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Review

ICD-11 and DSM-5 criteria for personality disorders: relevance for older people

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Abstract

With an aging population, the number of older adults with personality disorders will increase in the near future. There is a clinical need for adequate assessment of this age group. Diagnostic manuals have used a categorical approach to diagnosing personality disorders with little evidence to support their use in older people. Despite research on the demographics and management of late life personality disorders having progressed over time, diagnostic tool development has fallen behind. This article examines the personality disorder criteria of the DSM-5 and ICD-11, the diagnostic manuals currently in use. It discusses whether they can be applied to older people and if not, what can be done about it.

Key words

Age-Neutrality, Diagnosis, DSM-5, ICD-11, Older Adults, Personality Disorder

Introduction

Research on late life personality disorders is sparse owing to an assumption that they fade out over the lifespan. However, there is growing evidence that this is not the case. Studies show a prevalence rate of 7–80% in inpatient units.[1] With the increasing elderly population, there will be greater numbers of people with personality disorders hence an increased burden on health services.[2] The situation is not entirely bleak; many older people with personality disorders show more effective coping than their younger people, showing that experience and wisdom acquired with age may result in healthier coping responses despite probably greater exposure to losses and stressors. Dispositions that create personality disorders will probably not demonstrate much change, but their clinical presentations can sometimes be refined in ways that are less distressing for patients and carers. The timely identification of these patients is desperately needed so that they can receive support required to reduce their suffering.[3]

The Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD) are used to diagnose personality disorders. The eleventh edition of the ICD (ICD-11) will officially come into effect in 2022.[4] In contrast to the DSM system, the ICD system is the official world classification system for all diseases, including personality disorders.[5] The fifth edition of the DSM (DSM-5) was published by the American Psychiatric Association in 2013. The fourth edition of the DSM (DSM-IV), DSM-5 and the tenth edition of the ICD adopted a categorical approach to diagnosing personality disorders. In view of the evidence base not supporting the categorical model, both the DSM-5 and ICD-11 moved towards a dimensional approach; a focus on levels of impairment and personality traits.[6,7] A tremendous focus on traits versus categories has taken attention away from a consideration of personality disorders in later life.[8]

DSM-5 criteria for personality disorders

Since the release of DSM-III, experts have discussed alternatives to the categorical approach to diagnosing personality disorders which was considered to demonstrate poor validity and lack of clinical utility.[9] The belief that personality disorders are categories is not supported by the literature. The allocation of symptoms to certain disorders does not correspond to their empirical covariation. Thus, many patients erroneously received numerous personality disorder diagnoses, a "not otherwise specified" personality disorder diagnosis or no diagnosis, even it was applicable to the clinical presentation.[10] A dimensional approach was initially recommended for DSM-5, in view of the diagnostic heterogeneity within categories. The Board of Trustees of the American Psychiatric Association decided to maintain the DSM-IV-TR categorical conceptualization of personality disorder in Section II of the DSM-5 in order maintain continuity with current clinical practice. The proposed alternative model of personality disorders (AMPD) was included in Section III 'Emerging measures and models' of the DSM-5 as it needed more study.[9] In the AMPD, the individual's personality is assessed in terms of personality functioning (Criterion A) and personality traits (Criterion B). Personality functioning is characterized by how an individual typically experiences him- or herself (identity and self-direction) as well as others (empathy and intimacy), while a personality trait is

the tendency to feel, perceive, behave, and think in relatively consistent ways across time and situations.[11]

Criterion A, assessed by the Level of Personality Functioning Scale (LPFS), aims to assess the presence and general severity of personality pathology by delineating five levels of impairment of personality functioning, ranging from little or no impairment (Level 0) to extreme impairment of personality functioning (Level 4). Criterion B refers to 25 pathological personality traits organized around 5 broad domains, negative affectivity, detachment, antagonism, disinhibition, and psychoticism. A moderate or greater impairment of personality functioning as well as the presence of at least one pathological personality trait are required in order to establish a personality disorder diagnosis. In addition to these 2 primary criteria, criteria C and D refer to inflexibility and stability across time, respectively. Criteria E, F, and G refer to ensuring that the personality disorder is not better explained by "another mental disorder" (E), the effects of a substance or a medical condition (F), and to not being normative for the person's developmental stage or sociocultural environment (G).[4]

Combinations of functioning and traits are used to redesign antisocial, avoidant, borderline, narcissistic, obsessive-compulsive, and schizotypal personality disorders.[12] Personality disorder-trait specified replaces personality disorder not otherwise specified (a common DSM-IV diagnosis) in order to specify presentations that do not fit into particular types.[4] The measurement model of the pathological personality traits is the Personality Inventory for DSM-5 (PID-5).[13]

The PID-5 includes both self-report and informant report versions whereas the LPFS instrument is rated by a clinician.[12,13] Unlike the DSM-5, the ICD-11 does not contain an assessment of self-pathology.[14] The use of the LPFS and the PID-5 in the assessment of personality functioning and traits is relevant whether an individual meets criteria for a PD or not, as it is always important to know a person's difficulties and strengths. In contrast to the categorical approach, personality functioning as well as personality traits apply to everyone in different degrees rather than being present versus absent.[11]

ICD-11 criteria for personality disorders

There were problems with the ICD-10 diagnostic criteria for personality disorders which included a lack of evidence for 10 distinct categories and insufficient clinical utility. In contrast to assessing other mental disorders, assessing personality disorders is more difficult in routine clinical practice.[6] In response to these shortcomings, the ICD-11 adopts a dimensional approach thereby being notably closer to the AMPD than to the DSM-IV PD model.[4]

The first step is to classify the impairment of self and interpersonal personality functioning according to degree of severity ("Personality Difficulty", "Mild Personality Disorder", "Moderate Personality Disorder", and "Severe Personality Disorder"). One option is to stop there, concluding simply that a PD is present to a specific degree. However, the assessor also has the option to further describe the features of the case, using specifiers akin to the domains of the AMPD.[4] Specifically, the ICD-11 model describes trait domains of negative affectivity, detachment, dissociality, disinhibition, and anankastia. An optional qualifier is provided for 'borderline pattern', which was added to ensure continued recognition of borderline personality disorder, which has been of most use and interest to clinicians.[3] Personality Difficulty is not considered to be a mental disorder. One would have some problems in functioning which are not severe enough to cause significant disruption in social, occupational, and interpersonal relationships. Such problems may be restricted to specific relationships or situations. Problems with emotions, cognitions, and behaviours occur intermittently (e.g., during times of stress) or tend to be of a low intensity.[6]

Can late onset personality disorders get diagnosed using the ICD-11 and DSM-5?

The applicability of criteria is questionable since the presentation of late life personality disorders was not sufficiently considered during the development of the DSM categorical or dimensional models, leading one to question their age-specificity and age-neutrality.[15]

The DSM-5 and ICD-11 refer to personality traits as being "relatively stable" across time. This would suggest stability across adulthood and into old age or for a limited period of years. The literature on older adults discusses how the expression of personality disorders varies according to the unique contexts and frequently occurring challenges of later life. In some cases, a person who earlier did not have a diagnosable personality disorder, may develop one later in life. Sometimes, emergence of personality disorder in older adults may be related to the loss of social supports that had previously helped to compensate for personality disturbance.[6] In an international Delphi study, experts on personality disorders in older adults reached a consensus on the concept of a 'late-onset personality disorder'. This concept is consistent with ICD-11.[16]

The ICD-11, in particular, does not have an age limit for making a diagnosis except to have a preference for the presentation of the condition to have been present continuously for at least 2 years. Evidence suggests that this will probably raise the prevalence level of personality disorders in the population thus promoting the use of the diagnosis in older people.[17]

Most DSM-5 diagnostic criteria using the categorical approach do not take into account age-specific changes in behaviour and interpersonal functioning. In the ICD-11, the estimation of severity focuses on harm to self or others. Older adults with severe personality disorders, in contrast to younger people, tend to undergo diet restriction or medication misuse rather than self-mutilation.[3]

Diagnostic tools for older people

There is a shortage of diagnostic instruments for older people. Moreover, tools to assess personality disorder in older adults are not well validated, raising questions about the DSM-5 diagnostic criteria using the categorical approach.[16] Diagnostic tools are generally not considered suitable for older people as they are in the form of lengthy structured interviews (particularly PID-5) that rely on the self-reporting of behaviours, which can be overwhelming for this age group.[3] Lengthy instruments are not deemed practical to use in psychogeriatrics due to comorbidity of somatic and other psychiatric and problems.[18] Modern language often used in diagnostic assessment may not be helpful for older adults with less formal education. Language use can affect the validity of instruments. Older adults, in contrast to younger adults, are less likely describe their lives in terms of "problems" or "stress".[19] Personality disorders can manifest differently in later life as a result of psychosocial stresses, cognitive impairment and medication. Instruments do not always apply to older adults as most of the items were designed for younger adults. For example, borderline personality disorder criteria may be problematic for older adults. It would make sense for them to avoid abandonment, as they are dependent on others for support to meet their care needs.[3] Despite the paucity of diagnostic instruments specifically for older adults, research on assessing later life personality disorders is growing.[20]

The Severity Indices of Personality Problems (SIPP–118), a self-report questionnaire, has been shown to be a favourable tool for measuring personality pathology in younger people.[21] A number of studies have supported the psychometric qualities of the PID-5 however the later life context was not explicitly investigated during its development.[22,23] Due to the SIPP-118 being time-consuming and intensive for older adults, the shorter version i.e. the Short Form of the Severity Indices of Personality Problems (SIPP-SF) would be preferably used.[21] The same could be said for PID-5's shorter version i.e. Personality Inventory for Diagnostic and Statistical Manual of Mental Disorders, Fifth edition, Brief Form (PID-5-BF). The Dimensional Assessment of Personality Pathology – Basic Questionnaire (DAPP-BQ) contain factors for emotional dysregulation, dissocial behaviour, social avoidance and compulsivity. The DAPP-BQ has demonstrated a strong four-factor structure across various samples and cultures.[24]

The Gerontological Personality disorders Scale (GPS) is a screening tool for late life personality disorders that has been validated in community-dwelling elderly people sampled from general practices.[20] The literature shows that the SIPP-SF, PID-5-BF, DAPP-BQ and GPS are adequate instruments for assessing late personality disorders. However, as the studies were undertaken in either the general population or highly specific and relatively small study samples, the generalizability of these results may be limited. Overall, these studies indicate that over age groups the presentations of personality functioning (criterion A) can be more accurately assessed than the dysfunctional personality traits (criterion B). Moreover, it appeared that personality functioning and maladaptive traits were more strongly correlated in older adults than in younger people. This would suggest that, in older people, certain domains of personality functioning can be more indicative for the presence of maladaptive traits.[20]

The Five Factor Model (FFM) helps one to understand both normative personality and maladaptive personality/personality disorders. It consists of the five broad domains of neuroticism, extraversion, openness, agreeableness, and conscientiousness. The FFM has empirical support across eastern and western cultures and a demonstrated temporal stability across the lifespan.[25] The five trait domains included in Section III of DSM-5 are maladaptive variants of the FFM which also served as a framework for the development of the ICD-11 dimensional approach The FFM was a natural candidate given its robust representation in the literature and established connections to personality disorders.[25,26] The Five Factor Model is most commonly assessed using the Revised NEO Personality Inventory (NEO PI-R) whose age-neutrality has been empirically validated. An FFM count technique was developed that became a valid screening tool for the assessment of pathological personality traits in older adults.[27]

Studies on the face validity of DSM–5 categorical model demonstrate a bias against older adults. The Assessment of DSM–IV Personality Disorders (ADP–IV) is a self-report instrument that allows for both a dimensional and categorical assessment of the DSM–5 Section II personality disorder symptoms. A study of the ADP–IV showed that dimensional PD items gave a more nuanced analysis of different personality disorder symptom presentation across age groups.[18]

There are to date no instruments to screen the severity of later life personality disorders. A tool to detect older adults with severe personality disorders was developed via Delphi method, based on expert opinion. Psychometric properties were evaluated showing sufficient diagnostic accuracy. The tool could be used to detect older adults with severe personality disorders in order to refer them to highly specialized care in a timely manner.[1]

In view of the DSM-5 dimensional approach (particularly criterion A) demonstrating age-neutrality, information from diagnostic instruments created for the AMPD model can be used to form an ICD-11 personality disorder diagnosis. For example, the Structured Clinical Interview for the DSM-5 Alternative Model of Personality Disorders (SCID-AMPD) operationalizes personality functioning according to the DSM-5 Level of Personality Functioning Scale (LPFS) along with the 25 DSM-5 trait facets. The LPFS score along with the 25-facet personality profile can be converted into an ICD-11 Personality Disorder diagnosis using a "cross walk".[6]

It is also vital to also use other sources of information in order to complement the assessment and guide its interpretation. Older adults may have had several

treatments during their life therefore their medical and/or psychiatric records can provide insight into their personality traits and psychosocial functioning. Informant report can be useful in verifying life-events when sensory and cognitive impairment can impact on self-reports. Self-reports can also be influenced by impaired self-awareness, severe psychopathology or an unwillingness to reveal information. Excluding medical conditions such as head trauma, is also advised.[20]

Strengthening the evidence base for older people

There is the challenge of comparing personality disorder definition in the DSM-5 with late life epidemiological studies relating to the DSM-IV. There is also the question of what appropriate diagnostic labels can be given to paranoid, schizoid, histrionic, and dependent personality disorders; research suggests that these diagnoses can increase over the lifespan. Clinicians need to have a clear view on how the DSM-IV and DSM-5 relate to each other on the subject of late life personality disorders.[23]

Information on the course of personality disorders across the lifespan is deficient as a consequence of research being mostly in the form of reviews, editorials, comments, case reports and cross-sectional studies.[3] This could explain why it is difficult to ascertain their onset and temporal stability. More research including longitudinal studies are needed to ascertain whether the dimensional models of DSM-5 and ICD-11 can reflect changing presentations of personality disorders over time.[28]

Age-neutral measures are useful in that clinicians can rely on valid assessment instruments without having to adjust items to assess older adults. However, some clinicians may prefer measures validated for older people with items that explore the specific aging context. Further research and validation of such instruments are needed.[19] Investigating into previously examined instruments across various settings and cultures of older adults should also be carried out.[20]

A screening tool to detect older people with severe personality disorders and to direct them to the appropriate level of treatment would be beneficial. Increasing our knowledge about criteria for different levels of treatment would improve the efficacy of treatment for patients.[2]

Conclusions

There is evidence of ongoing efforts to examine the age-neutrality of existing diagnostic measures, design age-specific tools and validate diagnostic tools in older adults. Poor awareness of personality pathology can drive up costs of mental health treatment due to time taken up by staff to manage issues caused by people with personality disorders, especially in long term care settings. A greater understanding of late life personality disorders can help professionals create effective management strategies in order that hospitalizations can thus be prevented. The dimensional models appear age-neutral and may be useful in later life.

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