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DEPRESSION AND COGNITIVE IMPAIRMENT IN OLDER ADULTS IN CHILE: DIAGNOSTIC CHALLENGES AND COMPREHENSIVE MANAGEMENT IN PRIMARY HEALTH CARE

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ABSTRACT

Introduction: *Depression and cognitive impairment represent significant health problems among older adults and may coexist, making their identification and clinical management more challenging. This relationship is particularly relevant in Primary Health Care, where much of the initial assessment and follow-up of this population takes place.*

Objective: *To analyze the relationship between depression and cognitive impairment in older adults, describing the main diagnostic challenges and comprehensive management strategies within the Chilean Primary Health Care system.*

Methodology: *A narrative review of the scientific literature is proposed, based on a search for publications in PubMed, SciELO, and Google Scholar, in both Spanish and English. Observational studies, clinical trials, reviews, and meta-analyses addressing depression, cognitive impairment, differential diagnosis, and interventions in older adults are considered, with priority given to publications from 2015 to 2026.*

Results: *The literature demonstrates an association between depressive symptoms and cognitive impairment in older adults, as well as difficulties in distinguishing between these conditions due to the overlap of their clinical manifestations. The combined assessment of emotional and cognitive status, monitoring of functional abilities, and involvement of family members and caregivers are identified as essential components. Furthermore, collaborative care models and psychosocial interventions have shown favorable results in the management of late-life depression.*

Conclusions: *The identification of depression and cognitive impairment requires comprehensive assessment and continuous follow-up. Primary Health Care in Chile represents a strategic setting for strengthening early detection, interdisciplinary coordination, and continuity of care. Further national research is needed to adapt and evaluate interventions according to the characteristics of the Chilean older adult population.*

KEYWORDS*: Depression; Cognitive Impairment; Older Adults; Differential Diagnosis; Primary Health Care; Chile.*

INTRODUCTION

Population aging represents one of the main challenges for contemporary healthcare systems due to the increasing prevalence of chronic diseases, neurocognitive disorders, and age-related mental health problems. In Chile, this phenomenon is particularly relevant because of the progressive increase in the older adult population and the growing need to strengthen prevention, early detection, and comprehensive care strategies. According to data analyzed from the 2009–2010 National Health Survey, 10.4% of adults over 60 years of age were suspected of having cognitive impairment, a figure that increased to 20.9% among individuals aged 80 years or older. These findings highlight the importance of addressing cognitive and emotional problems as public health priorities(1).

Depression in older adults represents a particularly important clinical problem because of its association with alterations in memory, attention, processing speed, and executive functions. The coexistence of depressive symptoms and cognitive impairment may complicate clinical assessment, since the manifestations of both conditions can overlap and significantly affect patients' functionality and autonomy. In the Chilean population, Nazar and colleagues analyzed 1,384 adults over 60 years of age who participated in the 2009–2010 National Health Survey and found a positive association between self-reported physician-diagnosed depression and suspected cognitive impairment. The association was more pronounced in men (OR: 4.02) than in women (OR: 2.23), although these findings should be interpreted in light of the

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cross-sectional study design and the limitations of the measurements used(1).

One of the main challenges in caring for older adults is distinguishing cognitive manifestations secondary to depressive disorders from those associated with neurodegenerative processes, such as mild cognitive impairment and dementia. Late-life depression may manifest through difficulties with concentration, memory impairment, apathy, psychomotor slowing, and loss of initiative, symptoms that may be confused with the early manifestations of a neurocognitive disorder. Likewise, depressive symptoms may represent a prodromal manifestation of, or coexist with, neurodegenerative diseases. Therefore, comprehensive clinical assessment is essential and should consider the temporal progression of symptoms, personal medical history, functional status, emotional state, and information provided by family members or caregivers. This distinction is particularly important in Primary Health Care, where patients frequently have their first contact with the healthcare system(2).

Primary Health Care represents a strategic setting for the early identification, diagnosis, treatment, and follow-up of older adults with depressive symptoms and cognitive alterations. Within the Family Medicine model, care should move beyond an exclusively biomedical perspective and incorporate the psychological, social, family, and functional dimensions of aging. This involves promoting the participation of family members and caregivers, assessing modifiable risk factors, identifying support needs, and coordinating interdisciplinary interventions. In Chile, the implementation of follow-up strategies based on the family health model has demonstrated its relevance in caring for individuals with neurocognitive disorders, reinforcing the role of Primary Health Care teams in ensuring continuity of care(3).

Depression is a complex health problem whose management requires consideration of both its clinical manifestations and the different therapeutic options available. In a previous literature review, Flores Salinas et al. (2022), among whose authors is the present author, analyzed strategies used in the management of depression, highlighting the importance of psychotherapeutic and pharmacological interventions. This approach is relevant when studying older adults, in whom depressive symptoms may coexist with cognitive alterations and make the clinical recognition of both conditions more difficult. Therefore, it is necessary to expand the analysis to include the diagnostic and therapeutic particularities of this population, especially within the context of Primary Health Care(4).

METHODOLOGY

A narrative review of the scientific literature was conducted on the relationship between depression and cognitive impairment in older adults, with emphasis on its diagnostic and therapeutic implications within the context of Primary Health Care in Chile. The literature search was planned using the PubMed, SciELO, and Google Scholar databases, considering publications in both Spanish and English.

Search terms related to depression in older adults, cognitive impairment, dementia, geriatric depression, primary care, and Chile were used, together with their English equivalents. Scientific articles published between 2015 and 2026 were prioritized, including observational studies, clinical trials, reviews, and meta-analyses. Classical publications relevant to understanding assessment tools and intervention models were also considered.

Publications relevant to the thematic objectives of the review were selected, prioritizing those addressing the association between depression and cognitive alterations, the challenges of differential diagnosis, and comprehensive management strategies. Institutional documents and publications without bibliographic support verifiable through a DOI were excluded. The information was organized through a narrative synthesis, considering both international evidence and studies available in the Chilean population.

DEVELOPMENT

Epidemiology of depression and cognitive impairment in older adults

Aging and cognitive impairment in Chile

Population aging in Chile represents a growing challenge for healthcare services, particularly due to the increasing prevalence of chronic diseases and age-related neurocognitive disorders. Mild cognitive impairment is a clinically relevant condition characterized by objective alterations in one or more cognitive domains that do not necessarily compromise functional independence to a significant extent. In a cross-sectional study conducted by Felmer and Nazar, which included 1,271 adults over 60 years of age who participated in the 2019 Health and Cognition Study in Older Adults, the prevalence of mild cognitive impairment was 9.13%. These findings provide national evidence regarding the magnitude of the problem and support the importance of implementing early detection strategies in Primary Health Care services(5).

Epidemiological association between depression and cognitive impairment

The relationship between depressive symptoms and cognitive alterations has been documented in different populations of older adults. In Chile, Nazar and colleagues analyzed data from 1,384 participants over 60 years of age from the 2009–2010 National Health Survey, finding a positive association between self-reported physician-diagnosed depression and the presence of cognitive impairment assessed using the Mini-Mental State Examination (MMSE). The magnitude of this association was greater in men (OR: 4.02; 95% CI: 1.44–6.61) than in women (OR: 2.23; 95% CI: 1.03–3.43). Although these findings do not establish a causal relationship, they represent an important epidemiological reference for understanding the coexistence of both conditions in the Chilean population(1).

Late-life depression and clinical manifestations

Depression in older adults presents clinical characteristics that may make its recognition in healthcare services more difficult. Compared with younger adults, some older patients exhibit less prominent explicit sadness and a greater presence of somatic symptoms, anxiety, sleep disturbances, apathy, loss of interest, and complaints related to memory and concentration. Furthermore, it is important to distinguish depressive episodes that persist from earlier stages

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of life from those that first appear during aging, since late-life depression may coexist with cerebrovascular diseases and neurodegenerative processes. These characteristics reinforce the need for a clinical assessment that considers both emotional symptoms and cognitive functioning(6).

Clinical and pathophysiological relationship between depression and cognitive impairment

Cognitive alterations associated with depression

Depression in old age is not merely a mood disorder; it may also be accompanied by alterations in different cognitive domains. The most frequent manifestations include difficulties with attention, reduced information-processing speed, memory impairment, and executive dysfunction. A review published by Teixeira and colleagues in 2025 indicates that between 20% and 50% of individuals with late-life depression may meet criteria consistent with mild cognitive impairment. The authors also emphasize that executive dysfunction and psychomotor slowing may persist even after affective symptoms improve, demonstrating the complexity of the interaction between these two processes(7).

Shared pathophysiological mechanisms

The association between depression and cognitive impairment is likely related to multifactorial pathophysiological mechanisms involving neurobiological, vascular, inflammatory, and neuroendocrine alterations. Proposed mechanisms include dysfunction of the hypothalamic–pituitary–adrenal axis, prolonged exposure to elevated glucocorticoid concentrations, neuroinflammatory processes, and alterations in frontostriatal circuits involved in emotional regulation and executive functions. Additionally, cerebral small vessel disease may simultaneously contribute to the development of depressive symptoms and the decline of cognitive abilities. These pathways may partially explain the coexistence of both conditions, although no single causal mechanism accounts for all cases(8).

Depression as a possible risk factor and prodromal manifestation

The temporal relationship between depression and cognitive impairment remains under investigation. Depression may precede the onset of cognitive alterations, coexist with them, or develop as a consequence of the functional and emotional limitations associated with a neurodegenerative disease. In particular, late-onset depressive episodes have been considered possible prodromal manifestations of neurodegenerative processes in certain patients, whereas recurrent or persistent depression may contribute to the risk of cognitive impairment through vascular, inflammatory, and neuroendocrine mechanisms. However, this association should not be interpreted as an inevitable progression toward dementia, since important differences exist among patients' clinical profiles and individual trajectories(7).

Diagnostic challenges and differential diagnosis in older adults

Clinical overlap between depression and cognitive impairment

One of the main challenges in assessing older adults is distinguishing cognitive alterations associated with depressive disorders from those caused by neurodegenerative diseases. Both conditions may involve memory difficulties, attention deficits, reduced processing speed, and impaired executive functions. This clinical overlap may lead to misdiagnosis, particularly when assessment is limited to the isolated administration of cognitive tests or the identification of affective symptoms. Therefore, diagnosis should integrate the clinical history, the temporal progression of symptoms, assessment of emotional status, cognitive functioning, and the degree of independence in activities of daily living(9).

Cognitive dysfunction associated with depression

Historically, cognitive alterations associated with depression have been described using the term depressive pseudodementia, which refers to manifestations that resemble a neurocognitive disorder but are primarily related to a psychiatric condition. However, this concept has been questioned because it oversimplifies a complex clinical relationship and suggests a degree of reversibility that does not always occur. Currently, it is considered more appropriate to describe these manifestations as cognitive dysfunction associated with depression, recognizing that some patients experience cognitive improvement after antidepressant treatment, whereas others maintain persistent deficits or may subsequently develop a neurodegenerative disorder. Therefore, improvement in mood should not, by itself, be considered sufficient evidence to rule out a neurocognitive disease(10).

Clinical differentiation between depression and Alzheimer's disease

Assessing the characteristics of cognitive alterations may provide useful information to guide the differential diagnosis between depression and Alzheimer's disease. Patients with depression commonly exhibit difficulties with concentration, psychomotor slowing, and problems with spontaneous information retrieval, which may be related to attentional and executive dysfunction. In contrast, Alzheimer's disease usually involves progressive impairment in the ability to learn and store new information, accompanied by difficulties with recognition and a gradual loss of functional independence. Furthermore, individuals with depression frequently express concern about their cognitive difficulties, whereas some patients with Alzheimer's disease may have reduced awareness of their deficits. Nevertheless, these characteristics are clinical guidelines rather than definitive diagnostic criteria, given the considerable individual variability and the possibility that both conditions may coexist(7).

Mild cognitive impairment and coexistence of both conditions

Mild cognitive impairment represents an intermediate clinical category between expected cognitive aging and dementia. It is characterized by performance below that expected for age and educational level in one or more cognitive domains, without significant loss of functional independence. Its identification is particularly relevant in older patients with depression, since affective symptoms may coexist with objective cognitive alterations and complicate their interpretation. Furthermore, the persistence of cognitive difficulties after improvement in depressive symptoms should prompt clinical reassessment and longitudinal follow-up. In this

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regard, periodic assessment makes it possible to identify changes in cognitive progression and detect patients who may be progressing toward a major neurocognitive disorder(11).

Importance of longitudinal assessment and family information

The diagnostic assessment of older adults should incorporate a longitudinal perspective to establish when alterations began, how they have progressed, and what impact they have had on daily life. Information provided by family members and caregivers is particularly relevant for identifying progressive changes in memory, behavior, orientation, and the ability to perform instrumental activities, such as managing medication, handling money, or attending medical appointments. Likewise, assessment of psychiatric history, cardiovascular diseases, medication use, and social conditions helps identify factors that may contribute to clinical manifestations. Combining patient interviews, information from a reliable informant, and standardized cognitive tests improves clinical characterization and helps determine the need for specialized assessment(12).

Assessment tools and early detection in Primary Health Care

Assessment of depressive symptoms

Identifying depressive symptoms in older adults requires assessment instruments adapted to the clinical characteristics of this population. The Yesavage Geriatric Depression Scale (GDS) is a widely used tool for detecting depressive symptoms in older adults and is available in 30-item and 15-item versions. The 15-item short version facilitates its use in Primary Health Care settings and helps identify patients who require a more thorough clinical assessment. However, its results should be interpreted as screening findings rather than diagnostic confirmation. Therefore, they should be complemented by a clinical interview assessing symptom duration, severity, functional impact, medical history, and possible associated factors(13).

Assessment of cognitive function

Cognitive assessment in Primary Health Care can be performed using brief, standardized instruments that explore different domains, including memory, orientation, attention, language, and executive functions. The most commonly used tools include the Mini-Mental State Examination (MMSE) and the Montreal Cognitive Assessment (MoCA). The MMSE provides a general assessment of cognitive functioning, whereas the MoCA incorporates a broader evaluation of executive functions and visuospatial abilities, making it useful for identifying mild cognitive alterations. Nevertheless, performance on these tests may be influenced by educational level, literacy, language, sensory conditions, and the patient's emotional state. Consequently, scores should be interpreted in consideration of the sociocultural characteristics of the population being assessed and should never be used in isolation to establish a definitive diagnosis(14).

Assessment of functional status and activities of daily living

Functional assessment is an essential component in distinguishing mild cognitive impairment from major neurocognitive disorders. While individuals with mild cognitive impairment generally maintain their independence, although they may experience difficulties with complex tasks, patients with dementia develop cognitive alterations that significantly interfere with their ability to perform daily activities autonomously. Instruments such as the Barthel Index, which assesses basic activities of daily living, and the Lawton and Brody Scale, which evaluates instrumental activities, may be used for this purpose. Incorporating these tools complements cognitive assessment and helps determine each patient's needs for support, supervision, and follow-up(15).

Integrated assessment of depression and cognitive impairment

Given the frequent coexistence of depressive symptoms and cognitive alterations, complementary assessment is recommended to identify both conditions independently. In this context, the combined use of instruments such as the GDS or PHQ-9 to assess depressive symptoms and the MoCA or MMSE to explore cognitive functioning may contribute to better clinical characterization. Interpretation should take into account educational level, medical history, pharmacological treatments, and functional impact. Specialized neuropsychological assessment may be necessary when diagnostic uncertainty persists or when there is a discrepancy between reported symptoms, functional status, and the results of initial tests(12).

Limitations of cognitive screening in asymptomatic populations

Although cognitive assessment tools are important resources for identifying neurocognitive alterations, their use should be guided by clinical indications and should not replace diagnostic reasoning. In its 2020 recommendation, the United States Preventive Services Task Force (USPSTF) stated that the available evidence was insufficient to determine the balance between the benefits and harms of systematic cognitive impairment screening in asymptomatic, community-dwelling older adults. This recommendation does not discourage the assessment of patients with memory complaints, behavioral changes, or clinical suspicion of cognitive impairment. Rather, it distinguishes indiscriminate population screening from the active identification and diagnostic evaluation of individuals with clinical manifestations. This distinction is relevant for optimizing the resources available in Primary Health Care(16).

Identification of potentially reversible causes

The assessment of an older adult with cognitive alterations should include the search for potentially treatable medical conditions that may cause or worsen symptoms. These include thyroid disorders, vitamin B12 deficiency, metabolic disturbances, infections when clinically suspected, sleep disorders, and adverse effects of certain medications. The presence of delirium should also be considered, particularly when cognitive impairment has an acute or fluctuating onset, since this condition requires immediate assessment and management different from that of chronic neurodegenerative processes. Medication review, clinical history, and individualized complementary tests help identify contributing factors and prevent all manifestations from being prematurely attributed to primary dementia(17).

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Comprehensive management through Family Medicine and Primary Health Care

Collaborative care models for depression in older adults

The management of depression in older adults within Primary Health Care requires care models that integrate clinical assessment, psychological treatment, pharmacological follow-up, and interdisciplinary coordination. Collaborative care is a strategy involving primary care professionals, mental health specialists, and case managers to improve continuity of treatment. In the randomized clinical trial IMPACT, conducted among 1,801 patients over 60 years of age treated at 18 primary care centers, the collaborative care model achieved a reduction of at least 50% in depressive symptoms in 45% of participants, compared with 19% among those receiving usual care at 12 months. These findings support the usefulness of integrated models in improving clinical outcomes for depression in older adults(18).

Latin American evidence on psychosocial interventions in Primary Health Care

The implementation of low-intensity psychosocial interventions represents a promising alternative for improving access to depression treatment in older adults, particularly in settings with limited availability of mental health specialists. The PROACTIVE clinical trial, conducted in Primary Health Care centers in Guarulhos, Brazil, evaluated a collaborative intervention based on psychoeducation and behavioral activation, delivered mainly by community health workers. The study included 715 individuals over 60 years of age with clinically significant depressive symptoms and found depression recovery at eight months in 62.5% of the intervention group, compared with 44% of the control group (adjusted OR: 2.16; 95% CI: 1.47–3.18). These findings provide relevant evidence for Latin America and demonstrate that certain structured interventions can be implemented in Primary Health Care without relying exclusively on specialized mental health professionals(19).

Non-pharmacological interventions and individualized treatment

Non-pharmacological interventions are an important component of treatment for older adults with depression and cognitive alterations, particularly when comorbidities and susceptibility to medication-related adverse effects are considered. Strategies include behavioral activation, cognitive behavioral therapy, cognitive stimulation, and activities aimed at maintaining social participation. The PROACTIVE trial demonstrated that a structured intervention based on psychoeducation and behavioral activation, delivered through home-based sessions with the participation of community health workers, can significantly improve depression recovery. These findings support the incorporation of interventions adapted to the functional abilities, preferences, and socioeconomic circumstances of older adults(19).

Family involvement and caregiver support

Family members and caregivers should be considered central components of the care of older adults with cognitive impairment, since the progression of neurocognitive disorders may progressively increase the need for assistance and supervision. Interventions directed at both patients and their caregivers, known as dyadic interventions, aim to improve communication, promote meaningful activities, and reduce difficulties associated with daily caregiving. A systematic review and meta-analysis published in 2024 examined 22 randomized clinical trials involving 3,857 dyads of people with dementia and their caregivers. Although it found no significant overall effect across all interventions, it identified favorable results in certain programs that adapted activities to patients' abilities and interests and provided caregivers with education about the disease and communication. These findings highlight the importance of individualizing family interventions and considering the needs of both members of the dyad(20).

Collaborative care and applicability across different healthcare systems

The effectiveness of collaborative care models has also been evaluated in different healthcare settings, allowing their potential applicability to be considered in systems with diverse organizational and sociocultural characteristics. In a randomized clinical trial conducted in Singapore, Ng and colleagues compared usual care with a collaborative model for treating depression in older adults receiving primary care. The results demonstrated a greater reduction in depressive symptoms, higher response and remission rates, and improvements in quality of life and satisfaction with care among participants who received the collaborative intervention. These findings support the usefulness of developing care strategies that integrate general medical care with psychological follow-up and treatment coordination, adapting their implementation to the resources available in each healthcare system(21).

DISCUSSION

The reviewed evidence shows that depression and cognitive impairment have a clinically relevant relationship in older adults. Both conditions may coexist and share manifestations, such as memory difficulties, concentration problems, and functional alterations. In Chile, available studies have identified an association between depressive symptoms and cognitive impairment, reinforcing the importance of assessing both conditions jointly and avoiding the automatic attribution of cognitive difficulties to aging(5).

The main difficulty in clinical practice lies in establishing an appropriate differential diagnosis. Depressive symptoms may affect performance on cognitive tests, while neurocognitive disorders may be accompanied by depressive symptoms. For this reason, an isolated assessment may be insufficient, and it is important to consider symptom progression, clinical history, functional status, and information provided by family members or caregivers(9).

From a Primary Health Care perspective, collaborative care models offer alternatives for improving the recognition and treatment of depression in older adults. The PROACTIVE trial, conducted in Brazil, demonstrated favorable results through psychosocial interventions delivered in collaboration with community health workers. Although these findings cannot be directly extrapolated to Chile, they provide regional evidence regarding the feasibility of strategies adapted to Latin American contexts(19).

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Finally, the evidence highlights the need to strengthen continuity of care, family involvement, and coordination among healthcare professionals. However, challenges remain regarding resource availability, access to specialized assessments, and the adaptation of international interventions to the characteristics of the Chilean healthcare system(18).

CONCLUSIONS

Depression and cognitive impairment are frequent and clinically related conditions in older adults. Their coexistence represents a diagnostic challenge due to the overlap of clinical manifestations and the possibility that one condition may influence the identification of the other. Therefore, comprehensive assessment of each patient's emotional state, cognitive function, and functional capacity is essential.

In the Chilean context, Primary Health Care represents a fundamental setting for promoting early detection, follow-up, and timely treatment of these conditions. Interdisciplinary care models, the involvement of family members and caregivers, and continuity of care need to be strengthened, taking into account the characteristics and needs of the older adult population. Furthermore, additional research in Chile is needed to evaluate intervention strategies adapted to the country's healthcare context.

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DECLARATION OF CONFLICT OF INTEREST

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