Relevant to the content of this educational activity, I do not have any relationships with commercial interest companies to disclose.

OBJECTIVES

Be able to describe:
- The clinical features associated with the 10 personality disorders, and the 5 somatic symptom and related disorders
- The 3 clusters of personality disorders
- How the epidemiology and characteristics of personality and somatic symptom and related disorders differ between younger and older patients
- Principles of diagnosis and treatment of personality and somatic symptom and related disorders in the older patient

TOPICS COVERED

Personality Disorders
- Epidemiology
- Diagnostic Challenges
- Differential Diagnosis
- Long-Term Course
- Treatment

Somatic Symptom and Related Disorders
- Clinical Characteristics and Causes
- Treatment
• Presence of chronic and pervasive patterns of inflexible and maladaptive inner experiences and behaviors

• Leading to significant disruptions in several spheres of function, including:
  ➢ Cognitive perception and interpretation
  ➢ Affective expression
  ➢ Interpersonal functioning
  ➢ Impulse control

PERSONALITY DISORDERS

DSM-5 CLUSTERS AND CATEGORIES

• 10 personality disorders, grouped into 3 broad clusters based on common phenomenology
  ➢ No longer documented on a separate axis
  ➢ DSM-IV-TR categories of depressive and passive-aggressive no longer included in DSM-5 due to lack of empirical support
  ➢ Other DSM-5 classifications for personality disorders
    ➢ Other specified personality disorder
    ➢ Unspecified personality disorder
    ➢ Personality change due to another medical condition

CLUSTER A: ODD OR ECCENTRIC BEHAVIORS

<table>
<thead>
<tr>
<th>Cluster A Disorder</th>
<th>General Features</th>
<th>Features specific to geriatric patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paranoid</td>
<td>Pervasive suspiciousness of the motives of others, which often leads to irritability and hostility</td>
<td>Episodes of paranoid psychosis, agitation, and aggression</td>
</tr>
<tr>
<td>Schizoid</td>
<td>Disinterest in social relationships, coupled with isolative and sometimes odd behaviors</td>
<td>Poor, strained, or absent relationships with caregivers</td>
</tr>
<tr>
<td>Schizotypal</td>
<td>Characteristic appearance, behaviors, and beliefs that are strange, unusual, or inappropriate</td>
<td>Beliefs that can become delusional and lead to conflicts with others; relationships with caregivers can be strained or absent</td>
</tr>
</tbody>
</table>
### Cluster B: Dramatic, Emotional, or Erratic Behaviors (1 of 2)

<table>
<thead>
<tr>
<th>Cluster B Disorder</th>
<th>General features</th>
<th>Features specific to geriatric patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antisocial</td>
<td>Poor regard for social norms and laws, lack of conscience and empathy for others; frequent reckless and criminal behaviors</td>
<td>Frequent remission of antisocial behaviors with less aggression and impulsivity</td>
</tr>
<tr>
<td>Borderline</td>
<td>Impaired control of emotional expression and impulses associated with unstable interpersonal relations, poor self-identity, and self-injurious behaviors</td>
<td>Persistent emotional lability and unstable relationships, but less self-injurious and impulsive behaviors</td>
</tr>
</tbody>
</table>

### Cluster B: Dramatic, Emotional, or Erratic Behaviors (2 of 2)

<table>
<thead>
<tr>
<th>Cluster B Disorder</th>
<th>General features</th>
<th>Features specific to geriatric patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Histrionic</td>
<td>Excessive emotionality and attention-seeking behaviors, sometimes appearing overly seductive or provocative</td>
<td>Behaviors that may become excessively disinhibited and disorganized, appearing hypomanic</td>
</tr>
<tr>
<td>Narcissistic</td>
<td>Pervasive sense of entitlement, grandiosity, and arrogance, coupled with lack of empathy</td>
<td>Can present as hostile, enraged, paranoid, or depressed</td>
</tr>
</tbody>
</table>

### Cluster C: Anxious or Fearful Behaviors

<table>
<thead>
<tr>
<th>Cluster C Disorder</th>
<th>General features</th>
<th>Features specific to geriatric patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoidant</td>
<td>Excessive sensitivity to rejection and social scrutiny; social demeanor that can be timid and inhibited</td>
<td>Social contacts that can be extremely limited, providing for inadequate support</td>
</tr>
<tr>
<td>Dependent</td>
<td>Excessive dependence on others to help make decisions and provide support</td>
<td>Comorbid depression is common; clinical appearance often with demanding or clinging behaviors if dependency needs not met</td>
</tr>
<tr>
<td>Obsessive-compulsive</td>
<td>Pervasive preoccupation with orderliness and cleanliness; a perfectionistic, rigid, and controlling approach that can become more inflexible and indecisive under stress</td>
<td>Obsessive-compulsive traits can become exaggerated in efforts to maintain control over somatic and environmental changes</td>
</tr>
</tbody>
</table>
Older people with personality disorders can become overwhelmed by age-associated losses and stresses, largely because they may lack:

➢ Coping skills
➢ Personal, social, or financial resources

• Admission to a hospital or long-term-care setting poses a unique stress on people with personality disorders

PERSONALITY DISORDERS AND AGE-ASSOCIATED STRESSES

PREVALENCE OF PERSONALITY DISORDERS

• 10%–20% for all ages in the community
• 5%–13% for late-life personality disorders in the community
• 10% to over 50% for inpatient settings and with comorbid depression

DIAGNOSTIC CHALLENGES

• Older patients, their informants, and the chart often do not provide sufficient history
• Lifelong personality characteristics must be isolated from multiple comorbid problems, such as major depression and psychosis
• Current diagnostic terms are not age-adjusted
• Clinician may erroneously consider all older patients to have disruptive personality features as a normal function of age
DIFFERENTIAL DIAGNOSIS

• Not every older person with prominent or troubling personality features has a personality disorder
  ➢ Some individuals are better described as suffering from certain personality traits or an adjustment disorder
• There is often considerable overlap between symptoms of personality disorders and those of major psychiatric disorders
• Rule out personality change due to a specific medical condition

LONG-TERM COURSE

• Can enter quiescence in middle age and reemerge in late life
• Follow one of 4 possible courses:
  ➢ Persist unchanged
  ➢ Evolve into a different form or major psychiatric disorder
  ➢ Improve
  ➢ Remit

PRINCIPLES OF TREATMENT

• Goal is to decrease the frequency and intensity of disruptive behaviors, not cure the disorder
• Same basic approaches as with younger patients, but consider age-related stressors and comorbid disorders
• Clarify the diagnosis, then identify recent stressors that may account for the current presentation
  ➢ Guides the selection of realistic target symptoms and therapeutic approaches
  ➢ Allows treatment team to anticipate future stressors
THERAPEUTIC STRATEGIES (1 of 2)

Cluster A—Paranoid, Schizoid, Schizotypal Personality Disorders
- Always assess for and treat comorbid psychosis
- Do not force social interactions, but offer support and problem-solving assistance in a professional and consistent manner
- Do not challenge paranoid ideation; instead, solicit and empathize with emotional responses to the inner turmoil and fear of paranoid states

Cluster B—Antisocial, Borderline, Histrionic, and Narcissistic Personality Disorders
- Assess for and treat underlying mood lability, depression, anxiety, and substance abuse
- Adopt a consistent, structured, and predictable approach with strict boundaries to contain disruptive behaviors
- Adopt a team approach with all involved clinicians to devise a common plan; avoid staff splits between “supporters” and “detractors” of the patient

THERAPEUTIC STRATEGIES (2 of 2)

Cluster B—Antisocial, Borderline, Histrionic, and Narcissistic Personality Disorders (continued)
- Use behavioral contracts and authority figures when necessary to address recurrent disruptive behaviors
- Do not personalize belligerent behaviors directed toward staff members; instead, provide opportunities for staff to ventilate frustration and negative thoughts and emotions with professional colleagues

Cluster C—Avoidant, Dependent, and Obsessive-Compulsive Personality Disorders
- Assess for and treat underlying anxiety, panic, and depression
- Provide regularly scheduled clinical contacts rather than on an as-needed basis
- When possible, provide case managers to solicit the needs of avoidant patients and to provide extra reassurance and attention to the needs of dependent and obsessive-compulsive patients

TREATMENT IN LONG-TERM CARE SETTINGS

- Staff meeting or case conference
  ➢ Discuss disruptive patients and coordinate a consistent treatment plan
  ➢ Disruptive behaviors can sometimes be traced to particular activities or staff interactions
- Convey treatment plan to patient, all involved staff, and caregivers
  ➢ Nonadherent patients may need a written contract
  ➢ Recognize that patient may have conflictual relationships with family
**PHARMACOLOGIC THERAPY FOR PERSONALITY DISORDERS**

- Few studies in late life
- Best used as adjunct to psychotherapy
- Avoid multiple psychotropics, particularly if there is a history of nonadherence, confusion, or impulsivity
- Consider potential interactions with other medications
- Obtain informed consent for use of psychotropics when there is a history of dementia, recent delirium, paranoia, or conflictual doctor-patient relationships

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**PHARMACOLOGIC OPTIONS (1 of 2)**

- **Antidepressants**
  - For the symptoms of depression and anxiety found in most personality disorders
  - Commonly used to treat impulsive aggression as well as obsessive-compulsive symptoms, but efficacy not established

- **Mood stabilizers** (e.g., lithium carbonate and divalproex sodium) (off-label)
  - Reduce mood lability and impulsivity in borderline and antisocial personality disorder

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**PHARMACOLOGIC OPTIONS (2 of 2)**

- **Antianxiety agents**
  - Used for the transient agitation seen in borderline, antisocial, narcissistic, and paranoid disorders
  - May reduce social anxiety and panic in avoidant and dependent patients

- **Antipsychotic agents**
  - Can treat transient psychosis, agitation, and impulsivity of dramatic cluster and paranoid disorders, and the borderline psychosis and paranoia seen in odd cluster disorders
  - Reduce mood lability and impulsivity in borderline and antisocial personality disorder
• Comorbid substance abuse
• Chronic nonadherence
• Hx/potential for abusive or self-injurious use
  ➢ Often includes antisocial and borderline patients
  ➢ Dependent patients may insist upon medications as a means of fostering dependency on the clinician
  ➢ Obsessive-compulsive patients may perpetuate a maladaptive relationship with the clinician through detailed discussions of medication management

PHARMACOLOGIC STRATEGIES ARE NOT ALWAYS APPROPRIATE

• Heterogeneous group of 5 diagnoses
  ➢ Common factors: distressing physical symptoms, and abnormal thoughts, feelings, and behaviors in response to these physical symptoms
• Especially relevant to geriatric care
  ➢ Affected older people are seen in all health care settings and tend to overutilize medical services

SOMATIC SYMPTOM AND RELATED DISORDERS

Somatic Symptom Disorder
• Multiple, current, somatic symptoms that are distressing or result in significant disruption of daily life are typical.
• Sometimes, only one severe symptom, most commonly pain, is present.
• Symptoms may be specific (eg, localized pain) or relatively nonspecific (eg, fatigue).
• Symptoms sometimes represent normal bodily sensations or discomfort that does not generally signify serious disease.
• Somatic symptoms without an evident medical explanation are not sufficient to make this diagnosis; the individual’s suffering is authentic, whether or not it is medically explained.

TYPES OF SOMATIC SYMPTOM AND RELATED DISORDERS (1 of 4)
Illness Anxiety Disorder

- Most individuals with hypochondriasis are now classified as having somatic symptom disorder; however, in a minority of cases, the diagnosis of illness anxiety disorder applies instead.
- Illness anxiety disorder entails a preoccupation with having or acquiring a serious, undiagnosed medical illness.
- Somatic symptoms are not present or, if present, are only mild in intensity.
- Preoccupation with the idea that one is sick is accompanied by substantial anxiety about health and disease.
- Individuals with the disorder often examine themselves repeatedly.

Conversion Disorder

- Alternative names include “functional” or “psychogenic” to describe the symptoms of conversion disorder (functional neurologic symptom disorder).
- There may be one or more symptoms of various types.
- Motor symptoms include weakness or paralysis; abnormal movements, such as tremor or dystonic movements; gait abnormalities; and abnormal limb posturing.
- Sensory symptoms include altered, reduced, or absent skin sensation, vision, or hearing.
- Episodes of abnormal generalized limb shaking with apparent impaired or loss of consciousness may resemble epileptic seizures (also called psychogenic or nonepileptic seizures).
- There may be episodes of unresponsiveness resembling syncope or coma.
- Other symptoms include reduced or absent speech volume (dysphonia/aphonia), altered articulation (dysarthria), a sensation of a lump in the throat (globus), and diplopia.

Psychological Factors Affecting Medical Conditions

- Essential feature is the presence of one or more clinically significant psychological or behavioral factors that adversely affect a medical condition by increasing the risk of suffering, death, or disability.
- These factors can adversely affect the medical condition by influencing its course or treatment, by constituting an additional well-established health risk factor, or by influencing the underlying pathophysiology to precipitate or exacerbate symptoms or to necessitate medical attention.
- This diagnosis should be reserved for situations in which the effect of the psychological factor on the medical condition is evident and the psychological factor has clinically significant effects on the course or outcome of the medical condition.

Factitious Disorder

- Essential feature involves a person producing or faking illness when he or she is not sick and that is associated with the identified deception.
- Individuals with factitious disorder can also seek treatment for themselves or another after induction of injury or disease. The diagnosis requires demonstrating that the individual is taking surreptitious actions to misrepresent, simulate, or cause signs or symptoms of illness or injury in the absence of obvious external rewards.

Other specified somatic symptom and related disorders

- This applies to presentations in which symptoms characteristic of a somatic symptom and related disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the somatic symptom and related disorders diagnostic class.
- Examples:
  - Brief somatic symptom disorder: duration of symptoms <6 months
  - Brief illness anxiety disorder: duration of symptoms <6 months
  - Illness anxiety disorder without excessive health-related behaviors: avoids doctors’ appointments and hospital with negative impact on health
  - Pseudocyesis: a false belief of being pregnant associated with objective signs and reported symptoms of pregnancy

Unspecified somatic symptom and related disorder

- Applies to presentations in which symptoms characteristic of a somatic symptom and related disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the somatic symptom and related disorders diagnostic class.
- This category should not be used unless there are distinctly unusual situations in which information is insufficient to make a more specific diagnosis.
EPIDEMIOLOGY OF SOMATIC SYMPTOMS AND RELATED DISORDERS

• Prevalence in middle and late life <1%
• More common in women
• Generally not associated with increasing age
  ➢ Weak evidence for slight increase in hypochondriasis with age
  ➢ Depression in late life is associated with increased somatic preoccupation and symptoms

CLINICAL CHARACTERISTICS AND CAUSES

• Not an intentional, conscious attempt by older patients to present fictitious physical symptoms
• Symptoms are experienced by the affected person as real physical pain and discomfort, usually without insight into associated psychological factors
• Represent a complex interaction between mind and brain—the affected person unknowingly expresses psychological stress or conflict through the body

CAUSES OF SOMATIC SYMPTOM AND RELATED DISORDERS

• Usually multifactorial
  ➢ Often rooted in early developmental life experiences.
• Comorbid medical problems and use of multiple medications may provide somatic symptoms around which psychological conflict can center
• Older adults are faced with many overwhelming losses, and their own bodies often serve as the last bastion of control
• Foster an ongoing, supportive, consistent, and professional relationship with the patient
• Focus on symptom reduction and rehabilitation
  ➢ Respond to individual complaints, perhaps with regularly scheduled appointments
  ➢ Set limits on work-up and treatment
• Continuously entertain the possibility of an underlying or coexisting medical problem
• Consider referral to mental health clinician

SUMMARY (1 of 3)

• Personality disorders persist into late life and pose complex challenges to clinicians across various medical and psychiatric settings
• Personality disorders may be especially difficult to detect in late life because of:
  ➢ Age-associated changes in symptoms
  ➢ Comorbid psychopathology
  ➢ Lack of age-adjusted diagnostic instruments

SUMMARY (2 of 3)

• The goal of treatment of personality disorders in late life is not to cure the disorder, but to decrease the frequency and intensity of symptoms and improve ability to function
• Both psychotherapeutic and psychopharmacologic strategies are needed in the treatment of personality disorders
• Somatic symptom and related disorders involve the presence of distressing physical symptoms and abnormal thoughts, feelings, and behaviors in response to these physical symptoms.
SUMMARY (3 of 3)

- Treatment of somatic symptom and related disorders should focus on reducing symptoms and rehabilitating the patient.
- Most somatic symptom and related disorders tend to be lifelong; the goal of treatment is not to cure but to control symptoms.

CASE 1 (1 of 3)

- A 70-year-old retired engineer comes to the office for his twice-yearly appointment.
- He spent his career at a single firm.
  - He says that he was valued for his accuracy and punctuality, but colleagues thought he was inflexible.
- He never married.
- He exercises by swimming each Wednesday.
- History: acute depressive episode upon retirement.
  - The depression resolved with treatment.
- At his visit 6 months ago, blood pressure was slightly higher than at previous visits.
  - Today, he provides a 6-month record of twice-daily blood pressure measurements.

CASE 1 (2 of 3)

Which one of the following personality disorders is he most likely to have?

A. Antisocial
B. Avoidant
C. Obsessive-compulsive
D. Schizotypal
Which one of the following personality disorders is he most likely to have?

A. Antisocial  
B. Avoidant  
C. Obsessive-compulsive  
D. Schizotypal

CASE 1 (3 of 3)

A 63-year-old retired army major comes to the office accompanied by his wife, who is concerned about changes in his behavior over the past year.
- He is now messy and unpredictable.
- For example, last week he cut up all the curtains in the house.
- He gorges on food and is no longer quiet and polite.
- Now he is abusive and uses coarse language.
- During the interview, the patient is oblivious to his wife’s statements.

History: hypertension

Examination
- The patient appears unkempt.
- Hypertension is under control.
- Score on MMSE™: 23
- All other findings are normal.

CASE 2 (1 of 3)

- A 63-year-old retired army major comes to the office accompanied by his wife, who is concerned about changes in his behavior over the past year.
- For example, last week he cut up all the curtains in the house.
- He gorges on food and is no longer quiet and polite.
- Now he is abusive and uses coarse language.
- During the interview, the patient is oblivious to his wife’s statements.

History: hypertension

Examination
- The patient appears unkempt.
- Hypertension is under control.
- Score on MMSE™: 23
- All other findings are normal.

CASE 2 (2 of 3)

Which one of the following is the most likely diagnosis?

A. Delirium  
B. Frontotemporal lobar degeneration  
C. Adjustment disorder following retirement  
D. Substance use disorder
Which one of the following is the most likely diagnosis?

A. Delirium
B. Frontotemporal lobar degeneration
C. Adjustment disorder following retirement
D. Substance use disorder

CASE 2 (3 of 3)

A 70-year-old woman comes to the office because she has a self-inflicted wound to her left forearm. She describes herself as lonely, irritable, and anxious.
• She tried to treat herself but decided that a clinician should evaluate the wound.
• History: diabetes mellitus
  • The diabetes has been difficult to stabilize.
  • There is a distant history of anorexia, depression, and alcohol abuse.
• Examination
  • The bandage around her wound is elaborate.
  • The wound is superficial.

Which one of the following is the most appropriate intervention?

A. Hypnosis
B. Mood stabilizer
C. Anxiolytic (benzodiazepine) and cognitive-behavioral psychotherapy
D. Antidepressant and cognitive-behavioral psychotherapy
CASE 3 (3 of 3)

Which one of the following is the most appropriate intervention?

A. Hypnosis
B. Mood stabilizer
C. Anxiolytic (benzodiazepine) and cognitive-behavioral psychotherapy
D. Antidepressant and cognitive-behavioral psychotherapy

CASE 4 (1 of 3)

- A 73-year-old man requests a referral. An established patient for 10 years, he has a long history of somatic concerns.
- For the past 5 years, he has worried about an undiagnosed terminal cancer.
  - He frequently seeks care and specialty consultation (general hospital, ED, GI evaluations).
  - This year, he had 3 colonoscopies and CT of the pelvis and abdomen 3 times.
  - All radiologic and histopathologic findings have been negative for cancer.
- He refuses psychiatric consultation.

CASE 4 (2 of 3)

Which one of the following is the most appropriate management?

A. Electroconvulsive therapy (ECT)
B. Antidepressant therapy
C. Antipsychotic therapy
D. Cognitive-behavioral psychotherapy
Which one of the following is the most appropriate management?

A. Electroconvulsive therapy (ECT)
B. Antidepressant therapy
C. Antipsychotic therapy
D. Cognitive-behavioral psychotherapy