

EXPERT COMMENTARY

Schizophrenia in Older Adults: There Is Hope

A confluence of demographic and clinical trends makes this a good time to reconsider the outcome of older adults with early-onset schizophrenia.

Over the next 2 decades, the doubling of the number of people with schizophrenia aged 55 years and older—who will then represent roughly a quarter of all people with the disorder—will place enormous strains on a care system structured to treat younger patients.

For much of the last century, schizophrenia was seen as a bleak prognosis. In 1896, Dr. Emil Kraepelin first called it *dementia praecox*, and in 1980, the DSM-III still described the most common course as “one of acute exacerbations with increasing residual impairment between episodes.”

However, in the last quarter of the 20th century, 10-year long-term follow-up studies around the world showed an array of life courses, and roughly half of those diagnosed had favorable outcomes, that is, complete symptomatic remission or mild end states.

The most severe end state, the one seen as characteristic of schizophrenia by Dr. Kraepelin, was found in only about 15% of cases. Fortunately for our patients, the notion of a progressive downward spiral with a grim end point has been discredited.

Given these realities, we need a new paradigm that conceptualizes schizophrenia as a multifarious illness consisting of largely nonoverlapping indicators.

Such a shift in thinking would enable us to better serve older patients who were diagnosed with schizophrenia while young.

A positive step toward that end would be to capture this complexity in our references. The latest edition of the American Psychiatric Publishing Textbook of Geriatric Psychiatry (Washington: American Psychiatric Publishing, 2009), for example, states that the course for most people is “largely unchanged over time.” This is not incorrect. It’s just that increasingly, the approach to outcome has become more nuanced. This nuanced approach considers individual

and global measures that incorporate elements of the recovery model in schizophrenia and the successful aging model in gerontology.

In addition, this conceptual shift implies that under optimal circumstances, ideal states might be achieved, thereby suggesting possibilities for altering individual and societal conditions to attain those states.

For people with schizophrenia, the ideal life trajectory can be viewed as a process moving from diminishing psychopathology and impaired functioning to normalization to positive health and well-being. The process of transitioning from psychopathology to community integration is the principal feature of the recovery model, and the transition to a positive state of mental and physical well-being in later life is the key feature of the successful aging model.

Studies of specific outcome measures conducted with community-dwelling middle-aged and elderly adults with schizophrenia by research groups in New York City and San Diego have shown about 50% prevalence rates for having none or mild levels of positive symptoms, negative symptoms, cognitive impairment, and adaptive dysfunction. About two-thirds of these adults have depression, and it appears that the proportion is equally divided between subsyndromal and syndromal depression.

What is interesting is that the correlations among these outcome categories are modest. The correlations ranged from .01 to .54 (median value of .21 or 4% shared variance). Thus, a person doing well in one category is only somewhat more likely to be doing well in another.

My colleagues and I at the SUNY Downstate Medical Center have examined global outcome measures based on the life trajectory perspective described above. In our study of 198 people aged 55 and older living with schizophrenia and living in New York City, we found a range of favorable outcomes: clinical remission (median 49%), objective recovery (17%), community integration (23%), and successful aging (2%) (Psychiatr. Services 2008;59:232-9).

Among a comparable group of age peers in the community, 19% and 41% met criteria for successful aging and community integration.

Only modest associations were found among the global outcome indicators, with the median shared variance being 13% in the schizophrenia group.

Therefore, each measure offered a dif-

ferent perspective on outcome.

Older people with schizophrenia scored significantly lower than their community age peers on the community integration and successful aging measures, but had they averaged one component higher on each of those measures, they would have approached the levels of their age peers.

Finally, we found that individual and global outcome measures are associated with a variety of potentially ameliorable social and clinical variables, such as positive symptoms, negative symptoms, cognitive functioning, depression, physical health, locus of control, and the number of confidants.

Clearly, the research supports the notion that older persons with schizophrenia have a range of favorable outcomes and that given this, a new paradigm is needed.

Such a shift would have implications for the way in which we conceptualize research, policy, and clinical care for this aging population.

Perhaps it would be more beneficial to develop treatment strategies that are specific to each outcome category—although treating one category might have a modest impact on other categories. Targeted, age-appropriate interventions at the individual and systems level would go a long way toward helping people achieve outcomes that until recently would have seemed unattainable in later life. ■

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BY CARL I. COHEN, M.D.

EXPERT COMMENTARY

Can Nostalgia Lead to Clinical Depression?

By definition, nostalgia is a wistful desire to return in thought or fact to a former time in one’s life—to one’s home or homeland, or to one’s family and friends. It is a sentimental yearning for the happiness of a former place or time.

Perhaps this desire explains, in part, the seasonal journeys undertaken by birds of many species. Of course, they are motivated largely by weather and a quest for survival. But like clockwork, these birds return to their original habitats, often after enduring journeys fraught with danger.

We also see this trend among humans, albeit in a different way. The issues are in many ways similar, such as the search for greener pastures and economic uplift, and for better living, education, and employment. Still, the destination often proves alien, and there are many risks involved in migration.

Anthropologists have documented this trend since earlier times, when people used to migrate in large groups. Hence, the phenomenon has always been part of the human experience.

But migration often comes at a huge psychological price. After all, psychologically speaking, people who

are born and raised in a particular country develop an attachment to that place, and detachment sometimes leads to emotional turmoil. I’ve seen this in my practice, and so have my colleagues.

The type of emotional reaction differs, depending on whether the migration is forced or not. But the transition can prove challenging just the same.

Many of our colleagues who originated from developing countries are practicing medicine in places such as the United States, Canada, Australia, New Zealand, and the United Kingdom. These international physicians left their homes for a myriad of reasons, but often because of the prospects of better training and a better life.

Many of these physicians express a desire to repatriate back to their countries of origin, and I speculate that about 90% do not go back for one reason or other. About 10% opt to return home, only to find that they would come back to their adopted countries if they could. Often, life in the home country has changed, which can make people feel alienated when they go back.

In many cases, these medical doctors form listservs

with their classmates and continue exchanging e-mails remembering the old days. I receive these kinds of e-mails just about every day from former classmates from medical school. Very often, a sense of emptiness prevails within them.

I suspect that many of these doctors undergo brief periods of depression and other mood changes. However, a large number of them develop a phase of denial and a sense of pseudodetachment.

I have not been able to find anything in the literature that examines the extent to which mental health professionals can help lift the nostalgia among international physicians.

Considering our expertise, however, I’m sure that we psychiatrists have the skills to help.

This appears to be a fascinating area for research, particularly in light of the growing numbers of international medical graduates practicing in the United States, for example (N. Engl. J. Med. 2004;350:2435-7).

I wouldn’t be surprised if someday we develop a nostalgia-related diagnostic entity in the psychiatric classification system. ■

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