cord is depicted in a light blue color, extending down the neck. The skull and jaw are shown in a light blue, semi-transparent style. The background is a solid dark purple color.

Parkinsons Recovery Magazine
November 2010

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A Golden Opportunity to Transform our Thought Patterns

By Robert Rodgers, Ph.D.

November brings the magnificent celebration of Thanksgiving. The month is a golden opportunity to stop ourselves from negative thought patterns that fuel and sustain the symptoms associated with a diagnosis of Parkinson's disease. When symptoms are in our face, negative thoughts run wild. Fears flare. Anxiety peaks. Depression rears its ugly head.

When symptoms flare up, we are reminded there is an imbalance in the body that needs to be addressed. Nothing more. Nothing less.

Recovery hinges on our thought patterns. When thoughts run amuck, symptoms get worse. It is a vicious cycle that inevitably spirals downward.

Until November that is. This is a time to give thanks, a time to celebrate all that is good, exciting and fun about our lives. November is a special time to give thanks for our family, friends and the miracle of our body's ability to heal. It is an opportunity to be thankful for the acts of kindness others extend to us. It is also an opportunity to celebrate the gifts we give to others.

If you are a [Parkinsons Recovery member](#), be sure to visit the member website this week. I have recorded and posted daily meditations for

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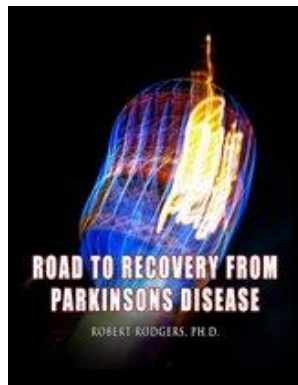
Thanksgiving week. As I prepared and recorded the meditations, I transformed my own negative thought forms.

Join with me this week in turning off the negative thoughts that do not serve our best and highest good. Switch to the truth of who we are.

May we together manifest the reality that recovery is possible now. When we hold this thought to be near and dear to our hearts - the miracle of recovery unfolds ever so gently and miraculously.

Robert Rodgers, Ph.D.

[Parkinsons Recovery](http://www.parkinsonsdisease.me)



www.parkinsonsdisease.me



www.parkinsonsrecovery.org

**The Second World Parkinsons Congress:
Where Do We Go From Here?**

By Pamela Quinn

“Fierce Urgency Now. Now is the time for a steady hand, a strong voice and a keen sense of smell. I had them once, and I want them back.”

Those are the words of Bryn Williams, a PD patient and speaker at the opening night ceremony of the second World Parkinson Congress. The whole event had that kind of force and poetry, and although almost a month has passed, I’m still running on the energy it produced. What made it a fabulous experience was the cross fertilization of ideas from different countries and people: neurologists, researchers, patients, caregivers, spouses, drug companies, advocacy groups. And there were people who were not there in actuality but there in spirit – by participating in the quilt project – 39 panels of beautiful squares with heartfelt messages from around the world. The lectures presented by professionals ranged from the role of mitochondria to fundraising to constipation and how it affects the absorption of medication. All bases were covered. The next Congress is in Montreal in 2013. I encourage you to go.

A video of the opening night ceremony is now up on the [WPC website](#). Try to see it. There’s beautiful singing, moving testimonies from people with Parkinson’s, appropriate thanks to the organizers and

contributors, and above all, a common sense of purpose.

(Unfortunately the videos shown that night were not picked up by the camera so you need to go to the heading [of video competition on the WPC website](#) to see them.) The winners of the video competition include my very own, “Welcome to our World”. Look at them all. You’ll get a sense of how big this community is.

Being around all that science and research was uplifting, but at the same time we know how long it takes for a promising drug to progress from an idea to a pill in the mouth – roughly ten years – and those of us who have PD want something NOW. So what are our options? What can we do to make our bodies function at optimum level; is there anything we can do to stabilize our condition so that if we have to make an adjustment in our medications, it’s a subtraction, not an addition?

We’re on to dance and exercise and music. We know that reinforcing normal movement patterns through moving as much as possible and with joy is very important.

The area where I believe we can improve our treatment is through diet and nutritional supplements.

Enter Lucille Leader. She is a nutritional therapist from the U.K. who has written and/or co-authored six books on PD. (She participated in a panel I moderated at the WPC called, “Taking Charge of your Parkinson’s”, which also included the renowned cyclist and PD

advocate, Davis Phinney and the wonderful music therapist Connie Tomaino.) One of Leader's books," Parkinson's Disease, Dopamine Metabolism, Applied Biochemistry and Nutrition (www.denorpress.com) demonstrates the biochemical logic of analyzing and supporting metabolic pathways pertinent to PD. Examination of her PD patients (she is Nutritional Director of the PD Management Clinic at Highgate Hospital in London – a multidisciplinary clinic under the direction of Dr. Geoffrey Leader) includes extensive blood work and stool analysis to determine the biochemical imbalances that exist in one's body. She then develops a customized program to encourage one's body to function at optimal level. Introductory remarks from one of her books," [Parkinson's Disease: Reducing symptoms with Nutrition and Drugs](#)," read as follows:

"Vitamin C deficiency may cause scurvy. Deficiency of vitamin B1 can be linked with beriberi, iron with anemia, essential fatty acids with inflammatory disease and calcium with osteoporosis. Similarly, dopamine deficiency may lead to Parkinson's Disease. Dopamine is metabolized from dietary protein. Therefore, deficiencies of digestive and other enzymes and their co-enzymes necessary for dopamine metabolism, may compromise this metabolic pathway and further amplify the degenerative process."

So achieving the proper balance between all our interdependent properties is necessary for the body to function at its best. And after all,

what are we made of ? - proteins, carbohydrates, fats, vitamins, minerals and water. So it makes sense that problems can result from improper amounts of the substances of which we're comprised. I encourage you to read her analysis. The examination of the effects of diet and nutrition is an area in which our country is behind. As patients, we need to find a way to get clinical studies going to test these waters to determine if we can make the most of what we have.

Another thought – there's a personal reason why I'm interested in this approach as a supplement to drug therapy. I have often asked myself, where did this disease come from? I have no family history (which supports the idea of co-factors necessary for its development) and I've spent my life in a dance studio. Where's the toxic exposure? The only explanation I've come up with over the years that makes sense with what scientists tell us about the cause of PD is that maybe my body is either more sensitive to pollutants or my organs that detoxify – kidneys and liver – aren't working at optimal level, so that I am exposed to toxins by virtue of improper elimination rather than excessive exposure. If this is true, then working to improve the functioning of those particular organs is essential. (Warning: popular detoxification regimes are not advisable for people with PD. Toxins released too quickly can cause ill health. See Leader's chapter on detoxification.)

So recognizing the imbalances in one's body chemistry and trying to understand its implications and consequences is, I believe, a very useful investigation to pursue. And this is why I think that we need to know

more about optimal health and how to achieve it. We need to let our doctors know that this is an avenue we want researched. For comprehensive therapy we need our drugs and exercise and nutrition to work together; as patients we need our doctors, researchers and drug companies and advocacy groups to work together. And it is through all of these collaborations and gatherings like the World Parkinson Congress, that we will find a way to rediscover “*a steady hand, a strong voice, and a keen sense of smell.*”

Pamela Quinn was a professional dancer before she was diagnosed fourteen years ago with Parkinson’s disease. Originally she became her first patient, as she worked on her own body to circumvent abnormal movement patterns as much as possible.

Her experiments with herself led her to teach others which she began to do with her class, Movement Lab, sponsored by the [Brooklyn Parkinson Group](#) at the Mark Morris Center, and a dance class for People With Parkinsons at the [Adele Smither’s Parkinson Center](#) at the New York College of Osteopathic Medicine. She also works privately with patients in New York City where she lives with her husband and two sons.

Recently she returned from the second World Parkinson Congress in Scotland where her video, [“Welcome to our World”](#) was featured at the opening night ceremony as a co-winner of the

video competition. To see the video and to learn more about her, you can visit her website at pamelaquinn.net.

Some Common Questions Regarding the Link between Hydration and Wellness

By Dr Jaroslav Boublik

In the second of this series of articles we will answer some common questions regarding the link between hydration and wellness.

What are the symptoms of dehydration?

The reason dehydration is such a difficult issue to manage is that the symptoms are not particularly obvious until the level of dehydration is quite extreme. If you encounter someone who is significantly dehydrated in an acute way – perhaps they are exercising hard at high temperatures or they simply have had no fluid intake for a period of time –

- They will be tired.
- They will be lethargic.
- They will often be confused.

But this is an extreme end state level of dehydration. That is not where people are the most of the time.

Most of us are at a point when we are only fractionally dehydrated. The symptoms of that are much harder to pick.

There are whole series of tests that people can use can use to identify the advancing stages of dehydration. These include picking up a small amount of skin on the back of your hand between the thumb and forefinger and seeing how quickly it returns when you let go. It is not a particularly accurate way of measuring dehydration and certainly depends a lot on factors like the age of the person. But it is a way that you can self-monitor to some degree. Observing urine volume and color and frequency of urination is another approach. Darkly colored urine, infrequent need to empty your bladder and small urine volumes suggest a level of dehydration. Overall this is about the limit in terms of being able to measure these things by symptomatology.

We have scientific techniques for measuring the relative state of dehydration such as bioimpedance body composition testing. Obviously, they are not available to most people.

The simplest way to address the issue is to make sure you take steps to maintain an optimal level of hydration at all times and never allow these signs and symptoms to creep into your experience. I acknowledge this is somewhat avoiding the question but it is the reality for most of us and it is the best way to approach the issue.

Why is it that as we age our bodies become more and more dehydrated, or at least it seems that is the case?

It may well be that we are looking at the question the wrong way around. Maybe our bodies age because they become more and more dehydrated. Perhaps if we are able to maintain the optimal level of

hydration in the cells that is needed by the body many of the age related processes of degeneration would actually be slowed.

It is certainly true that increasing dehydration and aging go hand in hand but perhaps we should be looking at that question from the point of view of making sure that we stay hydrated and in doing so that process will actually be slowed. It's clear that we can't stop it completely because many other factors are at play here.

This is not to suggest that dehydration is the only factor that can cause the aging process but certainly it is a significant one and if we can manage it, then we can gain some significant anti-aging benefits.

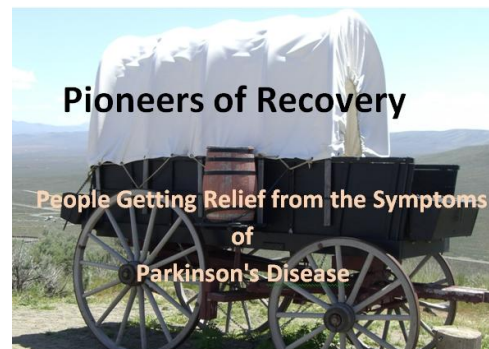
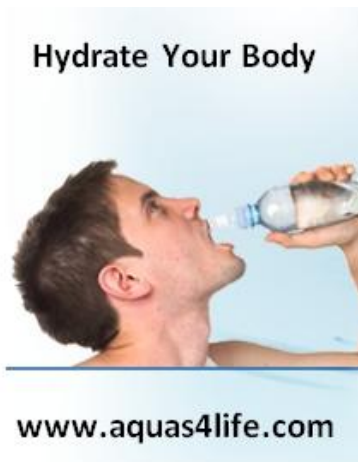
Why is it that a well hydrated body is so essential to being able to eliminate toxins in the body?

The analogy that is appropriate here is to think about the ebb and flow of the tide. The water that is available in the body is the most significant amount of matter that is able to move in and out of cells. It is in fact the mechanism by which all nutrients are brought into cells and also all toxins are taken out of cells.

If the mass, or volume, of water that is moving in and out of cells is low then the ability for nutrients to be taken into the cells is reduced and the ability of toxins to be removed from the cells is reduced. So, simply increasing the available volume of fluids that can move in and out of cells will both improve the uptake of nutrients and also the clearance of

toxins. It is very important for the body to be well hydrated to facilitate the clearance of toxins.

Dr Jaroslav Boublik B.Sc.(Hons), Ph.D. (Med), MRACI, C.Chem. AACNEM has spent almost 30 years in medical research with 15 years in drug development and then 15 years in nutritional medicine. He consults to the nutrition industry as a formulator, researcher, presenter and educator. His primary research interest is water and hydration and he is the co-developer of The [Aqua Formulas](#).



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General Mobility Guidelines for Transfers: Part II of Caregiver Training Series

By Kevin Lockette PT

The following guidelines will assist in maintaining a normal lumbar curve (neutral spine) and ultimately avoid injury.

Body Positions and Hand Placement, Considering Body Types

Tall or short, small or large, you need to apply the principles of good body mechanics when assisting care receivers with mobility, although there are differences in how to accomplish this. For example, when a tall person with long arms performs a dependent transfer of an average-sized person, a common approach would be to bend the care-receiver forward and to reach over the care-receiver for hand placement on his hips, as this is the easiest way to keep the care-receiver close to your body, to keep the normal lumbar curve and to have a stable base of support. If a tall caregiver approached this transfer by positioning himself in front of the care-receiver, with hand placement under the care-receiver's arms, he would have to bend down really low to keep the normal lumbar curve, which is hard on the knees and not as stable a base of support. In contrast, a caregiver of smaller stature most likely would be unable to perform the reaching-over style transfer, as his arms probably would not be long enough to reach over and around the care-receiver. Instead, he might position

himself in front of the care-receiver and reach his arms under the care-receiver's arms to keep a neutral spine.

Any time that the lower back is flat or rounded while lifting, stress will occur to this area, which can result in a back injury. The bottom line is that you must always keep the normal lumbar curve when lifting to avoid injury. You will have to figure out how to position your body and where to place your hands while maintaining the normal lumbar curve (neutral spine). There is no perfect way to do this; it depends on each circumstance. The body type of both the caregiver and care-receiver will dictate which position and hand placement is best.

Hand Placement for Transfers

Hand placement is an important consideration when assisting a care-receiver with transfers. It's also important to communicate to him where he will be touched, especially for the first time with a transfer. If the care-receiver is unable to weight-bear fully, you, as the caregiver, may need to hold on to his hips. Do not grab her clothes—that is not stable or sturdy, and it also is uncomfortable for the care-receiver, especially if you grab the back of the pants. It is better to use a transfer belt or to cup your hands around each side of the care-receiver's buttocks.

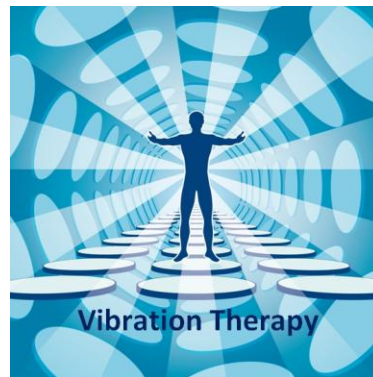
If your arms are not long enough to cup the care-receiver's hips, work a sheet or bath towel underneath the care-receiver's buttocks and hold on to the towel or sheet. This creates an extension and still allows for good control.

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This article is adapted from A Caregiver's Complete Guide to Safe and Independent Mobility in the Home, Langdon Street Press.

Release date in October 2010: www.ultimatecaregiversguide.com

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www.vibrationtherapy.org

What is Cognitive-Behavioral Therapy (CBT) and how can it help a person living with Parkinson's disease (PWP)?

By Roseanne D. Dobkin, PhD

What is CBT?

CBT stands for cognitive-behavioral therapy. It is a kind of psychotherapy or “talk therapy” that focuses on examining the connections between thoughts, feelings, and behaviors. More specifically, CBT helps people to become more aware of their thoughts and feelings and provides them with skills to change thinking patterns and behaviors that may be related to negative feelings like depression or anxiety.

CBT is based on the seminal work of Dr. Aaron Beck. However, recent research has focused on the various components of CBT and how they can best be applied to meet the needs of people with Parkinson’s disease (PD) and their families. Relatedly, research is also beginning to explore how to optimize mental health care utilization in PD, so that PWP can fully benefit from evidence-based approaches, such as CBT.

How is CBT different from other types of psychotherapy?

Unlike some other therapies, such as psychoanalysis, CBT is highly instructive in nature and involves active collaboration between the patient and therapist. Sessions are generally structured and specific

techniques/coping skills are explained during each meeting. CBT is tailored to each patient's unique goals and patients are encouraged to practice these coping skills between sessions in order to work toward their goals.

What kinds of problems does CBT treat?

CBT has successfully been used to treat a variety of problems, including depression, anxiety, addictions, phobias, and eating disorders, among other issues. Preliminary research also suggests that it may be helpful to treat depression and anxiety in Parkinson's disease.

How does CBT work?

The cognitive part of the treatment involves identifying and modifying key thoughts that lead to negative emotions (i.e., depression and anxiety) and/or behaviors (i.e., social isolation). In the CBT framework, it is not the stressors in peoples' lives that cause feelings like depression or anxiety. Rather, it is peoples' thoughts or interpretations about what is happening around them that drive their emotional and behavioral responses. For example, let's consider a person newly diagnosed with PD. While nobody would be "happy" to hear this news (nor would "happy" typically be considered a healthy reaction), the way in which the PWP views the diagnosis will strongly guide coping efforts. A person who thinks "*My life is ruined and I have no control*" will likely feel helpless and hopeless and take a more passive role in his/her care. Alternatively, a person who thinks "*I wish this didn't happen, but I know that I can still have a meaningful life even*

with PD” will probably feel less depressed and proactively work to manage his/her symptoms.

The behavioral part of the treatment focuses on helping people to increase meaningful and enjoyable activities and to decrease problematic behaviors, like social withdrawal, that cause distress. This often involves a lot of experimentation with new activities and/or testing out creative modifications to pre-existing routines. Consider the following: *Are there novel ways to stay socially connected? Is it possible to walk 15 minutes twice per day, instead of once for 30 minutes? Can a retired firefighter start to lead fundraising efforts for the fire department even if he or she is no longer responding to emergency calls?* Decreased exposure to activities and people associated with meaning and pleasure can cause and maintain depression. The behavioral components of treatment are intended to reverse this process.

How long does CBT take?

CBT is generally a brief, time-limited treatment. However, the number of sessions will vary depending on the needs of each individual.

How can CBT be helpful to people with Parkinson’s disease?

Many patients with Parkinson’s disease (possibly as many as 50%) are living with depression or anxiety. While medications are often used to treat depression and anxiety in PD, CBT is a non-pharmacological option to treating these conditions. CBT may be especially useful for PD patients who have side effects to, do not wish to take, or have not been

sufficiently helped by antidepressant and anti-anxiety medications. CBT teaches PWP specific skills that they can use on a daily basis to combat depression and anxiety. PD patients can continue to benefit from these skills long after treatment has ended.

PD can be challenging to cope with under optimal circumstances. Excessive negative thinking, social withdrawal, and decreased involvement in meaningful activities impede successful coping efforts and makes everyday living that much more difficult. It is well established that depression blocks optimal functioning in PD. For example, depression in PD has been linked with decreased quality of life, faster progression of physical symptoms, and greater cognitive decline. Therefore, the cognitive and behavioral correlates of depression are optimal targets for intervention.

How can I find out more information?

For additional information about CBT treatment resources in the community, please contact Dr. Dobkin at 732-235-4051. You may also contact your insurance carrier, your local Psychological Association, or the Association for the Advancement of Behavioral and Cognitive Therapies, <http://www.abct.org>, for referral information.

Roseanne D. Dobkin, PhD is an Assistant Professor with the Department of Psychiatry at the UMDNJ-Robert Wood Johnson Medical School



Barriers to Mental Health Care Utilization in Parkinson's Disease

A survey study for Parkinson's Disease patients funded by the National Institutes of Health (NIH)

Help Us Find Answers

Dr. Roseanne Dobkin, Assistant Professor of Psychiatry, at UMDNJ-Robert Wood Johnson Medical School in New Jersey is conducting a national survey in order to better understand the difficulties that PD patients may experience using the mental health care system. Interested participants will be asked to fill out an anonymous survey which will take 15-30 minutes to complete. The survey can be completed online <https://www.surveymonkey.com/s/improvecare4pd>, over the telephone, or on paper.

A history of mental health treatment IS NOT required for participation. We are interested in responses from participants who have had, as well as from those who have not had, mental health treatment in the past.

Results from the study may be used to develop new strategies to improve the access to and the quality of mental health care for people with Parkinson's disease. There is no payment for participation in this



study. For more information, please contact Dr. Dobkin at 732-235-4051 or dobkinro@umdnj.edu.

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