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Editorial

A call for a new positive psychiatry of ageing

Dilip V. Jeste and Barton W. Palmer

Summary

We propose a new model for geriatric psychiatry to help meet the needs of a rapidly growing population of older adults. This positive old age psychiatry would focus on recovery, promotion of successful ageing, neuroplasticity, prevention, and interventions to enhance positive psychological traits such as resilience, social engagement and wisdom.

Declaration of interest

D.V.J. is the President of the American Psychiatric Association.

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With the number of older people with mental illness expected to triple over the next 25 years, old age psychiatry faces a daunting challenge as well as a unique opportunity to redefine itself. The prevalent approach to treating psychiatric disorders will not suffice. We need a new positive psychiatry of ageing. This new model would focus, not simply on symptom relief, but on recovery[1] and promotion of successful ageing. It would view old age, not as a period of inevitable biopsychosocial decline, but as one with continued neuroplasticity leading to neuroregeneration. In addition, this new model would not only incorporate principles of prevention for conditions such as depression following open-heart surgery or strokes, but also employ interventions to enhance positive psychological traits including resilience, optimism, social engagement and wisdom. Positive psychiatry has the potential to improve patient (and non-patient) outcomes, reduce healthcare costs and reinvigorate what could become the boom field in psychiatry. We discuss the rationale and the proposed model for positive psychiatry of ageing.

Widening gap between demand and supply

Today there are 550 million people in the world older than 65 years; in 2040, there will be 1.4 billion.[2] In no field will this seismic demographic shift be felt more strongly than in geriatric psychiatry.[3] We anticipate a notable increase in incidence and prevalence of mental illness in older adults, especially among Baby Boomers, who have a greater acceptance and recognition of psychiatric disorders along with an elevated risk of mood and substance use disorders compared with earlier generations. Yet, while the need for geriatric mental health professionals will grow, we already know their supply is decreasing. The number of US board-certified geriatric psychiatrists has dropped during the past decade. This workforce shortage appears to be due as much to the economics of geriatric healthcare (expensive, yet poorly reimbursed) as to negative attitudes towards ageing and pessimism about the prognosis of psychiatric disorders. Remedial actions are urgently needed to expand the geropsychiatry workforce.

Recovery and successful ageing

Contemporary empirical data paint a brighter picture of the course of psychopathology and disability among older people with serious mental illness than the traditional conceptualisation. Older adults with schizophrenia are more likely to adhere to medication and less likely to misuse substances or have a psychotic relapse than their younger counterparts. A minority of older persons with schizophrenia experience sustained remission or recovery, the predictors of which include social support, early initiation of treatment, better premorbid functioning and having been married. There also are numerous individuals who have had lifelong struggles with mental illness, but led outstanding lives of courage, dignity, and contribution to the society, especially in their later years. Prominent examples include William Carlos Williams, a physician who had several major depressive episodes from age 16 through 75, but wrote Pulitzer Prize-winning poetry after age 50, and John Nash, the Noble Laureate who had schizophrenia but showed remarkable improvement in later life.

There is a growing recognition that medicine should encompass not only treatment of symptoms, but also promotion of well-being. For old age psychiatry, this would mean attention to 'successful ageing'.[4] But, what is successful ageing? We found 29 different definitions of successful ageing in 28 published studies on this topic.[5] The most commonly used definitions include objective criteria for establishing an absence of physical, cognitive and social disability.[6] Traditional notions of successful ageing emphasise staying youthful with high-level physical functioning – that is, how much one has not aged. However, a better way to conceptualise successful ageing may be to emphasise desirable traits associated with older age, such as wisdom, which is comprised of insight, compassion, emotional regulation and rational decision-making.[7] Also, objective criteria ignore subjective aspects of successful ageing. Studies show that a large proportion of older adults with chronic physical illness, who would not meet objective disability-based criteria, perceive themselves as ageing successfully.[8] Subjective assessments of successful ageing are meaningful because an individual is best positioned to know the subtleties of the range of relevant factors in her or his own life, to assign weights to these factors with appropriate values in view of personal goals and preferences, and to contextualise those elements within the overall trajectory of past and anticipated future life. Our studies suggest that different domains of ageing

– physical, cognitive, and psychosocial functioning – influence self-rated successful ageing,[9] which is the ultimate downstream outcome of importance to the individual.

Neuroplasticity of ageing

In the past two decades, neuroscience research has challenged many long-held concepts about brain development, clearly demonstrating that neuroplasticity, with associated brain growth and development, can continue into old age. These positive outcomes are related less to the genes inherited than to the behaviour, attitude and environment which affect expression of those genes. Although there has been strong emphasis in the scientific literature on the value of calorie restriction and physical activity for enhancing longevity and functioning, scant attention has been paid to the potential role of positive psychological attributes in facilitating successful ageing. Yet, a number of studies have demonstrated that optimism, resilience and social engagement are associated with not only better mental health but also greater longevity in older adults. Empirical research supports a model in which positive psychological traits interact with and feed into each individual's evaluation of the degree of successful ageing, and are a stronger predictor of self-rated successful ageing than physical health is.[8,9] The mechanisms underlying these findings are presently unclear, and uncovering them should be part of a new research agenda.

Positive psychological traits and prevention

Positive psychology has received considerable attention in recent years;[10] yet, the focus of psychiatry, as a branch of medicine, has been limited primarily to diagnosis and treatment of individuals with severe psychopathology. As medicine begins to appreciate the importance of wellness and positive psychosocial factors in the management and prevention of pathology, positive psychiatry (and especially, positive old age psychiatry) will increasingly take centre stage within medicine and healthcare. Treatment trials have shown beneficial effects of behavioural strategies buttressing resilience, changing attitudes towards ageing, or incorporating meditation on outcome measures such as alcohol consumption, biological response to stress, and mortality rates in older adults.

Is prevention in geriatric psychiatry an oxymoron? Emerging evidence suggests that prevention in later life can be practical and cost-effective. For example, depression following strokes, myocardial infarction and bypass surgery can be treated and even prevented, with a significant reduction in morbidity and mortality. Likewise, interventions aimed at altering partially malleable risk factors such as social isolation, physical disability and sleep problems can prevent or at least delay the onset of depression. Similarly, the risk of older victims of natural disasters, wars or tragic events developing post-traumatic stress disorder can be decreased with counselling.

Proposed role for old age psychiatry

The proposed role of old age psychiatrists would be threefold: as clinicians, as educators and as researchers. As clinicians, they will optimise the use of pharmacotherapy and employ psychotherapeutic/behavioural interventions including cognitive–behavioural therapy, work rehabilitation and intergenerational programmes to enhance everyday functioning in older adults with mental illness. They also would train their non-psychiatrist colleagues in implementing similar interventions in people with or at risk for physical illnesses. As educators, geriatric psychiatrists will seek to combat stereotypes of old age and promote the concept of successful psychosocial ageing for the general population. Reduction in ageism will also help in recruiting more healthcare professionals and trainees into old age psychiatry. As researchers, an exciting area of investigation will be identifying and then seeking to modify biopsychosocial factors or processes underlying positive psychological traits. For example, there has been tantalising research on the gene variations related to resilience and optimism,[11] as well as genetic mutations associated with specific variants of frontotemporal dementia characterised clinically by a loss of behavioural characteristics involved in wisdom. Developing biological treatments focusing on such processes may help enhance those positive traits in people with neuropsychiatric disorders. Another critical need in the field today is for psychotropic medications that are efficacious, safe and affordable for older adults with serious mental illness.

If effective interventions to strengthen the positive psychosocial factors were provided to all older psychiatric patients, we could see a significant increase in the number of seriously mentally ill older adults who achieve recovery.[1] Similarly, through well-designed and implemented preventive strategies, positive psychiatry has the potential to improve health outcomes and reduce morbidity as well as mortality.

In summary, positive old age psychiatry can, in the near future, develop into a core component of the overall healthcare system aimed at promoting successful ageing. We should welcome the growing ranks of the ageing population as a golden wave in which older people, including those with mental and physical illness, can be happy and productive, and make important contributions to their own welfare as well as that of younger generations. Admittedly, this will be an ambitious undertaking. However, our goal must be to ensure that successful psychosocial ageing becomes the norm rather than the exception.

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reflections

Karl Jaspers, *General Psychopathology*

David Goldberg

In my first months as a trainee at the Maudsley we met weekly with a genial tutor who took us through the whole of *General Psychopathology*, 50 to 100 pages at a time. Although this seemed an unimaginative way of organising what were optimistically called 'tutorials', the experience has stood me in good stead. Indeed, in work I have recently done in connection with the revision of both the ICD and the DSM, I had Jaspers' aphorism constantly in mind: 'classification . . . has only a provisional value. It is a fiction which will discharge its function if it proves to be the most apt for the time'.

Karl Jaspers qualified in medicine at the age of 25. After 4 short years in clinical psychiatry, at the age of 30, he wrote *General Psychopathology* (*Allgemeine Psychopathologie*), which is indeed the book on which his reputation as a psychiatrist rests.

This starts with what is still the best description of phenomena of abnormal psychological functioning. In making diagnostic assessments, we should be guided by the form, rather than the content of symptoms. His fundamental distinction was between understanding and explaining in thinking about mental disorders. As working clinicians, we are concerned to understand the patient's experiences, but such understanding is necessarily a limited undertaking. The more information we accumulate about an individual patient, the fewer are the possible meanings we can assign to particular experiences – with understanding, there are limits everywhere. In any given case, the judgement of whether a meaningful connection is real does not depend on its self-evident character alone, but depends primarily on tangible facts – about the patient's culture, his acts and way of life, and his underlying personality. The fewer the data, the more interpretations are possible, and the less we understand. Explaining, on the other hand, is the way knowledge advances in psychiatry, and advances by accounting for one set of phenomena in terms of another set of observations. It is essentially an unlimited procedure.

Jaspers considered that only psychological disorders accompanying known cerebral pathology were true disease entities, and within the psychoses 'the diagnosis has no specific alternative character. Either it is clear as a whole or the differential diagnosis over details determines nothing'.

'If the reader tries to get hold of the entity involved, he will find that it melts away even as he looks at it. The question of what underlies all phenomena in general used to be answered in the old days by the notion of evil spirits. These later turned into disease entities that could be found by empirical investigation. They have proved themselves however to be mere ideas'.

'We have intuitions of a whole which we call schizophrenia but we do not grasp it; instead we enumerate a vast number of particulars or simply say ''ununderstandable'', while each of us only comprehends the whole from his own experience of actual contact with such patients'.

Nor did he have much time for precise diagnoses in the field of neuroses and personality disorders (*psychopathien*): 'it is difficult to bring diagnostic order . . . into shifting phenomena which continually keep merging into one another . . . there is no sharp dividing line between types nor is there a decisive borderline between what is healthy and what is not. A diagnosis remains typological and multi-dimensional including a delineation of the type of personality'.

After leaving psychiatry Jaspers became one of the founding fathers of existential philosophy.

A series of 'Reflections on Karl Jaspers' commemorates the centenary of the first publication of his *Allgemeine Psychopathologie* in 1913.

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