

Personality disorders in the elderly

Peter Tyrer

Imperial College, London

Declaration of interest

I was the Chair of the World Health Organisation
ICD-11 Personality Disorder Revision Group
(2010-2017)

How am I going to retain your interest on this tiring day?

BY

1. Introducing you to the exciting world of ICD-11 personality disorder
2. Showing why you should take notice of personality disorder in your practice
3. Introducing the concept of Galenic syndromes and polypharmacy
4. Adding a note on dementia

What is the relevance of ICD-11 personality disorders to old age psychiatry?

- A. At least as relevant as for younger patients
- B. More relevant than in younger patients
- C. Less relevant than in younger patients
- D. Not really relevant at all

The failure of categories in ICD and DSM

- They describe a person as though they were characterised by a single set of personality traits
- We can recognise each categorical description but they do not represent real people
- They do not recognise that overlap is the rule, not the exception
- They make the diagnosis at around 18 years
- They are cartoon figures (Hogarth to Trump)



**A narcissistic
personality**



The histrionic personality



Some borderline personalities at play

rcpsych 2023



This is my antisocial personality face – don't you make fun of it - IF YOU DO I WILL EXACT **RETRIBUTION**

Bangash A (2022) – why categories in old age psychiatry do not work

The categorical approach to diagnosing personality disorders has little evidence to support its use in older people. Nearly a third of the personality disorder symptoms in the DSM-5's categorical model manifests differently in older people (van Reijswoud et al., 2021). A personality disorder diagnosis depends on behavioural manifestations that can be problematic in old age given the cognitive decline and somatic comorbidities that develop. For example, the criteria for antisocial personality disorder include physical activities such as aggressiveness that would probably decline in old age due to decreased strength. The dimensional approach, in contrast to the categorical model, appears to be age-neutral and more suitable to use in later life. The ICD-11 states that a personality disorder should present continuously for at least 2 years. Evidence suggests that this will probably raise the prevalence level of personality disorders in the population thus promoting the use of the diagnosis in older people. The dimensional model is helpful in that it

The exciting world of ICD-11 (January 2022)

- We are retaining the diagnosis of personality disorder but everything else has changed

ICD-11 general definition of personality disorder (World Health Organisation, 2018)

- Personality disorder is characterized by problems in functioning of aspects of the self (e.g., identity, self-worth, accuracy of self-view, self-direction), and/or interpersonal dysfunction (e.g., ability to develop and maintain close and mutually satisfying relationships, ability to understand others' perspectives and to manage conflict in relationships) that have persisted over an extended period of time (**e.g., 2 years or more**). The disturbance is manifest in patterns of cognition, emotional experience, emotional expression, and behaviour that are maladaptive (e.g., inflexible or poorly regulated) and is manifest across a range of personal and social situations (i.e., is not limited to specific relationships or social roles). The patterns of behaviour characterizing the disturbance are not developmentally appropriate and cannot be explained primarily by social or cultural factors, including socio-political conflict. The disturbance is associated with substantial distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

Main addition to ICD-10 definition

ICD-10 essentially confines manifestation of personality disorder to late adolescence or early adult life

ICD-11 will allow personality disorder to be diagnosed at any time in life if it has lasted for 2 years or longer

This allows the first diagnosis of personality disorder to be made in older people

Levels of personality dysfunction in ICD-11 – the personality spectrum



Cut –off point
for disorder

No personality dysfunction personality difficulty mild personality disorder moderate personality severe personality

Level 1 of ICD-11 – personality difficulty

Personality difficulty refers to pronounced personality characteristics that may affect treatment or health services but do not rise to the level of severity to merit a diagnosis of personality disorder.

Personality difficulty is characterized by long-standing difficulties (e.g., at least 2 years), in the individual's way of experiencing and thinking about the self, others and the world. In contrast to personality disorders, these difficulties are manifested in cognitive and emotional experience and expression only intermittently (e.g., during times of stress) or at low intensity. The difficulties are associated with some problems in functioning but **these are insufficiently severe to cause notable disruption in social, occupational, and interpersonal relationships and may be limited to specific relationships or situations.**

Level 2 of ICD-11 – mild personality disorder

All general diagnostic requirements for Personality Disorder are met. Disturbances affect some areas of personality functioning but not others (e.g., problems with self-direction in the absence of problems with stability and coherence of identity or self-worth), and may not be apparent in some contexts. There are problems in many interpersonal relationships and/or in performance of expected occupational and social roles, but some relationships are maintained and/or some roles carried out. Specific manifestations of personality disturbances are generally of mild severity. **Mild personality disorder is typically not associated with substantial harm to self or others, but may be associated with substantial distress or with impairment in personal, family, social, educational, occupational or other important areas of functioning that is either limited to circumscribed areas (e.g., romantic relationships; employment) or present in more areas but milder.**

-

Level 3 of ICD-11 – moderate personality disorder

All general diagnostic requirements for personality disorder are met.

Disturbances affect multiple areas of personality functioning (e.g., identity or sense of self, ability to form intimate relationships, ability to control impulses and modulate behaviour). However, some areas of personality functioning may be relatively less affected. There are marked problems in most interpersonal relationships and the performance of most expected social and occupational roles are compromised to some degree. Relationships are likely to be characterized by conflict, avoidance, withdrawal, or extreme dependency (e.g., few friendships maintained, persistent conflict in work relationships and consequent occupational problems, romantic relationships characterized by serious disruption or inappropriate submissiveness). Specific manifestations of personality disturbance are generally of moderate severity. **Moderate personality disorder is sometimes associated with harm to self or others, and is associated with marked impairment in personal, family, social, educational, occupational or other important areas of functioning, although functioning in circumscribed areas may be maintained**

Level 4 of ICD-11 – severe personality disorder

All general diagnostic requirements for Personality Disorder are met. There are severe disturbances in functioning of the self (e.g., sense of self may be so unstable that individuals report not having a sense of who they are or so rigid that they refuse to participate in any but an extremely narrow range of situations; self view may be characterized by self-contempt or be grandiose or highly eccentric). Problems in interpersonal functioning seriously affect virtually all relationships and the ability and willingness to perform expected social and occupational roles is absent or severely compromised. Specific manifestations of personality disturbance are severe and affect most, if not all, areas of personality functioning. **Severe personality disorder is often associated with harm to self or others, and is associated with severe impairment in all or nearly all areas of life, including personal, family, social, educational, occupational, and other important areas of functioning.**

Severe personality disorder is likely to be very rare in older people

What determines level of disorder?

- Degree of interpersonal social dysfunction and distorted self-perception
- Degree of pervasiveness
- Situational aspects
- Ability to perform societal roles
- Risk of harm to self or others
- Mental state comorbidity

Qualifying severity: Trait domains

Trait domain qualifiers may be applied to Personality Disorders or Personality Difficulty to describe the characteristics of the individual's personality that are most prominent and **that contribute to personality disturbance**. Trait domains are continuous with normal personality characteristics in individuals who do not have Personality Disorder or Personality Difficulty. Trait domains are not diagnostic categories, but rather represent a set of dimensions that correspond to the underlying structure of personality. As many trait domain qualifiers may be applied as necessary to describe personality functioning. Individuals with more severe personality disturbance tend to have a greater number of prominent trait domains.

Trait domains

- negative emotionality/negative affectivity
(equivalent to 'neurotic' in old terminology)
- detachment
- anankastia
- dissociality
- disinhibition

Relationship between domain traits and severity levels

- Each domain trait is a potential qualifier of each level of personality disturbance but not a diagnosis in its own right.
- A domain trait cannot therefore be judged in isolation – it has to be attached to the appropriate severity level

Trait Domains: Negative affectivity

Negative affectivity. The core feature of the Negative Affectivity trait domain is the tendency to experience a broad range of negative emotions. Common manifestations of Negative Affectivity, not all of which may be present in a given individual at a given time, include: experiencing a broad range of negative emotions with a frequency and intensity out of proportion to the situation; emotional lability and poor emotion regulation; negativistic attitudes; low self-esteem and self-confidence; and mistrustfulness.

Dissocial domain trait

Dissociality. The core feature of the Dissociality trait domain is disregard for the rights and feelings of others, encompassing both self-centeredness and lack of empathy. Common manifestations of dissociality, not all of which may be present in a given individual at a given time, include: self-centeredness (e.g., sense of entitlement, expectation of others' admiration, positive or negative attention-seeking behaviours, concern with one's own needs, desires and comfort and not those of others); and lack of empathy (i.e., indifference to whether one's actions inconvenience hurt others, which may include being deceptive, manipulative, and exploitative of others, being mean and physically aggressive, callousness in response to others' suffering, and ruthlessness in obtaining one's goals).

Anankastic domain trait

The core feature of the Anankastia trait domain is a narrow focus on one's rigid standard of perfection and of right and wrong, and on controlling one's own and others' behaviour and controlling situations to ensure conformity to these standards. Common manifestations of Anankastia, not all of which may be present in a given individual at a given time, include: perfectionism (e.g., concern with social rules, obligations, and norms of right and wrong, scrupulous attention to detail, rigid, systematic, day-to-day routines, hyper-scheduling and planfulness, emphasis on organization, orderliness, and neatness); and emotional and behavioral constraint (e.g., rigid control over emotional expression, stubbornness and inflexibility, risk-avoidance, perseveration, and deliberativeness).

Detached domain trait

The core feature of the Detachment trait domain is the tendency to maintain interpersonal distance (social detachment) and emotional distance (emotional detachment). Common manifestations of detachment, not all of which may be present in a given individual at a given time, include: social detachment (avoidance of social interactions, lack of friendships, and avoidance of intimacy); and emotional detachment (reserve, aloofness, and limited emotional expression and experience).

Disinhibited domain trait

The core feature of the Disinhibition trait domain is the tendency to act rashly based on immediate external or internal stimuli (i.e., sensations, emotions, thoughts), without consideration of potential negative consequences. Common manifestations of disinhibition, not all of which may be present in a given individual at a given time, include: impulsivity; distractibility; irresponsibility; recklessness; and lack of planning.

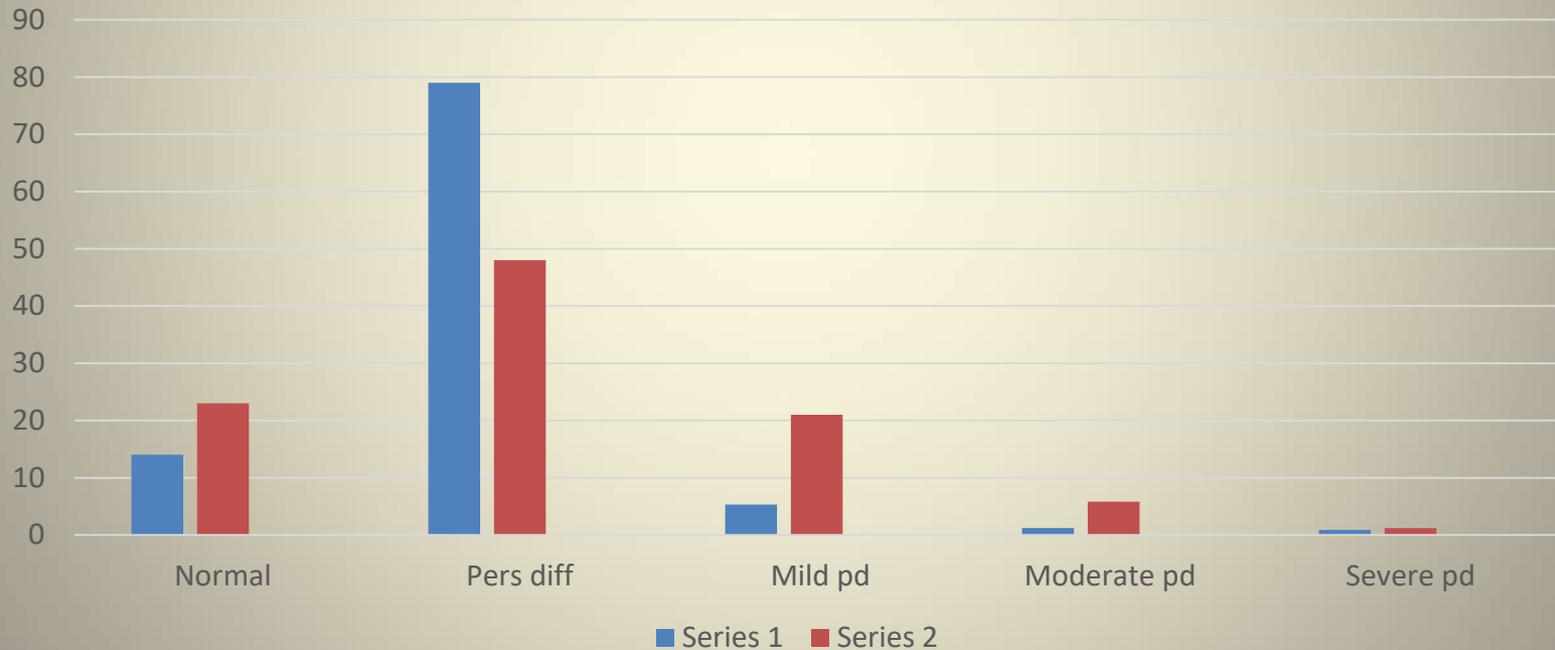
How many possibilities of classifying personality disturbance (if you wish)

Combining severity and domains you have 641 different options of classifying personality

So there is much room for variety

Distribution of ICD-11 personality disorders in general population

% distribution by severity level in Danish and English populations (Bach et al, 2023; Yang et al, 2010)



What are the implications of these figures?

- 1. Almost all patients in psychiatric care (and many with physical illness) have some personality disturbance
- 2. This is likely to be associated with other mental state disorders
- 3. We can no longer ignore this in our psychiatric management as it determines outcome

Many in old age psychiatry feel
that they left personality
disorder when they stopped
seeing younger patients

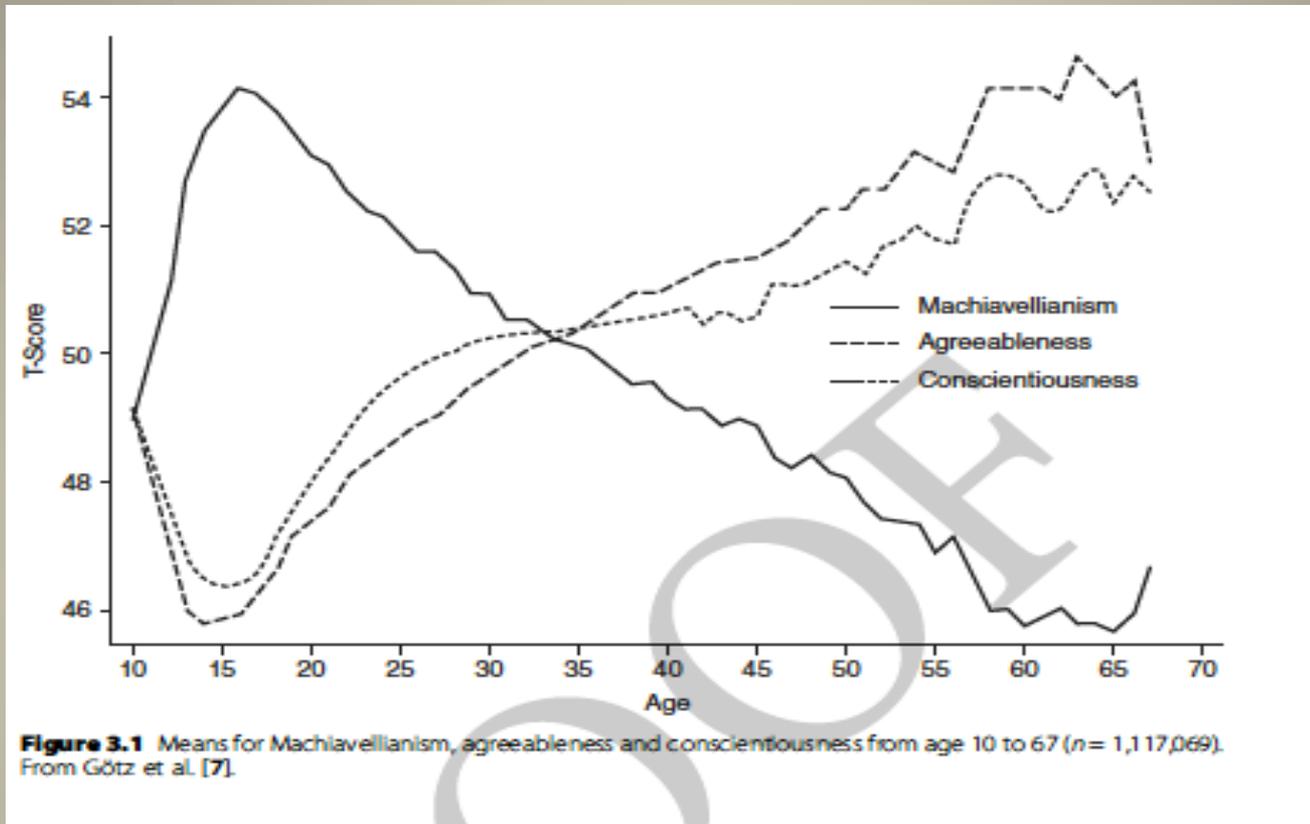


Figure from *Antisocial Personality* (Howard and Duggan (2022), Cambridge University Press), showing changes in the key components of antisocial personality characteristics over the life span

Machiavellianism is a personality trait that denotes cunningness, the ability to be manipulative, and a drive to use whatever means necessary to gain power.

Is this justified?

- To some extent it is, as antisocial personality characteristics get steadily less with increasing age, but other domains become more pronounced
- I now want to introduce you to a common Galenic syndrome

What are Galenic syndromes?

- Galenic syndromes are combined disorders of personality and mental state dysfunction in which their close nature indicates that they should be considered independently of both personality and mental state disorders
- They are named after Galen (192AD) who was the first to combine mental illness with personality status (choleric, melancholic, phlegmatic and sanguine personalities)

Editorial

Galenic syndromes: combinations of mental state and personality disorders too closely entwined to be separated

Peter Tyrer, Roger Mulder, Giles Newton-Howes and Conor Duggan



Summary

Many mental disorders are linked to personality, but this is rarely recognised in clinical practice. It is suggested here that when the links are very close, the two can be joined. Galenic syndromes are so named because Galen was the first physician to recognise the links between personality and disease.

Keywords

Alcohol disorders; anxiety disorders; autism spectrum disorders; personality disorders; nosology.

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Examples of Galenic syndromes

- A. The general neurotic syndrome: *the combination of anxiety and depressive symptoms (cothymia) and 'neurotic personality' (anxious, dependent worriers)*
- B. The Aristippian syndrome: *the combination of substance misuse and disinhibited impulsive personalities*
- C. The Diogenes syndrome: *the combination of social isolation and detached personalities*

The general neurotic syndrome

Background: It is now well known that both anxiety and depressive disorders in combination with personality disturbance have a significantly worse outcome than anxiety and depressive disorders alone

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INFLUENCE OF PERSONALITY ON THE OUTCOME OF TREATMENT IN DEPRESSION: SYSTEMATIC REVIEW AND META-ANALYSIS

Giles Newton-Howes, MRCPsych, FRANZCP,
Peter Tyrer, MD, FMedSci, Tony Johnson, PhD,
Roger Mulder, PhD, FRANZCP, Simone Kool, MD,
Jack Dekker, PhD, and Robert Schoevers, MD

Poor outcome more than doubled when personality disorder present

by consensus. Complex data extraction was completed within the study group. Data were synthesized using log odds ratios in the Cochrane RevMan 5 program. The finding of comorbid personality disorder and depression was associated with a more than double the odds of a poor outcome for depression compared with those with no personality disorder (OR 2.16, CI 1.83–2.56). This effect was not ameliorated by the treatment modality used for the depressive disorder. This finding led to the conclusion that personality disorder has a negative impact on the outcome of depression. This finding is important in considering prognosis in depressive disorders.

Nottingham Study of Neurotic Disorder

- Initial hypotheses (1982):
- (a) Personality diagnosis is more important than conventional clinical diagnosis in predicting the outcome of neurotic disorder
- (b) The outcome of neurotic disorder is independent of mode of treatment

- We also wanted to look at comorbidity closely

Nottingham Study of Neurotic Disorder

- Initial hypotheses (1982):
- (a) Personality diagnosis is more important than conventional clinical diagnosis in predicting the outcome of neurotic disorder.
- (b) The outcome of neurotic disorder is independent of mode of treatment.

Nottingham Study of Neurotic Disorder

- * Subsidiary hypothesis (1982):
- * (c) That patients with the general neurotic syndrome* (a combination of mixed anxiety and depressive disorders) with personality disorder in the obsessional or dependent group, would have the worst long-term outcome
- * Tyrer, P. (1985) Neurosis divisible? *The Lancet*, **325**, 685-688.

Plan of study

- ★ Patients: Those with a DSM-III diagnosis of GAD, panic or dysthymic disorder (using SCID (1983) interview)
- ★ Setting: General practice psychiatric clinics in Nottingham
- ★ Recruitment: Consecutive referrals to PT's clinical team over 4 years
- ★ Eligibility: Drug free at assessment, informed consent; no history of major psychiatric illness

Initial phase of study

- ★ Randomised controlled trial
- ★ 210 patients recruited with constrained randomisation to placebo (n=28), dothiepin (n=28), diazepam (n=28), self-help (n=42), cognitive-behaviour therapy (n=84)
- ★ Treatment for 6 weeks and then tapered to nil at 10 weeks (ie trial included both treatment and withdrawal phases)

The Lancet · Saturday 30 July 1988

**THE NOTTINGHAM STUDY OF NEUROTIC
DISORDER: COMPARISON OF DRUG AND
PSYCHOLOGICAL TREATMENTS**

P. TYRER
S. MURPHY
D. KINGDON
J. BROTHWELL
S. GREGORY

N. SEIVEWRIGHT
B. FERGUSON
P. BARCZAK
C. DARLING
A. L. JOHNSON¹

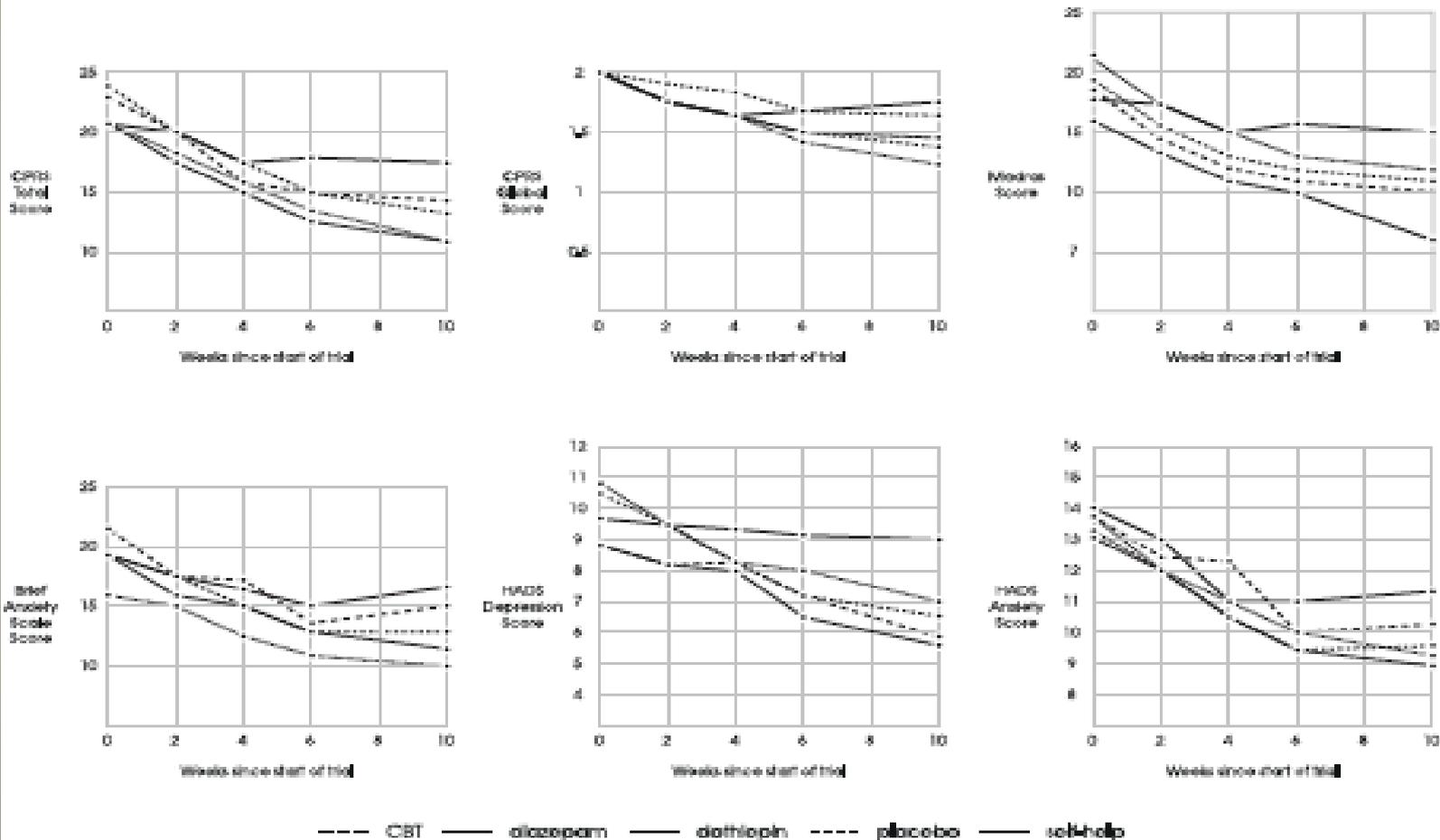
*Mapperley Hospital, Nottingham, NG3 6AA; and
Medical Research Council Biostatistics Unit, Cambridge¹*

Summary 210 psychiatric outpatients with
generalised anxiety disorder (71), or panic

over the relative merits of drug and psychological treatment and their specific diagnostic indications. In 1980 the diagnosis of panic disorder was introduced in the United States,¹ largely because of evidence that tricyclic antidepressants such as imipramine specifically "blocked" attacks.^{2,3} The benzodiazepine group of drugs was shown to be effective in treatment of generalised anxiety but less effective in panic disorder.^{5,6} Other studies have established that neurotic depression and mixed depressive states, also called atypical depression, and anxiety associated with hysterical and hypochondriac symptoms, were all helped by tricyclic antidepressants and monoamine oxidase inhibitors.⁷⁻¹⁰

Psychological treatments are also effective in an

CPRS = Comprehensive Psychopathological Rating Scale, MADRAS = Montgomery & Åsberg Depression Scale, BAS = Brief Anxiety Scale, HADS = Hospital Anxiety and Depression Scale (Anx and Dep separated)



Solid line = diazepam (significantly worse than other treatments)

Diagnostic outcome

- Diazepam worse outcome in all diagnostic groups
- Dysthymia (most of whom had cothymia (ie GAD as well as depression) had worst outcome
- Panic disorder had more severe anxiety symptoms but similar outcome to GAD

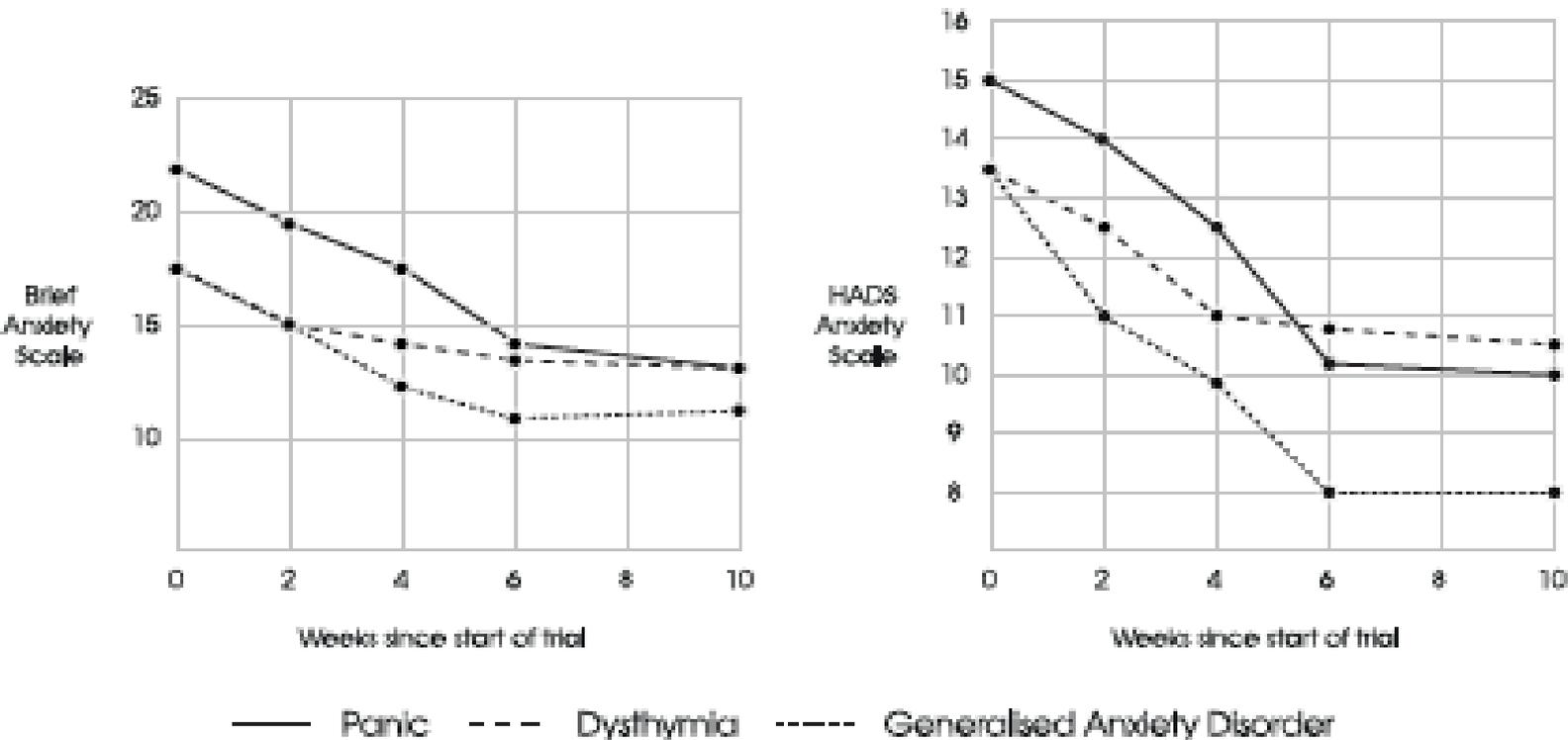


Figure 1: Mean observer (Brief Anxiety Scale) and self-rated (HADS) anxiety scores in patients with panic disorder (n = 73), dysthymia disorder (n = 63), and generalised anxiety disorder (n = 65).

Brief look at the general neurotic syndrome

Table 1. The General Neurotic Syndrome Scale

Positive characteristics	Score	Negative characteristics	Score
Simultaneous presence of syndromal anxiety and depressive disorders (cothymia)	+2	Persistent phobic and obsessional symptoms	-2
Variation in the primacy of depressive and anxiety symptoms at different times	+3	Symptoms of anxiety and depression only occur in response to immediate life events	-3
If symptoms of panic, obsessive-compulsive disorder and hypochondriasis are present they do not last longer than 3 months	+1		
Premorbid anxious or dependent personality disorder	+3		
Premorbid anankastic (obsessive-compulsive) personality disorder	+1	Premorbid impulsive, borderline or anti-social personality disorder	-3
At least one parent has mixed anxiety depressive syndrome (cothymia)	+2		
Total score (no general neurotic syndrome)	0-3		
Total score (likely general neurotic syndrome)	4-5		
Total score (definite general neurotic syndrome)	≥6		

Because work has suggested that the negative scores are a little high, a score of 4 on the scale is now indicative of the syndrome.

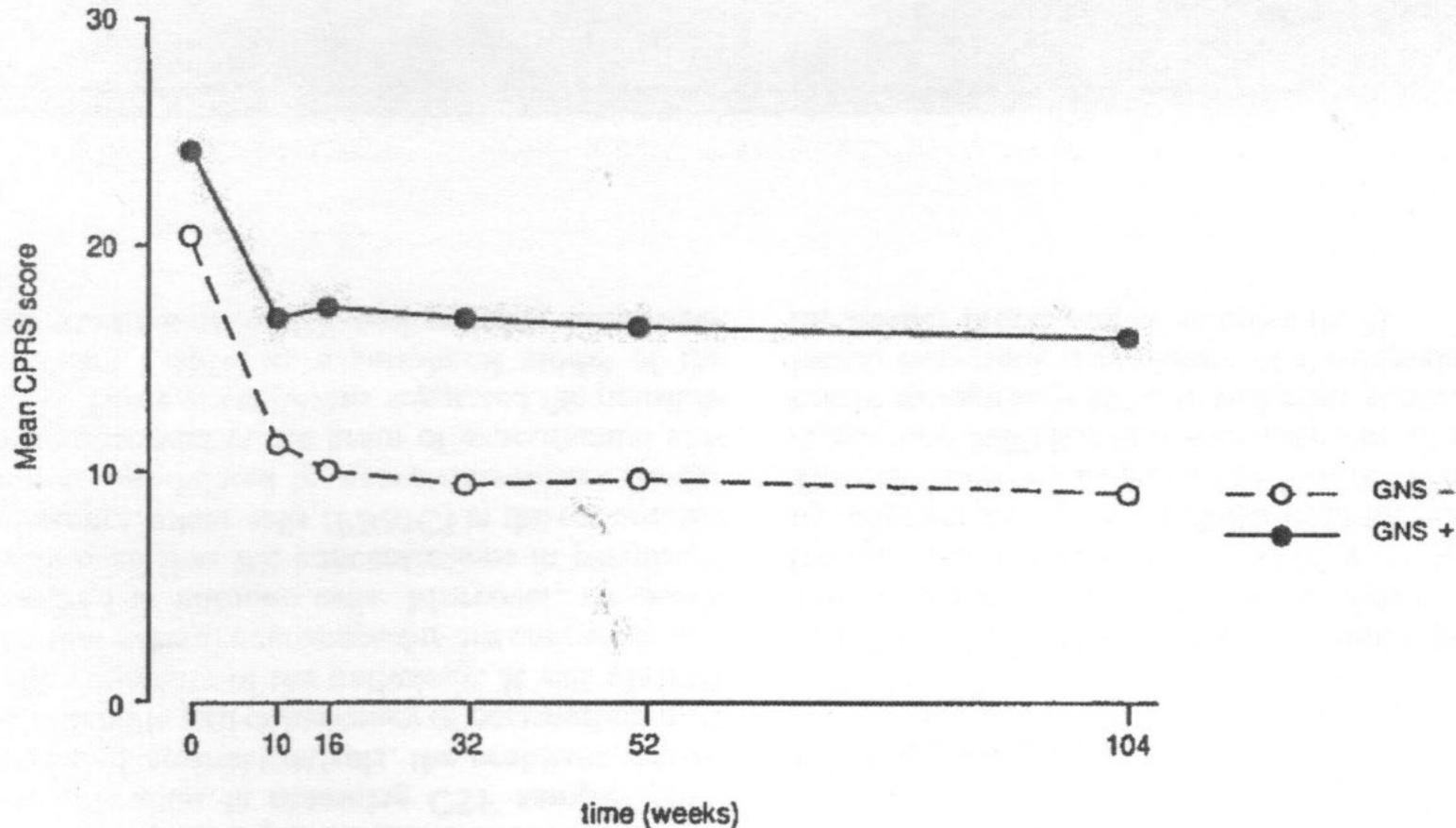
Why is the general neurotic syndrome important?

- Because it joins up the common mental symptoms of anxiety and depression with personality disturbance
- Unfortunately the personality aspects tend to be ignored in clinical practice
- They will not be ignored if you recognise the concept of Galenic syndromes

The general neurotic syndrome and its relevance to old age psychiatry

- More patients with the general neurotic syndrome have contact with psychiatric services than others
- Their anxiety and depressive disorders do not usually resolve
- They have a tendency to receive polypharmacy

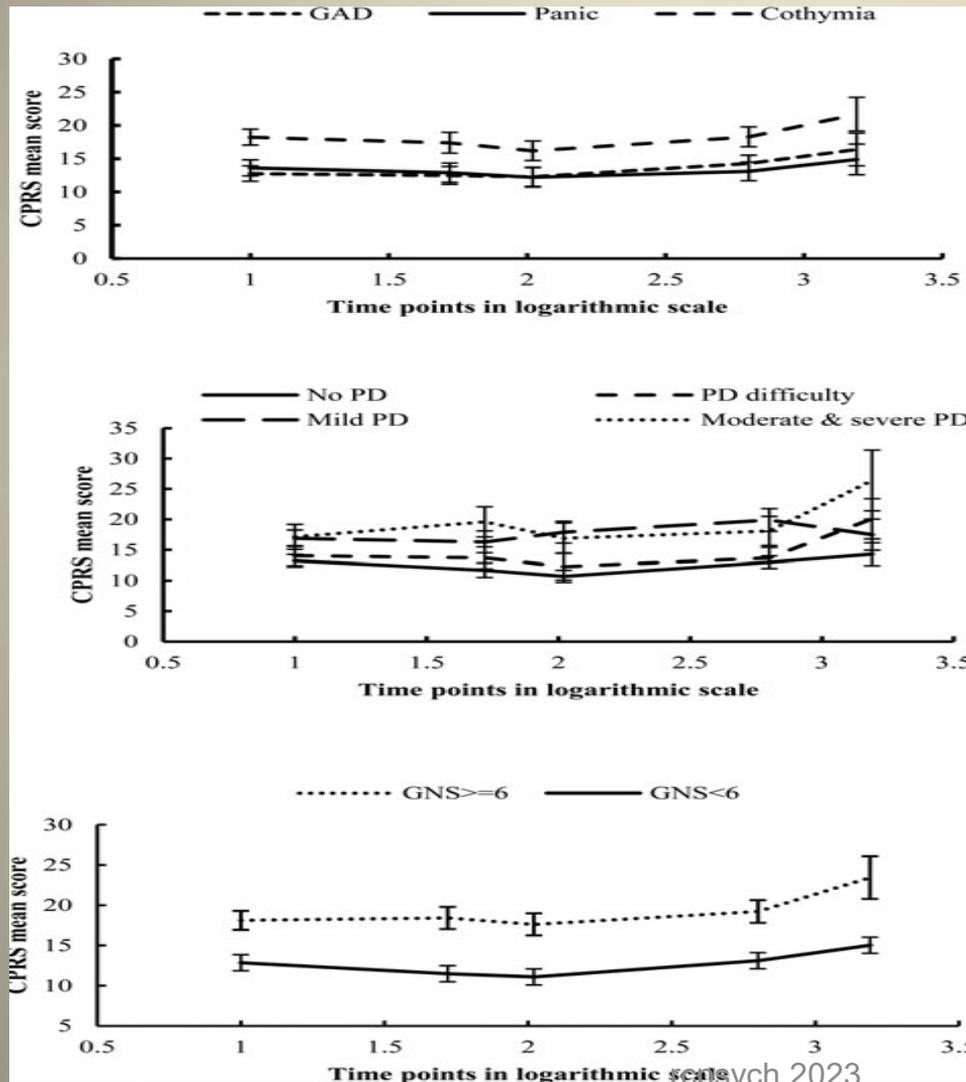
Two year outcome in those with and without the general neurotic syndrome (P<0.01)



Mean changes in total psychopathology scores (CPRS) for patients with the general neurotic syndrome (GNS +) (n = 66) and without (GNS -)

Tyrer P et al. Acta Psychiatrica Scandinavica, 1992, 85, 201-06.

Influence of personality, diagnosis and gns status over 30 year period



Tyrer et al (2022)
 Psychological Medicine,
52, 3999-4008.
 CPRS = Comprehensive
 Psychopathological Rating Scale

Note worse outcome over 30
 years in those with cothymia
 (mixed anxiety depression),
 moderate personality disorder
 and the general neurotic syndrome

Logarithmic scale used for better
 representation

Primary outcome

- Absence or presence of a significant DSM diagnosis (ie adjustment disorder, minor stress and adjustment disorders excluded) at assessment point
- Outcome suggested by Richard Doll (who said changes in ratings not recognized by patients)

Primary outcome overall

• Percentage with no diagnosis	12y	30y
• Generalised anxiety disorder	43%	42%
• Dysthymia (cothymia)	34%	27%
• Panic disorder	40%	59%
• Personality disorder– none at b/l	43%	56%
Pd present at baseline	25%	36%

Conclusions about primary outcome

- GNS and personality disorder worst outcome (but some recovery of pd at 30 years)
- Panic disorder has superior outcome, but only at 30 years (results supported by significantly better functioning also)

Results supported by NDOS (neurotic disorder outcome scale and SFQ (social functioning questionnaire)

Diagnosis	Mean NDOS at 30yr	Mean SFQ at 30 yr
GAD	1.58	8.15
Panic	1.22	5.88
Cothymia	2.35	9.93
Significance	P =0.016 rcpsych 2023	P=0.03

Long-term drug treatment (≥ 2 yr)

Drug	% taken for 2 yrs or more
MAOI's	0
Antihistamines	0
zopiclone	0
Benzodiazepine hypnotics	13
Benzodiazepine anxiolytics	21
fluoxetine	17
dothiepin	27
SSRI's	45
neuroleptics	50
paroxetine	78

3. Matters of concern

- If patients still unwell after receiving multiple treatments are the interventions of value?
- If patients had better more intensive treatment at the beginning would the results have been different?
- Why are drug treatments, especially SSRI's, being given for such long periods?

Influence of general neurotic syndrome on SSRI prescriptions

‘Over 30 years, patients with dependent and anankastic personality disturbance and cothymia (the general neurotic syndrome) were 2.27 times more likely to receive selective serotonin reuptake inhibitors (SSRIs) and new antidepressants (95% confidence interval [CI: 1.22–4.24), particularly paroxetine, and were 1.6 weeks (95% CI: 1.2–2.3) longer on the drug than those without the syndrome.’

Why might those with GNS have
more treatment?

Reasons

- More severe symptoms (true at baseline)
- Insufficient awareness of personality issues
- Fundamentally different course (ie many of others may only have had adjustment problems)
- Problems of dependence

Problems of dependence

- SSRI's may be very similar to benzodiazepines in their propensity to create dependence
- Those with shorter half-lives seem to be particularly at risk (eg paroxetine)
- Those with personality problems may be more at risk than others

Premorbid personality and withdrawal symptoms after gradual withdrawal of diazepam

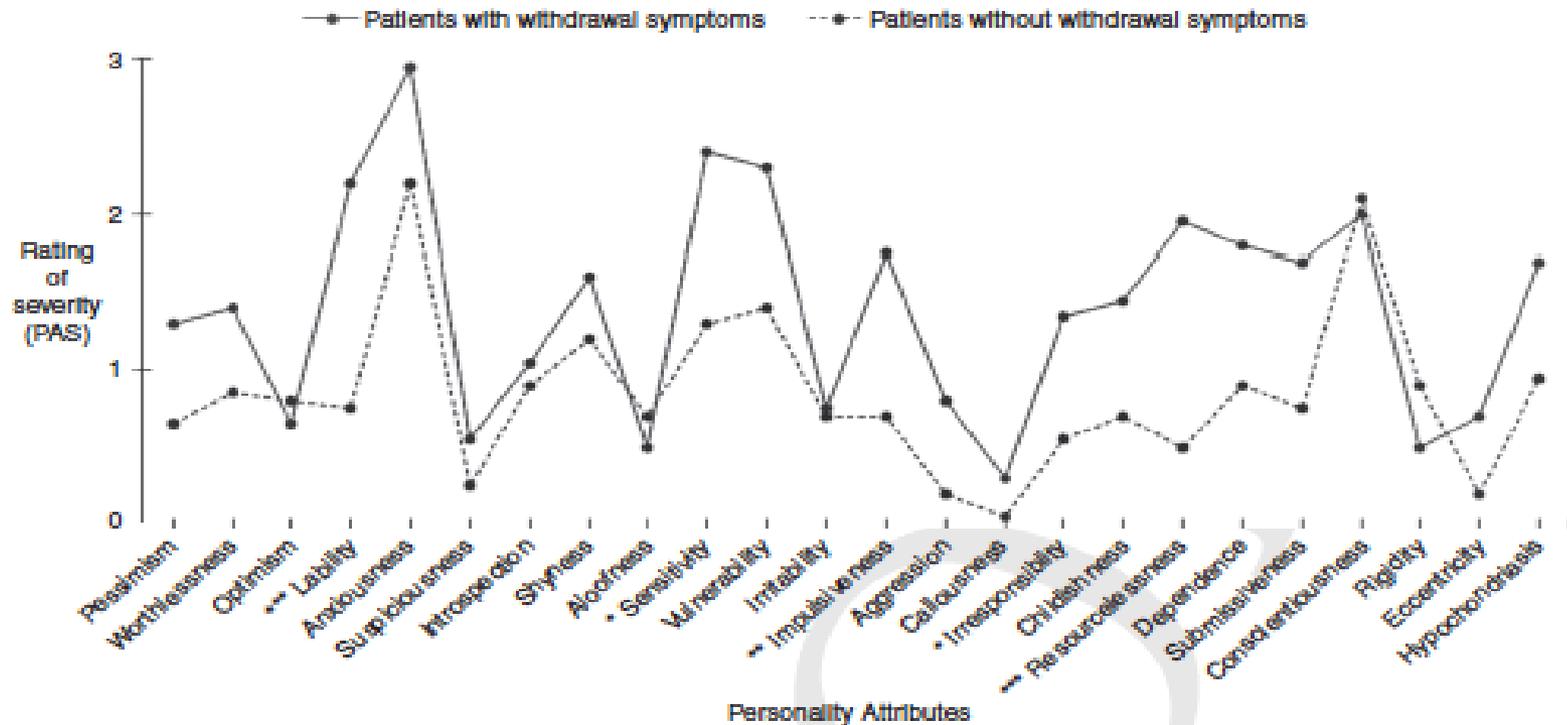


Figure 8.1 Personality characteristics (measured by the Personality Assessment Schedule (PAS) measured in patients on long-term benzodiazepine treatment before withdrawal of medication over six weeks. The patients with emotionally unstable (borderline) personality features were more likely to have withdrawal problems. (From Tyrer et al., 1983. Redrawn and reproduced by permission of the editors and publishers of the Lancet).

Last note on dementia

Reports from many quarters

- ***Trait anxiety, a personality risk factor associated with Alzheimer's Disease*** Song L et al, *Progress in Neuro-Psychopharmacology and Biological Psychiatry* Volume 1058 March 2021
- ***Henrique-Colado et al Personality disorders characterized by anxiety predict Alzheimer's disease in women: case-control studies.*** *Journal of General Psychology* Volume 147, Issue 4, Pages 414 - 4311 October 2020
- ***Terracciano et al Personality traits and risk of cognitive impairment and dementia.*** *Journal of Psychiatric Research* Volume 89, Pages 22 - 271 June 2017
- Neuroticism, high anxiety traits and conscientiousness (ie general neurotic syndrome) associated with higher rates of dementia compared with a control population

Late life personality disorders: Problems in assessment and management

Ayesha Bangash 

South West Yorkshire Partnership NHS Foundation Trust, Old Age Psychiatry, The Dales, Calderdale Royal Hospital, Halifax, UK

designs. Future revisions of diagnostic criteria should reflect the unique biopsychosocial aspect of late life. The timely identification of these patients is vital in order that they receive suitable management in their twilight years.

Personality and Mental Health, 2022, 16, 155-159

Conclusions

- We usually ignore personality status in old age psychiatry; this is unwise
- Galenic syndromes such as the general neurotic syndrome, need greater study
- Long term treatment is generally ineffective, may be unwise, and could be related to dependence

Do you want to know more?

