

Prime Living
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Depression and Cognitive Decline in Older Adults

For the past several months in this series, we have been discussing cognitive impairment in seniors. To me, the most important point made has been that cognitive decline in an older adult is not necessarily dementia, let alone Alzheimer's disease. It has been stressed that there are many potential causes of memory loss, disorientation, forgetfulness and other cognitive symptoms that are not caused by dementia. Probably the most common of these potential causes is depression.

Classic depression, in medicine referred to as "major depressive episode," is actually more common in young or middle aged adults. But the full spectrum of depressive symptoms, including less severe or less debilitating symptoms, are more common in older adults.

Most people conceptualize depression as a disease of the mind and the spirit. The word "depression" usually conjures up images of someone looking and feeling depressed. Synonyms like blue, melancholic, down, sad, or withdrawn commonly come to mind. For most seniors with a depressive illness, these words accurately describe how they look and feel.

Many seniors with depressive symptoms also experience what physicians refer to as "neurovegetative signs." These are troublesome symptoms due to depressive illness that affect the body rather than the mind and spirit. Common neurovegetative signs include sleep disturbance (too much or too little), appetite disturbance (too much or too little), bowel or bladder function changes, or weakness and lack of energy.

However, it's important to understand that a sizable minority of seniors--some experts say as many as one-third--do not feel depressed at all. People around such patients do not see them as sad, or withdrawn. They don't look or even feel depressed. The symptoms of depression in these seniors may be limited only to neurovegetative signs or may be limited only to *cognitive symptoms*. For some seniors with depression, trouble concentrating, memory loss, disorientation, and confusion may be the only manifestations of their depressive disorder.

How can a person develop a depressive disorder and not feel depressed? The problem, I think, lies in the word "depression." To repeat, most people with depressive illness *do* feel depressive symptoms. These symptoms usually *do* include sadness, social withdrawal, and melancholia. However, the symptoms of depression can also include physical (neurovegetative) dysfunction and also cognitive dysfunction. All of these symptoms—whether mood/spiritual, physical, or cognitive—can be part of the depressive illness. But for a sizable minority of depressed persons, the symptoms of their depressive illness are *limited* to physical and/or cognitive dysfunction.

Depression and depressive illness are believed to be due to the development of deficiency or relative inaction of certain chemicals in the brain, called "neurotransmitters." These neurotransmitter changes can affect a wide variety of brain functions, including mood, spirit, and energy level. But brain functions such as control of sleep, control of appetite, control of bowel and bladder, and cognitive function, are also under the influence of these

neurotransmitter chemicals. So, if we were to use the phrase, “neurotransmitter dysfunction” in place of “depression,” perhaps it would become easier to understand how persons with “depression” can have symptoms that might not involve mood, spirit, or feeling depressed.

Is it common to see older adults whose cognitive dysfunction is due wholly or partly to depression? Official statistics addressing this question have not yet been published but cognitive dysfunction in seniors due in whole or in part to depression is not uncommon. A primary care physician can expect to encounter this problem at least weekly, provided the physician is aware of the issue and keeps an open mind when considering the causes of cognitive dysfunction in seniors.

Some seniors who develop a depressive disorder have had trouble with depression or anxiety off and on for most of their adult lives. Others may have never had trouble with depression and develop depressive symptoms for the very first time in their golden years. People with cognitive dysfunction due to dementia of any type often develop depression. For these persons, their depression typically presents as deterioration in their cognitive performance.

It is critical for physicians to consider the diagnosis of depression in seniors with cognitive dysfunction. If the cognitive dysfunction is due in whole or in part to an underlying depressive disorder, the part of the cognitive dysfunction caused by depression is treatable and may be completely reversible. And that is no small thing if you are the senior with the cognitive dysfunction or that person’s spouse, son, or daughter.

Fortunately, there are proven clinical methods and diagnostic aids available to help physicians diagnose depression in seniors. By far, the most useful method is the interview with the patient and with the patient’s caregivers. An experienced physician learns to listen to patients carefully—not only to what patients say and to how they say it, but also to “tune into” the person, to “feel” what they are feeling. An old adage in medicine which has never misled me goes like this: “If you are interviewing a person and you begin to feel depressed, the person you are interviewing is depressed.”

But the symptoms of depression are subjective and neurovegetative signs are also seen in many seniors who do not have depression. Furthermore, many seniors are not comfortable talking about their feelings or their moods. Because of these limitations, tools have been developed to augment the clinical interview. The most widely used of these tools is the 30-Item Geriatric Depression Scale, or GDS. This tool asks 30 simple and straightforward questions that focus on the psychologic symptoms (the feelings) rather than neurovegetative symptoms. The questions are all in a yes-or-no format which makes it easier for some seniors to discuss their feelings. The GDS is scored and yields a *likelihood* of depression because the GDS and every other such tool are designed to *augment* the interview. No tool is diagnostic; it cannot replace the diagnostic acumen of an interview performed by an experienced clinician.

Similar to making any diagnosis in medical practice, diagnosing depression in a cognitively impaired senior begins with considering the possibility of its existence.