Clinton and the Jews
Threefold relationship
By RON KAMPPEAS
WASHINGTON — Hillary Clinton is a chameleon, her critics say, ready to adopt the colors of her environment: dove, hawk, social conservative, social justice warrior, friend, back-stabber.

Hillary Clinton is a Rorschach test, her supporters say, a projection of their hatreds: deepest fears and insecurities: the strong woman distorted into a witch, the progressive distorted into a radical, the pragmatist distorted into a pragmatist, the woman distorted into a witch, the colors of her environment: dove, hawk, social conservative, social justice warrior, friend, back-stabber.

Hillary Clinton, in her first autobiography, Living History, embraces another label: “policy maker,” one she embraced after a particularly painful evolution in her political life. She describes her estrangement from her mentors Peter and Marian Wright Edelman, children’s rights advocates Peter and Marian Wright Edelman, who were her husband President Bill Clinton’s enactment of welfare reform.

“Hillary Clinton? Who is the real Hillary Clinton?”

By ANDREA JACOBS

PART TWO

THERE ARE 50 FORMS OF DEMENTIA

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50 forms of dementia.

Many are rare. Some are reversible — but not Alzheimer’s disease. No one recovers from Alzheimer’s, which currently affects an estimated 5 million Americans.

According to the Alzheimer’s Foundation of America, the incidence of Alzheimer’s doubles every five years beyond age 65. As the US population ages, the disease will impact an enormous swath of Americans.

It’s estimated that about 500,000 Americans 85 and under — like Linda Forrest (Part I) — have some form of dementia, including early- or young-onset Alzheimer’s disease.

Dr. Sarah M. Viamonte, director of neuropsychology service at National Jewish Health, is an expert in the science of cognitive impairment, dementia and Alzheimer’s.

Although she works with a variety of medical cases involving cognitive impairment — strokes, epilepsy, head injuries — her “heart and passion are in neurodegenerative diseases and dementia.”

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She said, “We look at aging and memory loss on a continuum,” saying, “The most common symptoms we see in older people are memory loss and the brain’s inability to work as quickly and efficiently as it once did.”

“The speed at which you process information slows. Finding words becomes problematic. ‘That’s what they want?’ You forget people’s names; forget why you walked into someone’s office. This is normal.”

Mild cognitive impairment is at the middle of the continuum, Viamonte says. While an objective problem or a deficit might appear on psychological tests, this does not affect a person on a daily basis.

“She can’t recognize your face. They don’t know who you are.”

But her daughter is concerned because she witnesses others disturbing changes in her mother. Now what?

“Primary care physicians are the first stop,” Viamonte says. “However, patients usually don’t complain about their memory to a doctor. Alzheimer’s often goes undetected because visits to the primary care physician are fairly routinized.”

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Alzheimer’s

Part II: Symptoms & Testing

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Viamonte says, “but if it’s Alzheimer’s, it might not show up on those tests.”

“If the neurology workup is normal, the doctor may still order an MRI,” Viamonte cautions that an Alzheimer’s diagnosis should not be based solely on an MRI.

“Dementia is about how patients present,” as in clinical presentation, she says. “It’s about how his or her brain actually functions, and the issues they face in daily life. The MRI only shows you a picture of the brain.”

She compares two vintage cars, one in perfect condition and the other in total disrepair. How do they operate on the road?

Neuropsychological testing, her-alded as the gold standard for diag-nosing dementia, says “you know how that car runs. And there is no one-to-one correlation between how it looks and how it runs.”

Alzheimer’s, a different form of dementia, “it’s like there’s a different profile as other diseases that may cause cognitive impairment such as neuro-vascular disease or frontal temporal dementia.”

Testing specific to Alzheimer’s is standardized and utilizes a bio-psychosocial model. Scores undergo a normative comparison that corrects for four demographic variables: age, sex, ethnicity and education.

“We compare patients to other patients with similar backgrounds,” she says. “Is this what we would expect from a 65-year-old woman with a master’s degree? We also factor in information from their medical history: illness, mental health issues, prescription drugs, substance abuse, history of social life.

“So with everything we know about this person, does this account for the result? Or is something else going on?”

Viamonte focuses on a patient’s clinical presenta-tion during the three-to-four hour initial evaluation. What is this person able to do and unable to do?

Each evaluation is preceded by 40-90-minute interviews with the patient and family member, conduct-ded either separately or together. Discur-sion includes the experiences and perceptions of parents, spouses and adult children.

“When a person with Alzheimer’s disease comes into my office — and this is where art, science and experience combine — he or she looks different than people with other dementias,” she says.

“It’s part of the clinical gut feel. Other clinical dementias don’t present like this.”

Viamonte tests language abilities, normal and spatial skills, memory, verbal and visual memory, the abil-ity to process information, and execu-tive functions, which she calls the CEO of the brain.

“Anything that a good CEO can do, our executive function does for us: planning, reasoning, organiz-ing, problem solving, self-monitor-ing, social norms, inhibiting responses, emotional stability.”

The hallmark of Alzheimer’s dis-ease is a lack of insight.

“A woman might say, ‘Of course my memory is bad,’” Viamonte says. “So I ask her, ‘Do you understand the purpose of this appointment?’

“The mother says, ‘I don’t know, my daughter made me come.’ But if the daughter tells me she’s told her mother about this appointment 50 times, there’s a problem.”

Rapid forgetting is another pre-sentation of Alzheimer’s.

For example, during the drive to the appointment, patients might ask, “Where are we going today?” sev-eral times.

Five or 10 minutes later, they repeat the same question — total-ly unaware that they have asked it before.

“Then there’s repetitiveness,” Via-monte says. “Your mother calls and tells you she had a great time at the bridge.

“She calls you an hour later and you have the same conversation. And it keeps happening.”

Viamonte uses the analogy of a person acting erratically in the street to demonstrate the precise degree of difficulty in diagnosing Alzheimer’s.

“You see someone on the street and they look like they are ‘losing their mind.’ That person is behav-ing erratically — but schizophrenia, bipolar disorder, alcohol or substance abuse and other diseases might be causing this.

“Yes, the behavior is strange — but what’s behind it?” It might be Alzheimer’s, vascular or cerebral dementia, Parkinsonism and any num-ber of conditions.”

Twice-monthly calls to families who provide home care can cut costs and hospitalizations

Like the disease itself, diagnos-ing Alzheimer’s is a process. A person could have Alzheimer’s and test normally because it hasn’t progressed yet; have Alzheimer’s dis-ease, test abnormally but function well in day-to-day life; or have Alzheimer’s, test abnormally and be impaired on a daily basis,” she says.

Viamonte refers to the final sce-nario as “the tipping point.”

The Alzheimer’s Association esti-mates that half of the people with Alzheimer’s have not been diagnosed — and half of those diagnosed have not been told.

FINANCES

NORMALLY, Alzheimer’s patients are the ones who pay for care. But the Association says caregivers attending loved ones at home resist hiring professional help, while others consider institu-tional alternatives.

The expense is confounding. According to the Alzheimer’s Associa-tion, an estimated $220 billion is spent on Alzheimer’s treatment and care per year.

By 2050, as the age 85 and old-er population in the US doubles to 88.5 million, or 20% of the popula-tion, that figure is projected to soar to $1 trillion annually.

Viamonte says that locating appropriate financial support for both patients and families has a very simple answer, but it’s a hard thing to bring about.

“Fundraising, raising awareness and making Alzheimer’s a priority is really difficult because the general public thinks of it as an older per-son’s disease.”

“That’s the general attitude.”

People who are 37 or 52 or 60 and feel invulnerable to Alzheimer’s dis-ease are mistaken, she stresses.

Focusing on rare, early-onset Alzheimer’s disease, which is on the uptick primarily due to increased awareness, may turn the percep-tional tide.

“One of the things we’ve tried to do with the Alzheimer’s Associa-tion is put a younger face on the dis-ease and show that it is not limited to 85-year-olds,” she says.

Viamonte is enthusiastic about a new study detailing the benefits of trained or para professionals who make twice-monthly calls to fami-lies providing home care for Alzheimer’s patients.

“Half of the families received calls and the other half did not,” she says.

“The ones receiving calls had lower overall costs for care, lower rates of hospitalization and visits to the ER.”

“The caregivers had better mental health — and we all know that when the caregiver feels good, the patient’s health improves.”

Does Alzheimer’s exist?

“Do you know you can call a care-partner, you don’t get to that break-ing point where you can no longer handle the situation.”

She hopes this paradigm of care expands over time.

H eageway, a community for Alzheimer’s and dementia patients near Amsterdam, is attracting global atten-tion. It is planning to construct a similar model.

Residents of the ‘dementia vil-lage’ choose from seven lifestyles — urban, artisan, Indigenous, homoeopathy, nature, cultural or Christian — and live in homes with six like-minded indi-viduals.

Monitored by a permanent staff, they shop in stores, go to the theater and enjoy community activities. Within the limits of their illness, they fully explore independences.

Whether this concept will trans-late to the US is another question.

For now, Viamonte strongly encourages patients in the early, mild to moderate stages of Alzheimer’s and their families to take advantage of the Alzheimer’s Association of Colorado.

“It offers much more than sup-port groups where you go and cry and complain,” she says.

Alzheimer’s patients might sam-ple music, drawing and dance class-es, or connect with each other to share daily challenges.

Caretakers can avail themselves of a 24/7 hotline, explore pertinent educational and support classes, learn from the pros, and much more.

“The Alzheimer’s Association is invaluable,” Viamonte says. “And it’s free.”

NEXT WEEK

Alzheimer’s Part III: Early Prevention, Not A Cure

Andrew Jacobs may be reached at andrew@ijn.com.