

DOWNLOAD PDF DIFFERENTIAL DIAGNOSIS IN ADULT NEUROPSYCHOLOGICAL ASSESSMENT

Chapter 1 : neuropsychological evaluation of the older adult | Download eBook pdf, epub, tuebl, mobi

Students, trainees, and practitioners will find that Differential Diagnosis in Adult Neuropsychological Assessment is a reference that remains close at hand." -- Archives of Clinical Neuropsychology "Potentially very helpful for those in graduate or post-doctoral training programs in clinical neuropsychology.

Patients include men and women aged 18 and older who are psychiatrically hospitalized on one of three inpatient units two are locked units. All referrals are challenging to diagnose and treat. Interdisciplinary team approach is emphasized. Distribution of Clinical Activities: Assessments is comprehensive and timely we try to maintain hour turn-around. A flexible battery approach is used to incorporate intellectual, neuropsychological, and personality testing. Brief cognitive-behavioral interventions are frequently a part of the comprehensive treatment plan. The intern may follow cases after discharge in afternoon clinic for brief duration. Interns will also attend weekly cognitive-behavioral therapy case conference. Adult Outpatient "Community Psychiatry: Savage, PhD Patient Characteristics: Adults age 19 " 65 with serious mental illness; schizophrenia, bipolar disorder, major depression and sever anxiety disorders are the primary focus of this rotation. However, differential diagnosis issues encountered will include essentially all of the DSM-IV nosologies. Serious mental illness related neurocognitive disorders are a major focus of this rotation as well. Attendance and involvement in staff meetings, case conferences, and multidisciplinary evaluation clinics may also be expected. Providing inpatient coverage will be an element of this rotation from time to time, although the primary focus is outpatient. Assessment patients are seen by the intern and Dr. Savage for clinical interview. The majority of neuropsychological assessment procedures are conducted by the intern. Several computer based procedures are available. Assessments range from I. Psychotic symptoms are frequently reported and basic Rorschach skills are required or can be developed for assessing thought disorder. Interns are often sought out to provide short-term behavioral and cognitive behavioral interventions on this rotation. Intermediate and long-term therapy opportunities are available and may include group therapy and psycho-educational interventions Rehabilitation Day Program. Adult Outpatient Psychotherapy " A. Hal Thurstin, PhD Characteristics: Adult men and women 18 to 65 years present to the Neuropsychiatry Clinic with a variety of psychiatric disorders. Most commonly seen diagnoses include anxiety, depression, adjustment disorder, and panic disorder. Axis I diagnoses are often complicated by Axis II traits. This is a minor rotation. Interns are encouraged to attend Departmental Grand Rounds. Evaluation is done through diagnostic interviews, assessments of couples functioning, and symptom severity scales. Interventions are individualized and determined by patient characteristics and treatment plan. Individual therapy and couples therapy are the principle modalities with an emphasis on cognitive behavioral and interpersonal approaches. Clinical Activity in Substance Abuse Preceptor: This rotation is at an off-site location and is located within the UAB Substance Abuse Program which provides substance abuse treatment and monitoring for community corrections substance abuse clients. This minor rotation is generally for hours per week and can accommodate interns per rotation. This clinical rotation in substance abuse involves providing assessments for a range of individuals with substance abuse as well as comorbid psychiatric or medical conditions. Psychological assessments and evaluations will involve clients who have criminal justice involvement and who are being maintained in the community under criminal justice supervision. In addition, interns could maintain an active caseload of psychotherapy patients with co-occurring substance abuse and psychiatric diagnoses. Interns would also have the opportunity to provide psychological assessments for individuals who are being treated for substance abuse in an inpatient setting, including impaired provider evaluations for the Board of Nursing, the Board of Medicine, or other health providers. For either population, these assessments would address referral questions regarding psychiatric illness or personality disorders as well as questions of cognitive functioning. Interns would be expected to gain proficiency in conducting clinical assessments with this population and would work collaborative with a range of mental health and medical professionals. By the end

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of the rotation, interns would be expected to be proficient with identifying substance use disorders and will be able to provide basic recommendations for substance abuse treatment. Interns would generally perform new evaluations each week, including psychological testing, clinical interviewing, and write-up of the psychological report. If interested, a group therapy experience could be organized for the intern that would likely involve providing group psychotherapy for Anger Management or other psychosocial groups for substance abusers. Opportunities for conducting individual therapy could also be arranged, with the active caseload to be determined by the intern and supervisor. Interns selecting this rotation should plan to spend the bulk of their day onsite with Dr. These evaluations are generally performed on Tuesdays and Wednesdays.

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Chapter 2 : UAB - School of Medicine - Psychiatry and Behavioral Neurobiology - Department of Psychiatry

Differential Diagnosis in Epilepsy, Gregory P. Lee Differential Diagnosis of Toxic Exposure, Alice Armstrong Empirical Evidence Regarding the Neuropsychological Assessment of Moderate and Severe Traumatic Brain Injury, Robin A. Hanks, Joseph H. Ricker, and Scott R. Mills.

Executive skills such as problem-solving, planning, organization, mental and behavioral control, and cognitive flexibility Behavioral and emotional functioning How Does a Neuropsychological Assessment Differ from a Neurological Examination? Neurology is a medical specialty dealing with disorders of the nervous system. A neurologist diagnoses and treats a neurological condition. A neurological investigation focuses on structural networks or damage rather than functional processes involved in behavior and thinking. A neuropsychologist focuses on assessing brain functioning, such as the way a person thinks, feels, and behaves. The following are the steps an individual must take in order to be referred for a neuropsychological evaluation: If the individual does not intend to be reimbursed by insurance, no referral from the physician is necessary. In that case, the individual should call the neuropsychologist and discuss whether a neuropsychological evaluation is the right course of action. For educational testing learning disabilities , or when requesting testing accommodations, a referral is not necessary. Insurance does not pay for these types of evaluations. In that case, the individual should call the neuropsychologist and discuss how to proceed. If the individual expects to be reimbursed by insurance, the physician should complete the Referral Questionnaire, indicating on the script the reason for the referral and the specific areas of concern. A medical diagnosis is recommended and should be mentioned on the referral form. Referral questions that are medically relevant are approved by insurance companies more readily, so it is important that the primary medical condition suspected as being directly related to current symptomatology be mentioned on the referral form. The provision of available medical records is crucial so that the neuropsychologist has a better understanding of all the factors that may affect brain functioning. Provide the neuropsychologist with copies of previous assessments, if available. Some insurance plans will require a letter from the referring physician, indicating the medical necessity of the assessment. Medical necessity means that the physician needs the assessment in order to proceed with providing care for the individual. For example, a neuropsychological assessment is typically considered to be medically beneficial if it assists in formulating a differential diagnosis, determining appropriate medication or titrating medication, or documenting side effects of medication, and if it assists in deciding between behavioral and psychopharmacological interventions. Neuropsychological assessment used to establish, or confirm, a diagnosis as the basis for medical treatment is usually covered. Most insurance plans will deny coverage for assessment used to establish an educational diagnosis e. However, when problems emerge in the context of a neurological disorder, traumatic brain injury, or a chronic medical condition, the assessment of academic functioning in the context of a complete neuropsychological evaluation may be reimbursed. This process will allow the individual to receive services faster since insurance clearance for neuropsychological services may take up to several months. The individual will need to provide copies of previous medical records. The individual will be asked to complete history forms and questionnaires mailed by our practice. What Should Be Expected? That will always be done before testing. Testing involves paper and pencil, hands-on activities, and sometimes the use of a computer. Family members are not present during testing. Testing sessions can last from 2 to 6 hours at a time and up to 10 hours total. If the individual has special language needs, please alert the neuropsychologist prior to the appointment. Neuropsychological evaluation reports are permanent medical records, so the neuropsychologist will need to have as much information as possible before a final report is issued. Usually reports can take anywhere from 2 to 4 weeks to be completed, depending on the available information. However, preliminary results can be released within two weeks after the completion of the neuropsychological evaluation. If the above information does not provide answers to your questions please do not hesitate to contact our practice.

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Chapter 3 : Clinical applications of neuropsychological assessment

This text clearly presents a multitude of variables that potentially affect the results of neuropsychological tests. The chapter authors, all noted experts in their respective fields, begin with a general discussion of neuropsychological constructs known to impact performance on neuropsychological tests, including demographics, personality, and sociocultural factors.

This article has been cited by other articles in PMC. Abstract Neuropsychological assessment is a performance-based method to assess cognitive functioning. This method is used to examine the cognitive consequences of brain damage, brain disease, and severe mental illness. There are several specific uses of neuropsychological assessment, including collection of diagnostic information, differential diagnostic information, assessment of treatment response, and prediction of functional potential and functional recovery. We anticipate that clinical neuropsychological assessment will continue to be used, even in the face of advances in imaging technology, because it is already well known that the presence of significant brain changes can be associated with nearly normal cognitive functioning, while individuals with no lesions detectable on imaging can have substantial cognitive and functional limitations. Introduction Neuropsychological assessment is the normatively informed application of performance-based assessments of various cognitive skills. Typically, neuropsychological assessment is performed with a battery approach, which involves tests of a variety of cognitive ability areas, with more than one test per ability area. These ability areas include skills such as memory, attention, processing speed, reasoning, judgment, and problem-solving, spatial, and language functions. These assessments are commonly performed in conjunction with assessments designed to examine lifelong academic and cognitive achievement and potential, 1 for a variety of reasons described below. The assessment battery can be standardized or targeted to the individual participant in the assessment. Assessment data may be collected either directly by a psychologist or by a trained examiner, who performs and scores assessments and delivers them to the neuropsychologist. While neuropsychological assessments were originally targeted at individuals who had experienced brain injuries in wartime, 2 the populations for whom neuropsychological assessments are useful spans the whole range of neuropsychiatric conditions. Self-reports of functioning, as well as observations of behavior while performing testing, are critically important pieces of information, as described below. Self-reports of functioning are often affected by the presence of neuropsychiatric conditions, 4 and do not have the same value as performance under standard conditions, which is compared with normative standards. A critical concept in neuropsychological assessment is normative comparison. All of these demographic factors impact performance on the tests in a neuropsychological assessment battery, and interpreting the test performance of people, regardless of the illness or injury that they have experienced, is based on comparisons with individuals who are similar to them. These normative comparisons allow for determination whether an individual is performing as would be expected, given their lifetime levels of achievements and their educational attainment, or if their performance is poorer than expected. Performance that is poorer than expectations can be quantified and interpreted accordingly. Definition of a meaningful cognitive deficit Neuropsychological assessment provides both general and specific information about current levels of cognitive performance. An average or composite score across multiple ability areas provides an overall index of how well a person functions cognitively at the current time. As noted below, these global scores are the most reliable results of a neuropsychological assessment. These global scores are the indices most commonly used to predict real-world functional milestones and to make judgments about functioning in conditions where multiple ability domains are affected eg, serious mental illness or traumatic brain injury. For instance, an individual who experiences a focal stroke or brain injury may have limited cognitive deficits, with most abilities unchanged. This judgment process is complicated by the fact that healthy individuals with no evidence of, or risk factors for, neuropsychiatric conditions show some variability across their abilities. There are several factors that impact

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on within-individual variation across cognitive ability areas. These include the reliability of the measures, the normative standards for the measures, and the level of performance of the individual. Tests with less reliability produce more variable scores at both single assessment and retest. The discrepancies between ability areas that can be interpreted as truly different from each other also depend on whether the normative standards for the tests were developed in a single sample ie, co-normed or separately. Likewise, normative comprehensive standards for extended neuropsychological assessment batteries have also been developed with the same purposes in mind. This is because that, at the tails of the distribution, smaller absolute score differences lead to larger normative differences. In terms of interpretation of meaningful differences between abilities in neuropsychiatric conditions, a widely accepted rule of for a clinically meaningful difference between two ability areas is about one-half of a standard deviation. Specific, multiple studies have suggested that untrained observers can detect differences in functioning that occur over time that reach this threshold. As a result, treatment studies for cognitive impairments would not need to induce treatment effects smaller than this, because they might not be detectable. It should be noted that the changes seen in many neuropsychiatric conditions are much more substantial than this 0. Data examining differences in performance across ability areas at the time of diagnosis has suggested memory performance about 3. In that same, very large-scale study, memory performance was about 2. Conditions where neuropsychological assessment provides useful information Situations where an illness or injury has the potential to adversely impact on cognitive functioning is one where neuropsychological assessment is indicated. These situations include illnesses or injuries that directly impact on cognition Degenerative dementias or traumatic brain injuries or where the treatment for the illness impacts on cognitive functioning chemotherapy for breast cancer. Finally, as neuropsychiatric conditions are complex, many of them have the potential to induce changes in mood or motivational states that can have secondary impacts on cognitive functioning. As these secondary impacts can cause cognitive changes that are as just as real as those caused by a brain injury, part of a comprehensive contemporary neuropsychological assessment requires an assessment of other factors that may be contributing to impaired cognitive functioning. Information obtained from neuropsychological assessment There are several different uses for neuropsychological assessments. These include assessment for the purpose of diagnosis, differential diagnosis, prediction of functional potential, measuring treatment response, and clinical correlation with imaging findings. Some of these uses are related to each other and some are impossible in certain circumstances, because neuropsychological assessments do not provide information helpful for these tasks. These uses are presented in Table I. These impairments must be in two domains: For these conditions, therefore, neuropsychological assessment would serve to provide diagnostic information, because the presence of specific or multiple cognitive deficits, including memory, would provide information for a diagnosis. Similarly there are other conditions, such as postconcussion syndrome where the presence of cognitive impairments of various types is required as a part of the diagnosis. Further, mental retardation requires the presence of a certain level of current intellectual functioning that can only be obtained psychometrically. The way the DSM-TV-TR is structured, however, there is no diagnosis that is confirmed simply as a function of the data obtained in a neuropsychological assessment. In the case of dementia, for instance, there are multiple additional criteria that must be met as well, and many of these pieces of information are obtained from other sources. These include history eg, prior better levels of functioning , assessment of current adaptive deficits, and identification of a potential cause of the condition. As a result, neuropsychological assessments are only part of the diagnostic process. Due to the way the DSM-TV-TR is set up, neuropsychological assessment does not provide information relevant to the diagnosis of most conditions where cognitive impairments are present. For example, many serious mental illnesses are marked by the presence of substantial cognitive impairments. Schizophrenia, 15 bipolar disorder, 16 and major depression 17 have substantial cognitive deficits as a common feature of their presentation, even in patients with current minimal levels of symptoms. Since these impairments are not part of the diagnostic criteria, neuropsychological assessment does not provide diagnostically relevant information. As noted below, however, there is considerable information that can be

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obtained from neuropsychological assessments in these conditions, particularly in functional and prognostic domains. Differential diagnosis There are some conditions where neuropsychological assessment can be important for differential diagnosis. As noted above, dementia requires memory deficits in the presence of other cognitive impairments, while amnesia is diagnosed by the presence of only deficits in memory. Detection of multiple cognitive impairments would therefore rule out the presence of amnesia and argue for a diagnosis of dementia in this case. Differential diagnosis is much more challenging for most conditions, however. For example, studies attempting to differentiate between dementing conditions of different etiologies, such as vascular dementia as compared with AD, have found little evidence of differential diagnostic utility from neuropsychological assessment. Their meta-analysis includes all of the research published on neuropsychological test differences between healthy controls and several neuropsychiatric target populations during the years. As a result, there is a wealth of detail on how much information each of these neuropsychological tests provides for test-based differential diagnosis of the target populations compared with healthy comparison subjects. It is important in this area to consider the differences between differential diagnosis and statistically significant differences in performance across different conditions. An effect size of. Many statistically significant differences between samples would fare poorly as candidates for differential diagnosis. For example, people with schizophrenia routinely have more significant cognitive deficits than people with bipolar disorder, regardless of the mood state of the bipolar patients. In contrast to the differences between people with AD and healthy populations on delayed recall memory, there is little discrimination between bipolar and schizophrenia populations. The distributions of patients with severe mental illness and healthy people have substantial overlap. As can be seen in Figure 1, there is considerable overlap in the distributions of scores on neuropsychological assessments of people with schizophrenia and healthy people, even if the means of the distributions are two full standard deviations apart. The r-BANS 21 is an abbreviated neuropsychological assessment that examines multiple ability domains in a repeatable format. It is scaled like an IQ test, with a mean of and standard deviation of 15 in healthy populations. As can be seen in Figure 1, 22 people with schizophrenia have a mean level of performance that is 2. While a score of would be much more rare for someone with schizophrenia than a healthy individual, a score of 85 would be at the 67th percentile for someone with schizophrenia and at the 17th for the healthy population; both of these are clearly within not outlying scores.

Chapter 4 : GUIDE TO ADULT NEUROPSYCHOLOGICAL ASSESSMENT - Neuro-Psychology Practice, P

With Differential Diagnosis in Adult Neuropsychological Assessment, Editor Joseph H. Ricker has provided a text that addresses many of the diagnostic challenges faced by practitioners and answers many of the diagnostic questions that are likely to be raised in individual cases.

Chapter 5 : Neuropsychology Services - UIC Department of Psychiatry

The results of this study suggest that neuropsychological testing, particularly of the domains of sustained attention and impulsivity and verbal learning and memory, can help to improve the differential diagnosis between adult ADHD and ARMS for psychosis.