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

in varied situations. Each of his 30 characters was typically dominated by a single trait, but related traits were also described. These traits were as diverse as lying, flattering, talkativeness, cheapness, tactlessness, surliness, discontentedness, and rudeness. His description of the cheap person (penurious) overlaps with many of the general and associated features of the modern Obsessive-Compulsive Personality Disorder: stinginess with money, compliments, and affection; excessive devotion to work; rigidity; and inflexibility. His character dominated by superstitious beliefs may be a forerunner of the Schizotypal Personality Disorder; his lying character may herald the Antisocial Personality Disorder; his flatterer may suggest the Narcissistic Personality Disorder; and his discontented character may have features of both Passive-Aggressive Personality Disorder and Depressive Personality Disorder.

In more modern times, an important advance in thinking about personality problems was crafted by the English psychiatrist James Prichard (1786–1848). He noted the distinction between antisocial behavior (e.g., lying, gambling, and drug use), and other types of insanity more typically found in mental hospitals. Prichard (1835) called this behavior "moral insanity" and described its symptoms as including a perversion of feelings, habits, morals, and impulses without any defects of intellect or reasoning and without the presence of hallucinations.

This general category of disorders that Prichard described would much later come to be known as character disorders and still later as personality disorders. According to Millon (1981a), the word *character* is derived from the Greek word for "engraving," which was originally used to "signify distinctive features that serve as the 'mark' of a person" (p. 7). This engraving implies that the behaviors in question are deeply and permanently imprinted so that change is unlikely or extremely difficult. Until the early twentieth century, most character disorders remained largely unstudied entities. Until the mid-twentieth century, the bulk of personality disorder research was focused on the "morally insane," and the term *psychopath* (which is now synonymous with Antisocial Personality Disorder) was used predominately.

Even more influential on the overall structure and nature of current personality disorders has been the work of Kurt Schneider (1923/1950) who first published his taxonomy in 1923. He heralded the present *DSM* Axis II perspective in many respects. First, he did not view *psychopathologic personalities* (his term for personality disorders) as necessary precursors to other or more severe mental disturbances but saw them as coexistent entities. This contribution heralded the multiaxial diagnostic classification system and separate diagnosis for personality disorders that was introduced by the American Psychiatric Association in 1980 in *DSM-III.* Second, he proposed that psychopathologic personalities developed in childhood and continued into adulthood consistent with modern evidence. Third, he described 10 psychopathologic personalities commonly seen in psychiatric settings, many of which have greatly influenced current personality disorder diagnoses, such as his depressive personality (Depressive Personality Disorder), anankastic personality (Obsessive-Compulsive Personality Disorder), attention-seeking personality (Histrionic Personality Disorder), labile personality (Borderline Personality Disorder), and the affectionless personality (Antisocial and Schizoid Personality Disorders).

Modern Conceptualizations

The most modern tradition for the official diagnosis of personality disorders began in 1952 with the publication of the first edition of the *DSM* (American Psychiatric Association, 1952). The descriptions for all 12 main types of personality disorder in the *DSM* consisted of at most two paragraphs and typically four or five sentences. A further advance was shown in the *DSM-II* (American Psychiatric Association, 1968), which contained 10 major categories of mental disorders (up from 7 in the original *DSM*). Section V was entitled "Personality Disorders and Certain Other Nonpsychotic Mental Disorders." In the official coding system, number 301 was given to the 10 specific types of personality disorders. The general description of personality

disorders in *DSM-II* was brief (two sentences): "This group of disorders is characterized by deeply ingrained maladaptive patterns of behavior that are perceptibly different in quality from psychotic and neurotic symptoms. Generally, these are lifelong patterns, often recognizable by the time of adolescence or earlier" (p. 41).

The diagnosis of personality disorders took the equivalent of a quantum leap with the publication of *DSM-III* in 1980. The entire manual nearly tripled in pages from 134 in *DSM-II* to 494 in *DSM-III*. The major evolution in *DSM-III* came in the form of an innovative multiaxial approach, in which psychiatric diagnosis was divided into five separate *axes* or domains on which information about several important areas of functioning are recorded. Major clinical syndromes (e.g., Bipolar Disorder, Panic Disorder, Schizophrenia, Alcohol Dependence) were to be coded on Axis I, whereas Axis II was reserved for personality disorders. Also, the number of types of personality disorders expanded from 10 to 11.

Placement of personality disorders on Axis II had a profound effect. Clinicians were now strongly encouraged to evaluate each of their patients for a personality disorder and to appreciate the important role that personality style may play in the development and maintenance of clinical disorders. Because many people seeking treatment for clinical disorders also suffer from personality disorders or personality disorder features, the need for psychometrically sound instruments to assess personality disorders became obvious. In the *DSM-III*, there was a revolutionary development in the descriptions and diagnosis of personality disorders. For the first time in the history of diagnostic nomenclature, a specific list of numbered criteria was presented for each personality disorder. To receive a personality disorder diagnosis, the patient had to meet a specified minimum number of criteria. The set of criteria was considered to be *polythetic,* indicating that no single criterion was considered to be essential or sine qua non.

The *DSM-III* also revised the formal definition of personality disorders:

> *Personality traits are enduring patterns of perceiving, relating to, and thinking about the environment and oneself, and are exhibited in a wide range of important social and personal contexts. It is only when personality traits are inflexible and maladaptive and cause either significant impairment in social or occupational functioning or subjective distress that they constitute Personality Disorders. The manifestations of Personality Disorders are generally recognizable by adolescence or earlier and continue throughout most of adult life, though they often become less obvious in middle or old age. (p. 305)*

With the publication of *DSM-III-R* in 1987, the number of types of personality disorders remained the same at 11, but an official appendix was added to the manual. Appendix A introduced two new personality disorders for research purposes; the Self-Defeating and the Sadistic Personality Disorders. With the publication of *DSM-IV* in 1994, one personality disorder (Passive-Aggressive) was dropped from Axis II, and it was placed in an appendix along with a new personality disorder for research, the Depressive Personality Disorder. The Self-Defeating and the Sadistic Personality Disorders were dropped altogether. The current manual, *DSM-IV-TR,* had no changes to the list of personality disorders or the diagnostic criteria for the disorders. There are 10 official personality disorders on Axis II, with Passive-Aggressive and Depressive Personality Disorders listed as criteria sets for further study in the Appendix. For greater detail on the evolution of the personality disorder diagnostic category, the interested reader is referred to Coolidge and Segal (1998).

The DSM-IV-TR Personality Disorders

In the *DSM-IV-TR,* the 10 standard personality disorders are organized into three superordinate clusters based on presumed common underlying themes. Cluster A groups 3 disorders in which individuals often appear odd or eccentric: Paranoid, Schizoid, and Schizotypal Personality Disorders. Cluster B in-

cludes 4 disorders in which individuals appear to be dramatic, emotional, or erratic: Antisocial, Borderline, Histrionic, and Narcissistic Personality Disorders. Cluster C contains 3 disorders in which individuals often appear fearful or anxious: Avoidant, Dependent, and Obsessive-Compulsive Personality Disorders. Two additional personality disorders are not grouped into the clusters but instead are listed in an appendix of the *DSM-IV-TR* for further empirical justification; these are the Depressive Personality Disorder and the Passive-Aggressive Personality Disorder (which is also called the negativistic personality disorder). Importantly, a diagnosis called "Personality Disorder Not Otherwise Specified" is also available for use and is assigned for cases in which the patient has clear signs of a personality disorder but does not fit neatly into one of the specific personality disorder categories (e.g., a patient having three or four symptoms of two different personality disorders but not meeting the threshold for either one).

The *DSM-IV-TR* provides specific diagnostic criteria for each of the personality disorders, with criteria reflecting mostly behavioral manifestations of the disorder. The symptoms are listed in order of diagnostic importance, and a specific number of symptoms must be present to meet the threshold for diagnosis. Like all disorders in the *DSM-IV-TR,* diagnosis is categorical. Similar to Axis I, multiple disorders can be listed on Axis II as long as the patient meets the diagnostic threshold for each one diagnosed. Dysfunctional personality *features* can also be listed on Axis II when symptoms are noteworthy but below the diagnostic threshold. Significant uses of defense mechanisms can also be listed on Axis II although this technique appears uncommon in clinical practice. Little reference to age is made in the features of personality disorders with the exception that a personality disorder requires onset no later than early adulthood.

Next, we provide a broad overview of each of the 10 standard personality disorders and the 2 personality disorders under further review in the *DSM-IV-TR.* In subsequent discussions (Chapters 2 to 5), we provide the full *DSM-IV-TR* diagnostic criteria for each of the personality disorders, discuss potential problems in applying the criteria to older persons, and include

another additional but often neglected feature—the clinical presentation seen in the older adult (which in many cases differs markedly from that seen in younger persons) and the typical ways that specific personality disorders are affected by the common challenges associated with growing older (e.g., retirement, widowhood, physical illness, changes in appearance, and increased dependency).

The definitions of the personality disorders provided next are adapted from the *DSM-IV-TR:*

Cluster A Personality Disorders

- *Paranoid Personality Disorder:* A pattern of pervasive distrust and suspicion of others such that the motives of others are perceived as malevolent
- *Schizoid Personality Disorder:* A pervasive pattern of detachment from social relationships and a restricted range of emotional expression
- *Schizotypal Personality Disorder:* A pervasive pattern of social deficits marked by acute discomfort with close relationships, as well as eccentric behavior and cognitive and perceptual distortions

Cluster B Personality Disorders

- *Antisocial Personality Disorder:* A pervasive pattern of disregard for, and violation of, societal norms and the rights of others, as well as lack of empathy
- *Borderline Personality Disorder:* A pervasive pattern of instability in interpersonal relationships, self-image, and emotions, as well as marked impulsivity
- *Histrionic Personality Disorder:* A pervasive pattern of excessive emotionality and attention-seeking behavior, with superficiality
- *Narcissistic Personality Disorder:* A pervasive pattern of grandiosity, need for admiration, and lack of empathy and compassion for others

Cluster C Personality Disorders

- *Avoidant Personality Disorder:* A pervasive pattern of social inhibition, low self-esteem, and hypersensitivity to negative evaluation
- *Dependent Personality Disorder:* A pervasive and excessive need to be taken care of and a perception of being unable to function without the help of others leading to submissive and clinging behaviors
- *Obsessive-Compulsive Personality Disorder:* A pervasive pattern of preoccupation with orderliness, perfection, and control at the expense of flexibility, openness, and efficiency

DSM-IV-TR Appendix B Personality Disorders

- *Depressive Personality Disorder:* A pervasive pattern of depressive cognitions, feelings, and behaviors
- *Passive-Aggressive Personality Disorder:* A pervasive pattern of negative attitudes and passive resistance to demands for performance in social and work situations

Challenges Associated with Personality Disorder Psychopathology

Besides causing significant problems for the person so afflicted, personality disorders pose extensive difficulties to the mental health clinician. It is fair to suggest that the personality disorders are perceived as among the most challenging forms of psychiatric illness. Some clinicians, in fact, attempt to avoid treating them (Lewis & Appleby, 1988), although this is practically impossible. A complicating feature of personality disorders is that by their very nature they are *chronic* conditions, which can make treating clinicians feel ineffective and even hopeless.

Another important part of the challenge is that the personality disorders differ from the clinical disorders (coded on Axis I) in a fundamental way. In many cases, clinical disorders are perceived as illnesses, sicknesses, or diseases that "happen

to people." In the case of depression, for example, a relatively healthy person may experience a series of losses that temporarily overwhelm his or her ability to cope, and classic signs of depression may subsequently emerge (e.g., tearfulness, loss of interest in activities, lethargy, sleep and appetite disturbance, poor concentration). In this case, the person may then be diagnosed as suffering from major depression.

With treatment, the depression may remit and the person might have the perception, "I was depressed before, but I am not depressed now." Because the person was not depressed before the episode began and is no longer depressed after it ends, it would be reasonable for the person to see the depression as an illness that came upon him or her and then went away. The person might view the depression as having little to do with him- or herself personally and to be the result of external factors such as overwhelming life stressors. In short, being depressed can easily be distinguished from one's normal nondepressed state. This same type of "illness" analogy can readily apply to a host of Axis I clinical disorders that seem episodic in nature and are easily discriminated from one's normal functioning.

This distinction is not easily made with personality disorders. Because personality disorders are defined by personality traits that are labeled as maladaptive and inflexible, the disorders in this category do not seem like illnesses that come from outside the person (e.g., as in depression). Rather, what is "wrong" is the person's personality, which is not subject to easy change. The personality disorder construct signifies a pathological development of the self, at the person's core. As such, those who endorse a disease model of mental illness find it difficult to understand and conceptualize the nature and meaning of personality disorders because the disease metaphor does not readily apply.

This concept of personality disorders also affects those who suffer from them. A classic hallmark of the category is that those who have a personality disorder typically lack insight into it or are unaware of having the disorder. Many people with a

personality disorder perceive their symptoms as *ego-syntonic* (meaning congruent with their self-image) in contrast to seeing the symptoms as *ego-dystonic* or something outside the self to be fought, altered, addressed, or gotten rid of by some means. An unfortunate consequence of the poor insight associated with the personality disorders is that most patients with a personality disorder do not identify the need for treatment per se because they do not see any signs of having a problem. In contrast, it is axiomatic for individuals with a personality disorder to come to treatment seeking relief for the overt signs of clinical disorders they are also experiencing or for problems they are having with others although they typically see little of their own role in the conflict. Our case examples in the coming chapters emphasize this ego-syntonic quality of personality disorder.

This distinction between the clinical disorders and the personality disorders is also made explicit by the *DSM* classification system in which, as noted, the conditions are coded on different axes as part of the multiaxial diagnostic format. Of course, this division is artificial, as many Axis I disorders certainly represent problems at the level of personality. Dysthymia is defined as chronic low-level depression that lasts for at least 2 years. Pessimism is part of the common conceptualization of dysthymia although pessimism reflects a stable part of personality. Anorexia Nervosa, an eating disorder, is another example of the intermingling of clinical disorders and personality styles because anorexia is highly associated with perfectionism and a strong need for control, both of which represent dimensions of personality. Nonetheless, at present, clinical disorders and personality disorders are defined as separate diagnostic categories, and an important outgrowth of this distinction is the high probability of comorbidity between the clinical disorders and the personality disorders. This comorbidity is commonplace among older and younger persons in the clinical setting and provides a considerable challenge to the treating clinician.

An issue related to the distinction between Axis I clinical disorders and Axis II personality disorders is the stability and constancy of Axis II disorders. Defining hallmarks of Axis II

conditions have been their presentation by early adulthood and their stability. The maladaptive trait patterns for each of the personality disorders have been posited to endure through time and across venues. This stability is the major distinguishing criterion from Axis I conditions, which are suggested as being adventitious and episodic. It appears that, as Axis II disorders become better understood (and, indeed, Axis I disorders), this essential distinction is neither so clear nor pervasive. The challenge to what has clinically been accepted as a robust heuristic comes from several sources of inquiry:

- Many Axis I conditions present early in life, are established by young adulthood, become chronic, and do not remit fully enough to no longer meet criteria for the diagnosis. Schizophrenia is a good example of this (Shea & Yen, 2003).
- Although other Axis I conditions, such as mood and anxiety disorders, present with distinct episodes, there are subgroups that go on to incomplete remissions or rapid cycling so that the presence of the disorder, while not the degree of symptom display, evidences significant stability (Judd et al., 2002).
- The state of the Axis I condition can affect whether a personality disorder can be diagnosed (Shea & Yen, 2003). During personality disorder assessment, clinicians must evaluate the usual or typical personality functioning of the patient, which may be impaired during a period of clinical disturbance. A depressed patient who may be excessively negative and hopeless during the mood episode is a good example of this.
- The high comorbidity rate between Axis I and Axis II conditions suggests that they may share the same predisposing factors, be continuum phenomena, or are in some other highly significant relationship (Shea & Yen, 2003).
- Looking at the Axis II disorders, there are data as well as anecdotal evidence of change affecting the pattern of one's personality traits, thereby worsening or diminishing the degree of the disorder to where it can or cannot be diagnosed

as a formal personality disorder. Thus, the posited temporal stability of the personality disorders has been questioned (Shea et al., 2002).

- Important confounds inform the diagnosis. There is a question of whether the diagnostic criteria for personality disorders in general, or for specific personality disorders capture the presentation of personality disorders in older adults, missing the so-called "geriatric variants" of the disorders (Rosowsky & Gurian, 1991; Sadavoy & Fogel, 1992; Segal, Hersen, Van Hasselt, Silberman, & Roth, 1996). We return to this theme later in the book.

A final challenge concerning the personality disorder category is that sufferers (young and old) rarely present with the signs and symptoms of just one personality disorder. Rather, a person with one personality disorder is likely to present with significant signs and symptoms of other personality disorders (Oldham et al., 1992; Segal et al., 1996). Or a person may have signs of several personality disorders but does not meet full diagnostic threshold for any one disorder. In most cases, occurrence of personality disorder features from more than one personality disorder appears to be the rule rather than the exception across the life span. A part of the problem is that prototypes of the personality disorders were created in the *DSM* system to maximize discrimination among the types, although this procedure has led to the impression that pure types are regularly seen in clinical practice, which they are not.

Conclusions

We want to highlight a final important point about personality disorders: By their very nature, these disorders manifest as disruptions in the interpersonal sphere. All personality disorders reflect interpersonal difficulties, and while their exact nature will differ across the disorders, these social problems appear robust over the life course (Rosowsky & Gurian, 1991). Although most people with a personality disorder do not see themselves

as having a problem, they almost always identify having problems relating to others in their social world (Rosowsky, 1999). These others may include caregivers, neighbors, relatives, employers, and health care professionals, but the interpersonal dysfunction is particularly enhanced in intimate relationships, for example, with children, spouses, and romantic partners. We are emphasizing this chronic and characteristic social impairment because it becomes particularly salient for the aging individual. Interpersonal problems affect sufferers in their ability to handle stressors associated with growing older. There is a large body of literature on the buffering effects of social support: Close and supportive relationships can help people adjust to and cope with difficult life experiences. But social problems across much of adult life typically leave the personality disordered older adult with little or no remaining social support at a time in life when it is critically needed. This aspect of personality disorder makes patients particularly vulnerable to the challenges of aging. The social ineffectiveness of older adults with personality disorders also affects their ability to form an appropriate therapeutic relationship with the mental health clinician. Patients with personality disorders typically evoke strong feelings in their clinicians (Rosowsky, 1999), just as they do with other important people in their life. How clinicians use their emotional reactions to the patient and how they understand what the individual engenders in close relationships with others are important parts of the diagnostic and treatment process, and we return to this theme later in this book.

About This Book

In subsequent chapters, we provide a clinical description and the official diagnostic criteria for personality disorders grouped by the official clusters of the *DSM-IV-TR*. These include Cluster A (Paranoid, Schizoid, and Schizotypal Personality Disorders; in Chapter 2), Cluster B (Antisocial, Borderline, Histrionic, and Narcissistic Personality Disorders; in Chapter 3), and Cluster C

(Avoidant, Dependent, and Obsessive-Compulsive Personality Disorders; in Chapter 4). Chapter 5 examines personality disorders that have been part of the official diagnostic nomenclature in previous versions of the *DSM*. In Chapters 2 through 5, we discuss potential problems applying the diagnostic criteria for the personality disorders to older adults, provide a theorized pattern of each personality disorder in later life, examine the potential impact of aging on each of the personality disorders, and offer numerous extended case examples. We then present information about epidemiology and common comorbid disorders (Chapter 6); an analysis of theories of personality disorders (Chapters 7 and 8), with special attention to the manner in which aging is addressed in the theories; and an overview of assessment issues (Chapter 9). We conclude with two chapters that address intervention, including an overview of general issues and models of intervention (Chapter 10) and a model of goodness of fit (Chapter 11).