

Anxiety and Personality Disorders in the Elderly

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What is anxiety?

- Anxiety means "a state of being uneasy, apprehensive, or worried about what may happen." It is also described as a "feeling of being powerless and unable to cope with threatening events . . . [characterized] by physical tension."
- Normal, adaptive emotion
 - Run from a tiger
 - Pass a test
- When excessive, it is maladaptive
 - Cannot function at work, in school, in relationships
 - Paralyzing, embarrassing

Anxiety in Elderly

- Anxiety leads to impairment in quality of life
 - Related to disability in some cases
 - Anxiety about existing disability
 - Anxiety can lead to disability
 - Steeper cognitive declines when anxiety untreated in dementia- anxious people cannot focus or pay attention
- Most coupled with depression
 - Those with GAD became depressed over time - 40% had anxiety/depression or just depression 36 mos later (Schoerers et al., 2005)
- Dementia
 - High levels of anxiety exist in demented patients (UK Ballard, et al 1995)
 - 22% subjective anxiety
 - 11% autonomic anxiety
 - 38% tension
 - 13% situational anxiety
 - 2% panic attacks

Symptoms

- Cognitive
 - Worry
 - Fearfulness
 - difficulty concentrating
 - problems thinking clearly
 - Distractibility
 - mental fatigue
 - memory problems
 - decreased problem-solving ability
 - negative thinking
- Somatic
 - Heart palpitations
 - Hyperventilation
 - GI
 - ...
- Behavioral
 - avoid going out or doing something;
 - Only going to quiet places or being in very small groups
 - Only going to places where you can get lost in a crowd and avoid being alone with people;
 - Crossing the street to avoid people
 - Rushing out of places or situations when feeling anxious
 - Going to the toilet to escape from things
 - Not saying anything when with other people
 - Talking all the time to avoid feeling uncomfortable
 - Using 'props' before you go out - alcohol or drugs for example;

Introduction

- The concept of 'neurosis' is was originally coined in the 18th century to describe a category of disorders of the peripheral nervous system (Knoff, 1970). In the 20th century, it has usually been applied to emotional and behavioral disorders arising from the impact of stress factors on particularities of character.
- Researchers have dissected out specific conditions from the body of neurosis, on the basis of particular physiological characteristics, responses to drugs, genetic heritability and even neuropathology. In the US, the triumph of biology is complete, and words such as 'neurosis' and 'neurotic' no longer form any part of DSM-IV nosology. ICD-10 has also rejected the traditional division between neuroses and psychoses. Instead, it has placed many of the conditions previously associated with the neuroses in the group 'neurotic, stress-related and somatoform disorders'.
- Advances in medical understanding come from lumping, as well as splitting clinical phenomena. The biological evidence for discrete disorders needs to be interpreted in the light of clinical and epidemiological evidence that within individuals, and over time, there is considerable comorbidity and interchangeability between these disorders.
- In the elderly, where chronicity and multiple pathology are the norm, the concept of a general neurotic syndrome is useful in making sense of changing clinical pictures, in understanding the causes and outcome of neurotic presentations and in guiding their treatment.

ICD-10 classification of neurotic, stress-related and somatoform disorders (WHO,1992)

- Agoraphobia
- Social phobias
- Specific (isolated) phobias
- Panic disorder
- Generalised anxiety disorder
- Obsessive-compulsive disorder
- Post-traumatic stress disorder
- Adjustment disorders
- Dissociative disorders
- Somatisation disorders

Epidemiology

Table 30.2 Prevalence and incidence rates of specific DSM-III mental disorders (ECA study)

		Male	Female	Total
One-month prevalence (%)*	Dysthymia	65+ 1.0	2.3	1.8
	all ages	2.2	4.2	3.3
Phobic disorder	65+	2.9	4.1	4.8
	all ages	3.8	8.4	6.2
Panic disorder	65+	0.0	0.2	0.1
	all ages	0.3	0.7	0.5
Obsessive-compulsive disorder	65+	0.7	0.9	0.8
	all ages	1.1	1.5	1.3
Somatization	65+	0.0	0.2	0.1
	all ages	0.0	0.2	0.1
Generalized anxiety disorder	65+	—	—	1.0†
	45-64	—	—	3.1†
Annual incidence per 100 person-years of risk‡	Phobic disorder	65+ 2.66	5.52	4.29
	all ages	2.33	5.38	3.98
Panic disorder	65+	0.00	0.07	0.04
	all ages	0.30	0.76	0.56
Obsessive-compulsive disorder	65+	0.12	1.00	0.64
	all ages	0.39	0.92	0.69

*Rogler et al. 1988; Blass et al. 1991. †Blanton et al. 1989. ‡6-month prevalence.

Epidemiology

Table 30.3 One-month prevalence rates (%) of GMS/AGECAT neurotic disorders

	Male		Female	
	case	subcase	case	subcase
Anxiety neurosis	0.2	18.5	1.7	16.9
Phobic neurosis	0.0	3.7	1.2	5.6
Obsessional neurosis	0.0	2.4	0.2	1.4
Hypochondriacal neurosis	0.5	0.2	0.5	0.2

†Taken from Copeland et al. 1987 with permission.

Epidemiology

- In most neurotic disorders there is a fall in prevalence with age, in both genders, but the differences are not large compared with clinical populations.
- At all ages, prevalence rates for neurotic disorders are higher in women than in men, but this difference is least pronounced in the elderly.
- Community studies of neurotic disorders in the elderly confirm that the majority of cases are long-standing, with onset in young adulthood and middle age. However, a significant minority has an onset after the age of 65 years
- Leads to higher medical and psychiatric morbidity in geriatric patients

Associated Factors

- Biological- little research
- Genetics –
 - significant genetic component to vulnerability to these disorders as a group, it is not disorder-specific, and it is environmental factors which determine the particular form of illness that patients develop (Andrews et al. 1990; Kendler et al. 1992).
 - There is, however, some evidence that the genetic heritability of OCD and panic disorder may be more specific
 - Serotonin transporter, 5-HTT, may underlie differences in emotional regulation and in vulnerability to affective and anxiety disorders
- Brain structure and function- little is known
 - Studies of poststroke anxiety disorders show that the distribution of lesions differs from that in patients with poststroke affective disorders, but they are not consistent as to location; (Astrom (1996) has reported that in the acute phase following a stroke, generalized anxiety disorder (GAD) with depression was associated with left hemispheric lesions on CT, whereas GAD alone was associated with right hemispheric lesions. At 3-year follow-up, cerebral atrophy on a repeat CT scan was associated with both anxiety and depression)
 - PTSD- reduction in hippocampus volume, decrease function in medial and dorsolateral prefrontal cortex and increase function in posterior cingulate & parahippocampus gyrus
 - Altered function of hippocampus in panic disorder
 - Altered function of hippocampus, visual association cortex and anterior paralimbic cortex in simple phobias
 - More specific activation in amygdala in social phobia
 - OCD- increased orbitofrontal, caudate, and anterior cingulate blood flow

Associated Factors- Psychosocial

- Psychosocial factors are important in the aetiology of neurotic disorders in the elderly, particularly at the symptom level, where high scores are associated with low socio-economic status (Himmelfarb & Murrell, 1984; Kennedy et al. 1989). Studies of established cases of neurotic disorders have not found a substantive relationship with socio-economic indicators, such as occupational class or household tenure (Lindesay, 1991). However, generalised anxiety was associated with low household income in the ECA study.
- Adverse life events can provoke the onset of some psychiatric disorders in vulnerable individuals; it is the meaning of the event for the individual that is important, rather than the severity. Loss events generally lead to depression, while threatening events may lead to anxiety (Brown et al., 1987; Brown, 1993).
- Age-related experiences such as retirement, bereavement and institutionalisation may cause acute psychological disturbance, but they do not appear to be a major cause of persistent disorders in the elderly.
- In common with younger adults, early experience, such as parental loss, may be important in determining personal vulnerability to neurotic disorder (Zahner & Murphy, 1989; Lindesay, 1991). Perhaps, early experiences such as these lead to the development of particular cognitive habits and personality traits, which render the individual vulnerable to developing neurotic disorders in response to challenging experiences later in life.
- Unlike late-life depression, phobic disorders in the elderly are not associated with absence of confiding relationships (Lindesay, 1991); indeed, in some cases, the presence of close relationships may maintain phobic avoidance.

Associated Factors-Physical illness

- Physical causes of neurotic symptoms in the elderly (adapted from Pitt, 1995)
 - Cardiovascular: myocardial infarction, cardiac arrhythmias, orthostatic hypotension, mitral valve prolapse
 - Respiratory: pneumonia, pulmonary embolism, emphysema, asthma, left-ventricular failure, hypoxia, chronic obstructive airways disease, bronchial carcinoma
 - Endocrine and metabolic: hypo- and hyperthyroidism, hypoadrenal hypercalcaemia, Cushing's disease, carcinoid syndrome, hypoglycaemia, insulinoma, pheochromocytoma, hyperkalaemia, hypokalaemia, hypothermia
 - Neurological: head injury, cerebral tumour, dementia, delirium, epilepsy, migraine, cerebral lupus erythematosus, demyelinating disease, vestibular disturbance, subarachnoid haemorrhage, central nervous system infections
 - Dietary and drug related: caffeine, vitamin deficiencies, anaemia, sympathomimetics, dopamine agonists, corticosteroids, withdrawal syndromes, akathisia, digoxin toxicity, fluoxetine
- Physical illness mimicking neurotic disorder
- Neurotic disorder mimicking physical illness
- Neurotic disorder causing physical illness

Phobic disorder

- The irrational fears reported by elderly people are similar to those in younger age groups: animals, heights, public transport, going out of doors, and so on (Lindesay, 1991). Unfortunately, much is made of the 'reasonableness' of some of these fears in the elderly, particularly those who live in run-down areas of inner cities, and clinically important fears may be dismissed as rational. In fact, the evidence from fear of crime surveys indicates that an individual's perception of vulnerability is determined principally by factors such as physical disability and the availability of social support (Fattah & Sacco, 1989).
- **Long-standing disorder** - These are usually specific in nature, and associated with little in the way of distress or social impairment. These individuals have organized their lives so that they do not need to confront their fears, and it is only occasionally that the onset of old age makes such a confrontation unavoidable; for example, a needle phobic may have to contend with the onset of insulin-dependent diabetes or an agoraphobic may need to shop after the death of their spouse.
- **Late-onset disorder** - These are often agoraphobic in nature and associated with clinically significant levels of distress and disability. They usually develop following a traumatic event such as an episode of physical illness, a fall or a mugging. The resulting impairment usually persists long after the physical consequences of the event have resolved. Unfortunately, the psychological effects of traumatic physical health events in old age are still poorly appreciated, with the result that the statutory services and the family may unwittingly collude with phobic avoidance by providing well-meaning but misguided domiciliary support. Very few elderly people with disabling phobic disorders receive any appropriate treatment for their problem (Lindesay, 1991).

Generalized anxiety disorder (GAD)

- One result of the recognition of specific anxiety disorders, such as phobic disorders and panic disorder, by the new psychiatric classifications has been the relative eclipse of the concept of generalized anxiety as a diagnostic entity. Indeed in ICD-10, GAD may only be diagnosed in the absence of any other mood disorder. The current unpopularity of generalized anxiety is probably due in part to the lack of specific treatments (Tyler, 1985), and in part to the current emphasis on the organic as opposed to psychosocial causes of anxiety disorders (Blazer et al, 1991). In particular, the role of chronic stress in the aetiology of conditions such as generalized anxiety has been neglected in recent years.
- Concern has been expressed that the diagnosis of GAD may be inappropriately applied to elderly people because of their vulnerability and physical frailty (Shamoian, 1991). In fact, the epidemiological evidence indicates that only a small percentage of the elderly population meet diagnostic criteria for this disorder (Copeland et al, 1987a,b; Lindesay et al, 1989; Blazer et al, 1991; Maneta et al, 1996).
- Whatever the nosological status of generalized anxiety, the condition appears to be associated with an increased use of both physical and mental health services (Blazer et al, 1991). If service use is regarded as a criterion of clinical importance then generalized anxiety remains a useful concept, particularly at the primary care level.

Obsessive-compulsive disorder

- Of all the specific neurotic disorders OCD is the most persistent and stable diagnosis. It has a chronic, fluctuating course (Rasmussen & Tsuang, 1986), and the clinical features of OCD in elderly patients are similar to those seen in younger adults. Although a proportion of patients with OCD also develop significant depressive symptoms, other evidence suggests that OCD is a distinct disorder involving the orbitofrontal cortex, basal ganglia, substantia nigra and ventrolateral pallidum (Montgomery, 1980; Goodman et al, 1989; Insel, 1992).
- While the onset of OCD in old age is rare (Bajulajay & Addonizio, 1992), a minority of cases present late, and many elderly patients with long-standing disorders have never been adequately treated (Jenike, 1989). Therefore, it is important that all elderly patients receive thorough evaluation and treatment when they come to the notice of services.
- The development of obsessional orderliness and preoccupation with routines may presage the onset of dementia. Obsessional symptoms may appear at any age following head injury or cerebral tumour.

Panic disorder

- Panic attacks and panic disorder are rare in epidemiological studies of elderly community populations, although cross-sectional surveys may underestimate the true rates. The evidence from case reports, and non-psychiatric patient and volunteer samples, suggests that panic in old age is less common than in early adulthood, is more common in women and widows and is symptomatically less severe than in early onset cases (Sheikh et al, 1991). Elderly panic patients tend not to present to psychiatric services, but the prominent physical symptoms may result in their being referred instead to cardiologists, neurologists and gastroenterologists. In one study of cardiology patients with chest pain and no coronary artery disease, one-third of those aged over 65 years met diagnostic criteria for panic disorder (Beitman et al, 1991).

'Neurotic' depression

- Although ICD-10 has retained the concept of neurotic disorders, no depressive condition appears in this group. As a diagnostic category, neurotic depression has always been unsatisfactory; the criteria are vague, and it is defined more by the absence of psychotic symptoms than by the presence of anything specific. Nevertheless, as Snaith (1991) points out, "consideration of aspects of depression is integral to the understanding of many neurotic disorders" because:
 - (a) Conditions such as phobic disorder, generalised anxiety disorder, agoraphobia, obsessive-compulsive disorder (OCD) and somatisation are often accompanied by depressive symptoms, and these often come to dominate the clinical picture over time, particularly if the neurotic symptoms are severe and disabling. This depressive element of the clinical picture may well require treatment in its own right.
 - (b) At all ages, the most common psychiatric disorder seen in primary care settings is a mild to moderate mixture of depressive and anxiety symptoms, arising in response to a specific stressor, often in the context of particular maladaptive personality traits.
 - (c) Depression in the elderly sometimes presents with apparently 'neurotic' behaviour, such as hypochondriasis, anorexia, importuning and screaming, that can mislead the unwary diagnostician.

Somatiform disorders

Somatisation

- The somatisation of psychological distress usually starts in early adult life, and once established, has a chronic, fluctuating course showing little improvement with age (Pribor et al, 1994). Somatising patients are skilled at seeking medical treatment and avoiding psychiatrists, and it is not uncommon for these individuals to present to psychiatric services for the first time in old age. They come with a very extensive history of complaints, referrals and investigations; are usually depressed and anxious; and the clinical picture is often complicated by the presence of true physical illness. They are the epitome of the 'heartsink' patient, and a significant challenge to all involved in their care.

Hypochondriasis

- In contrast to somatisation, hypochondriacal patients usually restrict physical complaints to one or two body organs or systems. Typically they are preoccupied with the possibility of serious physical illness and their demand is for investigation rather than treatment (World Health Organization, 1992). In the elderly, primary hypochondriasis is usually long-standing; hypochondriacal preoccupations that present for the first time in late life are more likely to be a secondary manifestation of depression or anxiety.

Malingering

- Malingering is an abnormal illness behaviour that has yet to be dignified as a disorder by any psychiatric nosology. It is largely unresearched and there are no formal diagnostic criteria; nevertheless, it is well recognised and disapproved of by doctors who tend to ignore or dismiss what lies behind it. Doctors and other carers find malingering particularly irritating because the malingeringer is clearly physically ill, or disabled, and yet the complaints and crises, such as breathlessness, falls or episodes of incontinence, are timed to cause distress and inconvenience to those responsible for their care. It is important to understand what is being communicated by such behaviour, such as distress, anger, fear or depression. Failure to address this can result in rejection by carers, and institutionalisation, with subsequent escalation in the patient's distress and disruptive behaviour.

Diagnosis

- Clinical evaluation
 - Laboratory testing
 - Rule out common conditions that lead to anxiety
 - History and physical
 - Past medical history
 - Medication use, alcohol use
 - Family and social history
 - Physical exam
 - Trembling, racing heart, rapid breathing, sweating, dry mouth
 - Mental status exam
 - Poor attention, distractibility, much motor movement, easily startled, wide-eyed, feeling of dread
 - Rarely requires special psychological testing

Not recognized in the Elderly

- Yet, still not diagnosed readily in the elderly
 - Not commonly noted in clinics
 - If so, commonly seen as part of a mood problem
 - There is a strong correlation
 - Various scenarios
 - Preexisting
 - Mildly present, now with stressors more problematic
 - Completely new onset
 - Older people don't meet criteria
 - Current criteria don't capture the quality of anxiety in the elderly
 - Anxious mood, tension, vague somatic complaints
 - Elderly do not endorse daily worry

Not recognized in the elderly

- Age of onset for anxiety is presumed to be youth
 - Dementia, depression are "elderly problems"
 - Not PTSD, OCD and phobias
 - Older women are supposed to be anxious
 - Ageist assumption
 - Most anxiety disorders in the elderly are chronic, except:
 - Agoraphobia, fear of falling
 - Generalized Anxiety Disorder

Not recognized in the elderly

- Less need to leave ones' social network
 - Agoraphobia, fear of falling are common in geriatric patients
 - These patients avoid office visits
 - May not be able to travel to appointments readily
 - Anxiety doesn't disrupt functional life
 - Though present, there is likely no work or school or partner to interfere with
 - With move into long term care these anxieties come to the top

Differential Diagnosis

- Depression
- Dementia
- Delirium
- Paranoid states and schizophrenia
- Physical illness
- Sleep disorders

Treatment

- Anxiolytics
 - Benzodiazepines
 - Agents that calm and relieve anxiety across the lifespan
 - So make sure you are treating anxiety
 - Most common agents
 - Alprazolam (Xanax)
 - Lorazepam (Ativan)
 - Clonazepam (Klonopin)
 - Adverse events
 - Sedating
 - Potential for gait instability
 - Dependency producing
 - Paradoxical effect more prevalent in the elderly, esp. in dementia

Treatment



- Anxiolytics
 - Benzodiazepines
 - Some agents are longer lasting than others
 - Alprazolam<Lorazepam<Clonazepam
 - Longer lasting agents may accumulate in the residents system and lead to intoxication or adverse events
 - Metabolism differences
 - Some agents require less involvement of the liver
 - Lorazepam (Ativan)
 - Oxazepam (Serax)

Treatment



- Anxiolytics
 - Buspirone (BuSpar)
 - A unique nonbenzodiazepine agent
 - Serotonin 1-A agonist
 - No sedation, cognitive or motor impairment
 - Takes 4-8 weeks to fully work
 - Time frame is like an antidepressant
 - Not good for panic disorder
 - Good in mixed depression-anxiety states
 - May not work as well in chronic benzodiazepine users

Treatment



- Antidepressants
 - SSRIs used in GAD, panic, OCD, PTSD
 - First line agents in panic disorder and OCD
 - Safe in the elderly
 - Mild GI, headache symptoms
 - Irritability, anxiety and sexual dysfunction
 - Venlafaxine (Effexor), duloxetine (Cymbalta)
 - SNRIs used commonly for anxiety
 - Heightens blood pressure
 - Tricyclics
 - Clomipramine (Anafranil) good for OCD, but too anticholinergic for older patients
 - May employ nortriptyline (Pamelor) if cardiac disease not an issue

Treatment



- Antidepressants
 - Bupropion (Wellbutrin)
 - Mechanism a puzzle
 - Activating
 - Few drug-drug interactions
 - Mirtazapine (Remeron)
 - Sedating, appetite enhancing at low doses
 - Data exists supporting the medication being used in anxiety disorders
- Beta-blockers- caution with physical illness
- Antihistamines-relative safe
- Barbiturates- many serious side effects

Treatment



- Psychotherapy -CBT
 - Helpful if
 - The patient desires to be a therapy patient
 - If the patient is not motivated it will not work
 - Many elderly see therapy as proof they are now "nuts"
 - Nontraditional supportive therapists may be more palatable
 - Like ministers, priests, rabbis
 - The patient can comprehend the therapist's instructions
 - Cognitive-behavioral therapy
 - Supportive therapy
 - Make sure the therapist has some experience working with the elderly
 - Child therapy analogy

Interventions for anxious patients



- Routine
 - Structure is important since anxiety relates to loss of control
 - Many cognitively impaired residents improve with a higher level of structure because their anxiety is lessened
- Exercise
 - Physical activity burns off anxiety
 - Pacing may be the residents way of lessening anxiety
- Rote activity
 - Repetitive actions
 - From knitting to saying the rosary to rocking in a chair
- Brief, regular appointments with a trusted staff
 - For patients who wish to discuss anxiety
 - Reality testing, family phone calls, simulated presence

PERSONALITY DISORDERS IN THE ELDERLY



What is personality?

- Typical ways of perceiving self and the world
- Preferred coping mechanisms in response to stress
- Value derived from cultural, familial and individual experience.
- Most characteristic traits are formed by early adulthood including the tendency of being active or passive, the intensity in which one expresses emotion and degree of social extroversion.
- Adverse events may exacerbate negative aspects of personality however positive or adaptive traits also surface and in general baseline personality remain intact after a crisis has passed.

Personality across Lifespan



- 'Big Five' Model (Digman, 1990)
 - Neuroticism
 - Extraversion
 - Openness to experience
 - Agreeableness
 - Conscientiousness

Erik Erikson

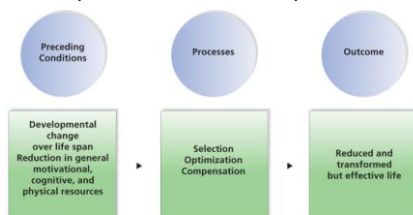
EGO-INTEGRITY-VERSUS-DESPAIR

Process of looking back over one's life, evaluating it, and coming to terms with it

- **Integrity**
 - Comes when people feel they have realized and fulfilled the possibilities that have come their way
- **Despair**
 - Occurs when people feel dissatisfied with their life, and experience gloom, unhappiness, depression, anger, or the feeling that they have failed

General Model of Successful Aging

Selective Optimization with Compensation



(Source: Adapted from Baltes & Baltes, 1992)

What is personality disorder?



- Chronically inadequate adaptive capacities affecting several realms of functioning such as social relationship or occupational performance
- DSM add criteria of pervasiveness across a broad range of situation and a long duration with onset in early adulthood

PERSONALITY DISORDER CLUSTERS

Cluster	Description	Personality Disorder
A	Odd/eccentric	Paranoid Schizoid Schizotypal
B	Dramatic/erratic	Antisocial Borderline Histrionic Narcissistic
C	Anxious/fearful	Avoidant Dependant Obsessive-compulsive

Epidemiology

- Prevalence of Personality Disorder in general population is 5-10% for all age (Agronin and Maletta 2000)
- Prevalence of PD in psychiatric settings usually three to four times higher than in the community with frequent comorbidity of axis I and II disorders (Kunik and al 1994; Zweig and Hillman 1999).

Natural History of Personality Disorder

- Most case early manifestation in adolescence or childhood
- Maladaptive traits causing major problems in social or occupational functioning and/or significant distress become more evident in young adulthood
- Impairment due to PD usually more pronounced during third and fourth decade and decreases thereafter.
- Some PD (obsessive-compulsive and schizotypal) are less likely to remit with age.

Evaluation In elderly population

- Careful and detailed review of the medical and psychosocial history.
- Collateral information particularly from family members are extremely important/useful
- Mental status and physical examination particularly neurological examination.
- Screening labs including in some case brain imaging, EEG and neuropsychological testing

Personality change in some neurologic disorders

- Dementia (e.g Alzheimer)
 - Early: apathy, narrowing of interests, loss of sense of humor, lack of social judgment, impulsivity, immaturity.
 - Late: irritability, oppositionality, aggressive outburst, suspiciousness.
- Frontal Lobe Damage
 - Apathy, indifference
 - Depression
 - Disinhibition, excitement

Association with other diagnoses-Depression

- In younger patients, the presence of a personality disorder significantly affects the treatment outcome of axis I symptoms (Peselow *et al*, 1994). *It is likely the same is true in the elderly. About a third of elderly depressed patients have a personality disorder, and this is associated with a chronic outcome for depression and poor social support.*
- Personality disorder is more common in older people with early-onset depression than late-onset depression. It may therefore reflect postdepressive personality change, predisposition to depression or a low-grade depressive subtype.
- Avoidant, dependent and compulsive traits are particularly likely to occur in patients with a depressive illness, irrespective of age. There may be an increase in compulsive traits in old age (Fogel & Westlake, 1990; Kunik *et al*, 1994).

Somatisation disorder

- Hypochondriacal personality disorder is associated with psychotic depression.
- One early study found 'hypochondria' in two-thirds of depressed elderly inpatients (De Alarcon, 1964). The main source of preoccupation was with bowels. In 30% of patients, hypochondriacal ideas preceded depressive symptoms by two to three months, demonstrating the importance of considering depressive illness in older people presenting with health anxiety, somatic preoccupation or hypochondria.
- Somatoform disorders are also common in older adults and are complicated by the frequency of concurrent physical illness. In some cases, antidepressants and psychological management, including a clear explanation and a planned physical examination, are important (Wattis & Martin, 1993).



Diogenes' syndrome

- Diogenes was a Greek philosopher, living in the fourth century B.C., who became famous for living in a barrel. When Alexander, the warlord, asked him if there was anything he could do to help, Diogenes asked Alexander to 'step out of the light'. Diogenes believed happiness could only be achieved through contemplation of oneself, and consequently, there was no need to involve others.
- The 'Diogenes syndrome' refers to a syndrome of self-neglect in older people, unaccompanied by a medical or psychiatric condition sufficient to account for the situation. It can be seen as the response of someone with a particular personality type to the hardships of old age and loneliness (Howard & Bergmann, 1993).
- Management is notoriously difficult as it is often impossible to form a therapeutic alliance with the patient.



Dementia

- Personality changes occur in organic disorders (Petry *et al.*, 1989; Dian *et al.*, 1990; Burns, 1992), although these changes are not classified as personality disorders.
- Negative personality changes are reported by relatives in two-thirds of people with dementia.
- Four patterns of personality change have been reported: alteration at onset of dementia, with little subsequent change; ongoing change with disease progression; regression to previously disturbed behaviours; and no change.
- Negative personality traits such as being more out of touch, reliant on others, childish, listless, changeable, unreasonable, lifeless, unhappy, cold, cruel, irritable and mean, tend to be attributed to people with dementia.
- Some of these perceived changes may be due to other person's reaction to the illness; some might be directly determined by organic change; and others may mark a reaction of the person, with dementia, to their experience.



Treatment

- PSYCHOTHERAPY
- PHARMACOTHERAPY
- CAREGIVER EDUCATION



Treatment issue in Elderly 1

- CBT or insight oriented psychotherapy may significantly help older individual who are functioning at higher level and are not otherwise incapacitated or seriously ill.
- For patient in psychiatric hospital or nursing home supportive and consistent psychotherapeutic contact can be of great benefit
- Individualized treatment aimed to treat specific symptoms is the most realistic approach e.g behavioral management.
- Principal feature of successful psychotherapy with geriatric patient are: consistency, availability, empathic and respectful listening, flexibility, open-mindedness.
- However global revision of maladaptive aspect of personality are unlikely to succeed.



Treatment issue in Elderly 2

- PHARMACOLOGICAL THERAPY must be guided by:
 - systematic trial for identified target symptoms area (affect, impulsivity/aggression, anxiety, thinking/psychosis).
 - assessment strategy
 - specific duration



Treatment issue in Elderly 3



- CAREGIVER EDUCATION:
 - very important for family members and care givers who may have important difficulties dealing with unfamiliar negative, disinhibited and/or inappropriate behavior.
 - Help reduce guilt, anxiety, uncertainty.
 - Help caregiver if not to accept at least to understand the “non volitional” aspect of some behaviors in patient with organic problems.

Treatment Summary



- PROVIDE STRUCTURE
- BE MATTER OF FACT. Calmly address affect-laden issues. Avoid expression of extreme emotions
- HELP PATIENT TO VALIDATE THEIR OWN EXPERIENCE by acknowledging their feelings while also CLEARLY STATING THE EXPECTATION OF BEHAVIOR CONTROL
- Consider frequent briefs, scheduled contact for needy, demanding or somaticizing patients. Gently encourage to reconsider relationship between psychological stressor and emotional stress and somatic symptoms.
- Be alert to the risk of suicide.