Group therapy proposal for Parkinson's patients

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Abstract: Parkinson's Disease (PD) is a common, chronic, and progressive neurological condition that is associated with the loss of dopamine-producing cells deep in the brain. Every year, over 60,000 Americans are diagnosed with Parkinson's and over six million people worldwide are living with the disease (Girouz & Farris, 2019). Parkinson's is classified as a movement disorder because the most recognized symptoms are movement related; however, psychological symptoms are also associated Parkinson's. The primary psychological symptoms are depression, and anxiety. This group proposal is designed to address primary and secondary psychological symptoms in patients diagnosed with Parkinson's disease, or any other neuromuscular disorder.

Keywords: Parkinson's disease; Neuromuscular disorders; primary and secondary psychological symptoms in patients

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Introduction

Parkinson's Disease (PD) is a common, chronic, and progressive neurological condition that is associated with the loss of dopamine-producing cells deep in the brain. Every year, over 60,000 Americans are diagnosed with Parkinson's and over six million people worldwide are living with the disease (Girouz & Farris, 2019). Parkinson's is classified as a movement disorder because the most recognized symptoms are movement related; however, psychological symptoms are also associated with Parkinson's. Dopamine is a key factor in both the movement and psychological symptoms. Common movement related symptoms, or motor symptoms, are tremors, rigidity, and changes in gait and balance. Tremors are involuntary shaking movements and are the most visible and recognizable symptom. Rigidity refers to a tenseness and tightness that can make movement difficult. Changes in walking and balance may include taking shorter steps, shuffling, and postural instability that may lead to falling (Girouz & Farris, 2019).

Although not as easily recognizable, significant psychological symptoms frequently occur with Parkinson's disease. These are classified as non-motor symptoms and may be primary or secondary symptoms. The primary psychological symptoms are depression, and anxiety. Depression in Parkinson's patients is very common and impacts 50 – 75% of those diagnosed (Weintraub & Mamikonyan, 2019). Anxiety disorders impact 25 – 40% of PD patients. Secondary psychological symptoms impact 60 - 70% of patients and include apathy, isolation, loss of control, concern about dependency, and worry and fear about the progressive nature of the disease (Dobkin, Mann, Interian, Gara, & Menza, 2019).

This group proposal is designed to address primary and secondary psychological symptoms in patients diagnosed with Parkinson's disease, or any other neuromuscular disorder. The proposal is for a hybrid group that combines psychoeducation with a process group format. The psychoeducation portion will focus on cognitive behavior therapy to decrease common secondary mental health diagnoses and common psychosocial issues that are secondary to Parkinson's disease. In addition, the group will focus on creating a supportive environment where patients and partners can share their experience. Family members or primary caregivers are encouraged to be included in the group due to evidence that suggests that this increases the effectiveness of psychological treatment in PD patients (Dobkin et al., 2019).

Common secondary mental health diagnoses

Depression and anxiety are common in Parkinson's patients and have far reaching impact. Compared to patients without depression, patients with depression have faster motor and cognitive decline, poorer quality of life, and increased mortality (Martinez-Martin, 2011). Those with anxiety show poorer response to treatment for depression and higher levels of movement and cognitive impairment (Berardelli et al., 2019). Despite the evidence of poorer outcomes for PD patients with psychological symptoms, only 10 – 20% receive psychological treatment (Yang, Sajatovic, & Walter, 2012).

Depression and anxiety in PD patients present in many different ways. These may include a loss of overall motivation, a lack of interest in activities that the client has enjoyed in the past, social withdrawal, or poor sleep patterns (Giroux & Farris, 2016). A common issue for PD patients is a lack of understanding related to both depression and anxiety. Patients will confuse the symptoms of depression and anxiety with Parkinson's disease and attribute those symptoms to the disease (Egan, Laidlaw, & Starkstein, 2015). Patients are surprised to discover that it is possible to experience a decline in depression and anxiety symptoms and to understand that these symptoms are not simply a part of living with PD (Eganet al, 2015). It is important for patients to understand this as soon as possible because this understanding can result in them feeling hopeful about the future and being more engaged in medical and therapeutic treatment (Yanget al,2012). In addition to understanding that depression and anxiety are distinct from PD, it is important to work with patients collaboratively to identify how depression and anxiety symptoms are impacting their life. It is common for patients to create excess disability when they are depressed and anxious (Egan et al., 2015). For example, one PD patient had stopped participating in photography, an activity he enjoyed, because he thought he could not do this due to his PD symptoms. After exploring this with a therapist, he realized that he was physically capable of being involved with photography. He understood that he was creating excess disability because of depression, not actual physical limitations (Egan et al., 2015).

Common psychosocial issues secondary to Parkinson's disease

In addition to common secondary mental health diagnoses, there are common psychosocial issues secondary to PD. These include loss of roles, decreased autonomy, and social isolation (Dobkin et al.,2014). How patients experience these symptoms is often related to core beliefs. Core beliefs play an important role in how patients respond to a PD diagnosis and how they manage psychological aspects related to disease progression (Egan et al., 2015). Research has identified three core beliefs that influence how individuals experience Parkinson's disease. They are overall core beliefs, illness beliefs, and cohort beliefs (Egan et al.,2015). Core beliefs are the rigid and inflexible beliefs developed early in life that are easily activated later in life. This activation is often in response to stressors, such as a serious medical (Beck, 1979). A PD patient may have long held to a core belief of competence and strength. If one cannot stand on their own and take care of themselves, they are incompetent and weak. A Parkinson's diagnosis may mean that they are no longer strong and never will be competent again (Egan et al., 2015). There are also illness beliefs that may drive negative emotions (Egan et al., 2015). It is common for patients to immediately view themselves through a lens of very advanced PD, although it may take years, or even decades, to reach that point (Girouz & Farris, 2019). Cohort beliefs refer to those values and beliefs shared by a generation or a group of individuals of the same age (Egan et al., 2015). Parkinson's disease is generally diagnosed over age 60 (Girouz & Farris, 2019) and this group is likely to hold a cohort belief that being disabled means that you are weak, needy, and dependent (Egan et al.,2015). This belief can negatively impact a range of secondary psychological symptoms and contribute to increased isolation. Increased isolation is common in PD patients and closely related to increased depression and anxiety (Mohr, Classen, & Barrera, 2004). Patients often isolate themselves when their motor symptoms increase. They become hyper-aware of their tremors and may no longer socialize, go out for meals, or eat in public places (Girouz & Farris, 2019). They are more likely to withdraw from friends and activities and see themselves as a burden to others. They are uncomfortable asking for help from friends or partners and this further contributes to increased isolation (Girouz & Farris, 2019).

When patients receive psychological treatment, pharmacological options are often the first choice; however, there are questions about efficacy and overall drug interactions. A recent meta-analysis that included placebo-controlled treatments for depression and anxiety in PD patients reported a moderate but insignificant effect of antidepressants on both depression and anxiety (Troeung, Egan, & Gasson, 2014). In numerous studies, CBT has been found to decrease depression and anxiety in PD patients (Farabaugh et al., 2010; Hoffman, Asnaani, Vonk, Sawyer, & Fang, 2012). In this same analysis, CBT was shown to have a larger effect size than antidepressants.

Research supports the use of individual and group CBT as an effective treatment for reducing psychological symptoms in PD patients (Farabaugh et al.,2010; Yang et al. 2012; Egan et al., 2015). Group CBT has similar effects as individual CBT (McDermut, Miller, & Brown, 2001); however, it also introduces a range of other factors that are likely to contribute positively to PD patients. Group therapy is more impactful than individual therapy regarding developing social support and improving social networks (Yalom, 2005). This directly addresses the issue of social isolation and withdrawal. Effective group CBT for Parkinson's patients focuses on decreasing primary and secondary psychological symptoms and improving emotional and social skills so that patients are better able to manage quality of life, in spite of disease progression (Berardelli et al., 2019; Hadinia et al., 2017).

Group theory

This group therapy proposal includes a psychological education component and a process group. The psychological education portion of the group will be based on CBT and will apply a specific CBT case conceptualization model for depression and anxiety in PD patients. This approach includes core beliefs, illness beliefs and cohort beliefs, as previously presented, and incorporates Parkinson's related cognitions (Egan et al., 2015). In addition to CBT, Yalom's existential theory will be woven into the psychological education portion of the group. Existentialists focus on the inescapable challenges of life and the freedom to reach beyond our circumstances and find meaning (Yalom, 2012).

The group process framework will be based on Bion's theory of group development (Garland, 2010). This group development model includes avoidance strategies that may relate well to this population. Considering group development within the context of avoidance (Garland, 2010), aligns well with patients who are new to a diagnosis of a degenerative disease. This model suggests three avoidance strategies. The first is a dependence assumption in which clients depend on the therapist and assume they will fix their problems. The second avoidance strategy is an assumption that members may create pairs or small sub-groups that become the focus and source of hope. This allows for members to find comfort but distracts them from the real work of finding hope within themselves. Finally, members can avoid the real work by engaging in a flight or fight response to anxiety and group pressures (Garland, 2010). Framing a process group in this way provides support and constructed direction for participants. This theory may help participants to understand how they may tend to avoid dealing with difficult aspects of this diagnosis and position them to take a more positive and proactive path of response.

Group description and objectives

This proposal and toolkit are for an 8-week (one session per week) psychoeducation and process group. Each session will be two hours and there will be a 20-minute break in the middle. The group will consist of 8 – 12 participants and two therapists. Participants will be recruited through referral from neurologists and movement disorder physical therapy services. Partners will be included based on the evidence that this contributes in a significant and positive way to patient outcomes (Yang, 2012).

The primary objective of this group will be to decrease psychological symptoms in Parkinson's patients, with a focus on depression and anxiety. The co-therapists will use a CBT model for the psychological education portion and the group process framework will be based on Bion's theory of group development (Garland, 2010). This program will apply evidence-based practices, as described in the literature (Dobkin et al., 2014; Hadinia et al., 2017; Troeung et al., 2014; Yang, 2012). The process group will provide a range of therapeutic factors that include installation of hope, universality, development of socialization, and group cohesiveness (Yalom, 2005).

Group selection and composition

Participants will be recruited through referrals from neurologists and recruitment through movement disorder physical therapy services. Participants must have received a Parkinson's disease diagnosis or be the primary partner of someone who has been diagnosed. Patients with advanced dementia are excluded because the design of this program does not address their needs.

Diversity

Diversity and culture may influence PD patients in several different ways. Cultural perspectives influence how individuals view disease and mental health issues that may be associated with disease. There are specific cultural and ethnic differences in how older adults understand mental health and depression and how they feel about stigmatization and seeking treatment (Substance Abuse and Mental Health Services Administration, 2011). Asian Americans, as a group, tend to perceive a higher level of stigma related to mental health services and are less likely to seek treatment. African Americans may be more likely to turn to their religious community for help dealing with depressive symptoms (Substance Abuse and Mental Health Services Administration, 2011). Sociocultural factors and generational influences certainly impact how symptoms of depression, mental health, and degenerative disease are responded to and managed. Corey, Corey and Callanan (1993) suggest that therapists gather information from group members about the sociocultural and generational influences that impact how they are navigating this diagnosis so that these may be addressed in the psychoeducation portion of group therapy.

Another diversity issue to be considered is socioeconomic status (SES) and the overall economic situation of the patient. This impacts access to services and overall life satisfaction when living with PD.

Patients with a higher SES will not only have a higher level of access to medical care for Parkinson's disease. They will also have more access to therapies that include both physical therapy, exercise therapy, and mental health therapy. A patient's overall economic situation and SES is a significant factor related to living with PD (Ambrosio, Portillo, Rodriguez, Rojo, & Martinez, 2019).

Ethical issues

Ethical considerations are an important component of group therapy. The primary consideration within this proposal is confidentiality and mandated reporting of abuse to Adult Protective Services. Therapists are required to report abuse or neglect of elder or protected adults. This mandate requires the breach of confidentiality. Facilitators are likely to learn information in this group that falls under this mandate. The mandated reporting requirements are managed at the state level.

Another ethical consideration is that of responding to advancing symptoms in PD patients that require a higher level of care. If the therapist becomes aware of advancing symptoms that are significant enough to require a higher level of care, they will initiate a meeting with the patient and their primary care giver for the purpose of discussing the situation and informing the primary care doctor.

Evaluation and Feedback

At the end of each session, participants will be allowed to provide feedback on the session. They will rank each session on a 5-point scale ranging from very helpful to not helpful. Participants will also be asked what "the most helpful aspect of attending the group" was and what was "least helpful or difficult". At the last session, participants will be asked to rank the overall program and share what was most helpful to them overall, and what should be changed or eliminated. Participants will also be asked questions related to their need for future support and will be given the opportunity to share contact information with other members.

Group agendas

Agendas for 8 sessions are included. Each session includes 50 minutes of psychoeducation, a 20-minute break, and 50 minutes of process group. The longer break is due to the age and health conditions of the clients in this group.

Prior to daily agendas, an overview of the learning objectives for each session is provided. All interventions are focused on treating depression and anxiety in PD patients or patients with other neuromuscular diseases. The psychoeducation components are CBT based and combine evidence-based practices and interventions that are directly related to treating depression and anxiety in patients with PD or similar neuromuscular, degenerative diseases.

Session 1: Introduction to group therapy

Part 1: 50 minutes

Learning Objectives:
Introduce the purpose of the group, develop group cohesion with sharing exercise and establish group norms with special consideration of the limitations and challenges of this group.

Outline of content
The purpose of this group is to help each group member actively manage in a positive way, the psychological challenges that are part of this diagnosis and this journey. We hope that by participating in this group, you will develop a sense of community and recognize that you are not alone in facing these challenges. By actively managing how you think about and respond to this disease, you can find new ways to live better with Parkinson's

Participant introductions
Include when you were diagnosed, and what were the symptoms you were dealing with before you were diagnosed

Activity and materials: How to establish group norms

Materials:
Large ball of yarn

Eight index cards with the following words:
- confidentiality
- not interrupting
- arriving on time
- managing time for sharing
- if you need to go to the bathroom
- if you need to bring a snack
- coming and participating
- bringing your partner

1 pair of scissors

Activity:
Have group members sit in a circle in their chairs. Review that the purpose of the activity is to discuss group norms and how we want to manage the logistics of this group. Also discuss how the yarn represents

how members of this group can become connected to one another and supported by one another, and the group overall. Distribute the cards and pass the yarn around. Discuss items on each card. For example, discuss timeliness. Members may have difficulty getting to therapy or may be delayed. If members are running late, encourage them to come. They can join in whenever they arrive. Set group norms that work for this group and respect the challenges that all members face. Do not make it feel difficult to commit to this group. Stress a sense of understanding and compassion around timeliness, needing to take extra bathroom breaks, and needing to take food or medication during the sessions.

Have group members pull the web tight and discuss the support that they can give and receive from this group. Take the scissors and cut the yarn, explaining that the norms set the framework for building this support and holding it in place.

Process and discussion:
- What was your support structure like before you came here today? What is it like now?
- Before you came today, how many people in your life relate to what is happening to you in terms of this diagnosis? Now, how many people in your life relate to what is happening?
- Focus on the importance of coming
- Ask if members are willing to share contact information.
- Plan to communicate with leaders if someone cannot attend or needs help with transportation.

Homework: none

Handouts: none

Resources:
spider web activity (Gass & Dobkin,1. 1991)

Part II: 50 minutes, Process Group

Session 2: Coping – Emotions (1)

Part 1: 50 minutes

Learning Objectives:

1. Participants will learn about coping using the tripartite model of coping (Folkman & Greer, 2000)
2. Patients will be introduced to emotions and identifying emotions in order to track thoughts and emotions (using a CBT thought log)

Outline of content

Individuals who have been diagnosed with a serious and degenerative illness can learn to manage how they cope with this. There are three main aspects of a coping model that I want you to think about.

1. The coping that involves your emotions.
2. The coping that involves problem solving.
3. The coping that involves finding meaning despite adversity.

Activity and materials

Index cards with the following words:

- Express your emotions
- Define and describe your emotions relative to being here today
- How would you rate your support structure (You may add options such as good, not good, positive, weak, negative)
- Can you still do things you enjoy?

A white board to write participant responses to questions

Modification: Divide into small groups

Break into small groups such as male, female, caregivers, and patients

Process and discussion:

- What did this experience feel like?
- Did you express feelings about your diagnosis that you have not expressed before?
- Did it help that you were talking with people who are in a similar situation?
- How did this exercise impact your understanding of how you are coping with this diagnosis? Did some areas stand out where you need help with coping?

Homework:
Part of coping is managing our thoughts, emotions, and behaviors. For Parkinson's patients, your emotions may impact your physical symptoms. Between now and next week, take some time to think about situations, physical symptoms, thoughts, emotions, and behaviors. Track these on this sheet and we will discuss together next week. Do not worry about the alternate thought column. We will talk about that as a group next week.

Resources:
See The Tripartite Model of Coping (Folkman & Greer, 2000): https://www.agpa.org/home/practice-resources/evidence-based-practice-in-group-psychotherapy/medical-and-health-issues-cancer-weight-loss-coronary-care
Emotions handout: https://www.therapistaid.com/therapy-worksheet/emotions-language-signs-behaviors/emotions/none
Homework handout: https://www.therapistaid.com/therapy-worksheet/thought-record/cbt/none
https://www.therapistaid.com/therapy-worksheet/thought-record/cbt/none

Part 2: 50 minutes, Process Group

Session 3: Coping: Emotions (2)

Part 1: 50 minutes

Learning Objectives:

Participants will be introduced to the CBT model and review how thoughts and emotions impact behaviors and PD symptoms

Outline of content

As many of you know, your physical symptoms change in response to your environment and your stress levels. What links these two things to your symptoms, or what is happening in your body? Your thoughts link this together. That is why what you think is so important.

Discuss CBT and have participants share some of their situations and automatic thoughts from their thought log. Discuss as a group some alternative thoughts

Introduce cognitive distortions and focus on catastrophizing.

Activity and materials:

Process and discussion

What are some of the more common thoughts and emotions that you experienced this past week?

[*Note to therapist:* take good notes and be prepared to discuss the primary thoughts and emotions of participants in the final group therapy session. Are these thoughts and emotions supporting positive behaviors or negative behaviors?]

Can we list 2 – 3 things we are doing that are not serving us well? Examples would be not exercising, drinking too much, not managing sleep well, and not eating well.

Homework:

Think about how not to get caught in catastrophizing and use the worksheet to think through at least one situation this week where you are catastrophizing.

Think about your behaviors this week and come back prepared to discuss 2 or 3 behavioral changes that you want to think about making.

Resources:

https://www.therapistaid.com/therapy-worksheet/cbt-practice-exercises/cbt/none
https://www.therapistaid.com/therapy-worksheet/decatastrophizing/cbt/adults

Part 2: 50 minutes, Process Group

Session 4: Core beliefs

Part 1: 50 minutes

Learning Objectives:
Participants will develop an understanding of core beliefs, illness beliefs, and cohort beliefs that may impact their automatic thoughts about PD.
Outline of content

Participants will be introduced to core beliefs related to Parkinson's disease that are incorporated into a CBT model for decreasing depression and anxiety in PD patients (Egan, Laidlaw & Starkstein, 2015).

Core beliefs tend to be rigid and overgeneralized. Individuals dealing with PD are likely to be impacted by specific core beliefs in three primary areas: general core beliefs, illness beliefs, and cohort beliefs. General core beliefs may relate to competence and strength. The tendency when diagnosed with PD is to overgeneralize and think that you are no longer competent or strong. Patients may feel like they will never do the things they used to do. Illness core beliefs relate to how they view their diagnosis. Many patients will view the disease as if they are already in stage 4, even though they have only recently been diagnosed and are in early stages. Being educated and informed about the progression of this disease is a way to combat illness core beliefs that assume the worst. Cohort core beliefs incorporate the beliefs of a specific group or generation. For example, it is common for baby boomers to view illness as weakness and being disabled as being weak and needy. Understanding how core beliefs influence our automatic thoughts is an important step in learning how to redirect and manage our thoughts.

Activity and materials:

Handouts:

Activities: ?
Break into small groups and discuss a specific core belief. Each group will be assigned a general core belief, an illness core belief, or a cohort core belief.

Use the core beliefs worksheet to help the group discussions.

Allow 5 minutes and reconvene the group. Write key points under each core belief on the white board and discuss as a group.

Process and discussion
What stood out for you in the core beliefs discussion?
What automatic thoughts do you feel are the most damaging to you?
What core belief are those thoughts related to?
How did it feel to discuss core beliefs related to PD?

Homework
Return to the automatic thought log from week 2 and revisit it. Consider core beliefs that are driving each automatic thought. Complete the full worksheet and include alternative thoughts.

Resources:
https://www.therapistaid.com/worksheets/core-beliefs-examining evidence.pdf
https://www.therapistaid.com/therapy-worksheet/thought-record/cbt/none
https://www.therapistaid.com/worksheets/core-beliefs-examining-evidence.pdf

Part 2: 50 minutes, Process Group

Session 5: Behavioral Activation: increased activity and relationship management

Part 1: 50 minutes

Learning Objectives:
Participants will develop an understanding of behavioral activation and be able to identify negative automatic thoughts that may be contributing to inactivity.

Outline of content
We have focused on automatic thoughts, emotions, and core beliefs and how these all interact in ways that may be positive or negative. Today we are going to get into a discussion about behavior, about what we do, what actions we take, and what things we chose to pass on. Parkinson's patients tend to deal with two primary mental health issues early on: depression and anxiety. This is often reflected in a decline in physical activity, a lack of socialization, and a movement toward isolation. Becoming active and managing relationships is one of the most important steps to take when dealing with these issues. Becoming active may mean very different things to different people. For some, it is about exercise. This may mean challenging workouts and trips to the gym, or a simple walk down the street. Managing relationships may mean engaging with family and friends on a regular basis, accepting an invitation to go to lunch with an old friend, or simply returning one phone call. Today we are going to examine our automatic thoughts and emotions as they relate to increasing activity and managing relationships.

Activity and Materials
A white board and markers

Divide group into smaller groups. Brainstorm which topics each group will discuss and offer a few ideas to get the group thinking. The purpose is for each group to discuss actions that they are having a hard time doing and discuss together how automatic thoughts, emotions and core beliefs may be contributing to that difficulty. Examples of group topics may include: an exercise or get moving plan, reach out to friends or family, ideas on how not to isolate yourself, activities that you used to enjoy but that you no longer do.

Give small groups about 10 minutes to discuss after topic selection.

Process and discuss

When the group comes back together, write the key ideas on the board and discuss. Brainstorm with the entire group ideas to help with each area of inactivity. Have each person select three activity goals for the week.

What was most surprising to you about this discussion today?
What activities have you stopped doing since your diagnosis?
What activities bring you joy in day-to-day life?

Homework

Use the tracking sheet to add POSITIVE experiences to your days. Keep track of them and consider how you feel at the end of each day. Assess if adding these positive activities has an overall positive impact on you. At the end of the week, and before you return to class, identity the one or two activities that had the most meaningful positive impact on you this week.

Resources:

https://www.therapistaid.com/therapy-worksheet/schedule-behavioral-activation/cbt/adults

Part 2: 50 minutes, Process Group

Session 6: Anxiety

Part 1: 50 minutes

Learning Objectives:
Participants will understand what anxiety is, how it impacts patients with PD, and how to use CBT techniques to manage anxiety in an effective way.

Outline of content
Review what anxiety is and how it impacts individuals.

We have learned about our automatic thoughts and emotions, and we will be applying what we know about those processes to anxiety. We are not at the mercy or our anxious thoughts. We can challenge them and get control of them.

Handout about challenging anxious thoughts:

We all understand that we can challenge our automatic thoughts around anxiety and the situations that create anxiety. Let's break into small groups and discuss the anxiety producing situations that are causing us the most concern.

Come back together as a group and discuss how we can challenge and change the anxiety producing situations that we listed on the board.
Activity and materials:

Start as one group and discuss what anxiety is.

Discuss as a group how anxiety impacts the day to day lives of participants. Get a list on the board of situations that create anxiety for participants.

In small groups, discuss how you can challenge your thoughts around anxiety and the situations that create anxiety for you.
Come back together as a group and discuss how we can challenge and change the anxiety producing situations that we listed on the board.

Process and discussion
- How did you feel during this discussion? Did this discussion make you feel anxious?
- How many people in this group were dealing with similar concerns?
- How would you rate anxiety relative to causing problems in your

day to day life? Use a 1 – 10 scale with 10 being very impactful and 1 being not an issue.

Homework
Use the worksheet and identify anxiety producing situations this week and how you challenged those thoughts.

Resources:
https://www.therapistaid.com/therapy-worksheet/what-is-anxiety/anxiety/adults.
https://www.therapistaid.com/therapy-worksheet/challenging-anxious-thoughts/anxiety/adults

Part 2: 50 minutes, Process Group

Session 7: Finding Balance

Part 1: 50 minutes

Learning Objectives:

- Participants will focus on how they will use what they have learned in the future.
- Participants will be introduced to the use of pie charts in setting goals and diagramming their lives for a variety of reasons.

Outline of content
We have learned many new things about how to manage and take control of how we respond to this disease and the challenges that this brings into our lives. We are now in the last two weeks, and I have given thought to what is the most meaningful way to wrap up this experience. Today we are going to step back and look at our lives from a broader perspective. We have been very focused in on details, and we are going to step way back and look at our lives from a distance.

We are going to use pie charts. This is a common technique in CBT practices (Beck, 2011) and there are different applications. We are going to focus on one within the context of finding balance in life. Regardless of medical state or diagnosis, this is an issue for all of us.

The pie charts are going to help us focus on what is important to us, what % of our time and energy goes into those things now, and what would be a picture of our ideal balance in the future.

Activity and materials:
Have paper and colored pens – 5 sheets of paper per person.

On the first piece of paper, make a list of the things that are most meaningful in your life. These may be relationships, work, activities that you do, things you enjoy, or creative experiences. Make a list of the things that you do to take care of yourself. Coming here would be one of those things.

Draw a pie that represents what is happening now. Big categories might include work, household chores and responsibilities, spiritual activities or practices, physical activities, having fun, seeing friends, seeing family, travel, and time with my loved ones. You may start with thinking about how many hours each week are being spent engaged in these activities. To keep it simple, think about roughly 10 hours a day of waking hours (give or take).

As a group, discuss the largest time allocations and consider what is realistic to change.

Using a different color, mark those areas that you would like to increase and those that you would like to decease. Draw a second pie that is your ideal balance.

Process and Discuss

- Did anything in this exercise surprise you?
- What were the top three categories that you want to increase?
- How many of those categories are impacted by your Parkinson's diagnosis?

Homework:
This week, think about your ideal pie chart. Identify specific things you can do to change how you allocate your time and your life energy. For each item, list if there are automatic thoughts and emotions that create a barrier to you doing this. Consider how easy it would be to change this behavior (range of 1/easy to 10/difficult) and how rewarding it would be (range 1/not very to 10/very rewarding).

Use the tracking form.

Resources:
https://www.therapistaid.com/therapy-worksheet/activities-behavioral-activation/cbt/adults

Part 2: 50 minutes, Process Group

Session 8: Living well today

Part 1: 50 minutes

Learning Objectives:
Participants will discuss their ideal pie chart, the behaviors they would like to change. Behavior changes will be discussed within the context of how easy it is to make the change and how rewarding it would be to make the change.

Outline of content
As we wrap up today, the focus will be on how we take what we have learned, identify what is most meaningful, and construct a plan to continue using and practicing these skills.

One thing that we have learned is the importance of structure. Structure often means a tracking and reinforcement process. This may be sheets like the handouts we used. It may be a notebook or journal. It may be a phone app.

Activity and materials:
Write this quote on the board from Davis Phinney:

> "The key to living well today with Parkinson's disease is actively choosing to do the things that will result in your best quality of life. Be informed, be engaged, be connected, be courageous, and be active. Each day will bring new challenges and opportunities for positive change. Remember the daily triumphs, large and small, are worth celebrating"

Handouts:
A booklet with a copy of each handout used

Process and discussion
Break into small groups and list the most meaningful insights gained from this process. (5 – 10 minutes)

Return to large group and discuss together. Make notes on the white board.

Turn and discuss with those near you what you found to be the most helpful tools and resources. Process is key and what we track and maintain an awareness of is what we will eventually change. What worked best for you?

Come back as a group and discuss the tools that worked. Distribute the packets that contain all handouts from these sessions.

Concluding thoughts:
With your permission, I would like to take us back to the beginning of this journey. I am going to share some of the thoughts and emotions that you all were dealing with in the beginning. Refer to your notes from session 2. Do not link names to the comments but share this information in a general sense.

I would like all of you to think about this therapeutic experience and focus on how you have changed. If some participants have felt that this was not a helpful process, discuss that and encourage them to keep searching for a process that works for them. Have each participant list 1 – 3 items on the list. Put these on the white board and discuss as a group how this list differs from the notes from Session 2.

In closing, I hope you will take from this experience a recognition of the strength and courage that you have within. You must decide for yourself how you will respond to the joy and challenges in the days ahead. May you manage your thoughts, your emotions and your behaviors and choose things that serve you and add to the process of increasing and enhancing your quality of life.

Part 2: 50 minutes, Process Group

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