1. First1995

The Structured Clinical Interview for DSM-III-R Personality Disorders (SCID-II): I. Description.

First, Michael B.; Spitzer, Robert L.; Gibbon, Miriam; Williams, Janet B. W.

Journal of Personality Disorders, Vol 9(2), 1995, 83-91.

Presents the history and description of the SCID-II. The SCID-II is a clinician-administered semistructured interview for diagnosing the 11 Axis II personality disorders of the Diagnostic and Statistical Manual of Mental Disorders-III-Revised (DSM-III-R) plus the Appendix category self-defeating personality disorder. The SCID-II is unique in its design with the primary goal of providing a rapid clinical assessment of personality disorders without sacrificing reliability or validity. It can be used in conjunction with a self-report personality questionnaire, which allows the interview to focus only on the items corresponding to positively endorsed questions on the questionnaire, thus shortening the administration time of the interview. One limitation of the SCID-II's ordering of questions is that making positive (or negative) ratings for several items in a disorder may bias the ratings of the remaining items.

Health and Quality of Life Outcomes

2. Moore2005 (truncated)

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Can the concepts of depression and quality of life be integrated using a time perspective?

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Abstract

Background: Little is understood about the conceptual relationship of depression and quality of life (QoL). Judgments concerning both, implicitly or explicitly, involve a time perspective. The aim of this study was to test de Leval's theoretical model linking depression and QoL with a time perspective. The model predicts that changes in cognitions about one's past, present and future QoL, will be associated with changes in depressive symptomatology.

Methods: Eighteen psychiatric in-patients with a clinically confirmed diagnosis of depression were assessed on commencing treatment and 12 weeks later. QoL was assessed by the Schedule for Evaluation of Individual Quality of Life (SEIQoL), depression by the Beck Depression Inventory (BDI-II) and hopelessness by the Beck Hopelessness Scale (BHS). Time perspective was incorporated by asking QoL questions about the past, present and future.

Results: Depression and hopelessness were associated with a poorer present QoL. Depression lowered present QoL but did not alter future QoL, as these remained consistently high whether participants were depressed or recovering. However, depressed individuals had a larger gap between their actual present QoL and future (aspired to) QoL. Changes in QoL were influenced by depression and hopelessness. Contrary to the model, perception of "past" QoL was not affected by depression or hopelessness.

Conclusions: de Leval's model was largely confirmed. Thus depression and hopelessness influence a person's present and future QoL. The analysis of a temporal horizon was helpful in understanding the link between depression and QoL.

Background

Assessment of quality of life (QoL) has become increasingly important in health care, particularly as an evaluative method to measure outcomes of the impact of disease and interventions. To date it is unclear how research on QoL relates to other psychological constructs such as depression and anxiety. Many clinical studies assess a number of related psychosocial dimensions but without a

theoretical basis for the unique contribution of each. On an intuitive level, QoL and depression can appear as opposing phenomena – crudely representing all the positive and negative aspects of well-being. Poor QoL is sometimes seen as a consequence of depression [1-3]. On the other hand, poor QoL may also be a precursor to depression. In other formulations, depression can be seen as a component of QoL. Whatever the implicit models of their interrelationships, there has been little theoretical attention or research to understand the relationship between depression and QoL.

A theoretical approach developed by de Leval [4,5,8] tries to capture and highlight possible relationships between depression and QoL in a "three-time-dimension" theory. This theory links depression and QoL on a timeline of the past-present-future. Time can be perceived objectively and subjectively. It consists of three dimensions: past, present and future. The presence of psychopathology, e.g. depression has been found to influence time perception. For instance, individuals who are depressed have been reported as finding that time passes more slowly [11]. In comparison to others, depressed individuals also have a temporal focus, which is less future directed and more focused on the past.

The "three-time-dimension" theory describes the dislocated temporal horizon of the depressed patient. It situates both depression and quality of life as part of a continuum in time rather than as independent phenomena. De Leval proposes that, for the depressed individual, time passes slowly, the present is dissociated from the past and the potential for the future is lost or viewed with hopelessness [4]. During the course of their depression, individuals want to go back to their past when things were perceived as better. This searching for the past becomes the individual's future. According to de Leval, depressed individuals have two pasts: the actual past when they were well and the past as a position they wish to regain or aspire to, i.e. the 'therapeutic future', when things were better than they are in the present. In the proposed model by de Leval, in accordance with DSM-III-R criteria, depression is referred to as "ill-being". Ill-being is the current or present state of the patient experiencing depression. De Leval uses the term depression for "phenomenological-depression", i.e., depression as perceived by the individual in question and it is placed on the past-present timeline. She proposes that this "phenomenological-depression" is related to the perception of a gap between a healthy past and a present ill-being. The greater the gap between past and present, the greater the phenomenological-depression.

In de Leval's theory, QoL is perceived as the gap between actual experience and future aspirations. Whereas depression is placed on the past-present timeline, QoL is placed along the timeline using present and future. QoL according to this model is defined as being "the appropriateness of future aspirations to the present" or "the making present of the future". The larger the gap, the lower the QoL of the individual (Figure 1). Although not included explicitly in de Leval's theory, the concept of hopelessness as described by Beck [2] is worth considering given its timeline focus on negative evaluations of the future.

In a cross-sectional study, de Leval [5] examined the three-time-dimension theory in a group of 110 clinically depressed psychiatric patients. They completed a 30-item questionnaire – the Three-Time-dimension Synoptic Scale (3TSS – French version) developed by the author [6]. Questions were chosen to reflect the content of existing mental health scales and each question asked about their feelings now, their feelings in the past (before being depressed) and what they wanted to feel in the future. Findings indicated preliminary support for the theory. No other study has to our knowledge tested Leval's theory empirically.

The present study sought to advance the understanding about the conceptual relationship of depression and QoL by empirically testing de Leval's model in a longitudinal study. It also sought to assess the model using a previously developed individualised system for assessing QoL. If de Leval's proposals concerning the centrality of the temporal assessment are correct, then any QoL assessment instrument which measures the present can be adapted to measure the past and the future as aspired to. In this study, the model was operationalised as follows: scores on standardised depression measures were taken to demonstrate an individual's level of depression, i.e., 'present ill-being'. QoL was the gap between an individual's present status ('*present ill-being*' in the case of depression) and anticipated status (i.e '*therapeutic future*') and was measured by the discrepancy between *present* and *future* actual QoL scores. The level of *phenomenological depression* – i.e. the gap between a person's perceived *past* and *present* "*ill-being*" was measured by the discrepancy between the past and present actual QoL scores. These gaps are referred to as time comparisons gaps. The full model is displayed in Figure 1. In addition to components of de Leval's model, aspirational QoL was measured and assessed for all three time periods: past, present and future. This was included to provide further information about the gap between where an individual is and where he/she would like to be. These gaps are referred to as preference comparisons gaps. It was hypothesized that the greater the gap between actual and aspirational scores at any time (past/present/future), the worse the QoL and vice versa. This reflects Calmans definition of QoL. He defines QoL as the gap between actual QoL and preferred QoL [3]. As an

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Quality of life in patients with personality disorders seen at an ordinary psychiatric outpatient clinic

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Abstract

Background: Epidemiological studies have found reduced health-related quality of life (QoL) in patients with personality disorders (PDs), but few clinical studies have examined QoL in PDs, and none of them are from an ordinary psychiatric outpatient clinic (POC). We wanted to examine QoL in patients with PDs seen at a POC, to explore the associations of QoL with established psychiatric measures, and to evaluate QoL as an outcome measure in PD patients.

Methods: 72 patients with PDs at a POC filled in the MOS Short Form 36 (SF-36), and two established psychiatric self-rating measures. A national norm sample was compared on the SF-36. An independent psychiatrist diagnosed PDs and Axis-I disorders by structured interviews and rated the Global Assessment of Functioning (GAF). All measurements were repeated in the 39 PD patients that attended the 2 years follow-up examination.

Results: PD patients showed high co-morbidity with other PDs and Axis I mental disorders, and they scored significantly lower on all the SF-36 dimensions than age- and gender-adjusted norms. Adjustment for co-morbid Axis I disorders had some influence, however. The SF-36 mental health, vitality, and social functioning were significantly associated with the GAF and the self-rated psychiatric measures. Significant changes at follow-up were found in the psychiatric measures, but only on the mental health and role-physical of the SF-36.

Conclusion: Patients with PDs seen for treatment at a POC have globally poor QoL. Both physical and mental dimensions of the SF-36 are correlated with established psychiatric measures in such patients, but significant changes in these measures are only partly associated with changes in the SF-36 dimensions.

Background

According to the DSM-IV [1] personality disorders (PDs) are characterized by enduringly deviating patterns of perceiving, relating to, and thinking about the environment and oneself that are exhibited in a wide range of social and personal contexts. Such patterns lead to "clinically significant distress or impairment in social, occupational, or other important areas of functioning". The DSM-IV does not indicate how "clinically significant distress or impairment" (page 633) should be evaluated, however, and a recent study showed that various formulations of this criterion hardly increased diagnostic validity [2].

disorder and/or severe socio-economic problems. Many patients seen at Furuset POC were out of work due to mental disorders, and/or due to socio-economic circumstances.

Patients

Patients aged from 18 to 75 years were consecutively recruited from January 1, 1996 to June 30, 1998. The patients were referred from the local GPs, and physical examination and adequate treatment and follow-up of physical diseases were the responsibility of the GPs. The six therapists screened for probable PDs among new patients scheduled for treatment. Exclusion criteria were mental retardation, lifetime psychosis and bipolar disorder, organic mental disorders, current strong suicidal ideation, and insufficient knowledge of the Norwegian language. Eligible patients received oral and written information about the study from their therapists. Then the patients were invited to take part in the study, and they all gave written informed consent. The Ethical Review Board of Department of Psychiatry, Aker University Hospital approved the project.

The six therapists did not miss out any patients at screening, but 5 (4%) eligible patients declined to take part in the study. Among 110 eligible patients referred to the study, only 91 filled in the SF-36 at baseline due to administrative misunderstandings. However, when they were compared to the 19 who did not fill in, the non-attenders only had significantly fewer co-morbid Axis I-disorders (data not shown).

In order to answer the research questions, the sample was divided into three groups: cluster A+B PDs (n = 39), cluster C (n = 33), and Axis I-disorders (n = 19). The cluster A+B group could also contain co-morbid cluster C PDs and Axis I-disorders, and the cluster C co-morbid Axis I-disorders.

Follow-up procedure

Two years after baseline, the patients received a mailed written appointment for a follow-up interview. Those who did not show up were sent a written reminder. If they still did not meet, they were called by phone, and if there was no answer, their addresses and phone numbers were checked at the Census register. Appointments were mailed to new addresses, and phone-calls were made in case of non-response. Only a few patients responded to these extended search procedures.

Norm sample

Norm data on the SF-36 was obtained from the Survey of Level of Living in Norway 1998 [18] comprising 6.638 participants aged 23 to 75 years. The norm data were adjusted by gender and distribution into 5-year age groups in relation to the PD sample.

Assessments

At baseline, diagnoses of PDs were made with the use of the Personality Disorder Examination, and Axis I-disorders were diagnosed by the MINI-International Neuropsychiatric Interview. Anamnestic data were collected, and global assessment of function was rated. The professional-based interviews and examinations of all patients at baseline and follow-up were carried out by a single experienced psychiatrist (KN), who did not take part in any treatment given.

All patients also filled in the following self-rating instruments at baseline: the SF-36, the Social Adjustment Scale, and the Symptom Checklist 90-Revised Personality Severity Index.

At follow-up all these assessments were repeated, and additional information about treatment as well as job/education, social- and family changes was collected.

Measures

Professional-rated

The *Personality Disorder Examination* (PDE) [19] is a structured clinical interview for PDs according to the DSM-III-R with good inter-rater reliability, and wide international application. Findings are reported as PD diagnoses, and as dimensional PD scores based on the sum of the scoring on each PD criterion (0: not present, 1: probably present, and 2: definitely present). Dimensional scores for the PD clusters are used as a main psychopathology variable, and the numbers of PDs are also reported.

The *MINI International Neuropsychiatric Interview* [20] was used to diagnose Axis-I disorders according to DSM-IV. The MINI covers 18 Axis-I disorders, has been translated into many languages and has demonstrated good inter-rater reliability. Findings are reported as numbers and percentages of patients with positive Axis-I diagnoses, and as mean number of such diagnoses.

The *Global Assessment of Functioning (GAF)* is a rating scale for the current evaluation of the overall functioning of a subject on a continuum from severe mental disorder to complete mental health that was defined as Axis V of the DSM-IV. Scale values range from 1 (sickest individual) to 100 (the healthiest person). The scale is divided in ten equal intervals from 1 – 10 to 91 – 100. Most outpatients will be rated between 40 and 70, although some individuals rated above 70 may seek therapy. The GAF is a reliable instrument [21], and the cut-off score for 'minimal impairment' has been set at 70 points or higher [22] and for 'serious mental disorder' at lower than 60 [3].

Table 5: Changes from baseline to follow-up in patients with personality disorders (n = 39).

Measure	**Baseline** Mean (SD)	**Follow-up** Mean (SD)	**P**
SF-36			
Physical Functioning	79.4 (19.2)	76.8 (24.6)	.95
Role Physical	31.4 (34.3)	51.3 (38.5)	.01
Bodily Pain	47.6 (28.9)	57.5 (25.6)	.06
General Health	51.4 (23.5)	56.0 (26.6)	.22
Vitality	35.0 (19.6)	36.3 (21.4)	.70
Social functioning	45.2 (28.5)	53.5 (28.7)	.09
Role-emotional	42.7 (39.7)	41.9 (38.0)	.89
Mental Health	42.5 (23.2)	50.1 (22.3)	.03
Global Assessment of functioning	46.0 (9.4)	54.6 (9.6)	< .001
Total no of PD criteria	34.8 (17.9)	25.7 (11.5)	< .001
SCL-90-R PSI	1.52 (.86)	1.30 (.80)	.035
Social Adjustment Scale (SAS)			
Overall adjustment	2.66 (.63)	2.42 (.62)	.007
Work	2.76 (1.49)	2.36 (1.39)	.20
Social and leisure	3.17 (1.22)	2.87 (1.11)	.045
Extended family	2.05 (.52)	1.97 (.50)	.34

correspond to findings of clinical studies of patients with anxiety disorders, depression, schizophrenia, and substance dependence [27-30]. However, the SF-36 dimension mean scores of our PD sample are lower than those reported for these diagnoses, and for co-morbid disorders [31]. In our sample we did not find any significant differences between the SF-36 dimension scores of the cluster A+B, cluster C, or Axis I groups, and all groups had significantly lower scores on all dimensions than their age- and gender-adjusted norm groups.

In contrast to the epidemiological study from Australia [12] we did not find worsening of MCS and PCS with increasing number of PDs present in our sample. This could be due to our small samples, but also due to the fact that our patients with 1 PD had considerably lower QoL than in the Australian survey [MCS: 33.7 (SD 10.6) versus 44.4 (SD 12.0), p < .001, and PCS: 43.8 (SD 8.6) versus 46.9 (SD 11.0), p = .03].

Comorbid Axis I disorders explained a significant part of scores of PF, GH, VT, SF, and MH scores of the total PD group. This is in accordance with the findings of the Australian study [12].

We found that the SF-36 dimensions had variable associations with established psychiatric measures. As expected the SF-36 MH was most strongly associated with the psychiatric measures, but so were also SF and VT. For the SAS we found that overall adjustment and social and leisure activities were significantly correlated to all the SF-36 dimensions. In our PD sample we observed a somewhat different pattern of significant correlations between the GAF and the SF-36 dimensions than reported by Meijer et al. [32] in patients with schizophrenia. Small sample sizes and different diagnostic classes could be the explanation. However, in sum the SF-36 had a considerable association with established psychiatric measures in our PD sample.

For both the patient- and professional-rated psychiatric measures significant changes at follow-up after treatment was observed in the 39 patients who also scored themselves on the SF-36. We cannot say if these changes were related to treatment, and ours is not an outcome study. We wanted to examine if changes in established psychiatric measures were associated with changes in the QoL measured by the SF-36 in the PD patients seen at a POC.

Significant changes at follow-up were found for only two of the SF-36 dimensions, however, one physical (RP) and one mental (MH). While the finding for MH was expected, the change in RP which covered problems with work or other daily activities as a result of physical health was more difficult to explain. The score on that dimension was extraordinarily low at baseline (mean 31.4), and regression towards mean could be a likely explanation. It seemed that only MH of the SF-36 changed in the same way as established psychiatric measures in our study. The

4. Psychopathy (truncated)

http://www.patient.co.uk/doctor/personality-disorders-and-psychopathy

Personality Disorders and Psychopathy

PatientPlus articles are written by UK doctors and are based on research evidence, UK and European Guidelines. They are designed for health professionals to use, so you may find the language more technical than the condition leaflets.

Introduction

A personality disorder is defined, in the Diagnostic and Statistical Manual of the American Psychiatric Association, 4th Edition (DSM-IV), as an enduring pattern of inner experience and behaviour that differs markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time and leads to distress or impairment. Personality disorders are a long-standing and maladaptive pattern of perceiving and responding to other people and to stressful circumstances.

The International Classification of Mental and Behavioural Disorders (ICD-10) (World Health Organization 1992), defines a personality disorder as: a severe disturbance in the characterological condition and behavioural tendencies of the individual, usually involving several areas of the personality and nearly always associated with considerable personal and social disruption.

The aetiology of personality disorders remains obscure. Traditional belief is that these behaviours result from a dysfunctional early environment that prevents the evolution of adaptive patterns of perception, response and defence.

Factors in childhood which are postulated to be linked to personality disorder include:[1]

- Sexual abuse
- Physical abuse
- Emotional abuse
- Neglect
- Being bullied

Emotional or behavioural factors that might play a part include:

- Truanting
- Bullying others
- Being expelled/suspended
- Running away from home
- Deliberate self-harm
- Prolonged periods of misery

The evidence base supporting a link between personality disorder and genetic factors is growing.[2]

People with personality disorders are at increased risk for many psychiatric disorders. Mood disorders are a particular risk across all personality diagnoses. Patients with depression and personality disorder have a more persistent condition than those who have depression alone.[3]

5. Morse2005

American Journal of Geriatric Psychiatry:
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Regular Research Article

Impact of Cluster C Personality Disorders on Outcomes of Acute and Maintenance Treatment in Late-Life Depression

Morse, Jennifer Q. Ph.D.; Pilkonis, Paul A. Ph.D.; Houck, Patricia R. M.S.H.; Frank, Ellen Ph.D.; Reynolds, Charles F. III, M.D.

Abstract

Objective: Personality disorders (PDs) have been associated with poor treatment outcomes in acute treatments for late-life depression and with persistent functional impairment after recovery from an episode of depression.

Methods: Using survival analysis and mixed-effects models, the authors examined the impact of Cluster C PDs on time-to-response and several aspects of functioning in acute and maintenance treatment of major depression in later life.

Results: Cluster C PDs were associated with longer time-to-response during acute treatment and non-response in continuation or maintenance treatment. Although not statistically significant, there was evidence of a cumulative negative impact of Cluster C PDs and residual depressive symptoms on instrumental activities of daily living (IADLs) during maintenance treatment.

Conclusions: These findings suggest that screening for PD may be important for clinicians treating late-life depression and that the combination of Cluster C PDs and residual depressive symptoms may predict functional declines even after recovery from the index episode of depression.

6. Harper1998 (truncated)

Psychological Medicine, 1998, **28**, 551–558. Printed in the United Kingdom

Development of the World Health Organization WHOQOL-BREF Quality of Life Assessment

THE WHOQOL GROUP[1–3]

ABSTRACT

Background. The paper reports on the development of the WHOQOL-BREF, an abbreviated version of the WHOQOL-100 quality of life assessment.

Method. The WHOQOL-BREF was derived from data collected using the WHOQOL-100. It produces scores for four domains related to quality of life: physical health, psychological, social relationships and environment. It also includes one facet on overall quality of life and general health.

Results. Domain scores produced by the WHOQOL-BREF correlate highly (0·89 or above) with WHOQOL-100 domain scores (calculated on a four domain structure). WHOQOL-BREF domain scores demonstrated good discriminant validity, content validity, internal consistency and test–retest reliability.

Conclusion. These data suggest that the WHOQOL-BREF provides a valid and reliable alternative to the assessment of domain profiles using the WHOQOL-100. It is envisaged that the WHOQOL-BREF will be most useful in studies that require a brief assessment of quality of life, for example, in large epidemiological studies and clinical trials where quality of life is of interest. In addition, the WHOQOL-BREF may be of use to health professionals in the assessment and evaluation of treatment efficacy.

INTRODUCTION

Quality of life is defined by the World Health Organization Quality of Life (WHOQOL) Group as individuals' perceptions of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. This definition reflects the view that quality of life refers to a subjective evaluation

[1] This paper was written by Alison Harper and Mick Power on behalf of the WHOQOL Group.

[2] The WHOQOL Group comprises a coordinating group, collaborating investigators in each of the field centres and a panel of consultants. Dr J. Orley directs the project. The work reported on here was carried out in the 15 initial field centres in which the collaborating investigators were: Professor H. Herrman, Dr H. Schofield and Ms B. Murphy, University of Melbourne, Australia; Professor Z. Metelko, Professor S. Szabo and Mrs M. Pibernik-Okanovic, Institute of Diabetes, Endocrinology and Metabolic Diseases and Department of Psychology, Faculty of Philosophy, University of Zagreb, Croatia; Dr N. Quemada and Dr A. Caria, INSERM, Paris, France; Dr S. Rajkumar and Mrs Shuba Kumar, Madras Medical College, India; Dr S. Saxena and Dr K. Chandiramani, All India Institute of Medical Sciences, New Delhi, India; Dr M. Amir and Professor D. Bar-On, Ben-Gurion University of the Negev, Beer-Sheva, Israel; Dr Miyako Tazaki, Department of Science, Science University of Tokyo and Dr Ariko Noji, Department of Community Health Nursing, St Luke's College of Nursing, Japan; Professor G. van Heck and Dr J. De Vries, Tilburg University, The Netherlands; Professor J. Arroyo Sucre and Professor L. Picard-Ami, University of Panama, Panama; Professor M. Kabanov, Dr A. Lomachenkov and Dr G. Burkovsky, Bekhterev Psychoneurological Research Institute, St Petersburg, Russia; Dr R. Lucas Carrasco, University of Barcelona, Spain; Dr Yooth Bodharamik and Mr Kitikorn Meesapya, Institute of Mental Health, Bangkok, Thailand; Dr S. Skevington, University of Bath, United Kingdom; Professor D. Patrick, Ms M. Martin and Ms D. Wild, University of Washington, Seattle, USA; and, Professor W. Acuda and Dr J. Mutambirwa, University of Zimbabwe, Harare, Zimbabwe.

Data were also taken from new centres field testing the WHOQOL-100 in which collaborating investigators were: Dr S. Bonicaato, FUNDONAR, Fundacion Oncologica Argentina, Argentina; Dr G. Yongping, St Vincent's Hospital, Victoria, Australia; Dr M. Fleck, University of the State of Rio Grande do Sul, Brazil; Professor M. C. Angermeyer and Dr R. Kilian, Universitätsklinikum Klinik und Poliklinik für Psychiatrie, Leipzig, Germany; and Mr L. Kwok-fai, Queen Elizabeth Hospital, Kowloon, Hong Kong.

In addition to the expertise provided from the centres, the project has benefited from considerable assistance from: Dr R. Billington, Dr M. Bullinger, Dr A. Harper, Dr W. Kuyken, Professor M. Power and Professor N. Sartorius.

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7. Straten2007(truncated)

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Personality traits and health-related quality of life in patients with mood and anxiety disorders

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Abstract

Background: Health-related quality of life (HRQL) is an accepted outcome measure in patients with mood and anxiety disorders. Yet, surprisingly little attention has been paid to the determinants. In this paper we test the hypothesis that it is associated with personality traits while controlling for mental disorders. *Methods*: A large sample of outpatients (n = 640) with mood and anxiety disorders was studied. The empirically supported five factor model of normal personality traits was assessed using the NEO-FFI and includes: neuroticism, extraversion, openness to experience, agreeableness, and conscientiousness. Mental disorders were assessed with the CIDI, and HRQL with the SF-36. *Results*: Regression analyses revealed that the NEO-FFI scores, with the exception of conscientiousness, were significantly associated with SF-36 subscales and summary scores, independently from the mental disorders. The percentage of explained variance due to the personality traits was highest for the subscales Vitality (10.0%), Mental Health (13.3%) and the Mental Health Summary Score (9.5%). Furthermore, specific personality traits were related to specific SF-36 subscales. *Conclusions*: A low HRQL of patients with mood or anxiety disorders is not only determined by the disease or the current health but is also shaped by personality traits that are relatively stable throughout an individual's life time.

Key words: Anxiety disorders, Depressive disorder, Health-related quality of life, Personality

Introduction

Health-related quality of life (HRQL) indices reflect the patient's burden associated with disease [1]. For a number of reasons, HRQL has gained popularity as an outcome measure in both clinical practice and research, for both somatic and mental conditions. Firstly, it measures the impact of the condition on a wide range of physical, social and emotional aspects that are highly relevant to the functioning of individuals. Secondly, while a diagnosis may only be absent or present, HRQL measures may detect (small) improvements or deteriorations. Thirdly, HRQL measures describe the impact of more than one condition simultaneously. This is especially important in conditions with a high prevalence of co-morbidity, as is the case in mood disorders which often occur simultaneously with anxiety disorders.

HRQL is greatly affected by the presence of mood and anxiety disorders [2–6]. Because these disorders are also highly prevalent, they are the major cause of HRQL deficits on a population level [7, 8]. Moreover, it has been demonstrated that patients without a fully-fledged mood

(13.3% improvement), the subscale Vitality (10.0% improvement) and the MCS (9.5% improvement). These three scales also showed the highest percentages of explained variance (30.8%, 22.5% and 22.8% respectively).

Older age was significantly associated with poorer (role- and overall) Physical Functioning, being female with poorer Physical Functioning and Vitality, while having no paid job was associated with poorer Physical Functioning and a higher Role-Emotional, Vitality and MCS score.

Furthermore, there were significant associations between the different DSM-IV diagnoses and the HRQL subscales and summary scores. Generalised anxiety disorder and panic disorder without agoraphobia were the only two diagnoses which were unrelated to the HRQL dimensions. Dysthymia and social phobia were each related to one subscale (Social Functioning) only. Depression (mild, moderate, severe) and panic disorder with agoraphobia were related to many different subscales and summary scores.

Most importantly, there were also significant associations between the different personality traits and the HRQL subscales and summary scores, *independent* of the demographics and DSM-diagnoses just mentioned. Conscientiousness (organisation, motivation and persistence in achieving goals) was the only personality trait unrelated to HRQL. Agreeableness, which refers to the extent of altruistic or antagonistic orientation towards others, is primarily associated with physical subscales. It is the only personality trait that is associated with the PCS. The association is positive, which means that a higher score on the agreeableness subscale is associated with better physical health. All three remaining personality traits (Neuroticism, Openness and Extraversion) are associated with the Vitality subscale and with the MCS. In addition, Neuroticism (the tendency to experience negative emotions and cope poorly) and Extraversion (the quantity and intensity of interpersonal interactions and positive emotions) are associated with General Health and Mental Health. All associations with Neuroticism are negative which means that a lower degree of Neuroticism corresponds with a higher HRQL score. All associations with Extraversion are positive. Finally, Openness which may be described as the appreciation of experience for its own sake is associated with Role-Emotional, and Social Functioning. Surprisingly, all associations are negative, which means that a lower score for openness corresponds with higher HRQL scores.

Discussion

Our results confirm the well-known association between mood and anxiety disorders and HRQL. The main contribution of this paper is that we demonstrated that personality traits are associated with different dimensions of HRQL independently of the presence of mood and/or anxiety disorders. Agreeableness was related to the Physical Component Summary score, while Neuroticism, Extraversion and Openness were related to the Mental Component Summary score.

Our study has several strengths. First of all, the number of patients included in this study was relatively large. Furthermore, all subjects were examined with extensive standardised diagnostic interviews, and all patients had established mood and/or anxiety disorders. However, the studied patients may not be representative with regard to the personality traits since they were all willing to participate and to be extensively interviewed. Another limitation of the study is that personality characteristics were assessed only once. Although personality characteristics are generally regarded as traits that are stable over time, it has been demonstrated that changes do occur in the long term [31]. The cross-sectional design prevents us from examining possible changes and their relationship to the changes in HRQL and the occurrence of mood- and anxiety disorders.

We demonstrated that different personality traits were associated with different HRQL dimensions. The association between Neuroticism and Extraversion with HRQL and subjective well-being has been demonstrated before in patients with a somatic condition and in healthy subjects [11, 32]. It is remarkable that persons with a high Agreeableness score have a better HRQL with regard to social and physical aspects but not emotional aspects. Possibly, persons with a high level of Agreeableness have more friends, are more relaxed and pay less attention to physical

discomfort or pain. As far as we know, this has not been found in earlier studies, and replication is necessary before any definite conclusion can be drawn. We also found Extraversion to be positively associated with several aspects of HRQL. The focus on external contacts associated with extraversion may also take away the focus on one's own problems and thus result in a higher HRQL. But again, there are no earlier studies which confirm our findings, and more research in this area is necessary.

It is well established that scores on personality traits of patients with mental disorder differ significantly from the scores of other persons [33–35]. In particular, Neuroticism has been shown to be strongly related to the presence of mental disorder [33, 34]. However, the nature of this association is still a highly debated issue [36]. The deviant scores on personality traits may be one of the causes of (repeated) episodes of illness, or one of the consequences, but there might also exist a continuum with the personality trait as an attenuated form of the mental disorder. The most interesting finding of this paper is however that we demonstrated that Neuroticism is associated with HRQL independently of the mental disorders.

In conclusion we found that personality traits are significantly associated with HRQL scores, independent of the relationship of HRQL with demographic variables and DSM-IV mood and anxiety disorders. This indicates that HRQL is not only influenced by the disease, current health, or current situation, but is also shaped by personality traits that are relatively stable throughout an individual's lifetime.

Acknowledgement

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Personality disorder and the outcome of depression: meta-analysis of published studies

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Background There is conflicting evidence about the influence of personality disorder on outcome in depressive disorders.

Aims Meta-analysis of studies in which a categorical assessment of personality disorder or no personality disorder was made in people with depressive disorders, and categorical outcome (recovered/not recovered) also determined.

Method Systematic electronic search of the literature for relevant publications. Hand searches of *Journal of Affective Disorders* and recent reviews, with subsequent meta-analysis of selected studies.

Results Comorbid personality disorder with depression was associated with a doubling of the risk of a poor outcome for depression compared with no personality disorder (random effects model OR=2.18, 95% CI 1.70–2.80), a robust finding maintained with only Hamilton-type depression criteria at outcome (OR=2.20, 95% CI 1.61–3.01). All treatments apart from electroconvulsive therapy (ECT) showed this poor outcome, and the ECT group was small.

Conclusions Combined depression and personality disorder is associated with a poorer outcome than depression alone.

Declaration of interest P.T. and T.J. belong to a UK Medical Research Council Cooperative Group (Mencog) evaluating mental health interventions. P.T. is Editor of the *British Journal of Psychiatry* but had no part in the evaluation of this paper.

Reports in the psychiatric literature that comorbid personality disorder is associated with a poor outcome in depression have recently been challenged (Brieger *et al*, 2002; Mulder, 2002). This is an important clinical issue that needs to be resolved and we judged that there have now been sufficient high-quality studies to enable a definitive answer to be obtained from a systematic review. Before the introduction of DSM–III (American Psychiatric Association, 1980) there were few studies examining the influence of personality disorder on the outcome of depression, although clinical opinion suggested that people with personality disorder responded less well to treatment (Sargant, 1966) and follow-up studies supported this (Greer & Cawley, 1966). However, both before and since the introduction of DSM–III, personality problems have been studied in some depth using self-rating questionnaires in which personality abnormality is assessed dimensionally (Eysenck, 1959; Eysenck & Eysenck, 1964; Cloninger, 1987). Although there is good evidence that personality abnormality is best viewed as a dimensional construct (Livesley, 1991), in clinical practice decisions are dichotomous and are aided by a categorical diagnostic system; hence we used this in our systematic review.

METHOD

The aim of the meta-analysis was to examine all studies of outcome in depressive disorders in which: (a) personality disorder was assessed formally and (b) outcome was recorded either using standard rating scales, such as the Hamilton Rating Scale for Depression (HRSD; Hamilton, 1960) or another measure, such as clinical judgement.

Inclusion criteria

Inclusion criteria were broad to ensure maximum accrual of information for systematic review. Papers were selected if: (a) written in English; (b) participants were assessed for both depression and personality disorder using a scale published in a peer-reviewed journal; (c) the population studied was aged at least 18 years; (d) assessment of outcome of depression was at least 3 weeks after initial assessment, this being considered the minimum time necessary for treatment response. Both observational studies and randomised trials were included and there were no restrictions with regard to type of treatment or its duration.

Exclusion criteria

Studies that examined personality using a dimensional scale were excluded, as these could not be compared directly with those in which a categorical diagnosis of personality disorder was made.

Search method

Medline, Clinhal and Psychinfo were searched online from 1966, 1982 and 1882, respectively. The terms DEPRESSION, MENTAL ILLNESS and PERSONALITY DISORDER were entered and combined. All abstracts were reviewed and those with data suggesting satisfaction of the inclusion criteria read in full.

In addition, a hand search of the *Journal of Affective Disorders* was carried out by G.N.-H. This served as an audit of the online search and provided additional sources of information. All relevant review articles were also examined closely for eligible studies, especially those by McGlashan (1987), Reich & Green (1991), Reich & Vasile (1993), Shea *et al* (1992), Ilardi & Craighead (1995), Corruble *et al* (1996), Dreessen & Arntz (1998) and Mulder (2002). The 'grey' literature was not examined as it was considered unlikely to provide further data.

Data extraction and checking

Two-by-two tables of the numbers of patients with or without personality disorder cross-classified by response to treatment (and stratified by treatment modality when possible) were drawn up for each paper, either by direct extraction from published tables and text (including associated papers), derived from summary percentages, or reconstructed from summary statistics such as χ^2. The resultant 2×2 tables were cross-checked against all

is no evidence of a trend with year of publication within any of the strata.

A secondary analysis was carried out by subdividing studies into four predominant treatment modalities: electroconvulsive therapy (ECT), drug treatment alone, any form of psychotherapy alone, and both drugs and psychotherapy available, although not necessarily used in combination. The purpose of this was to explore whether any particular modality was suggestive of better outcome, irrespective of the outcome measure employed. Figure 3 shows that all treatment modalities except ECT had a poorer outcome for the treatment of depression if personality disorder was present. The greatest divergence between the groups was among those treated with a combination of psychotherapy and drugs, those without a personality disorder being more likely to respond (OR=2.66, 95% CI 1.31–5.42) than those with a personality disorder. We caution against overinterpretation of this against a background of varying treatments, treatment intensities and durations.

In Fig. 4 the studies are stratified by their design and ordered within design type by interval from baseline to outcome assessment. The RCTs are less heterogeneous than the cohort studies and also suggest a smaller effect of personality disorder (OR=1.60 *v.* 2.73). Interval from baseline to outcome assessment does not appear to be related to the outcome of treatment. Table 2 shows that those with personality disorder had slightly higher mean Hamilton scores at baseline than those without (21.1 *v.* 19.9), and this could be associated with poorer response. However, they also had a smaller mean change (9.5 *v.* 11.0) and the duration of five of the seven studies exceeded 15 weeks.

DISCUSSION

In the spirit of evidence synthesis, we have described fully our search strategy, study selection, data summary and analysis to allow replication or sensitivity analysis of any aspect of our approach. We have included every study that to our knowledge satisfies our inclusion criteria and employed techniques of estimation that allow integration of diverse outcome measures. The results are clear: the co-occurrence of a personality disorder in a person with depression is about twice as likely to be associated with a poor response as in an individual without a personality disorder. This is a robust finding which is not altered significantly by the nature of the instrument used to measure depression outcome. Furthermore, no treatment modality stands out as being more effective than any other in the treatment of a person with depression and personality disorder. The trend was for psychotherapy to be associated with poorer outcome in those with personality disorder.

Overall, about 55% of patients with personality disorder had a poor outcome compared with about 45% of those without, demonstrating that many of those with depression and personality disorder remain unwell, a feature that is particularly noticeable in the long term (Kennedy *et al*, 2004; Tyrer *et al*, 2004). The total number of patients necessary to detect this difference (or larger) with 90% power, using a (two-sided) statistical test of the difference between two proportions at the 5% level of significance, exceeds 1000. None of the individual studies approached this target. The largest, by Hirschfield *et al* (1998), which included over 600 patients, achieved only 70% power to detect this effect. This partly explains the confusion in the literature and reinforces the need to combine evidence from separate studies to reach a sound conclusion.

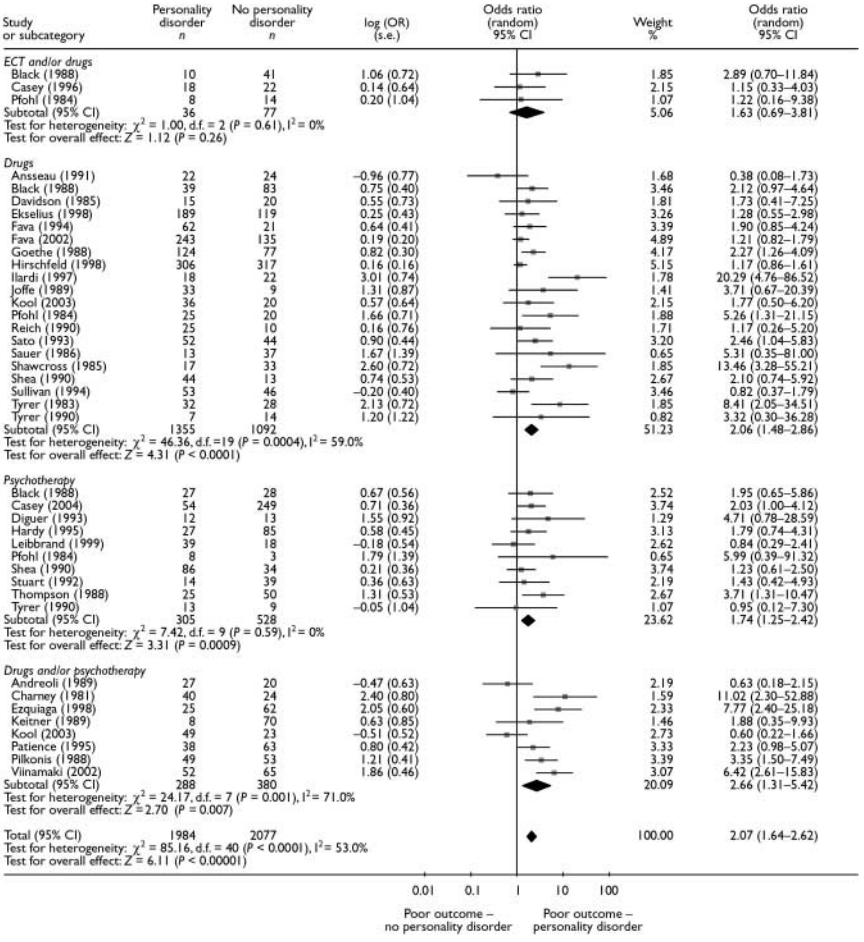

Fig. 3 Random-effects meta-analysis stratified by treatment modality. ECT, electroconvulsive therapy. For each study, only the first author is shown.

Methodological strengths and weaknesses

Our research strategy was comprehensive and studies excluded because they did not satisfy our inclusion criteria did not show important differences from the included papers. Resources to include searches for papers not written in English were unavailable.

A surprising finding was the relative dearth of studies exploring this issue either as a primary or secondary research aim. Depression is extremely common, the bread and butter of day-to-day psychiatry, and this is reflected in the research. Comorbidity with personality disorder is also common, but this is not as well reflected. Only a quarter of the studies identified as potentially useful provided the necessary data and only 14 were RCTs.

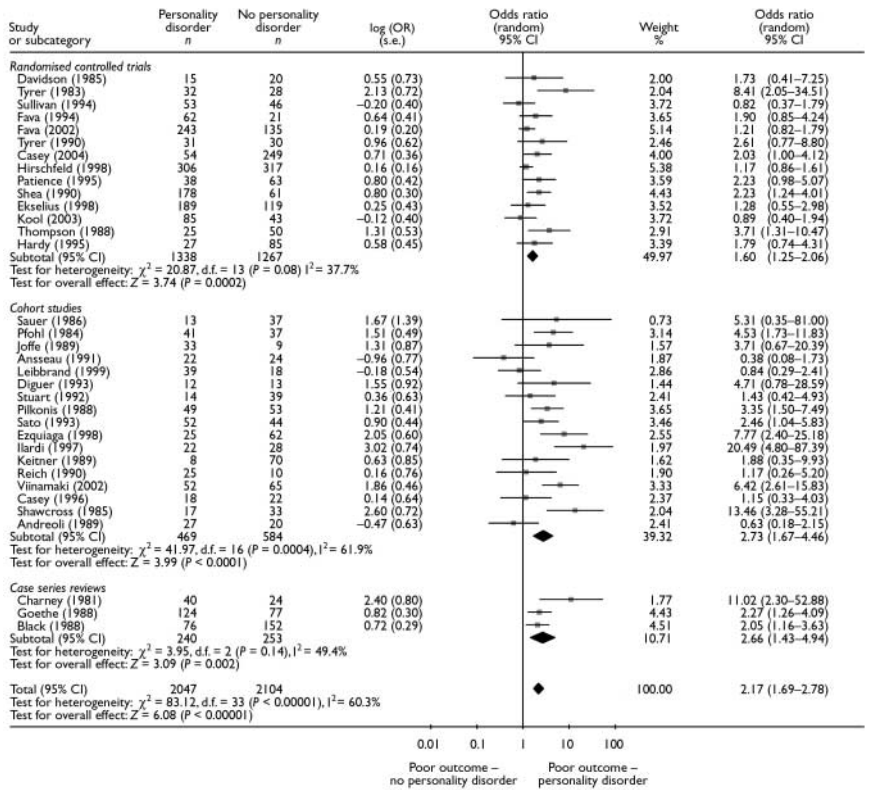

Fig. 4 Random-effects meta-analysis stratified by type of study and ordered by interval to assessment (shorter time periods shown first). For each study, only the first author is shown.

Our findings do not indicate whether the influence of personality disorder is independent of intervention. They suggest, however, that the treatment of depression with psychotherapy may be less effective in those with personality disorder. A recent study using interpersonal psychotherapy as maintenance treatment for women with depression found higher rates of recurrence and more rapid relapse in a subgroup with personality disorder (Cyranowski *et al*, 2004). It also found an increased need for pharmacotherapy, broadly supporting this conclusion. This somewhat counterintuitive finding needs cautious interpretation as the total numbers are not large and no effort has been made to substratify psychological treatment modalities. A specific type of psychological approach might have merit in this group, as has been shown for the specific treatment of borderline personality disorder (Linehan *et al*, 1991; Bateman & Fonagy, 1999; Verheul *et al*, 2003). The better result with drug treatment may also be a direct effect of treatment on personality pathology, as has been suggested in recent studies (Ekselius & von Knorring, 1998; Fava *et al*, 2002). There also might be important variation between the effects of different antidepressants in the presence of personality disorder (Mulder *et al*, 2003). The merits of combined drug and psychological treatment are also not yet known in the presence of personality disorder (Kool *et al*, 2003; de Jonghe *et al*, 2004).

Similarly the absence of a clear association with response to ECT requires cautious interpretation because of the comparatively small total numbers involved. Nevertheless there is some indication that ECT may be of benefit in those with severe depression and personality disorder. In many studies, initial depression scores were higher in the groups with personality disorder, potentially leading to a spurious conclusion of poor outcome when taking a fixed-scale score for recovery status. However, the difference was not large (an HRSD score difference of less than 1.5 between groups). The group with personality disorder also showed a smaller mean change with treatment regardless of the baseline measure, and there was no apparent relationship between the OR and the duration of study.

Finally by only analysing studies in which a categorical diagnosis was used, we excluded papers that provided dimensional ratings of personality only. This, however, allows for reproducible collation of the data in a fashion that is not only amenable to analysis but useful in day-to-day practice.

Implications for clinical practice

We conclude that if comorbid personality disorder is not treated patients will respond less well to treatment for depression than do those with no personality disorder; the same may apply even if no treatment is given. There is no particular treatment that defies this association, although there is some suggestion that the negative effect of personality disorder might be attenuated by drug treatment. The results emphasise the importance of studying the simultaneous treatment of depression and comorbid personality disorder, since there is now better evidence that both drug and psychological treatments, when specifically targeted at personality pathology, might be of value (Leichsenring & Leibing, 2003; Newton-Howes & Tyrer, 2003; Tyrer *et al*, 2003). Some of the contrary findings in the literature (Mulder, 2002) might reflect the extent to which personality disorder has been treated, either explicitly or covertly. Whatever the interpretation, a diagnosis of personality disorder is not necessarily a poor prognostic indicator. These patients simply require treatment of both the personality disorder and the depression. This offers a challenge to clinicians. Despite our best endeavours patients with personality disorder remain one of the most difficult groups in psychiatric practice.

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9. Abrams1998&2001

Am J Geriatr Psychiatry. 1998, 6(1):24-30

Personality disorder symptoms and functioning in elderly depressed patients

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Abstract

The authors evaluated the relationship of personality disorder symptoms to disability and social and interpersonal functioning in geriatric depression. Measures of personality disorder and cognitive, affective, social, interpersonal, medical, socioeconomic factors, and instrumental activities of daily living (IADL) status were administered to 47 elderly patients at various levels of remission from major depression. Total personality disorder scores were inversely associated with IADL, sociability, and presence of a satisfying relationship, both alone and in interaction with depression. The associations between personality disorder and functioning were most prominent in subjects with low residual depression. Symptoms of personality disorder in elderly patients may be associated with disability and impaired social and interpersonal functioning after an acute depressive episode; personality disorder symptoms may also have treatment implications for geriatric depression.

NOT cited

Am J Geriatr Psychiatry. 2001, 9(1): 67-71

Personality disorder symptoms predict declines in global functioning and quality of life in elderly depressed patients

Abrams, RC), Alexopoulos, GS, Spielman, LA, Klausner, E, Kakuma, T.

Abstract

The authors evaluated personality disorder symptoms as predictors of change in global functioning and quality of life among elderly depressed patients. Treated elderly patients (N = 40) who no longer met RDC criteria for major depression were assessed for personality disorders, depression global functioning, and quality of life after treatment of the acute episode and at 1-year follow-up. In interaction with persisting or recurrent depression, Cluster B personality disorder symptoms contributed to declines in global functioning and quality of life over a 1-year period Personality disorder symptoms in elderly patients appear to operate as co-factors that amplify, or exacerbate the impact of residual depression on long-term functioning and quality of life.

Cited

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Personality Disorder Symptoms, Drinking Motives, and Alcohol Use and Consequences:

Cross-Sectional and Prospective Mediation

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Abstract

Research shows high comorbidity between Cluster B personality disorders (PDs) and alcohol use disorders (AUDs). Studies on personality traits and alcohol use have identified coping and enhancement drinking motives as mediators in the relations among impulsivity, affective instability, and alcohol use. To the extent that PDs reflect extreme expression of these traits, drinking motives should mediate the relation between PD symptoms and alcohol involvement. This was tested using path models estimating the extent to which coping and enhancement drinking motives mediated the relation between Cluster B symptom counts and alcohol use and problems both concurrently and at a 5-year follow-up. Three hundred fifty-two adults participated in a multiwave study of risk for alcoholism (average age = 29 years at Wave 1). Enhancement motives mediated (a) the cross-sectional relation between Cluster B symptoms and drinking quantity/frequency, heavy drinking, total drinking consequences, dependence features, and AUD diagnosis and (b) the prospective relation to AUDs. Although coping motives mediated the relation between Cluster B symptoms and drinking consequences and dependence features cross-sectionally, prospective effects were limited to indirect effects through Time 1.

Keywords

alcohol use disorders; drinking motives; personality disorder symptoms; personality disorder-alcohol use disorder comorbidity

Research shows high comorbidity between personality disorders (PDs) and alcohol use disorders (AUDs; Ball, Tennen, Poling, Kranzler, & Rounsaville, 1997; Driessen, Veltrup, Wetterling, John, & Dilling, 1998; Morgenstern, Langenbucher, Labouvie, & Miller, 1997; Sher & Trull, 2002; Sher, Trull, Bartholow, & Vieth, 1999; Skodol, Oldham, & Gallagher, 1999; Verheul, Hartgers, Van Den Brink, & Koeter, 1998). For example, across studies of individuals with borderline personality disorder (BPD) in which rates of alcohol abuse or dependence were reported, approximately 48.8% of individuals with BPD also met criteria for an AUD, and across studies of individuals with AUDs, 14.3% of these participants also met criteria for BPD (Trull, Sher, Minks-Brown, Durbin, & Burr, 2000). Given the high rates of morbidity and dysfunction associated with these disorders, particularly when they co-occur, a better understanding of the mechanisms underlying this relation is needed (Trull et al., 2000). This knowledge would be useful not only for identifying factors relevant to prevention and

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Participants

Participants included 155 men and 197 women with an average age of 29 years (*SD* = 1.02) at Year 11 and 34 years (*SD* = 0.83) at Year 16. Participants were primarily Caucasian (94.43%), but 3.69% were African American, 0.57% were Hispanic, 0.28% were Native American, and 1.14% were Asian American. Participants were above average in educational attainment, as 81.01% held a college or advanced degree. At Year 16, 74.93% of participants were married, 1.14% were separated, 4.56% were currently divorced, 1.14% were engaged, and 17.66% had never been married. At Year 11, 20.51% (37 men, 22 women) met criteria for a Diagnostic and Statistical Manual of Mental Disorders (fourth edition, *DSM-IV*; American Psychiatric Association, 1994) diagnosis of an AUD (past-year), compared with 15% (29 men, 23 women) at Year 16. Only 2.28% met criteria for a *DSM-IV* personality disorder diagnosis at the time of the Year 11 assessment. Because these diagnoses were primarily due to diagnoses of two specific PDs (obsessive-compulsive and antisocial), only overall cluster symptom counts were used for the present analyses. The low base rates for personality disorders, the lack of a diverse ethnic population, and the high educational attainment of participants are important to note, as these participants are not representative of the general population.

Materials and Procedure

AUD diagnoses—For our criterion measure of alcohol use diagnoses, we assessed past year *DSM-IV* AUD (abuse or dependence) and antisocial personality disorder at Years 11 and 16 using the Diagnostic Interview Schedule, Version IV (DIS-IV; Robins, Cottler, Bucholz, & Compton, 1995). For Year 11, interviewers completed the DIS-IV training workshop offered by the DIS-IV training staff before collecting data. Year 16 interviewers were trained by senior, experienced research staff. All interviews (both Years 11 and 16) were cross-edited by a second interviewer and an interview supervisor.

Personality disorder symptoms—For all PDs except antisocial PD, which we assessed with the DIS-IV, we assessed *DSM-IV* personality disorder symptoms in each participant by administering the Structured Interview for DSM-IV Personality (SIDP-IV; Pfolh, Blum, & Zimmerman, 1997) at Year 11. The SIDP-IV provides total symptom counts for each of the 10 individual *DSM-IV* personality disorders as well as diagnoses. Further, it was possible to calculate symptom counts for each of the three *DSM-IV* PD clusters: Cluster A (odd-eccentric) includes the paranoid, schizoid, and schizotypal PDs; Cluster B (dramatic-erratic-emotional) includes the antisocial, borderline, histrionic, and narcissistic PDs; and Cluster C (anxious-fearful) includes the avoidant, dependent, and obsessive-compulsive PDs.

Two master's-level interviewers administered the SIDP-IV and DIS-IV interviews. These interviewers underwent extensive training before gathering data for this study. Training in the SIDP-IV was supervised by one of the authors of the SIDP-IV (Nancee Blum) and by Timothy J. Trull. These training sessions involved giving didactic instruction, reviewing written materials, reviewing and scoring previously taped interviews using the SIDP-IV, and conducting and scoring at least 10 practice SIDP-IV interviews that were reviewed and evaluated by the supervisor. The interviewers met weekly with senior project staff to discuss any questions regarding administration or scoring. All interviews were audiotaped, and 36 participants' interviews were randomly selected to assess the interrater reliability of SIDP-IV scores. (Given the highly structured nature of the DIS-IV, we only conducted reliability analyses on the SIDP-IV). Intraclass correlations (Shrout & Fleiss, 1979) were calculated by comparing the original symptom counts for each PD as well as the three cluster symptom counts with the corresponding independent reliability check ratings. For the individual PD symptom counts, the average intraclass correlation coefficient (ICC) was .73 (range = .43-.90). The ICCs for Cluster A, Cluster B, and Cluster C symptom counts were .80, .92, and .89, respectively.

11. Morse2000 (truncated)

Personality Disorders in Late Life

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There is growing empiric evidence to suggest that a large number of elderly patients who have chronic depression frequently have comorbid personality disorders as well. In addition, contrary to commonly held clinical beliefs, a recent meta-analysis suggests that rates of personality disorders among older adults are essentially equivalent to that of younger groups. Although understudied, personality-disordered elderly patients have been shown to be less responsive to mental health interventions, and personality dysfunction may be one of the most relevant factors to account for when examining late-life depression remission and relapse. The paper considers briefly the notion of personality and personality disorders in late-life, examines prevalence rates including a recent meta-analysis, explores relevant issues associated with treatment, and discusses new developments in treatment.

Introduction

With life expectancy generally increasing and baby boomers getting older, growing clinical attention and research has focused on mental health in late-life. Often depression and its risks, like suicide, are central concerns in late-life, particularly with estimates of the prevalence of late-life major depression ranging from 3% among community samples up to as high as 25% among nursing-home residents [1]. In addition, there is mounting evidence that personality disorders are no less prevalent in late-life than in adulthood and that the presence of personality disorders is associated with poor treatment outcomes and disability. With this background, this paper considers briefly the notion of personality and personality disorders in late-life, examines prevalence rates including a recent meta-analysis, explores relevant issues associated with treatment, and discusses new developments in treatment.

Conceptual Views

Three views of personality development in late-life have been articulated: 1) that personality does not change and that a change in behavior does not imply a change in personality; 2) that changes seen in cross-sectional research on personality reflect a generational impact not individual aging; and 3) that personality does change as a result of natural maturation or biologic processes. The growing consensus is that change in personality across the life span of healthy individuals is minimal and that personality is relatively stable after age 30, at least as measured by self-report measures [2–4]. Thus, the personality traits, like those of the Five Factor Model, thought to underlie personality disorders are believed to be relatively constant from middle-adulthood throughout the remainder of life. Despite this, the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, edn 4) and some researchers [5,6] suggest that "some types of personality disorders (notably, antisocial and borderline personality disorders) tend to become less evident or to remit with age, whereas this appears to be less true for some other types (*eg*, obsessive-compulsive and schizotypal personality disorders)" [7]. In addition, there is the opposite of the "burn out" hypothesis; that subthreshold personality disorders of youth or mid-life appear in late-life meeting full criteria or that earlier full criteria personality diagnoses remit only to come back later in life [8]. Despite these opposing hypotheses, sufficient evidence has mounted to suggest that personality disorders do persist into late-life.

Measurement Issues

One of the reasons that the controversy regarding late-life personality disorders is difficult to settle is that there are many difficulties in diagnosing personality disorders in late-life. Abrams [9] suggested that in depressed elderly, chronicity and cognitive impairment make valid personality assessment impossible. Similarly, Fishbain [10] suggests that changes in cognitive structure and personality due to aging limit the viability of Axis II diagnosis. Aside from cognitive impairment confounds, which can be controlled with appropriate screening employing a conservative cutoff, the diagnosis debate centers around the state-trait distinction.

For example, depressed mood might negatively bias self-report and exaggerate symptoms of personality psychopathology [11,12]. Some research has validated these concerns, finding higher personality disorder prevalence rates during treatment than in remission periods [11,13], whereas others have found similar proportions at both time points [14]. Abrams *et al.* [15] found significant