Physiology of behavior within chronic behavior patterns and Parkinson's disease

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ABSTRACT

Parkinson people, who manage their personal behavior and physical patterns, can prevent and reduce the multiple clinical disabilities, by synchronizing and entraining healthier Balanced Rhythmic Movements, body Expressions thus synchronizing the Energy within their body systems. **Method:**

There are three basic Rhythms: "Mid Rhythm" mainstream, around 90bpm, comparable to Alpha Brain waves. Mid Rhythm is the dominant factor in the organization and facilitation of body Movements such as: Walking rhythm, Speaking rhythm and balanced performing rhythm. The Expressive movements are round and straight.

Fast Rhythm: around 120bpm, comparable to Beta Brain waves.

Fast Rhythm is running rhythm, Stimulated towards Survival.

The Expressive movements are straight and more aggressive.

Slow Rhythm: around 50/60 bpm, comparable to Theta Brain waves.

Slow Rhythm is Meditative and Emotional.

The Expressive movements are round and slow bringing about a state of calmness, towards sleep and up to a frozen state.

The Parkinson person's "Awareness" and behavior according to entrained Rhythmic Movements; Body Expressions will have a parallel affect upon ones Energy. As a result the person's performance will change for the better also affecting his Health. In Parkinson's disease Fast Rhythms become Arrhythmic.

Slow Rhythms become Brady-Kinetic and/or Freezing.

Results: Reports showed physical improvements by using the Gyro-Kinetics method and exercises, which is based on Movement, Rhythm, Expression, Energy...Music therapy, and Physiology of Behavior.

The results show better motor performances, mental and emotional levels.

The Gyro-Kinetics method has a positive gradual effect on Parkinson people, especially in stages 1 and 2, bringing about healthier future behavior patterns and reducing Parkinson Disease symptoms.

Conclusion: Parkinson's disease is progressive in Arrhythmic and Brady-kinetic behavior Healthy Movements are productive when Parkinson people's "Home-base" is within their Mid-Rhythm and their Body Movements, Rhythms, Expressions and Energy (MREE) is entrained.

Practicing and performing these behavior patterns have to be within their daily activities such as:

Speaking, Breathing, Expressing, Walking and performing thus building up neural plasticity within their movement

inventory and healthier physiology of behavior.

This can affect the peripheral nerves in many ways:

An accident injury, a fall or a sport may stretch, compress, crush or cut nerves.

Health problems include diabetes, syndrome with Guillain-Barre and carpal tunnel syndrome.

Autoimmune conditions include lupus, arthritis rheumatoid, and the condition of Sjogren.

Certain factors include artery narrowing, hormonal imbalances, and tumours.

METHODS

Adults (n = 4,184) replied in a national survey to questions about the prevalence of 27 chronic conditions. We used latent class analysis to classify trends of chronic conditions and to investigate latent class membership associations with socio demographic characteristics, behavioral risk factors and health.

RESULTS

Latent class analysis showed 4 morbidity profiles: healthy class (class 1), predominantly physical health (class 2), predominantly mental health (class 3) and physical and mental health (class 4). Class 4 respondents reported substantially poorer physical health and well-being, and more days of reduced activity In the other latent groups, than those. Class 4 respondents were also more likely to be obese and sedentary and existing smokers were more likely to be those with primarily mental health conditions.

CONCLUSIONS

Subgroups with distinct trends of chronic conditions may provide guidance for screening and tracking, the creation of recommendations and the provision of complex care services.

Introduction

The rising prevalence of chronic diseases is putting a burden on people and society. The risk of death, injury, adverse events, symptom burden, reduced functional status and poorer health-related quality of life (HRQOL) is increased by multiple chronic conditions (MCCs) (1,2). In addition, 66% of all health care spending is related to treatment for the 27% of Americans with MCCs.

National health authorities have called for approaches to optimize the coordination of treatment and reduce adverse health consequences by improving self-management for those with MCCs (4) and promoting studies to inform evidence-based practice and improvement of programs to enhance consequences (4,5). Such calls contribute to improving the mechanisms of mental health services (6) and enhance our understanding of wellbeing Discrepancies among people with

MCCs, including mental illnesses.

MCCs have historically been evaluated through small summary scores. However, since these scores do not represent the dynamics of chronic conditions, there are still significant gaps in understanding relationships between chronic conditions and their impact on treatment. Such awareness gaps hinder our capacity in the largely single-disease-focused model of care delivery to provide successful and reliable health care.

Chronic conditions can cumulatively and synergistically affect the health outcomes, the stress on clinicians and the cost of treatment (8–10). The addition of only 1 additional disease to the index disease renders HRQOL significantly worse for multiple diseases; such adverse effects partly compensate for practical deficiencies (12). Knowledge of trends of chronic conditions, their impact on HRQOL and their correlation with health behaviors may inform strategies for the prevention or prevention of MCCs, minimize their burden (13,14) and improve service delivery (15,16) for chronic conditions (13,17).

The goal of this study was to use latent class analysis (LCA) to analyze 1) co-occurrence patterns of 27 self-reported chronic health conditions in a broad, nationally representative adult sample, and 2) whether these patterns were correlated with sociodemographic influences, tobacco use, physical activity, body mass index (BMI), and differences in self-assessed health status and well-being.

Sample and setting

The data was collected from Porter Novella's 2010 HealthStyles summer wave database. The HealthStyles database is gathered each year from multiple mailed panel surveys that gather information about the health of adults in the US. The sampling design included region-by-region stratification, annual household income, population density, age, and size of home.Of 6,255 adults aged 18 years or older, 4,184 (66.9 percent) responded to those mailed surveys in August and September 2010. Respondents earned $5 and entered a lottery (1 first-place $1,000 prize and 20 second-place $50 prizes) as reward for their time. Data analysed omitted personal identifiers.

Survey data is weighted demographically to match projections for the US population. Of the respondents to the survey, 49% were male, 69% were white, 12% were black and 14% were Hispanic / Latino. They included adults 18 to 24 (13%), 25 to 34 (18%), 35 to 44 (18%), 45 to 54 (20%), 55 to 64 (15%), and 65 or older (17%). Twenty-five per cent had less than $25,000 in annual household income and 43 per cent had an annual household income of $60,000 or more. There were 55 percent women, and 32 percent were college graduates.

Measures

The respondents answered the following question about 34 medical conditions: "Have you had (or are you currently having) any of these health conditions over the past year?" We omitted seasonal allergies and influenza for our studies because it is not considered a chronic disease. We have left out male erectile dysfunction and prostate enlargement, as they only affect men. Due to low prevalence, we grouped the 4 types of cancer-prostate, breast, lung, and other cancers-into one common cancer classification, "Cancer other than skin cancer."

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