

## EDITORIAL

### Under full sail

While writing these words I enjoy the view of the vast waters stretching to the horizon called Bass Strait, which lies between the Australian mainland and the north coast of Tasmania. The place is Lorne, founded in 1864, one of the more picturesque places along the Great Ocean Road. It is fitting for me to reflect here on *International Psychogeriatrics* and my new editorship since, not far from here, the immediate past editor, David Ames, spent some of his childhood years, and in 2001 he chaired the organizing committee for the regional IPA meeting held here in Lorne.

It occurs to me that there are similarities between the country of Australia and the discipline of psychogeriatrics. Australia is a young nation built on ancient foundations of indigenous cultures. Likewise, psychogeriatrics is a young specialist discipline built on a long history and written records dating back as far as ancient Egypt and Greece recording descriptions of symptoms of what we now call dementia and delirium. Modern Australia is a melting pot of people who came from all over the world and *International Psychogeriatrics* is the scientific flagship of the International Psychogeriatric Association (IPA), which comprises members from around the globe from different professional backgrounds who share a passion for psychogeriatrics.

With David Ames at the helm for the past eight years, *International Psychogeriatrics* has sailed from one success to another and it is daunting indeed to follow in his wake. It was a wise decision to have a handover period of more than a year between outgoing and incoming editor, and since we both live and work in the same town David Ames' expertise and advice is around the corner to support the editorial panel and to help me keep *International Psychogeriatrics* on a steady course. I won't attempt to summarize all the achievements David Ames secured for *International Psychogeriatrics*, but rather refer to his three editorials commenting on the beginning, midterm and end of his editorship which summarized the journey over the past eight years beautifully (Ames, 2003; 2006; 2011).

I am grateful to the board of directors of IPA for having given me the privilege to continue the journey for the next four years as the eighth editor of *International Psychogeriatrics*. But just like the skippers of the sailing boats who confront the turbulent waters of Bass Strait in the annual Sydney to Hobart yacht race, I can rely on a strong crew.

In 2010, because of a steady rise of submissions, *International Psychogeriatrics* increased the number of Deputy Editors, so that John O'Brien, Guk-Hee Suh, Nancy Pachama and Craig Ritchie will use their excellent skills and expertise as Deputy Editors to assist with editorial responsibilities. This support comes in addition to the already strong team of brilliant and dedicated Associate Editors, Michael Philpot as the Book Review Editor, three new statistical advisors (Chung-Chou H. Chang, Hiroko Dodge and Theodore K. Malmstrom), an excellent language advisory panel and our new Assistant to the Editor-in-Chief, Joan Mould. And of course this is more than a single boat travelling, but rather a strong fleet with IPA and Cambridge University Press making sure that *International Psychogeriatrics* can continue the journey under full sail.

By now you might have looked in astonishment at the cover of *International Psychogeriatrics* to check whether you had picked up a yachting journal instead, so we had better leave these waters for now and briefly focus on the current hot topics in psychogeriatrics. We live in exciting times considering the current developments and challenges in our field. Let us, for example, look at dementia and Alzheimer's disease. The centuries' old struggle to identify, describe and treat the syndrome we currently still call "dementia" is ongoing and has always extended beyond the medical field into social and legal areas, trying to establish rules which would protect the vulnerable individual with dementia from harm while defining competency (Kurz and Lautenschlager, 2010). Various international classification systems and consensus groups are addressing the term "dementia" at present, with suggestions to redefine or abandon it altogether, due partly to the inappropriateness of the term for very mild symptoms. This is not a modern problem, but caused difficulties almost a hundred years ago. The Swiss psychiatrist Eugen Bleuler, for example, struggled to find a suitable term for mild symptoms of organic origin affecting multiple cognitive domains in the absence of delirium, since the term dementia was clearly not appropriate. He finally suggested "psycho-organic syndrome" (Bleuler, 1916). When looking how to best categorize the various underlying causes of dementia, the current debate is active and healthy, and is based on a long tradition of past developments and controversies, such as when, in 1910, Emil Kraepelin named the syndrome

and pathology described by Alois Alzheimer in 1907 (Alzheimer, 1907) after him (Kraepelin, 1910). As today, academia was then often a competitive race between prestigious institutions, and naming a disorder was one way to carve out territories.

As exciting as this debate on what name might come to replace the term “dementia” is, you might ask yourself what’s in a name anyway, and judge that the far bigger challenge will be how to manage and prevent dementia, especially in light of the global graying of our societies, which is happening most dramatically in developing countries. Here we are faced not only with a semantic problem, but with the challenge of how best to incorporate new knowledge into clinical practice, so that as many people as possible might benefit from advances in research as quickly as possible. There are scientific and ethical questions, for example concerning the exciting technology of amyloid imaging (Nordberg *et al.*, 2010), relating to what the measured amyloid load really means for the prognosis of the individual and what (if anything) we should tell the patient, especially if the patient is clinically still well. At what stage do we call early signs of developing Alzheimer’s pathology a “disease” and what are the consequences for the individual as well as for society? Just as in ancient times these debates go beyond medicine and raise current sociological questions. How, as societies, do we want to support individuals who have been identified as having an increased risk of expressing Alzheimer’s disease, but have a life expectancy of potentially many decades when they still would like to contribute to society as best as they can? This broader focus requires help, in the multidisciplinary tradition of IPA and *International Psychogeriatrics*, from many disciplines including psychiatry, geriatrics, neurology, pathology, radiology, nuclear medicine, other medical disciplines, gerontology, ethics, health economics, psychology, neuropsychology, psychotherapy, nursing, occupational therapy, social work, physiotherapy and speech pathology, to name just a few. The debate is already in full swing, for example with regard to the clinical responsibility we face to give advice to patients diagnosed with mild cognitive impairment (Lautenschlager and Kurz, 2010), and this now extends even further to pre-clinical symptom-free risk carriers. What do we answer when asked for preventive strategies in light of the still huge divide between popular media reports and actual results from evidence-based science? This clinical challenge, however, forces us to revisit the semantics of classification approaches since they will determine in the end how we identify individuals who could take part in new preventive and treatment trials (Dubois *et*

*al.*, 2010). Even when this has been tackled there will remain the enormous challenge of how best to design modern treatment trials in the light of new underlying treatment mechanisms, so that there is a chance for success and ultimate improvement of clinical practice (Ganguli and Kukull, 2010).

The above examples cover just one area from a vast number of challenges across various syndromes and disorders within psychogeriatrics at present. Having this in mind it always amuses me when medical students ask me the endlessly recurring question: how on earth did I end up specializing in psychogeriatrics out of all the choices medicine can offer? As well as the cutting-edge scientific developments, I try to tell them about the privilege of working with and caring for older people, who are survivors with often fascinating life stories and rare wisdom. Next to the professional reward which comes with this there is the personal reward of learning from their experiences and thus enriching our own journey towards old age. Therefore I can hardly imagine a more exciting field and I will do my best to keep *International Psychogeriatrics* under full sail to explore new shores of knowledge and clinical care for better mental health for older people. I invite all members of IPA and readers of *International Psychogeriatrics* to join the voyage and help the editorial panel by submitting their contributions and sharing their visions of *International Psychogeriatrics*.

### Conflict of interest

None.

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