

Part H

Personality Disorders

Personality Disorders: Description, Aetiology, and Epidemiology

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According to the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, text revision (DSM-IV-TR)¹, 'A Personality Disorder 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' (p. 685). Also included in the definition of personality disorder is that the traits have to be rigid, maladaptive and pervasive across a broad range of situations rather than expectable reactions to particular life experiences or a normal part of a developmental stage. An important caveat in the DSM-IV-TR is that, although the definition of personality disorder requires an onset no later than early adulthood, it is often the case that a person with a personality disorder may not be diagnosed or treated until later life.

One possible explanation for this caveat is that the individual with personality disorder may have presented clinically with the more obvious signs of an Axis I clinical disorder such as anxiety, depression, disordered eating or substance abuse, whereas the underlying personality disorder features may not have been examined as closely. Another important factor is that in some cases, personality traits can be adaptive at one phase of life but become maladaptive at a later developmental phase. For example, an extremely aloof, reserved and emotionally detached man may have functioned successfully in the occupational sphere by choosing a job requiring little social interaction (e.g. a computer programmer who writes code at home). He managed to live alone and had little use for others during much of his adult life. Imagine the discomfort and distress he would face, however, if in later life he becomes physically frail and debilitated and out of medical necessity is re-located to a nursing home where he is forced to cope with the presence of medical professionals, caregivers and other residents. In this case, it would be only after the person has failed to adjust to his new living situation that his personality traits would be viewed as dysfunctional (and a personality disorder diagnosis given). Thus, the *context* in which personality traits are expressed is an extremely important concept in determining their relative usefulness or hindrance across the lifespan.

Personality disorder in older adults is an important area of study for a number of reasons. First, since personality disorder affects the way an older adult copes with life, individuals with specific person-

ality disorders may be less able to successfully negotiate age-related losses (e.g. a histrionic person who has relied on her physical attractiveness and sexual provocativeness to garner attention for herself may feel neglected as she ages and loses some of her seductiveness; an obsessive-compulsive individual may feel out of control because he feels his medical problems reduce his control over his body; a dependent person may lose his main source of support due to the death of a spouse, siblings, adult children etc.) or the interpersonal compromises necessary for peaceful institutional living (e.g. anger episodes erupt when the interpersonal needs of a borderline or narcissistic person are not immediately met). Second, personality disorder can influence the presentation of Axis I symptomatology, frequently generating complicated diagnostic and assessment dilemmas. For example, disruptive behaviour in the nursing home may camouflage the fact that the person is suffering from a depression that is exacerbating pre-morbid antisocial personality features. Third, just as for young adults, the presence of personality disorder warrants modification of treatment strategies and prognosis for those with co-morbid Axis I disorders in certain geriatric settings.

In recent years, there has been an ever-expanding body of knowledge about personality disorder in older adults. Notably, there has even been the publication of two books solely devoted to personality disorder in older adults^{2,3}. However, as we shall see, there remain many unanswered questions spawned by thorny conceptual and methodological quandaries in this controversial area. This chapter will summarize what is known about the aetiology, diagnosis, epidemiology and prognosis of personality disorder in older adults.

AETIOLOGY

Because personality disorders and personality disorder features begin relatively early in life and have a generally persisting impact across the lifespan, it can be assumed that the aetiology of personality disorders includes psychosocial and biological factors³. Concerning personality disorder among older adults, it is helpful to focus on dimensional aspects of personality as well as the categorical diagnosis of personality disorder.

Psychosocial Factors

Freud noted the importance of Axis II traits in the aetiology of Axis I symptoms. He embedded the idea of personality within his psychosexual schema regarding oral, anal, oedipal, latency and genital stages. Inborn temperamental traits combine with parental influences in these early developmental periods to shape an individual's personality. How early figures react to the growing child's bio-psycho-social needs forges a rigid template that is operative throughout the person's life, and reflects whether the person will satisfy his or her intrapsychic and interpersonal needs in an adaptive manner or in an exaggerated repetitious fashion. Acute symptomatology erupts when current stressors intersect with the psychosocial dynamics and interpersonal sensitivities laid out in early childhood forming this hard bedrock of personality traits. Working from this grand model, Freud erroneously concluded that by the age of 40 personality patterns were invariably set, and advised psychoanalysts to spend their time with younger analysands.

Erik Erikson⁴ enhanced the Freudian framework to include three stages of adulthood that were yoked to specific life challenges. Those in young adulthood are faced with the crisis of deciding on a career and achieving intimacy; those in middle adulthood raise their family, maintain a career and hopefully become generative; those in late adulthood are confronted with preparing for death, gaining wisdom and achieving ego integrity. Unfortunately, the heuristic value of these conceptualizations has not been realized because limited research has been conducted to validate these stages.

Coming from a more empirical tradition, Costa and McCrae⁵ conducted both cross-sectional and longitudinal research with their well-validated NEO Personality Inventory (which measures five broad lexically derived personality factors of neuroticism, extraversion, openness, agreeableness and conscientiousness) and concluded that there is general continuity of personality across the life span. However, other researchers have argued that Costa and McCrae's five-factor model tends to minimize personality change in adulthood, particularly with respect to environmental factors⁶. Indeed, in his 50-year follow-up study of Harvard undergraduates, Vaillant⁷ discovered that significant change can occur for certain individuals, related either to specific negative or positive adult life events (e.g. alcoholism; supportive spouse). Consistent with these formulations, Identity Process Theory⁸ postulates that older adults tend first to assimilate and (if assimilation is non-successful) then to accommodate discrepant experiences to maintain self-esteem via a consistent sense of self. Those with rigid understandings of themselves that characterize personality disorders may be less able to employ these more mature coping mechanisms and negotiate the vagaries of ageing. From this conceptual basis, too much or too little stability in personality as we age may become maladaptive.

Finally, a well-researched cognitive model of psychopathology suggests that personality disorders may be characterized by cognitive distortions which are derived from biases in information processing and dysfunctional schema or core beliefs that influence people's perceptions and thoughts at the conscious level⁹. Examples of cognitive distortions include all-or-none thinking (seeing personal qualities or situations in absolutist 'black and white' terms, and failing to see shades of grey), catastrophizing (perceiving negative events as intolerable calamities, commonly referred to as 'making mountains out of molehills'), magnification and minimization (exaggerating the importance of negative characteristics and experiences while discounting the importance of positive characteristics and experiences) and personalization (assuming one is the cause of an event when other

factors are also responsible). Schemas are often expressed as unconditional evaluations about the self and others. Some examples include beliefs that: 'I am incompetent', 'I am defective', 'I am unlovable', 'I am special', 'Others are hurtful and not to be trusted', 'Others need to take care of me', and 'Others must love and admire me'. Schemas are generally thought to be formed early in life but to persist if no conscious effort is made to identify, examine and challenge them.

Some examples of cognitive distortions and schema relevant to specific personality disorders include:

- an individual with paranoid personality disorder is prone to habitually and chronically perceive others as deceitful, abusive and threatening;
- an individual with borderline personality disorder is prone to sort people into categories of either 'all good' or 'all bad';
- an individual with obsessive-compulsive personality disorder tends to be a slave to the belief that he or she must be perfect and always in control;
- an individual with dependent personality disorder sees him- or herself as weak, incompetent and inadequate, requiring constant reassurance, nurturance and direction.

Whereas a few studies have attempted to validate the specific relationships between core beliefs and personality disorder pathology¹⁰, notably lacking are studies that specifically examine these relationships in older adult samples.

Genetic Factors

A growing literature base has focused on the genetic factors that contribute to personality disorders. In a study of 483 adult twin pairs, Jang *et al.*¹¹ found a median heritability of 0.44 for 66 of 69 personality disorder facet traits. Similar data were reported by Coolidge *et al.*¹² who found a median heritability coefficient of 0.75 for 12 specific personality disorders in their sample of 112 child twin pairs. Interestingly, Jang *et al.*¹³ found in their cross-sectional twin study that genetic contributions to personality disorder traits actually increase with age. Torgersen *et al.*¹⁴ used a structured interview to diagnose the full range of personality disorders, finding an overall heritability estimate of .60. Finally, a very recent study with a large sample of young adult Norwegian twins found one genetic factor reflecting a broad vulnerability to personality disorder pathology and negative emotionality whereas two other genetic factors more specifically reflected high impulsivity/low agreeableness and introversion¹⁵. In summary, there is clear evidence of heritability for some personality disorders but much that remains unexamined. Perhaps the best conclusion from this data is that heritable traits play a significant role in the formation of personality disorders but heritability alone does not directly cause an individual to develop a specific personality disorder.

DIAGNOSIS

The diagnosis of personality disorders is known to be particularly challenging across the lifespan. Specifically, in adulthood, it is generally difficult to distinguish one personality disorder from another¹⁶. Later life adds further complications to diagnosis. There are, for instance, problems in obtaining a reliable diagnosis and, at present, there is no 'gold standard' of diagnosis for personality disorder

in older adults. Molinari *et al.*¹⁷ studied geropsychiatric inpatients with depression, and found general discordance between patient self-report, family informant ratings, social worker evaluations and consensus case conference categorical diagnosis of personality disorder. It appears that there are varied perceptions of an individual's personality, all of which should be taken into account for a comprehensive evaluation of Axis II pathology.

Personality disorder is commonly seen in practice settings yet seldom formally identified. Mental health professionals are loathe to diagnose it, particularly in old age, due to concerns over pejorative bias, pessimistic beliefs about the prospects of therapeutic change for personality disorder pathology, managed care reimbursement biases, and focus on medical or Axis I pathology (particularly cognitive impairment) in old age. Often the patient with personality disorder presents in a demanding, blaming manner with an inappropriate, rigid interpersonal stance and limited insight. Unfortunately these same features are sometimes erroneously interpreted as part of the natural ageing process¹⁸. Perhaps it is most important to recognize that 'either/or' thinking is often incorrect in the diagnosis of older adults. Comorbidity is the rule rather than the exception, with research consistently finding that older adults with depression also may have longstanding maladaptive personality disorder traits^{18–20}.

Another factor that impacts identification and diagnosis of personality disorders in later life is that, in some cases, there is an emergence of personality disorder symptoms that were 'hidden' earlier in life³. For example, consider a highly dependent woman who was supported by a caring, perhaps dominating, spouse who did not mind making all of the decisions for the couple and essentially took care of his wife throughout much of their adult lives. It would not be until she struggled to take care of herself after becoming a widow that the extent of her 'disorder' would become recognized and perhaps diagnosed. A final diagnostic challenge is that the sets of diagnostic criteria do not fit older adults as well as they do younger adults³. In an empirical investigation of potential age-bias using item analysis, Balsis *et al.*²¹ found evidence of age-bias in 29% of the criteria for seven personality disorders. In this study, some diagnostic criteria were differentially endorsed by younger and older adults with equivalent personality disorder pathology, suggesting a bias.

EPIDEMIOLOGY

Some early anecdotal reports suggested that personality characteristics become uniformly less harsh with age^{22,23}. Other clinicians working with older adults believed that the 'high-energy' personality disorders (e.g. Cluster B) mellow whereas the 'low-energy' personality disorders (e.g. Cluster C) may be aggravated by the ageing process^{24–26}. DSM-IV-TR¹ states that 'Some personality disorders tend to become less obvious or remit with age, whereas this appears to be less true for some other types' (p. 688). Early research yielded wide variability in personality disorder prevalence rates due to inadequate definitions of personality disorder, non-standardized measures and different samples of older adults. With the employment of better diagnostic criteria, some consistent findings have emerged. This section on epidemiology will therefore largely focus on studies using standardized measures, and will be divided into community, institutional, outpatient and depression studies.

Community Settings

In community settings, two studies^{23,27} compared young and older adults utilizing the Coolidge Axis II Inventory. Coolidge *et al.*²³

found a greater need for organization and more restricted affect in older adults, whereas Segal *et al.*²⁷ found that older adults were significantly higher on obsessive–compulsive and schizoid personality disorder, but lower on the antisocial, borderline, histrionic, narcissistic and paranoid scales. Ames and Molinari²⁸ used the Structured Interview for Disorders of Personality scale (SIDP-R) and detected a trend of less personality disorder in older adults, with significantly fewer older adults meeting the criteria for more than one personality disorder. Cohen *et al.*²⁹ used the Structured Psychiatric Examination and found that individuals 55 years old and older were less likely (6.6% vs. 10.5%) to have personality disorder, due to a threefold decrease of Cluster B personality disorder in older adults. These data documenting personality 'mellowing' in older adult community samples are in stark contrast to the results of a study by Segal *et al.*³⁰, who found that a high number (63%) of community-dwelling older adults surveyed at a senior center met personality disorder criteria by self-report. However, this study used a measure known to be overly sensitive to personality disorder pathology, and the cognitive status of the participants was also not taken into account.

Institutional Settings

Early personality disorder prevalence rates in nursing home settings were reported to be 12–15%^{31,32}, whereas for geropsychiatric inpatients, personality disorder estimates were more variable (7–58%). In a large sample of hospitalized male veterans, Molinari *et al.*³³ conducted a cross-sectional investigation of personality changes across different age groups for those clinically diagnosed with personality disorder. Older adults with personality disorder were more responsible and less impulsive, paranoid, energetic and antisocial than young adults diagnosed with personality disorder. Kunik *et al.*³⁴ studied 547 older psychiatric inpatients, and found that a consensus case conference diagnosis of personality disorder varied widely, depending upon the specific co-morbid Axis I diagnosis (e.g. 6% for patients with an organic mental disorder, but 24% for those with depression). Only a few studies of geropsychiatric institutionalized patients utilized standardized instruments. Molinari *et al.*³⁵ used the SIDP-R and found that older adults had personality disorder rates similar to those of a young adult comparison sample; however, older adults were less likely to meet criteria for more than one personality disorder, and clinical diagnoses yielded fewer personality disorders than the SIDP-R. Likewise, Coolidge *et al.*³⁶ used the Coolidge Axis II Inventory and found similarly high personality disorder rates among young (66%) and old (58%) chronically mentally ill patients, but the younger group was more likely to be specifically diagnosed with antisocial, borderline, and schizotypal personality disorder. Finally, among older inpatient veterans, Kenan *et al.*³⁷ found a 55% personality disorder prevalence rate.

Outpatient Settings

The findings from the lone study conducted with a structured personality disorder scale in a geropsychiatric outpatient setting are consistent with the latter inpatient studies. Molinari and Marmion³⁸ found that older adults were less likely to meet the criteria for more than one personality disorder than younger adults, and clinical diagnosis again yielded fewer personality disorders than the SIDP-R.

Depression

One area of intense study has been the relationship between personality disorder and depression in older adults. Kunik *et al.*²⁰ studied 154

depressed older inpatients and identified 24% with co-morbid personality disorder, whereas Molinari and Marmion³⁹ determined that 63% of depressed geropsychiatric outpatients met personality disorder criteria. Thompson *et al.*⁴⁰ found that 33% of depressed older adults who were being treated with psychotherapy in a geropsychiatric outpatient clinic met personality disorder criteria. In a study investigating the relationship between personality disorder and functioning in acutely depressed older psychiatric patients, Axis II pathology was found to be associated with greater disability and more impaired social and interpersonal functioning⁴¹. In their review of the literature on personality disorder in older adults, Agronin and Maletta⁴² posit that personality disorder in late life may be intrinsically related to Axis I pathology, particularly major depressive disorder.

Summary of Epidemiological Studies

In an attempt to lend clarity to the burgeoning literature on personality disorder in older adults, Abrams and Horowitz⁴³ conducted a meta-analysis of the most methodologically sophisticated epidemiological studies. They inferred a personality disorder prevalence rate of 10% (with a range of 6–33%) for those over the age of 50, and concluded that research neither substantiates nor disconfirms an age effect. However, these authors remark that the bulk of the evidence supports, at least for certain personality disorders, a decline in frequency and intensity with age. The cause for this decline is one of the most controversial and debated topics in the literature on personality disorder in older adults. Four main reasons have been postulated.

First, there is a general mellowing of the ‘high-energy’ Cluster B personality disorders due to biological (reduced testosterone in males) and developmental changes (those with personality disorder finally master a single interpersonal strategy to manage stresses). This accounts for the consistent result that older adults are less likely to meet the criteria for more than one personality disorder, and is also supported by the study of Segal *et al.*²⁷, who discovered lower levels of dysfunctional dispositional coping styles among older adults compared with younger adults.

Second, the decline in ‘high-energy’ personality disorder relates to the greater mortality rates of those with Cluster B personality disorder in their younger years. Older adults with personality disorder are thereby a selective sample of less extreme personality disorder ‘survivors’. Third, personality disorder is generally under-diagnosed, particularly in older adults, where cognitive and medical causes are emphasized or personality disturbance (avoidance, dependency, emotional lability) is viewed as normal⁴⁴.

Fourth, the decline in personality disorder with age is a methodological artefact, since some DSM criteria are age-insensitive. For example, occupational and vocational impairment are often irrelevant to older adults. From this point of view, there really is no true decline in personality disorder rates with age, just a change in form that is inadequately assessed. These so-called ‘geriatric variants’⁴⁵ reflect the more subclinical, non-specific or age-relevant personality disorder traits that account for personality disorder NOS (not otherwise specified) to be diagnosed with particular high frequency in older adults. These formulations are consistent with the theory of heterotypic continuity⁴⁶ which proposes that core psychological constructs remain constant, but that they are manifested in different ways throughout the life cycle (e.g. failure to conform to social norms may be reflected by repeated fights in younger individuals with antisocial personality disorder, but by repeated rule infractions in long-term care settings by older adults with antisocial

personality disorder). The construction of a new geriatric nosology has been proposed to accommodate the late life changes in Axis II pathology^{42,43,45}. Such re-classification will need to: (i) reconsider the diagnostic requirement that maladaptive personality disorder behaviour be rooted so early in young adulthood; (ii) routinely address Axis II pathology in the context of more acute Axis I symptomatology; and (iii) integrate age-related developmental, medical (Axis III) and psychosocial/environmental stressors (Axis IV) with Axis II manifestations⁴².

PROGNOSIS

Unfortunately, only a few seemingly contradictory studies have investigated the prognosis of personality disorder in late life. In two separate studies of geropsychiatric outpatients, personality disorder was found to be a poor prognostic sign for the psychotherapeutic treatment of depression^{40,47}. However, Molinari⁴⁸ examined the one-year relapse rates for 100 male geropsychiatric inpatients and found no significant differences for those diagnosed with and without personality disorder. Consistent with the finding of Kunik and colleagues²⁰ that personality disorder diagnosis had no impact on the acute response of inpatient treatment for depression with older adults, no differences were found in relapse rates for a subgroup of depressed inpatients with and without personality disorder⁴⁸. It appears that in inpatient geropsychiatric settings, Axis I symptomatology overrides Axis II pathology as an outcome predictor, probably related to the complex combination of medical, cognitive and psychiatric symptoms often observed in those older patients needing acute care. More generally, the prognosis for older adults with personality disorder is highly variable and contextualized. Some adults with personality disorder clearly mature with advanced age, some seem to deteriorate in the face of challenges associated with ageing (e.g. loss of prestige, reduced physical stamina and attractiveness, increased need for assistance from others) and yet the third pattern is the unabated continuity of similar levels of dysfunctional behaviours from younger life to later life³.

SUMMARY

1. There are psychosocial and genetic determinants of personality disorder in older adults.
2. The assessment of personality disorder in older adults is challenging, especially due to the presence of Axis I and Axis III co-morbidities.
3. There are poor concordance rates of personality disorder diagnosis between clinical examination, structured interviews and self-reports, suggesting the need for data collection from a variety of sources.
4. There may be an age-related mellowing of the ‘high-energy’ personality characteristics of individuals with personality disorder, and/or there are ‘geriatric variants’ of personality disorder not tapped by DSM.
5. There is a positive association between depression and personality disorder diagnosis.
6. Identifying personality disorder in older adults may be more useful prognostically in outpatient settings, where the Axis I symptomatology is less severe.
7. DSM-V must do a better job of accommodating late life changes in personality disorder presentation.

Although age-related changes in personality disorder expression may be in the less volatile and impulsive direction, novel geriatric manifestations still can create a significant burden in stressful caregiving contexts for family members, friends, health care professionals and administrators of institutions attempting to support a flawed and vulnerable older adult. Future empirical research guided by conceptual advances in psychodynamic, self/identity, cognitive and life span developmental theories of personality that address the interrelationship of genetic, biological, psychological and social variables promises to yield exciting progress in the creation of gero-specific assessment instruments and treatment protocols for personality disorder in older adults.

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