Late-Life Schizophrenia: Remission, Recovery, Resilience

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In this issue of *The American Journal of Geriatric Psychiatry* four articles relate to late-life schizophrenia. Since its founding two decades ago, the Journal has been a forerunner in offering a generous stage to this field of interest, which at the time suffered from a dearth of data.[1] These days research is flourishing and a range of central issues are well set out. For instance, the diversity of outcomes among older individuals with schizophrenia, and the complex interaction of the disorder with the aging process are well established themes of interest in the research community. There is no reason to ease off, however, as the surge in scientific publications is still lagging far behind the rapidly increasing numbers of older individuals with schizophrenia. Largely due to demographic shifts, the elderly now constitute the fastest growing segment of the total schizophrenia population.

In the light of this development, the article by Hendrie et al.[2] presents important information on health outcomes and utilization of services from a single health care system that provides comprehensive services to a socioeconomically deprived population. The study is innovative, as it uses naturalistic observational data, incorporates a longitudinal design, and includes a comparison group. Schizophrenia patients ($N = 757$; mean age: 70 years) had a 25% increase in mortality risk compared with individuals without schizophrenia, suggesting that excess mortality is not confined to younger schizophrenia patients. Dementia was diagnosed at a markedly high rate in the schizophrenia group (64.5%), twice as often as in the comparisons (32.1%). This stands out as a surprising result, as the common view is that cognitive differences between community-living schizophrenia patients and comparisons do not increase with aging. The authors acknowledge a number of limitations that may have influenced this finding. Nevertheless, most earlier studies relating to this issue did not include oldest old patients (age >70 years), and a recent high-quality cross-sectional study found that schizophrenia patients over the age of 70 years experienced the greatest age-related differences in cognitive function compared with age peers.[3] Not unexpectedly, utilization of health services was substantially higher in the schizophrenia group. The huge impact that a comorbid diagnosis of dementia may have on health care costs provides another argument for the need to further explore this issue.

Kasckow et al.[4] report on additional information from their study of subsyndromal depression in 213 patients with schizophrenia and schizoaffective disorder (median age: 52 years; range: 40–75 years). In this sample, neither age nor "depressive symptoms by age" predicted suicidal ideation. Therefore, age did not moderate the relationship between depressive symptoms and suicidal ideation. The authors rightly state that when evaluating suicidal risk in later-life schizophrenia, depressive symptoms should be considered as a risk factor regardless of age.

Cohen et al.[5] elucidate another relevant clinical feature of schizophrenia in older age, assessing in detail the characteristics of auditory hallucinations in a large sample of older community-living adults with early onset schizophrenia. One in three patients experienced auditory verbal hallucinations, which is lower than what has been reported for younger populations. Interestingly, the percentage of auditory hallucinators hearing benevolent voices was higher than the rates in younger samples. Furthermore,

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patients were far more likely to obey orders by good voices than by bad voices. The authors consider this as a potentially healthy coping strategy to deal with persisting voices in later life. Even so, 68% of those who reported only good voices still had substantial levels of depressive symptoms (CES-D score >7).

From the same study site, Cohen et al.[6] report longitudinal data (mean follow-up: 4.5 years; range: 12−116 months) on symptomatic remission. One of the values of longitudinal research lies in its suitability to sort out causality among variables. Although in the past century a number of laborious long-term studies that followed patients for several decades (e.g., Bleuler[7]) provided information on late-life outcome in schizophrenia, the study by Cohen et al. can be welcomed as the first long-term follow-up study of older patients in the present era. At the same time, it demonstrates the logistic difficulties that come with such a design. Of the baseline sample of 250 individuals, slightly over one-third could not be traced. Despite this limitation, the study of the 104 participants consenting to follow-up interviews clearly indicates that in older age psychotic symptoms may fluctuate to a considerable extent, much like the patterns described for younger patients. The proportion attaining remission differed little at follow-up (49% baseline; 40% follow-up). In 4 out of 10 patients, however, remission status had changed at the study endpoint, with half of the patients who were remitted at baseline loosing this status at follow-up. The relevance of social variables in relation to remission is illustrated by two distinct results of the study. The comprehensive community integration measure utilized by the authors was one of the baseline predictors of remission at follow-up. The other way round, being in remission at baseline predicted a larger social network at follow-up.

The consensus definition of symptomatic remission in schizophrenia[8] has facilitated research into the diversity of the long-term course of schizophrenia and fueled a more optimistic view of outcome, in presenting remission as an attainable goal. Being in remission does not guarantee an overall satisfying life, however. For example, in our study of older Dutch schizophrenia patients,[9] remission was not associated with subjective increase in quality of life. Self-reported depressive symptoms indicative of clinically relevant depression were present in 47% of all patients, with equal levels in remitted and non-remitted patients. The founders of the remission concept themselves clearly stated that symptomatic remission alone is too restricted a goal, and that the focus in schizophrenia treatment should be widened to the far more demanding objective of recovery.[8]

Recovery is a multidimensional concept which, over and above the reduction of symptoms, includes adequate psychosocial functioning and subjective well-being. In this realm, the question arises of how to define standards for recovery that are age-appropriate and acknowledge the often chronic history of mental illness in older schizophrenia patients. For example, education and employment are crucial criteria in younger populations, but have little relevance for the elderly. Likewise, in old age societal participation has different features than earlier in life. Put in words that come closer to the individual's experience, recovery can be conceived of as the pursuit of a meaningful life in which mental illness does not prevail. This phrasing adequately emphasizes that recovery is not an end stage, but an ongoing process with ups and downs along the way. Another pivotal aspect of recovery is that the subjective evaluation by the person in question is leading.[10] A patient can be satisfied with his or her life while living in conditions that may seem adversarial and unpleasant to others.

Setting aside the complicated metrics of recovery, it is clear that at present enduring recovery is too high a goal for the large majority of younger schizophrenia patients.[11] Most likely, the same holds true for old age. Cohen et al. found that 17% of the patients in their cohort met criteria for recovery.[12] An earlier publication from the San Diego, California study group reported that sustained clinical and social recovery was obtainable for only 8% of their patients.[13] If recovery is considered as an all-or-nothing goal, these findings are clearly discouraging. Such a dichotomous approach, however, does not do justice to the versatile reality of coping with everyday life that most clinicians who work with older schizophrenia patients will recognize. Although most patients do not attain complete recovery, many show significant improvements in psychosocial functioning and well-being as they age. Interestingly, this parallels the finding in successful aging research, that positive self-appraisal increases with age, even in the midst of physical and cognitive decline.[14]

In this respect, next to remission and recovery, resilience is emerging as a valuable and rewarding