Older Adults With Schizophrenia

Patients are living longer and gaining researchers' attention.

By Julie Loebach Wetherell, PhD, and Dilip V. Jeste, MD

Dr. Wetherell is an Assistant Professor affiliated with the University of California at San Diego (UCSD) Advanced Center for Interventions and Services Research. Dr. Jeste is the Estelle and Edgar Levi Chair in Aging, Professor of Psychiatry and Neurosciences, and Chief of the Division of Geriatric Psychiatry at UCSD and the VA San Diego Healthcare System.

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Until recently, most research into schizophrenia focused primarily on younger patients. Yet shifting demographics, which are creating a much larger population of seniors, have helped lead to a growing interest in older adults with schizophrenia.

At the Center for Community-Based Research in Older People with Psychoses at the University of California at San Diego, Division of Geriatric Psychiatry, investigators have been studying schizophrenia in the elderly for several years. They estimate that up to 0.5% of people older than age 65 have schizophrenia.[1] Because the aging baby boomers ensure that the senior population will continue to increase in size for the foreseeable future, this statistic is expected to rise substantially during the next 30 years.

DISEASE ONSET

Although most people with schizophrenia have an early onset of the disease—developing schizophrenia in the second or third decade of life—a minority of patients will see the disease first emerge during their middle years, or even after age 65. Table 1 summarizes the differences among early-onset and late-onset schizophrenia and very late-onset schizophrenia-like psychosis.[2]

Late-Onset Schizophrenia. It doesn't occur frequently, but schizophrenia can be diagnosed later in life. Little research has focused on patients in whom schizophrenia first occurs in middle to late life (approximately 40 to 65 years old), but it's generally accepted that patients with late-onset schizophrenia represent a substantial minority—perhaps 15% to 20%—of all older adults with the disease.

Evidence compiled by researchers at our Center and by other investigators indicates that late-onset schizophrenia is best classified as a subtype of schizophrenia. Both conditions have similar presentations and risk factors.[2] Like patients with early-onset schizophrenia, those with late-onset illness experience delusions, hallucinations, bizarre behavior, and thought disorder. Ten percent to 15% of people with early- or late-onset schizophrenia have first-degree relatives who've been diagnosed with the disease. Early childhood maladjustment is likewise similar among people with early- and late-onset schizophrenia. Studies demonstrate that CT scans or MRIs of the brains of people with late-onset schizophrenia don't show the presence of strokes, tumors, or other abnormalities that could account for the development of psychosis in middle to late life.[2]

Several important differences between early- and late-onset schizophrenia suggest that the latter is a distinct subtype of schizophrenia[2]:

- Women predominate among those who are diagnosed with schizophrenia in middle to late life, whereas men are more likely to be afflicted with the disease early in life. One hypothesis is that estrogen helps delay the onset of psychosis until after menopause in women who are vulnerable to schizophrenia.
- The paranoid subtype of schizophrenia is more common among patients with late-onset versus early-onset schizophrenia.
- Those diagnosed later in life tend to have less severe negative symptoms, less cognitive impairment, and a better prognosis compared with those who were diagnosed at a younger age.

Very Late-Onset Schizophrenia-Like Psychosis. A small proportion of older adults experience an onset of psychosis after age 65. This disorder, termed *very late-onset schizophrenia-like psychosis*, is not hereditary and may be associated with dementia in some patients.

PSYCHOSIS OF ALZHEIMER'S DISEASE

When evaluating older adults with psychotic symptoms (delusions or hallucinations), members of the multidisciplinary team should keep in mind that a condition other than schizophrenia may be the cause. Psychosis of Alzheimer's disease is common in this population—as many as half of all patients with Alzheimer's disease develop psychotic symptoms.[3]

Table 2 summarizes the differences between psychosis of Alzheimer's disease and schizophrenia in the elderly. The former is more common than schizophrenia and is often

Table 1

Early-Onset Schizophrenia, Late-Onset Disease, and Very Late-Onset Schizophrenia-Like Psychosis

A closer look at the defining characteristics.

	Early-Onset Schizophrenia	Late-Onset Schizophrenia	Very Late-Onset Schizophrenia-Like Psychosis
Age of onset	Younger than age 40	Middle age (age 40 to 65)	Late life (older than age 65)
Predominant gender	Men	Women	Women
Paranoid subtype	Common	Very common	Common
Negative symptoms	Marked	Present	Absent
Thought disorder	Present	Present	Absent
Minor physical anomalies	Present	Present	Absent
Brain structure abnormalities (e.g., strokes, tumors)	Absent	Absent	Marked
Neuropsychological impairment:			
Learning	Marked	Present	Probably marked
Retention	Absent	Absent	Probably marked
Progressive cognitive deterioration	Absent	Absent	Marked
Family history of schizophrenia	Present	Present	Absent
Early childhood maladjustment	Present	Present	Absent
Risk of tardive dyskinesia	Present	Present	Marked
Daily neuroleptic dose	High	Lower	Lowest

Adapted from Palmer BW, McClure FS, Jeste DV. Schizophrenia in late life: findings challenge traditional concepts. *Harv Rev Psychiatry* 2001;9(2):51-8.

associated with visual hallucinations and the misidentification of caregivers. Remission is common among patients with psychosis of Alzheimer's disease, and, unlike people with schizophrenia, these patients don't usually need to receive maintenance therapies (antipsychotic medications) for many years.

Table 2

Psychosis of Alzheimer's Disease vs. Schizophrenia in Elderly Adults

Distinguishing between the two when evaluating older patients with psychotic symptoms.

	Psychosis of Alzheimer's Disease (AD)	Schizophrenia
Prevalence	Occurs in as many as 50% of patients with AD	Occurs in less than 1% of the general population
Typical hallucinations	Visual	Auditory
Typical delusions	Not bizarre	Bizarre, complex
Misidentification of caregivers	Occurs frequently	Occurs rarely
Past history of psychosis	Rare	Very common
Eventual recovery from psychosis	Frequent	Uncommon
Length of maintenance on antipsychotic medication	Brief	Long term
Recommended adjunctive psychosocial treatment	Environmental modification, behavior therapy, and work with caregivers	Cognitive–behavior therapy, social skills training

Adapted from Jeste DV, Finkel SI. Psychosis of Alzheimer's disease and related dementias. Diagnostic criteria for a distinct syndrome. *Am J Geriatr Psychiatry* 2000;8(1):29-34.

FUNCTIONING

As a type of psychosis, schizophrenia is characterized by positive symptoms, such as delusions, hallucinations, and loss of touch with reality. Negative symptoms are also associated with the disorder (social withdrawal, lack of motivation, blunted affect), as are cognitive deficits in learning and abstract thinking.

Outcomes from schizophrenia vary considerably. Nearly one out of five patients experiences remission of symptoms. Another 20% experience worsening of symptoms; in the remaining 60%, the course of disease is largely unchanged over time.[4] Some deterioration in function or increase in the number of symptoms usually occurs within the first five to 10 years after the onset of the disease, but this may be followed by stability or even improvement in symptoms as the patient ages. Factors that can lead to a better prognosis include[5]:

- Being female
- Developing the illness later in life
- Being married
- Obtaining appropriate treatment early in the course of the illness

Cognitive Function. In comparison to people without schizophrenia, older adults who've been diagnosed with the disease tend to have more difficulty learning new information and performing executive functions, such as long-term planning or interpretation of abstract concepts. The cognitive performance of most older adults with schizophrenia tends to remain stable over time; however, a small group of patients who are older, at lower educational levels, and have more severe positive symptoms seem to experience a decline in cognitive and functional status.[6]

Functional Impairment. The level of functional impairment varies considerably among older adults with schizophrenia. In one study, 30% of older outpatients had been employed at least part-time since the onset of psychosis, and 73% were living in the community.[7] In patients with schizophrenia, worse neuropsychological test performance, lower educational levels, and more

severe negative symptoms are associated with worse functional capacity.[8]

Treatment

Antipsychotic medications offer the most effective treatment for patients of all ages with schizophrenia (and for psychotic symptoms in general). The newer atypical antipsychotic medications are the first-line treatments for older adults with schizophrenia. As a class, the newer atypical antipsychotics tend to have fewer extrapyramidal side effects, like parkinsonism (with tremor and rigidity), than do older typical or conventional antipsychotics, such as haloperidol.[9] Because older adults are more susceptible to extrapyramidal symptoms, anticholinergic toxicity (which can lead to dry mouth, urinary retention, constipation, and confusion), and sedation, it's important that clinicians start with a low dose of the medication and increase it slowly. Patients with late-onset schizophrenia may require approximately half of the antipsychotic dose typically taken by older patients with early-onset schizophrenia.[10] Maintenance drug treatment is usually required for older patients with schizophrenia for many years, although the dose may decrease with aging.

Psychosocial treatment is a very useful adjunct to pharmacologic therapy. Moreover, cognitive behavior therapy and training in social skills, as well as supportive psychotherapy, are also valuable. Cognitive–behavior therapy and social skills training can improve functioning, disease management, and mood disorder symptoms in older patients with schizophrenia.[11] Research also suggests that environmental modifications—such as removing decorative mirrors from the home of a delusional patient who believes that people are living in the walls—may alleviate distress. Furthermore, social contact and structured activities, such as group exercises, may benefit older patients with psychosis. Educate caregivers about ways they can work with these patients, such as by distracting them or by not directly challenging false beliefs. This can successfully reduce both the patient's and caregiver's levels of depression and anxiety.

Reducing Social Stigma

In the coming years, continued advances in the management of schizophrenia are expected. There is, however, still a need to reduce the social stigma associated with serious mental illnesses, such as schizophrenia.

Although patients often learn to manage the symptoms of schizophrenia, they must still navigate their way through social situations, work, and personal care routines. Ignorance and discrimination can be devastating to these patients, and may lead to social isolation and loneliness. Health care providers can help to fight mental health stigmas by engaging in community and professional education and by encouraging family members to become involved in support or advocacy organizations.

Educate caregivers about ways in which they can work with patients, such as by distracting them or by not directly challenging false beliefs.

Conclusion

Although mortality rates in general—and suicide rates in particular—are significantly higher in adults with schizophrenia compared with those in the general population, many patients are now living into older adulthood due to better treatment and general increases in longevity. The result, in the majority of cases, is that members of the long-term care team are now treating and caring for people who were diagnosed early in life and have experienced a chronic course of illness spanning several decades.

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