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A New Approach to Neurocognitive Disorders Using Mana Psychology™: A Study of

Navigation

Keti Kamalani

Mana Gardening Institute, Kaneohe Hawaii



Late Life and Neurocognitive Disorders: A Study of Navigation

This paper explores personal and therapeutic modalities for navigating late life neurocognitive disorders a topic that was presented in Chapter 14 of our textbook *Abnormal Psychology* (Kring, Johnson, Davison, & Neale, 2010). I have selected this topic due to the events that have occurred in my personal life over the past 6 years. I am a 57 year old American woman of German heritage, married to Lew, a 62 year old Native Hawaiian man. This is the third marriage for us both so there is a devotion to making our marriage work that has kept us focused on building a new life when faced with the problems of blending families. We were both custodial single parents to our older children from previous marriages, which created a sense of historical confidence in who we are as individuals. Our personal relationship was built on passion and laughter, thus making us good friends. However, life as we knew it dramatically and unexpectedly changed ten years into our marriage when my husband, a non-smoking, non-drinking, slim man who exercised daily, suffered a massive bi-thalamic stroke. The Centers for disease control lists strokes as the cause of death for 130,000 Americans per year and stroke related care costs are an estimated \$34 billion dollars annually (National Center for Chronic Disease Prevention and Health Promotion, 2015).

We were then faced with navigating Lew's health concerns and creating a new picture for our lives in the midst of a late in life neurocognitive disorder. One might be tempted to say this was not late in life, as he was only 58 at the time, but the problems he faced placed us into an arena of elderly patients with similar problems. Suddenly we identified with the statement that "late life would qualify as the Olympics of coping" (Fisher, 2011, p. 145). In the early days we simply lived day by day but once we were certain that he was going to live, we were faced with

trying to verify exactly what were really facing. Thus evaluating the DSM-5 criteria for mild and major neurocognitive disorders became key to our next move.

The DSM-5 criteria for mild neurocognitive disorders identifies the following key criteria:

1. Modest decline from previous levels in one or more domains based on both of the following:
 - a. Concerns of the patient, a close other, or a clinician.
 - b. Modest neurocognitive decline (i.e., between the 3rd and 16th percentile) on formal testing or equivalent clinical evaluation.
2. The cognitive deficits do not interfere with independence in everyday activities.
3. The cognitive deficits do not occur exclusively in the context of delirium (Kring, 2011, p. 438).

At week three post stroke, all of the above diagnostic criteria were present. The decline seemed modest, but we were all concerned. Testing verified only modest changes and he seemed independent. Although for the first few days post stroke he was not able to walk, talk, remember family, or see well, by day three all of these issues appeared to be gone and he was clear minded.

Two months after the stroke, his memory and energy levels were unreliable. With the memory issues his frustration levels increased and he often swung into a state of rage and anger that was not validated by the situation and seemed to occur without provocation. Emotional, behavioral, and cognitive changes psychological changes can be common after stroke (Kneebone & Lincoln, 2012). Our doctors were worried that his condition might be far more serious than what we had first assessed. This also placed him at a greater risk to develop a generalized anxiety

and, or a post traumatic stress disorder (DeWit et al., 2007). The DSM-5 criteria for major neurocognitive disorders identifies the following key criteria:

1. Significant decline from previous levels in one or more domains based on both of the following:
 - c. Concerns of the patient, a close other, or a clinician.
 - d. Substantial neurocognitive impairment (i.e., below the 3rd on formal testing) or equivalent clinical evaluation.
2. The cognitive deficits interfere with independence in everyday activities.
3. The cognitive deficits do not occur exclusively in the context of delirium and are not due to another psychological disorder (Kring, 2011, p. 438)

Lew displayed unexpected momentary displays of the major criteria. We could not find a pattern to his frustration or bases for his sudden anger and we began to wonder if he had another psychological disorder that was occurring. Just as we started to wonder what we had missed he began to suffer from moments of delirium. In Latin this simply means 'out of track' The DSM-5 criteria for delirium is:

1. Disturbance in attention and awareness.
2. A change in cognition, such as disturbance in orientation, language, memory, perception or visuospatial ability, not better accounted for by a dementia.
3. Rapid onset (usually within hours or days) and fluctuation during the course of a day.
4. Symptoms are caused by a medical condition, substance intoxication or withdrawal, or toxin (Kring, 2011, p. 448).

Lew was clearly having moments of delirium and we also began to see deficits in his memory of recent events, which is classically associated with dementia (Kring, 2011, p. 449). He was also experiencing dementia or had we missed some other medical diagnosis beyond the stroke itself. Tests were run and he was assessed for dementia and since he had recently suffered a massive stroke, which was clearly visible on his MRI, we began with a review of the DSM-V criteria for the diagnosis of vascular dementia

The development of multiple cognitive deficits manifested by both: memory impairment (impaired ability to learn new information or to recall previously learned information)

One or more of the following cognitive disturbances:

- (a) aphasia (language disturbance)
 - (b) apraxia (impaired ability to carry out motor activities despite intact motor function)
 - (c) agnosia (failure to recognize or identify objects despite intact sensory function)
 - (d) disturbance in executive functioning (i.e., planning, organizing, sequencing, abstracting)
3. The cognitive deficits in criteria A1 and A2 each cause significant impairment in social or occupational functioning and represent a significant decline from a previous level of functioning.
 4. Focal neurological signs and symptoms (e.g., exaggeration of deep tendon reflexes, extensor plantar response, pseudobulbar palsy, gait abnormalities, weakness of an extremity) or laboratory evidence indicative of cerebrovascular disease (e.g., multiple infarctions involving cortex and underlying white matter) that are judged to be etiologically related to the disturbance.
 5. The deficits do not occur exclusively during the course of a delirium (APA, 2013).

Testing ruled out any other medical problem but with his memory impairment, agnosia, disturbance in executive functioning, and the fact that these moments occurred on their own, we added dementia to his diagnosis. This once amazing man now had to overcome a mild to major

neurocognitive disorder with delirium and dementia. Although he did not display the depression and anxiety seen in 30% of stroke survivors, he did show apathy which is seen in 27% (Hackett, Yapa, Parag, & Anderson, 2005).

The good news was that as this was based on a recent stroke, so he had every chance to come out of this and re-build his losses to become the person he had been before with careful attention for his real risk to develop a post-traumatic stress disorder (Bruggimann et al., 2006). A great deal of work lay ahead that I was willing to face without hesitation. In addition to all this, he also had begun to display rage and anger problems and there was beginning to be a question of a safety risk for the children and anyone that happened to be with him at moments when he was no longer able to control himself. We needed a new approach to his neurocognitive disorder.

He and I were given many prescription options, all of which would make him behave nicely all the time, but using these drugs would mean a lifetime of masking his behavior to make it livable. Some of the standard medication treatments include: SSRIs (Citalopram, Fluoxetine, and Paroxetine), Nortriptyline, Amitriptyline, Deanxit, Aniracetam, Reboxetine, and Trazodone. Unfortunately, the problem with treating depression with medication after a stroke is the high rate of adverse events (Hackett, Anderson, House, & Xia, 2009). Several studies also indicate that the use of anti-depressants should be used reservedly for those with severe disorders (Kirsch et al., 2008). This also raised the question as to how we rate anger. Is anger a severe problem, how do we assess anger as a safety risk or a threat? Still we felt that medication would only cover over a problem, not solve one.

The choices seemed slim but my desire was to win back the real person underneath all this and at this time, I was willing to risk living with a man who 'lost his cool' often. When my husband was the older version of himself he was adamant that he did not want to rely on any

prescriptions. However, the no meds choice now created a legal question for our doctors. Because his anger levels seemed to be escalating, we all had reservations about the no meds choice. We met with psychologists and therapists as a family and we were all well counseled. Together we worked to formulate an exit strategy to remove any risk of the anger being focused on anyone and it had to be a strategy which we were all committed to follow. Together, we did just this and every member of our household was on board to go this path. Anytime my husband became angry or enraged, we were to tell him we were going out for a while and we would be back in a while, so that he could have time to calm down. Then we had to get in the car and leave him at home by himself. No discussion, no talking about it, not one word, just be nice, and exit. No one person could be left behind, this meant no one, not a child, not one grandparent, not any teenager. This strategy could be simply summed up as ‘your behavior is not fair, so we will be back and give you time to calm down.’ Upon return, we went about as if nothing had happened. We saw a lot of movies and went to the beach without him many, many times. Interestingly, within a few months he would stop himself, pause, and say “can you let me shower, and I won’t behave badly.” Now while this helped us face the anger we also had to navigate the rest of his problems and this called for a lot of creative map making.

Motivational interviewing and problem solving therapy appeared to offer preventative effects in this regard after stroke. Other psychological interventions were discussed such as distress management, group support, **Mana Gardening® On-the-go meditation techniques**, **Mana Psychology™**, and music therapy which have been used in case studies, but the evidence for effectiveness is currently limited (Lincoln, Kneebone, Macniven, & Morris, 2012). We chose to combine three approaches the first being biweekly counseling. We used a combination of family, marital, and personal counseling and selected a counselor that was half Polynesian and half

Caucasian. This gave my husband and I both someone who understood us both to help us explore our lives. A reliable person to take what we said or heard and translate this into was really being expressed to each of us separately.

Using the 2017 **Mana Gardening® On-the-go Mediation and Mana Psychology™ and Techniques** allowed my husband to re-learn and experience Native Hawaiian Practices of looking inward to identify what he really wanted in every choice he had to make. It also gave him a way to regain his confidence and sense of empowerment. An aspect of these tools require that you make your problems, questions and needs as small as possible and then seek the most simple achievable solution to secure the outcome you most want. It had an overwhelming calming effect on him as he no longer focused his thoughts and energy on amplifying problems or adding more drama to a problem. **Mana Psychology™ is built on the Mana Gardening® Practices** of practice of relief from pressure through the **On the GO Meditation** method. Using these methods he was able to let go of the anger more and more.

Lastly, we decided on a return to school for my husband with focus on his music. He had been a lifetime musician and our family life was highly centered around music but after the stroke he seemed to struggle with simple musical skills. Thus he began a musical therapy program based on regaining some of what he felt he had lost. This proved to be a key part of him regaining his confidence and returning to his true self. Lastly was a commitment to 'all things are new,' this was shift in our family attitude to cope with his forgetful or displaced moments without being made to feel that he had once again forgotten or failed us. This mindset was vital or all of us to move past his mistakes and within a few months his memory did return to a much greater level of ability, which also positively affected his confidence. This cognitive rehabilitation did reduce his cognitive impairments and improved his functional outcome.

Studies in alignment with this mindful type of approach have suggested there is evidence to support the effectiveness of cognitive rehabilitation (Cicerone et al., 2005). We became explores into this realm and feel today that we navigated this in a manner that offered my husband and our family every chance to thrive and we have succeeded in finding what we were searching for, the man we all knew and love!

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