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COVENANT

DEPRESSION: Mood, Feeling or Illness?

by: *Harold Grossman, MD, FRCP(C)*

Far and away the most common condition presenting to mental health professionals is the cluster of symptoms called Depression. In mental health terms, depression is not a mood (in the moment) or a feeling (in the moment plus thoughts & memories) but an illness. It is seen as the end result of the accumulation of many factors, some physical, some experiential, some genetic. The diagnostic manual, DSM IV (Text Revised), categorizes several types of depression and tries to be more specific. It defines episodes of Major Depression, single or recurrent, and Dysthymic Disorder – which is depression at a low level for years or, depression that is secondary to another disorder, for example, a stroke.

The illness is called "Major" to distinguish it from a mood or feeling. It affects at least 10% of us at any given time and as many as 25% of us over the long term.

"...genetics…trauma, chaos, losses and physical illness all contribute to determine each person's threshold."

Depression is considered a threshold phenomenon. All humans have their own particular threshold, beyond which we will all develop the condition. Genetics, background experiences of trauma, chaos, losses and physical illness all contribute to determine each person's threshold. Once that threshold is breached, the individual develops significant symptoms. The criteria include depressed mood or loss of interest over at least a two week period *plus* five or more of the following symptoms:

1) Mood changes which may be loss of joy, flatness, anxiety or anger, most of the day, nearly every day, either subjective or observed by others.
2) Markedly diminished interest and motivation.
3) Weight loss or overeating.
4) Insomnia or hypersomnia.
5) Agitation or slowness.
6) Loss of energy.
7) Feelings of worthlessness or too much guilt.
8) Changes in thinking, lack of concentration, memory loss, and rumination.
9) Thoughts of death, as plan or an attempt.

The medication treatments available today for treatment of depression are all very effective. There is no medication that is considered better than the others. Instead, doctors try to match the medication to the degree of symptoms, such as anxiety or flatness, and to which side effects might be most tolerable to the individual.

However, medications, as powerful as they may be, are in no way considered to take a person "all the way down the block". Medications can be seen as providing a platform for a person to do the psychological work that is necessary. Psychological counselling may include working on the pathways that led toward depression in the first place: e.g. grieving for losses, re-evaluating and changing long outmoded or distorted beliefs about self and the world, or dealing with loneliness.

How much is Biological?

The Mind cannot exist with out the physiological functioning of the brain. There are brain changes when a person is suffering from depression. They can be seen on Functioning MRI scans (fMRI) or on SPECT Scans (Single Photon Emission Computed Tomography), a type of nuclear imaging test that shows how blood flows to tissues and organs. A scan is taken while a person is viewing pictures or asked to envision scenes. Watching the scans, the brain that is suffering psychiatric illnesses will light up in different amounts and in different areas than brains that are not suffering. These changes can be tracked and can actually be seen to resolve when the condition resolves symptomatically. Even after a course of successful psychotherapy and regular exercise regimes, one can see resolution in the changes in the brain scans.

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Understanding and Assessing Mild Cognitive Impairment

by Benjamin Williams, PhD

We are increasingly aware that a major issue facing the church today is the fact that as a population, religious and clergy are aging. Many changes accompany the aging process. In addition to inescapable changes occurring in our physical bodies, we might also undergo change in other areas, including our attitudes and values, our relationships, and our role in society. Change can be stressful and scary. Perhaps the most anxiety-provoking change that occurs is in our cognitive functioning - our ability to reason, to process information quickly, to pay attention, to understand and produce language, to process visuospatial information, and to remember. There are changes in cognition that are "normal" aspects of the aging process. However, as we age we are at a higher risk of experiencing cognitive changes associated with abnormal processes, such as diseases that cause dementia.

Dementia is a clinical condition that can be caused by a variety of diseases or conditions of the brain that affect cognitive functioning in a drastic manner.

When an individual is diagnosed with dementia, their cognitive impairment is so severe that they can no longer look after themselves or maintain day-to-day functioning.

Pathological changes in cognition sometimes come on suddenly and unexpectedly, as can occur with a stroke or following traumatic brain injury. Often, however, the changes are more subtle, occurring bit by bit over time, or perhaps in a step-wise manner. Recent developments in research and clinical practice have involved attempts to identify individuals who may be undergoing abnormal cognitive decline, but decline that is not drastic enough to be considered dementia. **Mild Cognitive Impairment (MCI)** is an example of such a category that is diagnosed when an individual meets the following conditions: there is a concern expressed by the individual (or by someone who knows the individual well) about cognitive functioning; there is objective evidence of abnormal cognitive functioning (while general cognitive functioning is nonetheless preserved); and the person is generally able to look after themselves and function in their day-to-day life.

The concept of mild cognitive impairment was developed in order to try to identify individuals who might be at risk of developing full-blown dementia in the future. For example, one study followed a group of individuals with mild cognitive impairment in the domain of memory and a normal control group over a period of 7 years. They found that of those within the group with MCI at the beginning of the study, approximately 10% per year ended up with Alzheimer's dementia, (i.e. approximately 70% over the course of the study). In contrast, over the entire study period, only 5% of those in the normal control group at the beginning of the study were subsequently diagnosed with Alzheimer's dementia.

Progressive deterioration is not assumed with MCI. It is important to recognize that while a diagnosis of MCI may mean that there is an increased risk of developing dementia in the future, this is not necessarily the case. In fact, it is possible to be diagnosed with MCI at one time, and to be assessed as normal one to two years down the road. In addition, like dementia, MCI can be caused by a number of different diseases. It could result from the build-up of the pathology that causes Alzheimer's dementia. Alternatively, it might be caused by an accumulation of brain damage caused by mini-strokes, or some other factor. Therefore, depending on what is causing the cognitive problems, a different course over time might be expected.

Changes in Memory and Cognition: Indicators of Potential Concern

- Leadership or those in regular contact are concerned about cognitive functioning.
- The cognitive problems represent a change or are out of keeping with the individual's previous functioning.
- The problems are out of keeping with others of a similar age.
- The problems are getting progressively worse.
- The problems are frequent.
- Forgets significant events (e.g. attending a funeral of a significant relation).
- Problems with familiar or routine activities or situations (e.g. forgetting name of family member, gets lost navigating a familiar environment).
- Severity of the consequences (e.g. forgetting important appointments, forgetting medications several times within a 24 hour period or taking more than the prescribed dose).
- Problems are noted by multiple people.
- The cognitive problems are beginning to interfere with ability to perform activities related to day-to-day functioning that the individual does or previously did (work-related activities, shopping, banking, driving).

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From the CEO's Desk:

It Takes a Village . . .

by: Miriam D. Ukeritis, CSJ, PhD

As I write this article, the Southdown staff is engaged in the experience of a site visit related to the accreditation of the Institute by Accreditation Canada (formerly the Canadian Council on Health Services Accreditation). You who have been engaged in healthcare or education accreditation exercises know well the work required to prepare for such a visit. The months of surveys, review of existing documentation and generating additional information from data collected sometimes seem to eclipse the mission of the organization itself.

Yet, the process of engaging staff in an honest examination of how an organization seeks to accomplish its mission and enhance its services is well worth the effort. While we at Southdown have yet to receive the final "grade" that results from this review, we know, from both past history and our current experience, that the mission is alive and well and continues to bear the mark of excellent and caring service that marks our commitment to this healing ministry. We have also learned much about the goodness of our staff and the wonderful contributions of our community partners from this exercise.

"There is a freedom in recognizing that 'it takes a village' to complete the service of healing..."

In reflecting on the experience, identifying all who collaborate and cooperate in achieving our mission was striking. That we rely on our staff clinicians – psychologists, psychiatrists, social workers, spiritual directors, addictions counselors, fitness staff, nurses – was obvious, as was the generous service provided by administration, kitchen staff, housekeeping, maintenance, business office and secretarial services. The accreditation process asked us to invite for conversation some Board members as well as a group of the additional health care practitioners in our community who work closely with us – the physicians, physiotherapists, dentists, chiropodists, hearing and vision specialists and pharmacists. As we considered additional partners, we identified those who provide kitchen and housekeeping supplies, who provide information technology/computer as well as auditing services and the many who are part of our referral network – either to refer to Southdown for services, or to whom we can refer as individuals conclude their residence here and look to outpatient and continuing care needs. The list was awesome, and the gratitude great.

In considering this host of connections, I recalled that several years ago, while she was First Lady, Hilary Rodham Clinton authored *"It Takes a Village: And Other Lessons Children Teach Us."* Sources tell us that the title actually comes from one of many African proverbs that say, approximately, "It takes a village to raise a child." There certainly seemed to be a profound truth in this as I thought of Southdown's ministry and all those whom we identified as community partners. While we are not raising children, we are entrusted with the care of women and men who come to us for healing. We are even more aware, having engaged in the reflection asked of us as we prepared for our site visit, of the many in "the village" committed to the fulfillment of our mission and of additional "villagers" in our board members whose mission focus and expertise were quickly noted by our surveyors as well.

As I have named some of what our community partners add to the care of our residents, the dedication of our staff is not to be overlooked. In preparing for this accreditation review, they completed surveys related to Patient Safety Culture and Worklife Pulse. Overall, their scores reflected significant concern for the well-being of residents and high satisfaction with their work environment. In their responses, for example, they affirmed that "patient safety is a high priority" (95%). Clarity about "what is expected of me to do my job" is high (98%), and the environment is such that 95% of our staff noted that they "can do [their] best quality work."

Here at Southdown, we often talk of significance of the interdisciplinary treatment team and the many clinical staff who are involved in the treatment of our clients. Be it an assessee who is with us for a week, a resident who spends an extended period of time here, or a former resident returning for a Connections workshop, the work done here is not done in isolation. We rely on the interactions of clinicians, the attention of our support staff, and the availability of our community partners to complete the circle of care and to work together for the healing of those whom we serve.

There is a freedom in recognizing that "it takes a village" to complete the service of healing that Southdown offers. It means that no one individual staff member is ever alone in his or her care of a resident. It also means that those who come to Southdown for healing have access to the incredible expertise of the "village" of our staff and our community partners. It provides for us all yet another experience of communion – a wonderful joining of individuals in service of the healing mission of Jesus.

P.S. As this was going to press, we received the good news from Accreditation Canada that our accreditation status has been extended. More about this in the next *Covenant.*

Depression... *Continued from Pg 1*

Major Depression or Bipolar Depression?

Mood instability is at the core of the spectrum of conditions called bipolar disorder. It is a different condition than "unipolar" depression and it has a very strong genetic and constitutional component. Unlike depression, just some of us have this bipolar potential, about 3% to 5% of the general population. The problem is, that as many as 20 to 30% of those people presenting with depression have, in fact, a bipolar disorder. What those patients often do not report to their physician are the episodes of high energy with racing thoughts and activities and a loss of inhibition that can point to a bipolar condition.

A diagnosis of bipolar disorder also needs to be carefully considered in cases where the individual is either resistant to the ordinary antidepressant medications or, when the medications cause greater agitation and instability. Although depression has a mortality rate of about 10% (mostly through suicide), bipolar conditions can be more dangerous, particularly when there is a mixture of agitated raciness and depressive thinking at the same time. Many who experience episodes of bitter irritability or uncontrolled rage may have a bipolar disorder and it can create great misery both for the person and for those around them.

The medications used to treat bipolar disorder are different from those used for depression. Prescribing antidepressants to those suffering with a bipolar disorder may serve to "switch" them into a manic state or cause more instability. Many people with bipolar illness need to be on a combination of two, or even three medications in order to gain control of the symptoms and then, they are required to maintain appropriate dosages for a lifetime. Unlike depression, it is not uncommon to have to "fine tune" or alter the medications over time. Finally, as with all psychiatric conditions involving mood and anxiety, *sleep* is of key importance and is often addressed at the outset of treatment.

For How Long?

There are a large number of people (as high as 30%) that can have incomplete remission of the illness even with treatment. The greatest predictor of relapse is lingering symptoms after incomplete treatment. Even more concerning is the tendency for relapse, even after one episode, if treatment is discontinued - 50 % in some studies, 70% in others.

For most people with mood disorders, maintenance treatment is the rule. Occasionally, a person with a single episode of depression precipitated by an event that is temporary and without a family history can decide to try going off medications after 6 months or a year, when their life is back in order. Because of the great advancements in treatment in just the last few years, people with bipolar conditions can expect to return to their normal lives. However, they will need to carefully monitor themselves and continue to take medications for life.

The influences of stigma and difficulties with acceptance of these disorders as chronic and recurring can make it difficult to stay motivated to continue on medications, particularly after a person has seemingly recovered. However, like all chronic conditions such as hypertension, heart disease, diabetes, etc. we are required to be aware every day, and to follow the necessary steps toward taking good healthy care of ourselves.

Understanding and Assessing Mild Cognitive Impairment ... *Continued from Pg 2*

When abnormal cognitive changes are suspected, seeking help, particularly through a thorough cognitive assessment, can be beneficial for a number of reasons. First and foremost, an assessment can clarify whether or not the cognitive changes that are of concern are normal changes (e.g. like the ones that accompany aging) or, are abnormal changes, such as those characterized by MCI. If MCI is diagnosed, clarification can often be made regarding underlying causes. Is this MCI with a high risk of future Alzheimer's disease, or are these cognitive changes likely suggestive of some other kind of problem? Such clarification can assist in guiding next steps, not only with respect to possible treatments, but also with important life and ministry decisions.

"Just because an individual may have experienced some decline doesn't mean that they cannot contribute..."

A comprehensive cognitive assessment can also clarify cognitive strengths and weaknesses. Just because an individual may have experienced some decline doesn't mean that they cannot contribute in ministry or community in a meaningful manner. However, it may be important to adjust ministry and life demands in accordance with one's cognitive capabilities. Knowledge regarding one's cognitive capacity may assist in optimizing functioning by identifying areas where assistance or compensation for weaknesses is needed.

It is understandable that fear, avoidance, and denial may accompany concerns regarding cognitive changes associated with aging. Recent advances that allow clinicians to identify cognitive deterioration when it is mild provide the opportunity to respond in a manner that can facilitate aging with grace.

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