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Disorder of Adult Personality - A Case Report

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Abstract: ***This is the case description of an elderly lady with long standing pattern of maladapted behavior and thinking process that showed a sudden change in response to a potential change in her way of life. The patient was treated like an axis-I disorder but showed minimal response to drug therapy. Discussed here are challenges in terms of diagnosis and management of such patients along with the need for research and investigation that builds further understanding of the complex issues in this patient population.***

Keywords: elderly, maladaptive, personality, challenges

1. Introduction

Personality, defined psychologically, is the set of enduring behavioral and mental traits that distinguish between individual humans. Hence, personality disorders are defined by experiences and behaviors that differ from societal norms and expectations. Personality disorders are characterized by an enduring collection of behavioral patterns often associated with considerable personal, social, and occupational disruption. Personality disorders are also inflexible and pervasive across many situations, largely due to the fact that such behavior may be ego-syntonic (i.e. the patterns are consistent with the ego integrity of the individual) and are therefore perceived to be appropriate for that individual. This behavior can result in maladaptive coping skills and may lead to personal problems that induce extreme anxiety, distress, or depression. These behavior patterns are typically recognized in adolescence, the beginning of adulthood or sometimes even childhood and often have a pervasive negative impact on the quality of life[17, 18, 19].

2. Review of Literature

Personality disorders may be construed as long-standing patterns of maladaptive interpersonal behavior[2]. Although one's core personality is thought to remain stable over the adult years, modest variation may arise in terms of its expression with advancing age.[3] There are relatively few prevalence studies concerning personality disorder in older people, yet ICD–10 asserts that such disorders are stable and enduring over time.[4,11] The prevalence of personality disorder among older people in the community has been estimated to be about 10%.[5] Personality disorders are often associated with an Axis I psychiatric disorder, and this may compound problems for patients and care-givers.[1] Consistent relationships have been established between personality disorders and affective disorders[6], anxiety disorders[7], substance abuse[8], dementias[10] and Diogenes syndrome[9] some of which were seen as presenting complaints in the following case. Rates of personality disorder in geriatric studies appear to be highest in depressives, 31% among those with either major depression or dysthymia.[16, 17] Diagnosis of personality disorders in an elderly population is often like walking on thin ice due to a whole lot of challenges in terms of varied presentation, dearth of guidelines for assessment and therapy along with attitudes of family members, as discussed in detail in the following sections

3. Case Description

The patient was a distraught looking 57 years old lady, who came along with her younger daughter, wanting to be in a round the clock care facility as she believed that she was not being taken care of properly at home. She was a homemaker, divorced for more than 8 years, mother of two, and came with chief complaints of suspiciousness, fearfulness at being left alone, repetition in behavior, slowness in activity along with worsening in neglect of personal hygiene since 2-3 weeks.

Her daughter seemed to be readily complying with the lady's demands of a private room, a nurse and a doctor at her bedside round the clock along with her daughter, all of whom were to be instructed to behave with utmost courteousness to her, a safe or locker for her personal belongings which nobody was to touch and medications that have no adverse effects whatsoever. She got tearful briefly while reporting how she has been unable to sleep for ages and wanted to be put to sleep before we ask her any more questions. Reassurances that the interview will not take very long fell flat, as she stubbornly replied to every question thereafter with "My Brain is not working Doctor! How can I answer without my brain working?"

The patient's daughter, who was taking care of her mother for 8 years, ever since her divorce, reported that her mother had had behavioral issues throughout her adult life. She was pervasively distrustful of people, including her family, often claiming that everyone had a bad intent towards her, her mother didn't love her and even her daughter wanted her off

her back. She had also reported to have made multiple appearances at her daughter's workplace, created a ruckus and demanded that she be sacked as punishment for being an ungrateful and negligent daughter and having an immoral character.

The lady expressed fear at being left unattended to even at home, when her daughter went to work, for the past 2-3 years, which had rapidly worsened in the past 2-3 weeks. She objected to her daughter going out saying that she was an ungrateful daughter who did not care for her mother, leaving her despite knowing that terrible things can happen to old people when they are left alone at home. The lady did not allow anyone to enter their home, including friends and family, even the household help due to similar fears.

She was also seen to be checking and rechecking the locks at doors and windows at home, for any signs of forced entry. She reportedly spent on an average 3-4 hours doing the same in the entire duration of 8-10 hours during which she was unattended to in a day. This behavior continued for some time even after the daughter got back home. The patient denied any anxiety if unable to carry out these activities but did them because she was particular about each and everything in her life.

Over the past 2-3 years her daughter noticed her mother taking much more time in doing her daily activities than before. She would check and recheck every step of even simple tasks and would not be able to complete them on time. With time, she gave up on whatever little work she used to do in the household earlier, claiming that it was very stressful for her in her frail state. Similar behavior was noticed regarding her personal hygiene. She would take 2-3 hours to take a bath, during which she would clean the bathroom floor and the buckets multiple times. Soon, she reduced her frequency of bathing claiming that it involved too much thinking which stressed her out. When asked why she reported poor sleep at night making it difficult for her brain to function. Her daughter, who kept checking on her at night, reported her to be sleeping soundly. The lady, when reassured, refused to believe her daughter asking her how she could be so sure unless she had been by her bedside the whole night.

In the past 2 months, the patient sought consultation from multiple Psychiatrists with a view that she needed to be in a round-the-clock care facility. She however, did not go to any of them for a second visit citing that they could not understand her problems. Documentations of all such visits were allegedly destroyed by the patient.

2-3 weeks ago, the time when her daughter was due for promotion at work, a dramatic deterioration was seen in the lady's condition. She completely stopped maintaining cleanliness around her and would not allow anyone including her daughter anywhere near her things. She stopped bathing altogether and even refused to go to the restroom, micturating and defaecating in the living room using kitchen utensils or plastic bags. She asked for her daughter's help in cleaning up, repeatedly saying that she was too frail to walk up to the restroom. She completely began to rely on her daughter for all her daily activities from serving her food to brushing her teeth. For simple tasks like taking a spoonful of food to her mouth she kept talking about everything that could go wrong in the process multiple times and kept repeating that she cannot do all the thinking involved in the task. She asked for even simple instructions to be repeated multiple times despite clear comprehension, claiming that her brain did not work unless she understood everything perfectly. She also began to vehemently object to her daughter's going out of the house forcing her to take time off work. Disturbed by her condition, her daughter decided to seek detailed psychiatric evaluation for her.

- There was no history of a head injury or loss of consciousness
- No ongoing medical or surgical illnesses or any known allergies were reported
- No history of low mood, guilt, loss of appetite or suicidal ideation reported.
- No history of elevated or expansive mood, physical hyperactivity, reckless/ irresponsible behavior, over-religiosity, grandiosity in ideas or any sexual indiscretions.
- No history of substance related disorders

4. Past Medical/Surgical/Psychiatric History

The patient reported to have taken medical treatment for Rheumatoid Arthritis around 15 years ago when she had developed pain and swelling in the small joints of her feet. Detailed records were not available. No recurrences had been reported since then.

10-12 years ago, the patient had been feeling dragging pain along with heaviness in her feet and calves and was diagnosed with varicose veins. The patient was advised medical treatment which she took for a few months and stopped upon seeing improvement in her symptoms. Detailed records were not available. No recurrences had been reported since then.

8 years ago, around the time of her divorce, she was advised Tab. Venlafaxine 150mg/day by her brother, a medical practitioner which had reportedly made her feel "less sad and stronger". The patient had continued Venlafaxine for 3 years before stopping it spontaneously.

There had been occasional threats at self harm in the past years, the last one being January, 2016; each during alleged verbal arguments with her daughter, but no suicide attempt was reported.

5. Family History

Family of origin had an upper middle socio-economic status; the patient was the third and the only female among four siblings born of a non-consanguinous, arranged marriage. Her father had passed away many years ago due to a heart ailment, the details of which were not available. Her mother, who lived by herself, had been reported to have behavior issues that included a pervasive suspiciousness, an overall bitter demeanor and maladjusted relationships with each of her children; though no professional help was ever sought for her. In the patient's own words, her relationship with her

mother was a source of sadness throughout her early years as she apparently hated her children, the patient in particular, and succeeded in poisoning her father's mind as well towards her by the time she reached adolescence.

Her eldest brother, an ENT surgeon was settled abroad, divorced, a known case of major depressive disorder maintaining well on Tab. Venlafaxine.

Her other two brothers, who lived in another town, were married and well settled, though not in contact with both the patient and her mother.

6. Personal History

Details of the patient's birth were not available; though no birth or early childhood medical conditions were reported. The patient was reportedly a bright student and had a Bachelor's degree in Home Science but never sought employment. The patient had a non-consanguinous, arranged marriage with a businessman whom she divorced 8 years ago on grounds of infidelity and alleged physical and mental abuse for 36 years that included violence towards the patient and lack of financial and emotional support. The patient's daughter is uncertain about her father's fidelity but denied any physical or mental abuse meted out to her mother by him.

The patient had two daughters with her former husband. Her elder daughter was settled abroad and was going through a divorce at the time of the first interview. Her younger daughter, who was also her primary care-taker, was unmarried and worked as a Public Relations manager.

The daughter reported that her mother was not very active in taking care of her family even when they were children. They were prepared for school by their father and household helps. The sisters helped each other with homework and career choices, and with other issues later in life. She reported to have become distant with her elder sister after she got married and went abroad, but the two had reconnected during her sister's divorce proceedings. The patient had an uneventful menstrual history, with menopause attained 10 years ago.

7. Pre-morbid Personality

- The patient was reported to be an introvert, who never had close friends or lasting relations. She did not like new experiences and was quite averse to any change in her routine. She was reported to have always been very staunch in her beliefs and was quick to express dissatisfaction.
- The patient was not very conscientious and was known to give up easily in the face of challenges.
- She didn't take well to disagreements and was quick to take them as an insult, with a low frustration tolerance and poor adjustability, often described by her daughter as inconsiderate and self-centered.
- The patient was reported to have displayed a strong tendency to become emotionally disturbed, having a pessimistic approach to problems, and often faced difficulty making decisions.
- She had poor tolerance to criticism or suggestions at improvement and is known to hold grudges against people.

8. On Examination

The patient was seen to be pale and discolored skin was noted on both legs and feet, along with deformed toes in both feet.
Systemic examination was within normal limits except harsh breath sounds in middle and lower lung zones along with cough accompanied by minimal expectoration.

Mental status examination revealed an elderly lady, appropriately dressed but with poor personal hygiene, who appeared anguished and was pleading for help. Reaction time was variable. The patient repeated herself a number of times and asked the examiner to repeat instructions on several occasions despite a good comprehension. She denied any perceptual disturbances.

Her thinking was goal directed, though with a retardation in flow. She would often stop mid-sentence and report that she cannot think anymore, and would not proceed further until having explained herself in detail. The patient expressed a dire need to be kept in round-the-clock care which her daughter does not give her. She also said that she has a lot of important things to think about but cannot due to lack of sleep.

Attention, concentration, calculation, funds of knowledge, memory and abstract thinking were intact. Insight was grade III and social judgment was impaired. Mini Mental State Examination score was 27 out of 30.

9. Approach

The patient was admitted for evaluation and routine investigations were sent. She was found to have hemoglobin of 8.4 with a microcytic hypochromic peripheral blood picture and was started on Iron, Calcium, Vitamin D and Folic acid supplements. She was also found to have suboptimal thyroid function for which Thyroxine was supplemented. MRI- Brain showed mild age related atrophic changes. A provisional diagnosis of Paranoid Schizophrenia with obsessive-compulsive features was made and the patient was advised oral Olanzepine 10mg/day, Quetiapine 200mg/day and Lorazepam 2mg at bedtime with injectable neuroleptics if required. In the next two days Quetiapine was increased to 400mg/day but no positive response was seen.

In the coming days, keeping in view her suspiciousness and uncouth behavior towards hospital staff, poor compliance to hospice care system and a non-significant response to drug regime, the patient was advised electro-convulsive therapy, which was deferred after 4 sessions seeing no improvement, with continued suspiciousness, repetitive behavior and a stubborn disregard for hospital rules along with continued demands for special provisions and considerations.

After about 10 days in hospital and without any significant changes in presenting psychiatric symptoms, the patient complained of pain and swelling in the feet for which detailed medical work-up was done. The patient came out to be positive for anti-TPO antibodies, Anti Nuclear Antibodies (ANA), RA factor but was negative for anti-CCP antibodies. ANA blot revealed SS-A, SS-B and Rho-52 positivity. Chest radiograph showed homogenous opacities in right upper and left lower lung zones. The patient was diagnosed with Undifferentiated Connective Tissue Disease with nutritional deficiency anemia and was put on oral Hydroxychloroquine 200mg/day, oral analgesics and continued with nutritional supplements.

Meanwhile, seeing no response to the ongoing treatment, Olanzepine and Lorazepam were tapered off and the patient was started on oral Aripiprazole 10mg/day increased to 20mg/day, Pregabalin 50mg/day. Quetiapine was continued at 400mg/day and Tab. Venlafaxine was reintroduced considering her earlier positive response to the same. However, no significant change was seen in the patient's symptoms.

Detailed Neuropsychiatric examination was done using Mini International Neuropsychiatric Interview (MINI v7.0.0) based on DSM-5 which revealed predominantly paranoid and obsessive-compulsive features with a long-standing duration along with depressive and anxiety features.

To evaluate the severity of depressive features, The Hamilton Rating Scale for Depression (HAM-D), a self-report scale, was used, whose score was 18 indicating moderate depression and Montgomery-Asberg Depression Scale (MADRS), an observer rated scale, score was 17 that suggested mild depression. Another self reported scale used to evaluate the severity of anxiety experienced by the patient, The Hamilton Rating Scale for Anxiety (HAM-A) score was 10 indicating mild anxiety. On Positive and Negative Syndrome scale (PANSS), score on the positive scale was 14, negative scale was 18 and general psychopathology scale was 46. Yale- Brown Obsessive compulsive Scale (Y-BOCS) scores indicated high severity in both obsessions and compulsions. Standardized Assessment of Personality Abbreviated scale (SAPAS) score was 4 indicating further assessment of personality.

Multiphasic personality questionnaire indicated above cut-off scores for paranoid and depressive personalities. On Personality Disorders Questionnaire (PDQ-4) the patient had above cut-off scores in Paranoid, Narcissistic and Obsessive-compulsive personality disorders. International Personality Disorder Examination module based on ICD- 10 indicated significant features of both Paranoid and Anankastic (Obsessive-compulsive) Personality Disorders.

Projective tests indicated low frustration tolerance, emotional instability, maladjustment in terms of affective modulation (family) and probable self-conflict.

Rorschach test protocol revealed a below average productivity, perseveration and stereotyped thinking, emotional withdrawal, poor overall synthesizing capacity but no bizarre responses.

The patient was given a final diagnosis of Disorder of Adult Personality: Paranoid-Obsessive, Undifferentiated Connective Tissue Disease with Nutritional Deficiency Anemia and Hypothyroidism.

10. Result

The patient was started on cognitive behavior therapy along with supportive counseling for her daughter that included allocating her mother simple responsibilities, boundary setting and coping with acting-out behavior. Encouragement for social interaction and long term institutional care for her mother were also advised along with a combination of sedative, antipsychotic and anti-obsessional medication. Treatment for Unclassified Connective Tissue Disease was also continued with regular follow-up visits.

As witnessed in the latest follow-up, one month after discharge, the patient showed positive response to treatment in terms of attempting to rebuild her relationship with her mother, improvement in maintaining personal hygiene, slight reduction in repetitive behaviors, a dramatic decrease in suspiciousness and acceptance of a round the clock nurse, much to the relief of her daughter who could return to work and reported a reduction in her distress related to her mother's condition.

11. Discussion

The diagnosis and management of personality disorders, especially in an older age group face a number of complex challenges not only because of varied presentation across physiological, social and occupational contexts, but also dearth of reliable measuring instruments for older patient groups, with available measures using mostly "younger-centric" criteria often not suitable for an older population.[11] For example, the item for avoidant personality disorder, "Avoids occupational context," has poor face validity for older adults, many of whom are retired.[11]

Also, there is difficulty encountered in distinguishing functional impairments related to personality from those related to physiological and environmental aspects of aging. The need to demonstrate an early age of onset also poses a problem, especially when patients' own reports of their past functioning are used because these can be distorted by memory impairment and influenced by the stigma attached to socially undesirable behaviors, as was experienced while taking the interview in detail. Most of the assessment instruments are structured interviews that rely on self-report of behaviors, and most are of a length that can overtax elderly people while none have been specifically validated for use with elderly people. [6, 16]

When Axis I and Axis II disorders coexist, treatment efforts are generally directed first to the Axis I disorder, which usually can be approached pharmacologically, mainly anti-depressants and anti-psychotics with which physiological issues that occur with age need to be kept in mind.[11, 16] However, because personality disorders represent a range of phenomena, psychopharmacological treatments tend to less frequently target whole entities.[16] Personality-disordered patients typically have higher rates of attrition with

pharmacological treatments. [16] Other problems commonly encountered in geriatric medical practice include excessive demands on physicians' time, nuisance or importuning telephone calls, complaints of pain disproportionate to the nature of the underlying illness, misrepresentation of medical advice to family members, abuse of or gross non-adherence to medication regimens. [16]

The application of psychotherapies has been slow to develop for this population, mainly because of ageism, negative stereotypes about the treatability of older people and a perceived lack of psychotherapeutic theories for later life.[12, 13] The trend has been in favor of directive techniques such as dialectical behavior therapy (DBT), interpersonal therapy (ITP), cognitive-behavioral therapy (CBT), or problem-solving therapy (PST). However, the applicability of these therapies to older adults with personality disorders has not been specifically evaluated.[16,18] There is limited evidence to suggest that adapted cognitive–behavioral therapy (CBT) is effective in addressing negative thoughts, identifying the dysfunctional cycles that can arise and intervening in unhelpful thinking patterns of older people, with modifications to accommodate the degree of cognitive change along with sensory and physical impairment encountered among such patients.[14, 15] Consistent with the fact that dysfunctional interpersonal relationships are a hallmark of personality disorders, therapeutic alliances between patient and physician, which are at the heart of any medical treatment, are likely to be adversely affected.[16] The principles of Nidotherapy might be applied to an older population to facilitate better coping skills and social functioning by manipulating their physical and social environment. The most obvious way of doing this is to offer patients access to residential care involving the caregivers and to modify (if appropriate and possible) their reactions to untoward behavior. [11]

12. Conclusion

The literature concerning personality disorder among older people is currently quite sparse. This might be because personality disorders themselves have been rather contentious and, traditionally, old age psychiatry services have tended to focus on the management of dementia and the major Axis I disorders.[1] Faced with a lack of guidelines based on clinical research; most clinicians take a practical, atheoretical approach to problems associated with personality psychopathology in the elderly. Medications are frequently prescribed for nonstandard or "off-label" indications and the selection of specific psychotherapies tends to depend on the inclinations of the patient and the nature of clinical setting.[16]

13. Future Scope

It is likely that a greater number of patients with persistent Axis II disorders will survive into old age making the present, a good time for psychiatric researchers to investigate the complex needs and issues in day to day living in general, and in particular, associated with ageing among this group of people.[1]

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