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Research Article

Particularities of Depressive and Anxious Symptoms in Patients with Neurocognitive Disorders

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Abstract

Mood disorders encountered by the elderly are of concern to specialists in the fields of psychiatry, psychology and other social sciences, especially in the current social and demographic context of increasing the elderly population. This study aimed to build an affective and emotional profile of the patient with neurocognitive disorder. The study involved 91 patients, 49 women and 42 men, aged between 55 and 85, hospitalized in a clinical psychiatric hospital. To assess cognitive impairment, the Minimental State Examination test, was applied. To assess the level of anxiety and depression, the Clinical Assessment Scales for the Elderly (CASE - SF) were applied. Cognitive impairment correlates positively with nonspecific symptoms of anxiety and depression. Among the non-specific symptoms of anxiety, overwhelming agitation ($r(89) = .40$, $p < .001$), irritability ($r(89) = 0.34$, $p < .001$) and anxiety are positively correlated with cognitive impairment. Depressive symptoms correlate poorly with cognitive impairment. Among the symptoms of anxiety, the strongest predictor is irritability ($\beta = -.46$, $t(85) = 4.72$, $p < .001$). In patients with cognitive impairment, the symptoms of depression and anxiety take on different and aspects. Therefore, it is necessary to develop a new diagnostic system for the elderly, because the psychiatric symptoms of the elderly have a different expression than that of adults.

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Keywords: mood disorders; psychiatry; psychology

Introduction

Neuropsychiatric symptoms always accompany neurocognitive disorders [1]. These symptoms have major consequences, which is why they need to be evaluated and treated [1]. The study of non-cognitive symptoms can lead to a deeper understanding of the relationship between behaviour and the brain [1]. Among the most common neuropsychiatric symptoms associated with dementia are apathy, depression, agitation / aggression, and sleep disorders [1]. Depression in the elderly must be evaluated and monitored along with cognitive functions, and the results involve interpretations in the clinical context of the patient [2].

Somatic symptoms that occur in the elderly's depression can lead to problems with the diagnosis, and when the elderly have multiple somatic complaints, the clinician should consider the presence of depression [3].

Elderly anxiety is often linked to physical and cognitive decline, poor medical condition, or physical and mental changes [4]. Irritability, as a symptom of mood disorders, has been little studied and defined [5]. Most authors, although not providing a definition, consider irritability to be a mood disorder with loss of control, involving behavioural changes [5]. The neurological factors that can underlie the appearance of irritability are brain lesions and brain tumours that can affect the temporal and frontal

lobes [5]. Other authors consider that there is no specific area of the brain that, being damaged, causes irritability [5]. However, the association of aggression with irritability in patients with temporal lobe epilepsy has been emphasised [5]. Anxiety has not been the focus of researchers as it is not considered to be specific to cognitive impairment [6]. In the elderly with depression, there may be other symptoms such as anxiety, irritability, and psychomotor agitation [7]. Anxiety seems to be the most common symptom in neurocognitive disorder [7]. Agitation, irritability, anxiety, hostility have always been manifested as symptoms specific to people with neurocognitive disorder [8]. The diagnostic criteria for cognitive disorders indicated by DSM - 5 [9] and Classification of Mental and Behavioural Disorders [10] are similar: reduced ability to concentrate, reduced self-esteem and self-worth, ideas of guilt and worthlessness (even in cases of mild depression), sad and pessimistic vision of the future, ideas or acts of self-harm or suicide, sleep disorders, decreased appetite, anxiety, irritability, reduced or diminished interest and pleasure in daily activities, fatigue and loss of energy, insomnia or hypersomnia, etc. [4]. Depression is a disorder that involves not only mood disorders, but also significant cognitive deficits [11]. Elderly depression tends to be omitted because the elderly's multiple complaints, somatic or loss-related, are attributed to normalcy [12]. In the elderly, depression can be associated with medical, psychological and social problems [11]. Knowledge of the causes that complicate the life of the elderly is necessary for a complex, multidisciplinary approach [11].

Methods

Minimental State Examination, Second Edition (MMSE – 2). In Romania, MMSE - 2 was translated, adapted and standardized, and the whole revision process was completed by making three versions: a very short version, a standard version and an extended version [13]. The two new versions, short and extended, represent improvements of the original scale, the former facilitates the work of the administration and scoring clinician, and the latter represents an increased variant as difficulty and increased sensitivity to screening [13]. In this study, the standard variant was used because it is the closest to the original one, keeping the structure and scoring of the MMSE test [13].

Internal consistency for samples of people with dementia is higher than internal consistency for normative samples because this test assesses multiple cognitive abilities, not just one cognitive domain [13]. Within the Romanian sample, the alpha coefficient for the standard variants was between .77 and .80 for the normative sample and much higher for the clinical sample, which was .91, for the red form [13]. The test-retest fidelity coefficients had very high values, reaching the value of 1.00 [13].

Clinical Assessment Scales for the Elderly (CASE SF, short version) is a set of tools aimed at capturing clinical disorders selected from Axis I of DSM - IV [14]. CASE-SF questionnaire have good reliability and a good validity related to construct. [14]. The same results were obtained on our sample: Anxiety scale: alpha Cronbach .79, Mc Donald's ω 0.8, Depression Scale: alpha Cronbach .83, Mc Donald's ω =0.84, Somatization: alpha Cronbach .79, Mc Donald's ω =0.80.

The "Anxiety" scale (ANX) includes items that capture the feelings of generalized, irrational fear, anxiety and agitation that accompany these states [14]. People who get high scores on this scale experience fear constantly, and these feelings generate discomfort [14]. Agitation and irrational thoughts accompany these feelings. Fear of failure and fear of ridicule can lead them to socially isolating behaviour [14]. The ability to make decisions is affected by cognitive rigidity. Very low scores obtained on this scale suggest a self-elevation that associates specific defense mechanisms. [14].

The "Depression" scale includes items that assess sadness, hopelessness, fatigue, but also cognitive deficits associated with depression. [14]. It is very likely that people who score high on this scale will be diagnosed with a major depressive episode [14]. Depression and sadness dominate the emotional state of these people, and the intensity of these mood disorders prevents them from changing their lives, which makes it increasingly difficult to continue living. If the score on the anxiety scale is high, one would expect the presence of suicide ideation. The elderly are characterized by a general decrease in the pleasure of living, where few things bring them a state of joy. Life can be hard for the elderly because of the difficulty of making decisions or solving a problem. [14].

The Somatization Scale (SOM) includes items that assess health concerns, non-specific somatic symptoms and complaints. [14].

All tests were applied individually, in the morning, Between 9 am and 1 pm. For the application of the Minimental State Examination, Second Edition, it took about 20 minutes. For the application of the Clinical Assessment Scales for the Elderly it took 30-40 minutes. The application of the tests was of the pencil-paper type.

Participants

The study involved 91 patients, 49 women and 42 men, hospitalized in a psychiatric hospital. Patients presented at the hospital alone or accompanied by family with a wide range of charges: anxiety, depression, somatoform. Specifically, patients had complaints about the appearance of anxiety and depression syndromes (decreased useful performance, sad or unstable mood, crying easily, irritability, initial or mixed insomnia, memory or prosex dysfunction, etc.) and / or somatoforms (headache, dizziness, multiple pain, etc.). Lack of response to antidepressant and anxiolytic treatment led to the hypothesis of cognitive impairment and the request for other types of assessments: computed tomography, neuropsychological evaluation or electroencephalogram, investigations for people with organic brain disorders.

The ages of the patients ranged from 55 to 85 years, the average age was 66.95 years (AS = 7.89). Most participants were in the 55-60 age range, and the fewest patients were between 80 and 85 years old.

For cognitive impairment measured with MMSE - 2 we have two groups of patients:

The group of patients without cognitive impairment (MMSE - 2 = 27-30): 40 participants.

The group of patients with cognitive impairment (MMSE - 2 = 10-26): 51 participants.

Inclusion criteria were: age of patients: 55-85 years, scores on the MMSE scale - 2 in the range 10-30, level of education: at least secondary school (patients must have literacy skills), patients with anxiety and / or depression, patients with impaired health, patients whose medical history suggests a favourable psychological, social and professional development (level of intelligence within normal limits, ability to adapt, etc.), visually impaired patients to have prosthetic devices (glasses).

The exclusion criteria were: patients with advanced neurocognitive disorders (MMSE - 2 scores less than or equal to 9), patients with a poor level of education (out of school or with less than 8 classes graduated), known patients with mental retardation, known patients with schizophrenia (the patient with schizophrenia has an inadequate insight into his own suffering or feelings), patients with severe sensory deficits (blind, patients with severe hearing loss), patients with severe neurological defects (all kinds of aphasia, agnosia, agraphia), known patients with degenerative neurological diseases (epilepsy, Huntington's disease, Wilson's disease), patients looking for side benefits (psychiatric forensic expertise, obtaining a certificate of disability, other financial and / or legal interests, etc.). Patients seeking secondary benefits were eliminated based on a preliminary interview.

Ethical considerations. The study was conducted in a psychiatric hospital in 2018 and had the approval of the Ethics Commission within the hospital. All patients read and signed the informed consent and received a copy.

Results

Clinical Characteristics

Within the whole group of participants, the arithmetic mean of the MMSE - 2 test scores (M = 25.08, AS = 4.03) corresponds to mild cognitive impairment [13] (see Table 1).

Variable	Minimum	Maximum	Average	Standard deviation
Anxiety	8	40.00	24.42	8.12
Depression	8	40.00	24.93	9.26
Somatization	8	38.00	20.92	0.40
MMSE - 2	13.00	30.00	25.08	4.03

Table 1 *Means for Clinical Assessment Scales for the Elderly, and Minimental State Examination, Second Edition (MMSE – 2) N = 91.*

It can be seen that the values of the averages are around the values 2 and 3, which corresponds to the annual (2) and monthly (3) symptoms (see Table 2). Overall, we can say that in patients with mild cognitive impairment, measured with the test MMSE - 2 (M = 25.08, AS = 4.03), symptoms of anxiety and depression occur monthly or yearly (see Table 3). Specifically, the symptoms of social anxiety (anxiety in the presence of other people, A42) and agitation (A41) belonging to anxiety occur annually. Also, feeling that life is too hard to live (D83) and lack of future perspective (D63), belonging to depression, occur very rarely, with annual frequency, in the patient with mild cognitive impairment. Symptoms of anxiety that occur monthly in the patient with mild cognitive impairment are agitation (A41), severe tension (A22), recurring concerns (A61) and irritability (A81). Symptoms of depression that occur monthly in patients with mild cognitive impairment are those of general dissatisfaction (D3), feelings of loneliness (D4), feeling that life is deserted (D23), sadness all day (D43), depression (D62), lack of hope (D82). The most common symptom that occurs monthly is irritability (A81: M = 3.67, AS = 1.55). Overwhelming agitation (A21) is the symptom of anxiety that occurs least frequently with a monthly frequency (M = 3.03, AS = 1.60). In fact, another item that concerns the agitation throughout the day (A2) also appears with an annual frequency. (M = 2.96, AS = 1.58).

	N	Average	Standard deviation	Minimum	Maximum
Anxiety that affects normal functioning (A1)	91	2.67	1.61	1	5
Agitation all day (A2)	91	2.97	1.59	1	5
Overwhelming agitation (A21)	91	3.03	1.60	1	5
Severe tension (A22)	91	3.05	1.54	1	5
Agitation (A41)	91	3.18	1.59	1	5
Social Unrest (A42)	91	2.38	1.59	1	5
Concern (A61)	91	3.46	1.53	1	5
Irritability (A81)	91	3.67	1.56	1	5
General dissatisfaction (D3)	91	3	1.69	1	5
Loneliness (D4)	91	3.35	1.79	1	5
Deserted life (D23)	91	3.10	1.65	1	5
Sadness all day (D43)	91	3.25	1.64	1	5
Depressed (D62)	91	3.45	1.57	1	5
Lack of perspective (D63)	91	2.92	1.76	1	5
Lack of hope (D82)	91	3.15	1.77	1	5
Life is hard (D83)	91	2.70	1.73	1	5

Table 2 *Average scores for anxiety and depression symptoms*

Emotional responses frequently occur in the early stages of cognitive impairment such as fear of losing autonomy and independence, but also concerns about the impact that neurocognitive disorder has on others and on family members [4]. This explains the high frequency of some anxiety symptoms.

Differences in profiles with / without cognitive impairment

First, we analysed differences in profiles with / without cognitive impairment with a classical frequentist inferential statistical test (see Table 3)

Variables	W	p	Effect Size Rank-Biserial Correlation
Anxiety that affects normal functioning A1	1355.5	0.005	0.329
Overwhelming agitation - A21	1478.5	< .001	0.450
Severe tension A22	1317.5	0.015	0.292
Agitation A41	1427.5	< .001	0.400
Social Unrest A42	1443.0	< .001	0.415
Concern A61	1384.0	0.003	0.357
Irritability A81	535.0	< .001	0.475

Loneliness D4	1378.5	0.002	0.351
Sadness all day D43	1347.0	0.007	0.321
Anxiety	1452.0	< .001	0.424
Depression	1380.5	0.004	0.353
Somatization	1155.5	0.280	0.133

Table 3. *Differences in profiles with / without cognitive impairment Mann-Whitney U test*

To support our findings we used a more advance statistical procedures: mean modelling, which is an accurate statistical analysis which improves the validity of data analysis [15] and it will be used to check the latent mean differences between the two groups: with and without cognitive deterioration, for anxiety and depression.

First, (see Table 4) the confirmatory factor analysis was conducted on each group: with and without cognitive deterioration. The number of participants is in the minimum range for a confirmatory factor analysis with 6 to 8 indicators and one factor, with factor loadings close to .65. [16]. Model fit indices for both groups suggest an acceptable data model fit (see Table 4). Taasoobshiraz and Wang [17] found that, especially RMSEA, among CFI, TLI and others, must be used with caution as a fit index for models with small sample sizes.

Latent Variable	**Fit indices**
Depression With cognitive deterioration	χ^2/df=1.68, p= RMSEA=.071, 90%CI=.039 -.102 : TLI=.924
Without cognitive deterioration	χ^2/df=1.65, RMSEA=.068, 90%CI=.024 -.110, TLI=.938
Anxiety With cognitive deterioration	χ^2/df=1.79, RMSEA=.081 , 90%CI=.049 -.112 90% TLI=.937
Without cognitive deterioration	χ^2/df=1.43, RMSEA=.063 , 90%CI=.031 -.095 TLI=.967

Table 4 *Confirmatory factor analysis confirmatory factor analysis*

The next step of analysis was to perform several invariance tests [18]

The invariance in configural models for Anxiety (χ2/df=1.61, RMSEA=.080, 90%CI=.048 -.110, TLI=.901, CFI=.909) indicate that the structural model is similar across groups. Measurement weights, Structural covariances and Measurement residuals models, presented in Table 5 suggested the invariance hypothesis was satisfied.

Model	DF	CMIN/DF	Nested Model Comparisons p	Delta CFI
Unconstrained	40	1.610		
Measurement weights	47	1.527	.391	.002
Structural covariances	48	1.505	.448	.003
Measurement residuals	56	1.451	.396	.006
Structural means	55	1.767	<.001	.089

Table 5 *Nested Model Comparisons Anxiety*

In testing for latent mean differences, the means must be constrained to zero in one group. The group whose mean was constrained to zero serves as the reference group against which the estimated mean of the comparison group will be compared.

The invariance in configural models for Depression (χ2/df=1.66, RMSEA=.080, 90%CI=.045 -.120, TLI=.918, CFI=.920) indicate that the structural model it is similar across groups. Measurement weights, Structural covariances and Measurement residuals models, presented in Table 6 suggested that the invariance hypothesis was satisfied.

Model	DF	CMIN/DF	Nested Model Comparisons p	Delta CFI
Unconstrained	40	1.665		
Measurement weights	47	1.524	.059	.010
Structural covariances	48	1.498	.058	.003
Measurement residuals	56	1.505	.068	.012
Structural means	55	1.515	.002	.031

Table 6 *Nested Model Comparisons Anxiety*

Absolute indices evaluate the overall discrepancy between observed and implied covariance matrices (and possibly means); fit improves as more parameters are added to the model: the Standardized Root Mean Square Residual (SRMR) should fall below .08.

Incremental indices assess absolute or parsimonious fit relative to a baseline model, usually the null/ independence model (which specifies no relations among observed variables): the Normed Fit Index (NFI), Non-normed Fit Index (NNFI; also referred to as Tucker-Lewis Index, TLI), and/ or Comparative Fit Index (CFI) have .95 as a minimum target value.

Regression models

In linear regression the criterion was cognitive impairment, and the dependent variables were symptoms of depression, somatization and anxiety. The proposed model explains 47% of the variance of cognitive impairment (measured with the test MMSE - 2): Adjusted R2 = .465, $F(6,84) = 14.02$, $p < .001$.

In the model the strongest predictor is A21 (overwhelming agitation): $\beta = .43$, $p < .001$, this variable contributes the most to the variability of the criterion (cognitive impairment measured with MMSE – 2). The variable that also has a strong effect is A 81 (irritability): $\beta = -.40$, $p < .001$ (see Table 7).

							Collinearity Statistics	
Model		**Unstandardized**	**Standard Error**	**Standardized**	**t**	**p**	**Tolerance**	**VIF**
H_1	(Intercept)	26.640	1.164		22.883	< .001		
	Overwhelming agitation A21	1.070	0.227	0.425	4.713	< .001	0.731	1.369
	Irritability A81	-1.029	0.218	-0.397	-4.723	< .001	0.840	1.191
	Deserted life D23	-0.828	0.212	-0.338	-3.909	< .001	0.795	1.258
	Resistant pain S65	0.891	0.241	0.343	3.695	< .001	0.692	1.446
	Body aches S84	-0.898	0.260	-0.338	-3.453	< .001	0.622	1.607
	Social unrest A42	0.732	0.222	0.290	3.300	0.001	0.770	1.298

Table 7 *Regression coefficients. Dependent variable cognitive impairment*

Agitation and irritability can be expressions of anxiety in the elderly and in the person with mild cognitive impairment, such as health fears, loss of independence and autonomy, decreased self-esteem [4]. At the same time, such experiences have, as an impact, a considerable state of emotional discomfort [14]. Agitation, emotional tension and worry arise in connection with small, irrational, and common problems [14].

The weakest predictor is social worry, this variable representing social anxiety („I get very anxious when I have to talk to people"), and this result suggests that the person with mild cognitive impairment has no tendency to social withdrawal / isolation. This can be a positive indicator for specific intervention processes. At the same time, social isolation can be a cause of depression in the elderly [4]. Simultaneously, the weak effect of this variable suggests that the patient is not afraid of failure at the time of evaluation. They probably feel understood and safe.

We notice that there is an inconsistency between the allegations of somatization at admission and the test results (small effect of variables representing somatization symptoms). This inconsistency could be an indicator of inadequacy in patients with cognitive impairment.

Discussion

Anxiety

Patients without cognitive impairment show monthly symptoms of agitation throughout the day, overwhelming agitation, severe tension, agitation, social unrest, worry, and annually (very rarely) restlessness that affects normal functioning and irritability.

Patients with mild cognitive impairment report social anxiety and agitation very rarely, with annual frequency.

Symptoms of anxiety that occur monthly in the patient with mild cognitive impairment are agitation, severe tension, recurrent worries, and irritability. In fact, overwhelming agitation and irritability are the strongest predictors of cognitive impairment. Irritability is common in all study participants, but is more common in patients with cognitive impairment. Ikeda et al. [19] states, based on a study, that irritability is a common symptom in people with cognitive impairment. Agitation of the patient with cognitive impairment is a frequently studied symptom due to the consequences it has in the life of the patient and their relatives [8], [20].

Symptoms of restlessness affecting the whole day, agitation for the whole day, restlessness, social restlessness that appear annually are less likely to lead to cognitive impairment. The more frequently the symptom of irritability occurs, the more likely it is to be associated with cognitive impairment. Symptoms of severe stress and social anxiety are equally common in patients with and without cognitive impairment.

Anxiety has not been the focus of researchers because it is not considered specific to cognitive impairment [6].

Depression

Patients without cognitive impairment present monthly general dissatisfaction, deserted life, sadness throughout the day, depressed mood, lack of perspective, lack of hope, feeling that life is too hard to live. The feeling of loneliness is experienced by the elderly patients without weekly cognitive impairment.

Patients with cognitive impairment report that life is too difficult to live and the lack of future prospect is rare, with annual frequency.

The symptoms of depression that appear monthly in patients with mild cognitive impairment are those of general dissatisfaction, feelings of loneliness, feeling that life is deserted, sadness all day, depression, and lack of hope.

The more frequent the symptoms of sadness, depression, lack of perspective, general dissatisfaction and feelings of loneliness, the more likely these symptoms are to be associated with cognitive preservation. Feelings of lack of perspective and hope and that life is deserted are common in patients with and without cognitive impairment. Considering that life is far too difficult to live should draw the attention and guide the specialist to the evaluation of the idea of suicide. Lack of perspective and hope requires additional investigations regarding the psychosocial environment, living conditions, family environment, because they can be the expression of a precarious existential reality in terms of supportive social relationships, a precarious economic condition or personality traits.

Limits

One of the important limitations is that the analysis of the results was not performed by gender, because the literature reports a higher frequency of women who report anxiety and depression.

Feelings of loneliness may be greater in widowed or divorced elderly people living alone. This aspect could delimit the experience of loneliness as a depressive symptom from an existential reality.

It is also possible that the rural or urban environment in which the elderly person lives could influence the nature of these results. If the elderly person lives alone, in rural areas, where they do not have many opportunities to socialize, all these accusations could be just a cry for help.

Another aspect not investigated is that of functional deficits. Complaints that the elderly have at hospitalization, related to a decrease in useful performance could, in fact, be the expression of disabilities, chronic pain or decreased physical strength, which are common in the elderly.

We do not consider it a limit not to investigate the side effects of various treatments that the patient has for chronic somatic diseases, because throughout the hospitalization the patient underwent complex investigations and treatment schemes were reviewed. Psychological evaluation was performed after somatic and psychiatric stabilization. This is another reason why the symptoms of anxiety and depression have been assessed by the elderly as being monthly or annual.

Implications for the future research and practice

This study looks at the particularities of affectivity in the elderly and the patient with neurocognitive disorder and could introduce new concepts that may constitute future diagnoses: **wavy mood, organic irritable syndrome, more suitable for the patient with neurocognitive disorder.** A new diagnostic system will require the creation of new treatment protocols and a more precise therapeutic conduct than at present. Longitudinal research is needed to see if the symptoms that occur equally in all patients are the first symptoms that signify a cognitive impairment.

Conclusions

The dispositional profile and its relationship with cognitive impairment is the argument for developing a diagnostic manual for the elderly and people with cognitive impairment. Patients included in the study accessed specialized medical services (psychiatry) for anxious and depressive complaints and accusations, one of the frequent complaints being that of the decrease in the useful performance (inability to have activities in or out of the household), accusations that depressed patients almost always have. The indication for psychological evaluation was made either because of old age, or because antidepressant and anxiolytic drug therapy did not have a desirable outcome. Elderly patients with cognitive impairment have uncommon depressive and anxiety symptoms. Only the feeling of loneliness and worry are experienced weekly. These feelings could, however, be rather existential problems and, in this case, it denotes the lack of a social care system for the elderly. It is about the absence of a system that includes the elderly in useful activities or leisure. Depressive and anxious symptoms of the elderly without cognitive impairment are "extinguished" and could be alleviated by psychotherapy.

Another conclusion that stands out is the particularity that affective pathology has in the elderly, respectively the tendency to "extinguish" the anxiety and depressive symptoms. This symptomatic attenuation does not refer to the intensity of the symptoms, but to the absence of a continuum in depressive and anxious feelings.

At the same time, this study draws attention to a very important aspect: the need for a multidisciplinary approach to the elderly and the patients with neurocognitive disorder. The elderly's approach is complex and requires medical, psychological and social assistance. Thus, the evaluation of the elderly should include all aspects of their existential reality. The lack of reduced accessibility of psychological and social services forces the elderly to access the only service available or known to them, such as the medical service.

Specification

All authors have contributed equally to the manuscript.

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