Personality Disorders in Late Life

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Thanks to Dr. Joel Sadavoy
Personality Disorders

Defined as:

- Pervasive, persistent pattern of maladaptive interpersonal behaviours
- Across multiple domains and consistent over time
- Impairing several domains of life (work, family, friendships)
Disorders of Personality

Cluster A- Odd or Eccentric
- Paranoid, Schizoid, Schizotypal

Cluster B- Dramatic, Emotional Erratic
- Antisocial, Borderline, Histrionic, Narcissistic

Cluster C- Anxious, Fearful
- Avoidant, Dependant, Obsessive Compulsive
Origin of Personality

Personality characteristics result from both

- constitutional factors e.g. genetic vulnerabilities/strengths, or capacity to modulate affect
- life experience, especially in childhood e.g. ineffective parenting or abandonment
Traits and Personality

**Traits** are individual response patterns e.g. aggressiveness if challenged or insulted, shyness, or over-sensitivity to criticism.

- Traits may be either normal or pathological.
- **Personality** is made up of the sum total of personality traits.
Five Factor Model of Personality

- **Openness** — (inventive/curious vs. consistent/cautious).
- **Conscientiousness** — (efficient/organized vs. easy-going/careless).
- **Extraversion** — (outgoing/energetic vs. solitary/reserved).
- **Agreeableness** — (friendly/compassionate vs. cold/unkind).
- **Neuroticism** — (sensitive/nervous vs. secure/confident).
The four basic personality types

The glass is half full!

The glass is half empty.

Half full... No! Wait! Half empty!... No, half... what was the question?

Hey! I ordered a cheeseburger!
Personality Change in Old Age

Longitudinal Studies in Normal Populations have found that **Traits Remain relatively Stable** (Tackett et al. 2009)
- Neuroticism, Extraversion and Openness decrease slightly, agreeableness, & Conscientiousness increase slightly (Roberts et al., 2006).
- **Maturation of traits** (Vaillant 1997)
  - dysfunctional traits continue with aging but may have less detrimental effects (Valliant and Milofsky, 1980)
While symptom expression changes and often becomes less dramatic with age Disturbances in interpersonal relationships, affect regulation, and self-identity remain stable with aging (Stevenson 2003)

e.g. reduced action oriented behaviours (Sadavoy 1996 Fogel; Bas Van Alphen Pers. Comm)
Neuroticism: negative personality traits

- An enduring tendency to experience negative emotional states. Respond poorly to stress, prone to anxiety, anger, guilt, hopelessness, fear & depression.
- May decline somewhat with aging
Neuroticism associated with:

- poor health behaviours that may contribute to earlier mortality (Friedman, 2000).
Positive traits & emotions are both emotionally and physiologically protective

- **positive reappraisal** (Folkman et al. 2000)
- **finding meaning** (Taylor 1983)
- **positive illusions of self** (Taylor et al. 2000; Gana et al. 2004)
- **situational optimism** (Scheier et al. 1992).
Lack Of Resilience And Negative Personality Features Are Important Factors Leading to Failure Of Adaptation

A common outcome is the emergence of dysphoric subsyndromal emotional states
Stress → Area(s) of psychological vulnerability → Symptoms → Defenses break down
An Example of Development and Psychological Factors

Those who have strong internal stores of self-worth and self-calming abilities respond to aging quite differently than others who require constant activity and feeling of achievement to maintain their sense of personal approval and hence self-esteem. (paraphrase of H Muslim)
Impact of adult life experience on late life dynamics

Adult relationships may sustain defences eg a spousal in acting as a self object by therapeutically containing projections of an immature (e.g. borderline) spouse (GABBARD 2000)

Death or loss of spouse leaves vulnerability to return of anxieties previously defended by projective or idealization defenses.
Adverse life events

Institutionalization, Illness, Loss, grief

Failed adaptation

neurotocism
negative emotions

Depressive symptoms (e.g. SSD)
Personality Traits and Health Outcomes

- Positive personality traits improve health outcomes (Kiecolt-Glaser 2002; Shepperd et al 1996)
- Pessimism predicts physical illness and mortality (Maruta et al 2000)
Common Age-Related Challenges/Stresses

- Physical change, chronic illness
- Loss/grief/bereavement - actual, anticipated
- Cognitive decline
- Roles - e.g. retirement, parenting, spousal
- Productivity/creativity
- Abandonment - institutionalization
- Forced dependency
- Societal devaluation - shame, humiliation

- Loss of control, influence, vitality, leadership and authority
- Economic losses
- Displacement by youth
- Sexual decline/attractiveness
- Facing regrets
- Relinquishing fantasies
- Facing foreshortened future
- Death

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Attachment and seniors 1

Older adults who recalled low parental responsiveness were more likely to experience high levels of anxiety and low self esteem; especially in those who lack an affectionate partner.

(Anderson and Stevens (1993),...
Attachment and seniors

- **securely attached seniors**: higher sociability
- **avoidantly attached seniors**: higher shyness, emotional lability, and intensity of emotion expression, anger, and contempt scores; higher inhibited emotion and emotional distance

(Magai et al 2004)
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Adaptive Tasks and Specific Vulnerabilities in Late Life

- capacity to **mourn**- mourning-liberation; conflicted inner relationships; impaired in PD
- develop and maintain **mature relationships** (friendship)- impaired attachment
- accept help-impaired capacity for **trust** e.g. illness, LTC
- Cope with **Alienation**; maintain vital involvement - impaired secure **self-worth**
Adaptive Tasks and Specific Vulnerabilities in Late Life 2

- Relinquish position, authority and stature - uncontrolled narcissistic needs
- maintain hope & \textit{continuity} - absent internalized good relationships
- Maintain \textit{self-efficacy} – impaired positive self regard
- control \textit{affect} - constitutional impairments
Five Psychological Conflicts that Interfere with Adaptation to Stressful Challenges in Old Age

- Oversensitivity to *narcissistic assault* (Kohut)
- Excessive fear of *abandonment* (Winnicott)
- Conflicts over, *intimacy and trust* (Fairburn)
- Intense *attachment/dependency needs* (separation and autonomy) (Mahler)
- Overly intense *emotional reactivity* (affect regulation) (Kernberg)
### Stress Interacts with Psychological Conflict to Produce Symptoms

<table>
<thead>
<tr>
<th>Stress</th>
<th>Developmental Conflict</th>
<th>Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutionalization</td>
<td>Intimacy/Trust</td>
<td>Anger/withdrawal/panic</td>
</tr>
<tr>
<td>Bereavement</td>
<td>Abandonment</td>
<td>Depression/Aberrant Grief</td>
</tr>
<tr>
<td>Illness/infirmity</td>
<td>Dependency</td>
<td>Clinging/helpless/rejecting</td>
</tr>
<tr>
<td>Relinquish roles</td>
<td>Narcissistic</td>
<td>Demean/mistrust</td>
</tr>
<tr>
<td>Physical change</td>
<td>Narcissistic</td>
<td>Shame/withdraw</td>
</tr>
<tr>
<td>Cognitive loss</td>
<td>Affect control</td>
<td>Fear/blaming</td>
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</table>
Personality change: Age or Illness?

- Personality remains pretty stable into old age so changes need to be investigated.
- But caregivers often interpret personality change as a sign of expected normal personality change in old age. What do you expect after all?
Definition of Dementia

- Multiple Cognitive deficits (particularly memory)
- Caused by general medical conditions (e.g. HIV, NPH, Vit defic), substance abuse (e.g. alcohol) or degenerative brain disease (E.g. VAD, AD)
- Severe enough to produce social or occupational impairment
Personality and Dementia

2 lines of inquiry

- how does dementia change personality
- how does personality affect the expression of dementia

About the first we have some data but about the second we have less knowledge and understanding.
Dementia looks like personality change

dementia is often not recognized as such by family and doctors- changes in behavior are often misinterpreted simply as personality alterations.
Most common behavioural change in dementia

Disengagement and increased passivity, including loss of interest in hobbies and overall loss of spontaneity \cite{Petry1989}.

Early increase in neuroticism with reduced conscientiousness and extroversion, some (but less) loss of agreeableness and openness \cite{McCrae1990, Welleford1995, Jacomb1996}. 
Neuropsychiatric symptoms in mild cognitive impairment (Geda et al, IPA Chicago 2003)

compared MCI, AD and normal subjects using the NPI (neuropsychiatric inventory)

clinical profile of MCI lies somewhere between normals and AD patients.

i.e. even in earliest preclinical stages of dementia there are measurable changes that may alter personality function as well as cognitive function
FTD and Major depression

METAANALYSIS

Studies of cognitive change with matched controls between mild/moderate FTD and depressed patients: N=312

- Moderate FTD - more impaired than depression - esp. language
- Mild FTD (MMSE 28) similar to depression except semantic memory and executive functions significantly worse

Magnitude of impairment in depression consistent across domains (and no specific memory and executive function deficits) while FTD showed greater deficits in some domains than others.

(Thompson et al Int J Neuropsychol Soc 2004: 10;753-771)

Almost half the caregivers reported non-cognitive symptoms or a combination of cognitive and non-cognitive symptoms as the trigger.

Almost 40% specified at least one “personality or behavioural change as the trigger.

Most common were depressive symptoms, violence and “attitude problems, lack of initiative, paranoia and delusions, decreased cleanliness.”
In other Words

- Personality change in old age should trigger a suspicion of the beginning of dementia
Past and Present

- Dementia erodes memory and time sense
- Increasing difficulty in differentiating what is now and what is then
- Long-past memories take on immediacy and power
- Interpretation of current reality may be contaminated by early experiences and the emotions that were associated with them
Personality features change based on Brain region affected

- Dementia affects different parts of the brain
- The part of the brain that is affected by the disease and the way these parts of the brain interact with one another determines the behavioural and personality changes.
Frontal lobes

dorsolateral region
*Regulates* attention, spatial orientation, emotional arousal;
*lesion* produces apathy, dulled affect lack of spontaneity

orbitomedial region
*regulates* acquisition and storage of emotional associations including social restraints
*lesion* produces disinhibition of behavior emotional lability and indifference to social decorum;
Temporal lobes

- Control memory function and affective tone
- Left- verbal memory
- Right- visual memory

Lesions

- intellectual change
- Personality changes
- occasionally schizophrenic like symptoms
depersonalization or sexual disturbances.
Fronto-temporal variants of dementia

- present as impaired social cognition with behavioural change without insight or empathy (orbito-frontal)
- cognitive features - impaired attention, self-observation, impulse control, abstract reasoning, capacity to carry complex plan of action, and ability to filter distracting stimuli.
  - Left lesions - verbal fluency
  - right lesions - inappropriate talking; especially associated with profound personality changes in interpersonal behavior, striking lack of insight (Mychack et al 2001)
Parietal lobes

- regulate somatic sensations, integration of sensory input, word finding, writing, mathematics, reasoning, spatial orientation, control of limb movement or recognizing an object by touch.
- Left lesions - language deficits apraxias agraphia finger agnosia and r-L orientation deficits, hemiattentional neglect.
- Right lesions - visuospatial perception, body image and sometimes facial recognition.
- Personality change - indifference or paranoia, apparent lying about deficits.
Subcortical structures

- **limbic** system lesions - change in arousal, emotional expression, drives
- **basal ganglia** lesions - reduced insight, judgment, and impulsivity
  - OCD with lesions of the basal ganglia, striatum and thalamus
- **hypothalamic and thalamic** lesions - frontal lobe syndromes especially shallow emotional lability and sudden violent outbursts.
Impact of Cognitive changes on Personality

Cognitive Change
- Impaired attention
- Visual perception
- Verbal mediation
- Memory

Personality impact
- Frustration, panic
- Idiosyncratic responses and limited social interaction
- Slowing, insecurity, and increased dependency
- Dependency on external support interpersonal clinging, avoidance of others, or paranoia.
Is Premorbid Personality Related to the severity and type of Symptoms in dementia?
Relationship between premorbid personality and patterns of emotion expressions in mid-to late-stage dementia (Magai et al Int J Geriatr Psychiatry 1997)

- Nursing home sample N=27
- Family and nurse aid observers
- Premorbid personality (attachment) and current emotional behavior measured

Results: secure attachment = + affect; premorbid hostility = negative affect

Conclusions: premorbid personality shows continuity in dementia (findings very similar to Chatterjee et al 1992)
Impact of Premorbid personality on behavior in dementia: Summary

- Data conflict
- Premorbid personality may alter behavioural symptoms of dementia
- Understanding premorbid personality and development can improve understanding of behavior and emotion and enhance specificity of management
How does Dementia Affect Behaviour and Personality?
Personality change in dementia

(Aitken et al Int Psychogeriatr 1999)

- Almost universal
- Negative in nature but not always
- Associated with severity of cognitive impairment, longer duration of illness, and neurological signs.

Some research findings emphasize the biological basis of personality changes in dementia.

Agrees with Brandt et al (Int J Ger Psychiat 1998) - No relationship between premorbid personality and adjustment to nursing home.
Premorbid personality less important than the disease process

(Low et al Int J Geriatric Psychiatry 2002)

- higher neuroticism
- higher agreeableness

Delusions
- hallucinations
- aggressiveness
- affective disturbance and overall behavioural disturbance

higher openness

affective disorder;
(Chatterjee 1992 found higher neuroticism associated)
Stage of Dementia

The stage of dementia is intimately tied to what changes in personality emerge in dementia.

Especially relevant to the patient’s ability to understand what is happening to her capacities and sense of self.
Defining Stages of Dementia

Scales to define and categorize stages of deterioration include the Geriatric Deterioration Scale (GDS) and Functional Assessment Staging (FAST) (Reisberg et al 1982 and 1988).
<table>
<thead>
<tr>
<th>FAST/MMSE</th>
<th>Cognitive Picture</th>
<th>Emotional Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/30</td>
<td>No complaints</td>
<td>none</td>
</tr>
<tr>
<td>2/29-30</td>
<td>mild forgetting</td>
<td>Slight discomfort</td>
</tr>
<tr>
<td>3/25</td>
<td>Functional poor performance, concentration</td>
<td>Early (increasing) anxiety, personality interacts with disease</td>
</tr>
<tr>
<td>4/20</td>
<td>Clear deficits</td>
<td>Denial, withdrawal</td>
</tr>
<tr>
<td>5/15</td>
<td>Lost independent function</td>
<td>Withdrawal/tearfulness</td>
</tr>
<tr>
<td>6/5</td>
<td>Unaware of recent events</td>
<td>Agitation peaks-aggression wandering</td>
</tr>
<tr>
<td>7/0</td>
<td>Chair/bedridden</td>
<td>Babbling/ screaming</td>
</tr>
</tbody>
</table>
Management Implications 1

- Personality change in old age should trigger suspicion of dementia or depression.
- Recognize that behaviour in dementia is multidetermined.
- Various factors affect behavior: some are reactions to brain changes while others are the reaction of the person to their awareness of new and unwelcome cognitive changes.
- The self is gradually eroded.
- (i.e. knowledge of personal identity and relationship to feeling states)
Management Implications 2

In optimal management both components (brain failure and personality effects) are accurately understood.

- This requires:
  - Careful premorbid history from collateral sources
  - Accurate diagnostic separation of organically induced behavior change from psychological
Management Implications 3

- During period of remaining insight and self-reflection, environmental and interpersonal interventions are important.
- Even at later stages, patients may remain sensitive to interpersonal issues which they tended to react to when less impaired, e.g., being left alone, demeaned.
Theory/Evidence-Based Treatment of Specific Vulnerabilities

- Impairments **in trust** – alliance building techniques
- **Abandonment** fears- IPT or CBT with environmental interventions- nurturing, caregiver education-unspoken needs, being left alone
- **Loss and grief** management – pharmacology, psychotherapy.
- Giving up **control** and accepting changes in **status** - educational techniques, consciousness raising, family therapy, interpersonal coaching
- **Maintenance of continuity**- reminiscence, life review, narrative therapies.

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Theory/Evidence-Based Treatment of Specific Vulnerabilities 2

- **Self efficacy** enhancement - locus of control based interventions e.g. Education, Skills training and PST
- Maintaining **Creativity** and vital involvement - centers of creativity
- **Dependency** conflicts-illness adaptation programs psychological vulnerability
- **Friendship** maintenance development programs- affiliation needs