Brief Report
Volume 8:3, 2022

Journal of Abnormal and Behavioural Psychology

ISSN: 2472-0496 Open Access

Behavioural Changes in Parkinson's Disease

Martin Robert*

Department of Psychology, Centre for Studies of Psychological Application, California, USA

Description

In Parkinson's disease, cognitive and behavioural symptoms are prevalent, can arise even in the prodromal phases of the disease, worsen with disease progression, and outnumber motor symptoms as the principal variables influencing patient quality of life and caregiver burden. The symptoms could be produced by the disease pathology, or they could be side effects of treatment, or they could be caused by both etiological sources. Many persons with Parkinson's disease (PD) have excellent memory and cognition and are able to function regularly. While forgetfulness is common with ageing, attention, reasoning, and memory problems can worsen as Parkinson's disease progresses. Mild cognitive impairment occurs when modest changes occur without having a significant impact on daily living. Dementia is a term used to describe when alterations are severe enough to interfere with daily tasks. Hallucinations or delusions are common in persons with PD who have cognitive impairment. When people have hallucinations, they see or hear things that aren't really there when awake. Visual hallucinations are the most common type of hallucination in Parkinson's disease. They could involve "seeing" animals or people who aren't actually present. Most people know that hallucinations aren't genuine at first [1].

"Parkinson's has made my spouse/partner/parent/sibling different," any family member of a person with Parkinson's disease will frequently comment. They claim that their loved one's personality has changed significantly. It could be subtle or overt, but the person is no longer the same person he or she used to be. I recently gave a discussion to a group of family members about Parkinson's disease and personality change, and I was blown away by the amount of people who connected with this concept [2].

In Parkinson's disease (PD), behavioural and cognitive symptoms are common, and their combined prevalence rises as the disease progresses. Patients and their family find the symptoms disturbing, and they have a greater impact on patient quality of life and caregiver distress than the motor symptoms of Parkinsonism alone. Therapy choices for cognitive impairment and dementia, psychosis, apathy, and impulse control disorders are less effective in long-term symptom compensation than treatment options for tremor, rigidity, bradykinesia, and motor fluctuations and dyskinesias. Furthermore, the coexistence of motor, behavioural, and cognitive symptoms in individual patients limits the ordinarily broad variety of therapy choices for PD motor symptoms, leaving clinicians with little options [3].

Furthermore, the coexistence of motor, behavioural, and cognitive symptoms in individual patients limits the otherwise broad range of treatment options for PD motor symptoms, leaving the clinician with only a few options that strike a balance between good motor function and acceptable behavioural compensation. Neurologists, especially movement disorder specialists, psychologists, psychiatrists, functional neurosurgeons, nurse specialists, social workers, and occupational therapists, as well as thorough and extensive counselling for patients and their caregivers, are required [4,5].

Conclusion

Why is this relevant to families dealing with Parkinson's disease? Because the most common form of family strife is when loved ones fail to see that a person with brain abnormalities is not the same person as they were before. Human beings place a high value on personality consistency, yet loved ones who want the individual to remain the same as they always were are inflicting brain insult on the person. This person couldn't wish away tremors or rigidity any more than he or she could return to a previous personality state. It's pointless to spend energy on anything other than coming to terms with this "new" person. There is some exciting study going on in this area, and it is likely to continue.

Conflict of Interest

None.

References

1. Erten Uyumaz, Begum, Loe Feijs and Jun Hu. "A review of digital cognitive behavioral therapy for insomnia (CBT-I apps): Are they designed for engagement?." *Int J Environ Res Public Health* 18 (2021): 2929.
2. Pardos-Gascón, Estela M, Lucas Narambuena, César Leal-Costa and Carlos J. Van-der Hofstadt-Román. "Differential efficacy between cognitive-behavioral therapy and mindfulness-based therapies for chronic pain: Systematic review." *Int J Clin Health Psychol* 21 (2021): 100197.
3. Aminoff, Victoria, Malin Sellén, Elise Sörliden and Mikael Ludvigsson, et al. "Internet-based cognitive behavioral therapy for psychological distress associated with the COVID-19 pandemic: A pilot randomized controlled trial." *Front Psychol* 12 (2021): 1998.
4. Jager, Inge J., Nienke C.C. Vulink, Isidoor O. Bergfeld and Arnoud J.J.M. Van Loon, et al. "Cognitive behavioral therapy for misophonia: A randomized clinical trial." *Depression Anxiety* 38 (2021): 708-718.
5. Cheng, Philip, Melynda D. Casement, David A. Kalmbach and Andrea Cuamatzi Castelan, et al. "Digital cognitive behavioral therapy for insomnia promotes later health resilience during the coronavirus disease 19 (COVID-19) pandemic." *Sleep* 44 (2021): zsaa258.

How to cite this article: Robert, Martin. "Behavioural Changes in Parkinson's Disease." Abnorm Behav Psychol 8 (2022): 167.

***Address for Correspondence:** Martin Robert, Department of Psychology, Centre for Studies of Psychological Application, California, USA; E-mail: martinr@gmail.com*

Received: 06 May, 2022; Manuscript No. abp-22-67153; **Editor Assigned:** 09 May, 2022; PreQC No. P-67153; **Reviewed:** 18 May, 2022; QC No. Q-67153; **Revised:** 24 May, 2022, Manuscript No. R-67153; **Published:** 30 May, 2022, DOI: 10.37421/2472-0496.2022.8.167