Personality Disorders in Late Life

Understanding and Overcoming the Gap in Research

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A review of the literature on personality disorders (PD) in late life reveals fewer research papers than those found for PD in younger adults and for other major late-life psychiatric diagnoses. The authors suggest that this gap is largely due to the difficult and inconsistent diagnostic process for late-life PDs. Diagnosis is complicated by the frequent unavailability and/or unreliability of longitudinal data, lack of age-adjusted diagnostic instruments, and failure of the current Axis II nosology to account for age-related issues, including changes in social functioning, and the effects of comorbid illness and cognitive impairment. They propose that the development of a geriatric subclassification for PD, along with improved clinical documentation of personality and data from dimensional instruments for both normal and pathologic personalities, would provide a more reliable, valid, and geriatric-friendly diagnostic process.

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Research into personality disorders (PDs) has grown significantly in the past 10 years, especially since the founding of The Journal of Personality Disorders and the International Society for the Study of Personality Disorders (ISSPD) in 1987. In a review of the literature on PD since 1992, Ruegg and Frances1 called this research “a young and exciting area, just defining itself and its methods.” At the same time, geriatric psychiatry research has undergone a similar period of growth, heralded by the founding of The American Journal of Geriatric Psychiatry in 1993 and the phenomenal growth of the American Association for Geriatric Psychiatry (AAGP) throughout the 1990s. There is a striking discrepancy, however, where these two fields cross: namely, the study of PDs in late life. Of the over 350 articles published in The Journal of Personality Disorders from 1987 through 1997, only 6 focused on individuals 65 years or older. Similarly, since its founding in 1993, through 1997, only 4 of over 120 articles in The American Journal of Geriatric Psychiatry and only 2 of over 620 articles in The International Journal of Geriatric Psychiatry since 1991 concerned PDs in late life.

Why is there so little research being published? Our own research efforts and those of numerous colleagues reveal again and again that the diagnostic process for PD in late life imposes a fundamental and enduring limitation to research. On the basis of a thorough review of the literature and our own efforts to establish a database of elderly individuals with PD in a geriatric psychiatry clinic, several formidable problems have been identified that make the diagnosis of PD in late life a difficult, inconsistent, and cumbersome task. First, obtaining an adequate longitudinal history from elderly pa-
patients, informants, and past psychiatric records can be extremely challenging. Second, the various methods of diagnosis, in particular the use of structured interviews, have not been well-adapted to the elderly patient. A third, and more basic, problem is that the current DSM-IV nosology for PD is based on a categorical model that does not account for age-associated changes in behavior, personality, and social functioning. Also, the evolution of this nosology across the five successive DSMs severely complicates and often precludes valid retrospective study. In this article, we will explore these factors in detail and propose that the most practical way to account for them is through the development of a geriatric subclassification for PD, similar to the way in which DSM criteria for many psychiatric disorders, including several PDs, have been adapted for childhood and adolescence.

AN OVERVIEW OF THE LITERATURE

The literature on PD in late life spans nearly 40 years, but does not exceed more than several dozen articles, at best. Although we will discuss several broad themes from the literature here, the reader is referred to an earlier article by one of the authors2 and to several other reviews3-6 for more comprehensive discussions. The bulk of the literature on late-life PD has consisted of prevalence studies in community and treatment populations. These studies have utilized the following methods to determine Axis II diagnoses: chart reviews, clinical interviews, structured interviews, and clinical consensus. With the exception of structured interviews, these diagnostic methods have not uniformly been based on strict DSM criteria. Several older studies include diagnoses under the rubric of personality or character disorder that are not currently part of Axis II (such as substance abuse or mental retardation), or that have changed considerably across successive Axis II nosologies. Prevalence rates of late-life PD in the community have ranged from 5% to 10%,2 which is a slightly lower range than the 10%-18% prevalence estimates for individuals of all ages in the community.7,8 A recent meta-analysis by Abrams and Horowitz9 found an overall 10% prevalence rate of DSM-III-based PD for individuals who were at least 50 years old and were evaluated in both clinical and nonclinical populations. Across studies, the most commonly identified PDs in late life include obsessive-compulsive, dependent, and “mixed.”2

A number of studies have suggested that PDs in late life are inextricably linked to comorbid Axis I disorders, particularly major depressive disorder,10,11 and that a diagnosis of PD worsens the prognosis of treatment.12,13 Not surprisingly, rates of late-life PD have been found to be much higher in treatment settings and with comorbid major depression.2,11

Long-Term Course

What happens to individuals with PDs as they age? This question is often posed by clinicians, but the course of PD across the life span has not been well discerned for any categorical diagnosis. One can, however, imagine the multiple pathways that personality dysfunction may take over the course of a lifetime. These disparate pathways schematized in Figure 1 illustrate several diagnostic dilemmas. It can be seen from several of these pathways that not all individuals with

Why Study Personality Disorders in Late Life?

What factors should motivate interest and research into this topic? Every health professional who works with elderly patients has encountered cases of PD. The affected individuals often present as some of the most difficult and treatment-resistant cases and may evoke strong countertransference. The nature of their psychopathology can create much conflict among family members and caregivers and can present significant disruptions to treatment settings, senior residential housing, and long-term care facilities. The first goal in studying these individuals is to find better ways to alleviate their struggles through the use of pharmacotherapy and various modalities of psychotherapy. Underlying this goal is a distinct challenge: we have only a rudimentary understanding of ways in which PD complicates the diagnosis, course, and treatment of comorbid psychiatric and medical conditions. A second goal in studying PDs in late life, then, is to illuminate their relationship with comorbid psychopathology. An understanding of this relationship may prove highly relevant to treatment outcome research. A final goal is to promote an accurate geriatric nosology—because there is widespread concern among geriatric mental health clinicians that the current nomenclature for PDs is inadequate for elderly patients. Both normal and pathologic aging processes may have important effects on the course of PD, and these processes must be identified and then accounted for in any diagnostic scheme.
Personality Disorders in Late Life

PD early in life will ever be comprehensively evaluated in mental health settings later in life. Individuals with dysfunctional personality traits such as suspiciousness, aversion, or lack of interest in interpersonal relationships, and idiosyncratic beliefs or habits, combined with a lack of insight into their difficulties, may instinctively avoid mental health settings or refuse to cooperate with psychiatric evaluation or research studies. It is more likely that these individuals come into contact with mental health services unwittingly and unwillingly when they are hospitalized for medical reasons and then run into conflicts with staff. They often precipitate crises on the wards because of odd demands, or extremely hostile, withdrawn, or uncooperative behaviors. Other individuals may never even make it into a mental health setting in late life. Fishbain\textsuperscript{14} has suggested that personality-disordered individuals who engage in risk-taking behaviors (e.g., substance abuse and/or reckless, impulsive, or suicidal behaviors) may suffer from excessive mortality before the age of 65. This would apply particularly to those with antisocial and borderline PDs.

The only PD examined in long-term follow-up studies of elderly individuals has been antisocial PD, and

FIGURE 1. The longitudinal course of personality disorders (PDs): potential pathways

<table>
<thead>
<tr>
<th>Diagnostic Course</th>
<th>Time 1 Original Diagnosis (Dx)</th>
<th>Time 2 Current Diagnosis</th>
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<tbody>
<tr>
<td>PD remains the same.</td>
<td><img src="image1" alt="Diagram" /></td>
<td><img src="image2" alt="Diagram" /></td>
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<tr>
<td>PD attenuates or remits over time.</td>
<td><img src="image3" alt="Diagram" /></td>
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<tr>
<td>PD remits in middle age but re-emerges in late-life, with similar or novel presentation.</td>
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<tr>
<td>PD remains, but with different presentation.</td>
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<td>Previous Axis I diagnosis now presents as PD.</td>
<td><img src="image9" alt="Diagram" /></td>
<td><img src="image10" alt="Diagram" /></td>
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<tr>
<td>Long-standing personality dysfunction now diagnosed as PD.</td>
<td><img src="image11" alt="Diagram" /></td>
<td><img src="image12" alt="Diagram" /></td>
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<tr>
<td>Patient dies because of PD-related reckless or impulsive behaviors.</td>
<td><img src="image13" alt="Diagram" /></td>
<td><img src="image14" alt="Diagram" /></td>
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<td>PD exists, but diagnosis is not distinguished from Axis I symptoms or diagnosis.</td>
<td><img src="image15" alt="Diagram" /></td>
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<td>Late-onset PD; e.g., a form of personality change disorder.</td>
<td><img src="image17" alt="Diagram" /></td>
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Note: 

- **○** Personality Disorder Dx
- **□** Axis I Dx
- **⋯⋯⋯⋯** Personality Dysfunction
- **——** Continuation of Symptoms
- **——** Remission or Absence of Symptoms
data indicate a trend toward antisocial symptom improvement or remittance in the majority of individuals who survive to late life.\textsuperscript{15,16} There are a number of long-term follow-up studies for individuals with borderline PD that also show a trend toward symptom improvement in middle age, but none of these studies look at late-life course.\textsuperscript{17-19} Despite the lack of long-term follow-up studies, several case studies and reviews\textsuperscript{5,18,20,21} have made observations that support a prognostic scheme proposed by Solomon.\textsuperscript{3} He suggested that individuals with PD characterized by affective and behavioral lability (antisocial, borderline, histrionic, narcissistic, avoidant, and dependent) demonstrate less impulsivity and aggression and have a tendency to improve in late life, but with depression and hypochondriasis as common endpoints. On the other hand, individuals with PD characterized by overcontrol of affect and impulses (obsessive-compulsive, paranoid, schizoid, and schizotypal) either remain the same or worsen in late life, and demonstrate persistent characteristics of rigidity and suspiciousness. Solomon and others agree that all PDs in late life are particularly vulnerable to the reemergence or exacerbation of maladaptive traits or to the development of secondary Axis I psychopathology as a result of acute stress or the accumulation of age-related losses and other stressful experiences.\textsuperscript{22,25}

The concept and possibility of personality change is critical to any attempt to understand the course of PD. It is likely that certain PDs demonstrate new behavioral manifestations in late life, compared with previous psychopathology. Although underlying personality dynamics might remain relatively stable into late life, they become expressed and observed through the lens of age-related changes in behavior and social functioning. We will outline many of these changes later in the article. It is also likely that certain individuals without a history of a formal diagnosis of a PD (perhaps, instead, they have a previously recognized neurotic or dysfunctional personality, or an Axis I diagnosis) may demonstrate a sufficiently pervasive and enduring pattern of maladaptive personality traits in late life to warrant an Axis II diagnosis. This change may result from a shift in underlying personality dynamics that overwhelms previously stable defense mechanisms and leads to novel and exaggerated expressions of personality dysfunction. Personality change may also be influenced by organic factors, such as dementia, cerebrovascular disease, or traumatic brain injury. The actual effects of organic damage will range from subtle and obscure to dramatic and pathognomonic, but these effects will almost always occur along with other likely nonorganic etiologies. As a result, labeling such changes as wholly organic establishes a false mind–brain dichotomy. Regardless of etiology, clinicians still have to work with various categories and degrees of disordered personality. As it stands, however, the current nosology classifies PD and personality change under different categories. Such potential variability in both the course and the diagnostic spectrum of PD sets the stage for the very complicated process of late-life diagnosis.

\section*{PRACTICAL CHALLENGES TO DIAGNOSIS}

Diagnosis is the foremost challenge in studying PD across the life span, especially in late life. Despite areas of consensus in the literature, there is no “gold standard” for diagnosis, and prevalence studies have utilized a variety of diagnostic methods that have yielded a wide range of contradictory prevalence rates. Diagnosis of PD in late life is a particularly labor-intensive process fraught with pitfalls, all of which we have encountered firsthand in an ongoing project to establish a database of geriatric patients with PD. In the following sections, we will critique the diagnostic process by examining its components step-by-step, at times using our own clinical and research efforts as a model.

\section*{Clinical Presentation}

Most elderly patients that we screen in our PD clinic are referred by other clinicians, who have already made a tentative diagnosis of PD on the basis of an initial diagnostic interview and several brief follow-up sessions. Almost all referrals also have one or more Axis I diagnoses and several Axis III diagnoses. Baseline Axis II diagnoses made prior to our interview are often stated in the form of “rule out personality disorder X,” or qualified with “X, Y, and/or Z traits,” with X, Y, and Z representing either DSM-IV categories or other labels, such as hysterical, passive-dependent, or hypochondriacal traits. These Axis II diagnoses are most often impressionistic because they are based on clinical observations without a formal review of DSM-IV diagnostic criteria. At the same time, these clinical diagnoses have a certain clinical usefulness because they allow clinicians to prioritize diagnoses\textsuperscript{24} and then triage the patient to the most relevant treatment.\textsuperscript{25}
Early on in our diagnostic process, some dysfunctional traits emerge in clinical encounters, whereas others remain quite hidden. Elderly patients themselves may compromise the diagnostic process by their reluctance to describe intrapsychic or interpersonal difficulties that seem shameful or socially inappropriate. They may also fail to report dysfunctional behaviors as “problems” because the behaviors are experienced in an ego-syntonic manner. This reporting bias handicaps the clinician, given that PD diagnoses are particularly dependent on reports of inappropriate or troublesome behaviors. Few elderly patients verbalize complaints of personality problems or a PD, in part because they were never made aware of a past diagnosis. Not only the complexity but also the stigma of this diagnosis probably prevent many clinicians from ever sharing it with the patient. When the diagnosis is conveyed to the patient, many of them are either confused as to its meaning and implications or disturbed and offended by its pejorative connotations. (Imagine the paltry turnout if a “National Personality Disorder Screening Day” were held modeled on those for depression and anxiety disorders!) The stigma of such a diagnosis, perceived by both clinicians and patients, is perhaps a result of the way we have conceptualized Axis II disorders as indicative of lifelong, insidious mental impairment. Although negative reactions to diagnosis are certainly not unique to elderly patients, they are further complicated in an older cohort that was raised in an era when any psychiatric diagnosis carried a tremendous social stigma.

The initial clinical presentations may provide very strong clues as to personality characteristics and potential dysfunction, but in themselves they should not provide enough data to make a reliable and valid diagnosis of PD. Why? A critical defining characteristic of PDs is that they represent chronic and pervasive maladaptive behaviors. Observation of chronicity requires time and repetitive historical accounts, and observation of pervasiveness requires both time and experience with the patient under a variety of conditions and settings. Both clinical and research diagnoses of PD often fail to observe these contingencies, and instead focus on salient features from brief clinical encounters.

**Case Vignette**

An elderly patient who presented to a clinician with repetitive noncompliant behaviors was labeled as passive-aggressive. Further work-up revealed, however, that he was suffering from a combination of mild cognitive impairment and poor concentration due to depression. Instead of basing the diagnosis on lengthy interactions, the clinician instead reacted to his or her own immediate countertransferential annoyance by viewing the patient as a “grumpy and passive-aggressive old man.”

Such diagnoses based on limited information run the risk of distorting the nature of age-appropriate and disease-specific behaviors and of overrepresenting ageist stereotypes and countertransference (here we use a broad definition of countertransference as representing both the clinician’s emotional reactions as well as any transference toward the patient). Table 1 lists several common diagnostic distortions and mistakes that may result when PD diagnoses are based on initial clinical presentation. Several sources of bias are reflected here, representing the following phenomenologic components of the clinical presentation: the patient’s manner of presentation, the clinician’s subjective “lens,” the presence of other psychiatric and medical conditions, the context of the clinical setting, and the previously recorded history about the patient.

What can be done when a patient’s presentation during routine clinical contact is not sufficient to con-

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<th>TABLE 1. Common diagnostic distortions and mistakes made by clinicians assessing for personality disorder (PD) in late life</th>
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<tr>
<td>• Age- or illness-related adaptive dependency seen as pathologic OR pathologic dependency viewed as normal in late life.</td>
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<tr>
<td>• Isolated, minimal, or adaptive behavioral eccentricities interpreted as representing schizoid or schizotypal personality disorder OR pathologic pattern of odd traits viewed as normal in late life.</td>
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<td>• Lack of social relationships exaggerated into diagnosis of schizoid or schizotypal personality.</td>
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<tr>
<td>• Paranoid delusions confused with nonpsychotic paranoid stance of paranoid personality disorder.</td>
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<tr>
<td>• Antisocial behaviors viewed as nonexistent in late life, and denied or minimized as a result.</td>
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<tr>
<td>• Adaptive, transferential, neurotic, or illness-related treatment resistance exaggerated into diagnosis of passive-aggressive personality disorder.</td>
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<tr>
<td>• Concept of hysteria and conversion symptoms confused with concept of histrionic traits.</td>
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<td>• Illness-related lability or agitation exaggerated into diagnosis of borderline or antisocial personality disorder.</td>
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<tr>
<td>• Symptoms of an Axis I mood disorder not differentiated from the maladaptive pattern of depressive traits found in depressive personality disorder.</td>
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<tr>
<td>• Pattern of maladaptive avoidant traits not separated out from symptoms of social phobia or posttraumatic stress disorder.</td>
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firm (or disconfirm) a diagnosis of PD? One common approach to the problem is that clinicians defer an Axis II diagnosis indefinitely,30 or until sufficient clinical contact occurs, and more psychiatric and psychosocial history are obtained. Only time and lengthy clinical interactions, always at a premium in managed care settings, allow the therapist to review the patchwork of clinical data and arrive at the most accurate assessment of personality. We have seen many patients demonstrate over time certain dysfunctional personality characteristics that they had either failed to report or denied having during an initial interview.

### Case Vignette

Mr. S was a 75-year-old man seen in our geriatric psychiatry clinic for complaints of mild anxiety. He appeared well-adjusted and charming to his clinicians, but he never followed through with any treatment recommendations. When seen for a structured interview for Axis II, he denied all symptoms, and did not meet criteria for any diagnosis. Over time, however, it became clear to this patient’s clinicians that his pleasant veneer was disguising dishonest replies and passive-aggressive attitudes toward treatment. When the patient eventually allowed his social worker to contact an estranged family member, she learned that this man had a history of extensive antisocial behaviors. Thus, an early series of clinical encounters that included a structured interview failed to identify a historical diagnosis of antisocial PD.

This case vignette raises the issue of using informants as important sources of information. The presence of a caregiver can provide critical longitudinal information, especially when a patient suffers from cognitive impairment. Family members usually have the vantage point of interacting with the patient over decades and may be less apt to deny unpleasant and troublesome behaviors or view them as ego-syntonic. This information can, however, be subject to the same recall bias as that of the patient in question, or can be skewed by the negative attitudes of caregivers who have borne the brunt of the dysfunctional personality. Zimmerman et al.31 studied the impact of adding informant data to structured interviews for Axis II diagnoses and found that this information led to changes in 20% of cases, usually revealing more psychopathology.

### Longitudinal Histories

Unlike most Axis I diagnoses, which are based on the presence of current, readily observable symptoms and/or discrete episodes of illness, Axis II diagnoses require a detailed longitudinal history. DSM-IV criteria specify that this history is rooted in childhood and first evident in young adulthood. To obtain an Axis II diagnosis, then, we are asking patients and/or informants to reconstruct four to seven decades of personal history, and fill this history with examples relevant to diagnostic criteria. Most of our patients do well with recalling events in the last few years and can often cite several particularly memorable examples over the decades of their life, but few can detail sufficient examples dating back to young adulthood. This ability is further compromised in some individuals by the presence of age-related decline in working memory or by frank cognitive impairment. In our experience, PD diagnoses in late life end up being based on reported life history from the past 5 to 10 years, with scattered memories from past decades. This diagnostic weighting on more recent history is problematic when maladaptive patterns of behavior that mimic dysfunctional personality traits appear transiently during acute episodes of Axis I disorders or in response to severe stress. Clinicians and researchers are thus faced with the dilemma of using a history that may only accurately go back several years in order to sort out chronic from acute behaviors, and long-standing personality dysfunction from more recent, reactive personality change. The clinician is caught in a bind: a diagnosis based on more recent memories does not represent a true longitudinal history, but a diagnosis based on older memories can become too speculative.

Epidemiologic research looking at the reliability of historical recall for diagnoses has highlighted this problem. In their review of this research, Simon and VonKorff62 cite rather low reliability for patients’ recall of remote episodes of psychiatric disorders. Poor reliability of recall even extends to recent episodes; in one study cited, only 48% of individuals who met criteria for major depressive disorder remembered the episode 18 months later. Across studies, individuals tended to forget episodes over time rather than create them. Or, they “telescoped” remote episodes toward recent years. Simon and VonKorff hypothesize that the higher lifetime prevalence of all psychiatric disorders in young adults may be due to older subjects’ failure to recall
earlier episodes of illness. In particular, the 50% increase in lifetime prevalence of depression seen in this century, along with the apparent decrease in prevalence of late-life disorders seen in cross-sectional studies, may be largely due to recall error. They also suggest that this recall error may be increased in those psychiatric disorders with less frequent episodes or with symptoms that decline with age. This potential artifact certainly applies to PD, the diagnosis of which is based on sporadic episodes of illness and on chronic, discrete behaviors and traits, some of which potentially diminish with aging. As an example, consider the borderline or antisocial individual who becomes less impulsive or aggressive with age and may thus forget to mention or simply omit a history of past reckless, irresponsible, and self-injurious behaviors that manifested these traits.

It would seem that one way around such a dilemma is to carefully review past medical and psychiatric records. In fact, in many epidemiologic studies of PD in late life, diagnoses were taken from reviews of past psychiatric records, usually inpatient discharge summaries. Unfortunately, the reliability of these diagnoses is compromised by the inconsistent diagnostic methods that yielded them, and the validity of these diagnoses may be limited by the presence of overwhelming Axis I symptomatology. These and other limitations are quite apparent in longitudinal psychiatric records reviewed at the Minneapolis Veterans Affairs Medical Center, which often go back to clinical encounters from shortly after World War II. Chart diagnoses appear from a range of different clinicians, diagnostic nomenclatures, and types of clinical contact (e.g., inpatient discharge summaries, outpatient treatment reviews, psychological testing, and compensation and pension evaluations). Each type of assessment has its own time frame and diagnostic modus operandus. Clinical notes often do not provide the amount of detailed history required to infer an Axis II diagnosis and rarely make reference to specific diagnostic criteria. Longitudinal chart information may confirm many features of a PD, but for the current cohort of elderly individuals it often presents symptoms in a variety of pre-DSM diagnoses. In our review of past records of individuals with current PD diagnoses, we frequently found pre-DSM-III diagnoses, such as psychoneurosis, schizophrenic reaction, or anxiety neurosis, within certain subtypes of dysfunctional personality (e.g., schizoid, compulsive, immature). Rather than representing different forms of psychopathology, these older diagnoses tend to reflect the same types of maladaptive traits that comprise more recent DSM-IV diagnoses. However, despite common themes that are usually apparent in all of these records, it is challenging to translate their findings into reliable Axis II diagnoses by use of current DSM-IV criteria.

The Use of Structured Interviews

After a psychiatric interview and chart review, our diagnostic process for personality dysfunction moves on to the administration of a structured clinical interview. In this format, the examiner asks the patient a series of verbatim questions from a written script. Each question corresponds to a diagnostic criterion, and the examiner codes for the criterion being met to a greater or lesser degree, depending on the instrument. Informants such as a spouse or child are also interviewed when a patient is not able to provide a coherent history. Structured interviews are sometimes viewed as gold standards because they ideally provide a consistent and reliable method of diagnosis that is directly based on DSM criteria. In our research, we used the Structured Clinical Interview for DSM-IV Axis II Personality Disorder, Version 2.0, also know as the SCID-II. Two other structured interviews for Axis II diagnosis that frequently appear in the literature on late-life PD include the Structured Interview for DSM-III, or SIDP, and the Personality Disorder Examination, or PDE. In our experience using structured interviews, we often encounter patients who either fail to endorse sufficient criteria to confirm the Axis II diagnosis provided by their clinician or who endorse criteria for PD not mentioned by their clinician. Some patients present with pervasive and maladaptive personality traits that do not clearly fit into any diagnostic category other than “Personality Disorder, Not Otherwise Specified.”

Despite their obvious advantages in standardizing diagnoses and maintaining a focus on DSM criteria, existing structured interviews for PD prove problematic when used to evaluate elderly individuals. First, elderly respondents may have difficulty answering questions that do not account for age-related changes in behavior and lifestyle. For instance, individuals who are retired from work must draw upon remote memories when answering questions for passive-aggressive and obsessive-compulsive criteria that focus on work-related behaviors. Older subjects who have limited social spheres because of losses of friends and loved ones, or limited mobility because of disability, sometimes find them-
selves endorsing avoidant, dependent, or schizoid criteria that seem incongruous with other spheres of social functioning. It can be difficult for interviewers to sort out age-appropriate behaviors from maladaptive ones. This is especially the case for elderly individuals who have become more dependent on caregivers because of medical or psychiatric disability, such as sensory loss or cognitive impairment. Attempts by interviewers to adapt questions and make them more relevant to elderly individuals can help correct these discrepancies, but they run a serious risk of changing the structured interviews in ways that potentially disrupt reliability and validity. Such changes also require well-informed geriatric perspectives in order to minimize ageist assumptions.

The hesitation of some elderly individuals to reveal socially unacceptable behaviors or attitudes is especially problematic in structured interviews. Several questions on the SCID-II are inadvertently worded in such a way as to pull for these distortions. For example, one question under Passive-Aggressive criteria asks: *When someone asks you to do something that you don’t want to do, do you . . . do a bad job?* Two questions designed to elicit narcissistic criteria ask: *Do you often have to put your needs above other people’s?* and *Are you not really interested in other people’s problems or feelings?* In our experience, many respondents fail to affirm any of these criteria despite clinical evidence to the contrary. An attuned clinician, especially when he or she knows the patient’s background, can usually “read between the lines” during an interview and try to account for any obvious recall or reporting bias; in fact, these instruments expect the person administering them to incorporate clinical information. However, in most research studies, the individuals administering the interviews usually do not know the subjects well and have not conducted extensive reviews of clinical information. As a result, the process of “reading between the lines” is unreliable and may potentially invalidate the criteria in question.

**Clinical Consensus**

The final approach to PD diagnosis is the clinical consensus method, in which a group of clinicians holding a conference to discuss an individual patient pool their respective data and impressions, and reach a diagnosis by consensus. This method requires that all involved clinicians have a sufficient understanding of current diagnostic criteria for PD and have knowledge of the individual’s functioning in various settings and over an extended period of time. It is especially important for these clinicians to be able to evaluate the individual in question outside of times or settings (e.g., inpatient, acute care) in which comorbid Axis I conditions may be distorting the observation of personality. Although resultant diagnoses may be the most valid and practical from a clinical standpoint, they may not be the best research diagnoses because of their lack of standardization. Not surprisingly, most studies in the literature failed to define exactly what “clinical consensus” consisted of, and did not discuss testing for reliability. Regardless of the diagnosis, one common result of the clinical consensus method is the development of a reasonable case formulation to explain the personality dynamics that underlie an individual’s presentation. However, a good formulation is not equivalent to a categorical diagnosis of PD, and the process of reconciling the two may be difficult.

**Nosological Challenges**

The final and perhaps most difficult hurdle to the diagnosis of PD in late life concerns the current nosology. Since the publication of DSM-I in 1952, the 12 categorical diagnoses that appear in DSM-IV are the result of nearly 50 years of nosologic evolution. These changes in the nomenclature are outlined in Figure 2. Several categories have remained relatively intact, whereas others have been added, deleted, or placed in the Appendix until further study can either substantiate their presence or support their exclusion. Although many of the labels remain the same, the criteria have changed significantly within all categories. Also, formal criterion sets under a separate diagnostic axis have only been in existence since the publication of DSM-III in 1980. Another major shift came when the diagnostic format was changed to a “polythetic” format in DSM-III-R, in which PD diagnosis was based on a combination of criteria under a given diagnostic category instead of on the requirement that an individual meet every criterion. This change was maintained in DSM-IV and has obviously allowed for increased phenomenologic variability within categories.

There are several key problems for this nosology across the life span. First, there is no established way to describe the degree or severity of personality dysfunction. Thus, it is difficult to classify individuals who meet several criteria in one or more categories, but not
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the requisite number to qualify for a diagnosis. Second, some individuals demonstrate dysfunctional traits not listed in any category. DSM-IV attempts to deal with both problems by providing the label “Personality Disorder, Not Otherwise Specified (NOS).” Third, age becomes a complicating factor when individuals meet criteria for one or more disorders as adults, but without evidence (or available data) to confirm the diagnosis since young adulthood. The literature has used terms such as “adult- or late-onset personality disorder” to account for these situations. DSM has not addressed the issue of late-onset PD, but instead it has traditionally classified personality change as an organic disorder. The term “organic personality disorder” that appeared in DSM-III-R was changed in DSM-IV to “personality change due to . . . ” (a specified medical condition). In contrast to DSM-IV, the 10th revision of the International Classification of Diseases, or ICD-10, retains the diagnosis of organic PD, but offers a broader classification of enduring personality change after a catastrophic experience or a psychiatric illness. This diagnosis would encompass personality change seen in posttraumatic stress disorder and substance abuse or after episodes of depression, mania, psychosis, and other psychiatric disorders.

A fourth problem is that the current categorical nosology does not account for important age-related issues that may alter the manner in which personality dysfunction manifests. Several of these issues include: 1) the impact of comorbid medical and psychiatric conditions on physical, psychological, and social functioning; 2) cognitive impairment; 3) psychosocial changes, such as retirement, widowhood, and adoption of new roles (e.g., caregiver, grandparent, elder, or role-reversal with spouse); and 4) declines in levels of activity and impulsivity. In Table 2, we have outlined the obvious ways in which these issues corrupt many current criteria.

**FIGURE 2.** Nosological evolution of DSM personality disorders (PDs): DSM-I to the present

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<td>Inadequate</td>
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<tr>
<td>Cyclothymic</td>
<td>Cyclothymic (Affective)</td>
<td>Cyclothymic D/O (Axis I)</td>
<td>Cyclothymic (Axis I)</td>
<td>Cyclothymic (Axis I)</td>
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<tr>
<td>Personality Trait Disturbance</td>
<td>Personality Trait Disturbance</td>
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<td>Personality Trait Disturbance</td>
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<td>Emotionally Unstable</td>
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<td>Compulsive</td>
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<tr>
<td>Obsessive-compulsive (Anankastic)</td>
<td>Obsessive-compulsive</td>
<td>Obsessive-compulsive</td>
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<td>Antisocial Reaction</td>
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<tr>
<td>Dysocial Reaction</td>
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<tr>
<td>Social Deviation</td>
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<td>Addiction</td>
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</tbody>
</table>

Note: Extension of category — Contributed criteria — Discontinued category

D/O= disorder

Appendix

Passive-aggressive

Depressive

Self-defeating

Sadistic

Int. Explosive D/O (Axis I)

Int. Explosive D/O (Axis I)
<table>
<thead>
<tr>
<th>Personality Disorder</th>
<th>Problematic Criteria in Late-Life Assessment</th>
<th>Age-Associated Problems and Suggested Modifications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CLUSTER A: ODD</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paranoid</td>
<td>All criteria apply in late life.</td>
<td>None</td>
</tr>
<tr>
<td>Schizoid</td>
<td>• Almost always chooses solitary activities.</td>
<td>Some elderly face social isolation due to deaths of relatives and peers, or physical disability, or placement in residential or nursing facilities with no familiar social contacts. Criteria need to focus more on the presence or absence of motivation or desire for social contacts rather than the quantity of contacts.</td>
</tr>
<tr>
<td></td>
<td>• Lacks close friends or confidants other than first-degree relatives.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Has little interest in sexual experiences.</td>
<td>Loss of sexual desire may be due to multiple physical and psychological causes or social circumstances in late life. This criterion may need to be dropped or should be qualified relative to baseline sexual functioning.</td>
</tr>
<tr>
<td>Schizotypal</td>
<td>Lacks close friends or confidants other than first-degree relatives.</td>
<td>Same concerns as noted above.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>CLUSTER B: DRAMATIC</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Antisocial</td>
<td>• Failure to conform to social norms . . . as indicated by repeatedly performing acts that are grounds for arrest.</td>
<td>Elderly individuals tend to commit fewer crimes and different types of crime (e.g., fewer property-related crimes).</td>
</tr>
<tr>
<td></td>
<td>• Impulsivity or failure to plan ahead.</td>
<td>Longitudinal studies of personality traits have suggested age-related declines in levels of impulsivity and aggression. Older antisocial individuals may not easily meet these criteria.</td>
</tr>
<tr>
<td></td>
<td>• Irritability and aggressiveness, as indicated by repeated physical fights or assaults.</td>
<td>The work-related example does not apply after retirement. More age-appropriate examples might include failure to comply with residential rules, attend appointments, manage medications appropriately, etc.</td>
</tr>
<tr>
<td></td>
<td>• Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations.</td>
<td>This history is often not available or reliable.</td>
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<tr>
<td></td>
<td>• Evidence of Conduct Disorder with onset before age 15 years.</td>
<td></td>
</tr>
<tr>
<td>Borderline</td>
<td>• A pattern of unstable and intense interpersonal relationships.</td>
<td>As noted above, an attenuation of social relationships in late life may lessen the impact of this criterion.</td>
</tr>
<tr>
<td></td>
<td>• Identity disturbance: markedly and persistently unstable self-image or sense of self.</td>
<td>Case studies have suggested that this criterion is less relevant in late life. It is also not clear how identity disturbance would present in late life, when defining life decisions about family, career, and work are no longer relevant.</td>
</tr>
<tr>
<td></td>
<td>• Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating).</td>
<td>As noted above, levels of impulsivity may decline. The examples provided are not as applicable in late life. Better examples may include refusal to comply with medical treatments, polypharmacy, and disordered eating.</td>
</tr>
<tr>
<td>Histrionic</td>
<td>All criteria apply in late life.</td>
<td>None</td>
</tr>
<tr>
<td>Narcissistic</td>
<td>Preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love.</td>
<td>The focus of the narcissistic fantasy in late life may be less on current preoccupations and more on past accomplishments.</td>
</tr>
</tbody>
</table>

*(continued)*
TABLE 2. Proposed modification of DSM-IV criteria for personality disorders (PDs) to account for age-associated changes in behavior and personality (continued)

<table>
<thead>
<tr>
<th>Personality Disorder</th>
<th>Problematic Criteria in Late-Life Assessment</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>CLUSTER C: ANXIOUS</strong></td>
<td></td>
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</tr>
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</table>
| Avoidant             | - Avoids occupational activities that involve significant interpersonal contact because of fears of criticism, disapproval, or rejection.  
- Is inhibited in new interpersonal situations because of feelings of inadequacy.  
- Is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing.  
- There may be a range of both age- and disability-appropriate avoidant behaviors that are more reflective of actual limitations and fears, and less reflective of a sense of inadequacy. As with Schizoid criteria, the focus in late life needs to be on the motivation and desire for age-appropriate social and occupational tasks in light of real limitations, rather than on the degree of social confidence in all situations. |
| Dependent            | - Has difficulty making everyday decisions without an excessive amount of advice and reassurance from others.  
- Needs others to assume responsibility for most major areas of his or her life.  
- Has difficulty initiating projects or doing things on his or her own.  
- Feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself.  
- Is unrealistically preoccupied with fears of being left to take care of himself or herself.  
- Dependency needs increase with age-associated mental and physical disability (e.g. cognitive impairment, sensory loss, impaired physical mobility, chronic pain, etc.), sometimes for many years without clear recognition or appreciation of underlying vulnerabilities and disability. Even though several of these criteria are qualified with the terms “exaggerated” or “unrealistic,” a judgment call is made with respect to these criteria that is open to ageist assumptions about how independent and capable individuals should be. The criteria need to be qualified with information on what is actually unrealistic and exaggerated for certain aged individuals (such as derived from an occupational evaluation). |
| Obsessive-Compulsive | - Is excessively devoted to work and productivity to the exclusion of leisure activities and friendships.  
- Is reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things.  
- Shows rigidity and stubbornness.  
- These criteria, like several others, require examples from work-related activities that do not apply to retired individuals or those in nursing facilities. Alternative age-appropriate activities that may reflect perfectionistic and rigid approaches need to be suggested (e.g., hobbies, volunteer work, room organization, personal hygiene, etc.).  
- This criterion reflects ageist stereotypes of older individuals as stubborn, or “set in their ways,” and may be falsely endorsed. An operationalization of both the terms “rigid” and “stubborn” might make this criterion more objective (e.g., “individual is consistently unwilling to consider other viewpoints.”) |

**APPENDIX:**

<table>
<thead>
<tr>
<th>Personality Disorder</th>
<th>Problematic Criteria in Late-Life Assessment</th>
<th>Age-Associated Problems and Suggested Modifications</th>
</tr>
</thead>
</table>
| Passive-Aggressive   | - Passively resists fulfilling routine social and occupational tasks.  
- See comments for obsessive-compulsive PD. |
| Depressive           | All criteria apply.  
- None |

### Notes
- Passive-Aggressive
- Depressive

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As a result of all of these deficiencies, the DSM-IV Axis II nosology does not provide much flexibility, guidance, or parsimony when it comes to assessing older individuals with personality dysfunction, especially those who fall into gray areas of diagnosis. Attempts to remedy these deficiencies with a vague “NOS” category and a rigid category of personality change are only marginally helpful. Clearly, something more is needed.

SOLUTIONS TO THE PROBLEM OF DIAGNOSIS

Given the enormous diagnostic problems described here for elderly individuals with personality dysfunction, how can we go about finding solutions in a reasonable manner? Elderly individuals, like children and adolescents, have unique components to psychopathology that can be missed or obscured under the current adult-oriented DSM-IV Axis II nosology. Clinicians who work with children and adolescents have the benefit of several age-specific diagnostic categories: perhaps it is time for geriatric clinicians to propose the same. A geriatric subclassification for PD will have to account for the following factors:

1. Longitudinal histories provided by older individuals may accurately go back only a few years, and not decades. The diagnostic requirement that maladaptive behaviors of PD be rooted in young adulthood may have to be reconsidered.
2. Most elderly psychiatric patients have one or more Axis I diagnoses. As a result, long-standing maladaptive personality traits will often have to be studied within the presence of more acute psychiatric symptoms.
3. A better understanding of the relationship between chronic medical and psychiatric illness and personality change must be integrated into the nomenclature.
4. There are important age-related issues that affect behavior and personality that must be identified and considered in any diagnostic scheme.

Taken together, these factors point to a nosologic convergence between the diagnostic concept of “personality disorder” and that of “personality change disorder,” whereby both long-standing personality traits and chronic dysfunctional states of more recent onset are considered in the same diagnostic scheme. As the great personality theorist Henry Murray so aptly stated, “the history of the personality is the personality.” Thus, dimensions of both normal and pathologic personality will reflect chronic (i.e., of years’ duration) but not necessarily lifelong characteristics. These considerations will certainly change the conceptualization of PD as stated in DSM-IV, but the result should be more valid and clinically relevant diagnoses of personality dysfunction in late life.

How could such a diagnostic scheme be constructed? Under the current nosology, we are immediately faced with a “catch-22.” On one hand, in order to know how to change the criteria, we need to study elderly individuals with PD. On the other hand, we have to identify these individuals by use of the current system that we are trying to change. There are several approaches to this problem.

The most time-consuming approach to constructing a geriatric subclassification for Axis II would be to look empirically at elderly individuals (especially those with presumed maladaptive personality traits), and identify relevant categories and/or dimensions of personality dysfunction. For instance, in our research, we have identified several individuals with anxious and hypochondriacal personality traits that are not adequately captured by any current diagnosis. We have also found among elderly veterans a preponderance of mixed PDs that include depressive and passive-aggressive diagnoses, despite the fact that the latter categories have been relegated to the Appendix of DSM-IV for further study. An empirical reconstruction of the diagnostic system might need to incorporate such findings. Such empirical research, however, is no easy task, and the results might well prove even more confusing and hamper research even more than the current system. Perry points out that there are a number of multivariate techniques that have been used to mathematically devise personality classifications and aptly comments that “whatever is derived by these methods may or may not have any predictive relationship to other clinical domains. Thus, what is descriptively parsimonious or elegant may or may not have any clinical utility (p 275).”

A less active approach would be to use the existing DSM nomenclature to identify samples of individuals who meet full or subthreshold criteria for various PDs, and then compare their symptoms with younger individuals with the same diagnosis. This approach, however, may not provide adequate samples, and it would
Personality Disorders in Late Life

exclude those individuals whose problematic personality traits do not fit neatly into any category or who have mixed diagnoses that introduce too much variance into comparisons. Also, it would be difficult to discern true age-associated changes from cohort effects. A more practical approach would be simply to modify existing DSM-IV criteria to account for obvious age-related changes. For instance, criteria that focus on work-related behaviors can be based instead on occupational activities in which older individuals participate, such as volunteer work, or hobbies, or care of grandchildren. Refer again to Table 2, in which we have described problematic aspects of existing criteria and have proposed ways in which they can be altered. Although these suggestions are based on both our clinical and research efforts and on a review of the literature, they are primarily meant to prompt interest and discussion and serve as a heuristic template for a geriatric subclassification. We must also add several caveats: these modifications may themselves alter criteria to such a degree as to invalidate current categorical diagnoses. There is also the risk of introducing ageist stereotypes.

There may be a middle ground in which to pursue research utilizing existing criterion sets and structured diagnostic instruments in addition to empirical data collection. Grove and Tellegen have proposed that PD researchers branch out and use instruments developed for normal personality assessment, but augmented with DSM features. Both self-report and observer-rated data should be used, but should be studied as distinct entities. There are numerous existing personality inventories that could serve this purpose. In particular, there has been much research attempting to combine existing PD diagnoses with the five-factor model of the NEO Personality Inventory and with the Million Clinical Multiaxial Inventory Grove and Tellegen suggest that iterative rounds of data collection, analysis, and then item and concept revision will help merge ideas with data to gradually evolve a valid assessment instrument: “in this way, both one’s ideas and the empirical nature of abnormal personality have a chance to influence the instrument, and in the process a good deal about the relevant trait’s domains can be learned (p 38).”

To maximize future research into late-life PD, regardless of the strategy chosen, it is clear that current clinical records must provide better phenomenologic descriptions of patients’ behaviors and personality traits and de-emphasize reliance on categorical diagnoses. In a review of psychiatric records spanning 50 years, we have seen a dramatic shift away from the detailed clinical case reports of previous eras to brief, diagnostically based notes in the current era. A return to a more comprehensive approach to personality description and diagnosis would accomplish several goals. First, it would lessen the impact of changes in Axis II nosology on retrospective study. Change or stability in behaviors across the life span would be illuminated by comparisons with descriptions from previous clinical notes. Clinicians in future eras could use these descriptive data to arrive at their own diagnoses consistent with future criteria. Second, it would focus the attention of clinicians on more substantial clinical observation and case formulation. The current focus on categorical diagnosis lends itself to lumping and labeling of patients in ways that can both obscure the complexity of personality and rigidify clinical treatment algorithms. Third, some honesty will be restored to clinical encounters by bringing personality diagnoses into the light of day, making it easier for patients to understand their difficulties without feeling pigeonholed into an unwieldy and often pejorative diagnosis. Perhaps a shift away from categorical diagnosis and toward descriptive clinical reporting of personality will provide dignity to patients by eliminating the present-day stigma associated with labels of PD that may inaccurately and narrowly mark a patient for his or her entire lifetime.

The ultimate solution to the lack of PD research depends, to a great extent, on what happens to the current nosology. There is a growing interest in adding or substituting a dimensional model for the current categorical one, perhaps rooted in the five-factor model of personality, as noted earlier. There are numerous advantages to a dimensional model. It could provide normative profiles of personality strengths and weaknesses for all individuals, not just those with known PD. After all, not every psychiatric patient has a depression or a psychosis, but every patient does have a personality that is important to evaluate. A dimensional personality profile would allow for easier comparisons between young and old cohorts, assuming that individual criteria are either age-adjusted or written so as to apply to all ages. Dimensional scores could be compared at different points across the life span, as well as during acute episodes of Axis I disorders. Personality change could be assessed by the same system that looks at personality structure. Dimensional scores can also be converted into a categorical model, if desired. Although there are numerous dimensional personality scales already in ex-
istence, there is no clear consensus on how best to utilize them to construct a “better” Axis II nosology, nor is there any timetable for its accomplishment.

For all practical purposes, reliable longitudinal diagnosis of late-life PD will be at a standstill until a sufficient cohort of individuals with post–DSM-III Axis II diagnoses becomes elderly. Despite our call for a geriatric subclassification for PD that incorporates important age-related issues, it must be realistically acknowledged that the geriatric subclassification will not resolve all of the major challenges to PD research, nor will it erase the many complex diagnostic challenges inherent in the assessment of personality, especially in a geriatric population. However, a geriatric subclassification will mitigate many of the current challenges to late-life Axis II diagnosis, hopefully resulting in a burgeoning of interest and research in this area similar to what has occurred for PD in young and middle-aged adults. It would open wider an important window for geriatric clinicians, allowing many researchers to bring their wisdom and expertise to bear on the study of both personality and personality dysfunction in late life.

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