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Mild neurocognitive disorders: Improving detection, diagnosis, and early interventions

This talk is designed to help clinicians understand the evolution, detection, and clinical significance of Mild Cognitive Disorder (MCI), which in DSM-5 is now termed Mild Neurocognitive Disorder (MiND). Beginning in the 1980's the idea of a transitional stage between normal cognitive functioning in older adults and dementia began to be explored. Before that, mild cognitive symptoms were often attributed to depression or anxiety. The term MCI was first used by Reisberg and colleagues in 1988 to refer to Stage 3 on the Global Deterioration Scale. In addition, the Clinical Dementia Rating scale sought to identify early signs of dementia with an eye towards diagnosing dementia at the earliest point possible so has to maximize the efficacy of interventions. By 1999, the idea that MCI could be a prodrome or risk factor for further cognitive decline into dementia began to take hold. Initially, just as with the earlier DSM criteria for a diagnosis of dementia, early conceptions of MCI focused on the presence of memory impairments. Since these early conceptualizations, MCI has come to be associated with an acquired decline in one or more of six cognitive domains: attention, memory, language, visuospatial, executive function, or social cognition, in the context of independence in everyday day activities (i.e., complex instrumental activities of daily living). Compensatory behaviors are required to deal with this cognitive decline that is significant but not disabling. Many elders note mild to moderate changes in cognitive functions and express concern about progression. In fact, memory complaints are ubiquitous amongst older adults. Concerns about memory or other cognitive faculties may lead an older adult to seek evaluation at this stage. Complicating accurate diagnosis is the fact cognitive symptoms often accompany psychiatric issues such as depression in older adults. Thus, an accurate diagnosis of MCI is critical to both rule out treatable causes of cognitive impairment and because MCI can represent the prodromal stage of major neurocognitive disorder, whether associated with Alzheimer's disease or another etiology. MCI is the single best predictor of future dementia. Yet at the current time, even with the diagnostic criteria described in the DSM-5, the construct of MCI lacks clear operational clarity. While the addition of biomarkers to the diagnostic process is promising, they still require more investigation. At the current time the use of neuropsychological testing in the context of a multidisciplinary approach remains the most efficacious method to yield both an accurate diagnosis and a practical treatment plan.

Biography

Donald A. Davidoff is the Chief of the Department of Neuropsychology and Director of the Neuropsychology Fellowship Program at the McLean Hospital, Harvard Medical School. He is also an assistant professor in the Department of Psychiatry, Harvard Medical School and Psychologist, McLean Hospital. He founded the Geriatric Neuropsychiatry Unit in 1993 and was its Psychologist-in-Charge for 15 years, retiring from that position to focus on research and the Department of Neuropsychology. He has published numerous papers and book chapters on the diagnosis and management of patients with dementia, treatment resistant affective disorders, optimal aging, the neurocognitive basis of Hoarding Disorder, nonverbal learning disabilities and affective and motivational aspects of memory functioning. He is a sought after speaker for interdisciplinary conferences and has taught courses at the American Psychiatric Association Meetings consistently for the last 15 years. He is an award-winning teacher and has mentored a large number of multi-disciplined professionals including pre- and post-doctoral psychologists and psychiatry residents. He is a member of the core faculty of the Harvard-South Shore Residency Training program and the McLean-MGH Harvard Residency Training Program.

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