Late-Life Schizophrenia: Editor’s Introduction

by Dilip V. Jeste

Abstract

Until recently, most of the research on schizophrenia has focused on young adults. With increasing longevity, the number of older schizophrenia patients in the population is expected to grow. Late-life schizophrenia patients fall into two groups: those who developed schizophrenia for the first time in later adulthood (late-onset schizophrenia) and those who developed the illness earlier in life and are presently middle-aged or elderly. There is a scarcity of published studies on late-life schizophrenia. The available data tend to challenge the commonly held view of schizophrenia as a disorder with onset restricted to the first half of life and a progressively deteriorating course. Further work on this important but long-neglected patient population is urgently needed for clinical as well as research purposes.

It is an irony in the history of science that certain notable conceptual advances seem, on occasion, to retard progress in unintended ways. A case in point is Kraepelin’s (1899) definition of dementia praecox, which was based not only on clinical symptoms but also on “typical” age of onset and course. Kraepelin’s nosology helped to bring considerable order to the then-chaotic area of psychiatric taxonomy. Unfortunately, the term dementia praecox, with its emphasis on onset during adolescence or early adulthood and a progressive mental deterioration, led to a rather rigid belief system among future generations of clinicians and researchers, especially in North America, about the age of onset and course of schizophrenia. Thus, a number of theories of the pathophysiology of schizophrenia were based on the assumptions that this disorder necessarily had its onset before middle age and that it followed a progressively downhill course. These theories persisted in spite of the fact that, in his later writings, Kraepelin (1919/1971) himself came to doubt the validity of the term dementia praecox.

This special issue of *Schizophrenia Bulletin* contains a series of articles on late-life schizophrenia. The late-life schizophrenia group consists of both patients with late-onset schizophrenia (i.e., those who developed schizophrenia for the first time after age 45, as defined by DSM-III-R [American Psychiatric Association 1987]) and patients who had an earlier onset of schizophrenia but are presently middle-aged or elderly.

It is intriguing that late-onset schizophrenia has received far less attention in the United States than in Europe. Harris and Jeste (1988) reviewed the literature (mostly European) and found that a sizable minority (approximately 23%) of all the hospitalized schizophrenia patients from the studies that met their review criteria reportedly had onset of schizophrenic symptoms after the age of 40. Bleuler (1911/1950), Post (1966), Roth (1987), and other European investigators studied schizophrenia with onset during older age, while late-onset schizophrenia was largely neglected in the United States. Bridge and Wyatt (1980) rightly attributed this inattention to nosologic issues. Fortunately, the past 15 years have seen new interest in late-onset schizophrenia (Rabins

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According to Gurland and Cross (1982), about 1 percent of the elderly population has schizophrenia. A large majority of these geriatric schizophrenia patients are those who had onset of their illness in earlier life, that is, before middle age. Although only a few investigators have followed earlier onset schizophrenia patients into old age, the available data show that the outcome of schizophrenia is usually not "dementia" (McGlashan 1988). A majority of the patients either improve (some to the point of remission) or have relatively stable psychopathology (Ciompi 1980). A minority, however, continue to have severe symptoms of psychosis.

Late-life schizophrenia is going to be increasingly important epidemiologically and clinically as the number of older persons in the population increases. Diagnostic and therapeutic concerns relevant to older schizophrenia patients will, therefore, acquire growing importance in clinical practice. From a research viewpoint, one cannot understand schizophrenia fully without trying to comprehend late-life schizophrenia. It is true that there are challenging issues in studies of older schizophrenia patients, such as medical comorbidity, polypharmacy, and age-associated cognitive impairment. At the same time, there are methodological and statistical ways of addressing these confounds (Jeste and Caligiuri 1991).

Although there is a dearth of published data on late-life schizophrenia, the articles published in this issue of the Schizophrenia Bulletin should serve to increase clinical and research interest in this understudied population. The authors report work on a variety of relevant areas: epidemiology, clinical features, neuropsychology, brain imaging, neuropsychology, course, and drug treatment. Of course, a number of important aspects (e.g., the role of psychotherapy) remain to be studied. Also, the results reported here do not always agree; for example, there is disagreement over the relationship of the long-term course of schizophrenia and dementia. Nevertheless, it is sincerely hoped that these articles will stimulate readers’ interest in undertaking and pursuing further work on late-life schizophrenia. Such work will be critical not only for the diagnosis and management of older schizophrenia patients, but also for a better understanding of the schizophrenic syndrome as a whole.

References


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