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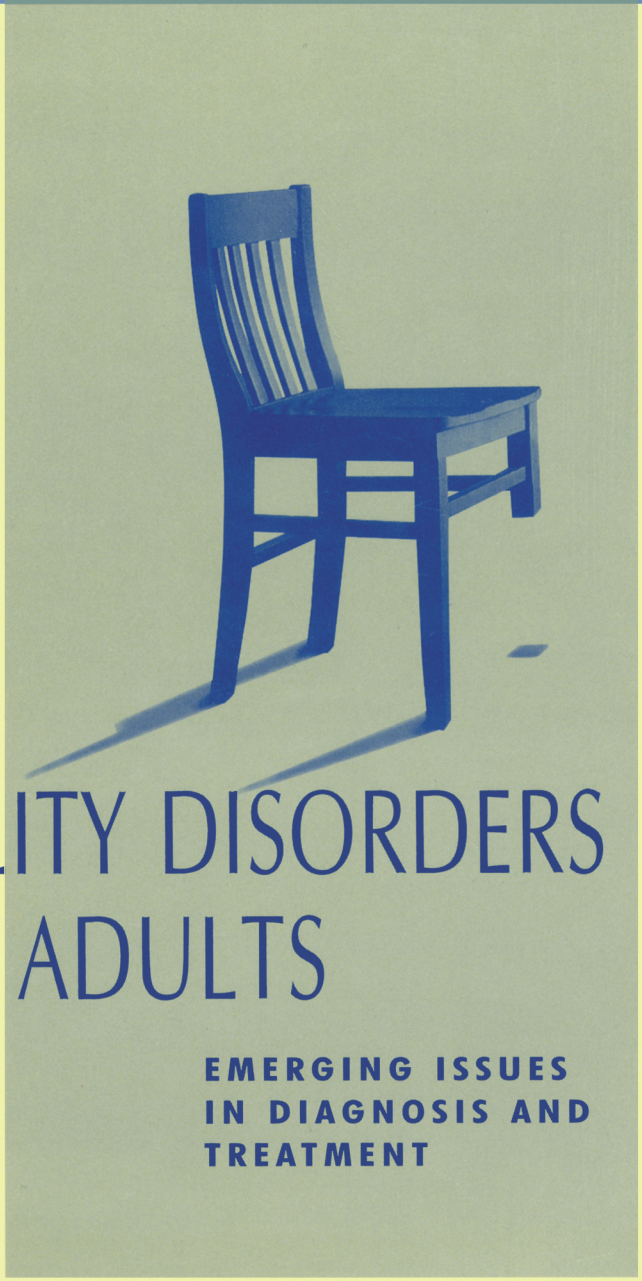

PERSONALITY DISORDERS IN OLDER ADULTS

EMERGING ISSUES IN DIAGNOSIS AND TREATMENT

edited by Erlene Rosowsky

Robert C. Abrams

and Richard A. Zweig

Personality Disorders in Older Adults

Emerging Issues in Diagnosis and Treatment

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Preface

As geriatric mental health clinicians we know that certain of our older adult patients are difficult to treat. We know, too, that their being "difficult" is often a byproduct of their personality functioning—who they are as people—and not exclusively a result of the Axis I disorder or medical condition for which they originally sought treatment. The interpersonal difficulties, affective instability, distortions of the clinician–patient relationship, and unpredictable responses to clinical interventions for which personality disorder patients are notorious are all to be found in older adults as well as in younger patients.

Yet we have discovered that neither the behavioral science nor the clinical literatures offer much guidance to the clinician or researcher seeking to understand the phenomenon of personality disorders in the second half of life. The data base on personality disorders in older adults is remarkably thin, providing only preliminary empirical research and descriptive clinical or theoretical articles. At a time when notions of "successful aging" and of successfully treating behavioral disorders of the elderly have begun to capture the imagination of both the scientific community and the broader public, this scarcity of research regarding geriatric personality disorder seemed striking and disproportionate to its relevance for geriatric mental health clinicians.

The catalyst for this volume was a symposium entitled "Personality Disorders in the Elderly: Research Problems and Clinical Implications," presented at the annual meeting of the American Psychological Association in 1995, at which two of the editors (Erlene Rosowsky and Richard Zweig) were organizers and participants and the other editor (Robert Abrams) served as discussant. We brought differing scientific perspectives and clinical backgrounds to the effort, but we found that we shared a seemingly eccentric interest in an under-researched but exciting area of psychological inquiry. It was this discovery, and our surprise at the large attendance and high level of interest shown at the symposium, that inspired this effort to bring together such work as now exists into a single volume, in the hopes of inspiring more.

The book has been designed in four parts. The first presents a conceptual overview of personality disorders and the aging personality. The second is a review of the research on personality disorder in adulthood and late life. The third and fourth parts are focused on clinical applications—diagnosis and treatment in the third, and the care of personality-disordered elderly patients in the institutional setting or nursing home, in the fourth. The final section also addresses ethical concerns raised by this specific population as well as public policy implications.

A broad range of leading scientists and clinicians were asked to contribute, each being given the difficult assignment of integrating the disparate topics of personality disorders, gerontology or geriatric psychology/psychiatry, and their own area of expertise. Consequently we have come to appreciate each chapter, each essay, as comprising a "three-legged stool." Considering the paucity of data from which most contributors were compelled to begin, we anticipated that the chapters would essentially become provocative starting points from which dialog and further research might emerge. The increasing inclusion of personality as a variable worth considering in geriatric mental health research and practice will be the most valid indication of our success in this endeavor.

Indeed, this collection of reports and essays arrives at few conclusions and raises many questions. Do we need a new nosology for personality disorders in older adults? What is the best way to study the disordered personality in old age—clinical categories or dimensions emerging from factor analyses? What are the core considerations for clinical management of these patients, and the implications for established forms of psychotherapy? What is the effect of older personality disorder patients on individual health care settings or larger systems of care? These questions only serve to raise further questions. Yet it is our hope that by having compiled some of the best thinking and writing currently available to address these issues, we will have forged a helpful beginning.

ACKNOWLEDGMENTS

We want to thank those who have made this book possible. Over the years, our older adult patients have helped us come to know the unique phenomenology of personality in later life. Our mentors—including George Alexopoulos, Bennett Gurian, David Guttman, Gregory Hinrichsen, and Charles Peterson—inspired and encouraged us to attempt to chart unmapped areas of geriatrics and gerontology. Our colleagues, a number of whom have contributed to this volume, urged us on with their enthusiastic and creative thinking as part of this initiative. We appreciate the institutional support of the Department of Psychiatry, Harvard Medical School,

the Joan and Sanford I. Weill Medical College of Cornell University, and the Hillside Hospital—Long Island Jewish Medical Center, our respective affiliations.

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Thank you to Susan Milmoe, senior consulting editor at LEA, and to Tracy Welch, who has tirelessly helped bring this project to light.

Our special thanks to our families and friends, whose support and patience make all challenges possible.

—Erlene Rosowsky
—Robert C. Abrams
—Richard A. Zweig

Foreword

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In attempting to consider the interaction between aging and personality disorder, one inevitably confronts the major questions facing investigators and clinicians dealing with personality disorders. Are personality disorders constant over time? If they were entirely constant, then changes would not be anticipated with aging. The physical and psychological changes that accompany aging offer a naturalistic opportunity to evaluate how personality changes over time. With aging comes an increased likelihood of a variety of illnesses, including dementing illnesses like Alzheimer's disease. Many of these may be associated with discrete brain changes that may induce "organic" personality disorders. However, other more subtle changes may come in the absence of a specific disease process. Some neurotransmitters decrease their activity throughout the aging process so that, for example, activity of the catecholamines may be reduced in their functional effectiveness because of changes presynaptically and in the sensitivity of postsynaptic receptors. Other changes associated with aging include waning cognitive capacities, loss of sensory activity, and decreased body strength.

These changes may contribute to the changes in behavior that clinicians observe in the personality disorders. For example, Abrams and Horowitz (chap. 4) allude to the "muting" or dampening of impulsivity and dramatic internalization in borderline and other "dramatic cluster" personality disorders. Could this be related in part to the natural tuning down, or "down regulation," of receptors or decreased availability of neuromodulaters related to arousal or activation? Other personality disorders such as obsessive-compulsive personality disorder or anxiety-related personality disorder may worsen during the aging process. Could this worsening have to do with increasing need for structure and rules in the face of declining sensory and cognitive capacities? Could increased paranoid traits be related to decreasing sensory capacity and ambiguity of incoming information?

If personality and its disorders are viewed as a set of coping strategies, defenses, and behaviors designed to adapt to the surrounding environment, then the success or failure of a person's adaptation will depend both on changes in environmental circumstances and/or the capacity of his or her internal resources including the integrity of central nervous system function. Depending on these changes and this capacity, the personality may drift in and out of a realm of what might be considered normalcy. In this way, the personality changes that are observed with aging represent an opportunity to broadly understand change in personality. The editors have done a commendable job in assembling chapters that address this fascinating topic from a number of vantage points.

Clarkin, Spielman, and Klausner (chap. 1), in the context of their historical overview of personality disorders, raise a number of critical issues that are echoed throughout the other chapters. They emphasize the distinction between personality, character, or temperament. They highlight the issue of change in personality throughout the life cycle and how the changes of old age interact with personality. The critical question that is raised is whether, because of the changes of aging including declining cognitive and sensory capacities, the boundary for what is normal and what is abnormal may need to shift as the individual ages. They wonder what degree of inflexibility would be sufficient to be considered abnormal in this age range. A corollary, of course, is whether there is any discontinuity between personality and personality disorder. Another area of interest is the stability and onset of personality disorders in childhood and adolescence, the other end of the spectrum, which is not the focus of this book but raises equally important issues regarding stability of personality.

Havens (chap. 2) provides a more personal perspective on the issue of aging and personality disorders drawn from his experience as a psychotherapist. He writes of the importance of intention in people's relations to the world. Whereas the patients he writes about were relatively intact in their cognitive and sensory capacities, it is precisely that sense of intentionality that may be challenged for many older adults who have to cope with declining capacities that interfere with their effectiveness and the demoralization that accompanies these declines. Working with such patients poses a particular challenge for therapists who must refine their intentionality in the context of a "self" that may feel compromised and ineffective.

The next section of the book covers research and assessment, particularly in relation to outcome measures. Zweig and Hillman (chap. 3) comprehensively review assessment issues in personality disorder in adults, emphasizing the problems inherent in objectively characterizing personality disorder traits. They introduce the dimensional concept, one that reemerges again and again throughout this volume. They address the most commonly presented hypotheses regarding the overlap between Axis I and

Axis II disorders and review longitudinal studies of the course of personality disorders. Particularly useful is the summary of the measures of DSM personality disorders. Abrams and Horowitz (chap. 4) provide a review of the prevalence of personality disorders in the second half of life and conclude that the literature may in fact lead to an underestimation of the clinical importance of personality disorders in the aging. They also emphasize the usefulness of a dimensional approach. The dimensional approaches utilized in academic psychology are reviewed in detail by Duberstein and colleagues (chap. 6), and a number of other conceptual and methodologic issues are covered by Mroczek, Hurt, and Berman (chap. 8).

Rosowsky (chap. 9) presents actual case studies of patients who have been in psychotherapy treatment that help to illuminate the issues of transference and countertransference in older adults. Miner (chap. 11) makes a valuable contribution in dealing with neuropsychologic issues that become critical when they are compromised by a variety of dementing processes that often occur in elderly patients. Myers (chap. 12) provides case histories of patients that seem more amenable to dynamically oriented psychotherapeutic treatments in their elderly years than they might have been in their youth, perhaps because of the decreased intensity of temperamental drives and the muting effect of life experience. Goisman (chap. 13) provides a perspective on cognitive behavioral therapy in the elderly, an approach gaining increasing empirical support for severe personality disorder patients in the general population, but that has not been examined so specifically in elderly personality disorder patients. Agronin (chap. 14) tackled some of the dynamic issues that often play out in the context to pharmacologic treatment of these patients and provides some useful guidelines for clinicians in how to approach the elderly patient with a personality disorder that may require pharmacotherapy. Molinari (chap. 16) addresses some of the ethical issues in clinical management of adult patients, including how to deal with the "difficult" patients that strain available support systems and, through clinical vignettes, confronts the dilemmas raised in determining competence of particular patients regarding the use of scarce health resources.

Other chapters deal with the relationship between comorbid personality disorder and outcome of Axis I disorders (Gradman, Thompson, & Gallagher-Thompson, chap. 5); differences between older patients' and clinicians' identification and assessment of personality disorders (Dougherty, chap. 7); the relationship of personality factors to the hospital experiences of older adults with medical illness (Viederman, chap. 10); and the implications of personality disorders for adaptation to life in nursing homes (Rosowsky & Smyer, chap. 15). The volume closes with a commentary on personality disorders in late life and public policy (Knight, Afterword).

All the chapters raise thought-provoking questions and highlight the scarcity of empirical data, as well as the limitations of clinical literature dealing with elderly patients with personality disorders. The editors are to be commended for collecting a wide range of perspectives and reviews addressing this important neglected area.

PART I

Conceptual Background

CHAPTER 1

Conceptual Overview of Personality Disorders in the Elderly

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Time is central to the concept of personality and personality disorders. Personality implies continuity of the individual across time such that each individual has a distinctive way of acting, thinking and feeling. It is what enables people to know friends, to count on them, and to predict what they will do (even though sometimes they are wrong). But life throws slings and arrows, and people are not totally consistent. This enables people to say that a person is "not himself (or herself) today." The issue of personality implies consistency, but there is always the issue of change within consistency.

Although stability is the hallmark of the individual, change is most likely to occur at certain points in the life span or the life trajectory of an individual. It is expected, for example, that adolescents will change as they leave the structured environment of high school and proceed to the less structured environment of college and work. Certainly changes in behavior and attitudes are anticipated when individuals marry and "settle down." And when considering aging and continuity and change in personality, it might be expected that some new balance between these two poles as an individual ages, retires from a lifetime of work, and the network of friends gets smaller or changes. This chapter considers both personality and personality disorders with a specific focus on how these constructs relate to older people.

EARLY CONCEPTUALIZATION OF PERSONALITY AND PERSONALITY TRAITS

The origin of the word "personality" comes from the setting of the Greek and the Roman amphitheaters. Due to the size of the amphitheater the actors wore masks that acted as a small megaphone through which the actor's voice was amplified. This was the "persona," and personality therefore represents the individual characteristics of the character being portrayed (Stone, 1993). "Persona," the Latin word for mask, emphasizes the outward, or surface, aspects of the individual. In contemporary personality research and personality psychology, the term usually connotes the individual's crystallization of typical ways of relating to other people and dealing with the environment (Millon, 1981). Personality researchers have attempted to capture personality in a limited number of traits that are defined as typical or characteristic ways that the individual has of relating to the environment. There seems to be a general agreement about the definition of traits and the emphasis on the measurement of traits, but, in contrast, there is much disagreement about which particular traits are most salient in large samples of individuals.

In addition to the traits of personality psychology, there has also been a focus on *temperament* and *character.* Interestingly, the word "temperament" comes from the Latin word for weather, suggesting the variable moods or dispositions of the individual. Every student of psychology and philosophy knows about the Greek temperaments that supposedly arise from the four elements of earth, air, fire, and water representing, respectively, temperaments characterized by sadness (melancholic), irritability (choleric), cheerfulness (sanguine), or sluggishness (phlegmatic). "Character" comes from the ancient Greek word indicating engraving, or to dig in, and thus refers to the individual qualities that have been etched into individuals in their developmental years. Early psychoanalytic theoreticians used the term *character* almost synonymously with the term *personality.* Freudian developmental stages were associated with oral, anal, and genital character. Character type also referred to the particular defense mechanisms and constellation of these mechanisms in the individual.

PERSONALITY DISORDERS AS CONCEPTUALIZED SINCE *DSM-III*

The creation of the "personality disorders" on Axis II in the *DSM–III* in 1980 was an initiative that has stimulated clinical and research attention to personality pathology as distinguished from symptomatic conditions (e.g., anxiety and depression). This initiative was preceded by an impressive history in psychology of describing and measuring personality traits and their consequences on quality

of life, and an extensive history in clinical psychiatry on the diagnosis of abnormalities of personality. The field is now faced with the daunting task of integrating the best from these traditions, and deriving descriptions of the personality disorders that provide reliable assessment and construct validity.

DSM–IV (American Psychiatric Association, 1994) describes a personality disorder as having four key elements: It has a pattern of inner experience and behavior (i.e., cognition, affectivity, interpersonal functioning, and impulse control) that deviates markedly from the cultures' expectations, it develops in adolescence or early adulthood and remains stable across the adult life span, it is inflexible and pervades a broad range of personal and social situations, and it leads to significant distress or impairment in functioning. The *International Classification of Diseases* (*ICD*) system is even more explicit about operational criteria for diagnosing a personality disorder in a yes–no manner before proceeding to assigning a specific personality disorder.

As outlined in *DSM-IV,* the first decision of the clinician is whether or not the patient meets these criteria for a personality disorder, and the second order decision is the type of personality disorder manifested. The patterns and types of inner experience and behavior that define specific personality disorders are described in 10 disorders, which in turn are grouped by heuristic and content reasons into three clusters of personality disorders. Cluster A includes paranoid, schizoid, and schizotypal personality disorders. Cluster B is composed of the antisocial, borderline, histrionic, and narcissistic personality disorders. Cluster C includes avoidant, dependent, and obsessive-compulsive personality disorders.

Difficulties with the *DSM* Approach

The intersection of advancing age and personality disorders brings to light difficulties and issues hidden in the whole personality disorder concept as conceptualized in *DSM.* Consider the issue of personality disorders and time, including aging. The *DSM* makes clear that a personality disorder diagnosis cannot be made on an individual younger than age 18, because that individual has not had time to consolidate a personality/disorder. In addition, there is the specification in the criteria that they must be enduring behaviors/traits that demonstrate consistency across time. But, there is little concern in the discussion about the other end of the life course. It is noted that in late life a diagnosis of Personality Change Due to a General Medical Condition is appropriate when enduring changes in personality occur as a result of physiological effects of a medical condition, such as a brain tumor (APA, 1994, pp. 631–632).

Thus, a consideration of the nature of personality disorders in the elderly provides a wonderful opportunity to consider all of the issues thus far ignored by the Axis II committee. These issues are: How does adult personality disorder change/remain the same across the adult life span, including old age; how do

cognitive changes that are common in old age affect personality/disorders; how does temperament, the biological component of personality and its disorders, change with age?

There is a strong, current conception that personality, and therefore personality disorders, remain stable in the adult years. There is research that substantiates the primacy of stability (Costa & McCrae, 1988). However, as is discussed in this chapter, the meaning of stability is heterogeneous, and the type of stability, and the nature of the measures of personality traits/disorders may lead to differing conclusions. Furthermore, empirical knowledge about how this complexity about change and stability intersects with advancing age in the human is quite meager indeed.

The 1980 creation of Axis II (i.e., the personality disorders) in *DSM–III* prompted a large group of empirical work on the personality disorders. It is argued here that whereas that initial burst of research activity has been quite informative, it is now time to access what has been accomplished and make adjustments so that the result is not simply more of the same. To date, much descriptive and phenomenological work at a cross-sectional level has been done. Relatively little of this work has been done with elderly populations. It is time to examine the theoretical conceptualization of personality disorders and to go beyond the nonvalidated checklists of *DSM–IV* Axis II. It is also time to utilize these theoretical conceptualizations in order to articulate longitudinal studies that could potentially explicate the mediating and moderating variables in the story of continuity and change in personality and personality disorders.

CURRENT RESEARCH DIRECTIONS IN THE FIELD OF PERSONALITY DISORDERS

The picture of personality and personality disorders in the elderly should be viewed in the overall context of research development in the field as a whole. The issues of concern for scientific theories of personality disorder have been noted elsewhere (Lenzenweger & Clarkin, 1996); normal personality and personality disorder, the state-trait issue, study populations and the epidemiology of the personality disorders, longitudinal course and life-span issues, genetic and biological underpinnings, and the validity of the personality disorders.

Whereas information is not extensive, personality disorder researchers suggest a general population prevalence for personality pathology in the range of 10% to 15% (Weissman, 1993). For example, a recently completed case identification study in a college student population confirmed a prevalence figure of approximately 10% (Lenzenweger, Loranger, Korfine, & Neff, 1997). Clearly, personality pathology is ubiquitous, but the prevalence is less well-estimated for the elderly population.

Normal and Abnormal Personality

The boundary between normal personality and personality disorder can be conceived of as a dimensional change or as a somewhat abrupt, clearly differentiated categorical one (Widiger, 1992). A related debate is whether or not normal personality traits, when exaggerated, become personality disorder symptoms. To put the issue somewhat differently, research to date has not addressed the comparability between the *DSM–IV* personality disorder classification, and the empirically based dimensional structures that define personality (Costa & McCrae, 1990).

Consistency Versus Change

A cardinal feature and basic assumption is that the personality disorders are enduring conditions that are traits rather than simply ephemeral states. The existing literature contains little longitudinal data, so this cardinal tenet is basically an assumption; the available empirical information consists of some data on the life course of antisocial personality disorder (Robins, 1966, 1978). Longitudinal studies do support the stability of normal personality traits in a number of age groups, including young adults (Finn, 1986) and even the elderly (Costa & McCrae, 1988).

The issue of change within a context of consistency is complicated by the fact that there are numerous ways to measure personality (i.e., self-report, observer data, test behavior) and there are numerous statistical definitions of change itself (Caspi & Bem, 1990). These concepts are important in order to appreciate the current research opinion that consistency in personality is greater than the amount of change. It is only with these concepts that it can be realized that this general statement has important exceptions.

Absolute stability refers to the constancy in the amount of an attribute over time. The most relevant example of this in the elderly literature is the work by Costa and McCrae (McCrae & Costa, 1990). They found evidence for consistency in personality traits as measured by the NEO–Personality Inventory in aging individuals. They noted little change in the amount or degree of traits over time. *Differential stability,* on the other hand, refers to stability of an individual within a group over time. For example, if person A ranks as 5 out of 100 people in amount of altruism, consistency is present if they keep that relative ranking over time whether or not the amount of altruism goes up and down over time in the group as a whole. *Structural stability* refers to the consistency of correlational patterns among traits across time. Thus, researchers may show that the factor structure of traits within a group of people remains the same across time. *Ipsative stability* refers to the continuity of the individual across time. The researcher can examine each individual for continuity or change across time and then group

individuals who have the same or similar patterns. Block (1971) found five male and six female types or typologies longitudinally.

In addition to describing the phenomena of continuity and change, scientists are interested in the factors that mediate and moderate continuity and change. Age, individual differences, developmental stages may all be mediators of continuity and change for the individual. Moderating variables—that is, variables that influence the change in time—could include genetic factors, environment factors, and person–environment interactions. This chapter emphasizes only several of the myriad of mediating and moderating variables of change on the personality and personality disorders in the elderly.

Biological Foundations

A promising area of research is the exploration of the genetic and biological underpinnings of personality and personality pathology. Genetic factors play an influential role in determining personality (Plomin et al., 1990). In contrast, research documenting the relation of genetic factors to personality disorders is more sparse. Another area of current speculation and research is the role of central nervous system neurotransmitters and personality traits and pathology. This material is reviewed later in reference to temperament and its potential change in the aging individual.

Validity

And finally, the issue of the validity of the personality disorders as currently defined in *DSM–IV* must be emphasized. Whereas the field is progressing in the reliable assessment of the personality disorders as defined on Axis II, this in no way guarantees the validity of these disorders as defined. There is, in fact, no clear benchmark or gold standard for validity in the personality disorder realm. Spitzer (1983) proposed a so-called LEAD standard (longitudinal data expert raters and the use of all available diagnostic information) in which the longitudinal study of personality disorders using expert raters could establish the validity of these conditions. Such a study does not exist at the present time in adults, let alone extend to the years of aging.

RESEARCH IN AGING AND PERSONALITY

The first issue of relevance to those interested in the elderly is the phenomenological, cross-sectional description of elderly who would be considered by clinicians to suffer from a personality disorder. Because the criteria for the presence of personality disorder were articulated without the elderly in mind, they must be examined for application to this age population. As noted earlier, *DSM–IV* (APA, 1994) described a personality disorder as a pattern of inner experience and

behavior that deviates markedly from the cultures' expectations, which develops in adolescence or early adulthood and remains stable across the adult life span. This pattern is inflexible and pervades a broad range of personal and social situations, and leads to significant distress or impairment in functioning.

This loose definition of the boundary between normal and abnormal personality raises issues as applied to the elderly. Notice the assumption that what has jelled by the end of adolescence remains stable across the entire adult life span. What are the cultural expectations about the personality of the elderly? Aging brings with it a certain amount of inflexibility, especially when the individual is hampered by medical illness or cognitive changes. What degree of inflexibility would be "inflexible" in this age range?

A major issue in the field concerns the nature of the border between personality and personality disorders. Some argue for the continuity between personality and personality disorders, others argue for a clear boundary between the two based on various notions of the difference. This is yet again another debate in the personality area that does not directly consider the elderly. It may be that the border between normal and abnormal personality is different, or should be defined differently at various points in the life span.

A second issue is, given the presence of a personality disorder in the elderly, what particular kind of personality disorder(s) does the individual have? The current criteria are based on data from young adult samples and may not relate to the way that geriatric patients express the symptoms related to personality disorders. Further, the taxonomy established by the *DSM* may not be as relevant for geriatric patients as for young adults. Symptoms may cluster together in different constellations as people age, and may be more or less predominant at different stages of life. Therefore, does the taxonomy of the current 10 personality disorders in *DSM–IV* map onto the types of personality disordered behavior that is observed in the elderly? There are reasons to think not. For one thing, many of the criteria in Axis II are behaviors (e.g., impulsive behaviors) that tend to dampen with age. The individual may no longer have those behaviors, and so would not meet the behavioral criteria for the disorder. Consider borderline personality disorder (BPD). The elderly individual may have had a history of impulsive behavior and suicidal behavior, but at this later age may only show the cognitive stigmata of BPD (i.e., identity diffusion). Thus, the individual would no longer meet the criteria for BPD. In contrast to the behavioral criteria, some of the cognitive criteria may become more prominent in the elderly. For example, some elderly become more obsessive and cautious. Another reason to doubt the applicability of the Axis II criteria to the elderly is the frequency of "not otherwise specified" (NOS) diagnoses in this population. This suggests that the disorder is present, but the typology is not rich enough to capture the individuals. For these reasons, there is enough concern to lead to research on the particular taxonomy of personality disorders with criteria that are more representative of elderly individuals.

There is a lack of epidemiological studies on personality disorders in older adults. The rates of illness cited in the literature, which average around 20%, are based solely on clinical samples. Most researchers agree that these rates are higher than what would be found in the general population, but, as yet, there are few educated guesses about what that rate would be.

Abrams and Horowitz (1996), in a study of personality disorders in elderly patients with comorbid Major Depression, found a rate of 18%. By far the most populous classification for patients with personality disorder diagnoses was NOS (36%), with the next highest category being Dependent (12%). This underscores the possibility that the taxonomy developed for *DSM* based on younger adults may not be the most accurate reflection of how personality disorders are expressed in geriatric patients.

Issues of Temperament

Another issue concerning the elderly and personality/personality disorders is the role of contributing variables to personality such as temperament and cognition. Personality researchers have appropriately emphasized the role of temperament in personality. Buss and Plomin (1975, 1984) suggested three fundamental temperaments: activity, emotionality, and sociability. Activity indicates the total energy output of the individual (i.e., busy, fast-moving vs. passive or lethargic). *Emotionality* refers to both the repetition and extent of emotional arousal. *Sociability* indicates the extent to which the individual craves the presence of others ranging from very gregarious individuals to those who are detached and loners.

Siever and colleagues (Siever & Davis, 1991; Siever, Klar, & Coccaro, 1985) articulated a dimensional model of temperament that involves four major areas: cognitive/perceptual organization, impulsivity/aggression, affective instability, and anxiety/inhibition. These dimensions are utilized to help understand various Axis I and Axis II disorders. Schizophrenia and schizotypal personality disorder, for example, are seen as disturbances in the cognitive/perceptual organization. The dimension of impulsivity/aggression would be manifested in explosive disorders, pathological gambling, and antisocial and borderline personality disorders. Siever and colleagues made speculations about these dimensions and their relation to biological systems.

Cloninger and colleagues (Cloninger, Svrakic, & Przybeck, 1993) hypothesized the presence of heritable dimensions of novelty seeking, harm avoidance, and reward dependence, each associated with neurobiological systems. *Novelty seeking* is the disposition toward the active seeking of novel stimuli and excitement. *Harm avoidance* is a disposition to avoid aversive stimuli, the avoidance of any form of punishment or novelty. *Reward dependence* is a proclivity to seek social approval.

Probably the most developed and sophisticated theoretical articulation of biological systems and personality is that by Depue (1996). Depue outlined an un-

derlying neurobiological system to understand three personality superfactors of positive emotionality, constraint, and negative emotionality. For example, Depue argued that the behavioral facilitation system (BFS) is a central component in positive emotionality, which involves incentive reward motivation, forward locomotion that supports goal acquisition, and cognitive processes related to active goal seeking. It is hypothesized that the four processes are mediated by two major ascending dopamine projection systems. Constraint relates to a core construct of affective and cognitive impulsivity and this system is hypothesized to be derived from the functional activity in central nervous system serotonin projections. Finally, negative emotionality highly related to Eysenck's trait of neuroticism is composed of traits that evoke a subjective experience of negative emotions such as anger, hostility, depression, anxiety, alienation, and proclivity to distress in response to life circumstances. Suggestions about underlying neurobiology of this negative emotionality are quite premature, but the locus ceruleus may modulate this affective system. Given the biological changes with aging, it is quite plausible that changes in temperament can lead to changes in the personality with age.

In each of these somewhat speculative but creative conceptualizations, it is quite plausible that with aging at least some of the temperamental substrates change enough to produce noticeable changes in behavior related to personality and the personality disorders. Activity, impulsivity/aggression, and novelty seeking are likely areas of temperamental change.

Cognitive Changes

A second variable that contributes to personality is cognition, and it too may change with age, manifesting concomitant changes in personality and personality disorders. Dementia and changes in personality and emotional expression is the extreme case of changes in cognition with aging and concomitant changes in personality traits and personality disorders. For example Lebert, Pasquier, and Petit (1995) examined the relation between affective change in frontal lobe dementia (FLD) and premorbid personality traits. Outpatients seen in a memory disorders unit were assessed with biological tests, and all fulfilled the *DSM–III–R* criteria for primary degenerative dementia. Moods assessed by patient interview and questionnaire included elation, flat affect, and emotionalism. Premorbid personality traits were assessed by a caregiver questionnaire assessing four personality traits clusters: paranoia, conscientiousness, obsession-compulsion, and extraversion. There was no correlation between premorbid personality traits with the affective state in FLD. Lebert et al. concluded that the affective states of elation, flat affect, and emotionalism were unrelated to the premorbid personality traits reported by the caregiver or relative. They assumed, therefore, that mood change in FLD is organically based. It is noted that personality change in the patient is cited by the families of these demented elderly as the most troubling aspect of the disease.

It is more difficult and challenging to study less extreme and more subtle changes in cognition and the way these might impact on personality. It is known that over the life span, impulsive aspects of the personality disorders, such as antisocial personality disorder, decrease, whereas dependent and obsessive-compulsive increase (Loranger, 1996). It could be speculated that doubts about people's cognitive abilities may lead to more dependency and more obsessive attempts at control.

Changes in Bodily Integrity

Aging brings with it both the issue of facing the finiteness of life and bodily changes, some of which are debilitating and eventually life threatening. How individuals, with their idiosyncratic crystallization of personality and personality disorders, cope with these changes is crucial for optimal adjustment in old age. The individual must cope with changes in physical appearance, changes in motor agility and speed, changes in cognitive speed, and various degrees of disability directly related to physical decline and illness. Is this process conceptualized as individuals with their personality coping with these changes, or do the changes bring about traitlike changes in the personality?

The term *disability* can refer to what the person can do (i.e., functional capacity) or to what a person actually does (i.e., behavioral disability). It is interesting and most relevant to the issue of personality that the correspondence between physical capacity and actual functioning is incomplete (Guralnik, Seeman, & Gill, 1994; Judge, Schechtman, Cress, & FICSIT Group, 1996). The temporal and causal relations between disability in the elderly, depressive symptoms, and comorbid conditions are not well-understood (Gurland, 1991).

The issues of change and stability in personality and personality disorders with aging is not just one of academic interest. There are serious practical family and clinical aspects to this issue. For example, irritability and hopelessness, more related to personality and to depression as a clinical syndrome, may be more important in the long-term adjustment of the elderly individual than just the resolution of acute depression itself. These and similar traits may shape the life satisfaction of both the elderly individual and the people in the environment. Social support, found to be so important to the life satisfaction and health of the elderly, may be heavily influenced for good or ill by such personality traits and their trajectory of change.

CONCLUSIONS

Despite major advances in the personality disorders since the field agreed on criteria for their diagnosis with the subsequent empirical research, there are major problems and potential areas of development in this area. Some of these diffi-

culties are general and beyond the realm of geriatric psychiatry, and others are highlighted by the consideration of aging and personality/personality disorders. A general issue is the empirical research without a general theoretical conceptualization to guide data collection and interpretation (Lenzenweger & Clarkin, 1996). A related issue is the general reliance on the *DSM* criteria, which are arbitrary and lacking in empirical validity, to guide the assessment process. Geriatric psychiatry would do well to avoid this limited approach that is prominent in adult psychiatry today. A third issue is the relevance of personality traits that relate to temperamental and biological mechanisms that can be articulated and examined. This approach should be encouraged in geriatric psychiatry. It is predicted that this dimensional approach will bear more fruit than a categorical approach based on an arbitrary diagnostic system on Axis II. What consistency is there if the realm of interpersonal behavior after the organism has developed beyond puberty? There is little information concerning what happens to this consistency as changes occur in old age related to memory and executive functions, temperamental variables, and dramatically changing life roles. As long as there is an almost exclusive emphasis on stability of personality disorders and traits, and ignorance of change and the mechanisms of change, the elderly and personality will be ignored.

The concept of personality disorder indicates a long-standing pattern of cognition, affectivity, and interpersonal functioning that is inflexible and leads to significant distress. The specific traits that describe the variety of ways this personality dysfunction can be manifested are currently captured in the 10 personality disorders of *DSM–IV.* Controversy remains over the differentiation, construct validity, and stability of these 10 disorders as currently conceptualized (Livesley, 1991). There is evidence that the personality disorders are a significant clinical issue with a prevalence rate of approximately 11% in nonclinical populations, and a higher prevalence of certain disorders in clinical populations. Most of the existing information is cross-sectional, and longitudinal studies are needed to describe both the long-term stability of these disorders and the mechanism of their impact on psychosocial adjustment and symptom disorders. Treatment approaches have been articulated for the personality disorders themselves, but this effort is in its infancy, and little has been done with the elderly. It has become clear in nonelderly adult samples that the treatment of Axis I conditions in the presence of personality disorders is slower and less beneficial than treatment for those without personality disorders.

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