Our Mission: Helping to prepare Iowa’s health practitioners to care for our growing population of elders. E-NEWS is one of our methods of teaching through technology.

Each month, E-NEWS delivers abstracts from current multidisciplinary healthcare journal articles related to a specific geriatric topic. This month’s E-NEWS focuses on MAJOR MENTAL ILLNESS: SCHIZOPHRENIA AND BIPOLAR DISORDER IN OLDER ADULTS.

MAJOR MENTAL ILLNESS: SCHIZOPHRENIA AND BIPOLAR DISORDER IN OLDER ADULTS

In this issue of the E-NEWS, you will find abstracts for:

- A study that compares prescription patterns of psychotropic medications between older adults and young adults who achieved a "recovered" status during the Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD).
- A study that analyzes the long-term course of nursing home admission among middle aged and older adults with schizophrenia.
- An article that discusses the needs of older adults with schizophrenia.
- A study that examines suicide attempts and associated factors in older adults with schizophrenia.
- A study that explores age transitions in the course of bipolar I disorder.
- A study that compares the risk for cardiovascular mortality between bipolar I and bipolar II subtypes and seeks to determine correlates of cardiovascular mortality.
- A study that researches the longitudinal course of cognition in older adults with bipolar disorder.
- A study that investigates whether late and very-late first-contact schizophrenia carries a risk for later development of dementia.
- A study that addresses cognitive impairment in early and late bipolar disorder.
- A study that evaluates the effects of age and age of onset on prescribed antipsychotic dose in schizophrenia spectrum disorders.

OBJECTIVES: This study compares prescription patterns between young adults and elderly with bipolar disorder who achieved a recovery status during the Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD). DESIGN: STEP-BD is a multicenter National Institute of Mental Health-funded project designed to evaluate the longitudinal outcome of patients with bipolar disorder. The STEP-BD study involved extensive assessment across multiple domains including demographic data, diagnosis, symptom severity, treatment, and clinical status. Patients achieved "recovered" status when they experienced eight consecutive weeks without significant symptoms. PARTICIPANTS: The authors analyzed data of all subjects who achieved a recovered status at least once in their participation. MEASUREMENTS: The authors compared treatment regimes and doses among young participants with middle age (N = 3,364), 20-59 years old, and older participants 60 and above (N = 246). RESULTS: Of the 3,615 STEP-BD participants who had a lifetime diagnosis of bipolar subtypes I or II, 67.6% (N = 2442) achieved a recovered status during their participation. A total of 78.5% (N = 193) of older patients recovered compared with 66.8% of the younger cohort. On average, participants who reached a recovered status took 2.05 medications with no difference between age groups. Lithium was prescribed to 37.8% of younger patients compared with only 29.5% of older participants. The mean dosages taken by younger and older patients differed significantly only for lithium, valproate, and risperidone with elderly individuals prescribed lower daily dosages. Significant reduction in lithium dosing was observed among individuals aged 50 and older and among individuals 60 and older for valproate. Although valproate was more often prescribed, 42.1% of recovered bipolar elder achieved recovery with lithium alone compared with only 21.3% of the younger cohort. CONCLUSION: This data shows recovery is achievable in the elderly though more than one medication is often needed regardless of age.


OBJECTIVE: Cross-sectional data indicate that persons with serious mental illness have increased risk of institution-based care, yet little is known about the long-term course of nursing home placement for persons with schizophrenia. This study describes nursing home entrance over a 10-year period among community residing Medicaid enrollees with schizophrenia compared with Medicaid enrollees with no mental illness. METHODS: The authors analyzed claims of 7,937 New Hampshire Medicaid beneficiaries aged 40 and older. Claims were followed annually from 1996 to 2005 to determine nursing home admission. Schizophrenia was identified from International Classification of Diseases: 9th Edition codes and used to model nursing home admission controlling for medical severity, physical disability, sex, and age. Cox proportional hazard models were run for the entire sample and then separately for middle-aged (40-64 years) and older-aged (65 years and older) subgroups. RESULTS: Persons with schizophrenia enter nursing homes earlier (median age 65) than persons with no mental illness (median age: 80). The greatest relative disparity occurs at middle age (40-64 years), where nursing home admission risk was 3.90 (95% confidence interval = 2.86-5.31) times greater for persons with schizophrenia than for persons with no mental illness. CONCLUSIONS: Middle-aged persons with schizophrenia have almost four times greater likelihood of early institutionalization in nursing homes compared with their same age peers with no mental illness. Efforts to prevent/reduce unwarranted nursing home admission among persons with schizophrenia should focus on health status in the fifth decade of life.


The paper assesses whether the needs of people with schizophrenia over 65 years differ from those of younger adults with the diagnosis. It reviews studies comparing older and younger adults and older adults with schizophrenia and non-clinical or clinical controls on measures of psychosocial functioning. It also considers how psychological interventions can be best designed to cater for the specific needs of older adults. There are relatively few studies assessing how the needs of people with schizophrenia change over the life course and studies comparing the needs of older and younger adults. However, compared to same age peers older adults with schizophrenia have needs in relation to symptoms, cognitive functioning, social functioning, psychological
resilience factors, social support, quality of life, physical health and medication adherence. Psychosocial interventions for this group therefore need to target these areas and there is evidence from three groups of researchers in the USA to suggest that cognitive behavioral or social skills interventions can be successfully adapted for older people. The paper concludes by summarizing recommendations for future research and treatment.


  BACKGROUND: Although there have been numerous studies of suicidality in younger populations with schizophrenia, there have been no studies focused on community-dwelling older adults with schizophrenia. This study provides data on the prevalence of suicidality and factors associated with previous suicide attempts among a mixed racial sample of older persons with schizophrenia living in New York City. METHODS: The schizophrenia group consisted of 198 persons aged >or=55 years who developed schizophrenia before age 45. A community comparison group (n=113) was recruited using randomly selected block groups. Fifteen predictor variables of lifetime suicide attempts based on a risk model of suicide in schizophrenia were identified. RESULTS: Persons in the schizophrenia group had a significantly higher prevalence of current and lifetime "suicidality" (i.e., wants to be dead, suicidal thoughts, or suicide attempts) when compared to the community group (current: 10% versus 2%; lifetime: 56% versus 7%) as well as past suicidal attempts (30% versus 4%). Within the schizophrenia group, in logistic regression analysis, 2 variables were significantly associated with lifetime suicidal attempts: current syndromal depression and higher scores on the Traumatic and Victimization Scale. CONCLUSIONS: The data confirmed that in later life, persons with schizophrenia continue to have a higher prevalence of suicidality than their age peers in the community. Our findings underscore the importance of monitoring for suicidality in this age group. The relative paucity of risk factors means that practitioners can more easily focus their therapeutic efforts on at-risk individuals.


  BACKGROUND: This analysis aimed to show whether symptoms of either pole change in their persistence as individuals move through two decades, whether such changes differ by age grouping, and whether age of onset plays an independent role in symptom persistence. METHOD: Participants in the National Institute of Mental Health (NIMH) Collaborative Depression Study (CDS) who completed at least 20 years of follow-up and who met study criteria for bipolar I or schizoaffective manic disorder, before intake or during follow-up, were divided by age at intake into youngest (18-29 years, n=56), middle (30-44 years, n=68) and oldest (>44 years, n=24) groups. RESULTS: The persistence of depressive symptoms increased significantly in the two younger groups. Earlier ages of onset were associated with higher depressive morbidity throughout the 20 years of follow-up but did not predict changes in symptom persistence. The proportions of weeks spent in episodes of either pole correlated across follow-up periods in all age groupings, although correlations were stronger for depressive symptoms and for shorter intervals. CONCLUSIONS: Regardless of age at onset, the passage of decades in bipolar illness seems to bring an increase in the predominance of depressive symptoms in individuals in their third, fourth and fifth decades and an earlier age of onset portends a persistently greater depressive symptom burden. The degree to which either depression or manic/hypomanic symptoms persist has significant stability over lengthy periods and seems to reflect traits that manifest early in an individual's illness.
OBJECTIVES: To compare the risk for cardiovascular mortality between bipolar I and bipolar II subtypes and determine correlates of cardiovascular mortality. Bipolar disorder conveys an increased risk of cardiovascular mortality.

METHODS: Participants with major affective disorders were recruited for the National Institute of Mental Health Collaborative Depression Study and followed prospectively for up to 25 years. A total of 435 participants met the diagnostic criteria for bipolar I (n = 288) or bipolar II (n = 147) disorder based on Research Diagnostic Criteria at intake and measures of psychiatric symptoms during follow-up. Diagnostic subtypes were contrasted by cardiovascular mortality risk using Cox proportional hazards regression. Affective symptom burden (the proportion of time with clinically significant manic/hypomanic or depressive symptoms) and treatment exposure were additionally included in the models.

RESULTS: Thirty-three participants died from cardiovascular causes. Participants with bipolar I disorder had more than double the cardiovascular mortality risk of those with bipolar II disorder, after controlling for age and gender (hazard ratio = 2.35, 95% Confidence Interval = 1.04-5.33; p = .04). The observed difference in cardiovascular mortality between these subtypes was at least partially confounded by the burden of clinically significant manic/hypomanic symptoms which predicted cardiovascular mortality independent of diagnosis, treatment exposure, age, gender, and cardiovascular risk factors at intake. Selective serotonin uptake inhibitors seemed protective although they were introduced late in follow-up. Depressive symptom burden was not related to cardiovascular mortality.

CONCLUSIONS: Participants with bipolar I disorder may face a greater risk of cardiovascular mortality than those with bipolar II disorder. This difference in cardiovascular mortality risk may reflect manic/hypomanic symptom burden.


OBJECTIVES: Epidemiological studies suggest that elders with bipolar disorder (BD) may be at increased risk for dementia compared to the general population. We sought to investigate whether older adults with BD would present with more cognitive dysfunction than expected for their age and education, and whether they would experience a more rapid cognitive decline over three-year prospective follow-up.

METHODS: Thirty-three subjects age > or = 50, mean (SD) age 69.7 (7.9) years, with BD I (n = 28) and II (n = 5) had neuropsychological examination at baseline and longitudinally over three years. All subjects were administered the Dementia Rating Scale (DRS) when euthymic. Thirty-six mentally healthy comparators ('controls'), equated on age and education, were selected from ongoing studies in our research center examining the longitudinal relationship between late-life mood disorders and cognitive function.

RESULTS: Compared to mentally healthy comparators, subjects with BD performed significantly worse on the DRS at baseline [mean (SD) 135.2 (4.7); n = 33 versus 139.5 (3.3); n = 36], and over follow-up [131.9 (7.7); n = 14 versus 139.1 (3.4); n = 22]. There was a group-by-time interaction between the subjects with BD and the controls [group x time: F(1,64) = 5.07, p = 0.028].

CONCLUSIONS: In our study, older adults with BD had more cognitive dysfunction and more rapid cognitive decline than expected given their age and education. Cognitive dysfunction and accelerated cognitive decline may lead to decreased independence, with increased reliance on family and community supports, and potential placement in assisted-living facilities.


OBJECTIVE: To examine whether late and very-late first-contact schizophrenia carry a risk for later development of dementia.

METHODS: By linkage of the psychiatric and the somatic nation-wide registers of all out- and in-patients with hospital contact in Denmark, we identified all patients with first ever contact during the period from January 1994 to December 2001 with one of the index main diagnoses: late (age >or=40) and very-late first-contact (age >or=60) schizophrenia. First contact osteoarthritis patients as well as data on the general population were used as controls. The first diagnosis of dementia for each individual at discharge or at out-patient contact was established. The probability of getting a dementia diagnosis is estimated using
Poisson regression models with dementia as the outcome of interest. RESULTS: Twelve thousand six hundred and sixteen and 7,712 individuals were included in the late and very-late sample, respectively. Follow-up time was between 3.00 and 4.58 years. The rate ratio (RR) of developing dementia in late and very-late first-contact schizophrenia compared to osteoarthritis patients were 3.47 (95%CI: 2.19-5.50) and 3.15 (95%CI: 1.93-5.14), respectively. Compared to the general population the RR were 2.36 (95%CI: 1.54-3.62) and 2.21 (95%CI: 1.39-3.50), respectively. CONCLUSION: schizophrenic patients with late- and very-late first-contact with the psychiatric hospital system are at two to three times higher risk of subsequently getting a diagnosis of dementia compared to patients with osteoarthritis and compared to the general population.


BACKGROUND: Late onset disorders are often associated with cerebral disfunctioning and cognitive impairment in elderly patients. It is unknown whether the age of onset affects cognition in patients with bipolar disorder. The authors compare cognition and clinical characteristics of early- and late-onset bipolar patients in a stable and euthymic condition. METHOD: One hundred and nineteen older patients (age >60) with an early- (<40 years) or late-onset bipolar disorder and a group of 78 comparison subjects were extensively tested for cognitive functioning. RESULTS: Bipolar subjects scored lower on most cognitive measures. The late-onset patients were more impaired in psychomotor performance and mental flexibility than the early-onset patients. These differences could not be explained by differences in exposure to cerebrovascular risk factors. CONCLUSIONS: Older patients with bipolar disorder have substantial cognitive impairments. Late onset bipolar disorder is associated with more severe cognitive impairment than early-onset bipolar disorder. For clinical practice, it is important to develop treatment strategies which take this into account.


OBJECTIVES: The relationship between age and prescribed antipsychotic dose in patients with schizophrenia has been examined by assuming only a linear correlation in two age subgroups at most. The age of illness onset has also not been under adequate consideration in past prescription surveys. The objective of this study was to better evaluate these age effects on antipsychotic dose prescribed in these patients across a broad age range. METHODS: Review of prescriptions for antipsychotic medications in patients with schizophrenia spectrum disorders was conducted across 30 sites in Tokyo. A total of 1,418 patients (655 inpatients, 763 males, age range: 16.6-90.2 years) were studied. RESULTS: Age had significant effects on prescribed antipsychotic dose; the dose increased with age through the third decade, subsequently plateaued, and decreased after the fifth decade. The age of illness onset also had significant effects on the dose; late-onset schizophrenia (LOS) and very-late-onset schizophrenia-like psychoses (VLOS) patients received lower doses than early onset schizophrenia (EOS) patients. LOS and VLOS patients who did not experience any hospitalization for the previous year were treated with (1/2) and (1/3), respectively, of the dose for EOS of comparable current age. CONCLUSION: Our results suggested biphasic effects of age on antipsychotic dose prescribed in patients with schizophrenia spectrum disorders. The natural history of schizophrenia and physiological aging may contribute to this inverted U-shaped relationship. In addition, our results may add another evidence of distinction among EOS, LOS, and VLOS from a clinical psychopharmacological perspective.
Next Month's Issue:

Alcoholism and Substance Abuse in Older Adults

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