Parkinson’s Disease and Mobility

GUILDFORD PARKINSON’S DISEASE RESEARCH GROUP

Fact Sheets 11-15
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Aims and learning outcomes

The aims of this module are to:

- build on the basic understanding of movement problems in Parkinson’s disease provided in Module One;
- provide further information about how the mobility of people with Parkinson’s can be improved.

By the end of Module Three you will:

- understand more about the movement problems that arise in Parkinson’s and how they are caused;
- be aware of how physiotherapists can help improve the mobility of people with Parkinson’s;
- be aware of how occupational therapists can help people with Parkinson’s cope with everyday activities;
- understand the posture problems caused by Parkinson’s and how to prevent falls;
- know how to help with some common movement problems that people with Parkinson’s have;
- understand the importance of relaxation, good breathing and regular exercise for people with Parkinson’s.
Parkinson’s disease is a movement disorder. This fact sheet reviews and extends the information about movement problems in Module One.

**What are the main movement problems of Parkinson’s?**

1. Slow movement (bradykinesia) – patients describe it as ‘moving through treacle’. Slowness gets less as activity continues, but changes in the speed and direction of movement are difficult.

2. Rigidity of muscles (stiffness) – limbs feel like ‘lead pipes’. Movements are not smooth, but are jerky, like the movement of a ratchet or cog-wheel.

3. Trembling or shaking (tremor). More follows on page 5.
What other movement problems can happen?

Other movement problems that can happen are:

- absence or lack of movement (akinesia) – patients get stuck, unable to move (called ‘freezing’), especially when starting a movement such as walking;
- reduced movement (hypokinesia) – only small movements or a limited range of movements are possible, e.g. small steps, and tiny handwriting that is hard to read;
- abnormal movements (dyskinesia) – large uncontrolled movements such as wriggling, restlessness, jerking or writhing. These are side effects of Parkinson’s medicines, often occurring at the peak of a dose;
- muscle spasms (dystonia) – leading to painful, abnormal posture.

Note: ‘Kinesia’ means movement.

Movement problems can vary and are called ‘on/off fluctuations’.

‘On’ means the medicine is working and the person can move.

‘Off’ means the medicine is not working and they cannot move.

Further reading:

Parkinson’s UK has Information Sheets on:
- ‘Motor fluctuations in Parkinson’s disease’
- ‘Muscle cramps and dystonias’

www.parkinsons.org.uk
More about Parkinson’s tremor

Tremor:

- is a series of small uncontrolled movements when muscles relax and contract rapidly;
- usually affects hands and arms, and sometimes legs;
- may start on one side of the body and spread to the other;
- tends to be worse when muscles are at rest;
- tends to lessen or disappear when muscles are moved on purpose or intentionally (voluntary movements), for example reaching the arm out to pick up an object;
- disappears during sleep;
- affects about 70% of people with Parkinson’s.

Note

People without Parkinson’s disease can get tremor. There are other conditions that cause different types of tremor.
What is mobility and why is it reduced in Parkinson’s?

Mobility means being able to move. Mobility depends on smooth co-ordinated actions of muscles. Most movements (for example, drinking from a cup or getting dressed) involve several muscle groups, working smoothly and in time together.

The sensory systems (eyes, ears, touch) prompt the brain which sends messages to the muscles to move.

Muscles are attached to bones by tendons. As a muscle tightens, the tendons get shorter or longer to allow the movement of the bones. Ligaments support the joints (for example, elbow or knee) and allow them to bend.

People with Parkinson’s have low levels of dopamine in the motor (movement) area of the brain. This means that nerve cells do not send clear messages to muscles in the body. Also, feedback from the body to the sensory areas of the brain is delayed. So control over movement is reduced and people with Parkinson’s have reduced mobility.

As dopamine in the brain runs out then movement becomes more difficult

This is like a car running out of petrol that coughs, splutters and sometimes stops
How does Parkinson’s disease affect mobility?

People with Parkinson’s tend to have poor co-ordination and control of movement. They may:

- walk with small steps (reduced stride);
- lean forward on the front of their feet when walking and without picking their feet up properly – called a ‘shuffling gait’;
- find it hard to start and stop movement;
- find it hard to control the speed of their movement. When walking they may:
  - have a slow speed with reduced arm swing;
  - sometimes speed up suddenly (festination);
  - sometimes hesitate or ‘freeze’, especially when there is a visual change, for example when approaching doorways, approaching obstacles such as furniture, when the floor pattern changes, or whilst turning;
- have stooped posture (they are bent instead of standing straight);
- have poor balance (postural instability) causing falls;
- lack confidence or be fearful because of movement problems and fear of falling.
Are all people with Parkinson’s disease affected the same?

Some people with Parkinson’s are more mobile than others.

Mobility may be worse on some days or at some times of the day e.g. when medicine is wearing off or when people are tired.

Mobility tends to worsen over time as Parkinson’s progresses.

Some people start to experience side effects from some medicines, after several years of taking them. People may start to get sudden ‘on/off’ fluctuations and dyskinesia.

As people get older they may have other conditions that reduce mobility, as well as Parkinson’s e.g. osteoarthritis.
How does lack of mobility affect people with Parkinson’s disease?

Movement problems mean that everyday activities become difficult, e.g. walking, dressing, bathing, writing, talking, eating.

Everyday activities are difficult and may need help

Poor posture can cause muscle shortening and so lead to other long term problems. Secondary problems include pain, sleep problems and tiredness.

Secondary problems e.g. pain and tiredness

All these problems can affect quality of life for both the person with Parkinson’s and their families and friends, for example causing strain on relationships or embarrassment.
What treatments are available to improve mobility?

The main way of managing the symptoms of Parkinson’s and improving mobility is through medicines. The medical treatments for Parkinson’s are described in Module Two.

In addition:

- physiotherapists (PTs or physios) can provide exercises to help with movement problems;
- occupational therapists (OTs) can give advice and suggest aids and adaptations to peoples’ homes to help people living with Parkinson’s to perform daily activities.
- speech and language therapists (SLTs) can help people with Parkinson’s to manage communication, eating, drinking and swallowing.

Best practice guidelines say that people with Parkinson’s should have regular access to multidisciplinary team (MDT) services. The team should work together to meet the needs of the person with Parkinson’s and should include allied health professionals (AHPs) such as physiotherapists, occupational therapists and speech and language therapists. All therapists must register with the Health Professions Council (See [http://www.hpc-uk.org/](http://www.hpc-uk.org/)).

This module explains how physiotherapists and occupational therapists help with everyday movement problems.

Module Four explains how speech and language therapists can help.
If mobility is badly affected, aids may be needed e.g. walking stick, walking frame or wheelchair

Falls are costly. In the UK:

- the National Health service (NHS) spends £1.7 billion to treat falls each year;
- there are 14,000 deaths due to hip fracture every year.  
  
(Help the Aged 2006)

For more information on falls see page 33.
How can carers help to improve the mobility of people with Parkinson’s disease?

1. Make sure that medication is taken on time.

2. Listen to the people living with Parkinson’s – including patients, family members or other informal carers.

3. Give them time to explain any mobility problems.

4. Look for the person ‘behind the mask’. Understand their fears and read their body language.

Carers can help
5. Help record when mobility problems arise. Observe any movement difficulties, and changes in mobility and discuss with the Parkinson’s disease nurse specialist and other members of the multidisciplinary team (MDT).

6. Check the correct walking aid is available and used.

7. Give reassurance and encouragement.

8. Remind people with Parkinson’s about maintaining their best posture and best gait (walking).

9. Remind them about the advantages of regular exercise.

10. Encourage people with Parkinson’s to practice the specific exercises or to follow advice prescribed for them by therapists and the MDT as noted in their care plan.
Fact sheet 11 exercise

Think of someone you know who has movement problems.

What sort of movements is difficult?

How does it affect their life?

What must it feel like?

Notes:
Fact sheet 12
Physiotherapy and Occupational Therapy

What is physiotherapy?

Physiotherapy (sometimes called ‘physio’ for short) is a physical form of treatment using exercise, manipulation and other types of muscle stimulation to help movement and maximise mobility.

Physiotherapy is delivered by a chartered physiotherapist. The mission of physiotherapists (according to The Chartered Society of Physiotherapy) is to provide ‘a means of treatment using physical methods to maximise human function, movement and potential.’ For more about physiotherapists contact The Chartered Society of Physiotherapists 0207 306 6666 or see http://www.csp.org.uk/.

How do physiotherapists work?

Some physiotherapists work in hospitals and others in the community. They:

- assess and report on individual’s movement problems;
- set future mobility aims and targets and make plans to achieve them;
- provide individual or group therapy;
- give advice and set exercises for people living with Parkinson’s disease to follow.
Physiotherapists may use equipment like exercise mats, special chairs and mirrors

How can physiotherapists help with Parkinson’s?

Many of the things that a physiotherapist does are explained in more detail in Fact Sheets 13, 14 and 15. They aim to:

- educate patients and carers about the movement problems;
- improve mobility by manipulation and by recommending exercises that will reduce muscle stiffness, loosen joints and prevent muscle contractures;
- reduce pain from muscle stiffness and cramps;
- correct and improve posture and increase awareness of balance to reduce falls;
- improve muscle strength;
- help with freezing problems;
- improve co-ordination and dexterity of the hands;
- improve lung function, maintain an effective cough, and help control of breathing (which is very important for clear speech);
- teach techniques to improve specific activities, such as walking, moving or transferring, rising from a chair or the floor, turning in bed;
- teach easier ways of coping with activities of daily life to help maintain independence;
- organise aids such as walking frames and sticks;
- explain the advantages of regular exercise for general fitness and suggest appropriate ways of taking it;
- teach relaxation methods and explain the advantages of breathing exercises and relaxation.
**When is physiotherapy needed?**

Physiotherapy is needed at all stages of Parkinson’s disease. Physiotherapists provide advice, education and exercises tailored to the needs of individual people.

If loss of movement and reduced muscle strength are treated early, it can help maintain good posture and prevent joint pain developing. Physiotherapy can help to prevent falls and avoid major disability.

In early stages, physiotherapists provide an understanding of Parkinson’s, and encourage general fitness to maintain mobility.

As Parkinson’s disease progresses more interventions may be required and physiotherapists may prescribe specific exercises to help with individual problems.

**Further reading:**

Parkinson’s UK has an Information Sheet on: ‘Physiotherapy and Parkinson’s Disease’

[www.parkinsons.org.uk](http://www.parkinsons.org.uk)
What is occupational therapy?

Occupational therapists find the best ways to carry out activities of daily living (ADLs) in order to maintain independence. They also help people to carry out leisure activities which are very important for well-being. Occupational therapists can make everyday life easier, safer and more enjoyable, within the limits of the abilities of the person with Parkinson’s.

Occupational therapy is delivered by a registered occupational therapist. For more about occupational therapists contact The British Association/College of Occupational Therapists 0207 357 6480 or see http://www.cot.org.uk/.

How do occupational therapists work?

Some occupational therapists work in hospitals and others in the community. They:
- assess and report on individuals’ problems with carrying out activities of daily living (ADLs);
- help set future aims and targets and make plans to achieve them;
- provide individual or group therapy;
- provide equipment to help carry out activities;
- give advice, and set exercises for people living with Parkinson’s to follow.
Occupational therapists work with people living with Parkinson’s to agree what the problems are. They may check physical ability to carry out tasks (strength, co-ordination, balance) and mental abilities such as memory. They review which activities people want to be able to perform more easily. They then look at what is needed to carry out the desired activity (furniture, equipment, clothes) and the environment (the layout of the home or place of work).

Occupational therapists will explore new ways of doing things and may work with an individual to draw up a list of everyday goals. They will see what support is available in the home, workplace or local community and try to provide equipment that will help people with their daily life.

### Areas of occupational therapy involvement

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<th>Handwriting</th>
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<th>Hair</th>
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<td>Parkinson’s UK membership</td>
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<td>Washing/bathing</td>
<td>Hobbies/social life</td>
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<td>Turning in bed</td>
<td>Eating</td>
<td>Getting in/out car</td>
<td>Getting in/out bed</td>
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<td>Communication</td>
<td>Drinking</td>
<td>Gardening</td>
<td>Telephone</td>
</tr>
<tr>
<td>Dressing</td>
<td>Cooking</td>
<td>Toileting</td>
<td>Driving</td>
</tr>
</tbody>
</table>
Hobbies and leisure activities
How do occupational therapists help with Parkinson’s disease?

Occupational therapists promote independence by:

- educating patients and carers about how to adapt to life changes as Parkinson’s progresses and finding practical ways to cope with everyday difficulties;
- advising on aids and equipment to help with daily activities. For example mealtimes may be easier with special cutlery, crockery and cooking utensils;
- advising on the best ways to perform personal daily tasks such as dressing, bathing and toileting. For example using adaptations such as Velcro (instead of buttons), elasticised shoelaces or a long handled shoe horn;
- advising on techniques to improve handwriting, such as weighted pens or using computers;
- planning ways to make the home safer, such as grab rails to prevent falls;
- recommending home adaptations to help maintain independence, such as stair lifts;
- supporting people to carry out suitable hobbies and leisure activities to maintain their well-being and social life.
Independence and activities needed for daily living
Aids and adaptations

Many kinds of aids and equipment are available to help people overcome difficulties with activities of daily living (ADLs). These range from simple kitchen equipment, such as kettle tippers to more complex items such as personalised computer systems.

Occupational therapists will know about where equipment can be obtained locally. They may be able to arrange for equipment to be loaned, so it is best to get advice from them before purchasing expensive items, such as a wheelchair.

Sometimes grants are available for equipment and home adaptations and occupational therapists can advise on these. More information on financial help is provided in Module Five.

Occupational therapists may advise on where to buy equipment. Items are available from large suppliers and stores across the country or by mail order. Sometimes second hand items can be purchased.

More information on where to buy aids and adaptations is provided in the Appendix to this module.
Aids and adaptations

A back pack or a body belt can be used for carrying small items as it leaves hands free.

Trolley to carry items

Long handled shoe horn

Elasticised shoelaces
Can people with Parkinson’s disease drive?

This depends on how the person with Parkinson’s feels about driving, and the views of their doctor. Giving up driving makes you reliant on others or on public transport for getting out and about which can be difficult. People with Parkinson’s should discuss their situation with their general practitioner (GP) or consultant.

It is a legal requirement that the Drivers and Vehicle Licensing Authority (DVLA) is informed when Parkinson’s is diagnosed. (Drivers Medical Group, DVLA, Swansea, SA 99 1DL) Telephone: 0870 600 0301 www.dvla.gov.uk.

The DVLA may contact the doctor and issue a short term licence. The person with Parkinson’s may be asked to undergo a medical examination or take another driving test.
Mobility Centres

There are mobility centres around the country that aim to help people achieve independent mobility as drivers, passengers and wheelchair users and offer driving assessment and advice:

- on adaptations for physical problems with vehicle control;
- with regard to ability to drive safely;
- on wheelchair and scooter loading and transportation;
- on wheelchair selection (some centres);
- regarding passenger/driver access to vehicles;
- on motorcycles or heavy goods vehicles (some centres).

See Motability schemes

http://www.motability.co.uk/
0845 456 4566

http://www.mobility-centres.org.uk/
(Freephone) 0800 559 3636
Fact sheet 12 exercise

Jack is a 60 year old man with Parkinson’s living in an old cottage with small rooms with lots of furniture. He has had Parkinson’s for 12 years. He is a very keen gardener and has a greenhouse which is down a narrow passage at the side of his house. Sometimes his body freezes up and this often seems to happen when he goes along the passage to his greenhouse. Other times he writhes around so much he knocks the plants over, which frustrates him. He is becoming depressed because of these difficulties in tending to his plants.

What suggestions can you make to help Jack continue with his hobby?

What health professionals might be able to help the situation?

What might be causing some of his problems?

Notes:
Fact sheet 13
Posture and falls

What happens to the posture of someone with Parkinson’s disease?

People with Parkinson’s disease tend to:

- stoop forward with shoulders hunched, head down and knees bent;
- have poor balance, especially when turning, and are likely to fall (postural instability);
- lean forward and take small steps on the front of the foot when walking (shuffling gait) – and may go into a shuffling run (festination);
- sit slumped in chair, chin down, and so miss seeing things or talking to people, and have difficulty eating, drinking or breathing properly.

Slumped in a chair.....
so miss seeing things
Why is posture important?

Posture is important because:

- it gives a first impression to other people;

- when body language looks sad, the person is more likely to feel sad;

- a sagging body and slumped posture is harder on muscles making the neck and shoulders ache;

- when the body is constantly bent it leads to muscle contractures so that eventually straightening up is impossible;

- bent posture makes normal movements of hips and shoulders difficult so that arm swing is lost and walking is affected;

- stooped postured reduces breath capacity so voice is weak and coughing ineffective;

- bad posture causes balance problems and makes falls more likely;

- slumped posture reduces awareness of surroundings and of opportunities and dangers.
<table>
<thead>
<tr>
<th>Good</th>
<th>Bad</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyes forward</td>
<td>Chin pokes forward</td>
</tr>
<tr>
<td>Shoulders relaxed</td>
<td>Shoulders stooped</td>
</tr>
<tr>
<td>Lumbar curve base of spine</td>
<td>Normal hollow of back is flattened</td>
</tr>
<tr>
<td>Straight legs and knees</td>
<td>Knees bent</td>
</tr>
<tr>
<td>Weight taken through mid foot</td>
<td>Weight thrown onto toes rather than heels</td>
</tr>
</tbody>
</table>
Why do people with Parkinson’s have falls?

Falls usually occur late in Parkinson’s. (Early falls may suggest a different diagnosis).

Falls may be caused:
- by stiffness (rigidity) of muscles and slowness of movement (bradykinesia);
- by slow muscle reactions to changes in body position;
- by poor posture (leaning forward);
- for no apparent reason, or when turning or reaching, due to balance problems (postural instability);
- dizziness on rising from lying or sitting (postural hypotension);
- shuffling gait and tripping over uneven surfaces.

Why is preventing falls important?

Preventing falls is very important because:
- they cause pain for the person;
- they cause strain on carers;
- they cause embarrassment which may lead to loss of confidence and fear;
- they cause secondary problems, like fractures, which further reduces quality of life;
- A&E admissions and emergency beds to treat falls and fractures are costly to the British NHS.
| **Posture** | Explain why posture is important.  
| Encourage people to work at good posture.  
| Show person a drawing of good and bad posture.  
| Encourage them to post it around the home.  
| Remind them to:  
| - stand tall with straight knees;  
| - sit up in chair and lengthen spine with chin up;  
| - lie flat and relax. |

| **To prevent falls** | Record and remind about the importance of taking medicines on time and monitor ‘off” periods.  
| Remind people – take their own time and don’t try to rush.  
| Encourage good posture.  
| Advise against turning quickly or on the spot.  
| Notice risks in the home like loose rugs on the floor, steps, pets, low furniture and slippery surfaces.  
| Ensure good lighting.  
| Encourage people to wear shoes that fit well and do not slip (slippers are only suitable for short periods).  
| Make sure walking aids (sticks or frames) are used properly – that they are the right ones and at the right height.  
| Observe, and ask people with Parkinson’s and their carers, about mobility problems or concerns. Report relevant issues to members of the MDT, Parkinson’s nurse or doctor. |

**Further reading**

Parkinson’s UK has an Information Sheet on:  
‘Falls and Parkinson’s Disease’.  
[www.parkinsons.org.uk](http://www.parkinsons.org.uk)
Fact sheet 13 exercise

Talk to an adult who has had a fall.

What happened and what was the cause?

Were they physically hurt?

Were they embarrassed or did they feel foolish?

Could it have been avoided, and if so how?

Notes:
Fact sheet 14
Tips for common movement problems

<table>
<thead>
<tr>
<th>Helping with movement problems – general advice</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Remember movement problems are not because people are difficult or lazy.</td>
</tr>
<tr>
<td>3. Even if they are slow, let them do what they can for themselves.</td>
</tr>
<tr>
<td>4. Reassure them. Share any frustration.</td>
</tr>
<tr>
<td>5. Listen to people with Parkinson’s and involve their family and carers. Ask what they find difficult and what they find helpful.</td>
</tr>
<tr>
<td>6. Learn from clients – they often have good ideas on ways to cope and have developed ‘tricks’ that work for them.</td>
</tr>
<tr>
<td>7. Monitor mobility by your own observations and listening. Be aware of small signs.</td>
</tr>
<tr>
<td>8. Report any problems or changes to other members of the MDT, Parkinson’s disease nurse specialist or doctor.</td>
</tr>
</tbody>
</table>
Helping with slowness (bradykinesia)

1. Give them time.
2. Encourage people to persevere with activities within their capacity.
3. Let them do things for themselves even if they are slow.
4. This is important to maintain agility and independence.

Helping with tremor

1. Sometimes, gently holding the affected hand may help reduce tremor.
2. Tucking the hand with tremor under the person’s leg so they are almost sitting on it can help.

Gently holding the affected hand can lessen tremor

Tucking the affected hand under the person’s leg
### Helping with shuffling gait (walking with little steps)

1. Encourage good posture.
2. When they take a step, suggest they put their heel down first.
3. Encourage big steps, and rhythmical stepping.
4. Suggest counting steps when walking (as if marching 1-2-3-4).
5. Encourage them to swing arms when walking, if possible.
6. Check for foot problems and report to the Parkinson’s disease nurse specialist in case referral to a chiropodist (or podiatrist) is required.

<table>
<thead>
<tr>
<th>Encourage to put heel down first</th>
<th>Using arms of the chair</th>
</tr>
</thead>
</table>

### Helping with freezing in a chair

1. Use a chair with arms to keep person secure.
2. Ask them to put their hands on the arms of the chair, lean forward, and then push up with their arms.
3. Use a chair with a seat level that is high.
4. Encourage them to sit on the edge of the chair and rock gently to get going. Make sure feet are squarely on the floor.
Helping with freezing when walking

Freezing often means a person cannot start to walk. They feel as if they are frozen to the spot. It also can occur when turning a corner, or going through a doorway, or even just if the pattern in a carpet changes. Freezing is more likely if the person feels stressed.

1. **DO NOT** pull or push as it may lead to a fall.
2. Rocking them gently from side to side may help.
3. Rotating them gently from the waist, so that they look first over one shoulder and then the other, may help.
4. Suggest they march on the spot until they feel they can move forward freely.
5. Use visual or auditory (sound) cues:
   - Ask them to imagine a line on the floor and try to step over it;
   - Put your foot sideways in front of theirs and they step over it;
   - Try counting 1-2-3-4;
   - Singing a favourite tune may help.
6. If turning, make a wide circle (pivoting on the spot is difficult).
## Helping with turning in bed

Stiffness (rigidity) of muscles in the trunk makes turning in bed difficult. To help someone in bed turn onto their side independently, advise to:

- start lying flat on their back with knees bent and feet flat on the bed and hands gripped together in front of them;
- turn head to side they want to lie on and reach top arm across body;
- allow knees to fall to that side and roll;
- ask them to grip the mattress and move into a more comfortable position;
- help with covers if wanted. Use cushions and pillows to support a comfortable position.

**Note:** Shiny sheets (more slippery) may help some people.

If they are unable to move without help:

- start with them lying flat on their back with knees bent and feet flat on the bed and hands gripped together in front of them.
- lift them up by the arms, straightening their elbows as you do so;
- ask them to turn their head to the side they want to lie on;
- swing their arms and legs to the same side;
- ask them to grip the mattress and move into a more comfortable position. Use cushions and pillows to support a comfortable position;
- help with covers if wanted.
Fact sheet 14 exercise

Mrs Jones is 75 years old and has Parkinson’s. She lives with her daughter, Sally, who is finding it difficult to cope. Sally reports that whatever she does, her mother always looks miserable. Sally thinks that sometimes her mother purposely ‘plays her up’, for example, she won’t get out of her chair, feed herself properly, or go to the toilet, ending up with her having a toileting ‘accident’. At other times, Mrs Jones can get out of her chair to do things in the kitchen without any apparent problems. Sally is getting tired as she has to get up several times at night to help her mother get to the toilet.

How could you help Sally cope better?

Which health professionals might help in this situation?

What could they do about the night time problem?

Notes:
Fact sheet 15
Breathing, exercise and relaxation

Why is breathing a problem in Parkinson’s disease?

Parkinson’s disease makes trunk muscles rigid. Ribs and lungs are cramped, breathing is restricted and coughing is weak.

Poor posture also makes breathing shallower.

Poor lung function and ineffective coughing increases the risk of chest infections.

Poor breath control makes talking quiet and husky.

<table>
<thead>
<tr>
<th>Exercises for breathing</th>
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</thead>
<tbody>
<tr>
<td>Good posture helps expand the chest for better breathing.</td>
</tr>
<tr>
<td>Practise good posture as advised in ‘Help with good posture’ on page 34.</td>
</tr>
<tr>
<td>Lifting arms above the head then lowering them is a good exercise to expand the chest.</td>
</tr>
<tr>
<td>1. Check shoulders are relaxed, sloping down and not hunching up.</td>
</tr>
<tr>
<td>2. Breathe in deeply through the nose, feel lungs expand downwards and pushing tummy out.</td>
</tr>
<tr>
<td>3. Let air escape slowly out through the mouth.</td>
</tr>
<tr>
<td>4. Repeat three times.</td>
</tr>
<tr>
<td>5. Do the exercise several times during the day.</td>
</tr>
</tbody>
</table>

This also helps with relaxation.
How can regular exercise help people with Parkinson’s?

Exercise helps with general fitness including heart, lungs and energy.

It helps ease muscle stiffness, and improves strength and flexibility.

It can improve balance and reduce slowness.

It improves mood and feelings of well-being.

It may help prevent constipation, sleep problems and brittle bones (osteoporosis).

Helping with regular exercise

Always check with the Parkinson’s disease nurse specialist or doctor before starting a new exercise programme.

- Encourage daily exercise within capabilities e.g. walk round the block, or down the hall, with correct posture, gait and arm swing.
- Encourage to follow exercises provided by physiotherapist in care plan.
- Suggest a group exercise class.
- Some complementary therapies such as Alexander Technique, yoga or Tai Chi may help physical and emotional well-being.

Further reading: Parkinson’s UK has an Information sheet and video ‘Keeping Moving’ www.parkinsons.org.uk.
What is relaxation?

Relaxation is both a physical and mental state that gives a sense of well-being and peace of mind. It refreshes and revitalises the body.

People may need to learn to relax, especially when muscles are stiff and tense.

How can relaxation help people with Parkinson’s?

Relaxation can help people with Parkinson’s when their muscles are stiff and tense. Carers may also benefit from relaxation to relieve the strains of caring.

Symptoms of Parkinson’s may make everyday situations more difficult and stressful (for example, packing and paying for groceries at the supermarket). Stress causes tension, and in turn, tension makes the symptoms of Parkinson’s worse.

Being able to relax is important to counteract the effects of stress. It helps to keep people calm in stressful situations.
What are the main methods of relaxation?

1. Muscle relaxation
   Learn to feel the difference between muscle tension and relaxation. Tighten then relax groups of muscles in turn:
   Right leg – left leg – buttocks – stomach – right arm, hand – left arm, hand – neck – face – forehead

2. Breathing for relaxation
   Breathe deeply, concentrating on calm breathing. It is important to breathe into the bottom of the lungs and not the top. Check that shoulders are relaxed and lowered, and tummy is moving in and out with each breath.

3. Use calming images – ‘visual imagery’ or ‘visualisation’ techniques.
   Imagining a mental picture of a pleasant scene can help achieve relaxation.

4. Use calming sounds
   Listening to recordings of music or calming noises can help with relaxation.

5. Use touch or smell
   Gentle massage or complementary therapies such as aromatherapy or reflexology can help relaxation.

Written exercises or recorded relaxation or breathing exercises may be available from the therapy team.
<table>
<thead>
<tr>
<th>Helping with relaxation</th>
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<tbody>
<tr>
<td>1. Allocate enough time – at least 15 minutes is needed.</td>
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<tr>
<td>2. Select a quiet place where you will not be disturbed.</td>
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<tr>
<td>3. Get the person in a comfortable position – lie down or sit supported on a comfortable chair.</td>
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<tr>
<td>4. Try different ways of relaxing and find what is best for you.</td>
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<tr>
<td>5. Practice regularly and it will get easier to reach a state of complete relaxation.</td>
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**Relaxation for hands**

**Remember – relaxation takes time**
Hands are often one of the first parts of the body to show tension. When hands tense up, they clench up into a fist, or hold tight onto something, such as the arm of a chair.

To relax the hands, stretch them out so that the fingers are straight and spread out. Hold that position for a moment and feel the tension across the palms and back of the hands. Then let your hands relax and flop beside you, or on your lap, fingers gently curved.

Relaxation for shoulders
Another area of the body often affected by tension is the shoulder. Tense shoulders are raised (or hunched). To relieve tension in shoulders, pull them downwards. Feel a pulling under the arms and in the neck. Hold that position for a moment. Then relax the shoulders and return them to a natural position (i.e. not hunched).

A simple relaxation exercise for the whole body
Choose a warm place. Sit comfortably and well supported in a chair, or lie flat on a bed. Close your eyes.

Breathe slowly and rhythmically.

Think about releasing tension in each part of your body in turn:

Tense each group of muscles first so you can feel the difference when you relax them. Repeat with each group of muscles 3 times.

Visualisation or Imagery can help to relax
Turn your mind away from stressful thoughts and situations, and instead think about something pleasant. This is a form of "day-dreaming" which you can turn to your advantage. Imagine somewhere, real or imaginary, that you would like to be and where you can relax and put aside the cares of the world for a little while; gradually begin to imagine the details of this place, the sights, sounds, smells. Imagine yourself "unwinding" and "recharging your batteries".
Fact sheet 15 exercise

Try the relaxation exercises.

How did you feel before you started?

How does muscle tension feel?

How does muscle relaxation feel?

How do you feel after completing the exercise?

Notes:
Remember the key messages

First key message

When caring for someone with Parkinson’s it is very important to:

LISTEN

GIVE TIME

LOOK FOR THE PERSON BEHIND THE MASK

Second key message

It is very important that people with Parkinson’s

TAKE THEIR MEDICINES ON TIME
Appendix:  
Where to get aids or adaptations

A few suggestions:

**Disabled Living Centres** A Disabled Living Centre (DLC) or ‘Independent Living Centre’ is a place where you can get free and ethical information and advice about products which can increase choices about how to live. At a DLC you can **see and try out products** and explore other solutions. Centres provide free information to people in person, by telephone, letter or email. Tel 0870 770 2866  [http://assist-uk.org/](http://assist-uk.org/)

**Disabled Living Foundation** – provide information and advice on equipment Tel 0207 289 6111  [http://www.dlf.org.uk/](http://www.dlf.org.uk/)

**Home Health shops on the High Street** – Co-operative Pharmacies and Boots, the Chemist offer a wide range of products.

**Home Health Products Online**
Nottingham Rehab Supplies  [http://www.nrs-uk.co.uk/](http://www.nrs-uk.co.uk/)
Hearing and Mobility  [http://www.hearingandmobility.co.uk/](http://www.hearingandmobility.co.uk/)

**REMAP** – design and adapt equipment especially for you.  [http://www.remap.org.uk/](http://www.remap.org.uk/)
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