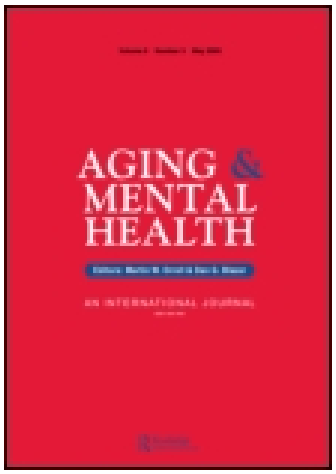

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Personality assessment among older adults: the value of personality questionnaires unraveled

Gina Rossi[a], Joke Van den Broeck[a], Eva Dierckx[ab], Daniel L. Segal[c] & Sebastiaan P.J. van Alphen[ad]

[a] Department of Clinical and Life Span Psychology, Vrije Universiteit Brussel (VUB), Brussel, Belgium

[b] Alexian Brothers Hospital, Tienen, Belgium.

[c] Psychology Department University of Colorado, Colorado Springs (UCCS), Colorado Springs, USA

[d] Mondriaan Hospital, Heerlen-Maastricht, The Netherlands.

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EDITORIAL

Personality assessment among older adults: the value of personality questionnaires unraveled

Recently, interest is growing in personality assessment among older adults (≥ 65 years), both in research and clinical practice (e.g., Oltmanns & Balsis, 2011). Older adults are a growing group in our Western and Asian 'aging' populations, characterized by specific challenges: they increasingly have to cope with health-related problems and go through a series of transitions, like retirement, 'empty nest', role changes, becoming a caregiver, etc. During periods of transition, underlying (mal)adaptive personality traits and coping mechanisms of an individual are challenged, and this can result in exaggerated behavioral and affective expressions. Therefore older age is considered to be probably the best period to study personality (disorders) (e.g. Cervone & Mischel, 2002). In this editorial, we discuss the assessment of personality traits, personality disorders (PDs), and related conceptual and methodological issues in later life. Until now, classification systems typically focused on younger adults as prototypes. For example, the Diagnostic and Statistical Manual of Mental Disorders 4th edition (DSM-IV-TR, American Psychiatric Association [APA], 2000) and DSM-5 (APA, 2013) did not give specific attention to older adults when developing their sections on PDs. Also, cognitive impairment is a difficulty with which many older adults are confronted. Consequently some older adults, for instance with dementia, will not be able to self-report their personality. More specifically, we address the following questions: What do we know about age-neutral and age-specific tools for personality assessment in older adults? What does the publication of the DSM-5 (APA, 2013) imply for the assessment of personality traits and disorders in older adults? Which perspective should be taken in assessment: self, informant, or multi-source report?

Age-neutral personality assessment

Only two major personality measures gave specific attention to older age groups and aimed at being able to measure personality across the whole adult life span and thus cover younger and older adults. Firstly, during the development of the Personality Assessment Inventory (PAI; Morey, 1991) with an age range 18–89 years, item response theory was applied to identify and eliminate items that contained measurement bias across two broad age groups (Oltmanns & Balsis, 2010). Secondly in the construction of the Revised NEO Personality Inventory (NEO-PI-R; Costa & McCrae, 2010), the later life context was considered theoretically during the item selection phase. Recently, Van den Broeck, Rossi, Dierckx, and De Clercq (2012) empirically investigated the age-neutrality of items on the NEO-PI-R. These results can be considered representative, since the sample largely consisted of the normative sample of the NEO-PI-R gathered in the Netherlands and Flanders. Overall, the vast majority of items (92.9% at domain and 95% at facet level) did not show an age-related endorsing bias. Nevertheless, differential test functioning (DTF) analyses revealed large DTF for extraversion (domain E) and tender-mindedness (facet A6), indicating that the additive effect of item-endorsing biases across all items of these scales have an impact on the scale level. To make conclusive interpretations of these results, further investigations are warranted: item bias can be a cause of differential item functioning, but another possibility is that it indicates an item with high impact, due to real age differences in the manifestation of the trait (Ackerman, 1992). Although the normative sample of the NEO-PI-R includes a group of adults age 55 years and older, the additional samples collected in the study partly remained samples of convenience to extend the older age group to have more adults 65 years and older. Future studies should extend the representativeness in older adults by also comparing smaller age groups within older adults, since there may be important differences between the youngest (65–74) and oldest old (≥85) (Segal, Coolidge, & Rosowsky, 2006).

The most recent version, the NEO-PI-3, was also developed for an age range from 12 – 99 years (Costa & McCrae, 2010). However, administration of the 240 items of the NEO-PI-R or NEO-PI-3 requires well-educated and healthy older adults. Indeed, test length is a practical bottleneck in older adults, especially in those with physical or cognitive difficulties. Therefore, Mooi et al. (2011) developed a NEO-PI-R short form for older adults. Item selection was done on the basis of clinical ratings of appropriateness of the items for older adults (rational approach) and psychometric properties (internal consistency, etc.). Unfortunately, the items removed do not correspond with items flagged as having age-related biases (empirical approach) in the study of Van den Broeck, Rossi, Dierckx, & De Clerq (2012). Therefore, the integration of the results of the two studies is an issue to be explored in following studies, combining rational and empirical approaches.

Age-specific assessment

As far as we know, only two age-specific personality measurements have been developed in geriatric psychiatry. The Gerontological Personality Disorder Scale (GPS; van Alphen, Engelen, Kuin, Hoijtink, & Derksen, 2006) is a screening instrument of 16 items with sensitivity and specificity values of 70% (patient section) for DSM-IV PD presence in older adults in mental health care. The GPS patient section can be used as an indicator for further (more time consuming) personality assessment in case of

PD. The informant section had a sensitivity of 48% and specificity of 78%, so the informant perspective is better in excluding the presence of personality pathology.

The Dutch informant questionnaire (HAP; Barendse & Thissen, 2006) was developed to address the need of clinical practitioners in Dutch nursing home settings for a tool using informant information to assess traits associated with DSM pathology in the assessment of personality of older adults. The HAP meets the need for a reliable and validated informant instrument for personality assessment among older adults in geriatric psychiatry (Barendse, Thissen, Rossi, Oei, & van Alphen, 2013). Since the age-specific needs of older adults were a special focus during the development of the HAP, a next logical step was to evaluate the extent to which HAP items are also suitable for younger adults. Recently, in a Delphi study, an expert panel considered all items of the HAP to be age neutral in 'content', making this a promising instrument for use in both middle aged and older populations. Moreover, the HAP items represented all DSM-IV or DSM-5 section II PD, with the exception of schizotypal PD (Barendse, Rossi, & van Alphen, 2013). This rational approach is an important first step, but the age-neutrality of the HAP and the variance it captures regarding DSM PD should also be explored with more empirical methods (e.g. item response analyses). For now, we can conclude that although development of the HAP specifically aimed at an older context, initial research results are promising in terms of the possible age-neutrality of the HAP.

Age-neutral versus age-specific personality assessment

Whether to advocate for an age-neutral or an age-specific measurement system is an important point of discussion. Both approaches have their advantages and disadvantages (Rosowsky & Segal, 2010). For research purposes, more specifically to study the course of personality longitudinally, or to investigate maladaptive personality features cross-sectionally among younger and older individuals, an age-neutral measure is necessary to be able to compare all age groups (Balsis, Gleason, Woods, & Oltmanns, 2007; Tackett, Balsis, Oltmanns, & Krueger, 2009). In clinical practice, an age-neutral measure would enable clinicians to rely on valid assessment instruments, without having to adjust items to assess their older patients (Zweig, 2008; Tackett et al., 2009). It would also be conducive for comparability after retesting; for example, when a 70-year-old patient has been hospitalized and tested, the current results could be easily compared with previous test results of this patient. On the other hand, one might argue that from a practical view, a first and foremost requirement is a valid instrument in order to screen and/or diagnose PDs within a specific population, whether the measure is age neutral or not. As a matter of fact, an age-neutral measure is no guarantee for practical usefulness, since it does not take the specific aging context into account. Items developed to be applicable across the whole adult life span may not necessarily represent specific manifestations of traits during certain adult life periods. To address such differences in manifestations and needs, adaptive testing according to the age group, could be more informative to adequately include age-specific aspects, besides more 'lifelong' manifestations of traits.

Assessment of PDs with adaptive traits

A first issue in classification is whether to use adaptive or maladaptive traits in describing personality disorders. A primary advantage of the use of the NEO-PI inventories, for example, is that the five factor model (FFM) of personality has become a widely accepted standard for the assessment of adaptive trait variance, but the model also has proven to be successful in capturing maladaptive trait variance. The NEO-PI-R is applicable to screen almost all PDs (with the exception of antisocial PD and obsessive-compulsive PD) in older adults (Van den Broeck, Rossi, De Clercq, Dierckx, & Bastiaansen, 2012) and the measure exhibited adequate convergent and divergent validity with the Assessment of DSM-IV Personality Disorders Questionnaire (ADP-IV; Schotte, De Doncker, Vankerckhoven, Vertommen, & Cosyns, 1998). The ADP-IV itself is an excellent measure for PDs: it allows for a dimensional as well as dichotomous assessment of DSM-IV (APA, 2000) and DSM-5 Section II (APA, 2013) PD diagnostic criteria on the basis of self-report. Additionally, the PD scales of the ADP-IV showed no DTF meaning the items were age-invariant when three age groups (18−34 years vs. 35−59 years vs. 60−75 years) were compared (Debast et al., submitted). Still, the ADP-IV study was limited to patients with substance abuse. It would be useful to study the age-neutrality of the ADP-IV in patients with different kinds of psychopathology, such as inpatients and outpatients with depression, anxiety, or specific PDs.

Although the NEO-PI-R captures pathological trait variance, it remains a non-clinical model. Models focusing more explicitly on clinical domains differentiate themselves from the NEO-PI-R and associated Five Factor Model by including a dimension of Psychoticism.

The DSM-IV and DSM-5 approach

There is a high need for instruments to validly assess PD-related pathology in older adults, especially DSM PD criteria. The most fundamental issues among older adults concern the applicability and relevance of the DSM nosology (Tackett et al., 2009; Segal, et al., 2006). Many DSM-IV (APA, 2000) and DSM-5 (APA, 2013) PD diagnostic criteria do not take into account the age-specific changes in behavior and interpersonal functioning. Balsis et al. (2007) demonstrated that 29% of the DSM-IV Axis II criteria result in over- and under-diagnosis of personality pathology in older age. The PD criteria in DSM-5 remain problematic since nothing changed. Indeed, the DSM-5 section II (APA, 2013) completely retained the DSM-IV criteria, specific disorders, and clusters for the PDs. In the lead up to formal publication of DSM-5, many researchers in the field advocated a dimensional approach to the PDs (e.g., Widiger & Trull, 2007) and therefore section III of DSM-5 provides an alternative dimensional trait approach

for further research with five higher order dimensions (maladaptive variants of the FFM) including: Negative Affect (i.e. Neuroticism), Detachment (i.e. Introversion), Antagonism (i.e. low Agreeableness), Disinhibition (i.e. elements of low Conscientiousness), and Psychoticism (specific to clinical domains, and as such containing extreme variations not encompassed by openness (Krueger et al., 2011)), and 25 associated primary traits, operationalized with the Personality Inventory for DSM-5 (PID-5; Krueger, Derringer, Markon, Watson, & Skodol, 2012). Despite not having explicitly considered the later life context during the development of the PID-5, most scales (21 out of 25) measured the traits equally well across both younger and older age groups (Van den Broeck, Bastiaansen, Rossi, Dierckx, & De Clercq, 2013). However, large DTF was found for 4 scales: Withdrawal, Attention Seeking, Rigid Perfectionism, and Unusual Beliefs. To make the PID-5 entirely age-neutral, 33 items should be replaced. We think the choice for maladaptive traits and associated 'clinical' trait models is a good step for usability in clinical settings. However, more work is needed to develop a system that also validly measures these traits in older adults.

Also new in DSM-5, besides the pathological trait model, is the attention that has been given in section III to impairment in personality functioning. However, how pathological personality traits and personality functioning should be integrated into an overarching personality diagnostic model is still a black box. Although conceptually both aspects (namely pathological traits to describe the personality style, and impairment in personality dysfunctioning to describe the degree or severity), are interesting, the degree of independence versus overlap should be empirically examined. Only if the concepts can be empirically disentangled, separate measurement instruments can be adequately developed. Moreover, the assessment of personality functioning/impairment is a relatively new measurement domain, lagging considerably behind the trait measurement domain (Clark & Ro, 2014). How this domain could be assessed in older adults remains completely unexplored.

Self-report, informant-report or multi-source information

Although most personality research relies on self-report, the shortcomings of this approach are extensively described in the research literature (e.g., Klonsky, Oltmanns, & Turkheimer, 2002; McDonald, 2008). One important drawback, especially for the assessment of PD, relates to the limited insight in self and interpersonal relations, inherent to the ego-syntonic nature of many individuals with a PD. An ego-protective bias is problematic for self-accuracy. One could also argue that, among older adults, some PD features may become even more ego-syntonic with advancing age, simply as a function of the PD symptoms being present for a longer duration (Segal et al., 2006).

A major limitation of relying on one method of reporting (self or informant), pertains to the fact that it provides only one viewpoint, whereas ideally, personality assessment involves the gathering and evaluation of various sources of information (Klonsky et al., 2002). Indeed, research showed that using peer-ratings adds a unique perspective in the description of PD features: informants are able to provide the clinician with a more nuanced picture of the patient by not succumbing to halo representations found in self-report (Lawton, Shields, & Oltmanns, 2011).

Also, older people sometimes neglect instructions from questionnaires because they are inclined to make a life review and answer from a perspective of 'those were the days'. On the other hand this life review perspective can shed light on the long standing features. Especially within an older adult population, multi-source reports may combine strengths of both report methods and alleviate some of the shortcomings when relying on one method alone. Interestingly, the comparison between self-report and other reports often reveals a paradox, such as when people who are rated by others as being paranoid and suspicious rather describe themselves as being angry and hostile (Clifton, Turkheimer, & Oltmanns, 2004). However, from the opposite perspective, people who describe themselves as being paranoid are often seen by others as being cold and unfeeling.

Moreover, a recent study (Cooper, Balsis, & Oltmanns, 2014) using informant-report points out significant increases in pathology when measuring PDs over time, and when measuring normal personality, there were increases in neuroticism and decreases in extraversion, agreeableness, and conscientiousness. This clearly challenges the findings with self-reported data that many PD and personality features generally mellow with age (e.g. Lenzenweger, Johnson, & Willett, 2004, estimated a decline of 1.4 PD diagnostic criteria per year; APA, 2000, states that several PD 'become less evident or remit with age', p. 688). Although effect sizes were generally very small, changeability of adaptive and maladaptive traits over time results in contradictory results depending on the source of report. Research into the informant perspective on the longitudinal course of (mal)adaptive traits and PDs is scarce, yet the recent study of Cooper et al. (2014) makes clear informant reports are a necessity to assess the course of PD traits in adulthood.

A multi-source approach is preferable. Probably self-report is a better predictor for some traits (only the person has access to all his/her feelings and thoughts), and informant report for other traits (people with PDs are not always aware of the effect of their behavior on other people). We could therefore hypothesize that self-report can emphasize internalizing problems (e.g. subjective distress) and informant-report more externalizing problems (e.g. grandiosity) in PDs, although this issue has yet to be studied empirically. Vazire (2010) developed a Self-Other Knowledge Assymetry (SOKA) model to predict which aspects of self are best judged by self or others. Both are good in extraversion related traits, however self is more accurate in traits with low observability (e.g. neuroticism related 'feelings' of anxiousness), and others are more accurate in openness/intellect-related traits (e.g. creativity). We agree with the opinion of Vazire and Carlson (2011, p. 105) who stated that 'Self and other-ratings of a

person's personality do not simply provide redundant information. Instead, they capture different aspects'.

A fundamental question is how one should handle discrepancies between self-reports and other reports. Typically for informant report, a patient is asked to suggest a friend or family member who knows the patient well, and mostly patients select someone they like and whom they assume like them back. These selected informants are more inclined to provide overly positive ratings, and the value of these selected informant ratings does indeed depend on the type of problem being assessed. For example, selected informants report lower levels of narcissism, paranoia, and antisocial PD compared to scores provided by other informants (not selected by the patient) (Oltmanns & Turkheimer, 2006).

Clearly more research is needed to understand fully how, besides the common use of self-report, informant reports should be incorporated into the personality assessment process, especially among older adults who often have longer and more complicated personal histories. Which information informants can give on the personal history of an older adult will largely depend on their unique relation with the person and what is revealed by the person to the informant in this relation or by the behaviors to which the informant is exposed. This typical person-situation interaction is very relevant information for clinicians in order to be able to focus treatment on the assessment of relevant behavioral problems in different contexts and related interpersonal interactions.

However, in the case of older adults, sometimes self-report, and thus a multi-source approach, is simply not possible. Informants play a crucial role in the process of data collection in cases of cognitive decline as a result of normal aging or due to degenerative diseases (American Psychological Association, 2013).

Specifically with regard to older adult samples with important cognitive impairment, some more specific considerations need to be addressed, such as who can provide the most reliable information (e.g., clinicians, spouses, or adult children), and which instructions to give to the informant, in terms of the reported time period (e.g., report on the whole life, or the past 10 years, etc.). Regarding this latter issue, it is important to denote whether one is interested in the present or in premorbid personality characteristics, and depending on this choice, one has to decide which kind of informant is best qualified to provide the most useful information.

Conclusions

Age-neutral assessment gives a picture of long-standing characteristics whereas age-specific assessment gives attention to age-related characteristics. Still, results of age-neutral or age-specific personality questionnaires should always be interpreted in light of the actual context of the older adult and verified by life review. Due to increased health problems and an increased frequency of transitions, later life is commonly seen as a turbulent period in terms of behavioral and affective expressions (Oltmanns & Balsis, 2011). Thus, integrating maladaptive personality traits into a more holistic framework that takes into account a patient's life story is a valuable and rewarding challenge. The alternative dimensional DSM-5 approach seems promising, yet much work remains to adequately address the needs of older adults and to develop valid measurement instruments. One thing is sure: looking at personality pathology is preferably done from an integration of various sources of information. Whenever possible one should combine self-report and informant-report, a strategy that we believe to lead to a better understanding of PDs in later life.

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Gina Rossi
Department of Clinical and Life Span Psychology, Vrije Universiteit Brussel (VUB), Brussel, Belgium
Email: grossi@vub.ac.be

Joke Van den Broeck
Department of Clinical and Life Span Psychology, Vrije Universiteit Brussel (VUB), Brussel, Belgium
Email: jrvdbroe@vub.ac.be

Eva Dierckx
Department of Clinical and Life Span Psychology, Vrije Universiteit Brussel (VUB), Brussel, Belgium. Alexian Brothers Hospital, Tienen, Belgium.
Email: Eva.Dierckx@vub.ac.be

Daniel L. Segal
Psychology Department University of Colorado, Colorado Springs (UCCS), Colorado Springs, USA
Email: dsegal@uccs.edu

Sebastiaan P.J. van Alphen
Department of Clinical and Life Span Psychology, Vrije Universiteit Brussel (VUB), Brussel, Belgium. Mondriaan Hospital, Heerlen-Maastricht, The Netherlands.
Email: b.van.alphen@mondriaan.eu