Personality disorders in later life: an update

ARTICLE

Ayesha Bangash

SUMMARY

Personality disorders can worsen with age or emerge after a relatively dormant phase in earlier life when roles and relationships ensured that maladaptive personality traits were contained. They can also be first diagnosed in late life, if personality traits become maladaptive as the person reacts to losses, transitions and stresses of old age. Despite studies focusing on late-life personality disorders in recent years, the amount of research on their identification and treatment remains deficient. This article endeavours to provide an understanding of how personality disorders present in old age and how they can be best managed. It is also hoped that this article will stimulate further research into this relatively new field in old age psychiatry. An awareness of late-life personality disorders is desperately needed in view of the risky and challenging behaviours they can give rise to. With rapidly growing numbers of older adults in the population, the absolute number of people with a personality disorder in older adulthood is expected to rise.

KEYWORDS

Personality disorder; personality; older people; borderline personality disorder; psychosocial intervention.

LEARNING OBJECTIVES

After reading this article you will be able to:

- understand how and why personality disorders can present in older people
- identify when personality changes are not due to personality disorders
- assess and treat late-life personality disorders, appreciating the challenges in managing them.

Approximately 9% of the world's population is 65 years of age or older. This proportion is expected to increase to 13% by 2035. This increase in the number of older adults is likely to result in an increase in the number of older adults with personality disorders (van Alphen 2023). As people get older and mature, they adopt ways of managing their psychic equilibrium to establish coping mechanisms or social scaffolding (Segal 2006: chap. 10). However, older people experience stresses due to periods of transition, losses and health problems that lead to dysfunctional behavioural and affective expression (Hall 2015). Thus, a person can be diagnosed with a personality disorder for the first time in old age. Later-life personality disorders are frequently comorbid with mood, anxiety and substance use disorders and are associated with an increased suicide risk (Brudey 2021). Age limits of 18–65 years are generally used in personality disorder research, along with exclusion criteria such as substance abuse, suicide risk and comorbidity. This limits the participation of older adults (Ekiz 2023). Lack of longitudinal data and age-appropriate diagnostic instruments, together with nosology that fails to account for age-related factors, have contributed to the dearth of research on personality disorders in older populations (Penders 2020). Limited awareness of late-life personality disorders can drive up mental health treatment costs because of staff time taken up by behaviours that take the form of psychological and somatic complaints: hospital admissions are costly alternatives (Molinari 2020). Early recognition and appropriate treatment are essential to improve the quality of life of affected individuals (Wu 2022). This article is an update of my previous article on personality disorders in later life (Bangash 2020), which was accompanied by a commentary (Tyrer 2020). The case vignettes are fictitious – no real patients are described.

Prevalence and onset

In general, the prevalence of personality disorders declines with increasing age (Brudey 2021). A national survey of psychiatric disorders in US older adults found that a prevalence of approximately 14.5%. Obsessive–compulsive personality disorder was the most prevalent, followed by narcissistic personality disorder. Dependent and histrionic personality disorders were the least common (Reynolds 2015). Paranoid, avoidant and dependent personality disorders are more prevalent in women (van Alphen 2023).

Challenges to using the evidence base to predict the longitudinal trajectories of personality disorder symptoms over time include age inclusion criteria, methodological variability, settings, length of

Ayesha Bangash, MBBS, MRCPsych, is a consultant old age psychiatrist with South West Yorkshire Partnership NHS Foundation Trust, Wakefield, UK. She did her higher training in old age psychiatry in the West Midlands. Since becoming a consultant in 2018, she has been working at The Dales, an in-patient unit for people with functional and organic disorders at Calderdale Royal Hospital, Halifax, UK. She has a research interest in old age psychiatry, particularly late-life personality disorders.
Correspondence Ayesha Bangash. Email: 520ayesha@gmail.com

First received 19 Feb 2024
Final revision 19 Jun 2024
Accepted 1 Jul 2024

Copyright and usage
© The Author(s), 2024. Published by Cambridge University Press on behalf of Royal College of Psychiatrists

https://doi.org/10.1192/bja.2024.41 Published online by Cambridge University Press

follow-up, presence of psychiatric comorbidities and presence or absence of a control group. Studies suggest that personality disorders, whether assessed categorically or dimensionally, are not as stable as previously thought. Symptomatic remission does not always lead to full recovery and many never fully participate in society (Hylton 2015; d'Huart 2023). Most studies have been cross-sectional, and therefore have not allowed for a definitive understanding of how the ageing process affects the extremes of personality (Molinari 2020). Expert opinion and case studies suggest that personality disorders can take four different courses to late adulthood. The first course is stable, with onset in adolescence or early adulthood. The second involves a personality disorder in remission and not meeting diagnostic criteria in old age. The third represents a re-emergent personality disorder, with temporary remission of symptoms in middle adulthood followed by the clinical features becoming prominent in old age. The fourth course depicts a late-onset variant of personality disorder whose presence was not evident in early adulthood (Rosowsky 2019).

Roles and significant others can compensate for people's difficulties and make personality disorders less maladaptive. The loss of a role or significant other can lead to a reversal of traits and hence the emergence of an old-age variant of a personality disorder. Buffering can occur when roles or significant others provide an interface between the patient and other people, thus protecting them from feedback or responses that can enhance maladaptive traits (Box 1). Binding occurs when a role or significant other suppresses maladaptive traits (Box 2). Bolstering takes place when a role or significant other strengthens the adaptive traits of a patient to reduce the manifestation of dysfunctional traits (Box 3). When roles or significant others are no longer in the picture, the personality disorder becomes apparent. This can surprise others who were not aware of the role or significant other serving as an auxiliary personality to make the personality disorder less maladaptive. Changes in circumstances (such as a move to a long-term care placement) or health status can also activate or reactivate dysfunctional behaviours (Segal 2006: chap. 10).

Clinical features

Paranoid personality disorder

In paranoid personality disorder there is a pervasive pattern of suspiciousness of others without adequate justification even when benign comments are made. Individuals believe that others are out to do them harm and will get into hostile confrontations with them to protect themselves. There is a preoccupation with jealousy and perceived infidelity of people they are romantically involved with. People with this disorder tend to experience social isolation, which exacerbates their paranoia as they are not being given the reassurance that would have occurred had they been in relationships. People can consider healthcare professionals to be untrustworthy and will refuse them entry into their homes. On admission to long-term care settings, patients may file complaints against staff for holding them against their will and multiple aspects of their care (Agronin 1999; Segal 2006: chap. 2).

Schizoid personality disorder

Individuals tend to be emotionally detached from social relationships in a pervasive way that is not linked to age-related losses. They experience little distress over this if their fiercely independent style is not threatened. Marriage is a rarity. People tend to be passive during the courtship and afterwards. Losing a spouse would not be as challenging for them as expected because the attachment to this person would have been less emotionally meaningful, given the emotional detachment. Grief would be more likely to occur for practical reasons, such as losing someone to do the cooking. They do not react well to situations in which they have to be in regular contact with other people, for example moving to a care home. They aim to leave hospital as soon as possible to avoid sharing rooms with other patients. Anxiety and eccentricity are common in later life (Agronin 1999; Segal 2006: chap. 2).

Schizotypal personality disorder

People with this disorder show a restricted range of expressions and inappropriate affect. They come across as bizarre and eccentric. Individuals may dress in a peculiar manner and have unusual thought patterns. Living in unhygienic conditions is not unusual and they can come across as unkempt and malodorous. The disorder can therefore be confused with a presentation of dementia. They have high levels of social anxiety and suspiciousness that can contribute to social deficits in care homes (Agronin 1994; Segal 2006: chap. 2).

Antisocial personality disorder

Homicides, accidents and suicide contribute to premature mortality in antisocial personality disorder (Brudey 2021). However, in contrast to younger individuals, older adults have lower levels of energy and are less physically aggressive (Holzer 2021). The disorder is therefore manifested through behaviours that require less energy, such as deception, interpersonal difficulties, hostility,

BJPsych Advances (2025), vol. 31, 173–185 doi: 10.1192/bja.2024.41

https://doi.org/10.1192/bja.2024.41 Published online by Cambridge University Press

BOX 1 Case vignette: moderate personality disorder with negative affectivity and detachment in accordance with ICD-11 dimensional model

History

Mr M was born to parents with chronic cannabis use. Social services placed him in foster care at an early age as his parents were not deemed fit to care for him. He was moved between foster parents a few times before reaching adulthood. His foster parents did not take much interest in him. He was bullied throughout his school life for being a foster child, quiet and the type to get easily upset. His schoolmates were too scared to be friends with him for fear of becoming targeted by the bullies. He was in the habit of writing a diary. It was the only friend he had and it helped him release his emotions and stress. The bullies stole his diary and read it out to other children and he became the subject of ridicule. He decided that people were not to be trusted: they were always going to demean or threaten him. Throughout his university life, he was exceptionally good at debating and English literature. However, he interpreted constructive feedback or humorous comments as threatening personal attacks. He would have conflicts with others even when it was pointed out that his allegations were unjustified. He was quick to react with anger and would hold long-lasting grudges against others. He was constantly scrutinising his peers and teachers and he would not open up to them. Any information divulged would be used against him. By the time he left university he had become socially isolated and embittered. He began to write crime novels and within 5 years, he had made a name for himself. At the same time, he was facing challenges. Any constructive feedback and offers of support from his editors implied that he was unable to do his work on his own. He refused to be interviewed on television as he did not want anyone knowing anything personal about him. He kept scrutinising his mail from fans and was having arguments with his editor over hidden meanings within it. As a consequence, his editors and agents frequently changed as they found him difficult to work with.

During his 30s, he met his wife Mrs M, who was also an author. It took them some years to get married as he found it very hard to believe that anyone could be loyal to him. She frequently liaised with his editor to ensure that editorial processes ran smoothly. She worked with Mr M's agent in handling fan mail. She encouraged Mr M to attend interviews either by helping him prepare for them beforehand or by sitting in them with him. Thus, she was able to shelter him from reactions that would enhance his paranoid behaviours. Owing to his wife's actions, Mr M enjoyed immense success for several years.

Mrs M died when Mr M was in his late 60s and he was having to manage his work without her support. His agent and editor, who had worked with him for 20 years, became alarmed on discovering his 'new' personality. He was handling their feedback on his work in a confrontational manner and was holding grudges against them. He wanted to be in control of his working relationship with them and kept challenging their loyalty and intentions even to the extent of accusing them of giving his ideas to other authors. They both felt that they were under constant scrutiny. Mr M stopped giving interviews as he believed that anything he said would be used against him. He would fly into rages over innocuous comments made by the editorial team that he deemed to be slurs on his character. His editor and agent told him that they were going to leave him unless he did something about his behaviour. They reminded him of the hard work they and his wife had undertaken to ensure his long and lucrative career. They suggested taking him to see his general practitioner (GP). Mr M did not think there was anything wrong with him but agreed to see his GP as Mrs M would never have wanted anything to happen to his career. The GP referred him to the community mental health team.

Psychiatric intervention

Mr M was seen by a psychiatrist. A collateral history was taken from the editor and agent. With Mr M's permission, the psychiatrist contacted previous editors who had worked with him. They said that his challenging personality became less discernible when Mrs M came into his life. However, the loss of Mrs M had reactivated his paranoid views of the world. The psychiatrist informed Mr M that he had a moderate personality disorder. Despite his behaviour towards others, he had been able to maintain employment. He had poor understanding of other peoples' perspectives and the effects of his behaviour on others. He could not develop and maintain close relationships. He had difficulty controlling his impulsive reactions to situations and considering the consequences of his behaviour. The trait domain of negative affectivity applied to Mr M as he had strong tendencies to get angry, bitter and be mistrustful. He also held grudges and would get worked up over perceived insults from others. The trait domain of detachment also applied to Mr M as he had no close friends and kept a distance from others. His personality disorder had not been apparent to his current agent and editor owing to Mrs M's buffering role between her husband and others. Mr M had an insecure attachment brought about by early life experiences causing mistrust in others.

The psychiatrist referred Mr M to a psychologist. The psychologist had a discussion with his agent and editorial team. He advised them to adopt a calm, reassuring and neutral attitude and not challenge any unreal thoughts, as that would reinforce them. Any factual questions should be asked in a non-threatening manner with awareness of non-verbal messages conveyed with body language. Mr M's fear and anxiety over his thoughts were real to him. Therefore, without validating his thoughts, he should be encouraged to talk frankly about his feelings. Mr M underwent cognitive–behavioural therapy. He was taught how to change his responses to his beliefs. Rather than responding to comments with anger or hostility, he had to learn more appropriate ways of dealing with his emotions. Progress was slow because Mr M struggled to trust the psychologist. However, he continued therapy as the agent and editor told him that they would leave if he ended it prematurely. A year later, they both said that he was still difficult to work with, but he was viewing the world differently.

occupational problems and irritability. There is often misuse of alcohol, marijuana, cocaine, heroin and nicotine. Depression, generalised anxiety disorder, manic episodes, panic disorder, agoraphobia, social phobia, post-traumatic stress disorder (PTSD) and specific phobias can occur (Holzer 2021, 2022). There is evidence that criminal offenders whose antisocial behaviours have been ongoing since childhood have higher rates of psychopathology compared with those whose behaviours occurred later (Holzer 2021).

Borderline personality disorder

Most individuals show periods of remission and relapse from early life to old age, and some demonstrate stable remission, although the related psychosocial disability and psychopathology can frequently be chronic (Ouwens 2022). Dysphoria, feelings of emptiness,

https://doi.org/10.1192/bja.2024.41 Published online by Cambridge University Press

identity disturbance, interpersonal difficulties and anger can persist into later life (Bourgeois 2015; Jo 2023). However, identity disturbance is not so clear in older people because life choices relating to marriage and careers may be less relevant. Impulsivity decreases with age (Hall 2015). Individuals' behaviour may be experienced as passive-aggressive by those caring for them. There are both unconscious and conscious wishes to have their needs met. People can idealise staff and become over-attached to some while denigrating and devaluing others (splitting) (Bourgeois 2015). Fear of abandonment and loss can be amplified as insecure attachment patterns are rekindled (Hall 2015). There is extensive use of healthcare services, including in-patient, substance misuse and emergency services for behavioural crises and overdoses (Bourgeois 2015). They may have exhausted relationships with significant others and thus have limited social support. Younger patients have higher levels of aggression and suicide attempts compared with older patients, who have higher levels of somatisation, depression, anxiety and functional deficits. Emotional dysregulation persists into old age. Self-harm manifests as substance misuse, poor treatment adherence, eating disorders and food or hydration refusal (Hall 2015; Ekiz 2023). Pain is more likely to be rated as severe. Opioid, alcohol and benzodiazepine dependence are common (Box 2) (Bourgeois 2015).

Histrionic personality disorder

Individuals can come across as superficial in nature. They struggle to cope with physical changes that accompany ageing. Throughout their lives they have relied on physical attributes and seductiveness to gain a feeling of interpersonal connectedness on a superficial level. Their response to ageing is to use anti-ageing techniques or attract attention via somatic and/or hypochondriacal complaints. They have relied on seductiveness for so long that they struggle to relate to people without trying to seduce them. Facing retirement can be problematic if the patient used the work environment to undertake seductive behaviours. Self-centredness can lead to negative responses from others in a care home setting, leading to petulance and irritability on the part of the histrionic individual. Core features such as arrogance, need for admiration and limited capacity for empathy generally do not improve with age. Their machinations can cause them to be alienated from family members (Agronin 1999; Segal 2006: chap. 3).

Narcissistic personality disorder

Being narcissistic is a defence construct to cope with feelings of insecurity. Narcissistic people require praise to maintain their self-esteem. Narcissistic injuries are experienced when people lose their power and prestige in old age. They cannot cope with age-related changes in their appearance or physical illnesses, as these would mean that they are vulnerable. Narcissistic defences that were part of the personality structure break down, leading to severe depression, particularly if some success was achieved in earlier life. Some older people feel a greater degree of powerlessness, which, in this case, may lead to the need for greater amounts of external admiration to compensate. They do not believe that they need help from others, as this would indicate that they are vulnerable. They may seek power through relationships with clinicians. They demand special consideration, such as seeing clinicians at their convenience and only seeing those who are exceptionally well qualified. Social isolation is common because of a long history of manipulating family members and coming across as demanding (Agronin 1999; Segal 2006: chap. 3).

Avoidant personality disorder

Individuals have intense social inhibition persisting into old age. They are extremely shy and long for relationships but they are afraid of being rejected or criticised. They struggle to replace relationships that they have lost and are reluctant to meet new people unless it is guaranteed that they will be liked. As a result, their limited networks shrink further. They do not apply for support because of worries over being evaluated (Box 3) (Segal 2006: chap. 4).

Dependent personality disorder

People with this disorder have a need to be taken care of. They fear being alone and need others to assume responsibility for them. Losing a spouse can be problematic as the person is in the unfamiliar position of depending on himself or herself. They turn to other family members as they cannot make decisions for themselves. Their neediness can become irksome, causing relatives to feel overwhelmed. Dependent individuals seek out supportive services and opportunities for greater dependence in later life (Segal 2006: chap. 4).

Obsessive–compulsive personality disorder

Individuals may have spent a lifetime of devotion to their work rather than developing relationships with others. On reaching old age, they do not have adequate social support networks in place. They struggle to depend on others. Not having to compromise with others in the way things are done makes them resistant to change. They believe that there is only one way to get things done and therefore they find it difficult to become flexible when they experience cognitive or physical impairment. Individuals can be offended when help is offered as

https://doi.org/10.1192/bja.2024.41 Published online by Cambridge University Press

BOX 2 Case vignette: late-life borderline personality disorder in accordance with the DSM-5 categorial model

History

Mrs X's childhood was characterised by her mother frequently leaving her alone at home to visit the pub. At school, she was an above-average student as she enjoyed studying. However, she would feel empty and lonely. By the time she was in university, she was having multiple short-lived relationships with young men. The men would struggle to handle her frequent changes in mood. Every time they would try to end relationships with her, she would fly into rages and hit them. She would also shower them with lavish gifts to prevent them from leaving her. When was in her mid-20s, Mr X, who had been one of the young men she had dated, married her and paid her university fees as she had no money left. She trained to become an occupational therapist, the role giving her a sense of fulfilment and immense joy.

Mrs X retired at the age of 68 because she had developed back and mobility problems. When she subsequently developed heart problems Mr X arranged for her to move to a care home as he was no longer able to care for her. She started asking the staff for increasing amounts of opioids for back pain. She also complained of various physical ailments of a non-specific nature. There were frequent mood swings and anger outbursts during which she would throw things at staff. She would praise a staff member, saying she was the best carer she had ever had, only to say the complete opposite the next day. She would talk about not fitting in and not knowing what to do with her life.

Psychiatric intervention

The general practitioner did not feel that Mrs X needed large doses of opioids and referred her to the local community mental health team as the care home staff were struggling to cope with her behaviours. She was seen by a psychiatrist and psychologist. Collateral information was obtained from Mr X. The psychiatrist diagnosed her with borderline personality disorder in accordance with the categorical model of DSM-5. In earlier life, she had presented with the features of this personality disorder but Mr X said that these disappeared during her work life and jokingly said work had kept her out of mischief. The psychiatrist said that Mrs X's work role had carried out the role of 'binding' in that it had inhibited the maladaptive behaviours of the personality disorder. The loss of her job role or lack of binding had led to the re-emergence of the dysfunctional personality traits.

The psychologist had a discussion with Mrs X about her former job description. She informed him that she had worked on a neurorehabilitation ward where she had organised group art, music and games sessions. The psychologist suggested that care home staff allow her to support them in arranging such sessions as well as contributing to planning routines for the care home residents. Over time, Mrs X's mood swings and anger outbursts became less frequent, and she required less intense opioid dosage regimens.

this would indicate that they are not in complete control. When help must be received, catastrophic depression can occur. They do not handle retirement well, particularly after achieving occupational successes. They become distressed over having to learn new routines. Relaxing after retirement is difficult for these people as they perceive this to be a waste of time (Agronin 1994; Segal 2006: chap. 4).

Personality changes not due to personality disorders

Maladaptive personality traits can occur due to medications (Table 1), physical health conditions (Table 2) and substance misuse (Table 3). Like personality disorders, autism spectrum disorder (ASD) can manifest in old age for the first time as a result of stresses such as the loss of social roles (Videler 2020) (Table 4). Dysfunctional personality traits can be seen in functional illnesses such as depression, anxiety and PTSD that resolve with treatment of the underlying mental disorder (Brudey 2021). The paranoia of a delusional disorder tends to be fixed, severe and resistant to treatment, whereas the paranoia of psychosis can be bizarre or fragmented and associated with hallucinations (Segal 2006: chap. 2). In contrast to a dementia, paranoid personality disorder is generally associated with an earlier age at onset; the paranoia heightens when the individual has to rely on strangers for help (Agronin 1999). Hoarding is common in both obsessive–compulsive personality disorder and dementia (Segal 2006: chap. 4). People with dementia can experience exacerbations or deteriorations in their personality traits, which can include aggressiveness, disinhibition, neuroticism, anger, impulsivity, apathy, lack of empathy, social withdrawal and dependency. Personality disorders are associated with subtle impairments in executive function, memory, processing speed and visuospatial abilities and therefore it can be hard to exclude an organic cause (Segal 2006: chap. 4; Brudey 2021). Changes in personality can be the earliest signs of Alzheimer's disease (Oltmanns 2011). Delirium is caused by an underlying medical condition and is not better explained by a neurocognitive disorder. The underlying cause can involve anything that stresses the baseline homeostasis of a vulnerable patient. Examples include metabolic derangements, infections and surgery. Hyperactive delirium can present with emotional lability, psychosis and combative behaviours; hypoactive delirium can present with confusion, apathy and a withdrawn attitude (Ramírez Echeverría 2022).

Diagnosis

Assessment

Assessing personalities using several different methods is likely to improve the accuracy of

https://doi.org/10.1192/bja.2024.41 Published online by Cambridge University Press

BOX 3 Case vignette: avoidant personality disorder in accordance with DSM-5 alternative model for personality disorders (AMPD)

History

Ms A's parents were strict disciplinarians at home, although her father was hardly around owing to the nature of his work (an air force pilot). Ms A was studious but was often criticised by her parents for not doing well enough. She felt that her classmates were not only better than her but that they were constantly judging her. She went to university to escape the critical environment of home. She desperately wanted to feel connected to others but, to avoid disapproval, she joined societies with smaller numbers of students. Teachers and peers found her to be a rather shy person who rarely spoke. She would anxiously study others for signs of approval or rejection and made friends with only a few people who she thought would like her as they had a mutual interest in animals. However, she steered clear of social opportunities to avoid feeling shame and embarrassment. She took up jobs in small veterinarian clinics and pet sitting as she preferred to avoid people and instead talk to animals 'who would never judge her'. Her friends expressed disappointment at this. With her abilities in science and maths, they felt she could have done much better for herself. Her friends introduced her to several men, but any relationships with them were brief and unsuccessful. She would reject them to avoid being rejected by them. She was anxious that she would be viewed in a negative light and she struggled to open up to them for fear of ridicule and shame. She was terrified that they would find her unappealing.

At the age of 65, Ms A developed heart and back problems and had to move to a care home and retire from her work with animals. Staff found her behaviour worrying. Ms A preferred to spend long periods in her room. She would leave the dining room and group activities earlier than other residents. She would become intensely anxious and distressed when staff tried to engage her more with others. It was noticed that she liked to participate in pet therapy but, when spoken to by staff or residents during sessions, she would stammer or blush. When teased by other residents in a good-natured way, she would become anxious.

Psychiatric intervention

Staff discussed Ms A with the general practitioner (GP) covering the care home, saying that they were struggling to understand her personality. Moreover, she was not adjusting to her new environment. The GP and the staff had a discussion with Ms A, advising her to accept a referral to the community mental health team (CMHT) as she had to stay permanently at the care home and needed support in adjusting to this. Ms A reluctantly agreed but did not want to be involved with many professionals. The GP spoke with the CMHT, who decided to send a psychiatrist and psychologist to review Ms A.

The psychiatrist and psychologist interviewed Ms A and the care home staff. They took a collateral history from her friends. The psychiatrist confirmed a diagnosis of avoidant personality disorder in accordance with the DSM-5 alternative model for personality disorders. There was moderate impairment in personality functioning manifested by difficulties in identity; she believed herself to be socially inept and unappealing. As regards self-direction, she had been reluctant to pursue goals in careers related to maths or science and had instead taken on jobs with animals to limit interpersonal contact. She was preoccupied with rejection or criticism by others and would avoid them owing to a worry that she would not be liked. There were also personality traits of anxiousness, withdrawal and avoidance of intimacy. The psychologist felt that the personality disorder was not diagnosed earlier in life because the roles with animals augmented or bolstered Ms A's adaptive traits, thus reducing the expression of maladaptive characteristics.

The psychologist and the staff arrange for Ms A to join pet therapy with two residents. The number of residents attending was slowly increased over time. Some months later, Ms A was encouraged to attend other group activities with initially small numbers of residents that were slowly increased over time. The psychologist and staff hoped that Ms A's problems would be easy to manage owing to the fact that the care home was not a large one and she would gradually feel more at ease with everyone. The psychologist also introduced cognitive–behavioural therapy, which focused on reducing negative thought patterns and building social skills. Several months later, Ms A was able to say that she did not feel as unlikeable as she had previously and that she was able to attend a variety of activities with less apprehension about being judged.

personality disorder diagnoses. Assessment involves the collection of observational data, biographical data, informant data and medical records (including old paper and electronic records) (Wu 2022). Personality disorders, in general, are difficult to assess in older adults. There is low reliability of retrospective history, given the amount of time passed since childhood (Holzer 2022). People with avoidant and dependent personality disorders have a desire to please others. They are often respectful and adhere to treatment and therefore a personality disorder will not be considered. Those with cluster A and cluster B personality disorders may be dismissed as eccentric. Patients are often unaware of dysfunctional traits (Hall 2015). Those with a history of trauma may struggle to disclose sensitive information and therefore clinicians should allow time for patients to develop trust in them. Longitudinal clinical encounters aid in a diagnosis (Brudey 2021). It can be useful to examine personality disorders during periods of significant transition because the enduring behavioural and affective expressions will be magnified during these phases (Oltmanns 2011). Despite the difficulties in assessing personality disorders, an accurate diagnosis is crucial to ensure a nuanced intervention approach (van Alphen 2023).

Diagnostic criteria

The DSM-5 diagnostic criteria for personality disorder are based on the categorical model (American Psychiatric Association 2022). They lack face validity for older adults and can be contextually inappropriate: for example, older patients with antisocial personality disorder may be physically

https://doi.org/10.1192/bja.2024.41 Published online by Cambridge University Press

TABLE 1 **Medications causing psychiatric side-effects that can affect personality**

Medication	Psychiatric side-effect
Aciclovir	Psychosis and lethargy
Amantadine	Depression, anxiety, mania, psychosis
Aminoglycosides	Psychosis
Angiotensin-converting enzyme inhibitors	Fatigue, depression, hallucinations, mania, delirium
Anticholinergics	Depression, anxiety, psychosis
Antitubercular agents	Depression, anxiety, psychosis
Baclofen	Depression, anxiety, mania, psychosis
Benzodiazepines	Anxiety, aggression, mania, psychosis
Betablockers	Psychosis, delirium
Calcium channel blockers	Lethargy, mood disorders, psychosis, delirium
Cephalosporins	Mania, psychosis
Chloroquine	Anxiety, depression, psychosis
Digoxin	Apathy, depression, psychosis, delirium
Disulfiram	Depression, anxiety, mania, psychosis
Esomeprazole	Confusion, agitation
H_2 receptor antagonists	Lethargy, anxiety, agitation, hallucinations, delirium
Isosorbide dinitrate	Anxiety, hypomania, agitation, psychosis, delirium
Ketoconazole	Decreased libido, mood disorders, psychosis
Lamotrigine	Irritability
Levetiracetam	Emotional lability, depression, agitation, aggression
Levodopa	Depression, anxiety, mania, psychosis
Lignocaine	Delirium, mood changes, confusion, psychosis, lethargy
Methotrexate	Irritability, delirium
Methyldopa	Depression
Montelukast	Irritability, anger, agitation
Non-steroidal anti-inflammatory drugs	Psychosis, fatigue, anxiety, agitation, mood disorders
Opioids	Depression, anxiety, mania, psychosis
Penicillin	Anxiety, irritability, encephalopathy, hallucinations
Quinolones	Mood disorders, psychosis
Sedating antihistamines	Agitation, psychosis, delirium
Selective serotonin reuptake inhibitors	Agitation, nervousness, anger, restlessness
Statins	Depression, anxiety
Steroids	Mania, depression, psychosis, delirium, agitation, euphoria, anxiety
Stimulants	Mania
Thiazine diuretics	Depression
Trimethoprim	Depression

unable to assault others. Items such as 'Avoids occupational activities' and 'Prefers solitary activities' cannot be easily applied to older adults whose occupational, physical and social circumstances may constrain their behaviours (Brudey 2021; Wu 2022). The DSM-5 criteria were created for younger people and do not relate to age-specific changes in older adults regarding behaviours and interpersonal functioning. The dichotomous approach used by the categorical model (you either have a personality disorder or you do not) lacks sensitivity. In contrast, a dimensional model allows for varying degrees of severity of personality disorder pathology. It considers 'personality' on a continuum ranging from very healthy to extreme personality impairment (van Alphen 2023). Although the categorial approach was retained in DSM-5, a dimensional model referred to as the alternative model for personality disorders (AMPD) was included in section III to stimulate further research. The AMPD and ICD-11 (World Health Organization 2019) use a dimensional conceptualisation that entails impairments in self and interpersonal functioning to describe the severity of personality disorders. Maladaptive personality trait domains can delineate differences in their expressions. Dimensional assessments allow a more meticulous assessment of features, therefore the AMPD and ICD-11 could offer new approaches for diagnosing personality disorders in older adults (Oltmanns 2021).

ICD-11's dimensional approach to diagnosing personality disorders is supported by the view that they are only 'relatively' stable. Symptoms can undergo alternating increases and decreases, accommodating other presentations, such as re-emergence after a period of relative dormancy in middle

https://doi.org/10.1192/bja.2024.41 Published online by Cambridge University Press

TABLE 2 **Medical conditions causing personality changes**

Condition	Personality change
Alcohol misuse	Decreased conscientiousness, increased extraversion, reduced emotional stability, decreased agreeableness, cognitive impairment
Anterior cingulate syndrome	Apathy, withdrawal
Basal ganglia dysfunction	Psychosis, irritability, mood lability
Brain tumours	Depression, mood changes, apathy, disinhibition, confusion, aggression
Corticobasal ganglionic degeneration	Inflexible behaviour, emotional lability, suicidal behaviours, confusion psychosis, depression
Demyelinating conditions	Fatigue, depression, mood changes, anxiety
Encephalitis	Low mood, anxiety, frustration, aggression, impulsivity, disinhibition, poor emotional regulation
Environmental toxicants (e.g. lead, mercury)	Mood changes, depression, anxiety, irritability
Epilepsy	Fetishism, irritability, apathy, exhibitionism, aggression, timidness, hypersexuality
Huntington's disease	Depression, negativity, anxiety, compulsiveness, restlessness
Hyperadrenocorticism	Irritability, anxiety, depression, confusion
Hyperthyroidism	Irritability, anxiety, restlessness, fatigue, confusion, mania, depression
Hypoadrenocorticism	Fatigue, agitation, mood changes, psychosis
Hypothyroidism	Confusion, fatigue, mood changes
Orbitofrontal–subcortical circuit syndrome	Blunted emotional experience or emotional dysregulation, social inappropriateness
Parietal lobe dysfunction	Social withdrawal, apathy, disinterest
Parkinson's disease	Inflexibility, shyness, pessimism, dissociality, frugality, cautiousness, features similar to those of obsessive–compulsive personality disorder
Pernicious anaemia	Depression, anxiety, irritability, poor concentration, confusion
Post-concussion disorder	Social or sexual inappropriateness, irritability, aggression on little provocation, anxiety, depression, apathy, emotional lability
Progressive supranuclear palsy	Rigid perfectionism, restricted affectivity
Sensory impairment	Paranoia, hallucinations
Stroke	Self-centredness, apathy, decreased motivation, depression, anxiety, disinhibition, aggression, agitation
Systemic lupus erythematosus	Confusion, paranoia, anxiety
Temporal lobe dysfunction	Paranoia, rage, aggression, altered sexual behaviour
Thalamic dysfunction	Euphoria, apathy

adulthood. ICD-11 also admits 'late-onset' personality disorder, where diagnosis is made for the first time in later life (World Health Organization 2019). DSM-5 also admits late-onset personality disorder, but requires that other medical conditions or substance use disorders are excluded before it can be diagnosed (American Psychiatric Association 2022).

Diagnostic tools

Available instruments, mostly designed for younger adults, are not automatically applicable to the elderly. Hence, there is a need for age-appropriate instruments. Studies have either validated existing instruments in older adults or examined their age neutrality (Penders 2020). Completing self-report instruments requires sustained attention, the ability to think abstractly and reflect on oneself. These tasks can be challenging for older individuals with cognitive or physical disabilities. Therefore, instruments for older adults should be brief and simple (Wu 2022). On a positive note, research on assessing personality disorders in older adults is growing. Recent studies show that there are now many validated brief, age-neutral instruments of the self-report type. However, they are for general or highly specific populations (Penders 2020).

The Gerontological Personality Disorder Scale (GPS) has been validated in older adult out-patient settings. There are patient and informant versions of this tool (Brudey 2021). The Severity Indices of Personality Problems Short Form (SIPP-SF), the Personality Inventory for DSM-5 Brief Form (PID-5-BF) and the GPS are brief instruments that seem helpful for evaluating personality functioning and dysfunctional personality traits. However, as studies using them were undertaken in the general population or smaller samples, the results may have limited generalisability. In all, these studies have highlighted that expressions of personality functioning (criterion A) can be more assuredly compared and evaluated over age groups than maladaptive personality traits (criterion B) (Penders 2020). The Personality Inventory for DSM-5 Brief Form Plus Modified (PID-5-BF+M) is a self-report tool that assesses maladaptive personality traits in

BJPsych Advances (2025), vol. 31, 173–185 doi: 10.1192/bja.2024.41

https://doi.org/10.1192/bja.2024.41 Published online by Cambridge University Press

TABLE 3 Substance misuse causing personality changes

Substance	Short-term effects	Long-term effects
Alcohol	Confusion, poor concentration, disinhibition, poor judgement, euphoria, drowsiness, relaxation, talkativeness, dizziness, fluctuating mood	Anxiety, depression, psychosis, anger, decreased conscientiousness, cognitive impairment, sleep disturbances, reduced libido, reduced motivation, slowed reaction time, decreased extraversion
Amphetamines	Quicker reaction time, feeling energetic, excitability, increased attentiveness, hostility, anxiety, panic, derealisation, increased concentration, euphoria	Cognitive impairment, paranoia, hallucinations, violence, depression, obsessive behaviours
Cannabis	Mistrust, fear, hallucinations, relaxation, euphoria, panic attacks, change in perception of time, altered sensory perception, fluctuating mood, inattentiveness, poor short-term memory, depersonalisation, mania, delirium, derealisation	Psychosis, poor concentration, anxiety, depression, cognitive impairment, suicidal thoughts, difficulty with learning
Cocaine	Excitability, talkativeness, restlessness, heightened sexual desire, violence, anxiety, paranoia, depression	Cognitive impairment, psychosis, mood swings, depression, paranoia, panic attacks
Hallucinogens (e.g. LSD, psilocybin, ecstasy)	Hallucinations, fearfulness, euphoria, relaxation, insomnia, odd behaviours, fearfulness, panic attacks, confusion, agitation	Cognitive impairment, psychosis, intrusive flashbacks, anxiety, depression, suicidal ideation
Heroin	Euphoria, mood swings, confusion, drowsiness, agitation	Insomnia, depression, antisocial personality traits, impaired impulse control, indecisiveness, cognitive impairment, social withdrawal, anxiety

accordance with the AMPD and ICD-11. It has construct validity for older adults. However, research on the age neutrality of the instrument is still needed (Facon 2023).

The Hetero-Anamnestic Personality Questionnaire (HAP) has been validated in older adults in long-term care and is used by informants (Brudey 2021). It has good to excellent interrater reliability, construct validity and internal consistency (Wu 2022).

So far, the Personality Inventory for ICD-11 (PiCD) is the only self-report tool that has been designed specifically to assess the five personality trait domains. Evidence has shown multi-method validity for the PiCD and for its informant version, the Informant-Personality Inventory for ICD-11 (IPiC). Both can be used for the assessment of the ICD-11 domains in older adults. The IPIC and PiCD are associated significantly with important life functioning areas, including health, social and satisfaction variables (Oltmanns 2021).

The Level of Personality Functioning Scale (LPFS) is used to assess criterion A of the AMPD. Evidence supports the reliability and validity of the LPFS in older people using Life Story Interviews and suggests that personality functioning ratings may have utility in predicting clinically relevant outcomes (Cruitt 2019). There is preliminary evidence for the use of the Level of Personality Functioning Scale - Brief Form (LPFS-BF 2.0) among community-dwelling older adults (Stone 2021).

For differential diagnosis, the Alcohol Related Problems Survey (ARPS) was designed for older

TABLE 4 Autism spectrum disorder (ASD) and personality disorders

Personality disorder	Characteristics shared with ASD
Avoidant personality disorder	People with ASD can be misdiagnosed as having avoidant personality disorder because of their avoidance of social activities
Borderline personality disorder	Self-mutilating behaviours can occur in borderline personality disorder and ASD, but in ASD they are associated with sensory overstimulation, whereas in borderline personality disorder they occur in the context of emotional dysregulation
Dependent personality disorder	People with ASD can be uncertain about how to behave in social situations, which can lead to a dependent attitude
Histrionic personality disorder	Owing to an inability to sense which behaviours are socially appropriate, individuals with ASD can appear histrionic
Narcissistic personality disorder	People with ASD may proudly bring out their achievements, thus giving the impression of being narcissistic
Obsessive–compulsive personality disorder	Similarities between obsessive–compulsive personality disorder and ASD include a preference for a predictable environment; a diagnosis of obsessive-compulsive personality disorder can be made because of an assumption that people become more rigid in personality as they get older, but this rigidity can be an understandable reaction to physical or emotional threats
Schizoid personality disorder	People with either ASD or schizoid personality disorder can have a reduced capacity for a social life; however, those with schizoid personality disorder have a lack of interest in close relationships, whereas people with ASD can have close relationships with others

https://doi.org/10.1192/bja.2024.41 Published online by Cambridge University Press

patients in a primary care setting. The CAGE (cutting down, annoyed, guilty and 'eye-opener' drinking) alcohol questionnaire and Michigan Alcoholism Screening Test – Geriatric Version (MAST-G) have been validated for older people in in-patient settings (Hall 2015).

Diagnosis by consensus

The last step in reaching a diagnosis is for clinicians to hold a conference to finalise it by consensus. Clinicians should be familiar with the latest diagnostic criteria and the individual's problems in various settings over an extended period to exclude differential diagnoses. A case formulation could be developed to explain the dynamics underlying the patient's presentation (Agronin 2000).

Management

When deciding on a suitable intervention for an older adult, it is crucial to evaluate the individual's level of motivation, the type and severity of the personality disorder, and the intensity of functional limitations and cognitive comorbidities (Penders 2020). Factors specific to old age, such as changing life perspectives and the loss of social roles, should be a focus of treatment. Treating older people with personality disorders therefore seems to require a more tailored and personalised approach. Interventions can be allocated on a continuum ranging from adaptation-focused strategies such as social skills training to personality-changing interventions such as schema therapy (Penders 2020). If treatment is on an in-patient basis, a discharge date should be agreed in advance with the patient. A comprehensive suicide risk assessment should be undertaken. Those with a history of suicidal behaviour are at greatest risk of dying by suicide (Waserman 2015).

Paranoid, schizoid and schizotypal personality disorders

In paranoid personality disorder, individuals would benefit from a straightforward and consistent approach to management. A solicitous or challenging approach could be misinterpreted as threatening, leading to hostility and accusations. Professionals may need to tolerate the peculiarities of individuals with schizotypal personality disorder unless these are leading to behaviours that pose a risk of danger to the patient or others (Agronin 1999). Clinicians may need to deviate from a warm, supportive stance when managing patients with a schizoid personality disorder. This is because such patients typically would prefer to keep all interactions to a minimum and do not want praise or encouragement (Segal 2006: chap. 2).

Borderline, antisocial, histrionic and narcissistic personality disorders

Where borderline personality disorders are concerned, there needs to be a shared understanding with the patient, carer(s) and clinicians. A care plan can be in the form of a written contract. This is useful for managing people in residential and institutional settings such as hospitals and care homes. It is personalised and contains concrete goals that are realistically achievable. The plan should allow the patient to taper rather than suddenly stop maladaptive behaviours. If the contract requires the patient to stop using dysfunctional mechanisms (starving, medication non-adherence, etc.) it should provide alternative methods of coping (listening to music, journaling, etc.). The plan should be used as an adjunct to other treatments. It is important for the clinician to adopt an empathic and validating stance while maintaining appropriate boundaries. Professionals need reflective space and should meet regularly to establish consistency of care (Hall 2015; Parthasarathi 2015).

Non-adherence to treatment is common in people with antisocial personality disorder. Staff should manage this by arranging a meeting with a person of authority, such as the care home manager. Individuals with antisocial personality disorder have difficulty in forming meaningful relationships with others and it will therefore be difficult to establish a collaborative working relationship. Instead of trying to help these patients to develop empathy for others, it might be more useful to help them think through the consequences of their actions and discover strategies to stay out of trouble. Professionals may become overwhelmed by the emotional needs of a patient with histrionic personality disorder, which can be expressed in dramatic ways. This individual could benefit from participation in group activities which can provide manageable interpersonal connection and constructive feedback. The maladaptive attempts of someone with a narcissistic personality to cope with losses of attractiveness and physical function may include hostility and controlling behaviours. It is important to identify the losses that are devastating to the patient. Supportive interactions will help mitigate their need for admiration (Segal 2006: chap. 3).

Avoidant, dependent and obsessive–compulsive personality disorders

It is vital to identify losses and fears that cause avoidant behaviours. Someone who avoids social situations because of incontinence can be treated with medications, exercises and protective undergarments. Health professionals can struggle to cope with the excessive questions and neediness of a

BJPsych Advances (2025), vol. 31, 173–185 doi: 10.1192/bja.2024.41

https://doi.org/10.1192/bja.2024.41 Published online by Cambridge University Press

patient with dependent personality disorder. Failure to obtain enough nurturance can lead to clinging behaviours and frequent somatic complaints. This can be overcome by scheduling brief, regular and supportive contact. Clinicians should explain limits in their ability to provide care while also conveying their willingness to help. People with anankastic traits prefer precise routines for scheduling treatment. It can be difficult for clinicians to adjust their schedules to meet the patient's needs. They should instead focus the energies of these individuals on tasks in which they have a sense of control (Agronin 1999; Segal 2006: chap. 4).

Psychological therapy

Research on the effectiveness of psychotherapies for older adults with personality disorders is quite scarce and studies have small sample sizes. Psychotherapies could be organised on three levels – treatment aimed at personality change, adaption-focused treatment and supportive-structuring treatment – and can be delivered individually or in groups (Penders 2020). Dialectical behaviour therapy, psychodynamic psychotherapy and schema-focused therapy are aimed at personality and behavioural changes. There is some evidence of effectiveness for older adults with personality disorders. Schema-focused therapy is considered to be most relevant for older patients with personality disorders. There is no evidence for adaption focused treatment in older people (e.g. interpersonal therapy). There are no studies on supportive-structuring treatment in older adults with personality disorders (Laheij-Rooijakkers 2020; Wu 2022; Khasho 2023). Importantly, active listening is the basis of psychodynamic psychotherapy as difficulties can be understood in a relational context with the therapist, perhaps for the first time.

Pharmacological therapy

Guidance for the pharmacological management of personality disorders in older people is scarce. Randomised controlled trials have not assessed medications in this group. However, medications are commonly used for impulsive aggression, affective instability, dissociation, anger and comorbid psychiatric conditions and to improve participation in psychotherapy. Reviewing evidence from the general adult population can be helpful. Most studies have been involved people with borderline personality disorder. These individuals tend to have 'black and white' or 'all or nothing' thinking, and expectations can range from believing a drug to be useless to considering it to be a panacea. Clinicians should highlight that medications are only one part of a larger treatment plan. Patients at high risk for substance use disorder should be prescribed addictive medications with caution. Ageing affects pharmacokinetics, including changes in serum protein levels and volume of distribution owing to altered ratios of lean body weight to body fat. Ageing also affects liver and kidney function. Medications can increase the risk of falls and hypotension. Adherence problems can be due to declining memory and mobility. The maxim 'start low and go slow' should be used (Kocsis 2015; Waserman 2015; Brudey 2021).

Antidepressants

Antidepressants are commonly used for comorbid mood and anxiety disorders (Kocsis 2015). Serotonergic agents are commonly used in avoidant personality disorder, as social anxiety disorder is often associated with it (Brudey 2021). Schulkens et al (2021) conducted in international Delphi study to reach consensus on the suitability of selective serotonin reuptake inhibitors (SSRIs) for the treatment of older adults with borderline personality disorder. They composed a flowchart with treatment recommendations, but these are yet to be investigated in clinical practice. SSRIs are indicated for affective dysregulation and are a second choice for impulsivity (for impulsivity, low-dose antipsychotics or anticonvulsants could be used). Preferred SSRIs were citalopram and sertraline, but no consensus was reached on optimal doses. Daily dosages of citalopram should not exceed 40 mg because of the risk of prolonged QT interval. No consensus was reached on the treatment of suicidality with an SSRI.

Mood stabilisers

In contrast to antidepressants, mood stabilisers appear to have more positive effects. Sodium valproate can reduce interpersonal problems, anger, impulsive aggression, depression and irritability. Lamotrigine may improve impulsivity, affective instability and anger. Gabapentin and pregabalin can be used in people with both avoidant personality disorder and social anxiety disorder. Lithium is often used to treat affective instability and can reduce the risk of suicide, particularly in those with mood disorders. Evidence does not suggest that it can reduce self-harm. The anti-suicidal effect is ensured by reducing the relapse of mood disorders and decreasing aggression and impulsivity (Waserman 2015; Brudey 2021).

Antipsychotics

Second-generation antipsychotics can reduce impulsive aggression, psychosis and sensitivity to interpersonal rejection in people with borderline personality disorder. Olanzapine and aripiprazole

https://doi.org/10.1192/bja.2024.41 Published online by Cambridge University Press

MCQ answers
1 b 2 d 3 d 4 e 5 a

are the best studied antipsychotics in this regard. Aripiprazole is effective in reducing non-suicidal self-injury, interpersonal problems, impulsivity, anger and psychosis. Haloperidol has some benefit in reducing anger. Olanzapine can help improve anxiety, affective instability, anger, psychosis, depression and anxiety. Antipsychotics are helpful for psychotic symptoms in schizotypal personality disorder. Antipsychotics can cause worsening of Parkinsonism, falls and orthostatic hypotension (Kocsis 2015; Brudey 2021).

Conclusions

Managing personality disorders in older people poses challenges due to the convoluted nature of these conditions and paucity of research. Being more mindful of later-life personality disorders can enable treatments to be customised to accommodate specific needs of individual patients. 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. With appropriate care, clinical recovery is possible for many individuals.

Data availability

Data availability is not applicable to this article as no new data were created or analysed in this study.

Funding

This research received no specific grant from any funding agency, commercial or not-for-profit sectors.

Declaration of interest

None.

References

Agronin M (1999) Pharmacological treatment of personality disorders in late life. In *Personality Disorders in Older Adults: Emerging Issues in Diagnosis and Treatment* (eds E Rosowsky, RC Abrams, RA Zweig): 229–54. Lawrence Erlbaum Associates.

Agronin ME (1994) Personality disorders in the elderly: an overview. *International Journal of Geriatric Psychiatry*, **27**: 151–91.

Agronin ME, Maletta G (2000) Personality disorders in late life: understanding and overcoming the gap in research. *American Journal of Geriatric Psychiatry*, **8**: 4–18.

American Psychiatric Association (2022) *Diagnostic and Statistical Manual of Mental Disorders* (5th edn, text revision) (DSM-5-TR). APA.

Bangash A (2020) Personality disorders in later life: epidemiology, presentation and management. *BJPsych Advances*, **26**: 208–18.

Bourgeois JA, Hategan A, Veltman A, et al (2015) Overview of borderline personality disorder in older patients: evolution and complexity. In *Borderline Personality Disorder in Older Adults: Emphasis on Care in Institutional Settings* (eds A Hategan, JA Bourgeois, GL Xiong): 3–14. Nova Science Publishers.

Brudey C (2021) Personality disorders in older age. *Focus*, **19**: 303–7.

Cruitt PJ, Boudreaux MJ, King HR, et al (2019) Examining criterion A: DSM-5 level of personality functioning as assessed through life story interviews. *Personality Disorders: Theory, Research, and Treatment*, **10**: 224–34.

d'Huart D, Seker S, Bürgin D, et al (2023) Key insights from studies on the stability of personality disorders in different age groups. *Frontiers in Psychiatry*, **15**(14): 1109336.

Ekiz E, van Alphen S, Melssen A, et al (2023) Adapting Systems Training for Emotional Predictability and Problem Solving (STEPPS) for older adults with personality disorder: a Dutch Delphi study. *Journal of Clinical Psychology*, **51**(1): 105–9.

Facon MF, Dierckx E, van Alphen SPJ, et al (2023) Integratie van de DSM-5 en ICD-11 Maladaptieve Trekken bij Ouderen: Constructvaliditeit van de PID-5-BF+M [Integration of the DSM-5 and ICD-11 maladaptive traits in older adults: construct validity of the PID-5-BF+M]. *Tijdschrift voor Gerontologie en Geriatrie*, **54**(1).

Hall E, Bourgeois JA (2015) Clinical diagnosis. In *Borderline Personality Disorder in Older Adults: Emphasis on Care in Institutional Settings* (eds A Hategan, JA Bourgeois, GL Xiong): 33–42. Nova Science Publishers.

Holzer KJ, Vaughn MG, Fearn NE, et al (2021) Age bias in the criteria for antisocial personality disorder. *Journal of Psychiatric Research*, **137**: 444–51.

Holzer KJ, Vaughn MG, Loux TM, et al (2022) Prevalence and correlates of antisocial personality disorder in older adults. *Aging and Mental Health*, **26**: 169–78.

Hylton J, Seritan AL (2015) Personality and aging. In *Borderline Personality Disorder in Older Adults: Emphasis on Care in Institutional Settings* (eds A Hategan, JA Bourgeois, GL Xiong): 15–22. Nova Science Publishers.

Jo R, Broadbear JH, Hope J, et al (2023) Late manifestation of borderline personality disorder: characterization of an under-recognized phenomenon. *Personality and Mental Health*, **17**: 165–75.

Khasho DA, van Alphen SPJ, Ouwens MA, et al (2023) The effectiveness of individual schema therapy in older adults with borderline personality disorder: a multiple-baseline case series design. *Clinical Psychology & Psychotherapy*, **30**: 1313–23.

Kocsis BJ, Scher LM (2015) Pharmacotherapy. In *Borderline Personality Disorder in Older Adults: Emphasis on Care in Institutional Settings* (eds A Hategan, JA Bourgeois, GL Xiong): 99–110. Nova Science Publishers.

Laheij-Rooijakkers LAE, van der Heijden PT, Videler AC, et al (2020) Development of a tool to detect older adults with severe personality disorders for highly specialized care. *International Psychogeriatrics*, **32**: 463–71.

Molinari V (2020) Research on personality disorder in late life. *International Psychogeriatrics*, **32**: 427–9.

Oltmanns JR, Widiger TA (2021) The self- and informant-personality inventories for ICD-11: agreement, structure, and relations with health, social, and satisfaction variables in older adults. *Psychological Assessment*, **33**: 300–10.

Oltmanns TF, Balsis S (2011) Personality disorders in later life: questions about the measurement, course, and impact of disorders. *Annual Review of Clinical Psychology*, **7**: 321–49.

Ouwens MA, Videler AC, van Alphen SPJ (2022) Clinical staging as a novel approach for selecting psychological treatment levels for older adults with borderline personality disorder. *Clinical Gerontologist* [Epub ahead of print] 21 Feb. Available from: https://doi.org/10.1080/07317115.2022.2041143

Parthasarathi U, Holoyda B (2015) Therapeutic alliance and boundary issues. In *Borderline Personality Disorder in Older Adults: Emphasis on Care in Institutional Settings* (eds A Hategan, JA Bourgeois, GL Xiong): 61–70. Nova Science Publishers.

Penders KAP, Peeters IGP, Metsemakers JFM, et al (2020) Personality disorders in older adults: a review of epidemiology, assessment, and treatment. *Current Psychiatry Reports*, **22**(3): 14.

Ramírez Echeverría MdL, Schoo C, Paul M (2022) Delirium (updated 19 Nov 2022). In *StatPearls*. StatPearls Publishing (https://www.ncbi.nlm.nih.gov/books/NBK470399/).

https://doi.org/10.1192/bja.2024.41 Published online by Cambridge University Press

Reynolds K, Pietrzak RH, El-Gabalawy R, et al (2015) Prevalence of psychiatric disorders in U.S. older adults: findings from a nationally representative survey. *World Psychiatry*, **14**: 74–81.

Rosowsky E, Lodish E, Ellison JM, et al (2019) A Delphi study of late-onset personality disorders. *International Psychogeriatrics*, **31**: 1007–13.

Schulkens J, Bergs N, Ingenhoven T, et al (2021) Selective serotonin reuptake-inhibitors for symptom-based treatment of borderline personality disorders in older adults: an international Delphi study. *Clinical Psychopharmacology and Neuroscience*, **19**: 53–62.

Segal DL, Coolidge FL, Rosowsky E (2006) *Personality Disorders and Older Adults: Diagnosis, Assessment, and Treatment*. John Wiley & Sons.

Stone LE, Segal DL, Noel OR (2021) Psychometric evaluation of the Levels of Personality Functioning Scale-Brief Form 2.0 among older adults. *Personality Disorders: Theory, Research, and Treatment*, **12**: 526–33.

Tyrer P, Howard R (2020) Late-onset personality disorder: a condition still steeped in ignorance. *BJPsych Advances*, **26**: 219–20.

van Alphen SP, van der Werff S, Rosowsky E, et al (2023) Assessment of personality disorders in older adults: a practice guide. *Journal of Geriatric Psychiatry and Neurology*, **36**: 470–8.

Videler AC, Heijnen-Kohl SMJ, Wilting RMHJ, et al (2020) Differentiële diagnostiek van persoonlijkheidsstoornissen en autismespectrumstoornis bij ouderen [Differential diagnosis of personality disorders versus autism spectrum disorder in older adults]. *Tijdschrift voor Gerontologie en Geriatrie*, **51**(2): 10.

Waserman JE, Saperson K, Gojmerac CB, et al (2015) Suicidality in geriatric borderline personality disorder: clinical approaches and management. In *Borderline Personality Disorder in Older Adults: Emphasis on Care in Institutional Settings* (eds A Hategan, JA Bourgeois, GL Xiong): 71–80. Nova Science Publishers.

World Health Organization (2019) *International Classification of Diseases, 11th Revision (ICD-11)*. WHO.

Wu A, Francois D (2022) Personality disorders in late life: an update. *Journal of Gerontopsychology and Geriatric Psychiatry*, **35**: 167–75.

MCQs

Select the single best option for each question stem

1 Why do personality disorders occur in later life?

a all older people develop coping strategies to cope with life's challenges
b people can experience stresses due to losses in later life
c buffering occurs when a significant other suppresses an individual's maladaptive traits
d bolstering occurs when a significant other provides an interface between patients and others thus protecting them from feedback that can enhance maladaptive traits
e binding occurs when a role or significant other strengthens the maladaptive traits of a patient to reduce the manifestation of dysfunctional traits.

2 Regarding differential diagnoses of late-life personality disorders

a autism spectrum disorders cannot be diagnosed in older people
b dysfunctional traits cannot be seen in depression
c the paranoia of a delusional disorder tends to respond well to treatment
d people with dementia can experience exacerbations of their personality traits
e personality disorders themselves are not associated with disturbances in executive function.

3 Where cluster A personality disorders are concerned:

a those with paranoid personality disorders would benefit from being regularly challenged on their beliefs
b a general approach can be used for all personality disorders
c those with schizoid personality disorders prefer to be encouraged to participate in social activities
d the peculiarities of individuals with schizotypal personality disorder should be endured unless they are associated with risky behaviours
e people with paranoid personality disorders do not believe others are out to do them harm.

4 Regarding the emergence of late-life personality disorders:

a personality disorders cannot be diagnosed in older adults
b DSM-5 and ICD-11 do not support the concept of personality disorders manifesting for the first time in later life
c personality disorders can emerge in old age due to the loss of buffering, binding and bolstering
d binding occurs when a spouse encourages the expression of maladaptive traits
e buffering can occur when a wife provides an interface between her husband and other people, thus protecting him from feedback that can enhance maladaptive traitse.

5 In the management of late-life personality disorders:

a a comprehensive suicide risk assessment should be undertaken
b level of motivation does not need to be ascertained
c people with antisocial personality disorder should be taught how to develop empathy for others
d people with anankastic traits should not be encouraged to focus on tasks that give them a sense of control
e when starting medications, high doses can be used straightaway.

https://doi.org/10.1192/bja.2024.41 Published online by Cambridge University Press