Affective problems and decline in cognitive state in older adults: A systematic review and meta-analysis

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Abstract

Evidence suggests that affective problems, such as depression and anxiety, increase risk for late-life dementia. However, the extent to which affective problems influence cognitive decline, even many years prior to clinical diagnosis of dementia, is not clear. The present study systematically reviews and synthesises the evidence for the association between affective problems and decline in cognitive state (i.e. decline in non-specific cognitive function) in older adults. An electronic search of PubMed, PsycInfo and ScienceDirect was conducted to identify studies of the association between depression and anxiety separately and decline in cognitive state. Key inclusion criteria were prospective, longitudinal designs with a minimum follow-up period of one year. Data extraction and methodological quality assessment using the STROBE checklist were conducted independently by two raters. A total of 34 studies (n=71,244) met eligibility criteria, with 32 studies measuring depression (n=68,793), and 5 measuring anxiety (n=4,698). A multi-level meta-analysis revealed that depression assessed as a binary predictor (OR=1.36, 95% CIs: 1.05-1.76, p=.02) or a continuous predictor (B=-0.008, 95% CIs: -0.015, -0.002, p=.012; OR=0.992, 95% CIs: 0.985-0.998) was significantly associated with decline in cognitive state. The number of anxiety studies were insufficient for meta-analysis and are instead described in a narrative review. Results of the present study improve current understanding of the temporal nature of the association between affective problems and decline in cognitive state. They also suggest that cognitive function need to be monitored closely in individuals with affective disorders, as these individuals may be at a particular risk of greater cognitive decline.
Introduction

Decline in cognitive state is a central feature of ageing, and severe deterioration in cognitive function has frequently been associated with poorer quality of life and worse performance on physical tasks (Tabbarah et al 2002). Accelerated decline in cognitive state also has an influential and adverse impact upon the psychological, social, emotional and financial status of the individual, which can subsequently contribute to heightened levels of burden and distress (Wilson et al., 2007). Cognitive symptoms are common in affective disorders, particularly impairments in memory, executive control, feedback sensitivity and affective processing (Clark et al 2009). These cognitive symptoms are associated with pathophysiology across a distributed neural circuit, which is made up of various regions across the prefrontal cortex, as well as subcortical regions and also temporal lobe structures (Clark et al 2009). Both affective disorders, such as depression and anxiety, and poor cognitive function are very common in older adulthood (Alexopoulos 1991; Rovner et al. 1989; Sano et al. 1989). It is estimated that after age 70, the combination of low mood and poor cognition doubles with every five years. By age 85, around 1 in 4 of individuals experience both these comorbid conditions (Arve et al 1999). Due to the high prevalence of these conditions in older adulthood, this is a research area of clinical relevance and importance.

Previous research has proposed that affective problems, such as depression and anxiety, may be associated with accelerated cognitive ageing (da Silva et al 2013; Gulpers et al 2016). However, there are significant gaps in our understanding of this link. For instance, the precise temporal order of the association between affective problems and decline in cognitive state is currently unclear. It is possible that affective problems may act as an early risk factor for decline in cognitive state, or alternatively that affective problems may be a prodromal symptom of oncoming cognitive impairment. Additionally, previous studies,
including several meta-analyses, have been largely diagnosis driven, with a primary focus on
dementia (Jorm 2001; Byers & Yaffe 2011; da Silva et al 2013; Bennett & Thomas 2014;
Cherbuin et al 2015; Ownby et al 2006) as an outcome. Less is known about the impact of
affective problems on decline in cognitive state across the entire population spectrum. The
focus on transition to dementia as an outcome may be problematic, as it is now believed that
there is long pre-clinical period of several decades before cognitive impairment becomes
evident (Morris 2005). It is possible that participants who transition to dementia at follow-up
assessment may have already developed substantial cerebral pathology by the time of
baseline assessment, even if they were not yet presenting with any cognitive symptoms. In
this case, associations between affective disorders and development of dementia may be the
result of reverse causality. The present study focuses on the association between affective
disorders and decline in cognitive state in healthy older adults in order to minimise effects of
a possible reverse causality.

Cognitive state refers to a composite measure of overall cognitive function. It has
been studied extensively in previous research (Sohrabi et al 2008; Kavé et al 2008; Esslinger
et al 2011; Nordin et al 2006), using assessments of overall cognitive status, such as the Mini-
Mental State Examination (MMSE) or composite assessments of multiple cognitive domains
(e.g., memory, information processing speed, executive function). Therefore, decline in
cognitive state is defined in the present review as a decline in overall cognitive function,
rather than decline in specific cognitive domains. There is evidence from longitudinal
research that low scores on cognitive state tests may predict onset of functional impairment
(Moritz et al 1995; Gill et al 1996), and functional dependence over time (Aguero-Torres et al
2002; Wang et al 2002; Gill et al 2002). For this reason, it is important to investigate how
affective problems influence decline in cognitive state over time.
There are large individual differences in the extent of cognitive decline experienced by healthy older adults, however decline in cognitive state occurs at a steady and gradual rate over time. On average there is a decline of around 1-2 standard deviations in fluid cognition from age 20 to age 70, after which average decline increases to around 0.5 SD each 10 years (Anstey & Low 2004). This stable decline is often maintained over time until symptoms of dementia begin to manifest, at which point a sharper decline in cognitive state may be observed (Rubin et al 1998). As such, studies in which substantial cognitive decline is apparent within a short time frame of under one year may be more indicative of pathological ageing (e.g. oncoming dementia), rather than healthy ageing. Since the present study aims to examine the longitudinal association between affective disorders and decline in cognitive state in cognitively healthy individuals, it includes only longitudinal studies in which there was sufficient time between baseline and follow-up assessments (minimum one year) for substantial decline to occur within these populations. There are several studies that have investigated the association between affective problems and decline in cognitive state (Bassuk et al 1998; Brailean et al 2017; Bunce et al 2012; Chang et al 2015, Chen et al 2016; Gale et al 2012; Ganguli et al 2006; Geerlings et al 2000; Johnson et al 2013; Kohler et al 2010; Neubauer et al 2013; Paterniti et al 2002; Rajan et al 2014; Reyes Ortiz et al 2008; Royall et al 2013). However, it is difficult to draw a straightforward conclusion from this work due to conflicting findings. Specifically, some studies report a significant association between affective problems and decline in cognitive state (Geerlings et al 2000; Chang et al 2015, Chen et al 2016; Johnson et al 2013; Kohler et al 2010; Paterniti et al 2002; Rajan et al 2014; Reyes Ortiz et al 2008; Royall et al 2013), while conversely others report that affective problems do not predict decline (Bassuk et al 1998; Brailean et al 2017; Bunce et al 2012; Gale et al 2012; Ganguli et al 2006; Neubauer et al 2013). These contradictory results are likely attributable to inconsistencies in methodologies and study design, such as length of
follow up, sampling, definitions used, differences in assessment tools, and also the primary aim of each study (Bennett & Thomas 2014). To date, however, there have been no systematic reviews or meta-analyses addressing associations between affective problems (depression and anxiety) and subsequent decline in cognitive state, prior to onset of dementia. Due to inconsistencies in findings, as well as the lack of attempts to synthesise these data, it is still unclear whether affective problems across the life course are associated with decline in cognitive state, prior to onset of dementia and cognitive impairment. The primary aim of the present study therefore was to systematically review and synthesise current evidence regarding the longitudinal association between affective problems (depression and anxiety separately) and subsequent decline in cognitive state, with consideration of several potential moderators, including mean age of sample at baseline, length of follow-up, quality of study and publication year.
**Method**

**Search Strategy**

This review was conducted in accordance with the Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) guidelines (Moher et al. 2009). A systematic literature search was conducted using PubMed, PsycInfo, and ScienceDirect databases for studies investigating the association between affective problems and decline in cognitive state. All studies published up to November 2016 were included in the search. There was no restriction on start date. Our search terms comprised three search blocks (Table 1). The first search block included key words relating to affective problems. The second search block contained key words describing decline in cognitive state. To reduce number of hits, a third search block was added, which contained key words related to methodology, to ensure all studies with cross-sectional designs were excluded from search results. In addition, reference lists of relevant papers were scanned for articles of interest.

**Inclusion/Exclusion Criteria**

Stringent inclusion/exclusion criteria were applied to articles identified through the initial search.

**Design criteria:** Original studies written in English up to November 2016 were included. Only studies using longitudinal, prospective designs with human participants were included in order to test for the association between affective disorders and decline in cognitive state over time. Cross-sectional, case-control, experimental, including intervention and treatment studies (e.g. RCTs) were excluded. Studies with a follow-up period of one year or greater were included, as it is possible that substantial decline in cognitive state may not be observed over very short follow up periods in a general population. Included studies used samples drawn from a general population, whereas studies using specific clinical populations.
only, for example a sample of stroke patients, were excluded. This criterion was used because inclusion of clinical samples may increase heterogeneity of data synthesis and reduce the comparability of studies. Studies with a sample size of 100 or less were also considered ineligible, due to insufficient statistical power.

**Outcome-related criteria:** Samples with cognitive impairment or dementia present at baseline were excluded. In addition to this, studies with any measure of change in cognitive state from baseline to follow-up were selected for inclusion. Other outcomes, such as transition to dementia or cognitive performance at follow-up without consideration of change from a baseline measure were omitted. This was because the present study aimed to look at the association between affective disorders and cognitive decline within healthy ageing populations, rather than samples with dementia. Additionally, studies assessing specific cognitive domains, such as attention or visuospatial ability exclusively, rather than cognitive state, were also excluded to reduce heterogeneity.

**Predictor-related criteria:** Both diagnostic as well as dimensional measures of depression and anxiety at baseline assessment were judged as eligible. Retrospective assessments of affective problems were excluded, as such assessments may be less reliable. Both binary indicators of affective problems, defined as either a diagnosis or as a score above a threshold level, or continuous symptoms scores, as assessed by a validated scale of affective problems were included in this review.

**Screening Procedure**

All articles identified through our search strategy were screened for eligibility using a three-step process. All references were first reviewed by title. Next, the remaining references were screened by abstract. Finally, all remaining articles were read in full and final eligibility determinations were made on this basis. All articles were reviewed for inclusion by one rater.
and 10% of all articles were additionally screened by an independent rater, in order to assess consistency of screening. Any disagreements were resolved during consensus meetings.

**Data Extraction**

Data from the relevant articles were extracted using a detailed coding form.

Information extracted included: Study information (Authors, publication year, DOI); Sample information (Country, mean age at baseline, gender composition, ethnicity, year of data collection, number of follow-ups, time between lags, total length of follow up, sample size at baseline, sample size at final follow up); Instrument information (Type of affective problem, measure used to assess affective problem, measure used to assess decline in cognitive state); Statistical information (Statistical test used, effect sizes, covariates adjusted for in statistical model). Where results for more than one follow-up were reported, the longest follow-up was selected for our analysis, as longer follow-up times allow a greater period for decline in cognitive state to occur. Similarly, where multiple models were reported with various adjustments made, the most conservative model (with the greatest amount of adjustments) was selected. In cases where insufficient statistical information was available, original authors were contacted directly via email (20% response rate). All studies were evaluated for methodological quality using STROBE (Strengthening the Reporting of Observational Studies in Epidemiology) guidelines (Elm et al 2007).

**Statistical Analysis and Data Synthesis**

All analyses were conducted in R Studio (Studio R 2012), using the *metafor* package. Separate meta-analyses were run for studies in which affective problems were assessed as a binary predictor (using a defined threshold), and studies where affective problems were assessed as a continuous predictor (using a symptom score). In addition, separate analyses
were conducted for studies that use depression or anxiety as predictors of decline in cognitive state.

Odds ratios (ORs) were used as a common effect size across studies with a binary measure of affective problems. When ORs were not reported in original studies, these were estimated from available data using standard computational techniques (Borenstein et al 2009; Field & Gillett, 2010, Lipsey & Wilson 2000). Log ORs were then computed for subsequent analysis. Standardised regression coefficients were used as a common effect size across studies with a continuous measure of affective problems. If unstandardised effect sizes were reported, or measures were not standardised to a z score before analysis, coefficients were converted to standardised coefficients using standard computational methods (Duncan 2014; Kim & Ferree 1981). In cases where insufficient information was reported in the study to calculate the standardised coefficients, authors were contacted directly via email. We also converted the estimated regression coefficients into ORs to facilitate the comparison with the analyses using a binary predictor of depression.

Multi-level meta-analyses were conducted to account for multiple effect sizes within studies (Van Den Noortgate & Onghena 2003). Heterogeneity across studies was assessed using the Q statistic, with p<.1 suggesting significant heterogeneity between studies, and the I² statistic, in which 25%, 50% and 75% represent low, medium, and high heterogeneity (Higgins et al, 2003).

Additional meta-regression analyses were also conducted to assess the effects of potential moderators, including length of follow-up, age of sample at baseline, publication year, method of affective problem assessment (diagnosis or self-report), and quality of studies. All moderators were entered initially as continuous variables, except for the assessment method of affective problems which was coded as a binary variable. For
significant moderators, binary variables were created using the average values, and sub-group analyses were run using these variables.

Publication bias was assessed using Begg’s funnel plot, and Begg’s rank correlation test (Song et al 2000; Richard & Pillemer 1984; Egger et al 2008).
Results

Literature Search

Our search identified 25,844 references. After exclusion of duplicates, 20,954 unique citations remained. At stage 1, citations were screened by title and 981 were determined to be eligible (inter-rater reliability=96%). In stage 2, remaining citations were screened by abstract, and 185 were judged as relevant (inter-rater reliability=91%). Finally, all 185 citations were selected for full text screening, after which 84 references remained (inter-rater reliability=94%). At this stage, a further 36 studies were excluded, as they were addressing decline in specific cognitive outcomes, rather than cognitive state. Of the 48 studies remaining, initially there were 18 with insufficient information for calculation of effect sizes. Authors were contacted directly by email about this, and 4 (22%) responded to provide the relevant information. This left a total of 34 studies with sufficient information to calculate effect sizes, with 32 studies investigating the link between depression and decline in cognitive state (n=68,793), and 5 studies investigating anxiety and decline in cognitive state (n=4,698; Figure 1 and Table 2).

Depression studies: Of the depression studies, 17 used a binary measure of depression (k=34) and 16 measured depression as a continuous variable (k=36). Depression studies had a mean follow-up length of approximately 6.61 years (SD=4.41). The mean age of participants was 72.15 at baseline (SD=7.56) and the gender composition of the sample was approximately 59.48% female. The majority of studies took place in the USA (n=14), followed by the Netherlands (n=4) and Taiwan (n=3). Studies also took place in Australia, Canada, France (n=2 for each), Germany, England, Italy, Singapore, and Japan, Hawaii, and the mainland-US (n=1 for each). Overall, the majority of studies used the Center for Epidemiologic Studies Depression Scale (CES-D) to assess depression present at baseline.
(n=16), followed by the Geriatric Depression Scale (GDS) (n=7), the Diagnostic Interview Schedule (DIS) (n=3), the Neuroticism scale from the NEO Personality Inventory, the Duke Depression Evaluation Schedule (DDES), the Goldberg Depression Scale, Neuropsychiatric Inventory, Hamilton Rating Scale for Depression (HDRS), the Symptom Checklist (n=1 for each). Only one study reported separate effect sizes for more than one follow-up period (Bassuk et al 1998). This study reported effect sizes at 3 years after baseline (n=2030), 6 years after baseline (n=1447), and 12 years after baseline (n=756). The effect size with the longest follow up (12 years) was selected for inclusion in the meta-analysis.

**Anxiety studies:** Of the five anxiety studies, two used a binary indicator of anxiety (k=2) and three used a continuous measure of anxiety (k=3). Anxiety studies had a mean follow-up time of 5.9 years (SD=4.36). On average, participants were 76.56 years old at baseline (SD=4.23), and were predominantly female (60.14% female). The majority of studies took place in Australia (n=2), followed by the USA, the Netherlands, and Israel (n=1 for each). Anxiety was assessed using Sinoff's Short Anxiety Screening Test (SAST), Hospital Anxiety and Depression Scale-Anxiety (HADS-A), Neuropsychiatric Inventory, Goldberg Anxiety Scale, and the Neuroticism scale from the NEO Personality Inventory (n=1 for each). All anxiety studies had a score of 60% or greater on the STROBE checklist (maximum score=81%, median score=78%).

**Depression and Decline in Cognitive State**

**Meta-analysis of studies with depression as a binary predictor.**

There were 34 relevant effect sizes across 17 studies with a binary measure of depression (Bassuk et al 1998; Brodaty et al 2012; Chang et al 2015; Downer et al 2016; Dufouil et al 1996; Ganguli et al 2006; Geerlings et al 2000; Han et al 2008; Kohler et al 2010; Niti et al 2009; Paterniti et al 2002; Raji et al 2007; Reyes-Ortiz et al 2008; Rosenblatt 2008).
analysis of 34 effect sizes revealed that depression was associated with an increased risk of
subsequent decline in cognitive state (OR=1.36, 95% CIs: 1.05-1.76, p=.02; Figure 2).

**Assessment of heterogeneity, meta-regression, and sub-group analyses.**

Significant heterogeneity was observed across the studies with a measure of binary
depression (Q=106.83, df=33, p<.0001, I²=69.08%). An omnibus meta-regression analysis
including publication year, mean age at baseline, length of follow up, method of depression
assessment (diagnosis or self-report), and quality of study revealed that these variables
together were able to explain a significant amount of heterogeneity in the model (QM=13.32,
df=5, p=.02). However, even after accounting for these factors, significant heterogeneity
remained in the model (QE=93.51, df=28, p<.0001). To further explore the effect of
publication year, age at baseline, length of follow up, depression assessment, and quality on
heterogeneity, individual meta-regressions were conducted for each of these potential
modifiers. These analyses revealed that mean age at baseline (p=.13), publication year
(p=.19), quality of study (p=.09), and depression assessment (p=.91) did not significantly
explain between-study variability.

Meta-regression analyses including length of follow-up showed significant between-
study variability, whereby studies with shorter follow-up periods had significantly greater
effect sizes than studies with longer follow-up periods (B=-0.03, SE=0.009, p=.002).
Additionally, meta-regression analyses including method of cognitive assessment (MMSE vs
neuropsychiatric batteries) showed significant between-study variability (B=-0.2, SE=0.08,
p=.01). To further explore precisely how these significant factors were involved in this
association sub-group meta-analyses were conducted.
To explore how length of follow-up was involved in the association, effect sizes were divided by the mean follow-up length in years (M=6.35 (SD=4.25) years), resulting in two groups of longer (k=7, M=10.79 (SD=2.45) years), and shorter follow-up periods (k=10, M=3.25 (SD=1.48) years). Multi-level sub-group meta-analyses revealed that depression was significantly associated with decline in cognitive state in studies with shorter follow-up periods (OR=1.43, 95% CIs: 1.03-2.00, p=.03) and was approaching significance in studies with longer follow-up periods (OR=1.15, 95% CIs=0.98-1.36, p=.08). However, the overall effect size is larger for studies with shorter follow-up periods than those with longer follow-up periods. Studies with longer follow-up periods did not differ significantly from studies with shorter follow-up periods on quality (t(14.29)=1.08, p=.3), publication year (t(15.38)=0.1, p=.92), mean age at baseline (t(10.67)=0.41, p=.69), or depression assessment (t(14.07)=-0.5, p=.63).

The meta-regression analysis including method of cognitive assessment suggested that effect sizes were significantly smaller for studies using the MMSE than studies using neuropsychiatric batteries (B=-0.2, SE=0.08, p=.01). However, there were only four studies using neuropsychiatric battery assessments of cognition, so results need to be treated with caution.

**Meta-analysis of studies with depression as a continuous predictor.**

depression was significantly associated with decline in cognitive state (B=-0.008, 95% CIs: -
0.015, -0.002, p=.012; Figure 3; OR=0.992, 95% CIs: 0.985-0.998).

Assessment of heterogeneity and meta-regression analyses.

Significant heterogeneity was observed across studies (Q=93.86, df=35, p<.0001,
I²=69.74%). In order to try and explain some of this heterogeneity, an omnibus meta-
regression analysis was conducted, including mean age at baseline, length of follow-up,
quality, and publication year as potential moderators. This analysis revealed that together
these variables were not able to explain a significant amount of the heterogeneity in the
model (QM=8.97, df=4, p=.06), but even after accounting for these factors, significant
heterogeneity remained within the model (QE=84.9, df=31, p<.0001). In order to explore the
influence of age at baseline, follow-up length, quality, and publication year in more depth,
individual meta-regressions were conducted for each. These analyses revealed that mean age
at baseline (p=.27), length of follow-up (p=.1), publication year (p=.18), method of cognitive
assessment (p=.47), and quality (p=.11) could not significantly explain between-study
variability individually.

Publication Bias

Publication bias is unlikely for meta-analyses of depression studies measured as a
continuous variable, as Begg’s rank correlation test was non-significant (p=.07). Begg’s
funnel plot also appears relatively symmetrical (Supplementary Figure 1). There may have
been some publication bias present in the meta-analysis of studies with depression as a binary
predictor, as although Begg’s funnel plot appears symmetrical (Supplementary Figure 1),
Begg’s rank correlation test was significant (p=0.02). Results should therefore be interpreted
with caution.

Anxiety and Decline in Cognitive State
Due the limited number of studies which met our inclusion criteria for anxiety, meta-
analyses were not possible. Instead, these studies are described in the form of a narrative
review. Of the 5 relevant anxiety studies, 2 used a binary indicator of anxiety (Brodaty et al
2012; Sinoff et al 2003) and 3 used a continuous measure of anxiety (Bierman et al 2008;

Two of these studies reported that anxiety was a significant predictor of decline in
reported that in a sample of 100 people, anxiety (assessed using Sinoff’s Short Anxiety
Screening Test - SAST) had a strong direct and indirect effect on predicting future decline in
cognitive state over 3.2 years (B=0.23, 95% CIs: -0.03-3.95, p<.05). Similarly, Wilson et al
(2011) found that in 785 older adults, higher levels of anxiety symptoms (assessed using the
anxiety sub-scale from the 48-item Neuroticism scale) were significantly associated with
more rapid decline in cognitive state over a 3.4 year period (B=-0.003, SE=0.001, p=.01).

Conversely, three of these studies found no association between anxiety symptoms
and decline in cognitive state (Bierman et al 2008; Brodaty et al 2012; Bunce et al 2012).
Bierman et al (2008) found no evidence that anxiety (assessed using the anxiety sub-scale
from the Hospital Anxiety and Depression Scale – HADS-A) predicts a linear decline in
cognitive state in a sample of 2351 people over a period of 9 years. Instead, a significant
negative quadratic trend for cognition is reported. The authors state that this is suggestive of a
curvilinear association between anxiety levels and cognitive performance. Specifically,
milder anxiety symptoms may be associated with an improvement on the MMSE until it
reaches an optimal level, beyond which the beneficial influence reduces, so more severe
anxiety is related to poorer cognitive function. The authors posit that the Yerkes and Dodson
law regarding the association between arousal and cognitive performance (Mendl 1999;
Yerkes & Dodson 1908) may also apply to anxiety symptoms. Brodaty et al (2012) found that
in a sample of 480 non-impaired people, the odds of decline in global cognitive state over a period of 2 years were not significantly higher for participants with anxiety (assessed using Neuropsychiatric Inventory) at baseline than those without (OR=1.63, 95% CIs: 0.5-5.8, \( p=.45 \)). They did, however, find a significant effect of anxiety at baseline on decline in executive function (OR=3.54, 95% CIs: 1.3-9.9, \( p=.016 \)). Finally, Bunce et al (2012) found no evidence that anxiety (assessed using the Goldberg Anxiety Scale) affected change in cognitive state over a period of 12 years in a sample of 836 community-dwelling individuals over the age of 70 (B=-0.14, SE=0.19, \( p=.46 \)).
Discussion

The aim of the current study was to systematically investigate associations between affective problems (depression and anxiety) present at baseline and subsequent decline in cognitive state. Our findings revealed that individuals with depression (measured as a binary or continuous predictor) were at an increased risk of a greater decline in cognitive state. These findings are consistent with previous reviews which have indicated an association between affective problems and development of dementia (Jorm 2001; Ownby et al 2006; Byers & Yaffe 2011; da Silva et al 2013; Bennett & Thomas 2014; Cherbuin et al 2015; Gulpers et al 2016). Our results extend these findings by linking affective problems to greater decline in cognitive state in samples free of dementia at baseline.

Strengths and limitations

Several limitations of the current study must be acknowledged. They are subject to the limitations of the included studies. Our analyses suggest that there are several key methodological differences between studies which significantly affect the results produced. For example, our results suggest that effects may differ based on length of follow-up. As shown, this is unrelated to differences in publication year, age at baseline, or method of depression assessment (self-report or diagnosis). It is possible that this is more likely attributable to additional unobserved heterogeneity.

This review only included studies of decline in cognitive state as an outcome. For this reason, it is not clear whether affective problems may differentially influence decline in different cognitive domains. Additionally, the majority of included studies assessed cognitive state using the Mini-Mental State Examination (MMSE). This measure has been criticised for lacking sensitivity to subtle changes in cognition, and for ceiling and floor effects (Tombaugh & McIntyre 1992). Consistent with this, the meta-analysis of studies using depression as a
binary predictor revealed that effect sizes are significantly smaller for studies using the
MMSE than studies using neuropsychiatric batteries. It is therefore possible that the
widespread use of the MMSE may have resulted in an underestimation of the association
between affective disorders and decline in cognitive state in healthy older adults over time.
One further limitation is that excluding cognitive impairment and dementia at baseline does
not completely rule out the possibility of reverse causality.

Beyond this, included studies used different approaches and instruments to assess
affective problems. Research suggests that there is low overlap among different scales of
depression and anxiety, with content analysis suggesting that different types of assessments
may capture different symptoms (Fried 2017). It is therefore possible that studies included in
this review are not entirely comparable on the basis that the methods of assessing depression
are heterogeneous and may each be capturing different kinds of symptoms. Beyond this, there
were also very few studies which met our inclusion criteria which examined the association
between anxiety and decline in cognitive state, meaning that a quantitative meta-analysis was
not possible. Moreover, an additional limitation is that as there were no studies investigating
comorbidity between anxiety and depression. Finally, many of the studies did not report
separate effect sizes for different types of symptoms of affective problems (e.g. negative
affect symptoms, somatic symptoms etc.), meaning we could not look at how different
symptoms of affective problems may influence decline in cognitive state in the current study.

**Plausible mechanisms**

Three major hypotheses have been proposed to explain this observed association. The
first states that affective problems may act as an aetiological risk factor for subsequent
decline in cognitive state, perhaps by lowering the threshold for manifesting decline (Butters
et al 2008; Bennett et al 2014). The second hypothesis proposes that affective problems may
act as a prodromal feature of dementia. Specifically, affective problems may manifest as an early clinical presentation of this disorder. Affective problems and decline in cognitive state may therefore be different symptoms of the same underlying condition (Panza et al 2010; Bennett et al 2014). The third hypothesis posits that affective problems and decline in cognitive state are separate processes but may share common risk factors and underlying neurobiological substrates (Djernes 2006; Enache et al 2011; Bennett et al 2014). These hypotheses are not necessarily mutually exclusive and it is likely that multiple pathways and mechanisms underlie this relationship.

There are several biological and behavioural pathways which may be involved in the association between affective problems and decline in cognitive state. These include vascular disease, increased cortisol production leading to atrophy of the hippocampus (Geerlings & Gerritsen 2017), increased deposition of β-amyloid plaques (Byers and Yaffe 2011), inflammatory changes (Byers and Yaffe 2011), and a decline in the levels and activities of neurotrophic factors (Royall et al 2017). A multiple pathways model has also been proposed by Butters et al (2008), which posits that depression-associated cerebrovascular disease and glucocorticoid neurotoxicity may operate to decrease levels of brain and cognitive reserve, as well as interact with pathology of Alzheimer’s disease, giving rise to the clinical manifestation of Alzheimer’s disease and accelerated cognitive decline. Additional potential lifestyle and behavioural pathways associated with affective problems include educational attainment, social support, early life adversity, and health behaviours such as exercise regime, alcohol consumption, smoking status, and medication status. It is more likely that a complex interaction of biological and sociobehavioural mechanisms are involved in linking affective problems with cognitive decline, rather than one single aetiological determinant (da Silva et al 2013).

**Implications and future directions**
Future research should focus on investigating whether effective treatment and management of affective problems may reduce risk of decline in cognitive state. Additionally, future reviews could focus on how affective problems are associated with decline in specific cognitive domains, such as memory, executive function, and information processing speed. This information can help to elucidate the pattern of decline characteristic of individuals with a history of affective problems. The present review could not address the issue of comorbidity between depression and anxiety and how the comorbidity is associated with subsequent decline in mental state. Indeed, comorbidity of depression and anxiety disorders is extremely common. It is estimated that around 50-60% of individuals who have experienced depression also have a history of anxiety disorder (Kessler et al., 1996; Fava et al., 2000). Additionally, it is believed that comorbidity of anxiety and depression may be related to a higher symptom severity and persistence, as well as poorer functional outcomes (Angst et al., 1999; Roy-Byrne et al., 2000). For this reason, it is important for future research to address how comorbid depression and anxiety is associated with future cognitive decline, and whether comorbidity of these conditions may result in poorer cognitive outcomes than depression or anxiety in isolation. One additional question which remains unresolved is whether affective problems act as a risk factor for accelerated decline in cognitive state or whether they are an early biomarker representing prodromal dementia. While we excluded studies where cognitive impairment were present at baseline, it is also known that dementia has a preclinical period of many decades (Sperling et al 2011). It is therefore possible that participants in included studies may have already built up substantial dementia pathology at baseline, even if cognitive symptoms were not yet apparent. Associations could therefore be due to reverse causality from subtle cognitive changes short of dementia. Future research should focus on distinguishing more clearly between these possibilities.
As average life expectancy lengthens and rapid demographic ageing occurs in populations worldwide, there is a dramatic predicted increase in the number of older adults living in our society (Oeppen & Vaupel 2002; Lutz et al 2008). By 2030, it is estimated that approximately one in five people in England will be over the age of 65 (House of Lords 2013). Given the predicted increase in population size of adults over the age of 65, as well as the poor outcomes and economic costs associated with decline in cognitive state and impairment, it is important to identify life course risk factors for poorer late-life cognitive outcomes, for potential early intervention. These findings may have value in identifying individuals who may be at a greater risk of deterioration in cognitive function over time. It is possible that effective management and treatment of depression may reduce risk and improve cognitive outcomes within these individuals. However, there has also been some evidence to suggest there may be persisting neurocognitive disturbances even after remission of depression (Weiland-Fiedler et al 2004; Frasch et al 2000; Paelecke-Habermann et al 2005). Additionally, cognition may be an important treatment target for depression (Kaser et al 2017). Due to the high prevalence of depression in the population, these results are of great public health importance.

In conclusion, demographic ageing is occurring rapidly worldwide and the number of people living with dementia is expected to grow substantially in prevalence over the next thirty years. As such, focussing research on potentially modifiable life-course risk factors, such as affective problems, is of increasing importance. This review highlights the importance of affective problems, particularly depression, in this context.
References


Brodaty, H., Heffernan, M., Draper, B., Reppermund, S., Kochan, N.A., Slavin, M.J.,
Trollor, J.N. and Sachdev, P.S. (2012). Neuropsychiatric symptoms in older people with

Bunce, D., Batterham, P.J., Mackinnon, A.J. and Christensen, H. (2012). Depression,
anxiety and cognition in community-dwelling adults aged 70 years and over. *Journal of
psychiatric research*, 46(12), pp.1662-1666.

Butters, M.A., Young, J.B., Lopez, O., Aizenstein, H.J., Mulsant, B.H., Reynolds III,
persistent cognitive impairment and dementia. *Dialogues in clinical neuroscience*, 10(3),
p.345.

Reviews Neurology*, 7(6), pp.323-331.

Chang, S.L. and Tsai, A.C. (2015). Gender differences in the longitudinal associations of
depressive symptoms and leisure-time physical activity with cognitive decline in≥ 57year-old


symptomatology and general cognitive status among older adults: inter-relationships and


association between depressive symptoms and subsequent cognitive decline. *Alzheimer's &
Dementia*, 9(3), pp.318-325.

2 Rubin, E.H., Storandt, M., Miller, J.P., Kinscherf, D.A., Grant, E.A., Morris, J.C. and

3 Sawyer, K., Corsentino, E., Sachs-Ericsson, N. and Steffens, D.C. (2012). Depression,
hippocampal volume changes, and cognitive decline in a clinical sample of older depressed
outpatients and non-depressed controls. *Aging & mental health*, 16(6), pp.753-762.

loss in the elderly as a predictor of future cognitive decline. *International journal of geriatric
psychiatry*, 18(10), pp.951-959.

cognitive state and depression in elderly admitted in sanitarium with elderly sited in personal


the preclinical stages of Alzheimer’s disease: Recommendations from the National Institute
on Aging-Alzheimer's Association workgroups on diagnostic guidelines for Alzheimer's


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