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Patient Views of Mild Cognitive Impairment

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Virginia Clinics:

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Research Program Goals

- Family level of analysis
- Family focus within memory loss research
- Identify beliefs about causes of MCI
- Uncover range of responses, strategies, & views about future
- Assess availability of information and support
- Assess stability/change over time

Conceptual Frameworks

- Life Course Perspective
- Pearlin's Caregiving Stress Process Model
- Boss's Ambiguous Loss Theory

Methods

- Mixed Methods
- Family-Level Data – 99 families at T1
  - Elder with MCI, age 60+
  - Primary care partner
  - Secondary support person
- Two Contacts (3rd in 2008)
  - T1 (face-to-face / phone)
  - T2 (~1-year; face-to-face / phone)

Focus on Elders' Perceptions

- Awareness of MCI
- Predictors of Awareness
- Views of effects of MCI on everyday life

Elder Characteristics (*N* = 99)

	M, R or %
Age	75.6, 60-91
Female	25.3
White	93.9
Education (>H.S.)	59.6
Married/Partnered	76.8
Years	42, < 1 – 67
Co-reside	75.8
Religion (somewhat - very important)	93.8

	%
Health (good – excellent)	63.3
Health (interferes a little - not at all)	67.0
Ever employed	94.8
Employed now	5.1
Monthly income	
≤ $1,999	31.9
$2,000-3,999	34.0
≥ $4,000	34.0

Subsample and Measures

- *n* = 56 with 2 data points
- Demographic characteristics, self-reported health, functional memory, awareness of deficits
- Interview data

	M	*SD*	*R*	*t*	*df*	*p*
MMSE T1	26.89	2.68	16-30	2.82	55	.007
MMSE T2	26.04	3.39	13-30			

Dependent Variable

Deficit Awareness Scale, 16 items, T 2

1 = ability is very poor

5 = ability is very good

(e.g., remember names, past events, phone numbers; follow conversations, do math, drive, ignore distractions)

M	scale: 56.34, items: 3.52
SD	7.23
α	.81
R	possible: 16-80, sample: 40-77

Regression Results

Significant Predictors	β	*p*
MMSE T1	-.567	.003
Education	.321	.021
Self-rated health	.412	.002
Monthly income	-.281	.037
Adj R^2	.381	
F	3.484	.001

MMSE & Deficit Awareness

Elder #	MMSE T1	MMSE T2	DAS T2
189	16	13	66
190	20	20	65
184	24	22	62
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114	30	29	53
128	30	29	49
157	30	30	58

Case Studies: ↓MMSE ↑DAS

- 189: F, 79 – memory problems began with heart surgery 9 yrs ago; admits being very dependent on husband but believes she functions better than he thinks she does
- 190: F, 75 – memory problems began in 1999 but are related to life-long thyroid problem and learning difficulties; surprised by MCI Dx and has withdrawn from social activities
- 184: F, 74 – memory problems began 6 mo ago and are worse when husband makes her nervous; Dx shows memory is worse than she thought

Case Studies: ↑MMSE ↓DAS

- 114: M, 76 – understands memory problems and is making needed adjustments; physical health is more of a problem; better off than his brother who has AD
- 128: F, 77 – memory problems began w/ seizures 10 yrs ago; resents that she can no longer drive but continues to write a news column and go to art shows
- 157: M, 64 – aware of memory problems but has more difficulty related to MS, hearing & vision loss; readily accepts help and remains active in clubs, performs ADLs

Conclusions

- Views of memory status and functioning varied from awareness of and insight into implications of memory loss to denial of impairment.
- Those accepting the diagnosis expressed relief that they did not have AD and participated with family members in making adaptive arrangements currently and planning for the future.
- Those reluctant to acknowledge cognitive changes tended to attribute their condition to a physical illness or previous injury and often became irritated when reminded of their forgetfulness or confusion.

Conclusions

- All elders functioned fairly well in familiar situations but exhibited greater impairment in novel circumstances, leading many to withdraw from social situations & reduce their range of interests and activities.

- Such responses may be maladaptive because premature social isolation can have negative consequences for physical and psychological well being.