Personality Disorders and Older Adults

Diagnosis, Assessment, and Treatment

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In loving memory of my grandfather and hero, Samuel H. Segal,
who always believed in me and my potential.
—D. L. S.

To the newest joys in my life, my grandbabies,
Melissa, Allison, and Ryan.
—F. L. C.

To the memory of my father, William Cohen.
Pa lived to 103 and did old age so very well.
—E. R.

Contents

Foreword

Personality disorders (PDs) are among the most complex aspects of human behavior to understand and manage. When the vicissitudes of old age further complicate these disorders, mental health clinicians are faced with immense challenges to their therapeutic skills.

Why is the diagnosis of PD especially important in old age? Adaptation in late life is increasingly challenging, and as this book so expertly describes, PD can impair adaptive capacities in many ways. This impairment has many negative outcomes such as association with several Axis I disorders that are precipitated by or complicated by PD. The interpersonal maladaptive patterns associated with PD in late life can be destructive to elders. In addition, certain maladaptive personality traits such as undue pessimism, a tendency to helplessness, and overreliance on supportive relationships with others—so-called sociotropy—are associated with physiological reactions that may produce severe consequences if they are unrecognized or untreated. These consequences may include predisposition to depression associated with a rise in inflammatory markers such the interleukins, heart disease, and cancer. Although the cause-and-effect nature of these associations is not yet well defined, there is enough data to suggest that

understanding and treating PD or trait disturbances could have important physical and mental health benefits. Similarly, other aspects of management of the problems of the elderly by caregivers will be much more challenging in the presence of the primary problem of PD: the associated impairment of interpersonal relationships. Elders, whose PD-based pathology compels them to demean and reject those on whom they must rely, can provoke rejection and abandonment at a time in their lives when they are often most in need of practical support, care, and love. The outcome can be disastrous. Even professional mental health practitioners often shrink from the task of dealing with such patients knowing instinctively or from experience that the treatment can be unrewarding, personally difficult, and complex.

To our rescue have come Segal, Coolidge, and Rosowsky, who are just the seasoned authors we need to guide the profession into this challenging arena of diagnosis, assessment, and treatment of PD in elders. Their important book synthesizes the accumulated knowledge of personality and its disorders in late life, combining the rigor of science with the sensitivity of that indefinable, essential component of practice called clinical art.

As every practitioner of mental health care for older adults will readily know from both experience and epidemiological data, the old retain the capacity to express all the psychopathology of the young including personality disorders. As is true for other disorders, however, old age creates additional clinical features that often obscure the immediate recognition of PD by the clinician who is using criteria of diagnosis created for younger patients. In old age, the many changes in health, intellectual ability, physical capacity, and social circumstance all interact to produce behaviors that, as the authors so well describe, mimic PD; for example, the withdrawal of the schizoid or the clinging neediness of the dependent personality. Similarly age-associated alterations can induce behavioral changes that obscure an underlying personality disorder such as diminishing the expression of the drama of Cluster B symptoms.

In the arena of personality disorder, the iconoclastically inclined reader may question the utility of applying the *Diagnostic*

and Statistical Manual of Mental Disorders (fourth edition, text revision; *DSM-IV-TR*) criteria for PD to any age group. Thankfully, this book refreshingly deals with diagnosis by recognizing both the value of the formal criteria and the complexity of the issues. The criteria for each PD diagnosis are well presented and then thoroughly dissected from the perspective of diagnosis of the elderly patient using case histories to enliven the discussion. This careful analysis, supported by clinical cases, should help the framers of the next generation of *DSM* criteria specifically define age-appropriate criteria for PD.

Segal, Coolidge, and Rosowsky not only have established an important clinical and heuristic base for the practical application of PD diagnostic criteria to the elderly but have also highlighted those areas where the clinician must be cautious in applying the standard criteria to aging patients. This is especially true for the more dramatic personality disorders such as the borderline.

The criteria of the *DSM-IV-TR* appropriately rely, wherever possible, on the most observable behaviors to define diagnosis. However, behavior is multidetermined especially in the elderly. To understand the behaviors of personality disorders in elders, the clinician must be guided to elicit the full range of factors that influence behavioral expression—affect, cognition, inner conflicts, and motivations must all be explored systematically with each patient to accurately distinguish which behaviors arise out of personality-based factors and which are precipitated by other age-related problems such as brain pathology or physical limitations. In addition, the clinician must be able to gather the longitudinal data to establish the early evidence in support of habitual aspects of the behavior necessary for diagnosis of PD, a sometimes challenging task when dealing with the lifelong histories of elders. The authors have embraced the tangled diagnostic web and have begun to create a diagnostic map to guide the clinician. Their approach also highlights those areas where empirical and systematic data are lacking and need further research, thereby implicitly suggesting a research agenda for investigating diagnosis of PD in elders in a targeted fashion.

Empirical approaches to diagnosis are further strengthened by the thoughtful discussion of standardized PD diagnostic instruments, emphasizing the strengths and weaknesses of each and in particular emphasizing the utility or lack of it for the elderly. All standardized instruments have the great advantage of systematically eliciting data from the patient. But their focused nature also imposes limitations that should lead to cautious interpretation of results. Some instruments such as the Structured Clinical Interview for *DSM-IV* (SCID-II) simply offer a structured approach for defining the presence or absence of the symptoms used for making a *DSM* diagnosis. Others such as the NEO Personality Inventory (NEO-PI) rely on a theoretical base that arbitrarily restricts the features of human behavior to predetermined categories. Standardized interviews therefore are but one useful approach to understanding the diagnosis of PD in elders.

An important, but as yet unresolved, question is whether maladaptive personality-based behavior can newly emerge in late life. The authors usefully examine this ongoing debate. Firm conclusions cannot be drawn based on the data at this point in time, but clearly, behaviors can change and evolve in late life. The clinician meeting the patient in a cross-sectional fashion, must, among other possibilities, decide on the origin of the symptoms. New, previously unexpressed behaviors can arise when the patient's prior capacity to deal with psychological stress fails. Why might this occur? One possibility is that age-associated life stressors such as loss and grief may selectively assault the patient at points of long-standing personality-based vulnerabilities that were dormant earlier in life when the stresses of life required different strengths and capacities.

One of the most important aspects of this book is the careful interweaving of detailed and well-described case histories. Throughout, the reader is guided by comprehensive cases that acknowledge the complexities of diagnosis and management. The observational perspectives are integrated with the psychological, social, and psychodynamic. In addition, for each case,

the authors address the challenge of effective management strategies tailored to the needs of each type of PD. This by itself is worth the price of the book.

The final section deals with the core of the matter for clinicians—what are we, the therapists, to do with these extremely difficult patients; how do we help them? The answer derives from the way in which the problems are conceptualized, and here again Segal, Coolidge, and Rosowsky draw on their well-honed clinical experience integrating it with the existing, and admittedly small, pool of empirical data on effective outcomes. Management of PD must deal with a disorder that has by definition been present for a long time, perhaps lifelong, and that tends to permeate the fabric of the patient's life. The clinician therefore must be able to define and respond to those problems that are amenable to intervention.

The authors recognize that treatment addresses the syndromal (e.g., anxiety or depressive elements requiring medication) and the less well-defined elements of behavioral disturbance. They acknowledge the difficulties of trying to implement intensive psychodynamically oriented techniques in this population although the outcome data in this regard are scarce indeed. Rather they appropriately combine in-depth understanding of the patient and marry it to the most effective environmental, cognitive, and behavioral interventions.

While therapeutic optimism is important in treating any patient, the clinician must be realistic about the extent of change that is possible in certain PDs and be prepared to accept limited gains which, though small, may be significant to the patient's life. In the process, the therapist often endures intensely unpleasant interactions with these patients, who are renowned for their ability to induce some rather untherapeutic feelings in therapists. Therapy is often best when the therapist is highly self-aware during treatment, thereby avoiding being driven away by the patient or responding in an otherwise untherapeutic manner. It is here that the depth of understanding of the psychodynamics and thought patterns of these patients becomes

crucial to management. Phenomenology alone will not equip the therapist adequately.

This book is the best of its kind in the field of personality disorder of the elderly. It is a landmark description of the state of current knowledge and a wise guide to move the field forward to the next phase of understanding and intervention.

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PREFACE

The inspiration for this book comes out of our combined experience over the past 20 to 30 plus years as teachers, researchers, and clinicians. As teachers, we appreciate the necessity of educating our students to recognize when mental health becomes mental illness and how this might present in later life. Indeed, as the baby boomers move into later life and increase the proportion of the population that is older, this need becomes ever more pressing. The rate of mental illness in the current cohort of older adults is high (estimated at about 20%) and the boomers are bringing even higher rates of illness and greater use of mental health services with them to later life (Jeste et al., 1999). Many more trained specialists in geropsychology are needed to meet the needs of older adults now and in the coming decades (Qualls, Segal, Norman, Niederehe, & Gallagher-Thompson, 2002).

As clinicians, we are called on to assess, diagnose, and treat the spectrum of older adults who come to us for help. They come for relief from suffering and for the hope that their later years might be better, or at least less difficult.

The understanding of personality disorders is limited. Our diagnostic criteria are often reductionistic and likely not adequately relevant to many older adults given the unique

context of later life. However, we do need to assess, understand, and treat, and we do need a reasonable lens through which to make sense of what presentations and problems we see. Some areas within the field of clinical geropsychology are better understood; there has been more research conducted and more evidence-based treatments suggested especially for the Axis I disorders. The Axis II disorders have always been in the shadow of the Axis I disorders for a number of reasons. Perhaps chief among these is their "reputation" of immutability as well as the difficulty we have in truly understanding that the essence of the individual, the personality, *is* the pathology. To this is added the uncertainty about what are normal age-related changes and what effect these might have on the personality, as well as the implications of the historical moment.

Yet, it is critical, in our opinion, that clinicians and students of clinical geropsychology achieve an understanding of the personality system as well as the symptoms and expressions of personality disorders in the older individual, and how such expressions affect people and systems outside the individual. We wrote this book with the hope of providing some of this fundamental knowledge.

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Acknowledgments

We are grateful to have had the opportunity to come together to work on this volume. We represent different professional emphases—theory, research, clinical—but are joined by a common interest (some might say passion) in the area of personality disorders in older adults. We have collaborated and worked together on each chapter with the hope of bringing the material to the reader in an interesting and clinically relevant way. We also hope to encourage interest in this area among students and trainees who come across this text, whether by intent or assignment.

No book is created in a vacuum. Therefore, we would like to gratefully acknowledge those who have helped each of us along the way. Our mentors—Bennett Gurian, Michel Hersen, C. Michael Levy, Edward J. Murray, Sara H. Qualls—are always within us as dynamic introjects, encouraging us to think clearly and creatively, and to stay the course. We appreciate the institutional support of the Department of Psychology at the University of Colorado at Colorado Springs, The Department of Psychiatry, Harvard Medical School, and the Massachusetts School of Professional Psychology. We also thank the many students we have each trained and worked

with over the years for their valuable contributions to our research and thinking in this area.

A special thank you goes to our friends at John Wiley & Sons, specifically to Peggy Alexander and Tracy Belmont for sharing our vision and supporting the project, to Patricia Rossi, our senior editor, for being understanding and patient throughout the process, and to Isabel Pratt and Katherine Willert for their professionalism and diligence during production. We also wish to thank Brenda Phillips for her research assistance and Tracy Welch for her administrative management, always with a cool head and a warm heart.

Finally, we are deeply appreciative and indebted to our families and friends for their encouragement and support. They understand intuitively how to help us be less "difficult."

D. L. S.
F. L. C.
E. R.

Introduction to Personality Disorders and Aging

Chapter 1

Perplexing. Vexing. Bedeviling. Frustrating. Confusing. Maddening. Exasperating! These are just a few of the words clinicians commonly use to describe their interactions with patients who have a personality disorder. Now, on top of this already challenging clinical situation, add in the common stressors associated with aging: physical declines, social losses, reduced independence, financial stressors, and cognitive declines. Adults with personality disorders are woefully ill prepared to meet these challenges of aging. Their interpersonal worlds are characterized by dysfunction, conflict, distance, or chaos, and they often lack the necessary social support networks that help buffer stress. Intrapsychically, they arrive at later life with lifelong coping deficits and, in most cases, diminished self-esteem due to a lifetime of problems and failures. They are often defeated and demoralized. Sadly, they can often be described as "surviving not thriving" with age. They are the "problem" cases that cause considerable consternation on the part of the clinician.

This synergistic combination of personality disorder psychopathology with the stressors of aging creates a host of unique clinical dilemmas. Older adults with a personality disorder are some of the most difficult patients to understand, evaluate, and treat effectively. And because older adults with a personality disorder commonly experience comorbid mental health problems, such as anxiety and depression,

treatment is predictably more complicated and less successful for them.

We have written this book for clinicians and clinical students interested in working with older patients and for others who provide services for the difficult older person. Although our professional training is in clinical psychology, we intend this book for all mental health professionals who work with older adults. Our impetus is to provide the reader with a greater understanding of personality disorders within the context of aging and to offer guidelines for assessment and intervention. Our premise is that with increased understanding of this challenging clinical population, we can help personality disordered older adults age more gracefully and successfully, and improve their quality of life.

The Demographics of Aging

Traditionally, 65 years of age has been used as the demarcation of old age or later life. This may be useful for demographic purposes (e.g., to describe the number of older adults in the United States) but it is also limiting because there are wide variations in life experiences, physical challenges, psychological experiences, and social opportunities between the "young-old" (usually defined as those between the ages of 65 and 74), the "old-old" (between the ages of 75 and 84) and the "oldest-old" (85 years of age and older). Regardless of the exact entry point into old age, the demography of aging in the United States indicates that this population is booming, and the trend is similar in most regions around the globe.

As of 2001, almost 13% of the citizenry of the United States was over age 65, representing 35 million people. By 2030, this number is expected to double to over 70 million representing a noteworthy 20% of the population. The fastest growing subpopulation of older adults is the oldest-old group, who are also the frailest. The oldest-old group is projected to increase from the current 4.4 million to 8.9 million by 2030 and

to 19.4 million by 2050 (U.S. Bureau of Census, 2003). As of 2000, there were 70,000 centenarians in the United States—by 2050, this number is expected to increase by 10-fold to over 800,000. The aging of the massive baby boomer cohort is a main reason for this bulge in the demographic profile of the United States, but other important factors include decreased birth rates and increased life expectancy (due to better health care, nutrition, exercise, and medical treatments). The culmination of these trends has generated a profound impact on modern society—for the first time in human history, surviving into later life is an expected part of the life cycle.

Mental Health and Aging: The Big Picture

With the reality of the greatly expanding aging population comes pressing challenges to meet the physical and mental health needs of this group. As the actual number of older adults increases, so does the number of older adults with mental health problems (even if prevalence rates for mental illness remain static). Estimates indicate that about 20% of older adults have a diagnosable mental disorder (Gatz & Smyer, 1992; Jeste et al., 1999). Physical illness and advanced age further negatively impact these rates. Dementia is one of the most serious and debilitating illnesses among older adults. Although normal aging does not cause dementia, it is an age-related disease, which means that prevalence rates increase with advancing age. Conservative estimates suggest that 2% to 5% of people over the age of 65 experience some kind of diagnosable dementia, whereas about 20% of people over 85 suffer from dementia. Rates of mild cognitive impairment (but not full-blown diagnosable dementia) are even higher, affecting 25% to 50% of those 85 years old and older (Bachman et al., 1992). Depression is another common mental health problem in later life, with an estimated 8% to 20% of older adults in the community experiencing significant depressive symptoms (Gurland, Cross, & Katz, 1996). Anxiety disorders are an even

greater concern among older adults, with their prevalence estimated to be more than double that of diagnosable affective disorders (Regier, Narrow, & Rae, 1990).

A serious and unfortunate consequence of mental health problems (most notably depression) is suicide, and contrary to common perception, older adults have the highest suicide rate of any age group (National Center for Health Statistics, 2000). Older adults constitute about 13% of the population but commit about 20% of all suicides. These alarmingly elevated numbers are due primarily to the exceptionally high rate of suicide among older White males. Settings also impact rates of mental disorders among older adults: Acute medical settings and long-term care settings have particularly elevated rates, ranging from 40% to 50% in hospitals to 65% to 81% in nursing homes (Burns et al., 1993; Lair & Lefkowitz, 1990). A troubling portend for the near future is that the rates of mental illness are expected to increase even more because the baby boomers have higher lifetime rates of mental illness and are expected to carry these problems with them into later life (Jeste et al., 1999). This baby boomer group also has a greater familiarity with mental health services and a higher expectation for services that will no doubt strain the psychotherapeutic community's ability to provide adequate help.

We have provided only a cursory overview of mental health and aging as a context for our specific discussion of one class of mental health disorder: personality disorders. But the reader should appreciate that the field of geropsychology has blossomed in the past 2 decades; as a consequence, several excellent books now provide solid overviews of mental health, aging, and the fundamentals of clinical practice in geropsychology (Duffy, 1999; Knight, 2004; Laidlaw, Thompson, Gallagher-Thompson, & Dick-Siskin, 2003; Lichtenberg, 1998; Molinari, 2000; Nordhus, VandenBos, Berg, & Fromholt, 1998; Smyer & Qualls, 1999; Zarit & Zarit, 1998). The interested reader is encouraged to seek out these resources.

Compared with the amount of research devoted to the cognitive, mood, and anxiety disorders among older adults, personality disorders and aging have received scant attention. This is

surprising because personality disorders are among the most problematic and debilitating of all mental health disorders, and individuals with such problems have a particularly difficult time negotiating the challenges associated with aging. Personality disorders are now better understood than ever before, but their impact in later life has not yet been fully explored. Rates of personality disorders in older adults will be discussed in detail later, but between 10% and 13% of persons in the general adult population are believed to suffer from a personality disorder (Casey, 2000; Weissman, 1993), and this rate is generally stable across adulthood.

Overview of Personality and Personality Disorder

To introduce our examination of personality disorder, we need to first understand the nature of personality. The term *personality* can be defined as an individual's pattern of psychological processes, including his or her motives, feelings, thoughts, behavioral patterns, and other major areas of psychological function. Personality is expressed through its influences on the body, in conscious experience, and through social behavior (Mayer, 2006). Thus, personality is roughly synonymous with the major trends in an individual's mental and behavioral functioning, and as such is generally stable over time.

A classic approach to understanding personality is the trait approach, which conceptualizes personality in terms of stable features that describe a person across many different situations. Many people are able to identify the major personality traits in those whom they know well, and similarly many people can identify and describe their own prominent personality traits. What the trait approach emphasizes is one's characteristic way of thinking, feeling, and behaving across diverse life situations, and not atypical ways one may act under especially unusual circumstances. We all have our moments when we do not act like ourselves, but such moments would not define us at the trait level unless those behaviors become persistent and pervasive. To give some simple examples of trait descriptors—some people

are characteristically shy, quiet, and reserved; whereas others are typically outgoing, boisterous, and loud. Some are impulsive and churlish, whereas others are thoughtful and measured. Some are caring and selfless, whereas others are cruel and insensitive. Literally thousands of words can be used to describe enduring personality traits; this is an area in the English language where there is particularly great depth and breadth of description.

All people have a mix of some personality traits that are adaptive and others that are less than ideal. In psychologically healthy individuals, however, the majority of personality traits are positive ones that are adaptive and functional for the person in everyday life, whereas the negative traits are displayed either parsimoniously or appropriately. Not all individuals possess a generally adaptive personality style, but instead have prominent maladaptive traits. Some people may be characteristically untrusting, hostile, arrogant, ruthless, rigid, egocentric, labile, shallow, aloof, fearful, or bizarre. Personality traits can be dysfunctional in many ways, and where these dysfunctional traits become rigid and inflexible impairing a person's ability to function successfully, then a personality disorder diagnosis may be warranted.

According to the fourth edition, text revision of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV-TR;* American Psychiatric Association, 2000), a personality disorder is "an enduring pattern of inner experience and behavior 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). A part of the formal personality disorder definition is that the traits have to be rigid, maladaptive, and pervasive across a broad range of situations rather than as expectable reactions to particular life experiences or as a normal part of a specific developmental stage. Adolescence, for example, is a developmental stage frequently accompanied by intense psychological turmoil, and as such, a personality disorder diagnosis would not be warranted if the adolescent appears to

be going through an expectable and typical developmental process. An important caveat in the *DSM-IV-TR* is that, *although the definition of personality disorder requires an onset no later than early adulthood, a person with a personality disorder may not be diagnosed or treated until later life.*

A possible explanation for this caveat is that the personality disordered individual may have presented clinically with the more obvious and florid signs of a clinical disorder such as anxiety, depression, eating disorder, or substance abuse, and the underlying personality disorder features may not have been examined as closely (Sadavoy & Fogel, 1992). 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 and reserved man might have functioned successfully in the occupational area by choosing a job requiring little social interaction (e.g., a computer programmer who writes code at home). He managed to live alone, was fiercely independent, and had little use for others during much of his adult life. Imagine the psychological challenges that he would face if, in later life, he became physically frail and debilitated and subsequently was forced to move into an assisted living facility or a nursing home where he had to cope with medical professionals, caregivers, and other residents. In this case, it would only be after the person failed to adjust to his new living situation that his personality traits would become apparent and 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. We return to this important idea later in this book.

To conclude this section, we want to highlight the debilitating nature of personality disorders. According to Fabrega, Ulrich, Pilkonis, and Mezzich (1991), nearly 80% of people with personality disorders suffer from a concomitant Axis I disorder. Similarly, between one-half and two-thirds of psychiatric inpatients and outpatients meet the criteria for at least one

personality disorder (O'Connor & Dyce, 2001). Thus, anyone doing clinical work is likely to encounter personality disorders, and it is therefore important that they be understood and carefully considered by the clinician.

History of the Personality Disorder Category

The earliest writings concerning personality disruption and problems can be traced to the Greek physician Hippocrates (460 B.C.–377 B.C.). He was also the first physician to postulate that thoughts, ideas, and feelings come from the brain and not the heart as Egyptian cultures had long proposed. Hippocrates described four fundamental body fluids associated with specific personality patterns (e.g., black bile is indicative of melancholia). His theory was physiologically based, but he also associated environmental features like climate and temperature with the exacerbation or even creation of such personality traits as aggression or gentleness (e.g., mild climates produce gentle races, and climatic extremes arouse strong emotions and passions).

With the death of Aristotle in 322 B.C., Theophrastus (372 B.C.–285 B.C.) was recognized as Aristotle's preeminent student, and he assumed direction of Aristotle's teaching traditions. Theophrastus wrote on such topics as marriage, child raising, alcoholism, melancholy, epilepsy, and the effects of various drugs on mental states. Interestingly, he also wrote about people's characters or temperaments. In his relatively short book *Characters,* Theophrastus described 30 different characters or personalities that were differentiated on the basis of such fundamental traits as bravery, aggression, passivity, trustworthiness, friendliness, superstitious beliefs, and vanity. In *Characters,* Theophrastus appears to have established the beginnings of many of the concepts for modern personality disorders. The Greek writer Homer, centuries earlier, had adopted a similar stance by ascribing to some of his characters a single dominant personality trait, such as the "brave Hector" or the "crafty Ulysses." Theophrastus went beyond Homer's single master trait by describing how an individual's character might express itself