PDs in Older Adults: Scope of the Problem

- Less favorable response to a variety of empirically supported treatments (psychotropic and psychosocial) for depression, and poorer response to treatment in general.
- Impaired functioning even after affective symptoms improve.
- Impaired social support.
- Decreased quality of life.
- Increased risk of suicide and disability.
Pathways to Older Adult PD

• Previously diagnosed individual with either a chronic or fluctuating presentation of a PD, ages into older adulthood.

• Previously undiagnosed individual, newly diagnosed as an older adult.
  - Previously subthreshold but has worsened with added stressors related to aging.
  - Previous circumstances may have reinforced personality pathology but change in circumstances may result in formerly adaptive behavior, now maladaptive.
  - Cognitive changes leads to personality changes – PD?
DSM-IV/V Clusters of PDs

• Cluster A (odd, eccentric)
  – Paranoid, Schizoid, Schizotypal

• Cluster B (impulsive)
  – Borderline, Narcissistic, Histrionic, Antisocial

• Cluster C (anxious)
  – Avoidant, Dependent, Obsessive-Compulsive

• Provisional – Not included in DSM-V
  – Passive-Aggressive, Depressive, Masochistic
Personality Change due to Another Medical Condition

- In DSM-IV, an exclusion.
- In DSM-V, appears in Other Personality Disorders.
DSM-V Hybrid Alternative Model

- **Personality Functioning**
  - Whether or not a patient has a personality related problem and how severe it is.

- **Personality Type**
  - Characterization of personality problems using broad descriptions

- **Personality Traits**
  - Further description of the heterogeneity.
Personality Functioning

- Adaptive failure involving impaired sense of self-identity or self direction OR failure to develop effective interpersonal functioning (e.g. empathy, intimacy).
Personality Type

- Antisocial/Psychopathic
- Avoidant
- Borderline
- Obsessive Compulsive
- Schizotypal
Personality Traits

• Negative Emotionality
• Introversion
• Antagonism
• Disinhibition
• Compulsivity
• Schizotypy
Assessment Issues for PD in Older Adults

• Very few studies of PD in older adults, and complex comorbidities make this very hard to assess.

• Lack of diagnostic instruments that are specifically developed to diagnose personality disorders in the elderly.
  – Unreliability of retrospective reporting
  – Lack of age adjusted diagnostic instruments
  – Failure of current nosology to account for age-related issues; a number of DSM criteria (e.g. work) are inappropriate for many older adults.

• PD classification system has been in flux.
Reviews of Stability of PDs Post DSM-III studies

- “The degree of stability of BPD, 57%, is moderate...”

- “The available data on BPD do seem to imply that long-term stability is not a hallmark.”

McDavid & Pilkonis, 1996
Stability of PDs

• Large scale, multisite, longitudinal studies spanning 10+ years have concluded that PDs are not lifelong, less stable than conceptualized (Shea et al 2002, Grilo et al 2004, Zanarini et al 2007).

• Impulsive type behaviors in Cluster B disorders, such as antisocial and borderline, appear to decrease with older age.

• Some evidence to suggest that of the PD disorders/traits, obsessive compulsive and schizoid traits are more likely to increase.

• Functional impairment remains relatively stable (Skodol et al, 2005).
## Cumulative Probability of Remission (12 mo definition)

<table>
<thead>
<tr>
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<th>STPD</th>
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<th>AVPD</th>
<th>OCPD</th>
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Data from Collaborative Longitudinal Study of Personality Disorders
Stability of Functioning
Mean GAF Scale Score
From Skodol et al

Data from Collaborative Longitudinal Study of Personality Disorders (Skodol et al., 2005)
Possible Reasons for Instability

- Successful treatment
- Maturational changes
- Environmental changes
- PD course is more fluctuating than stable
- Methodological artifact
Tx of PDs in Older Adults

- Paucity of empirical studies of pharmacological or psychosocial intervention of PD in older adults

**Pharmacological interventions:**

- Neuroleptics often used for Cluster A or psychotic sx
d- SSRI, mood stabilizers, and to lesser extent neuroleptics often used for Cluster B, aggressive sx
- SSRI may be used for Cluster C, but no good data to support.

- Dialectic Behavioral Therapy (DBT) adapted for older adults.

- Supportive Psychotherapy w/ Case Management.

DeLeo et al (1999)
## Integrating Case Management and Supportive Psychotherapy

### Case Management

- **Purpose**
  - Provision of basic needs
  - Maintaining independence
  - Max quality of life

- **Assessment**
  - Activities of daily living
  - Food, shelter, clothing, transportation, healthcare
  - Social support
  - Environmental safety
  - Cognitive functioning

### Supportive Psychotherapy

- **Purpose**
  - Symptom reduction
  - Max adaptive behaviors
  - Min maladaptive behaviors
  - Restore self-esteem

- **Assessment**
  - Depression, anxiety
  - Risk factors
  - Interpersonal relationships
  - Cognitive functioning
  - Reality testing

Adapted from Clark, S. (2011)
Integrating Case Management and Supportive Psychotherapy

Case Management

• Intervention
  – Engagement and building relationships
  – Resource provision
  – Linkage with resources
  – Brokering of services
  – Environmental changes
  – Mobilize supportive network
  – Advocacy
  – ST and LT goals

Supportive Psychotherapy

• Intervention
  – Engagement and building relationships
  – Validation of feelings
  – Empathy
  – Encouragement, guidance, praise, reassurance, reframing, instill hope
  – Social skills training
  – Anticipating consequences
  – Increasing self-observation

Adapted from Clark, S. (2011)
Dialectics

- The process of change whereby an idea or event (Thesis) generates and is transformed into its opposite (Antithesis) and is preserved and fulfilled by it, leading to a reconciliation of opposites (Synthesis).

- A method of logic or argumentation by disclosing the contradictions (antithesis) in an opponent’s argument (thesis) and overcoming them (synthesis).

Dialectical Behavior Therapy

• Multimodal: Individual, medication management, skills group, telephone consultation, consultation to the therapist.
• Theoretical basis is predominantly behavioral with influences from Zen practice.
• Stages of treatment; within stages, hierarchy of treatment targets

DBT Stages of Treatment

- Stage 1: Behavioral Dyscontrol → Behavioral Control
- Stage 2: Quiet Desperation → Emotional Experiencing
- Stage 3: Problems in Living → Ordinary Happiness and Unhappiness
- Stage 4: Incompetence → Capacity for Sustained Joy

Stage 1: Primary Behavioral Targets

- Suicide crisis behaviors
- Parasuicidal acts
- Suicide communication
- Suicide ideation
- Suicide related expectancies and beliefs
- Suicide related affect
- Any behavior that poses threat to life

From Linehan, M. 1993
DBT Rules re: Suicidal Behavior

• Parasuicidal acts and suicide crisis behaviors are always analyzed in depth.

• A patient who engages in parasuicidal acts cannot call her therapist for 24 hours following the act, except in a medical emergency where she needs the therapist to save her life.

• Potentially lethal patients should not be given lethal drugs.

Individual Therapy

- Weekly diary cards to collect info about ongoing problems; can be individually tailored.
- All self-harm, suicidal crisis behavior and significant changes in suicide ideation or urge to self-harm are immediately addressed.
- Behavioral or chain analysis
- Solution analysis

Chain Analysis - I

- Describe the problem behavior.
- Locate event in the environment that set off the chain of behaviors.
- Identify possible events or situations that may be vulnerability factors increasing likelihood of problematic behavior.
- Describe in excruciating detail each link in the chain of events that led to behavior.

Chain Analysis - II

- What were the consequences of the problem behavior?
- What other solutions might have been available?
- What prevention strategy could have kept the chain from getting started?
- How to repair significant consequences of the problem behavior?

Validation

- Communicating to the patient that his/her responses make sense in the current context.
- Does not mean approval.
- Also important to validate internal private behaviors such as thoughts and feelings.
- Validation can occur on a number of levels

Skills Training

• Mindfulness – Wise Mind
  – Observe, Describe, Participate

• Emotion Regulation
  – Identifying and understanding function of emotions.
  – Reducing vulnerability, increasing positives

• Interpersonal Effectiveness
  – Balancing relationships, assertiveness, self-respect.

• Distress Tolerance
  – Crisis survival strategies

Telephone Consultation

• Provide skills coaching in-vivo and promote generalization
• Promote emergency crisis intervention in a contingent manner
• Provide opportunity to resolve conflicts and misunderstandings that arise during therapy sessions

DBT Crisis Survival Checklist – I

- T attends to AFFECT rather than content.
- T explores the problem NOW
  - T focuses on time since last contact
  - T identifies key events setting off current emotions
  - T formulates and summarizes the problem

DBT Crisis Survival Checklist – II

- T focuses on PROBLEM SOLVING
  - T gives advice and makes suggestions.
  - T frames possible solutions in terms of behavioral skills P is learning.
  - T predicts future consequences of action plans.
  - T confronts P’s maladaptive ideas/beh directly
  - T clarifies and reinforces P’s adaptive response
  - T identifies factors interfering with productive plans of action

DBT Crisis Survival Checklist – III

- T focuses on AFFECT TOLERANCE
- T helps P COMMIT herself to a plan of action
- T assess P’s SUICIDE POTENTIAL
- T anticipates a RECURRENCE of the crisis response.

Consultation Team

- Therapist applies DBT to patients while consultation team applies DBT to therapist.
- Helps clinician remain in the therapeutic relationship, effectively.
- Provide support to T and cheerlead. Validate T’s reactions, feelings.
- Prevent T from becoming entrenched in one position.

DBT for comorbid depression and PD in older adults

- Modified theoretical perspective:
  - “...the transaction between a biological predisposition for negative affectivity and environmental feedback that either disconfirms or confirms the individual’s style of emotional responding produces a pattern of rigid maladaptive coping that over time results in the development of a personality disorder.” (Lynch et al., 2007).
DBT for comorbid depression and PD in older adults

- Synthesizes behavioral skill deficits and deficits in behavioral flexibility (e.g. overly rigid responses, perfectionism, interpersonal difficulties, avoidance behavior, isolation).
  - PD older adults lack interpersonal self-regulation and acceptance skills.
  - Personal and environmental factors inhibit the flexible use of behavioral coping skills the individual does have and often reinforce dysfunctional behavioral pattern.

Lynch et al., 2007
DBT in older adults: new skills

- Cognitive restructuring to challenge myths
- Fixed mind vs. fresh mind dialectic
- Asked to find the truth and value in both poles and to resolve the dialectical tension
- Skills to creating meaning over the life course
- Looking forward (skills focus on values/goals, goal setting, and goal planning)
- Looking back (skills focused on forgiveness of self/other/environment and development of a personal life story that focuses on overcoming obstacles and contributions.

Lynch et al., 2007
Discussion Topics

• How relevant are personality disorders when assessing or treating older adults?

• How impairing is personality dysfunction in context of other problems of older adults? Does it exacerbate problems, or become irrelevant in the face of other (e.g., medical, health) problems?

• Does having a PD impact the delivery of medical treatment?

• What factors should be considered in assessing PDs in the elderly?