Geriatric Psychiatry May Be the Mainstream Psychiatry of the Future

There is an old Indian saying: "If we are lucky, we will not be poor; if we are lucky, we will not be disabled; but if we are lucky, we will live to be old." Indeed, as the average lifespan in many parts of the world has increased over the past century—in the United States, from 47 years in 1900 to 76 years today—we should consider ourselves lucky. One modification to the Indian saying that is required, however, is that we should not merely live to be old, but should also continue to be in good health in old age. Considerable research is currently focusing on increasing longevity and reducing morbidity and mortality from heart disease, cancer, diabetes, and other illnesses. A similar effort is needed with respect to psychiatric disorders related to aging.

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The overall population demographics related to aging are staggering. In the United States, the number of persons age 65 and over has increased from 3 million in 1900 to 35 million today; yet it will double to nearly 70 million in just 30 more years, thanks to the aging of the baby boomers (1). Even more impressive is the rise in the number of people living into "very old" age. For example, whereas there were only about 6,000 centenarians in the United States in 1905, about 120,000 people will be over age 100 in the year 2005. Recent work on telomerase—the enzyme that preserves telomere, which is tied to cell replicability and lifespan—has even challenged the inevitability of aging and death. Thus, these are exciting times regarding the prospects of at least delaying physical decline with age. What about mental health and mental illnesses in relation to aging? This is an area where much more work is needed—and urgently too.

There is a common misconception, stemming partly from the Epidemiologic Catchment Area (ECA) study (2), that psychiatric disorders are infrequent in elderly individuals. According to the ECA study, 1-year and lifetime prevalence figures for *any psychiatric disorder* (excluding cognitive impairment) were considerably lower among elderly individuals than among younger adults. While this difference may be partly due to higher mortality associated with certain serious mental illnesses, an important explanation for the ECA finding is that psychiatric disorders were grossly underdiagnosed among elderly persons, because of problems such as the use of age-inappropriate diagnostic criteria (3).

Furthermore, we can expect that there will be an increase in the number of elderly mentally ill people that will be disproportionately greater than that of elderly persons in the general population. This will be due to a variety of factors, including earlier and more accurate diagnosis (using age-appropriate diagnostic criteria and better assessment procedures), reduced social stigma against mental illness resulting in less denial of psychiatric disorders among the aging baby boomers, and improved overall health care (managed care notwithstanding!) secondary to better pharmacologic and other treatments. A near-normal longevity among seriously mentally ill individuals may occur as a consequence of improved treatments. At present, younger adults age 30–44 with a diagnosable psychiatric disorder outnumber psychiatrically ill individuals age 65 and over by more than 2:1. Within the next three decades, the numbers in these two age categories are expected to increase by less than 15% and more than 100%, respec-

tively (4). The latter estimate is conservative, as it excludes the substantial numbers of geriatric patients with delirium and those with dementia uncomplicated by psychosis or depression. The result will be that most general psychiatrists will have a far greater proportion of patients from the ranks of the elderly than they do now.

It is critical for psychiatry to prepare itself for this upcoming explosion in the number of mentally ill elderly persons. Geriatric psychiatry as a subspecialty has come a long way in the United States during the last 20 years (4), and it will continue to make impressive strides. Yet, it is not generally well appreciated that over the next several decades, mainstream psychiatry itself will include much more geriatric psychiatry, just as a large part of adult neurology now addresses the problems of geriatric patients. The number of trained geriatric psychiatrists will be too small to meet the needs of the expanding population of elderly mentally ill people, and geriatric psychiatrists will predominantly serve as consultants and teachers (as well as specialized researchers) rather than providing direct care for most elderly patients.

What is required is for general psychiatrists to become better trained in geriatric psychiatry. The recently revised requirements for training of psychiatric residents will now include 1 month of training in a geriatric setting. While this is a welcome improvement over the previous lack of any mandated geriatric training, 1 month is really too short a time period, considering that the psychiatrists of the future will be spending a much higher proportion of their time caring for elderly mentally ill patients and their caregivers. Admittedly, there are many competing demands on residents' training schedules; nonetheless, a concerted effort should be made to extend training in geriatric psychiatry to be commensurate with their future workload.

There is also a need for more research about elderly mentally ill persons in different settings. Specific diagnostic criteria, assessment instruments, and treatment strategies should be developed for geriatric psychiatry patients. Just as children are not small adults, the elderly are not merely chronologically older adults. There are important biopsychosocial differences that have an impact on their care. For example, compared to younger adults, older patients are likely to have much greater biological heterogeneity, more physical and cognitive comorbidity, higher risk of side effects of medications, greater therapeutic pessimism fostered by societal as well as professional ageism, and more aging-related socioeconomic stressors, to name a few salient characteristics. The federal government currently requires inclusion of children, women, and ethnic minorities in all mental health research protocols (unless there are specific reasons for their exclusion). I believe that elderly people must also be included in all appropriate studies, especially those involving pharmacologic as well as nonpharmacologic treatments. One step in the direction of increasing the general awareness of geriatric psychiatry is to have superior articles in this area published in a mainstream psychiatric journal. *The American Journal of Psychiatry* deserves to be applauded for making a conscious effort to achieve that goal.

This issue of the *Journal* includes at least four such outstanding articles. Blazer calls attention to the issue of depression and other psychiatric disorders among the oldest old—those over the age of 85. He makes a passionate case for psychiatry to go back to its roots in medicine and develop comprehensive models of interdisciplinary assessment and therapy. Butters et al. present findings suggesting that although successful pharmacotherapy for late-life depression may improve selected cognitive abilities, patients may remain cognitively impaired and may be in the early stages of dementia. The other two articles deal with the more painful topic of death. Hendin et al. report that therapists whose patients (not necessarily geriatric) have committed suicide can benefit from participation in discussions with a disinterested independent group of mental health professionals. Finally, in a moving personal account, Berkey describes how issues of death and dying—along with ethically complex questions of euthanasia—can hit home when they affect a psychiatrist's near and dear one.

As a forward-looking field, psychiatry has a great opportunity to make modifications in its overall agenda for training and research that will affect the care of aging psychiatric patients in the years to come. We can help change the age-old stereotype that late life is a gray and dark period and help make late life a golden time for our patients.

References

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