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Publisher: Routledge

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Aging & Mental Health

Publication details, including instructions for authors and subscription information:

<http://www.tandfonline.com/loi/camh20>

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To cite this article: Daniel L. Segal, Juliana Gottschling, Meghan Marty, William J. Meyer & Frederick L. Coolidge (2015) Relationships among depressive, passive-aggressive, sadistic and self-defeating personality disorder features with suicidal ideation and reasons for living among older adults, *Aging & Mental Health*, 19:12, 1071-1077, DOI: [10.1080/13607863.2014.1003280](https://doi.org/10.1080/13607863.2014.1003280)

To link to this article: <http://dx.doi.org/10.1080/13607863.2014.1003280>

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Aging & Mental Health, 2015

Vol. 19, No. 12, 1071-1077, <http://dx.doi.org/10.1080/13607863.2014.1003280>



Relationships among depressive, passive-aggressive, sadistic and self-defeating personality disorder features with suicidal ideation and reasons for living among older adults

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(Received 3 August 2014; accepted 15 December 2014)

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Objectives: Suicide among older adults is a major public health problem in the USA. In our recent study, we examined relationships between the 10 standard DSM-5 personality disorders (PDs) and suicidal ideation, and found that the PD dimensions explained a majority (55%) of the variance in suicidal ideation. To extend this line of research, the purpose of the present follow-up study was to explore relationships between the four PDs that previously were included in prior versions of the DSM (depressive, passive-aggressive, sadistic, and self-defeating) with suicidal ideation and reasons for living.

Method: Community-dwelling older adults (N = 109; age range = 60–95 years; 61% women; 88% European-American) completed anonymously the Coolidge Axis II Inventory, the Reasons for Living Inventory (RFL), and the Geriatric Suicide Ideation Scale (GSIS).

Results: Correlational analyses revealed that simple relationships between PD scales with GSIS subscales were generally stronger than with RFL subscales. Regarding GSIS subscales, all four PD scales had medium-to-large positive relationships, with the exception of sadistic PD traits, which was unrelated to the death ideation subscale. Multiple regression analyses showed that the amount of explained variance for the GSIS (48%) was higher than for the RFL (11%), and this finding was attributable to the high predictive power of depressive PD.

Conclusion: These findings suggest that depressive PD features are strongly related to increased suicidal thinking and lowered resilience to suicide among older adults. Assessment of depressive PD features should also be especially included in the assessment of later-life suicidal risk.

Keywords: suicide; personality; aging; elderly; assessment

Introduction

Personality disorders (PDs) are thought to arise when one's personality traits become inflexible and maladaptive, and cause clinically significant personal distress or impairment in social or occupational functioning. Notably, the manifest psychopathology of diverse forms of PDs has been identified and classified for centuries, dating back at least to the seminal writings of Greek philosopher Hippocrates. In the fourth century BC, Hippocrates theorized that all diseases were caused by imbalances of four bodily humors, with each conferring a specific personality type or basic temperament. One of his contemporaries, Theophrastus (Rusten, 1993), heralded a majority of modern PDs in his short book entitled *Characters*. The diagnosis of PDs has evolved significantly in modern classification systems (Coolidge & Segal, 1998), most notably across the various editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM). The most current version of the manual, DSM-5 (American Psychiatric Association [APA], 2013), included without change the 10 standard PDs that were included in DSM-IV-TR (APA, 2000) despite years of debate about the merits of a complete overhaul and reformulation of this diagnostic category (see Livesley, 2012). The 10 standard PDs include the paranoid, schizoid, schizotypal, antisocial, borderline, narcissistic, histrionic, avoidant, obsessive-compulsive, and dependent PD (APA, 2013).

Although these 10 PDs remained unchanged, the multiaxial diagnostic system was eliminated in DSM-5 as it was replaced by a non-axial system. As such, the PDs no longer are classified on a separate diagnostic axis than traditional clinical disorders. Perhaps a more subtle change was the elimination of four specific PDs that were included

in the appendix of prior editions of the DSM, designated as requiring further validation before inclusion in the main body of the DSM. These disorders were the depressive, passive-aggressive, sadistic, and self-defeating PDs. Unfortunately, removal of these diagnoses from the DSM-5 does not preclude clients from presenting with robust forms of these personality deficits, as these personality patterns have been identified and used clinically for decades (e.g., Millon, Millon, Grossman, Meagher, & Ramnath, 2004). We agree with the astute observation of Millon et al. (2004) who noted regarding the depressive, passive-aggressive, sadistic, and self-defeating PDs that 'Despite their controversial nature, they are, nevertheless, widely known among clinicians and describe aspects of human nature that have no equivalent in the remaining constructs' (p. 520). Moreover, these four PDs appear in older individuals, although in modified form, similar to that of the standard PDs that also have hypothesized geriatric variants in later life (Segal, Coolidge, & Rosowsky, 2006).

One important focus of research in geropsychology is the understanding of risk and resilience factors for suicide in later life, since older adults have long had elevated rates of death by suicide compared to the general younger population (see review by Conwell & Thompson, 2008). In our recent study (Segal, Marty, Meyer, & Coolidge, 2012), we examined relationships between the 10 standard PDs of the DSM-IV-TR/DSM-5 with suicidal ideation and reasons for living among older adults. Regarding suicidal ideation, multiple regressions indicated that the 10 PD dimensions explained a majority (55%) of the variance in suicidal ideation. Two independent variables had significant contributions to the model: the borderline PD scale was a significant positive predictor, whereas the histrionic PD

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scale was a significant negative predictor. Regarding reasons for living, the total variance explained by the model was 21%. Only the standardized regression coefficient for the schizoid PD scale approached statistical significance ($p < .06$), whereas the remaining PD scales made minimal and non-significant contributions.

This study showed that the 10 standard PDs in the DSM-5, measured dimensionally, were meaningfully related to suicidal ideation, and to a lesser degree, to reasons for living among older adults. However, the aforementioned four other PD dimensions (depressive, passive-aggressive, sadistic, and self-defeating) were not included in these analyses. Because these PDs have a long and rich history of clinical utility (Millon et al., 2004) and each prototype has been included in prior editions of the DSM, the purpose of the present study was to explore relationships between these four PD dimensions with suicidal ideation and reasons for living among older adults. We predicted that these four PD dimensions would explain a significant amount of variation in suicidal ideation and in reasons for living, which would provide further evidence of the validity and usefulness of these PD features in understanding the links between personality and later life suicide. To examine further the significance of these four PD dimensions, we additionally investigated their predictive power above and beyond the standard DSM-5 PD traits that were identified as important predictors by Segal et al. (2012), namely borderline, histrionic (suicide ideation), and schizoid PDs (reasons for living). Additionally, the four PD dimensions were evaluated in relation to anxiety and depression, both well-known important predictors for suicide ideation and reasons for living.

It is clear that the depressive, passive-aggressive, sadistic, and self-defeating PDs are relatively understudied, especially in the geropsychological literature. Indeed, to provide a gross estimate of the amount of research attention directed toward the depressive, passive-aggressive, sadistic, and self-defeating PDs, we conducted an electronic literature search in the PsycINFO database (on 12 December 2014) using the following 'key terms' in the titles of journal articles: depressive personality; passive aggressive personality; sadistic personality; and selfdefeating personality. The search results revealed the depressive personality was clearly the

most studied of the group (with 125 citations), followed by self-defeating personality (69 citations), passive aggressive personality (27 citations), and sadistic personality (17 citations). Depressive PD has the most evidence for construct validity (see review by Maddux & Johansson, 2014). Few, if any, of these studies included older adults in the samples, revealing a significant dearth of knowledge about the impact and expression of these PD dimensions in later life. No empirical studies to date have specifically examined their impact on suicidal risk and resilience in later life.

Method

Participants and procedure

Recruitment and sampling procedures for participants in this study have been described previously (Segal et al., 2012). Briefly, the sample consisted of 109 community-dwelling older adults (41 men, 66 women (61%); 88% European-American; M age = 71.4 years, SD = 8.2 years; age range = 60-95 years old). Participants were recruited via newspaper advertisements and an older adult research registry database. They completed anonymously a packet of self-report questionnaires and informed consent was obtained from all participants. The procedures, protocol, and informed consent in the present study were approved by the Institutional Review Board of the University of Colorado, Colorado Springs.

Measures

Coolidge Axis II Inventory. The Coolidge Axis II Inventory (CATI) is a popular and well-validated, 250-item self-report measure of the 10 PDs listed in the DSM-IVTR/DSM-5, as well as depressive, passive-aggressive, self-defeating, and sadistic PDs and different Axis I diagnoses (Coolidge, 2000). The CATI measures PDs as dimensional, rather than categorical, in nature, and can therefore be used in clinical as well as non-clinical populations. The CATI has been used successfully in many studies with older adults (see Segal et al., 2006). Items are answered on a 4-point Likert-type scale, and raw scores of each scale are translated into T-scores (M = 50, SD = 10) with scores above 70 indicating the likely presence of the particular disorder. For the purpose of the present study, the CATI was used to assess dimensional scores on the Depressive, Passive-Aggressive, Self-Defeating, and Sadistic PD scales, as well as Borderline PD, Histrionic PD, Schizoid PD scales, and both the Anxiety and Depression scales. The scale reliabilities, computed as Cronbach's alpha coefficients, in the current sample are displayed in Table 1.

Reasons for Living Inventory. The Reasons for Living Inventory (RFL) is a 48-item self-report measure developed to assess a range of beliefs thought to be important in differentiating suicidal from non-suicidal individuals (Linehan, Goodstein, Nielsen, & Chiles, 1983). The RFL consists of items that assess potential reasons for not completing suicide. Answers are given on a 6-point

Table 1. Descriptive statistics of the CATI scales, RFL, and GSIS.

	M	SD	T	α
Coolidge Axis II Inventory (CATI)				
Depressive (7)	11.49	3.32	43.25	.79
Passive-Aggressive (23)	48.02	7.02	46.57	.75
Sadistic (17)	25.32	5.24	43.82	.73
Self-Defeating (21)	43.67	6.04	48.91	.71
Borderline (23)	41.35	7.19	46.07	.80
Histrionic (30)	68.81	8.49	43.91	.67
Schizoid (9)	17.18	3.99	53.27	.69
Axis I Anxiety (28)	57.30	8.43	46.94	.89
Axis I Depression (24)	41.20	9.11	47.68	.80

Reasons for Living Inventory (RFL)				
RFL total (48)	4.10	0.80		.94
Survival and coping beliefs (24)	4.75	0.90		.94
Responsibility to family (7)	4.44	1.22		.86
Child-related concerns (3)	4.28	1.57		.78
Fear of suicide (7)	2.46	1.09		.78
Fear of social disapproval (3)	2.59	1.38		.81
Moral objections (4)	3.55	1.67		.82
Geriatric Suicide Ideation Scale (GSIS)				
GSIS total (31)	51.14	15.88		.92
Suicide ideation (10)	13.76	4.73		.81
Death ideation (5)	8.85	3.58		.70
Loss of personal and social worth (7)	13.69	5.18		.80
Perceived meaning in life (8)	13.32	4.51		.82

Note: Number of items for each subscale is listed in parentheses.

Likert-type scale. Mean scores were calculated for each of the subscales and the total score as per Linehan et al. (1983), with higher scores indicating stronger reasons for living. The RFL encompasses six subscales: survival and coping beliefs, responsibility to family, child-related concerns, fear of suicide, fear of social disapproval, and moral objections. The RFL has a solid theoretical base, is extensively used in research, and has abundant evidence of reliability of scale scores in diverse populations and validity for use as a screening measure of suicide resilience (see Range, 2005) including several studies with older adults (e.g., Marty, Segal, & Coolidge, 2010; Miller, Segal, & Coolidge, 2001; Segal, Levenson, & Coolidge, 2008; Segal & Needham, 2007). Alpha coefficients in the present sample are shown in Table 1.

Geriatric Suicide Ideation Scale. The Geriatric Suicide Ideation Scale (GSIS) is a 31-item multidimensional self-report measure of suicide ideation in older adults. The component subscales of the GSIS assess suicide ideation, death ideation, loss of personal and social worth, and perceived meaning in life. Items on the latter scale are reverse scored so that higher scores are indicative of higher suicidal ideation. Additionally, the item 'I have tried ending my life in the past,' loads only on the total score but not on any subscale (Heisel & Flett, 2006).

Respondents rate to what extent they agree with each item on a 5-point Likert scale. The GSIS demonstrates strong reliability of scale scores and has ample evidence of validity for use as a screening measure among older adults (Heisel & Flett, 2006). Alpha coefficients in the present sample are also presented in Table 1.

Results

Descriptive statistics and correlations

Mean subscale scores and standard deviations for the CATI scales, the RFL scales, and the GSIS scales are provided in Table 1. The mean scores of the Passive-aggressive and Self-defeating PD scales were moderate, whereas the mean scores of the Depressive and Sadistic PD scales indicated a relatively lower level of depressive and sadistic PD

features. The RFL means represented moderate levels of reasons for living, whereas the GSIS means represented a relatively low level of suicidal ideation, with some variation, as would be expected in a community sample.

Pearson correlations were calculated between the four PDs with the RFL scales and the GSIS scales (see Table 2). Overall, the correlations between the PD scales and the GSIS subscales were generally stronger than with the RFL subscales. More precisely, the RFL total score only had a significant small negative relationship with the depressive PD scale.

Regarding RFL subscales, survival and coping beliefs showed a moderate negative correlation with the depressive and the self-defeating PD scales, and a small negative

Table 2. Pearson correlation between the four CATI scales, RFL, and GSIS.

	DP	PA	SA	SD
Coolidge Axis II Inventory				
Depressive (DP)				
Passive-Aggressive (PA)	.65			
Sadistic (SA)	.18	.30		
Self-Defeating (SD)	.59	.70	.48	
Reasons for Living Inventory				
RFL total	i.23	i.02	i.19	i.12
Survival and coping beliefs	i.39	i.23	i.05	i.15
Responsibility to family				i.09
Child-related concerns	i.26	i.07	i.10	i.08
Fear of suicide	.35	.43	i.10	.00
Fear of social disapproval	.01	.14	.04	.12
Moral objections	i.17	i.11	i.18	i.17
Geriatric Suicide Ideation				
GSIS total	.63	.56	.34	.59
Suicide ideation	.55	.47	.38	.50
Death ideation	.35	.30	.05	.36
Loss of personal and social worth	.64	.56	.36	.57
Perceived meaning in life	.50	.43	.23	.42

p < .05; p < .01.

relationship with the passive-aggressive and the sadistic PD scales. The responsibility to family and child-related concerns subscales both correlated significantly and negatively with depressive PD. Fear of suicide, on the other hand, had moderate positive relationships to depressive, passive-aggressive, and self-defeating PDs. Finally, fear of social disapproval and moral objections showed no significant relationships to any of the four PDs.

With regard to GSIS subscales, all of the CATI PD scales had medium-to-large positive relationships, with the exception of sadistic PD traits, which was unrelated to the death ideation subscale. All remaining correlations ranged from small (.23) to large (.63).

Multiple regression results

Initially, multiple regression analyses were used to test the contribution of each of the four PD scale scores in predicting the RFL total score and the GSIS total score. For RFL (see Table 3, Model 1), the total variance explained by the four PD scales was 11% ($R^2 = .34$, $R^2_{adj} = .11$, adjusted $R^2 = .07$), $F(4,87) = 2.78$, $p < .05$. Only the standardized regression coefficient for the depressive PD scale reached statistical significance ($p < .01$). Passive-aggressive PD had a medium standardized b , but only approached significance ($p = .08$). The remaining PD scales made small and non-significant contributions. As already reported for the correlations, the amount of explained variance for the GSIS (48%) was higher than for the RFL (11%). However, as can be seen in Table 4 (Model 1), this finding was completely attributable to the high predictive power of depressive PD ($p < .001$). Passive-aggressive, sadistic, and self-defeating PDs had only small and non-significant standardized regression coefficients.

In a second set of multiple regression analyses, the significant predictors from the Segal et al. (2012) study for

Table 3. Multiple regression analyses for the CATI scales predicting RFL total score.

Model	Predictor	B	SE B	b	R	R ²	Adj. R ²	DR ₂	DF (df ₁ ,df ₂)
1	Constant	4.24	0.65		.34	.11	.07		2.78 (4,87)
	Depressive	1.09	0.04	0.39					
	Passive-Aggressive		0.02	.31					
	Sadistic	1.03	0.02	1.17					
	Self-Defeating	1.01	0.02	1.02					
2	Constant	5.34	.35		.36	.13	.12		13.28 (1,90)
	Schizoid	1.07	.02	1.36					
3	Constant	4.46	.64		.43	.19	.14	.06	1.49 (4,86)
	Schizoid	1.07	.03	1.34					
	Depressive	1.07	.03	1.28					
	Passive-Aggressive		.02	.25					
	Sadistic	1.02	.01	1.10					
4	Constant	3.98	.71		.28	.08	.06		3.78 (2,89)
	Axis I Anxiety	.04	.03	.46					
	Axis I Depression	1.06	.03	1.66					
5	Constant	3.28	.86		.39	.16	.09	.08	1.87 (4,85)
	Axis I Anxiety	.04	.03	.39					
	Axis I Depression	1.05	.03	1.62					
	Depressive	1.07	.04	1.30					
	Passive-Aggressive		.02	.34					
	Sadistic	1.02	.01	1.10					
Self-Defeating		.02	.05						

RFL total score and GSIS total score were included as a first block of predictors (Model 2), whereas Model 3 (see Tables 3 and 4) added the four additional PDs. As presented in Table 3, schizoid PD alone explained 13% of the variance in the RFL ($R^2 = .36$, $R^2_{adj} = .13$, adjusted $R^2 = .12$, $F(1,90) = 13.28$, $p < .01$), with a significant standardized regression coefficient of $b = .36$ ($p < .01$). As can be seen from Model 3 (Table 3), the four additional PDs predicted an additional, but non-significant portion of the variance in one's reasons for living beyond schizoid PD (6%; $F(4,86) = 1.49$, $p = .21$). However, depressive PD had a medium standardized b similar to the contribution of schizoid PD ($b = .28$; $p < .05$) and passive-aggressive PD ($b = .25$; $p = .10$).

Regarding the GSIS, as in the previous analysis, the amount of explained variance in suicide ideation was

Notes: Model 1 D four PDs alone; Models 2 and 3 D significant PDs from Segal et al. 2012 entered as first block and 4 PDs entered as second block; and Models 4 and 5 D anxiety and depression entered as first block and four PDs entered as second block. $p < .05$; $p < .01$.

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Table 4. Multiple regression analyses for the CATI scales predicting GSIS total score.

Model	Predictor	B	SE B	b	R	R ₂	Adj. R ²	DR ₂	DF (df ₁ ,df ₂)
1	Constant	15.85	1.97		.70	.48	.46		22.45 (4,96)
	Depressive			.42					
	Passive-Aggressive	0.23	0.25	.11					
	Sadistic	0.38	0.25	.13					
	Self-Defeating	0.53	0.30	.20					
2	Constant	35.84	10.20		.65	.42	.41		35.84 (2,98)
	Borderline	1.67	.20	.76					
	Histrionic	1.79	.17	.42					
3	Constant	8.92	11.35		.75	.57	.54	.14	7.79 (4,94)
	Borderline	.78	.24	.36					
	Histrionic	1.60	1.47	.26					
	Depressive			.47					
	Passive-Aggressive	.27	.25	.12					
	Sadistic	.24	.24	.08					
4	Constant	14.02	9.88		.71	.50	.49		49.06 (2,98)
	Axis I Anxiety Axis I Depression	1.61	1.74	.39 .36	.32	1.00			
5	Constant	8.51	11.69		.74	.55	.52	.05	2.68 (4,94)
	Axis I Anxiety	1.93	1.37	.40					
	Axis I depression			.38					
	Depressive	1.48	.52	.31					
	Passive-Aggressive	.11	.25	.05					
	Sadistic	.17	.25	.06					
	Self-Defeating	.29	.33	.11					

Note: Model 1 D four PDs alone; Models 2 and 3 anxiety and Depression entered as first block and 4 PDs entered as second block. D significant PDs from Segal et al. 2012 entered as first block and four PDs entered as second block; and Models 4 and 5 D $p < .05$; $p < .01$.

considerably higher than for reasons for living. Borderline and histrionic PDs (Model 2, Table 4) explained 42% of the variance ($R = .65$, $R^2 = .42$, adjusted $R^2 = .41$, $F(2,98) = 35.84$, $p < .01$), whereas the four additional PDs explained 14% more of the variance (Model 3, Table 4; $F(4,94) = 7.79$, $p < .01$). Besides borderline and histrionic

PDs, only depressive PD had a significant standardized regression coefficient of medium size ($b = .31$; $p < .01$).

A final series of regression analyses was performed including CATI Anxiety and Depression scales into the prediction of the RFL total score and the GSIS total score. Two models were compared (see Tables 3 and 4): Model 4 included only the Anxiety and Depression scales, whereas Model 5 added the four PDs. For reasons for living, anxiety and depression alone explained 8% of the variance ($R = .28$, $R^2 = .08$, adjusted $R^2 = .06$, $F(2,89) =$

3.78, $p < .05$) and the four PDs explained 8% of the variance beyond anxiety and depression (Model 5), albeit the change in R^2 was not significant ($F(4,85) = 1.87$, $p = .10$). Depression and depressive PD both showed significant standardized regression coefficients ($b = .62$ and $.34$, $p < .05$). For suicide ideation, anxiety and depression alone explained 50% of the variance ($R^2 = .71$, $R^2 = .50$, adjusted $R^2 = .49$, $F(2,98) = 49.06$, $p < .01$) and the four PDs additionally explained 5% of the variance ($F(4,94) = 2.68$, $p < .05$). Along with anxiety and depression, depressive PD had a significant standardized regression coefficient of $b = .31$ ($p < .01$).

Discussion

The present study examined the associations between four specific PD dimensions (depressive, passive-aggressive, sadistic, and self-defeating) and suicidal ideation in community-dwelling older adults. Support for the hypothesized relationships was strong. As expected, PD features were associated strongly and positively with suicidal ideation and explained a significant proportion of the variance in suicidal ideation. These findings are consistent with our previous study in which the 10 standard PD dimensions significantly and strongly predicted suicidal ideation. Present findings are also consistent with previous studies which indicated that PD features increase risk for suicidal thinking, suicide attempts, and death by suicide among older people (e.g., Duberstein et al., 2000; Harwood, Hawton, Hope, & Jacoby, 2001; Heisel, Links, Conn, Van Reekum, & Flett, 2007).

Similar to our earlier study (Segal et al., 2012), PD features explained a larger proportion of variance in suicidal ideation than for reasons for living. For the RFL, the depressive PD was the sole significant predictor, in the negative direction. Likewise, for the GSIS, the depressive PD was the sole significant predictor, in the positive direction. These findings suggest that depressive PD features are strongly related to increased suicidal thinking and lowered resilience to suicide among older adults. Core features of the depressive type include a generally gloomy, negative, and cynical outlook on life and the future. Indeed, people with this type have a usual mood dominated by dejection and gloominess, a poor self-concept centered around feelings of worthlessness, a critical and self-blaming stance, a tendency to brood and worry, a negativistic and overly critical attitude toward others, a pessimistic orientation, and a tendency to feel guilty and remorseful (DSM-IV-TR; APA, 2000). According to Segal et al. (2006), older people with depressive PD are likely to do poorly in interpersonal relationships as their pessimism and negativity are likely to drive others away. Notably, people with depressive PD are at a greater risk of

developing dysthymic disorder than a comparable group of people without depressive PD (Kwon, Kim, Chang, Park, & Yoon, 2000). Furthermore, people with depressive PD who also suffered from major depression had lower likelihood of remission of baseline depression at two-year follow-up compared to depressed patient with dysthymia but not depressive PD (Markowitz et al., 2005). It is possible that the link between depressive PD and suicidal thinking found in our study is mediated or moderated by clinical episodes of dysthymia or major depression, and future studies should explore this issue.

We wish to acknowledge several limitations of the present study. First, the correlational design, although informative, precludes inferences about causality. Prospective studies are needed to advance knowledge in this important area. Second, the non-clinical sample precludes generalization of the results to older adults diagnosed formally with specific PDs. Although PDs are widely understood to represent dimensional variants of normal personality traits that become extreme and rigid, this study focused on PD dimensions and not formally diagnosed PDs per se. Third, we found a number of relatively high inter-correlations among the 4 PD scales, ranging from $r = .18$ (between sadistic and depressive PD scales) to $r = .70$ (between self-defeating and passive-aggressive PD scales), raising the possibility that these PD dimensions may not represent truly distinct forms of personality psychopathology. However, we wish to note that similarly substantial inter-correlations are found among some of the 10 standard PD dimensions. As such, overlap is a problem for the entire diagnostic category of PDs (Clark, 2007; Trull & Durrett, 2005) and is not unique to the four PD dimensions on which the present study focuses. Moreover, Zimmerman (2013) persuasively argued that comorbidity among the PDs occurs for many reasons, most notably that it increases treatment-seeking behaviors and thus artificially elevates rates among clinical samples, and that comorbidity in and of itself does not indicate a problem with nosology. A final limitation is that there was slight overlap between items on the GSIS and the depressive personality subscale of the CATI.

Despite some limitations, due to the strength of the predictive relationships in this study, we encourage future studies to include all variants of PD features in the study of elder suicide, especially in more psychopathological and ethnically diverse samples of older adults. Assessment of depressive PD features should also be especially included in assessment of later life suicidal risk. Finally, we strongly encourage systematic inclusion of the depressive, passive-aggressive, sadistic, and self-defeating PDs in ongoing PD research to determine whether these specific PD dimensions have as much evidence for construct validity as the standard PDs already included in the current manual. Certainly, their removal from DSM-5 should not be taken as endorsement of their irrelevance in standard psychological assessment.

Disclosure Statement

No potential conflict of interest was reported by the authors.

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