



Features and challenges of personality disorders in late life

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EDITORIAL

Features and challenges of personality disorders in late life

Introduction

A personality disorder (PD) is an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment (American Psychiatric Association, APA, 2000). In the DSM-IV-TR are ten specific PDs organized into three superordinate clusters based on presumed common underlying themes. Cluster A groups the paranoid, schizoid and schizotypal PDs in which individuals often appear odd or eccentric. Cluster B includes antisocial, borderline, histrionic and narcissistic PD in which individuals appear to be dramatic or erratic. Cluster C contains avoidant, dependent, and obsessive-compulsive PD in which individuals often appear fearful or anxious. Finally, the diagnosis 'personality disorder Not Otherwise Specified' is available for use and is assigned for cases in which the patient has clear signs of a PD but does not fit neatly into one of the ten specific PD categories (APA, 2000). The prevalence in general adult population is 13.5% and in psychiatric populations is 60.4%; PD Not Otherwise Specified is the most frequently diagnosed axis II disorder (Verheul, Bartak, & Widiger, 2007).

The prevalence of PD among older people in the general population is reported as lying between 2.8% and 13% (Ames & Molinari, 1994; Weissman, 1993). For older mental health patients treated in outpatient settings, percentages between 5% and 33% have been reported (Mezzich, Fabrega, Coffman, & Glavin, 1987; Molinari & Marmion, 1993). The prevalence of (co morbid) PD in older inpatients who receive mental health treatment has been reported as between 7% and 80% (Casey & Schrodtt, 1989; Silberman, Roth, Degal, & Burns, 1997). The wide spread in this range reflects the different research methods, diagnostic criteria and instruments used in the studies. In addition, the size of the samples varied widely from 30 subjects (Silberman et al., 1997) to 547 subjects (Kunik et al., 1994).

The meta analysis of Abrams and Horowitz (1999) reported on 16 studies conducted in different venues: The mean prevalence of older adults with PD (≥ 50 years) is 20%, compared to 22% for younger adults. It should be noted that this meta analysis included studies defining 'old age' as 50 years or older. The authors otherwise would not have been able to

incorporate adequate prevalence data for their meta analysis (Abrams & Horowitz, 1999).

Cross-sectional prevalence studies on specific PDs in different venues indicate that personality disorders from the A and C clusters remain relatively stable over time, while those from the B cluster tend to diminish during midlife and older age (Coolidge, Burns, Nathan, & Mull, 1992; Engels, Duijsens, Haringsma, & Van Putten, 2003; Molinari, Ames, & Essa, 1994; Stevenson, Maeres & Comerford, 2003; Ullrich & Coid, 2009; Watson & Sinha, 1996). One factor that could contribute to the lower prevalence of cluster B disorders is a selective mortality for this group. In one study, at 10–25-year follow-up, 3–9% of borderline patients had committed suicide (Stone, 1993). Further, risky behaviours such as substance abuse or reckless driving also lead to increased mortality (Fishbain, 1996). The prevalence figures cited above could also give a distorted image as we know that PD can manifest differently in later life as a result of cognitive deterioration, somatic comorbidity, medications and psychosocial challenges (Van Alphen et al., 2012).

Being able to identify and accurately diagnose PD in older adults (defined as ≥ 65 years) has critical clinical relevance as well as important relevance for providers and settings responsible for their care. The presence of a PD is typically manifested through a complex presentation of symptoms and syndromes challenging both diagnosis and treatment.

Specific therapeutic effects and side effects of treatment may also cause problems. While patients with primary or comorbid PD can be expected to benefit from regular, directive and symptom-focused treatment, it is likely that the response to treatment will take more time. In addition, patients with a PD have an increased risk of relapse, and the course of their illness is likely to be more complicated and chronic compared to those without a PD. Overall it is difficult to manage their care in any context. For example in designing a treatment plan for older adults in a psychiatric hospital, it is important that the plan address the specific PD, in order to avoid a premature termination of treatment (Sadavoy, 1999).

The presence of PD also has great relevance to the relationships of the older adult. The nature and severity of PD of necessity need inform the care management and specific behavioural advice should be provided to relatives of the patient as well as to

professional caregivers to optimize the likelihood of favourable response to treatment.

Both in somatic and psychological interventions for older adults, the presence of PD, co morbid or otherwise, tends to complicate medical interventions due to resistance to care (cluster A), noncompliance with therapy or medication abuse (cluster B), or excessive care demands (cluster C). It is difficult to achieve the connection, or alliance, necessary to engage and maintain cooperation with and adherence to the treatment or plan of care.

In the international literature, since the third edition the Diagnostic and Statistical Manual of Mental Disorders (APA; 2000) PD in younger adult mental health patients has long been an important theme. However, this area has been comparatively neglected for older adults. The fact that there is little research on PD in older people stands in stark contrast to the clinical relevance of this usually chronic disorder. The introduction of axis II PD in 1980 formed an important stimulus for scientific research on diagnostics and treatment. From the mid-1990s, only a modest number of English-language publications reported on PD in older people.

This article provides an overview of specific features in the expression, diagnosis, assessment and treatment of PD in older adults and future challenges in this field.

Expression of PD in old age

While personality traits in non-clinical populations appear to remain relatively stable with advancing age, there are some evident shifts. Neuroticism, extraversion and openness decrease while agreeableness, and conscientiousness increase. (Roberts, Walton, & Viechtbauer, 2006). These changes are in keeping with clinically observed shifts in behavioural manifestations of PD in older adults. As early as 1981, Solomon's case studies showed that PD can manifest differently at a later age (Solomon, 1981). This appeared particularly so for older adults with a cluster B PD. These people often show a decrease in the more dramatic symptoms of personality disorder such as aggressive and impulsive behaviour and an increase in hypochondriacal and depressive complaints, passive-aggressive behaviour and medication abuse (Rosowsky & Gurian, 1992; Sadavoy, 1992; Van Alphen, Engelen, Kuin, & Derksen, 2006). In older adults with paranoid, schizoid, schizotypal or obsessive-compulsive PD, the behaviours seem more likely to remain unchanged, although specific traits like rigid behaviour or suspicion may increase (Solomon, 1981; Agronin & Maletta, 2000).

It is apparent that there are changes in the phenomenological expression of personality disorder with aging based on conclusions derived from other studies such as that of Stevenson and co-authors (2003), as well as clinical experience and expert opinion

(Sadavoy, 1992; Van Alphen et al., 2012). However, empirical geriatric data are very limited and, to date, derive predominantly from extrapolations from studies of adults not yet 'older adults'.

Changes in symptom expression of PD in older age assume that symptoms that are evident in earlier years may evolve and change with increasing age. It is not unreasonable to suggest that the symptoms that rely on energy, sexuality, mobility, and opportunities for social interaction, may find fewer avenues for expression in later life and hence are not as evident. There are additional challenges in old age to those PD's. It can be expected that forms of disturbed interpersonal relationships may be aggravated in the various contexts of care (Sadavoy, 1987). Individuals with borderline PD have difficulty tolerating being alone in both youth and old age. In older adults this can be exemplified by anxious clinging behaviour, such as frequent phone calls or messages of desperation to caregivers or families, or through heightened somatic complaints. Descriptions of clinical experiences suggest that affective instability remains common in old age with marked mood shifts from baseline to depression, irritability and anxiety. The lack of control over anger and displays of shouting or invective, are often directed at caregivers and family, or manifested through physical signs of agitation (Sadavoy, 1987). Signs of impulsivity may be more common in older adults than is suggested in the literature. It may be, for example, that age related factors cause such 'dramatic features' to be more subtle or expressed through 'proxy' behaviors (Rosowsky & Gurian, 1992). Such behaviors might include abuse of prescription medications or alcohol, chaotic help-seeking such as 'firing' healthcare providers and caregivers, withholding important facts from them, impulsively switching providers, signing out of hospital against medical advice, or violating or ignoring prescribed diet and exercise regimens. A challenge is to determine what kind of features would work equivalently across all age groups (Oltmanns & Balsis, 2011).

Diagnosis & assessment

Important features for diagnosing PD are clinical assessments, semi-structured interviews, self-report questionnaires and informant questionnaires. However, the current Axis-II criteria are not adequately attuned to the living situations and experiences of older people. A large, cross-sectional study in the general population (age range 18–98 years) using item response theory analyses demonstrated that 29% of the DSM criteria for PD lead to measurement errors in older people (Balsis, Gleason, Woods, & Oltmanns, 2007). This gives rise to the possibility of under- and overdiagnosis in old age populations (Balsis, Woods, Gleason, & Oltmanns, 2007). Moreover, a modest survey among Dutch forensic psychiatrists and forensic psychologists showed that the DSM IV criteria for

antisocial PD are not fully applicable to older people; only three of the seven criteria proved useful (Van Alphen, Nijhuis, & Oei, 2007).

The LEAD standard is an example of a diagnostic procedure to assess PD. The acronym 'LEAD', which stands for Longitudinal, Expert and All Data (Spitzer, 1983), addresses the problem of the absence of a 'gold standard' of diagnosis by proposing that a consensus diagnosis can be reached by way of different longitudinal data (e.g. observational data, biographical data, informant data, test data, medical records and even the care providers' experiences with the patient). Limitations of the LEAD standard are that it is a time-consuming procedure and lacks operational guidelines as to how to process contradictory information. A recent expert study 35 Dutch and Belgian experts in the field of PDs in older adults examined the LEAD standard for diagnosis of PD in older adults. The aim of this expert study was to investigate age-related diagnostic and therapeutic aspects of personality disorders in later life and implications in clinical practice, such as diagnostic assessment procedure. The experts agreed that the LEAD standard combined with a stepwise, multidimensional diagnostic approach appears highly suitable for personality assessment in older adults. This process enabled all biographical, informant and/or medical data to be incorporated into the diagnostic process (Van Alphen et al., 2012).

Beyond the inadequacy of formal diagnostic criteria and the limitations of the LEAD standard, there are few validated questionnaires and interviews to detect PD in older adults. Recently, Oltmanns and Balsis (2011) published an overview of psychometric challenges in this area. There are also additional problems in older people: Self-reports require the capacity for sustained attention, and the current measurement instruments for PD are inappropriate to their life situations. Moreover, these instruments often consist of many items, frequently formulated in a quite abstract manner, and the administration of the test is often complicated by sensory and motor problems (Van Alphen, Engelen, Kuin, Hoijtink, & Derksen, 2006).

Nevertheless, to date, three measurement instruments have been specifically developed and validated for older people: a very short screening instrument of 16 items, the Gerontological Personality Disorders Scale (GPS; Van Alphen, Engelen, Kuin, Hoijtink, et al., 2006; Tummers, Penders, Hoijtink, Derksen, & Van Alphen, 2011); a hybrid PD scale of 100 items (Balsis & Cooper, submitted); and the Hetero-Anamnestic Personality questionnaire (HAP; Barendse, Thissen, Oei, Rossi, & Van Alphen, submitted), an instrument of 62 items for use by informants of the patient. The HAP item pool is based on age neutral items and the vision of informants (e.g. spouse, children) on both adaptive and maladaptive behavior of older adults. Informants are asked to fill in this questionnaire with the older patient in mind before

suffering from an axis I disorder, such as dementia or severe depression. This approach may reduce the influence and bias of the axis I diagnosis on evaluation of PD symptoms and personality traits.

As with younger patients, using personality assessment also requires a reasonable capacity for introspection that is generally limited in people with a personality disorder. Informant information may help compensate for this, in that it can provide verification or supplementary information. To this end, it is preferable only to ask the informant questions that refer to observable or interpersonal behaviors. Assessment, based on information by informants, of less clearly observable, intrapsychic characteristics, such as mood and self-perception, are likely less diagnostically valid (Van Alphen, Rettig, Engelen, Kuin, & Derksen, 2005). If the proposed new DSM 5 axis II diagnostic category is adopted as currently described, it will make the reliability and validity of informant observations even more questionable. In the revised DSM-5 proposal (June 2011) the essential features of a PD are impairments in personality (self and interpersonal) functioning and the presence of pathological personality traits (www.dsm5.org). Using informants to provide information on difficult-to-observe significant impairments in self (identity or self-direction) and interpersonal functioning (empathy or intimacy) will likely be invalid.

Related to the DSM-5 proposal Krueger, Derringer, Markon, Watson, and Skodol (2011) developed a maladaptive personality trait model and corresponding instrument the Personality Inventory for DSM-5 (PID-5; Krueger et al., 2012). The first psychometric results are promising, however a new challenge is to validate this instrument among older adults.

Treatment

No research has yet been carried out on the effects of the treatment of PD as a primary diagnosis (without a comorbid Axis-I diagnosis) in older people, however, a handful of case studies and opinions have been published. One of the first papers in this area came from De Leo, Scocco, and Meneghel (1999). In their opinion psychotherapeutic treatment modalities that emphasize personality change in older adults are too ambitious as a treatment goal. They suggest that cognitive deterioration, serious somatic disorders, a lifelong inability to accept unpleasant facts and a history of poor interpersonal relationships complicate psychotherapy that is rooted in insight.

De Leo et al. (1999) recommend a number of psychotherapeutic treatment modalities for older people, focusing particularly on cognitive behavioural therapy, short-term psychoanalytic therapy, dialectical behaviour therapy (DBT) and interpersonal psychotherapy (IPT). Their preference is for the latter two treatment modalities which primarily identify current

behaviours or relationships as foci of the therapy. According to De Leo et al., changes in behaviour or in interpersonal relationships are realistic therapeutic goals for older people. In their view, short-term psychoanalytic therapy (in which focal conflicts are examined using techniques of confrontation and interpretation) and cognitive psychotherapy (which focuses particularly on basic errors of reasoning), are less suitable for older adults as they make considerable demands on the individual's capacity for introspection or abstract thinking. However, no empirical or strong clinical evidence is offered in support of these assertions. Further, they stand in contrast to the proven efficacy of cognitive behaviour therapy and brief psychodynamic therapy, in the treatment of geriatric anxiety disorders and depression (Hendriks, Oude Voshaar, Keijsers, Hoogduin, & Van Balkom, 2008; Pinquart, Duberstein, & Lyness, 2007).

More recently, Lynch et al. (2007) examined the efficacy of DBT in a small randomized clinical trial among older people with comorbid depression and PD ($n = 35$). However, it should be noted that it is unclear whether DBT was addressing the depression, the personality disorder, or both. Moreover, it is surprising that the number of PDs in remission (in total 16 out of 35) was almost the same with medication treatment alone ($N = 7$) compared to combined treatment of medication and DBT ($N = 9$). This outcome contrasts with earlier studies on the treatment of PD in younger adults which showed only a marginal treatment effect of medication without psychotherapy. It raises the questions of whether subjects were accurately diagnosed or whether the outcome of treatment in older adults with PD actually differs from that of younger adults. The authors did not offer a valid explanation for this difference in outcomes.

Currently, treatment of PD in older adults can only be extrapolated from treatments of younger patients, since very little has been developed and reported specifically for older adults. However, there are no convincing reasons why forms of psychotherapy shown to be successful with younger adults should not also be successful in older adults. Published case studies and empirical reviews indicate that cognitive behavioural therapy (CBT) and schema focused therapy (SFT) in particular can be useful for older adults (Bizzini, 1998; Dick & Gallagher-Thompson, 1995; Laidlaw, 2001; Van Alphen, 2010). However, these psychotherapeutic treatments might need to be adjusted to better fit with the living situations and experiences of older people (Laidlaw, 2001). To this end, psychogerontological features like beliefs about and consequences of somatic disorders, cohort-related, and sociocultural influences, intergenerational ties and the loss of social roles must be addressed by any treatment (James, 2008; Laidlaw, 2001; Laidlaw & Thompson, 2008; Laidlaw, Thompson, Dick-Siskin, & Gallagher-Thompson, 2003). Videler, Van Royen, and Van Alphen (in press) are conducting explorative research on relevant

age specific aspects that can be used to adapt SFT to a treatment protocol that is moulded for older cohorts.

Older adults are often realistically dependent on others for supportive and life-sustaining care. This throws the elderly person with PD into unavoidable, intense interpersonal interactions. Since the core of the difficulties that those with PD encounter are in the interpersonal sphere (Segal, Coolidge, & Rosowsky, 2006) management of PD in late life poses specific and important challenges for caregivers and therapists alike. Specific challenges can be expected for those older adults with PD who move through a spectrum of contexts of care. Multiple care transitions, both planned and unplanned, are increasingly frequent events as the individual progresses into and through old age. These contexts include acute care hospitals, rehabilitation units, assisted living facilities, skilled nursing facilities, rest homes, and retirement communities as well as systems introduced into the individual's own home to provide healthcare, various therapies, meals, aide and support services. This trajectory of care transitions has become 'the new normal' for older adults and poses extra challenges for individuals with PDs as well as for the systems responsible for their care.

Conclusion

The study of personality disorders is a relatively new field within the greater field of geriatric mental health. For the time being, the prevalence figures of PD remain poorly defined, dedicated diagnostic assessments specifically designed and validated for use with this population are few, and studies reporting the efficacy of treatment are nearly nonexistent. While studies of treatment efficacy are sorely lacking, published case studies suggest that therapies, such as CBT, DBT and SFT, might be applicable to older adults with PD.

As the American Psychiatric Association is currently working toward the publication of the fifth DSM edition (DSM-5), research into the suitability of the six proposed PD prototypes and traits for older people would seem to be necessary. Since their introduction, the utility and accuracy of categorical phenomenological threshold criteria for diagnosis have been the subject of an ongoing debate. In the DSM-5, the PD work group has proposed a model that recognizes the inherent dimensionality of personality expression (<http://www.dsm5.org/ProposedRevision/Pages/PersonalityDisorders.aspx>, last accessed January 1 2012). Two domains for personality assessment are proposed, Self (inner functions) and Interpersonal (self –other functions) each of which has two subcomponents.

While no provisions for diagnostic criteria specific to the elderly have been recognized the new dimensional approach may permit a more age-independent approach to identifying trait characteristics that

appear to be more stable and enduring with age unlike some of the phenomenological criteria currently being used, especially those for the dramatic cluster. We suggest that PD or trait disorder diagnostic criteria for older adults may be more accurate if greater weight is given to the less observable but more stable internal psychological factors of PD and less weight given to 'dramatic' behavioural expression. We suggest regarding older adults to focus more on those features which are relatively stable across all age groups emphasizing factors such as unintegrated and undifferentiated affects and poorly developed representations of self and other.

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