Saint Luke Institute

LukeNotes

Vol. XIX, No. 3
Winter 2016

Depression or Dementia?

by Gary Thompson, Ph.D.

As individuals age, behaviors often change, but the cause may not be clear. For example, depression and dementia often present similar symptoms on the surface. Neuropsychological assessment, which involves the study of brain-behavior relationships, is an important tool for making a differential diagnosis of psychiatric and neurological disorders.

It utilizes tests that evaluate a broad range of cognitive skills. These include intellectual functioning, attention, memory, problem solving, motor skills, visuospatial abilities and information processing speed. By comparing an individual's test results to appropriate normative data, a profile can be generated that shows the presence versus absence of impairment, degree of impairment, pattern of impairment and areas of relative strength.

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Among the neuropsychological tests used at Saint Luke Institute are the Wechsler Intelligence and Memory Scales and measures of mental flexibility, problem solving and motor function from the Halstead-Reitan Neuropsychological Battery.

Dementia in Older Adults

Depression in non-demented older individuals can be associated with deficits in many neurocognitive abilities and frequently is an early indicator of the development of Alzheimer's disease (AD). Since these conditions have radically different courses and outcomes, distinguishing between them is of major importance. AD accounts for 65 percent of dementia, but there are as many as 60 different types, some reversible.

When used with information obtained from clinical interviews and psychological testing, neuropsychological assessment helps to determine if a person has depression, dementia or both. In general, older individuals who present with both depression and neurocognitive impairment are at greater risk for progressing to AD than those experiencing depression alone.

Establishing an early baseline of neurocognitive functioning is very important to help guide future treatment. Approximately 31 to 44 percent of individuals with any type of mild cognitive impairment, defined as cognitive impairment that is greater than expected for an individual's age and education level, but does not interfere notably with activities of daily life, go on to develop AD.

Depression or Dementia?

Temporal orientation (i.e., orientation to person, time, place and circumstance), memory impairment and visual-spatial abilities exhibit differently for someone with AD versus depression.

With major depression, temporal orientation is usually intact or only marginally off, and is likely to be well-retained when corrected. With early AD, gross impairment of temporal orientation is fairly common, and much less responsive to correction.

While both depression and the early stages of AD frequently present with memory impairment, qualitative and quantitative differences are recognizable. Immediate learning/retention of verbal information (e.g., a short story) may be similar for the two groups, and be impaired to some extent. However, marked differences usually are evident in the rate of forgetting over time. Providing retrieval cues (e.g., using a multiple-choice format when assessing delayed recall) can lead to significantly improved recall in the case of depression, but is of little help when the memory impairment is due to evolving AD.

The types of memory errors made by these two groups also differ. When asked to recognize whether individual words were among a list previously presented, older individuals with major depression are more likely to make false negative errors (i.e., failing to identify words that were a part of the list). Individuals in the early stages of AD are more likely to make more false positive errors (identifying non-target words as

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Case Study **Sister Moira**

by Kathleen Glufling, Psy.D.

Though retired from teaching, Sr. Moira continued to stop in at the parish school almost daily. At first this was fine, but then she began to become disruptive.

Always a bit strong-willed, Sr. Moira was getting into more conflicts with school staff and within her community. She also seemed to be having trouble remembering things. She would blame others for conflicts, and become angry quickly. It came to a head after she refused to leave her room or answer knocks at the door for three days. She was told she would need to move to the motherhouse, a decision she resisted.

There, her unusual behavior continued, and she began giving one-word answers. When asked to elaborate, her answers often became tangential and confused. Her superior thought she might have become depressed about retiring, but wasn't sure and called Saint Luke Institute.

> Her superior thought she might have become depressed about retiring.

Sr. Moira came to Saint Luke for an evaluation that included psychological, spiritual and psycho-social assessments, neuropsychological testing and consultations with Saint Luke's physician and nursing staff.

While meeting with the psychologist, she expressed feelings of depression, saying, "I was never like this. I enjoyed everything. I'm scared. I feel like I am going out of my mind trying to remember stuff. I find I don't have much to say anymore. I can't figure out what's wrong with me."

The psychologist not only talked with Sr. Moira, but administered a number of tests. Personality tests assessed Sr. Moira's personality traits and the strengths and weaknesses that accompany those traits, as well as the level of psychological distress she currently is experiencing. Projective testing assessed her habitual ways of handling thinking, emotional processes and the presence of specific psychological conflict areas.

Her responses were compared to objective norms to help validate interview impressions. Sr. Moira was engaged during this testing and showed moderately to significantly impaired cognition, moderately impaired attention and concentration, and fair to limited insight/judgment. The Rorschach test suggested she was experiencing situational stress that was overwhelming her capacity to cope.

This stress appeared to consist of both abstract and emotional demands. Tests also indicated she tended to display more dependency than most people, yet struggled to form close attachments to others and escaped into fantasy when confronted with difficult situations.

Sr. Moira next met with Dr. Thompson, Saint Luke's neuropsychologist. He administered more in-depth tests that assessed whether Sr. Moira's depressive symptoms might actually be indicators of dementia.

The neuropsychological evaluation revealed significant impairment in multiple neurocognitive abilities. Sr. Moira was able to give the correct year, but not the correct month, date or day of the week. Her memory of verbal and nonverbal material (i.e., stories, word lists and two-dimensional drawings) was moderately impaired when assessed immediately after exposure and was severely deficient after a delay of 30 minutes.

On problem-solving tests, her responses were concrete. She was not able to use feedback about answers to improve her performance. She had difficulty drawing a clock face with a specific time. The shape, symmetry and location of numbers were distorted. Yet, her expressive vocabulary, auditory attention span, simple motor skills and perceptual abilities were intact.

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Sister Moira, *continued*

At the feedback session with Sr. Moira and her superior, the evaluation team indicated the findings were consistent with a major neurocognitive disorder, most likely due to Alzheimer's disease, with depressive features, late onset.

The team recommended Sr. Moira meet with a psychiatrist to prescribe medications that would help address her Alzheimer's symptoms. Assessment interviews, especially the psycho-social portion of her assessment, indicated she had suffered childhood and adult abuse. Team members recommended that Sr. Moira begin outpatient treatment that is trauma-focused to deal with resulting PTSD and to consider adjunct therapies such as Eye Movement Desensitization and Reprocessing (EMDR) to deal with reactivity and emotional stimulation that is a part of PTSD.

The team also provided practical suggestions on how to engage with Sr. Moira more effectively in the future. This included asking concrete and concise questions that were not open-ended, breaking tasks down into basic steps, and ensuring the community is aware of issues related to cognition so she has appropriate structure and support. Her superior also was advised if she expresses sadness or confusion, it would be better not to engage in a discussion, as this would negatively reinforce Sr. Moira's presenting issues.

Six months later, the superior called to say things were going much better for Sr. Moira and the community after following the recommendations.

Kathleen Glufling, Psy.D., served on the Continuing Care clinical staff.

Depression or Dementia, *continued* *from page 1*

having been on the list).

Individuals with major depression typically do not have problems with visual recognition (i.e., recognizing common objects), but it is fairly common with early AD. Likewise, the ability to accurately copy simple and complex drawings typically remains intact with major depression, but is frequently compromised to a substantial degree with early AD.

Neuropsychological testing may also help determine whether a person's neurocognitive impairment may be reversible by assessing consistency vs. inconsistency within specific neurocognitive domains. An assessment of attention, memory, problem solving, etc. typically includes multiple tests, evaluating various aspects of that domain. Conclusions are based on whether tests within that domain show no evidence of impairment, inconsistent evidence of impairment, or impairment on all or nearly all of the tests in that domain.

Factors Differentiating Depression from Dementia

- Temporal orientation
- Memory impairment: immediate learning/retention of verbal information and types of memory errors
- Visual recognition
- Consistency within individual tests

The consistency or lack thereof displayed within each individual test is also important. With major depression, the most frequently encountered pattern is inconsistent performance within individual tests and within specific neurocognitive domains. This inconsistency is the by-product of fluctuations in cognitive efficiency caused by a variety of factors, such as mood, affect, motivation, effort, etc. In the early stages of AD, there is less fluctuation within tests, lower overall performance, and selective domains showing prominent impairment on all or most tests.

Since AD is a progressive condition and major depression is not, longitudinal monitoring of neurocognitive status is particularly important in differentiating between them. With major depression, neurocognitive deficits are likely to fluctuate with the changing nature and degree of mood disturbance. When a major depressive episode resolves, prominent improvement in neurocognitive status typically follows. As AD progresses, gradual deterioration occurs over time, initially in the first-affected domains, and eventually in a much broader range of neurocognitive ability areas.

Gary Thompson, Ph.D., is a psychologist and coordinator of neuropsychological services at Saint Luke Institute.

Annual Benefit Honors Cardinal Wuerl; Raises Scholarship Funds

His Eminence Donald Cardinal Wuerl, Archbishop of Washington, received the 2016 Saint Luke Award during Saint Luke Institute's annual benefit, at the Apostolic Nunciature in Washington, D.C. on Oct. 17.

The evening raised $500,000 to provide treatment for priests and religious in financial need and was chaired by Larry and Maria Elena Fisher.

The Saint Luke Award is given annually to an individual whose professional life or charitable works embody the mission of Saint Luke Institute: the rebuilding of the spiritual, physical, emotional and intellectual life of clergy and men and women religious.

In his remarks, Reverend David Songy, O.F.M.Cap., S.T.D., Psy.D., president of Saint Luke Institute, noted that Cardinal Wuerl has given tremendous "service to all levels, from seminarian to bishop to priest," adding, "Priests, seminarians, bishops can learn from you what it means to truly give your heart" to others.

Cardinal Wuerl served as staff to the Congregation for Clergy; vice-rector and rector of St. Paul Seminary in Pittsburgh, PA; and founder of the Saint John Paul II Seminary in Washington, DC. A noted author, Cardinal Wuerl also serves on the Congregation for Bishops and has numerous other responsibilities with the Vatican and national and international organizations.

Cardinal Wuerl said, "Saint Luke Institute is the mercy of God made real, made present to people who at that particular moment in their lives need to know this is not an abstraction; it's something that touches you. It touches your heart, touches your soul, touches your mind."

New Webinars in 2017

New webinars are being added to the schedule at SLIconnect.org. Topics include Transformational Leadership: Skills for Pastoral Ministry; Counseling or Spiritual Direction: Making the Right Call; Healthy Anger: Skills for Communication & Confrontation; and Skills for Mental Health First Responders.
Learn more and register at sliconnect.org or contact Beth Davis at sliconnect@sli.org or 502.632.2471.

Terry Lindsay, chairman, Saint Luke Institute Board of Directors; Most Reverend Christophe Pierre, Papal Nuncio; Larry and Maria Elena Fisher, Benefit Co-Chairs; Cardinal Donald Wuerl; and Reverend David Songy, O.F.M.Cap., at the Saint Luke Institute Benefit in October 2016.

Honor a Priest or Religious

This Christmas, honor a priest or religious who is or was important in your life with a gift to Saint Luke Institute. Your support will help us provide quality, specialized care to another priest or religious in need.

Visit sli.org/donate or call 301-422-5405. On behalf of those we serve, thank you.

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