Late-Onset Schizophrenia and Late Paraphrenia

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Abstract

The term “late-onset schizophrenia” was first coined by Manfred Bleuler (1943) to describe a form of schizophrenia with an onset between the ages of 40 and 60. This concept has been adopted by German psychiatry. Until recently, British and American psychiatrists had little interest in this patient group. However, they often used the term “late-onset schizophrenia” interchangeably with late paraphrenia or as a generic term for both these diseases, even though the concept of late paraphrenia is quite different from that of late-onset schizophrenia. Late paraphrenia is a British concept that includes all delusional disorders starting after age 60. This confusion of terms and concepts is even more important now, because recent neuroimaging and neuropsychological studies suggest that an organic substrate probably exists in most cases of late paraphrenia, while only minor organic abnormalities can be found in late-onset schizophrenia. We believe it is of utmost importance to establish a clear boundary between late-onset schizophrenia and other delusional disorders in middle and old age, because the confusion in terminology and concepts is a serious impediment to comparative international research.


Man kann sich kaum mit den spät schizophrenen Krankheitsbildern abgeben, ohne immer wieder daran erinnert zu werden, wie sehr Kraepelin recht hatte, wenn er die Lehre von den Psychosen des höheren Lebensalters als “das dunkelste Gebiet der Psychiatrie” bezeichnete. In der Tat scheint einem heute wie früher der Boden unter den Füßen zu schwanken, und unsere grundlegenden psychiatrischen Begriffe scheinen ihren Sinn zu verlieren, wenn man um Erkenntnisse über die Spät schizophrenien ringen will. [M. Bleuler 1943, S. 259]

One can hardly deal with late onset schizophrenic pictures without being reminded again and again how right Kraepelin was when he called the science of psychoses of old age “the darkest area of psychiatry.” Indeed, today as in earlier times the ground seems to shake under our feet, and our basic psychiatric terms seem to lose their meaning when one grapples with late onset schizophrenias. [M. Bleuler 1943, p. 259]

Although Bleuler and Kraepelin wrote many decades ago, their message applies today. Even now, there is a “dearth of published data” on late-onset schizophrenia, as was stated by Jeste (1993) in a recent issue of Schizophrenia Bulletin dedicated to late-life schizo-

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phrenia (p. 688). It is still difficult to compile findings on late-onset schizophrenia, mainly because of confusion in terms and concepts. The literature uses the term "late onset schizophrenia" for two different entities. In the classical Bleulerian tradition, late-onset schizophrenia is diagnosed when a patient first manifests specific schizophrenic symptoms after age 40. Schizophrenia beginning after age 60 is included, but it is considered very rare. On the other hand, this label has also been used for a group of patients diagnosed with late paraphrenia. This concept derives from British psychiatry and includes patients with the onset of not only schizophrenic but also delusional disorders after age 60.

The late paraphrenia diagnosis is "a peculiarly British [one] and has no international counterpart" (Howard 1992, p. 63). Even so, this concept had some impact on the International Classification of Diseases (ICD; World Health Organization 1967, 1978, 1992) as well as on international research and literature. Thus, authors do not unequivocally distinguish between late-onset schizophrenia and late paraphrenia (e.g., Grahame 1984; Stoudemire and Riether 1987; Gurland 1988; Flint et al. 1991; Yassa 1991; Hassett et al. 1992; Howard et al. 1993b; Yassa and Suranyi-Cadotte 1993). Reviews of late-onset schizophrenia do not adhere to a stringent definition of this disease, and they mix findings on late-onset schizophrenia with those on late paraphrenia (e.g., Castle and Howard 1992). The same is true for reviews of late paraphrenia (e.g., Bridge and Wyatt 1980a, 1980b). One can even find empirical studies on late paraphrenia under "late-onset schizophrenia" (Howard et al. 1993a). Because these two diseases have not been clearly differentiated, international research in this domain has suffered greatly.

One of the causes of confusion is the evolution of the term "paraphrenia." Kraepelin (1919/1971) originally defined this disease phenomenologically and did not set age boundaries. Since then the term has undergone an unorthodox change in definition to include only patients with late-onset paraphrenia. Even Roth (1955), who coined the term "late paraphrenia," originally described patients as manifesting paraphrenia-like symptoms after the age of 45 with most cases occurring after age 60. It was not until later that illness onset after age 60 became a quasi-obligatory criterion for the diagnosis of late paraphrenia.

In the meantime, some authors even use the term "paraphrenia"—omitting the "late"—synonymously with late-life psychoses (e.g., Miller and Lesser 1988) or paranoid states in late life (e.g., Bridge and Wyatt 1980a, 1980b). In contrast, other researchers are faithful to Roth's original definition of late paraphrenia, which delineates age 45 as the earliest boundary for illness onset (e.g., Rabins et al. 1984).

This confusion in terminology and concepts has grown in importance, because in the past few years it has become clear that one can encounter many diseases under the umbrella of a late paraphrenia diagnosis. These diseases include late-onset schizophrenia and other delusional disorders, especially those that are of clear organic origin (Naguib 1991). Up to now, however, it was not known how many late paraphrenia patients in fact had late-onset schizophrenia, that is, how often "true" schizophrenia occurs after age 60. According to the pertinent literature, which is mainly German, the number of patients with very late onset schizophrenia is minimal.

### Historical Development in Germany

In 1893 Kraepelin chose the word "dementia praecox" to describe the endogenous psychoses whose progression has a distinct process resulting in dementia. In 1905 Kraepelin wrote: "I chose the term dementia praecox because of the terrible outcome as well as the fact that the suffering develops in early age. At the time, these two characteristics seemed to apply to this group of newly described patients" (p. 577). However, he quickly realized that dementia praecox did not always begin in youth. In his textbooks he sketched a diagram showing that two-thirds of the cases began between ages 15 and 30. The number of first-onset cases then dwindled as age progressed, although in a small number of cases the illness developed in the fourth, fifth, and even the sixth decade of life. Even so, Kraepelin found that only 0.2 percent of the 1,054 patients he studied experienced their first symptoms after age 60 (Kraepelin 1909–15).

Kraepelin also realized early on that not all patients suffering from dementia praecox had the same symptoms, so he tried to identify specific subgroups. For example, he tried to isolate a group with paraphrenia. He characterized this group as having a minimal disturbance of affect and will without progression to insanity. Patients had a very insidious development...
of an ever-worsening paranoia with ideas of grandiosity in the later stages, but personality was preserved (Kraepelin 1909-15, p. 974). Hallucinations were also observed. The symptoms were described as beginning mainly between ages 30 and 50. But, Kraepelin later abandoned the distinction between paraphrenia and schizophrenia because of a study conducted by W. Mayer. In 1921 Mayer followed up on the 78 cases that Kraepelin had diagnosed as having paraphrenia and found that 50 of them had developed a clear diagnosis of dementia praecox.

Paraphrenia, then, was never a diagnostic entity based on age, but on phenomenology. Kraepelin never tried to delineate a specific symptomatology of dementia praecox in elderly patients, even when his work was presented in Anglo-Saxon literature in such a way as to justify the term “late paraphrenia” for elderly patients experiencing schizophrenia-like symptomatology.

Gaupp (1905) was one of the first to try to distinguish specific cases of late-onset from dementia praecox (Bleuler 1943). He described a rare illness in women characterized by a depressive climacteric agitation resulting in mental weakness. The beginning of this disease was observed between ages 45 and 60. In 1906 Stransky also made an effort to differentiate between dementia praecox and similar illnesses that occur in old age. He named the latter group “dementia tardiva.” Typical symptoms were “a prephase of depression, the contrast between the absurdity and incoherence of delusions as well as the clearness of hallucinations on the one hand as compared to the well-preserved affectivity” (quoted in Bleuler 1943, p. 263). Bleuler (1943) believed that Stransky had described the main characteristics of late-onset schizophrenia, which many authors after him have confirmed. Stransky considered dementia tardiva to be a subclassification of dementia praecox.

Berger (1913) attempted unsuccessfully to delineate paranoia chronica as an independent mental illness of later life separate from schizophrenia. Kleist (1913) coined the term “involutional paranoia” for an illness that supposedly affected mostly women ages 40 to 50. It was regarded as an exacerbation of “hyperparanoid” prepsychotic personality characteristics into pathological symptomatology. This illness was supposedly caused by “innersecretory change.” Unlike dementia praecox, involutional paranoia and its affect would remain in a clear relationship and never result in “imbecility.”

Albrecht (1914) studied 138 patients with a late-life psychosis not explained by brain pathology. Among these cases he could identify 24 with a so-called “presenile paraphrenia,” the symptoms of which were similar to those of Kleist’s involutional paranoia. Another 19 cases were characterized by a depressive madness resulting in imbecility, which according to Bleuler (1943) could be regarded as late-onset schizophrenia.

Later, Serko (1919) coined the term “involutional paraphrenia” and Medow (1922) came up with the term “stiffening involutional psychosis” (“erstarrende Rückbildungspsychose”).

Kolle (1931) took up the term “paraphrenia” (schizophrenic paraphrenic type) for schizophrenia occurring in middle and old age. However, most German psychiatrists, among them Leonhard (1957), used the term “paraphrenia” as Kraepelin had originally intended, that is, for a specific category of paranoid schizophrenia patients with characteristic psychopathology and independent of age.

Manfred Bleuler coined the term “late-onset schizophrenia” in 1943 after conducting a comprehensive empirical study on schizophrenia-like disorders with onset in older age. He defined late-onset schizophrenia as a group of psychoses fulfilling the following criteria:

1. The psychosis must begin after the 40th year of life.
2. Symptomatology does not differ fundamentally from that of schizophrenia in early life.
3. There is neither an amnestic syndrome nor accompanying physical findings unequivocally indicating that symptoms could be due to brain disease. [M. Bleuler 1943, p. 260]

According to Bleuler’s results, 15 percent of all schizophrenic disorders begin between ages 40 and 60, and onset after age 60 is negligible. Half the patients with late-onset schizophrenia that he investigated did not differ in symptomatology from early-onset schizophrenia subjects. And the other half seemed to have a “special kind of schizophrenic coloring.”

Over the years, many German researchers have continued to use Bleuler’s criteria for diagnosing late-onset schizophrenia (Klages 1961; Siegel and Rollberg 1970; Berner et al. 1973; Huber et al. 1975, 1979; Gabriel 1978).

Some authors have used other diagnostic labels such as “paranoid-hallucinatory psychosis in involutional age,” “paranoid involutional psychosis with schizophrenic coloring,” and “paranoid climacteric psychosis.” In 1952 Knoll studied 114 patients who
had developed paranoid illnesses for the first time after age 40 and found their symptoms to be so close to schizophrenia that he saw no need to create an independent diagnostic group for them.

Janzarik (1957) was one of the few German psychiatrists interested in patients whose first signs of illness occurred after age 60. He used the term "Altersschizophrenie" (old-age schizophrenia) for this patient group. According to his observations, these cases were comparatively rare. While he did not limit his study to first-admitted patients, patients suffering from the illness for the first time, or subjects with other such limiting criteria, he could identify only six patients whose schizophrenia had begun after age 60 at the psychiatric university hospital of Heidelberg over 5 years. Among these 6 and 44 patients from other institutions, he noted relevant organic findings in a large number of cases. These cases would certainly be excluded from a diagnosis of schizophrenia according to modern diagnostic criteria. Janzarik wrote: "When schizophrenic, cyclothymic, and organic symptomatology are mixed, and when reactive and endogenous symptoms are intertwined, then the dubiosity of the term schizophrenia becomes obvious" (1957, p. 541).

More recently, Huber et al. (1979) used the concept of late-onset schizophrenia in the same way Bleuler did. In a followup study of 502 patients with schizophrenia, they found that the illness had begun after age 40 in 14 percent and after age 60 in only 0.6 percent of all patients.

Marneros et al. (1992) used diagnostic criteria similar to DSM-III (American Psychiatric Association 1980), but they considered schizophrenia with onset after age 45, which DSM-III did not regard as schizophrenia, as late-onset schizophrenia. With this age cutoff, which is slightly later than that of other German authors, they found the proportion of subjects with late-onset schizophrenia to be less, that is, 8 percent of all those with schizophrenia. However, like most authors, they did not give an exact definition of "onset." As we know, age at onset in schizophrenia can be difficult to assess, and psychotic symptoms start on average about 2 years before the first admission (Häfner et al. 1992, 1993). If, as in many studies, onset is defined as first admission, some of the so-called late-onset cases could in fact be early-onset cases with a delayed hospitalization. Although Kraepelin (1909-15) had already mentioned this problem, it has to our knowledge never been empirically tested.

Apart from this problem of an inexact definition of onset, psychiatrists in the German-speaking tradition have generally regarded age 40 as the age boundary for late-onset cases. Schizophrenia is considered to be an illness that occurs in the early years of life. It can begin later, but it rarely develops after age 40 and only in exceptional cases after age 60.

**Historical Development in Great Britain**

British psychiatrists took hardly any interest in late-onset schizophrenia in the Bleulerian sense and in the German tradition, that is, the schizophrenia-like illnesses mainly beginning at 40 to 60 years of age. British researchers did quote Bleuler and his concept of late-onset schizophrenia but in connection with studies of a completely different group of diseases also known as late paraphrenia.

The diagnosis of late paraphrenia can be traced back to Roth and Morrissey (1952), who were working on the differential diagnosis of dementia in old age. They explicitly focused on the age group over 60 because they thought that senile, presenile, or arteriosclerotic psychosis was diagnosed much too often in this group, while the area of functional psychoses was neglected. They analyzed the charts of 150 inpatients older than 60 at admission from a single hospital. They suspected that 12 of the 150 were suffering from schizophrenia, although their criteria were not strictly defined. All 12 patients had manifested their first symptoms after age 60 and were paraphrenic in their character. Their idea of paraphrenia, then, was similar to Kraepelin’s earlier phenomenological description of this disease.

In a further study Roth (1955) found, among 450 psychiatric patients older than 60, 46 patients with paraphrenia-like illnesses whose first symptoms had begun after age 45 (except one case); 75 percent of these 46 patients had even experienced their first symptoms after age 60. He proposed the term “late paraphrenia” and gave the following definition: “patients … with a well-organized system of paranoid delusions with or without hallucinations existing in the setting of a well-preserved personality and affective response” (Roth 1955, p. 283). He also concluded from his studies that most patients experience their first symptoms after age 60. This conclusion seems precarious because
all his subjects were over age 60. Nevertheless, Roth never regarded this age cutoff as an obligatory criterion for the diagnosis. In fact, although he investigated only elderly people in this study, he had found a substantial proportion of patients with onset before age 60. On the other hand he obviously thought that if schizophrenia occurs in old age it shows a paraphrenic picture. Thus, a later manuscript coauthored with Kay (Kay and Roth 1961) states that "Late paraphrenia has to be regarded as the mode of manifestation of schizophrenia in old age" (p. 680). In British psychiatry, the term "late paraphrenia" became widely accepted and used. And unfortunately—contrary to Roth's original intent—onset after age 60 slowly became a quasi-obligatory diagnostic criterion.

In 1960 Fish criticized the term "late paraphrenia." First, the studies conducted in Germany showed that the diagnosis of paraphrenia merges into that of paranoid schizophrenia. Second, he wrote, "Late paraphrenia can also be confused with Bleuler's late schizophrenia. Thus, it would appear that Roth's choice is unfortunate" (Fish 1960, p. 940). He proposed the term "senile schizophrenia" as an alternative to Roth's to describe patients with schizophrenic symptomatology beginning after age 60. However, this proposal was not accepted. After conducting his own study, Fish accepted that a certain number of patients manifested their first symptoms of schizophrenia in old age. In his study he examined 264 inpatients age 60 and older and found among them 16 subjects with schizophrenia who had experienced onset after 40, only 7 of them after 60. However, Fish already believed that so-called late paraphrenia consisted of a heterogeneous group of diseases that are only partly schizophrenia. Post (1966) was also of this opinion. He cautiously named this illness group "persistent persecutory states of late life." He also doubted the high incidence of schizophrenia onset after age 60.

Thus, since the introduction of the concept of late paraphrenia there have been disputes about whether the illness group is uniform; if not, what proportion of this illness group has schizophrenia; and, finally, how high the incidence of schizophrenia after age 60 really is. Until recently, psychiatrists have debated whether patients diagnosed with late paraphrenia actually have schizophrenia or whether this term defines an etiologically heterogeneous group. The former position was held by Grahame (1984) and the latter by Holden (1987). Förstl et al. (1991, 1994), Häfner et al. (1991), and Howard et al. (1992a, 1992b). Grahame (1984) based his conclusions only on a cross-sectional study of a nonrepresentative sample of 25 patients. In contrast, Holden (1987) studied a representative group of 47 first-admission patients over age 60 with paranoia. His 10-year followup included interviews and other sources of information. He identified 37 patients who fulfilled Roth's criteria for late paraphrenia. Of these 37 patients, 13 showed signs of organicity and developed dementia within 3 years. Of the remaining 24 functional cases, 5 were diagnosed with schizoaffective psychoses and 9 with paranoid psychoses without first-rank symptoms. Only 10 patients were classified as having schizophreniaiform disorder (with first-rank symptoms). Other studies on the course of these diseases also suggest that the diagnosis of late paraphrenia covers a wider range of disorders than schizophrenia. At least some of the cases seem to develop dementia (Post 1966; Holden 1987; Hymas et al. 1989). Also, an affective psychosis with paranoid symptomatology can be misdiagnosed as paraphrenia (Pitt 1986).

Modern technology, such as cranial computed tomography and cognitive testing, has brought about progress in this field. Recent studies show that a substantial number of patients diagnosed with paraphrenia have indications of gross organic abnormalities (Naguib and Levy 1987; Hymas et al. 1989; Förstl et al. 1991; Miller et al. 1991; Howard et al. 1992a, 1992b; Post 1992). In 1991 Naguib summarized the new findings in a review: "Evidence suggests that paraphrenia is distinct from schizophrenia and that an organic substrate probably exists in most cases" (p. 371).

Late-onset schizophrenia in the German tradition, which is a narrowly defined "true" schizophrenia with mostly first-rank symptoms and exclusion of any cases with a suspected organic basis, has not been a research topic in Britain so far. Some recent studies on so-called late-onset schizophrenia use this label for a wide spectrum of diagnoses including all nonaffective psychoses beginning after age 45, that is, also including late paraphrenia with all its paranoid and organic subgroups (Castle and Murray 1993; Castle et al. 1993; Howard et al. 1993b). In a review on the etiology of late-onset schizophrenia, Castle and Howard (1992) differentiate the terms "late-onset schizophrenia" and "late paraphrenia" in their introduction.
but then treat both diagnoses the same in their meta-analysis, thereby implying again that patients diagnosed with late paraphrenia actually have schizophrenia.

The British discussion is mirrored in the development of the ICD. ICD–8 (World Health Organization 1967) had no independent diagnostic group for late-onset schizophrenias. Schizophrenia had no age-at-onset limit. Paraphrenic schizophrenia was part of the sub-group “paranoid schizophrenia.” But within the paranoid states, “paraphrenia (late)” was mentioned as one of “other paranoid states” (ICD 297.9).

The 9th revision of ICD (World Health Organization 1978) then offered an independent diagnostic category for paraphrenia under the group of paranoid states (ICD 297.2). It was described as a paranoid psychosis with conspicuous hallucinations, without affective symptoms and disordered thinking dominating the clinical picture, and with a well-preserved personality. The definition did not include an age limit, though involuntional paranoid psychosis as well as late paraphrenia were placed in this group, which indirectly implied an age association.

The first drafts of ICD–10 omitted the paraphrenia category and the term “late paraphrenia.” A controversy ensued in Britain (Quintal et al. 1991; Almeida et al. 1992; Howard 1992), and the term “paraphrenia (late)” did appear in the final version of ICD–10 (World Health Organization 1992) though only as part of “delusional disorders” (F 22.0) and not as an independent category. Cases formerly diagnosed as late paraphrenia should be seen as either delusional disorder or schizophrenia under the new classification (Quintal et al. 1991; Almeida et al. 1992; Howard 1992). Some, however, still favor an independent diagnostic category for late paraphrenia (Almeida et al. 1992; Howard et al. 1993b).

### Historical Development in North America

North American researchers were not particularly interested in the concepts of late paraphrenia and late-onset schizophrenia (Harris and Jeste 1988). As late as 1980, Bridge and Wyatt (1980b), in a comprehensive review of the American and European literature, stated that “there is a singular ... paucity of American research in this area” (p. 201). Harris and Jeste (1988) attributed this lack of interest to a historical tendency to diagnose these types of illness as affective or organic.

The first Diagnostic and Statistical Manual of Mental Disorders (DSM–I; American Psychiatric Association 1952) had only one age-bound diagnostic category, that of “involuntary psychotical reaction.” DSM–II (American Psychiatric Association 1968) described an “involuntary paranoid state (involuntary paraphrenia),” which differed from schizophrenia because it lacked the characteristic thought disorders. It did not set an age limit for the diagnosis of schizophrenia. In 1972 Feighner et al. defined their research criteria for a diagnosis of schizophrenia, one of which was that the onset occurs before age 40. Spitzer et al.’s Research Diagnostic Criteria (RDC; 1978), on the contrary, did not set an age limit for onset of the disease. DSM–III (American Psychiatric Association 1980) no longer had the category “involuntary paranoid states/paraphrenia.” Also, schizophrenia could be diagnosed only if onset occurred before age 45. A similar illness occurring after this age had to be classified as an “atypical psychosis.” In DSM–III–R¹ (American Psychiatric Association 1987), the diagnosis of schizophrenia was again allowed even if onset occurred after age 45. However, if the illness (including its prodromal phase) began after age 45, it was additionally coded as “late onset.”

The development of the American classification system as sketched above mirrors the development of the diagnostic concepts in American research. There is still a good deal of confusion over terms in the American literature (Harris and Jeste 1988). Just as British researchers often misquoted German authors or at least did not cite them in the correct context, so did American researchers partly misunderstand or incorrectly quote the European literature. Some have prematurely assumed an association between late-onset schizophrenia and late paraphrenia and have ignored differences in the definition of late onset (Levy 1990). One can already observe this phenomenon in Bridge and Wyatt’s review (1980a) of the European literature on this subject. Under the title “Paraphrenia: Paranoid States of Late Life,” these authors discussed late paraphrenia, late-onset schizophrenia, and other delusional disorders.

¹DSM–IV (American Psychiatric Association 1992), which has been published recently, did not bring major changes in regard to the aspects mentioned in this article, other than not allowing for a special coding of “late onset” anymore.
of middle and old age. They did so without clearly differentiating these groups and the respective findings. The term “late paraphrenia” was probably also used for late-onset schizophrenia-like illness because DSM-III did not allow a diagnosis of schizophrenia for illnesses beginning after 45.

In 1984, prompted by the European literature, Rabins et al. published “Can Schizophrenia Begin After Age 44?" which questioned DSM-III. While studying 35 patients with late paraphrenia who met Roth’s original criteria (continuous delusions, onset after age 45), not based on affective or cognitive disturbances), they discovered that 32 of the 35 patients fulfilled all the DSM-III criteria for schizophrenia or a schizophreniform disorder except the age limit criterion. Thus, the age limit set on schizophrenia was omitted in the revised version (see above).

Leuchter and Spar (1985) as well as Pearlson and Rabins (1988) focused more on the British tradition, studying patients over age 60 without applying specific diagnostic terms. Nevertheless, the confusion over terminology and concepts continued. Most of the authors (e.g., Stoudemire and Riether 1987; Gurland 1988; Flint et al. 1991; Yassa 1991; Yassa and Suranyi-Cadotte 1993) did not distinguish studies of late-onset schizophrenia from those of late paraphrenia. It has become clear in the meantime that late-onset schizophrenia is a strictly defined “true” schizophrenia that usually begins between ages 40 and 60, while late paraphrenia is a heterogeneous group of disorders that includes paranoid and organic psychoses and only in part is schizophrenia with very late onset.

Harris and Jeste (1988) were the first to explicitly criticize the confusion between late paraphrenia and late-onset schizophrenia. However, in their meta-analysis they ran into the same difficulties as other authors who tried to review this field of overlapping and confused concepts. Pearlson et al. (1989) also pointed out the confusion between the terms “paraphrenia” and “late-onset schizophrenia.” They chose to use late-onset schizophrenia only for patients meeting the DSM-III-R criteria for schizophrenia with onset after age 45.

All in all, the concept of late-onset schizophrenia as seen in German psychiatry was adopted more readily in America than it was in Britain, as evidenced by DSM-III-R, where late-onset schizophrenia can be classified as schizophrenia with the addition of “late-onset.” However, because of the simultaneous presentation of the German and British concepts, a confusion over terms also occurred in America and continues to persist.

Conclusions

The problems of terminology and nosology outlined above have until now seriously limited the comparability of studies. The result is a serious deficit in empirically sound knowledge in this area. In our opinion, it is therefore of utmost importance to (re)establish clear boundaries between late-onset schizophrenia and other delusional disorders with onset in old age, especially those disguised as late paraphrenia that are partly of organic origin. In practical terms, this means that first, the term “late paraphrenia” should be abandoned to avoid further confusion. There is now enough evidence that this is not a valid entity but an umbrella diagnosis for a heterogeneous group of diseases, including many cases of organic etiology. Second, ICD should—like DSM-III-R—allow for a late-onset coding within the schizophrenia category.

The diagnostic criteria of DSM-III-R and the British-influenced ICD-10 basically agree on the diagnosis of schizophrenia-like illness in old age. Even among the elderly, the diagnosis of schizophrenia is based on the presence of characteristic productive symptomatology, especially Schneider’s first-rank symptoms, as well as on characteristic negative symptomatology in clear consciousness and after exclusion of gross brain pathology. The age at onset per se should no longer influence the diagnosis. Yet, the age factor is handled differently in these two manuals. DSM-III-R allows for the additional coding of late onset (after age 45) in the category of schizophrenia, but not in the category of delusional disorders. ICD-10, on the other hand, does not allow for an additional coding of late onset in the schizophrenia category, but includes late paraphrenia with the delusional disorders. Thus, with ICD-10 there is still a danger of diagnosing true late-onset schizophrenia patients as having delusional disorder rather than schizophrenia, as, according to British tradition, these patients are still seen as having late paraphrenia. According to DSM-III-R the same patient would be given the diagnosis of schizophrenia (late onset).

Unfortunately, when researchers report on the same sort of patients using different terms (and vice versa) it is not possible to arrive
at a reliable and valid description of late-onset schizophrenia, and the boundaries with other delusional disorders of middle and old age are obscured. This confusion in terms may also prohibit the identification and exact description of other subgroups of late-onset paranoid patients, especially those with an organic substrate. Thus, this confusion about terms and concepts is a serious impediment to comparative international research.

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