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Adapted Physical Activity Can Increase Life Appreciation in Patients with Parkinson's Disease

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2  
3 **1 Title: Adapted physical activity can increase life appreciation in patients with Parkinson's Disease**

4  
5 **2 Abstract**

6  
7 **3 Objectives:** This study aimed to measure the effect of a treatment of adapted physical activity (APA) on  
8  
9 **4** motor symptoms and on positive psychological resources in a group of patients with PD.

10  
11 **5 Methods:** 37 patients with PD ( $M_{age} = 71.5$ ; 70.3% male) completed measures of disability level, motor  
12  
13 **6** performance, distress, well-being and quality of life before and after participating to a program of APA  
14  
15 **7** (duration: 7 months). Analysis of variance - repeated measures was performed to evaluate the effect of  
16  
17 **8** APA on disability, distress and well-being.

18  
19 **9 Results:** After intervention, patients reported significant improvements in their motor autonomy,  
20  
21 **10** disability level, psychological distress and in life appreciation.

22  
23 **11 Discussion:** A brief physical activity program was beneficial not only on patients' motor functioning, but  
24  
25 **12** also on their mental health, by reducing distress and promoting life appreciation.

26  
27  
28 **13** Keywords: Parkinson; Physical activity; Disability; Life appreciation; Well-being

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## 1 Introduction

2 Parkinson's disease (PD) causes a progressive decline of functional autonomy. It is characterized by  
3 physical symptoms such as resting tremor, muscle rigidity, bradykinesia and balance disorders and by  
4 mental symptoms such as depression, apathy, somatic stress and anxiety. The complexity of this disorder  
5 may progressively impair patients' quality of life (Anzaldi & Shifren, 2019; Frazier, 2002; Sabari et al.,  
6 2015).

7 Even though PD is a progressive disease, medical guidelines recommend treatments aimed at reducing the  
8 motor side effects associated with PD's medical treatment, together with programs aimed at  
9 maintaining/re-activating the patient's physical and mental autonomy.

10 Recommended strategies consist in guided physical activity and physical rehabilitation (Sabari et al.,  
11 2015). These treatments benefit cardiorespiratory and musculoskeletal functions, metabolism, posture,  
12 body structure and also mental health (Sabari et al., 2015; Inoue et al., 2019; Ylitalo et al., 2019). Adapted  
13 physical activity - APA was applied for patients with PD and it was found to yield positive effects in terms  
14 of motor and physical functioning (e.g., motor symptoms) (Abrantes et al., 2012; Canning et al., 2012;  
15 Cugusi et al., 2014; Morris et al., 2009; Protas et al., 2005). Additionally, APA program was found to  
16 improve patient's life quality by providing benefits for self-efficacy, autonomy and social support (Inoue et  
17 al., 2019; Kosma et al., 2007).

18 The positive psychological effects of APA can be related to individuals' engagement in meaningful and  
19 challenging activities that may trigger a state of enjoyment and pleasure (Delle Fave et al., 2011; Hefferon  
20 & Ollis, 2006; Inoue et al., 2019). Furthermore, practicing physical activity is useful to prevent states of  
21 depression, stress and anxiety and it can be considered a key ingredient for promoting individual's well-  
22 being (Boen et al., 2019; Diener et al., 2017; Huffman et al., 2022; Netz et al., 2005). This approach is in  
23 line with the recent studies on neurodegenerative disorders, that broadened their focus by including also  
24 the positive aspects of life that may favour patients' coping with the illness, their resilience and well-being  
25 (Anzaldi & Shifren, 2019; Cesetti et al., 2017; Dural et al., 2003; Frazier, 2002; Vescovelli et al., 2019a,  
26 2019b, 2020; Zhang and Chen, 2019).

27 Among different models of well-being, the one postulated by Ryff (1989, 2014) underlines the strong  
28 connections between psychological well-being (PWB) and physical well-being. PWB may have a buffering  
29 effect for stress and may influence the onset and progression of chronic illnesses (Huppert, 2009; Ryff,  
30 1989, 2014). Ryff's model of PWB encompasses 6 dimensions (e.g., self-acceptance, positive relations with

1  
2  
3 1 others, autonomy, environmental mastery, purpose in life, and personal growth), which were found to  
4  
5 2 have various patterns of correlations with different physical biomarkers (Ryff, 2014; Ryff et al., 2004).  
6  
7 3 The protective effect of physical activity and sports on well-being emerged also for older individuals (Bae  
8  
9 4 et al., 2017; Boen et al., 2019; Diener et al., 2017; Huffman et al., 1995; Netz et al., 2005; Rector et al.,  
10  
11 5 2019). Netz et al. (2005) found that aerobic and moderate intensity activities were significantly related to  
12  
13 6 psychological well-being. At the same time, greater well-being may help sustain physical activity in the  
14  
15 7 long term (Rector et al., 2019).  
16  
17 8 Physical activity may be linked to PWB in various ways. For instance, patient's awareness of his/her own  
18  
19 9 physical condition may promote self-acceptance; the physical benefits of exertion may foster autonomy;  
20  
21 10 an improvement in psychomotor skills and a direct familiarity with the environment may favour  
22  
23 11 environmental mastery. Finally, group activities, social comparison and the opportunity to share personal  
24  
25 12 experience with other group members may encourage positive relations with others and social well-being,  
26  
27 13 leading participants to achieve a sense of personal growth and purpose in life out of the rehabilitation  
28  
29 14 program (Boen et al., 2019; Claesson et al., 2018; Ghorbani et al., 2014; Kang & Ellis-Hill, 2015; Smith &  
30  
31 15 Bryant, 2016; Zhang & Chen, 2021).  
32  
33 16 While some patients could perceive the chronic illness as traumatic other patients may experience it as a  
34  
35 17 process of growth and may re-discover new sources of meaning and well-being (Vescovelli et al., 2018,  
36  
37 18 2019a, 2020). This psychological process had been labelled as post-traumatic growth (Tedeschi &  
38  
39 19 Calhoun, 1996). Psychological well-being and post-traumatic growth, in turn, may favour patients'  
40  
41 20 psychological adaptation to the illness and protect their physical and mental health (Vescovelli et al.,  
42  
43 21 2018, 2019a, 2020).  
44  
45 22 Studies focused on the experience of positive psychological resources within a medical illness found a  
46  
47 23 specific type of illness-related growth, conceptualised as "new awareness of the body" (Ghielen et al.,  
48  
49 24 2017; Hefferon et al., 2009; Hefferon, 2012; Vescovelli et al., 2020). Originally, Tedeschi and Calhoun  
50  
51 25 (1996) did not conceptualize this path of growth in their model of post-traumatic growth (PTG).  
52  
53 26 Specifically, it consists in a new manner of connecting with the body, which leads to a greater awareness  
54  
55 27 of the physical and the mental self and to a more positive illness adaptation. The embodied perception of  
56  
57 28 PTG may be indicative of a peculiar dimension of this construct, conceived as "Corporeal PTG" (Hefferon,  
58  
59 29 2012). Individuals with cancer, cardiovascular diseases, HIV and other chronic medical conditions  
60  
30 influencing body functioning reported to experience this corporeal PTG (Kampman et al., 2015; Barskova

1  
2  
3 1 & Oesterreich, 2009). Unfortunately, the PTG inventory developed by Tedeschi and Calhoun (1996) did  
4  
5 2 not assess corporeal PTG and no other psychometric tools have been created up to date.

6  
7 3 While some studies focused on psychological and post-traumatic growth in PD, only little research  
8  
9 4 explored the benefits of physical activity programs in terms of promoting well-being and post-traumatic  
10  
11 5 growth. With a qualitative methodology, Sheehy (2014) documented that PD patients were able to  
12  
13 6 perceive benefits by participating to a group physical activity program, such as improvements in  
14  
15 7 psychological symptoms through the use of better self-regulation strategies, and improvements in well-  
16  
17 8 being. Patients reported that they were able to appreciate the use of humour and to help others, rather  
18  
19 9 than focusing on their negative illness complaints.

20  
21 10 To the best of our knowledge, none of existing studies on well-being and personal growth in chronic  
22  
23 11 illnesses have explored these dimensions in a sample of patients with PD undergoing a physical  
24  
25 12 rehabilitation program (APA). Given the protective role of well-being on the progression of chronic  
26  
27 13 diseases as PD, this study aimed at evaluating the effects of APA in patients with PD, by analyzing  
28  
29 14 neurodegenerative condition, physical/motor functioning, psychological distress, well-being and personal  
30  
31 15 growth. Based on previous findings with other groups of PD patients, it was hypothesized that this specific  
32  
33 16 APA program would have yielded beneficial effects in terms of reduction of disability and of psychological  
34  
35 17 distress and improvement in well-being dimensions.

36 18

## 37 38 19 **Methods**

### 39 40 20 ***Participants***

41  
42 21 This study is part of a larger Phd project concerning the evaluation of well-being and psychological  
43  
44 22 distress in patients with Parkinson's disease and their caregivers. For the purpose of the present  
45  
46 23 investigation we included 37 consecutive patients with PD. They were recruited in a physical  
47  
48 24 rehabilitation center located in Northern Italy. The inclusion criteria established by preliminary physician  
49  
50 25 screenings were the following: diagnosis for PD (established by previous neurological exams based on  
51  
52 26 specific clinical criteria and neurological tests); Hoehn and Yahr scale < 4 (Hoehn and Yahr, 1967); Mini  
53  
54 27 Mental State Examination (MMSE) (Folstein et al., 1975) > 24; absence of a psychiatric illness or cognitive  
55  
56 28 impairment. Patients participated to a 7-month adapted physical activity (APA) program in accordance  
57  
58 29 with the regional directives of the healthcare system, consisting of exercises specifically tailored for PD  
59  
60 30 patients.

1  
2  
3 1 The APA program started in September 2020 and finished in April 2021 and consisted of two 1-hour  
4  
5 2 weekly sessions delivered by an expert in physical activity trained in physical exercises for PD. The  
6  
7 3 program has never stopped but was interrupted only during Christmas holiday for 3 weeks, in compliance  
8  
9 4 with the anti-covid regulations. During that period patients were recommended to continue the physical  
10  
11 5 exercise at home guided by a manual delivered to them before the Christmas break. The physical exercises  
12  
13 6 that were taught are displayed in BOX 1.

14  
15 7 Only participants who voluntarily accepted to take part in the research study and provided their written  
16  
17 8 consent were included in the research. All patients provided their informed consent and at the end of the  
18  
19 9 program there were no drop-outs. These patients were involved only in this physical treatment (they did  
20  
21 10 not take part to any other type of rehabilitation intervention). The Ethical Committee of the rehabilitation  
22  
23 11 center approved the study protocol.

24  
25 12

### 26 13 ***Measures***

28 14 All patients underwent an extensive medical and psychological evaluation (BOX 2) before the beginning of  
29  
30 15 the physical activity program (September 2020) and after its ends (April 2021).

#### 32 16 *Neurodegenerative condition*

34 17 A physician (D.S.) evaluated patients' neurodegenerative condition with the following tools:

37 18 The *Unified Parkinson's Disease Rating Scale* (UPDRS) (Martinez-Martin et al., 1994) is one of the most  
38  
39 19 used clinical interviews for measuring common symptoms of PD including psychological distress and the  
40  
41 20 degree of motor disability. UPDRS is composed of four sections: evaluation of mental activity, behaviour  
42  
43 21 and mood; self-evaluation of activities of daily living; evaluation of motor function; evaluation of therapy  
44  
45 22 complications. The clinician administers semi-structured questions and rates patients' answers using a  
46  
47 23 likert scale from 0 = normal functioning to 4 = severe impairment. For example, for evaluating cognitive  
48  
49 24 impairment, a suggested question could be "Over the past week have you had problems remembering  
50  
51 25 things, following conversations, paying attention, thinking clearly, or finding your way around the house  
52  
53 26 or in town?"

56 27 The *Hoehn and Yahr Scale* has been used for the staging of the functional disability associated  
57  
58 28 with Parkinson's disease. It helps in describing the progression of the disease through various stages, thus  
59  
60 29 allowing us to measure the severity of each condition. The scale was originally published in 1967 in the

1  
2  
3 1 journal Neurology by Melvin Yahr and Margaret Hoehn. That version included stages 1 (symptoms on one  
4  
5 2 side only, unilateral) to 5 needing a wheelchair or bedridden unless assisted. Since then, stage 0 has been  
6  
7 3 added (no signs diseases) and stages 1.5 and 2.5 have been proposed and are widely used.

8  
9 4  
10 5 The *Mini-Mental State Examination* (MMSE) (Folstein et al., 1975) measures the severity and the  
11  
12 6 progression of cognitive changes and impairment over time.

13  
14 7 The *Parkinson's Disease Questionnaire 39 item* (PDQ39) (Jenkinson et al., 1997) is a patient-reported  
15  
16 8 clinical trial endpoint, which estimates the state of health and the quality of life of patients with PD. With  
17  
18 9 39-item it aims to analyse the following conditions: mobility (10 items), activities of daily living (6 items),  
19  
20 10 emotional well-being (6 items), stigma (4 items), social support (3 items), cognitions (4 items),  
21  
22 11 communications (3 items), and bodily discomfort (3 items). Patients may answer this questionnaire by  
23  
24 12 choosing an answer on a Likert-type scale ranging from 0 (never) to 4 (always). They have to rate how  
25  
26 13 often in the last month they have experienced specific difficulties for having Parkinson's disease.  
27  
28 14 Examples of items are "Had difficulty doing the leisure activities which you would like to do?" or "Had  
29  
30 15 difficulty dressing yourself? The scores of the eight sub-scales could be summarized in a single total score  
31  
32 16 Scale scores can range between 0 and 100 (100 = maximum level of problems). In the present study,  
33  
34 17 Cronbach's alpha ( $\alpha$ ) for the PDQ39 total scale was 0.908. Cronbach's alpha for the PDQ39 subscales was  
35  
36 18 as follows:  $\alpha = 0.880$  for mobility,  $\alpha = 0.847$  for activities of daily living,  $\alpha = 0.855$  for emotions,  $\alpha =$   
37  
38 19  $0.713$  for stigma,  $\alpha = 0.596$  for social support,  $\alpha = 0.651$  for cognition,  $\alpha = 0.676$  for communications,  $\alpha$   
39  
40 20  $= 0.557$  for bodily discomfort.

#### 41 21 *Physical / Motor functioning*

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43  
44 22 An expert in physical activity (D.M.) administered the following tests:

45  
46 23 The *Six Minute Walking Test* (6MWT) (Balke, 1963) is a test that measures the patient's ability to walk as  
47  
48 24 fast as possible for 6 minutes (taking breaks if needed). It provides information about the normal physical  
49  
50 25 abilities and its potential functional limitations. After each minute, the instructor measured the patient's  
51  
52 26 pulse rate, oxygen haemoglobin saturation and the meters walked. Dyspnoea was also measured before  
53  
54 27 the conclusion of the test. For the purpose of this study, only the meters walked were considered.

55  
56 28 The *Short Physical Performance Battery* (SPPB) (Guralnik et al., 1994) is an objective assessment tool that  
57  
58 29 combines the results of the gait speed, chair stand and balance tests. The battery is composed of three  
59  
60 30 sections. The first section consists in evaluating the motor balance of patients and is subdivided into three

1  
2  
3 1 different sections (1) the maintenance of balance in upright stand for a duration of 10 seconds; (2) the  
4  
5 2 maintenance of balance in semi-tandem stand — by placing the hallux of one foot near the heel bone of  
6  
7 3 the other — for a duration of 10 seconds; (3) the maintenance of balance in tandem stand—by placing the  
8  
9 4 hallux of one foot behind the heel bone of the other—for a duration of 10 seconds. In this first macro-  
10  
11 5 section a score between 0 and 4 may be assigned. The second section consists in evaluating patients’  
12  
13 6 walking ability over a 4 linear meter surface on the basis of the performance time. In this section a score  
14  
15 7 between 0 (unable to perform the test) and 4 (able to perform the test in less than 4.8 seconds) may be  
16  
17 8 assigned. The third section consists in evaluating patients’ ability to stand up and sit down from a chair for  
18  
19 9 5 times in a row. In this section, a score between 0 (unable to perform the test) and 4 (able to perform the  
20  
21 10 test in less than 11.2 seconds) may be assigned.

22  
23 11 *Psychological distress*

24  
25 12 A clinical psychologist (F.V.) administered the following psychometric tests:

26  
27 13 The *Psychosocial Index (PSI)* (Sonino & Fava, 1998; Piolanti et al., 2016) is a screening tool divided into  
28  
29 14 two different sections: a self-rating test and an observer-rating test. The scale of self-rating includes 55  
30  
31 15 items, of which 38 items (item 1-20; 37-54) were selected from Kellner’s Screening List for Psychosocial  
32  
33 16 Problems (SLP). The first observed rated part of the questionnaire (12 items) was administered to collect  
34  
35 17 *sociodemographic* and *clinical data* including information concerning medical and psychiatric history, the  
36  
37 18 patient's family, employment and habits (such as alcohol or drug use). Then, patients answered to the self-  
38  
39 19 report part of the questionnaire including 4 sections: stress, psychological distress, well-being, abnormal  
40  
41 20 illness behaviour, quality of life. The section on stress (17 items with yes/no answers) is an integration of  
42  
43 21 both perceived and objective stress, life events and chronic stress. The total score ranges from 0 to 17. The  
44  
45 22 *Well-being* section (6 items with yes/no answers) covers different areas of well-being, such as positive  
46  
47 23 relations with others, environmental mastery and autonomy, with a score ranging from 0 to 6. The  
48  
49 24 *Psychological distress* section (15 items) consists of a checklist of symptoms addressing sleep  
50  
51 25 disturbances, somatization, anxiety, depression and irritability. The total score may range from 0 to 45.  
52  
53 26 Questions 37-40 refer to sleep disturbances (range 0-12) and may also be scored separately from the  
54  
55 27 other questions. The section on *Abnormal illness behavior* (3 items) guides the clinician in the assessment  
56  
57 28 of hypochondriacal beliefs and bodily preoccupations. The total score may range from 0 to 9. Finally the  
58  
59 29 last item is a question for measuring *Quality of life* and its score may range from 0 to 4. Cronbach’s alpha  
60  
30 for the PSI total score in the present study is reported in BOX 3.



1  
2  
3 1 The *Symptom Questionnaire* (SQ) (Kellner, 1987) is a 92-item self-rating questionnaire composed of 92  
4  
5 2 dichotomous questions (“Yes” / “No”). It contains 4 scales of distress (anxiety, depression, somatic  
6  
7 3 symptoms, hostility-irritability) and 4 scales of well-being (relaxation, happiness, physical well-being and  
8  
9 4 friendliness). Each scale of stress varies within a range of 0-17 scores, whereas each scale of well-being  
10  
11 5 varies within a range of 0-6 scores. Cronbach’s alpha indicators in SQ total scales are reported in BOX 3.  
12  
13 6

14  
15 7 *Psychological well-being and personal growth*

16  
17 8 The *Psychological Well-Being Scales* (PWBS) (Ryff, 1989) is a 42-item self-rating scale. It is composed of six  
18  
19 9 sub-scales in accordance with the six factors of positive functioning, namely autonomy, environmental  
20  
21 10 mastery, personal growth, purpose in life, positive relations with others and self-acceptance. Patients  
22  
23 11 answer the survey using a Likert-type scale ranging from 1 (strongly disagree) to 6 (strongly agree). The  
24  
25 12 negative answers have to be recoded and summarized in the final score. In the present study the same  
26  
27 13 items of the well-being section of the PSI were excluded in order to avoid redundancy (see previous  
28  
29 14 section). Examples of items are: “In general, I feel I am in charge of the situation in which I live”; “I think it  
30  
31 15 is important to have new experiences that challenge how you think about yourself and the world”.  
32  
33 16 Cronbach’s alpha values for the PWBS values are reported in BOX 3,

34  
35 17 The *Post-traumatic Growth Inventory* (PTGI) (Tedeschi & Calhoun, 1996) is a 21-item scale assessing the  
36  
37 18 positive changes reported by individuals who have experienced a traumatic event. Patients are requested  
38  
39 19 to provide an answer referring to their PD diagnosis on a Likert-type scale ranging from 0 (I did not  
40  
41 20 experience this as a result of my crisis) to 5 (I experienced this change to a very great degree as a result of  
42  
43 21 my crisis. ). Patients are requested to answer to item as follows: “I have a greater appreciation for the  
44  
45 22 value of my own life”, “I have a greater sense of closeness with others”. The questionnaire provides a final  
46  
47 23 score and five sub-scales scores of the following sections: relating to others (7 items), new possibilities (5  
48  
49 24 items), personal strength (4 items), spiritual change (2 items), and appreciation of life (3 items). The total  
50  
51 25 score may range from 0 to 105. In the present study, Cronbach’s alpha for the PTGI total score is reported  
52  
53 26 in BOX 3.

54  
55 27 The *Life Satisfaction* (LS) (International Wellbeing Group, 2013) scale is a 1-item rating scale to estimate  
56  
57 28 patients’ life satisfaction by asking “How satisfied are you with your life as a whole?”. Answer may range  
58  
59 29 from 1 (completely dissatisfied) to 10 (completely satisfied).  
60  
30

## 1 **1 Statistical analyses**

2 Socio-demographic characteristics of the sample were analysed with descriptive statistics.

3 Bivariate correlations among neurodegenerative condition measures, physical/motor functioning  
4 measures, psychological distress measures and well-being measures before and after the physical activity  
5 program were calculated using Pearson's  $r$  coefficients (small = 0.1; medium = 0.3; large = 0.5) (Cohen,  
6 1988). Since these are descriptive data, only correlations for the total scale scores are provided.

7 Pre-post differences in neurodegenerative condition (UPDRS, PDQ39), physical/motor functioning and  
8 psychological distress measures (PSI, SQ) and well-being measures (PWBS, PTGI and LS) of the sample  
9 were analysed with Anova Repeated Measures. Effect sizes were calculated using Cohen's  $d$  (small = 0.2;  
10 medium = 0.5; large = 0.8). In order to provide a complete overview of the APA's effect, differences in all  
11 subscales of the questionnaires were analysed and reported. The software used for our statistical analyses  
12 was SPSS Statistics (25.0 version).

## 13 **14 Results**

15 Socio-demographic characteristics of the sample are reported in Table 1.

16 Correlations between variables are reported in Table 2 and Table 3. The most robust correlations were  
17 among indicators of physical/motor functioning and scores at UPDRS and PDQ39. Measures of  
18 psychological distress and psychological well-being were inversely correlated, but not significantly  
19 correlated to indicators of motor functioning, also after the APA program.

20 After APA, significant improvements were reported in UPDRS total score ( $F_{1,36} = 15.040, p = 0.001$ ), and  
21 PDQ39 total score ( $F_{1,36} = 35.445, p < 0.001$ ) (Table 4). PDQ39 resulted to be improved particularly in the  
22 sub-scales of mobility ( $F_{1,36} = 13.069, p = 0.001$ ), activities of daily living ( $F_{1,36} = 22.262, p < 0.001$ ),  
23 emotional well-being ( $F_{1,36} = 7.765, p = 0.008$ ), stigma ( $F_{1,36} = 5.797, p = 0.021$ ), cognitions ( $F_{1,36} = 10.593, p$   
24  $= 0.002$ ), and bodily discomfort ( $F_{1,36} = 22.396, p < 0.001$ ).

25 Concerning physical/motor functioning (Table 4), a significant improvement both in meters walked ( $F_{1,36}$   
26  $= 14.532, p = 0.001$ ) and in the physical test's final score ( $F_{1,36} = 5.484, p = 0.025$ ) emerged after APA.

27 Concerning the psychological distress dimensions, after APA patients reported significant improvements  
28 in PSI total score ( $F_{1,36} = 14.331, p = 0.001$ ), SQ total scale of anxiety ( $F_{1,36} = 11.731, p = 0.002$ ), somatic  
29 symptoms ( $F_{1,36} = 13.385, p = 0.001$ ), hostility-irritability ( $F_{1,36} = 3.938, p = 0.055$ ) (Table 4), documenting  
30 a beneficial effect of APA on patients' psychological distress.

1  
2  
3 1 Concerning pre-post differences on well-being dimensions (Table 5), a significant improvement in PTG  
4  
5 2 sub-scale of appreciation of life ( $F_{1,36} = 7.901, p = 0.008$ ) was observed with the largest effect size among  
6  
7 3 all variables included. PWBS and LS final scores were improved, but they did not reach statistical  
8  
9 4 significance.

## 10 11 5 12 13 6 **Discussion**

14  
15 7 The main purpose of this research was to examine the role of APA in improving physical and psychological  
16  
17 8 health in individuals with PD. Our findings documented the beneficial effects of APA in regard to mobility,  
18  
19 9 activities of daily life, bodily discomfort, and motor function. These results confirmed previous literature  
20  
21 10 on the important role of APA in Parkinson's disease (Abbruzzese et al., 2016). Abbruzzese and his  
22  
23 11 research team (2016) observed that physical rehabilitation should be considered as a key-factor of the  
24  
25 12 medical treatment (medicines / surgery) for PD patients.

26  
27 13 Concerning psychological distress, our results are in line with previous findings showing significant  
28  
29 14 reduction in emotional distress, anxiety, somatic symptoms, and hostility-irritability following the  
30  
31 15 physical activity program. The positive impact of the physical activity program on patient's mental  
32  
33 16 symptoms appears to be in line with recent research studies and reviews (Abbruzzese et al., 2016; Boen et  
34  
35 17 al., 2019; Cusso et al., 2016; Inoue et al., 2019; Wu et al., 2017).

36  
37 18 The APA intervention had also a beneficial effect on some dimensions of well-being, particularly the life  
38  
39 19 appreciation subscale of the PTG inventory, which showed the most robust change after APA, according to  
40  
41 20 its effect size value. Life appreciation represents a core dimension of existential well-being and  
42  
43 21 psychological growth. This result fits with the model of "corporeal growth" as conceptualized by Hefferon  
44  
45 22 et al. (2012). A previous investigation documented that PD patients with high levels of psychological well-  
46  
47 23 being reported also changes in the perception of their body functioning and more awareness of their  
48  
49 24 bodies following the onset of their illness (Vescovelli et al., 2020). After improving their motor abilities  
50  
51 25 through the APA program, our PD patients reported an increased appreciation of life. It is possible that  
52  
53 26 they may have increased their body awareness and body functioning through the APA and, as a result,  
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55 27 they also developed a better appreciation of their present life conditions. Alternatively, it is possible that  
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57 28 the improvements in life appreciation might be due to the important role of social support, since APA was  
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59 29 delivered in a group setting. This setting may favour a process of social support and social comparison  
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30 among patients with PD (Boen et al., 2019; Claesson et al., 2018; Ghorbani et al., 2014; Kang & Ellis-Hill,

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3 1 2015; Smith & Bryant, 2016; Zhang & Chen, 2021). These social benefits might result in a better  
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5 2 appreciation of life as well. In fact, during the post assessment, patients referred that they found the group  
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7 3 format very supportive and that the struggle of engaging in exercises helped them appreciate what they  
8  
9 4 were still able to do. Since to date no standardized measures have been developed for evaluating the  
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11 5 dimension of “corporeal growth”, future studies are recommended for filling this gap of research  
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13 6 (Vescovelli et al., 2020).

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15 7 On the other hand, other dimensions of well-being, such as life satisfaction or other subscales of PTG and  
16  
17 8 of PWB did not show significant differences from pre to post intervention. A possible explanation for these  
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19 9 null results may be related to the small sample size, which limited the statistical power. Alternatively, it is  
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21 10 possible that the APA program did not affect the cognitive dimensions of well-being, such as satisfaction  
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23 11 with life or PWB subscales. In fact, the former has been defined as a global cognitive judgement of  
24  
25 12 satisfaction with one’s life (International Wellbeing Group, 2013), while the six dimension model of  
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27 13 psychological well-being was found to be strongly associated with the level of education, with the  
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29 14 cognitive skills and with the characteristics of the participants (Blasco-Belled & Alsinet, 2022). Thus, the  
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31 15 suitability of these measures for detecting improvements in well-being following APA programs needs to  
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33 16 be tested by future studies with larger samples.

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35 17 This study is limited by the small, self-selected sample size, the absence of a control group, and the use of  
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37 18 self-reports for assessing psychological distress and well-being. However, the findings documented that  
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39 19 the physical activity program (APA) not only helped patients to improve their motor abilities, but it also  
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41 20 helped patients to reduce their psychological symptoms and to increase their well-being.

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43 21 The results of this study call for the necessity of enlarging the standard evaluation of patients with  
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45 22 Parkinson’s disease by including the assessment of well-being and other dimensions of positive  
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47 23 functioning. The combined assessment of well-being and distress, through appropriate and sensitive  
48  
49 24 quantitative measures, according to the clinimetric approach (Carrozzino et al., 2020) may help clinicians  
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51 25 to better capture profiles of patients’ problems and resources and to tailor treatments to their specific  
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53 26 needs (Anzaldi & Shifren, 2019; Cesetti et al., 2017; Vescovelli et al., 2018, 2019a, 2019b, 2020).

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55 27 APA program appeared to be particularly beneficial for our sample of patients in terms of physical  
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57 28 functioning, psychological distress and life appreciation. However, APA’s implementation may be difficult  
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59 29 and it is not always included in the national health systems of countries. Future studies should better test  
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30 30 the beneficial effects of APA interventions for PD patients by using control groups or by comparing APA

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3 1 with other types of physical treatments.

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5 2 A promising approach may be represented by the development of new digital technologies, such as virtual  
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7 3 reality (VR) in order to deliver the APA treatment (Alves et al., 2015; De Melo et al., 2018; Thangavelu et  
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9 4 al., 2020; Van der Kolk et al., 2019). Future studies should test if such VR approach might have similar  
10  
11 5 positive results as traditional APA. In fact VR and computerized therapies may overcome barriers that  
12  
13 6 patient with physical disabilities may encounter within traditional intervention and may be delivered  
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15 7 directly at home. During the recent Covid-19 pandemic waves across countries, the possibility of  
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17 8 maintaining rehabilitative programs for patients with chronic conditions as PD may be crucial, although  
18  
19 9 the beneficial effects of the group setting might be lost. At the same time, it would be useful to support  
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21 10 APA with a specific psychological program aimed to promote emotional well-being and life satisfaction in  
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23 11 patients with vulnerable psychological profiles (Thangavelu et al., 2020; Zhang & Chen, 2021). Well-  
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25 12 established psychological treatments (e.g., cognitive behavioural therapy, Thangavelu et al., 2020) or  
26  
27 13 other mind-body techniques such as "Mindfulness" resulted to be well accepted by PD patients  
28  
29 14 (Fitzpatrick et al., 2010) and to be effective in improving their cognitive and emotional functions (Advocat  
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31 15 et al., 2016; Cash et al., 2016; Dissanayaka et al., 2016). These psychological programs may support and  
32  
33 16 motivate PD patients to engage in specific rehabilitation program, which could further ameliorate their  
34  
35 17 physical and mental conditions. The findings of this preliminary study, in fact, suggested that a simple  
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37 18 rehabilitation program improved life appreciation and well-being of PD patients. Future studies with  
38  
39 19 larger samples are needed to confirm and replicate these promising findings.

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## 41 21 **Clinical Implications**

- 42 22 • Significant improvements in distress, cognition, mobility, activities of daily life, bodily discomfort,  
43 23 motor function and life appreciation emerged after an adapted physical activity program.
  - 44 24 • A combined assessment of motor functioning and distress with the measurement of well-being may  
45 25 help clinicians to better capture profiles of patients' problems and resources to tailor treatments  
46 26 according to their specific needs.
  - 47 27 • A brief physical activity program was beneficial not only on patients' motor functioning, but also on  
48 28 their mental health, by reducing distress and promoting well-being.
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## References

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45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60
- Abbruzzese, G., Marchese, R., Avanzino, L., & Pelosin, E. (2016). Rehabilitation for Parkinson's disease: Current outlook and future challenges. *Parkinsonism & Related Disorders*, 22, S60-S64. <https://doi.org/10.1016/j.parkreldis.2015.09.005>
- Abrantes, A. M., Friedman, J. H., Brown, R. A., Strong, D. R., Desaulniers, J., Ing, E., ... & Riebe, D. (2012). Physical activity and neuropsychiatric symptoms of Parkinson disease. *Journal of Geriatric Psychiatry and Neurology*, 25(3), 138-145. <https://doi.org/10.1177%2F0891988712455237>
- Advocat, J., Enticott, J., Vandenberg, B., Hasted, C., Hester, J., & Russell, G. (2016). The effects of a mindfulness-based lifestyle program for adults with Parkinson's disease: a mixed methods, wait list controlled randomised control study. *BMC Neurology*, 16(1), 166. <https://doi.org/10.1186/s12883-016-0685-1>
- Alves, P. D. R., McClelland, J., & Morris, M. E. (2015). Complementary physical therapies for movement disorders in Parkinson's disease: a systematic review. *European Journal of Physical and Rehabilitation Medicine*, 51(6), 693-704.
- Anzaldi, K., & Shifren, K. (2019). Optimism, pessimism, coping, and depression: a study on individuals with Parkinson's disease. *International Journal of Aging and Human Development*, 88(3), 231-249. <https://doi.org/10.1177/0091415018763401>. Epub 2018 Mar 20. PMID: 29557181.
- Bae, W., Ik Suh, Y., Ryu, J., & Heo, J. (2017). Physical activity levels and well-being in older adults. *Psychological Reports*, 120(2), 192-205. <https://doi.org/10.1177%2F0033294116688892>
- Balke, B. (1963). *A simple field test for the assessment of physical fitness* (No. FAA-AM-63-6). Civil Aerospace Medical Institute.
- Barskova, T., & Oesterreich, R. (2009). Post-traumatic growth in people living with a serious medical condition and its relations to physical and mental health: A systematic review. *Disability and Rehabilitation*, 31(21), 1709-1733. <https://doi.org/10.1080/09638280902738441>
- Blasco - Belled, A., & Alsinet, C. (2022). The architecture of psychological well - being: A network analysis study of the Ryff Psychological Well - Being Scale. *Scandinavian Journal of Psychology*, 63, 199-207. <https://doi.org/10.1111/sjop.12795>
- Boen, F., Pelssers, J., Scheerder, J., Vanbeselaere, N., Vos, S., Hurkmans, E., ... & Fransen, K. (2020). Does social capital benefit older adults' health and well-being? The mediating role of physical activity. *Journal of Aging and Health*, 32(7-8), 688-697. [s://doi.org/10.1177/0898264319848638](https://doi.org/10.1177/0898264319848638)

- 1  
2  
3 Canning, C. G., Allen, N. E., Dean, C. M., Goh, L., & Fung, V. S. (2012). Home-based treadmill training for individuals  
4 with Parkinson's disease: a randomized controlled pilot trial. *Clinical Rehabilitation*, *26*(9), 817-826.  
5 <https://doi.org/10.1177%2F0269215511432652>  
6  
7  
8 Carrozzino, D., Patierno, C., Guidi, J., Montiel, C. B., Cao, J., Charlson, M. E., ... & Fava, G. A. (2021). Clinimetric  
9 criteria for patient-reported outcome measures. *Psychotherapy and psychosomatics*, *90*(4), 222-232.  
10 <https://doi.org/10.1159/000516599>  
11  
12  
13 Cash, T. V., Ekouevi, V. S., Kilbourn, C., & Lageman, S. K. (2016). Pilot study of a mindfulness-based group  
14 intervention for individuals with Parkinson's disease and their caregivers. *Mindfulness*, *7*(2), 361-371.  
15 <https://doi.org/10.1007/s12671-015-0452-1>  
16  
17  
18 Cesetti, G., Vescovelli, F., & Ruini, C. (2017). The promotion of well-being in aging individuals living in nursing  
19 homes: a controlled pilot intervention with narrative strategies. *Clinical Gerontologist*, *40*(5), 380-391.  
20 <https://doi.org/10.1080/07317115.2017.1292979>  
21  
22  
23 Claesson, I. M., Ståhle, A., & Johansson, S. (2018). Being limited by Parkinson's disease and struggling to keep up  
24 exercising; is the group the glue? *Disability and Rehabilitation*, *8*, 1-5.  
25 <https://doi.org/10.1080/09638288.2018.1522552>  
26  
27  
28 Cohen, J. (1988). *Statistical Power for the Behavioural Sciences*. Hillsdale, NY: Lawrence Erlbaum.  
29  
30  
31 Cugusi, L., Solla, P., Zedda, F., Loi, M., Serpe, R., Cannas, A., ... & Mercuro, G. (2014). Effects of an adapted physical  
32 activity program on motor and non-motor functions and quality of life in patients with Parkinson's  
33 disease. *NeuroRehabilitation*, *35*(4), 789-794. <https://doi.org/10.3233/NRE-141162>  
34  
35  
36 Cusso, M. E., Donald, K. J., & Khoo, T. K. (2016). The impact of physical activity on non-motor symptoms in  
37 Parkinson's disease: a systematic review. *Frontiers in Medicine*, *3*, 35.  
38 <https://doi.org/10.3389/fmed.2016.00035>  
39  
40  
41 De Melo, G. E. L., Kleiner, A. F. R., Lopes, J. B. P., Dumont, A. J. L., Lazzari, R. D., Galli, M., & Oliveira, C. S. (2018).  
42 Effect of virtual reality training on walking distance and physical fitness in individuals with Parkinson's  
43 disease. *NeuroRehabilitation*, *42*(4), 473-480. <https://doi.org/10.3233/NRE-172355>  
44  
45  
46 Delle Fave, A., Massimini, F., & Bassi, M. (2011). Flow and health: A bio-psycho-social perspective.  
47 In *Psychological Selection and Optimal Experience Across Cultures* (pp. 295-320). Springer, Dordrecht.  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

- 1  
2  
3 Diener, E., Pressman, S. D., Hunter, J., & Delgado-Chase, D. (2017). If, why, and when subjective well-being  
4 influences health, and future needed research. *Applied Psychology: Health and Well-Being*, 9(2), 133-167.  
5  
6 <https://doi.org/10.1111/aphw.12090>  
7  
8  
9 Dissanayaka, N. N., Idu Jion, F., Pachana, N. A., O'Sullivan, J. D., Marsh, R., Byrne, G. J., & Harnett, P. (2016).  
10 Mindfulness for motor and nonmotor dysfunctions in Parkinson's disease. *Parkinson's Disease*.  
11  
12 <https://doi.org/10.1155/2016/7109052>  
13  
14  
15 Dural, A., Atay, M. B., Akbostanci, C., & Kucukdeveci, A. (2003). Impairment, disability, and life satisfaction in  
16 Parkinson's disease. *Disability and Rehabilitation*, 25(7), 318-323.  
17  
18 <https://doi.org/10.1080/0963828021000043761>  
19  
20  
21 Fitzpatrick, L., Simpson, J., & Smith, A. (2010). A qualitative analysis of mindfulness-based cognitive therapy  
22 (MBCT) in Parkinson's disease. *Psychology and Psychotherapy: Theory, Research and Practice*, 83(2), 179-192.  
23  
24 <https://doi.org/10.1348/147608309X471514>  
25  
26  
27 Folstein, M. F., Folstein, S. E., & McHugh, P. R. (1975). "Mini-mental state": a practical method for grading the  
28 cognitive state of patients for the clinician. *Journal of Psychiatric Research*, 12(3), 189-198.  
29  
30  
31 Frazier, L. D. (2002). Stability and change in patterns of coping with Parkinson's disease. *The International*  
32 *Journal of Aging and Human Development*, 55(3), 207-231. <https://doi.org/10.2190/UA78-79LB-4GCF-8MJT>  
33  
34  
35 Ghielen, I., van Wegen, E. E., Rutten, S., de Goede, C. J., Houniet-de Gier, M., Collette, E. H., ... & van Vliet, B. (2017).  
36 Body awareness training in the treatment of wearing-off related anxiety in patients with Parkinson's disease:  
37 Results from a pilot randomized controlled trial. *Journal of Psychosomatic Research*, 103, 1-8.  
38  
39 <https://doi.org/10.1016/j.jpsychores.2017.09.008>  
40  
41  
42 Ghorbani Saeedian, R., Nagyova, I., Krokavcova, M., Skorvanek, M., Rosenberger, J., Gdovinova, Z., ... & van Dijk, J.  
43 P. (2014). The role of social support in anxiety and depression among Parkinson's disease patients. *Disability*  
44 *and Rehabilitation*, 36(24), 2044-2049. <https://doi.org/10.3109/09638288.2014.886727>  
45  
46  
47  
48 Guralnik, J. M., Simonsick, E. M., Ferrucci, L., Glynn, R. J., Berkman, L. F., Blazer, D. G., ... & Wallace, R. B. (1994). A  
49 short physical performance battery assessing lower extremity function: association with self-reported  
50 disability and prediction of mortality and nursing home admission. *Journal of Gerontology*, 49(2), 85-94.  
51  
52 <https://doi.org/10.1093/geronj/49.2.M85>  
53  
54  
55  
56 Hefferon, K. M., & Ollis, S. (2006). 'Just clicks': an interpretive phenomenological analysis of professional dancers'  
57 experience of flow. *Research in Dance Education*, 7(2), 141-159.  
58  
59 <https://doi.org/10.1080/14647890601029527>  
60



- 1  
2  
3 Hefferon, K., Grealy, M., & Mutrie, N. (2009). Post-traumatic growth and life threatening physical illness: A  
4 systematic review of the qualitative literature. *British Journal of Health Psychology*, *14*(2), 343-378.  
5  
6 <https://doi.org/10.1348/135910708X332936>  
7  
8  
9 Hefferon, K. (2012). Bringing back the body into positive psychology: The theory of corporeal posttraumatic  
10 growth in breast cancer survivorship. *Psychology*, *3*(12A), 1238-1242.  
11  
12 <http://dx.doi.org/10.4236/psych.2012.312A183>  
13  
14  
15 Hoehn M, Yahr M (1967). Parkinsonism: onset, progression and mortality. *Neurology*, *17*(5), 427-  
16 42. doi:10.1212/wnl.17.5.427.  
17  
18  
19 Huffman, M. K., Christ, S. L., Ferraro, K. F., Klenosky, D. B., Marceau, K., & Amireault, S. (2022). Measuring physical  
20 activity regulatory styles and identity among adults 55 years or older. *Journal of Aging and Health*,  
21 08982643211063349. <https://doi.org/10.1177/08982643211063349>  
22  
23  
24  
25 Huppert, F. A. (2009). Psychological well-being: Evidence regarding its causes and consequences. *Applied*  
26 *Psychology: Health and Well-Being*, *1*(2), 137-164. <https://doi.org/10.1111/j.1758-0854.2009.01008.x>  
27  
28  
29 Inoue, Y., Wann, D. L., Lock, D., Sato, M., Moore, C., & Funk, D. C. (2020). Enhancing older adults' sense of  
30 belonging and subjective well-being through sport game attendance, team identification, and emotional  
31 support. *Journal of Aging and Health*, *32*(7-8), 530-542. <https://doi.org/10.1177/0898264319835654>  
32  
33  
34  
35 International Wellbeing Group (2013). *Personal Wellbeing Index: 5th Edition*. Melbourne: Australian Centre on  
36 Quality of Life, Deakin University. Retrieved from  
37 <http://www.deakin.edu.au/research/acqol/instruments/wellbeing-index/index.php>  
38  
39  
40  
41 Jenkinson, C., Fitzpatrick, R. A. Y., Peto, V. I. V., Greenhall, R., & Hyman, N. (1997). The Parkinson's Disease  
42 Questionnaire (PDQ-39): development and validation of a Parkinson's disease summary index score. *Age and*  
43 *Ageing*, *26*(5), 353-357. <https://doi.org/10.1093/ageing/26.5.353>  
44  
45  
46  
47 Kampman, H., Hefferon, K., Wilson, M., & Beale, J. (2015). "I can do things now that people thought were  
48 impossible, actually, things that I thought were impossible": A meta-synthesis of the qualitative findings on  
49 posttraumatic growth and severe physical injury. *Canadian Psychology/Psychologie Canadienne*, *56*(3), 283.  
50  
51 <https://psycnet.apa.org/doi/10.1037/cap0000031>  
52  
53  
54  
55 Kang, M. Y., & Ellis-Hill, C. (2015). How do people live life successfully with Parkinson's disease? *Journal of*  
56 *clinical nursing*, *24*(15-16), 2314-2322. <https://doi.org/10.1111/jocn.12819>  
57  
58  
59  
60 Kellner, R. (1987). A symptom questionnaire. *Journal of Clinical Psychiatry*, *48*(7), 268-274.

- 1  
2  
3 Kosma, M., Ellis, R., Cardinal, B. J., Bauer, J. J., & McCubbin, J. A. (2007). The mediating role of intention and stages  
4 of change in physical activity among adults with physical disabilities: An integrative framework. *Journal of*  
5 *Sport and Exercise Psychology*, 29(1), 21-38. <https://doi.org/10.1123/jsep.29.1.21>  
6  
7  
8  
9 Martínez-Martín, P., Gil-Nagel, A., Gracia, L. M., Gómez, J. B., Martínez-Sarries, J., Bermejo, F., & Cooperative  
10 Multicentric Group. (1994). Unified Parkinson's disease rating scale characteristics and structure. *Movement*  
11 *Disorders*, 9(1), 76-83. <https://doi.org/10.1002/mds.870090112>  
12  
13  
14 Morris, M. E., Ianseck, R., & Kirkwood, B. (2009). A randomized controlled trial of movement strategies compared  
15 with exercise for people with Parkinson's disease. *Movement Disorders*, 24(1), 64-71.  
16 <https://doi.org/10.1002/mds.22295>  
17  
18  
19 Netz, Y., Wu, M. J., Becker, B. J., & Tenenbaum, G. (2005). Physical activity and psychological well-being in  
20 advanced age: a meta-analysis of intervention studies. *Psychology and Aging*, 20(2), 272.  
21 <https://psycnet.apa.org/doi/10.1037/0882-7974.20.2.272>  
22  
23  
24 Piolanti, A., Offidani, E., Guidi, J., Gostoli, S., Fava, G. A., & Sonino, N. (2016). Use of the psychosocial index: a  
25 sensitive tool in research and practice. *Psychotherapy and Psychosomatics*, 85(6), 337-345.  
26 <https://doi.org/10.1159/000447760>  
27  
28  
29 Protas, E. J., Mitchell, K., Williams, A., Qureshy, H., Caroline, K., & Lai, E. C. (2005). Gait and step training to reduce  
30 falls in Parkinson's disease. *NeuroRehabilitation*, 20(3), 183-190. <https://doi.org/10.3233/NRE-2005-20305>  
31  
32  
33 Reavenall, S., & Blake, H. (2010). Determinants of physical activity participation following traumatic brain  
34 injury. *International Journal of Therapy and Rehabilitation*, 17(7), 360-369.  
35 <https://doi.org/10.12968/ijtr.2010.17.7.48893>  
36  
37  
38 Rector, J. L., Christ, S. L., & Friedman, E. M. (2019). Well-being and long-term physical activity participation in  
39 midlife adults: A latent class analysis. *Annals of Behavioral Medicine*, 53(1), 53-64.  
40 <https://doi.org/10.1093/abm/kay016>  
41  
42  
43 Ryff, C. D. (1989). Happiness is everything, or is it? Explorations on the meaning of psychological well-  
44 being. *Journal of Personality and Social Psychology*, 57(6), 1069-1081. [https://doi.org/10.1037/0022-](https://doi.org/10.1037/0022-3514.57.6.1069)  
45 [3514.57.6.1069](https://doi.org/10.1037/0022-3514.57.6.1069)  
46  
47  
48 Ryff, C. D. (2014). Psychological well-being revisited: Advances in the science and practice of  
49 eudaimonia. *Psychotherapy and Psychosomatics*, 83(1), 10-28. <https://doi.org/10.1159/000353263>  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

- 1  
2  
3 Ryff, C. D., Singer, B. H., & Dienberg Love, G. (2004). Positive health: connecting well-being with  
4 biology. *Philosophical Transactions of the Royal Society of London. Series B: Biological Sciences*, 359(1449),  
5 1383-1394. <https://doi.org/10.1098/rstb.2004.1521>  
6  
7  
8 Sabari, J. S., Ortiz, D., Pallatto, K., Yagerman, J., Glazman, S., & Bodis-Wollner, I. (2015). Activity engagement and  
9 health quality of life in people with Parkinson's disease. *Disability and Rehabilitation*, 37(16), 1411-1415.  
10  
11 <https://doi.org/10.3109/09638288.2014.972588>  
12  
13  
14 Sheehy, T. L. (2014) The Parkinson's experience of group physical activity: Understanding social support, social  
15 comparison, physical self-perceptions, and posttraumatic growth. *Open Access Theses*. 680. Retrieved from:  
16  
17 [https://docs.lib.purdue.edu/open\\_access\\_theses/680](https://docs.lib.purdue.edu/open_access_theses/680)  
18  
19  
20 Smith, J. L., & Bryant, F. B. (2016). The benefits of savoring life: Savoring as a moderator of the relationship  
21 between health and life satisfaction in older adults. *The International Journal of Aging and Human*  
22 *Development*, 84(1), 3-23. <https://doi.org/10.1177/0091415016669146>  
23  
24  
25 Sonino, N., & Fava, G. A. (1998). A simple instrument for assessing stress in clinical practice. *Postgraduate*  
26 *Medical Journal*, 74(873), 408-410. <http://dx.doi.org/10.1136/pgmj.74.873.408>  
27  
28  
29 Tedeschi, R. G., & Calhoun, L. G. (1996). The Posttraumatic Growth Inventory: Measuring the positive legacy of  
30 trauma. *Journal of Traumatic Stress*, 9(3), 455-471. <https://doi.org/10.1007/BF02103658>  
31  
32  
33 Thangavelu, K., Hayward, J. A., Pachana, N. A., Byrne, G. J., Mitchell, L. K., Wallis, G. M., ... & Dissanayaka, N. N.  
34 (2020). Designing virtual reality assisted psychotherapy for anxiety in older adults living with Parkinson's  
35 disease: Integrating literature for scoping. *Clinical Gerontologist*, 1-33.  
36  
37 <https://doi.org/10.1080/07317115.2019.1709597>  
38  
39  
40 Van der Kolk, N. M., de Vries, N. M., Kessels, R. P., Joosten, H., Zwinderman, A. H., Post, B., & Bloem, B. R. (2019).  
41 Effectiveness of home-based and remotely supervised aerobic exercise in Parkinson's disease: a double-blind,  
42 randomised controlled trial. *The Lancet Neurology*, 18(11), 998-1008. [https://doi.org/10.1016/S1474-](https://doi.org/10.1016/S1474-4422(19)30285-6)  
43 [4422\(19\)30285-6](https://doi.org/10.1016/S1474-4422(19)30285-6)  
44  
45  
46 Vescovelli, F., Sarti, D., & Ruini, C. (2018). Subjective and psychological well-being in Parkinson's Disease: A  
47 systematic review. *Acta Neurologica Scandinavica*, 138(1), 12-23. <https://doi.org/10.1111/ane.12946>  
48  
49  
50 Vescovelli, F., Sarti, D., & Ruini, C. (2019a). Well-being and distress of patients with Parkinson's disease: a  
51 comparative investigation. *International Psychogeriatrics*, 31(1), 21-30.  
52  
53 <https://doi.org/10.1017/S1041610217002575>  
54  
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- 1  
2  
3 Vescovelli, F., Cesetti, G., & Ruini, C. (2019b). Optimal well-being, depression, and caregiving: an explorative  
4 investigation. *Clinical Gerontologist*, 1-13. <https://doi.org/10.1080/07317115.2019.1702130>  
5  
6  
7 Vescovelli, F., Minotti, S., & Ruini, C. (2020). Exploring post-traumatic growth in Parkinson's disease: A mixed  
8 method study. *Journal of Clinical Psychology in Medical Settings*, 1-12. [https://doi.org/10.1007/s10880-020-](https://doi.org/10.1007/s10880-020-09713-9)  
9  
10  
11  
12  
13 Wu, P. L., Lee, M., & Huang, T. T. (2017). Effectiveness of physical activity on patients with depression and  
14 Parkinson's disease: A systematic review. *PLoS One*, 12(7).  
15  
16  
17 [https://dx.doi.org/10.1371%2Fjournal.pone.0181515](https://dx.doi.org/10.1371/journal.pone.0181515)  
18  
19 Zhang, Z., & Chen, W. (2021). Longitudinal associations between physical activity and purpose in life among older  
20 adults: a cross-lagged panel analysis. *Journal of Aging and Health*, 33(10), 941-952.  
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22  
23 <https://doi.org/10.1177/08982643211019508>  
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Table 1 *Socio-demographic and clinical characteristics of patients with PD (N=37)*

	M / N	SD (%)
Age	71.5 (age range 52-84 yrs)	7.1
Years of education	11.6	4.4
Years since diagnosis	5.4	3.9
Gender		
<i>Male</i>	26	70.3%
<i>Female</i>	11	29.7%
Marital Status		
<i>Not Married</i>	6	16.2%
<i>Married</i>	31	83.8%
Children		
<i>Yes</i>	35	94.6%
<i>No</i>	2	5.4%
MMSE	28.8 (score range 24-30)	1.3

Notes. PD=Parkinson's Disease; MMSE=Mini Mental State Examination.

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Table 2 Correlations in patients with PD before APA

Variable	1	2	3	4	5	6	7	8	9	10	11	12
Covariable												
1. SPPB	-											
2. 6MWT	.748**	-										
3. UPDRS	-.628**	-.399*	-									
4. PSI total	-.107	-.145	.234	-								
5. PDQ39 total	-.280	-.302	.385*	.831**	-							
6. PWBS total	.233	.165	-.205	-.396*	-.375*	-						
7. SQ anxiety	-.211	-.071	.293	.643**	.641**	-.608**	-					
8. SQ depression	-.321	-.207	.397*	.531**	.535**	-.753**	.734**	-				
9. SQ somatization	-.195	-.210	.274	.699**	.594**	-.244	.652**	.507**	-			
10. SQ hostility-irritability	-.088	-.005	.325	.627**	.609**	-.336*	.678**	.583**	.525**	-		
11. LS Life satisfaction	.174	.104	-.191	-.318	-.347*	.472**	-.358*	-.244	-.217	-.154	-	
12. PTGI total	-.167	-.226	-.074	.066	.104	.275	-.048	-.212	.115	-.012	-.041	-

Notes. SPPB=Short Physical Performance Battery; 6MWT=Six minute Walking Test; UPDRS=Unified Parkinson's Disease Rating Scale; PSI=Psychosocial Index; PDQ39=Parkinson's Disease Questionnaire; PWBS=Psychological Well-being Scales; SQ= Symptom Questionnaire; LS=Life Satisfaction; PTGI=Post Traumatic Growth Inventory. \* $p < 0.05$ . \*\* $p < 0.01$

Table 3 Correlations in patients with PD after APA

Variable	1	2	3	4	5	6	7	8	9	10	11	12
Covariable												
1. SPPB	-											
2. 6MWT	.657**	-										
3. UPDRS	-.205	-.190	-									
4. PSI total	.259	-.258	.267	-								
5. PDQ39 total	-.052	-.291	.552**	.577**	-							
6. PWBS total	.064	.217	-.186	-.413*	-.462**	-						
7. SQ anxiety	.184	-.026	.529**	.708**	.742**	-.506**	-					
8. SQ depression	.160	-.006	.410*	.605**	.618**	-.739**	.854**	-				
9. SQ somatization	-.100	-.298	.272	.515**	.373*	-.121	.528**	.402*	-			
10. SQ host,-irritability	.120	-.025	.408*	.538**	.670**	-.366*	.729**	.669**	.264	-		
11. LS	.025	.188	-.157	-.356*	-.489**	.500**	-.493**	-.478**	-.276	-.328	-	
12. PTGI total	-.137	-.167	.006	-.155	.092	.319	-.086	-.290	-.041	-.022	.097	-

Notes. SPPB=Short Physical Performance Battery; 6MWT=Six minute Walking Test; UPDRS=Unified Parkinson's Disease Rating Scale; PSI=Psychosocial Index; PDQ39=Parkinson's Disease Questionnaire; PWBS=Psychological Well-being Scale; SQ= Symptom Questionnaire; LS=Life Satisfaction; PTGI=Post Traumatic Growth Inventory. \* $p < 0.05$ . \*\* $p < 0.01$

Table 4 Differences in patients with PD (N=37) between T1 (before APA) and T2 (after APA) in PSI, SQ, UPDRS, PDQ39, 6MWT, SPPB

	T1		T2		F	Cohen's <i>d</i>
	M	SD	M	SD		
PSI						
<i>Distress</i>	10.59	5.29	7.35	6.31	13.036**	0.56
<i>AIB</i>	0.67	1.00	0.62	0.86	0.075	0.05
<i>Stress</i>	1.54	1.52	1.40	1.26	0.417	0.10
<i>Well-being</i>	7.03	1.14	7.24	1.74	0.722	0.14
<i>Quality of life</i>	2.49	0.77	2.65	0.79	0.225	0.20
<i>PSI total</i>	12.81	6.00	9.38	6.89	14.331**	0.53
SQ						
<i>Anxiety</i>	6.25	4.78	4.42	4.67	11.731**	0.39
<i>Depression</i>	6.11	4.21	5.78	4.45	0.496	0.08
<i>Somatization</i>	11.05	4.55	8.94	4.56	13.385**	0.46
<i>Hostility-irritability</i>	4.14	3.93	3.33	4.40	3.938*	0.19
UPDRS						
<i>Non motor problems</i>	14.53	6.63	12.22	5.91	6.846*	0.37
<i>Motor problems daily life</i>	13.03	7.30	10.25	6.3	11.065**	0.41
<i>Motor exam</i>	22.69	14.94	15.44	10.86	11.286**	0.55
<i>Motor complications</i>	1.28	2.63	0.69	1.73	2.190	0.26
<i>UPDRS total</i>	51.53	25.08	38.31	17.57	15.040**	0.61
PDQ39						
<i>Mobility</i>	40.59	24.47	28.73	20.67	13.069**	0.52
<i>Daily activity</i>	36.81	23.43	22.38	22.94	22.262**	0.62
<i>Emotional Well-being</i>	28.81	21.86	20.40	21.64	7.765**	0.39
<i>Stigma</i>	20.24	20.38	12.08	13.00	5.797*	0.48
<i>Social support</i>	13.05	21.86	9.86	19.70	1.068	0.15
<i>Cognitions</i>	35.54	23.37	25.76	18.03	10.593**	0.47
<i>Communications</i>	21.62	23.08	18.03	20.84	1.653	0.16
<i>Bodily discomfort</i>	42.59	28.07	24.08	21.71	22.396**	0.74
<i>PDQ39 Total</i>	238.70	106.90	160.89	84.84	35.445**	0.81
6MWT	384.2	110.0	415.7	102.4	14.532**	0.30
SPPB	9.3	2.5	10.1	2.6	5.484*	0.29

Notes. PSI=Psychosocial Index; AIB=Abnormal Illness Behavior; SQ=Symptom Questionnaire; UPDRS=Unified Parkinson Disease Rating Scale; PDQ39= Parkinson's Disease Questionnaire; SPPB=Short Physical Performance Battery; 6MWT=Six minute Walking Test \* $p \leq 0.05$ . \*\* $p \leq 0.01$



Table 5 Differences in patients with PD (N=37) between T1 (before APA) and T2 (after APA) in PWBS, LS, PTG

	T1		T2		F	Cohen's <i>d</i>
	M	SD	M	SD		
PWBS						
<i>Autonomy</i>	31.89	5.36	33.13	5.28	2.327	0.23
<i>Environmental mastery</i>	30.94	5.88	31.78	6.51	1.276	0.13
<i>Personal growth</i>	30.67	6.79	30.62	5.58	0.005	0.01
<i>Positive relationships</i>	33.05	6.08	33.59	5.23	0.568	0.09
<i>Purpose of life</i>	28.11	5.28	27.94	5.83	0.024	0.03
<i>Self-acceptance</i>	30.86	6.54	31.29	6.38	0.276	0.07
<i>PWBS total</i>	185.54	27.09	188.38	25.01	0.947	0.11
LS	7.14	1.60	7.57	1.42	0.122	0.28
PTGI						
<i>Relationships</i>	20.46	7.94	21.29	8.46	0.454	0.10
<i>New possibilities</i>	11.51	7.51	12.40	6.40	0.760	0.13
<i>Personal forces</i>	9.86	5.51	10.84	4.84	1.931	0.19
<i>Spirituality</i>	4.27	3.61	4.51	3.16	0.267	0.07
<i>Life appreciation</i>	7.59	4.58	8.89	4.21	7.901**	0.29
<i>PTGI total</i>	53.70	26.33	57.94	23.84	1.714	0.17

Notes. PWBS=Psychological Well-Being Scales; LS=Life Satisfaction; PTGI=Posttraumatic Growth Inventory. \* $p \leq 0.05$ . \*\* $p \leq 0.01$

## BOX 1

*Exercises included in the protocol of Adapted Physical Activity*

1. Mobilization for neck and back pain
2. Mobilization for posture
3. Exercises of stretching
4. Exercises for manual dexterity
5. Exercises for coordination, resistance and breathing
6. Exercises for flexibility
7. Exercises facial gymnastics and gesture
8. Mobilization for the ankle
9. Exercise for balance and equilibrium
10. Relaxation
11. Aerobic exercises

## BOX 2 Description of questionnaires

Questionnaire	Abbreviation	Minimum value	Maximum value
Hoeh and Yahr	n/a	0 (absence of disability)	5 (most severe level of disability)
Mini Mental State Examination	MMSE	0 (most severe level of deterioration)	30 (absence of deterioration)
Unified Parkinson's Disease Rating Scale	UPDRS	0 (absence of signs and symptoms)	199 (most severe level of disability)
Parkinson's Disease Questionnaire 39	PDQ39	0 (absence of disability)	100 (most severe level of problems)
Six Minute Walking Test	6MWT	N/A	N/A
Short Physical Performance Battery	SPPB	0 (impaired lower extremity function)	12 (better lower extremity function)
Psychosocial Index	PSI	0 (lowest level of distress)	48 (higher level of distress)
Symptom Questionnaire Anxiety Scale	SQ	0 (lowest level of anxiety)	23 (all of the symptoms are present)
Symptom Questionnaire Depression Scale	SQ	0 (lowest level of depression)	23 (all of the symptoms are present)
Symptom Questionnaire Somatization Scale	SQ	0 (lowest level of somatization)	23 (all of the symptoms are present)
Symptom Questionnaire Hostility-Irritability Scale	SQ	0 (lowest level of hostility-irritability)	23 (all of the symptoms are present)
Parkinson's Disease Questionnaire 39	PDQ39	0 (absence of problems)	100 (maximum level of problems)

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Psychological Well-being Scale	PWBS	0 (lowest level of well-being)	252 (higher level of well-being)
Post-Traumatic Growth Inventory	PTGI	0 (lowest level of change)	105 (highest level of change)
Life Satisfaction	LS	0 (lowest level of life satisfaction)	10 (highest level of life satisfaction)

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BOX 3 Cronbach’s Alpha indicators in the questionnaires at T1 (before APA) and T2 (after APA)

Questionnaire	Pre-test	Post-test
PDQ39 total scale	0.913	0.913
PSI total score	0.729	0.775
SQ anxiety	0.658	0.650
SQ depression	0.549	0.555
SQ somatic symptoms	0.709	0.725

SQ anger-hostility	0.773	0.726
PWBS total scale	0.726	0.699
PTGI total scale	0.956	0.939

Notes. PDQ39 = Parkinson's Disease Questionnaire; PSI=Psychosocial Index; AIB=Abnormal Illness Behavior; SQ=Symptom Questionnaire; PWBS=Psychological Well-Being Scales; PTGI=Posttraumatic Growth Inventory.