Treatment of personality disorders in older adults

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Beyond Therapeutic Nihilism

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Beyond Therapeutic Nihilism

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A dissertation submitted in fulfillment of the requirements for the degree
of Doctor in Psychological Sciences
Joint PhD Vrije Universiteit Brussel – Tilburg University

Brussel, 2 december 2016

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Chapter 1

Introduction

Introduction

This dissertation focuses on the treatment of personality disorders (PDs) in older adults. Throughout this dissertation, older adults are defined by their age, that is over the age of 65 years old. Of course, in life span theory aging is a much more complex and heterogeneous concept, defined by many interacting factors, biological, social, cultural and psychological of nature (Kessler, Kruse, & Wahl, 2014). The general term "older adults" was chosen however for reasons of readability, although acknowledging the wide diversity and heterogeneity of this age group.

Our current concept of PD is based on the Diagnostic and Statistical Manual of Mental Disorders (DSM); its fifth edition (American Psychiatric Association, 2013) defines a PD as "an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture" (p. 646). This implicates a chronic course of maladaptive personality traits associated with the PD, that may persist into later life after an onset in adolescence or early adulthood. The diagnosis of a PD requires that the enduring pattern is pervasive across a range of situations, and leads to distress or impairment in important areas of functioning. This pattern may not be better accounted for as a manifestation of another mental disorder, and may not be due to the direct physiological effects of substance use or medical illness. Besides these general criteria, DSM-5 lists ten specific PD diagnoses. For individuals who meet the general criteria but not the required threshold for any specific PD, an additional category "other specified PD" is available. Because of diagnostic heterogeneity within the specific PDs and the high degree of comorbidity between them, a dimensional approach is included in the DSM-5 as an alternative model (Section III, "Emerging measures and models"). This DSM-5 Section III PD model contains a conceptualization of personality psychopathology in the domains of self and interpersonal functioning that distinguishes personality pathology from health and from other mental disorders, as well as an empirically

based model of pathological personality traits. Although there are some issues still to be resolved, like the overlap between functioning and traits, the key aspects of the model appear to work well (Krueger, Hopwood, Wright, & Markon, 2014).

However, the suitability of the DSM's definition and criteria of PDs, especially that of Section II which is nearly identical to the DSM-IV PD definition, has a number of limitations when applied to older adults. Often, it is impossible to trace back the personality functioning of an individual over the course of many decades (Van Alphen et al., 2015). Furthermore, a number of DSM criteria (like those related to work and relationships) are not appropriate for many older adults (Oltmanns & Balsis, 2011). In a large study among people from 19 to 98 years old in the general population, fewer diagnostic criteria of DSM-IV PDs were identified in older adults compared to younger persons (Balsis, Gleason, Woods, & Oltmanns, 2007). Moreover, in older adults measurement errors were found in nearly a third of the diagnostic criteria of DSM-IV PDs. Besides this, the temporal stability of both PDs and personality traits is less than originally thought (Debast et al., 2014). The course of cluster C PDs (avoidant, dependent and obsessive-compulsive PDs) appears to be more stable throughout the life span than that of cluster B PDs (Cooper, Balsis, & Oltmanns, 2014; Gutiérrez et al., 2012). Particularly, the prevalence of cluster B PDs (borderline, antisocial, narcissistic and histrionic PDs) declines with age (Debast et al., 2014). Probably, people do not longer meet the threshold for DSM PDs because of a decrease in expressive, impulsive, and aggressive behavior, and a shift towards depressive, somatic, and passive-aggressive behaviors with aging (Van Alphen, Engelen, Kuin, Hoijtink, & Derksen, 2006; Van Alphen, Nijhuis, & Oei, 2007). Secondly, unhealthy lifestyles, violence, suicides, and accidents result in a shorter life expectancy among adults with cluster B PDs (Black, Baumgard, & Bell, 1995).

As the amount of older adults is increasing worldwide at an impressive rate, especially in Western and Asian countries, the number of older adults with PDs will also increase substantially (Beard, 2014). PDs are much more prevalent in later life than many presume, with a rate of 8% among community-dwelling older adults in the US (Schuster, Hoertel, Le Strat, Manetti, & Limosin, 2013). Furthermore, PDs are highly associated with disability as well as medical and other mental disorders (Schuster et al., 2013). Comorbid PDs complicate treatment of other mental disorders (Rosenbluth, Macqueen, McIntyre, Beaulieu, & Schaffer, 2012). For instance, a comorbid PD doubles the odds of a poor outcome in the treatment of depression as compared to having no PD (Newton-Howes et al., 2014). The only study conducted among older adults, showed that the combination of cluster C PDs and residual depressive symptoms predicts a worse course of the depressive symptoms, even after recovery from the index episode of depression (Morse, Pilkonis, Houck, Frank, & Reynolds, 2005). Moreover, in adult psychiatry, if the burden of PDs is high, it is common practice to treat the PD itself in order to improve treatment outcome (Newton-Howes, Tyrer, & Johnson, 2006).

A lifespan perspective has played a crucial role in our understanding of many forms of psychopathology and, during the last decade, there is a renewed interest for such a life span perspective. Despite of this, little attention has been given to PDs in later life (Oltmanns & Balsis, 2011). Several issues can be held responsible for this. Among those are the difficulties applying the diagnostic criteria for PDs to older adults and the challenges in identifying appropriate samples of older participants (Oltmanns & Balsis, 2011). Van Alphen and colleagues (2015) further blame a lack of clinical interest as an important obstacle. Especially regarding the treatment of PDs in older adults, it seems that little has changed since the time of Sigmund Freud, who assumed that people over the age of 40 were too inflexible for therapeutic change to occur (Freud, 1905). Since the last decade of the twentieth century, specific psychotherapeutic treatments have

been developed and found efficacious for several PDs, especially for borderline PD (Verheul & Herbrink, 2007). However, the average age of the participants in all studies is between 25 and 35 years of age and clinical and scientific attention was almost exclusively directed to adults up to people in their forties (Stoffers et al., 2012). In sum, treatment of PDs in older adults remains relatively unexplored (Van Alphen, Derksen, Sadavoy, & Rosowsky, 2012: Van Alphen et al., 2015). Therefore, this dissertation focuses on this neglected, yet important subject.

In the following paragraph, the growing evidence for the effectiveness of psychological treatment of older adults is discussed. Next, from a lifespan perspective the challenges for the treatment of PDs in older adults are deducted. Finally, the central aim of this dissertation is given, after which the specific research objectives are described, along with an outline of this dissertation.

Psychological treatment of older adults

Despite Freud's therapeutic nihilism regarding the efficacy of psychotherapy for older adults, there is an accumulating body of evidence for the efficacy of psychological treatment in later life. The vast majority of studies concern the treatment of depression and, to a lesser extent, anxiety disorders, and most research was conducted into cognitive behavior therapy (CBT) (Gould, Coulson, & Howard, 2012a; 2012b; Laidlaw & Thompson, 2014; Scogin & Shah, 2012).

A recent meta-analysis of 44 randomized controlled trials (RCTs) into psychological treatments of depression in older adults concluded that psychological therapies in general are effective in late-life depression, and this is especially well-established for CBT and problem-solving therapy and to a lesser extent for life review therapy (Cuijpers, Karyotaki, Pot, Park, & Reynolds, 2014). There were not enough studies yet to examine the long-term effects of psychotherapies and to compare psychotherapy with pharmacotherapy or combined treatments. Interestingly, life review therapy is an age-specific treatment, especially developed for the treatment of depression in older adults

(Bhar, 2014). There are indications that the efficacy of psychotherapy for depression diminishes in the context of physical and cognitive limitations (Pinquart, Duberstein, & Lyness, 2007). But even in depressed older adults with cognitive deficits, CBT, with a focus on problem solving, appeared more effective than supportive therapy (Simon, Cordas, & Bottino, 2015). Cuijpers and colleagues (2014) suggested including caregivers of depressed older adults in the treatments, as these caregivers have a major role in the care for the oldest old.

Gonçalves and Byrne (2012) concluded from their meta-analysis of 27 trials into the treatment of generalized anxiety disorder in later life that older adults benefited equally well from both pharmacological and psychotherapeutic interventions, the last of which mainly concerned CBT. A meta-analysis of 19 RCTs into the treatment of a heterogeneous mix of anxiety symptoms in older adults showed that CBT and relaxation training are effective (Thorp et al., 2009). However, treatment of anxiety disorders in older adults appears somewhat less effective than in younger age groups (Wetherell et al., 2013). This lower treatment effectiveness argues for the development of age-specific treatment strategies to augment the outcome of psychological treatments for anxiety disorders in old age (Oude Voshaar, 2013)

Concerning other mental disorders, not enough studies have been conducted yet to perform a meta-analysis. Still, there are encouraging results from two RCTs, one non-randomized concurrent control study and one post hoc effectiveness study that exposure therapy and EMDR are acceptable and effective for post-traumatic stress disorder in older adults (Dinnen, Simiola, & Cook, 2015).

Despite the growing evidence for the efficacy of psychotherapy for the treatment of mental disorders in older adults, this has mainly been examined in the young-old, between 60 and 75 years of age, without comorbid cognitive impairment and medical illnesses. Furthermore, we know very little about the effectiveness of psychotherapy for several other mental disorders in later life, like

obsessive compulsive disorder (Carmin, Calamari, & Ownby, 2012) and somatic symptom disorders (Hilderink, Collard, Rosmalen, & Oude Voshaar, 2013). And regarding the treatment of PDs in older adults, our knowledge is extremely scarce.

Treatment of personality disorders across the lifespan

Until about 1990, therapeutic nihilism prevailed concerning the treatment options of PDs (Livesley, Dimaggio, & Clarkin, 2016). The publication of "Cognitive therapy of personality disorders" by Beck, Freeman and associates in 1990 paved the way for a new perspective on the treatability of PDs. Since then, several manualized therapies have been shown to be effective in the treatment of PDs (Livesley et al., 2016; Oldham, 2014). Psychotherapy has been proven efficacious with respect to reducing symptomatology and personality pathology, and improving social functioning (Leichsenring & Leibing, 2003; Perry, Banon, & Ianni, 1999; Verheul & Herbrink, 2007). Most research has been conducted into the treatment of borderline PD. Concerning this particular PD, a more recent Cochrane review concluded that beneficial effects have been mainly demonstrated for five comprehensive treatments: dialectical behavior therapy, mentalization-based treatment, transference-focused psychotherapy, schema therapy, and systems training for emotional predictability and problem solving (STEPPS) (Stoffers et al., 2012). Over the past decade, the treatment of other PDs has gained more attention, especially of cluster C, but also of paranoid, narcissistic, histrionic and antisocial PDs (Bamelis, Evers, Spinhoven, & Arntz, 2014; Dixon-Gordon, Turner, & Chapman, 2011).

Interestingly, no major differences have been found in effectiveness between different psychotherapeutic treatment models (Dimaggio & Livesley, 2012; Livesley, Dimaggio, & Clarkin, 2016). This finding reminds of the so-called 'Dodo Bird Verdict', the more general assertion that after decades of meta-analytic psychotherapy reviews different psychological therapies for several

mental disorders are of broadly similar efficacy (Budd & Hughes, 2009). It is argued that the equivalence of different therapies is a consequence of the methodology of RCTs (Budd & Hughes, 2009). Usually, RCTs are used to examine the effectiveness of a certain treatment model by comparing this treatment to a waiting list condition, treatment as usual or to another psychotherapeutic treatment. RCTs would need enormous numbers to be capable of isolating effects that are specific to aspects of therapies, diagnoses and patients. There is a relative lack of knowledge about the actual effective mechanisms of change that underpin successful psychotherapies. Therefore, some advocate focusing future research on an integrated treatment of personality pathology in which empirically-supported strategies and techniques are selected from different traditions (Dimaggio & Livesley, 2012). Other authors insist on improving each treatment through component analysis studies, or to examine the similarities and differences between each treatment approach to aid in treatment matching to the patient (Ronningstam et al., 2014).

The above mentioned evidence-based psychotherapies for PDs have all been developed for the treatment of adults up to middle age. There is a sharp contrast between the evidence concerning treatment of PDs in adults and our knowledge about treatment in earlier and later stages of the life span. Longitudinal and cross-sectional studies into the course of PDs tend to show that PDs have a chronic but also a fluctuating course across the lifespan (Debast et al., 2014; Cooper, Balsis, & Oltmanns, 2014; Gutiérrez et al., 2012; Zanarini, Frankenburg, Reich, & Fitzmaurice, 2012). However, we still know little about the effectiveness of treatment of adolescents with PDs (Feenstra et al., 2014) and we know even less about treatment of PDs in older adults (Van Alphen et al., 2012). In fact, no research whatever has been conducted yet into the effectiveness of treatment of PDs as the main focus of treatment in later life.

Treatment of personality disorders in later life: Challenges

As said, the amount of empirical data concerning treatment of PDs in older adults is very limited (Oltmanns & Balsis, 2011; Van Alphen et al., 2012; Van Alphen et al., 2015). In 2006, Abrams and Bromberg described the study of PDs in the elderly as "a flagging field of inquiry." PDs in later life have received little serious attention, although they complicate the course and treatment of other mental disorders, and adversely affect quality of life. Since then, in the field of assessment of PDs in older adults, awareness is growing for the need of both age-specific personality assessment instruments and age-neutral personality tests, as well as the cross-validation of personality questionnaires in older populations that have been developed for younger age groups (Rossi, Van den Broeck, Dierckx, Segal, & Van Alpen, 2014). A number of personality measures have now been validated for older adults and a number of studies have examined the age neutrality of personality questionnaires (Van Alphen et al., 2015).

However, the literature on treatment of PDs in older adults still mainly consists of charismatic calls for more attention for this complex group of patients (Segal, Coolidge, & Rosowsky, 2006; Van Alphen et al., 2012) and of case studies (e.g., Bizzini, 1998; Dick & Gallagher-Thompson, 1995; Van Alphen, 2011). Only one small RCT examined treatment in older adults with depression and comorbid PDs (Lynch et al., 2007). In this trial 37 depressed older patients with a comorbid PD were randomized to antidepressant therapy or to antidepressant therapy combined with dialectical behavior therapy. The combined treatment did not significantly improve depressive symptoms over antidepressant therapy alone. The only advantageous effect of the combined treatment was found on interpersonal sensitivity and interpersonal aggression. A very remarkable finding was that about half of the PDs remitted after treatment in both conditions. Because pharmacotherapy has not been proven efficacious in treating PDs themselves (Ingenhoven, Lafay, Rinne, Passchier, & Duivenvoorden, 2010), probably the PD diagnoses were confounded by the comorbid depressions (Van

Alphen, Tummers, & Derksen, 2007). In conclusion, effectiveness studies focusing on treatment of PDs as the main focus of therapy in older adults are lacking.

A first important issue in the treatment of PDs in later life concerns the optimal choice of intervention. Older adults are very heterogeneous with significant variations in life experiences, physical ability, cognitive functioning, psychological features, and social circumstances (Kessler, Kruse, & Wahl, 2014; Segal et al. 2006). The selection of treatment might depend on a number of age-specific factors. For example, there seem to be enormous differences between the therapeutic possibilities of a 65 year old narcissistic man, who functioned relatively well as a chief executive of a large company until his retirement, and a 85 year old narcissistic farmer, suffering from dementia, who upsets a nursing home department.

Another question is whether – despite the therapeutic nihilism amongst clinicians and researchers - existing evidence-based treatments for PDs in adults are equally feasible and effective in later life? After all, as described above, there is a substantial body of evidence showing that older adults with depression and anxiety disorders respond well to a variety of forms of psychotherapy, mostly to a degree comparable with younger age groups. However, some authors believe that the aim of changing pathological aspects of personality is not possible in older adults, because of the rigidity of lifelong dysfunctional patterns or the consequences of cognitive and physical decline (e.g., De Leo, Scocco, & Meneghel, 1999; Segal et al., 2006). They believe that focusing on skills and symptoms is more attainable, like in CBT. Indeed, a CBT approach, in various forms, may be an effective avenue for treatment of PDs, as CBT is the most evidence-based treatment for older adults (Cuijpers et al., 2014; Gould et al., 2012a, 2012b; Scogin & Shah, 2012). Furthermore, case studies and empirical reviews indicate that CBT and schema therapy are applicable for the treatment

of PDs in later life (Bizzini, 1998; Dick & Gallagher-Thompson, 1995; James, 2008; Van Alphen, 2010; Van Alphen et al., 2012; Van Alphen et al., 2015).

A third major question is whether psychological treatment of PDs in older adults requires adjustments to better fit with their specific needs and experiential world (Segal et al. 2006; Van Alphen et al., 2015)? For example, older adults often are more reluctant than younger cohorts to disclose emotional issues to others, and sometimes there is need for additional motivational techniques (Laidlaw & Thompson, 2008). Furthermore, older adults are confronted with age-related loss experiences, such as loss of health, loss of significant others and loss of autonomy (Knight & Pachana, 2015). Concerning CBT for depression in older adults, integrating age-specific process factors to enhance the outcome in later life have been suggested, like wisdom enhancement and attitudes to aging (Laidlaw, 2009; Laidlaw & Thompson, 2014).

Aim of this dissertation

The aim of this dissertation is to explore the flagging field of inquiry that the treatment of PDs is in the current phase of scientific research. In this pioneering phase, this topic will be examined from several different perspectives to explore the three main research questions:

1. How can we determine the optimal choice of intervention in the heterogeneous population of older adults with PDs?
2. Are existing evidence-based treatments for PDs in younger age groups feasible and effective in later life, especially treatment from a cognitive-behavioral perspective?
3. What possible adjustments to psychological treatment of older adults with PDs are required to better fit with their specific needs and experiential world?

Specific research objectives and outline of the dissertation

Because of the lack of empirical evidence in this field, the role of age-specific factors is explored in both the selection of treatment for PDs in older adults and in the treatment itself in chapter two. This is done using the Delphi method, which has become increasingly viable as a tool for solving problems in health and medicine, especially in dealing with topics about which empirical data are sparse (Fink, Kosecoff, Chassin, & Brook, 1984; Wollersheim, 2009).

Next, an exploratory study is conducted on the clinical relevance and applicability of the findings of this Delphi study in chapter three. This is done by means of three case studies that explore the three treatment levels for PDs, which were identified in the first study, that is the personality-changing treatment level, the adaptation-enhancing treatment level and the supportive-structuring treatment level. We chose for a cognitive behavioral perspective as it provides treatment interventions on all three treatment levels, that is schema therapy, CBT and behavioral therapy. We also explore the age-specific psychotherapeutic topics in this patient group.

After this, chapter four zooms in on the personality-changing treatment level from a CBT perspective. After all, psychotherapy aimed at treatment of the PD itself is the most unexplored domain in the treatment of PDs in later life. In this chapter, a proof of concept study is described with a pre-mid-post design into the application of short schema group therapy in later life. The aim of this study is to evaluate, as a proof of concept, whether this treatment is feasible and effective in older adults with relapsing mood and chronic adjustment disorders and comorbid PDs or PD features. A proof of concept seeks to confirm a concept by evaluating intermediate outcomes that seem relevant for the mechanism and outcome of the intervention (Lawrence Gould, 2005). Because schema therapy is supposed to diminish early maladaptive schemas in order to mediate changes in symptoms (Young, Klosko, & Weishaar, 2003), we explored

whether changes in early maladaptive schemas indeed mediated changes in symptomatic distress.

In chapter five, the effectiveness of individual schema therapy as a treatment for PDs in older adults is assessed. As this is the first test of schema therapy for PDs as the main focus of treatment in later life, we use a multiple baseline design (Kazdin, 2010). This design uses frequent assessments within subjects, which makes it possible to distinguish time and treatment effects, and allows that each case is its own control. Thus, the high number of assessments of this central variable compensates for the relatively small number of participants in a multiple-baseline design. Like a RCT, a multiple baseline design can demonstrate significant change and also that this change is the result of the intervention and not of time (Hawkins, Sanson-Fisher, Shakeshaft, D'Este, & Green, 2007; Onghena, 2005).

In chapter six, possible adaptations of schema therapy for older adults are explored by examining the process of individual schema therapy on a microscopic level in a case study of a 65 year old man with a cluster C PD. By discussing the emerging possible adaptations of schema therapy, this can contribute to improving the applicability of schema therapy in older adults and ultimately enhance its outcome for use in later life.

Finally, the major findings of the studies will be summarized and discussed from a broader perspective in the general discussion in chapter seven. This chapter reports on the contributions of this entire dissertation to our understanding of the treatment of PDs in older adults. Recommendations are discussed for theory, research and clinical practice.

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Chapter 2

Treatment of personality disorders in later life:
Conceptual analysis, expert opinion and research suggestions

Abstract

Diagnosis and treatment of personality disorders (PDs) are important aspects of geriatric psychiatry. There is still a lack of empirical research in this area, especially concerning age-related diagnostic and therapeutic aspects of PDs in later life. Therefore, a Delphi-study was conducted among 35 Dutch and Belgian experts in the field of PDs in older adults. The aim was to investigate age-related diagnostic and therapeutic aspects of PDs in later life (≥ 60 years) and their implications for clinical practice, such as the introduction of a specific mental health care program, a diagnostic assessment procedure, and treatment criteria for PDs in older adults. Consensus on a statement was defined as agreement by two thirds or more of the experts. This Delphi study ultimately yielded consensus concerning 20 of the 21 statements. It was generally agreed that late-onset PD is a useful construct in geriatric psychiatry and that aging can lead to a distinct behavioral expression of PDs in older adults. The experts confirmed that a specific mental health program is useful to refine the diagnostic assessment and treatment in older patients with PDs. The Longitudinal, Expert, and All Data (LEAD) standard, combined with a stepwise, multidimensional diagnostic approach, was seen as highly suitable for personality assessment in later life. Finally, stratification of subjects among four treatment levels was regarded as a useful strategy and there was agreement concerning specific criteria for each level of treatment. In conclusion, it is recommended that age-specific aspects in the diagnosis and treatment of PDs be included in guidelines and protocols and addressed in future scientific research. Further research is indicated involving cross–validation of these Delphi statements in other countries, and evaluation of the clinical implementation of a specific mental health care program, the diagnostic assessment procedure, and treatment criteria on clinical utility. At the personality-changing treatment level, it is suggested to examine the feasibility of schema therapy for PDs in older adults. Furthermore, as evidence on treatment of PDs in later life is lacking, further explorative research is recommended, which

can shed light on relevant age-specific aspects that can be used to adapt schema therapy to a treatment protocol that is molded for older cohorts.

Introduction

There are limited empirical data concerning age-specific factors in the diagnosis and treatment of personality disorders (PDs) in older adults (Abrams & Bromberg, 2006). For instance, PDs are defined by the American Psychiatric Association (2000) as an enduring pattern of dysfunctional behavior with an early onset, but this definition does not seem entirely appropriate where elderly people are concerned. Some authors suggest that PDs are not always marked by an enduring pattern of the same behavioral and interpersonal problems (Agronin & Maletta, 2000; Van Alphen, Engelen, Kuin, & Derksen, 2006). In addition, personality pathology does not have to be prolonged. A cross-sectional study shows that PD characteristics can be present differently during the life course (Balsis, Gleason, Woods, & Oltmanns, 2007). There is just one longitudinal study of personality pathology up to old age. Black, Baumgard, and Bell (1995) reported a decrease of DSM-III antisocial PD features in 58% of their study population (N = 45). However, the DSM-III antisocial PD criteria have been criticized for inapplicability in older adults (Van Alphen, Nijhuis, & Oei, 2007). In contrast to the DSM-concept, defined by temporal stability of dysfunctional behavior criteria in an enduring pattern beginning in adolescence or young adulthood, it is conceivable that personality pathology can manifest itself for the first time in later life, with an underlying vulnerability always having been present. In each life phase, surrounding factors or compensatory mechanisms may have concealed the underlying personality pathology. In addition, the manifestation of PDs can be different in later life (Agronin, 2007). This mainly concerns, but is not limited to, cluster B PDs. In case studies, older adults with antisocial, borderline, histrionic or narcissistic PDs show less aggressive and impulsive behavior when compared with younger adults. However these older adults show more hypochondriac, psychosomatic, and depressive complaints, as well as passive-aggressive and addictive behaviors (Agronin & Maletta, 2000). Possible explanations of this differential behavioral expression of PDs in older adults

could be decreased impulsivity, cognitive aging and somatic comorbidity (Segal, Coolidge, & Rosowsky, 2006). In addition, overlap and intermingling with other mental disorders can likewise influence symptom expression.

The reliability of diagnosing PDs in older adults might benefit from the use of longitudinal data and consensus among clinicians. The Dutch multidisciplinary clinical guideline for PDs regards the Longitudinal, Expert, and All Data (LEAD) standard (Spitzer, 1983) as suitable for the assessment of PDs (Trimbos-instituut, 2008). The LEAD standard uses longitudinal data to ultimately reach a consensus diagnosis among clinicians. The longitudinal data are gathered from several sources, including observational, biographic, informant, test, and file data, as well as staff experiences with the patient. In a validity study in younger adults, LEAD standard diagnoses showed greater temporal stability and predictive validity when compared to diagnoses obtained by various semi-structured interviews (Pilkonis, Heape, Ruddy, & Serrao, 1991). The LEAD standard seems particularly useful as a framework for diagnosing PDs in older adults, whose long life makes for a host of biographic, informant and/or file data that can offer clues concerning long-term psychosocial (dys)function (van Alphen et al., 2006). When conducting psychological tests with older adults in a clinical setting, it is important to keep in mind that there are age-specific factors which can seriously interfere with personality assessment (Tummers, Penders, Derksen, Hoijtink, & Van Alphen, 2011).

The selection of treatments for PDs in older adults is discussed in a limited number of studies (James, 2008; Lynch et al., 2007). As yet, efficacy studies focusing on treatment of PDs in older adults are lacking. The optimal choice of intervention in older adults with personality pathology might depend on a number of specific factors, such as the degree of functional limitations stemming from somatic comorbidity and the patient's degree of motivation and cooperation. Moreover, it has been shown that older adults often are more reluctant than younger cohorts to disclose emotional issues to others, and that

sometimes there is need for additional motivational techniques (Laidlaw & Thompson, 2008; Segal et al., 2006).

Psychological treatment of older adults with PDs requires some adjustments to better fit with their specific needs and experiential world (Laidlaw, Thompson, Dick-Siskin, & Gallagher-Thompson, 2003). It is recommended that specific gerontological aspects be integrated into therapy; for example, beliefs about—and the consequences of—somatic ailments, as well as beliefs determined by cohort and sociocultural context, intergenerational linkages and the loss of social roles. In addition, the changing life perspective can be an important topic in therapy. While life review is a normal psychological task in older age, there are indications of increased risk for older adults with PDs in that they might develop psychiatric symptoms that correlate with the actual life review process. PDs are often characterized by dichotomous thinking (Beck, Freeman, & Davis, 2004), and the process of life review can lead to evaluating certain aspects of one's own life (extremely) negatively, even triggering traumatic experiences from the past.

In short, a relatively small amount of research has been conducted on PDs in later adult life. However, this topic comprises a rapidly expanding area of interest within the field of psychiatry and psychology.

Because of the lack of empirical evidence in this field, a Delphi study was conducted among Dutch and Belgian experts. The aims of the study were to address the role of age-specific factors in the diagnosis and treatment of PDs in older adults ($\geq$ 60 years) and their implications for clinical practice. The research questions were:

1) What is the opinion of Dutch and Belgian experts concerning age-specific factors of PDs in late life?

2) What are the expert opinions about several statements concerning implications of specific diagnostic and treatment methods in clinical

practice, such as a specific mental health care program, diagnostic assessment and treatment criteria for PDs in older adults?

Method

Participants

The Delphi panel was multidisciplinary. In total, thirty-seven potential panel members were identified and invited to participate. Thirty-five (95%) agreed to participate, including two geriatricians (6%), nine psychiatrists (26%), two psychiatric nurses (6%), and twenty-two psychologists/psychotherapists (62%). Twenty-four of the experts (69%) were Dutch, and eleven (31%) were Flemish.

Recruitment

The experts were selected by the Dutch research group Expert panel Personality & Older adults (EPO) to participate in this study. Selection criteria were demonstrated interest and expertise in the area of PDs in older adults, especially in terms of the conceptual, diagnostic, and/or therapeutic aspects of their fields. Furthermore, these experts were published authors, had conducted research, taught, and/or had many years of experience in the field of PDs in older adults.

Procedure

This Delphi protocol consisted of four written rounds of questions, which were presented in sequence to the experts by e-mail. All items were presented to all respondents in each round. In total, 21 gerontological assumptions were presented to this expert panel using a 5-point Likert scale to rate agreement with a given assumption. The responses were: fully agree, agree, neutral, disagree, fully disagree. The average score served as a measure of the level of agreement, i.e., consensus (Sharkey & Sharples, 2001). Agreement, for our purpose, was taken to mean that at least two-thirds of the respondents (≥67%) "agreed" or "fully

agreed" with an assumption. A literature overview compiled from suggestions by the research group EPO, was presented prior to the presentation of the assumptions. EPO members also constructed the Delphi-items. Feedback about the previous round was given by e-mail after each round. Items were revised in an iterative process in order to improve agreement from one round to the next. For each item, the experts were asked to judge their own expertise and decide whether they had enough to answer this particular item. The idea behind this was that not every panel member would be a Delphi expert in all specific subtopics relating to PDs in elderly people. EPO members did not participate as experts in these Delphi rounds.

The Delphi technique

The Delphi technique is a systematic, interactive forecasting method that relies on a panel of independent experts (Sumsion, 1998). The selected experts answer questionnaires in several rounds. After each round, a facilitator provides an anonymous summary of the experts' forecasts from the previous round as well as the reasons they provided for their judgments. This consensus study is focused on carefully defined problems. The Delphi method has become increasingly viable as a tool for solving problems in health and medicine (Fink, Kosecoff, Chassin, & Brook, 1984), and is used frequently in dealing with topics about which there are sparse, if any, empirical data in the literature (Wollersheim, 2009). Researchers from a variety of disciplines in the clinical sciences have used this technique because of its reputed ability to take advantage of the practical experience of recognized experts to focus on scientifically underexplored topics. When the Delphi technique is used properly, the panel members are unknown to each other and, in subsequent rounds, responses of all panel members in the previous rounds are revealed (Powell, 2003; Turuff & Linstone, 2002).

Results

The response rate was high: 100% in the first, 91% in the second, 91% in the third, and 100% in the fourth round. Table 1 presents the results of the agreement within Delphi-experts on conceptual and diagnostic items. Table 2 presents the results per therapeutic item.

Table 1: Overview of agreement within Delphi-experts per conceptual/diagnostic item

	Conceptual and diagnostic assumptions Delphi-study	%	R	N
1.	Personality pathology can have a first onset in later life.[L]	89*	1	35
2.	Cluster B personality disorders can have a specific manifestation in later life (less aggressive and impulsive behavior, more hypochondriac, psychosomatic and depressive complaints or passive-aggressive, addictive behavior).[L]	82*	1	33
3.	Age-specific factors can influence the behavioral expression of personality disorders in older adults.[L]	95*	1	35
4.	A specific mental health program for personality disorders in older adults is clinically relevant.	75*	1	33
5.	Specific Axis I disorders (such as adjustment disorders, relational issues and dysthymia) should be included in a mental health program for personality disorders in older adults.	71*	1	34
6.	The proposed *Main Group I* is clinically relevant in a mental health program for personality disorders in older adults.	77*	1	33
7.	The proposed *Main Group II* is clinically relevant in a mental health program for personality disorders in older adults.	52	1	28
8.	A stepwise diagnostic procedure of personality diagnostics is preferable in older adults.	91*	2	31
9.	A multidimensional approach to diagnose personality disorders is also preferable in older adults.	88*	2	30
10.	The LEAD standard is a good starting point for personality diagnostics in older adults.	78*	2	29

[L]=Based on the literature

In tables 1 and 2 the values marked with an asterisk (∗) met the criterion of at least 67% agreement. The Delphi round (R) and the response to every assumption (N) are also shown. Assumptions based on age-specific aspects in the literature are marked with L, while the rest, mostly clinical implications, were based on the clinical view of the Dutch research group EPO.

In the first Delphi round, this specific program for PDs in older adults was based on two main groups incorporating a total of five subgroups:
● *Group I:* Older adults with an Axis II disorder as the principal diagnosis and recurrent Axis I disorders precipitated in old age. In this group, the Axis I disorder is considered to be precipitated by the presence of the PD, typically resulting from inadequate coping styles and limited social skills for addressing age-specific problems, such as loss of health, loss of significant others, or loss of independence. The precipitating factors for the condition differ in the sense that they are age-specific. The Axis I disorders in this group are relatively mild, and are not specific psychiatric syndromes related to old age.
● *Group II:* Older adults with specific psychiatric syndromes, manifesting themselves in later life and superimposed on a PD. These syndromes are a result of underlying PDs, but are often misinterpreted as neurodegenerative disorders - such as Diogenes syndrome (Van Alphen & Engelen, 2005).
The Delphi panel agreed with group 1, but disagreed with group 2 because of the low frequency and heterogeneity of these syndromes (see table 1).

In the second Delphi round the Delphi panel agreed that a stepwise and multidimensional diagnostic procedure as well as the LEAD standard are preferable in mental health and nursing home settings (see table 2). Only one part of the LEAD standard is the test diagnostic approach. Figure 1 illustrates an example of a stepwise and multidimensional test diagnostic approach in clinical practice. Most of these tests have been or will be validated in a Dutch population of psychiatric inpatients and outpatients.

Figure 1. Example of a stepwise and multidimensional test diagnostic approach

Phase I:	Screening:
	Gerontological Personality Disorders Scale (GPS)[1]
	Suspicion of personality disorder → Phase II
Phase II:	Global assessment:
	Cognition: Coping Inventory for Stressful Situations (CISS)[2]
	Biosocial: Hetero-Anamnestic Personality Questionnaire (HAP)[3]
	Traits: NEO-Five Factor Inventory (NEO-FFI)[4]
	Temperament: Short version (V) of Temperament Character Inventory (VTCI)[5]
	Good cognitive and intellectual capacities, motivation, and cooperation → Phase III
Phase III:	Specific assessment:
	State-trait: Minnesota Multiphasic Personality Inventory Reconstructed Form (MMPI-2-RF)[6]
	Schema: Young Schema Questionnaire (YSQ)[7]
	Psychodynamic: Developmental Profile (DP)[8]

[1]Van Alphen et al., 2006; [2]De Ridder & Van Heck, 1997; [3]Barendse & Thissen, 2006; [4]Hoekstra, De Fruyt, & Ormel, 2003; [5]Duijssens, & Spinhoven, 2001; [6]Ben-Porath & Tellegen, 2008; [7]Young & Brown, 1990; [8]Abraham, 2005.

Table 2. Overview of agreement within the Delphi-experts per therapeutic item

	Therapeutic assumptions Delphi-study	%	R	N
11.	The choice of treatment in older adults with personality disorders depends mainly on the needs of the patient, the degree of functional limitations reflecting somatic comorbidity, and the type and severity of the personality disorder.	81*	3	30
12.	Specific gerontological aspects (such as beliefs about - and consequences of - somatic ailments, beliefs determined by cohort and socio-cultural context, intergenerational linkages and the loss of social roles) are essential topics in the therapy of older adults with a personality disorder.[L]	90*	3	29
13.	The mentioned description of the personality-changing, adaptation-focused and supportive-structuring treatment is useful in geriatric psychiatry.	83*	3	30
14.	Pharmacotherapy (on a symptom level) is useful in the treatment of personality disorders in older adults.[L]	79*	3	19
15.	The proposed treatment-algorithms for medication are also useful in older adults with a personality disorder.[L]	67*	3	15
16.	The in- and exclusion criteria for personality-changing treatment in older adults with personality disorders are useful in geriatric psychiatry.	53	3	28
17.	The in- and exclusion criteria for adaptation-focused treatment in older adults with personality disorders are useful in geriatric psychiatry.	65	3	29
18.	The in- and exclusion criteria for supportive-structuring treatment in older adults with personality disorders are useful in geriatric psychiatry (table 5).	72*	3	28
19.	The in- and exclusion criteria for pharmacotherapy in older adults with personality disorders are useful in geriatric psychiatry (table 6).	83*	3	18
20.	The *adjusted* in- and exclusion criteria for personality-changing treatment are useful in geriatric psychiatry (table 3).	73*	4	35
21.	The *adjusted* in- and exclusion criteria for adaptation-focused treatment are useful in geriatric psychiatry (table 4).	76*	4	35

[L]=Based on the literature

There was consensus about the following assumptions of treatment levels:

1. Treatment aimed at personality change: At this level, the therapy is focused on changing the pathologic aspects of the personality. Such treatment is often lengthy (i.e., >30 sessions). Examples are schema therapy, dialectical behavior therapy, and transference focused psychotherapy. Further, cognitive behavioral therapy, brief psychodynamic therapy, and marital therapy may be situated at the boundary between personality-changing and adaptation-focused treatments. Furthermore, there was agreement with several specific indication and contra-indication criteria for personality-changing treatment in round 3 and some criteria were fine-tuned with feedback of the experts in round 4 (see table 2 and table 3).

Table 3. Specific indication criteria for personality-changing treatment

Indications	Contra-indications
The individual is willing to enter a therapy focused on complains originating from the personality disorder, or there is some estimate that this willingness will emerge during the initial phase of the treatment.	Moderate to serious cognitive disorder.
	Florid psychotic disorder.
The individual possesses sufficient discipline and persistence to participate in therapy.	Serious depressive episode.
	Unstable bipolar disorder.
The personality issues are the primary factors causing and/or maintaining psychological and/or relational problems.	Serious inability to achieve a therapeutic alliance.
The individual is capable of self-reflection on a reasonable level.	Drug abuse demanding detoxification.
The individual is able to tolerate the disorganizing effects which can derive from the treatment.	Presence of acute psychosocial or somatic factors which are the exclusive focus of the individual's attention.

2. Treatment focused on adaptation enhancement: This treatment is focused on older adults who are motivated for treatment, yet are limited in their ability to change, for example, because of poor introspection and empathy. In this case, a treatment can be chosen which focuses on influencing the critical aspects of the patient's adaptation to his or her environment, particularly to age-specific problems. Treatments in this category include interpersonal psychotherapy, social skills training, or other brief psychotherapies specifically addressing the interpersonal functioning of the patient such as systemic therapy or cognitive-behavioral therapy. Furthermore, there was agreement with several specific indication and contra-indication criteria for adaptation-focused treatment in round 3 and some criteria were fine-tuned with feedback of the experts in round 4 (see table 2 and table 4).

Table 4. Specific indications for adaptation-focused treatment

Indications	Contra-indications
The involved individual has (some degree of) willingness to change his or her behavior or feels enough pressure to enter treatment.	Moderate to serious cognitive disorder.
Especially the age-specific factors in interaction with personality issues lead to psychological complaints and/or social dysfunctioning.	Florid psychotic disorder.
The involved individual is not willing or not capable of entering a long-term therapy focused on changing personality aspects.	Serious depressive episode.
	Unstable bipolar disorder.

3. Treatment providing support and structure: When a patient is not able to change, or cannot benefit from direct psychological treatment because of, for example, severe cognitive disorders, one can opt for interventions such as supporting the patient and advising him or her about how to make the best of his or her environment. For example, support can be focused on acquiring and keeping an adequate pattern of activities and creating an adequate life structure. A surrogate support system, such as a geriatric day-care program, can be useful when the patient's social system is overburdened, limited, or absent altogether. Another option is to use less direct interventions, such as psychoeducation of the patient's informal or formal (i.e., professional) care providers and context of care. Consensus was reached on specific indication and contra-indication criteria for this treatment level (see table 2 and table 5).

Table 5. Specific indication criteria for supportive-structuring treatment

Indications	Contra-indications
Serious inactivity.	Non-compliance with nearly all kinds of care.
Exceptionally limited social support system.	
Overloaded (professional) support system.	
Absence of willingness and/or capacity to participate in psychotherapeutic treatment.	

4. Pharmacotherapy: Pharmacotherapy of target symptoms can be significant for patient subgroups with PDs characterized by a host of symptoms, a complicated course, a poor prognosis, and a minimal responsiveness to psychotherapy or a lack of willingness to participate in psychotherapy. Pharmacotherapy in the treatment of older adults with PDs is complicated by, for instance, somatic multi-morbidity, polypharmacy, and/or cognitive disorders. Soloff (1998) has developed useful treatment algorithms for the choice of medication to be prescribed to adults under the age of 60. These algorithms are based on three defined symptom clusters: cognitive-perceptual symptoms, affective dysregulation, and symptoms of impulsive behavioral dyscontrol. Consensus was reached on specific indication and contra-indication criteria (see table 2 and 6).

Table 6. Specific indication criteria for pharmacotherapy

Indications	Contra-indications
Cognitive-perceptual symptoms.	Hypersensitivity to psychopharmacological treatment (for example because of somatic comorbidity).
Serious affect dysregulation.	Serious therapy disloyalty.
Serious impulse-control issues.	Complicating interactions with pharmacological treatment.

Discussion

The aim of this study was to expand theory and inform clinical practice concerning age-specific diagnostic and therapeutic considerations regarding PDs in later life. Therefore, we focused on the opinion of Dutch and Belgian experts concerning these age-specific factors as well as their opinion about a specific mental health care program, diagnostic assessment, and treatment criteria for PDs in older adults. This Delphi study ultimately yielded consensus concerning 20 of the 21 statements about age-specific diagnostic and therapeutic considerations and their clinical implications. To our knowledge, this is the first Delphi study focusing on both the diagnosis and treatment of PDs in older adults.

Consistently with the experts' agreement with the construct of late onset PD, it appears that there was disagreement with the PD criterion of DSM IV-TR (American Psychiatric Association, 2000), requiring an enduring pattern of dysfunctional behavior from adolescence onward. The experts also confirmed the view that the behavioral manifestations can differ between younger and older adults. Thus, the contemporary DSM PD assessment, based on behavior of younger adults, might be inadequate for older adults. The lack of validated screens, personality questionnaires and interviews appropriate for older adults could lead to underdiagnosis and underestimated prevalences (Balsis, Woods, Gleason, & Oltmanns, 2007; Van Alphen, Engelen, Kuin, Hoijtink, & Derksen, 2006). Epidemiological data show that PDs within the A and C clusters are relatively more prevalent in the elderly while cluster B disorders are more common in younger cohorts (Engels, Duijsens, Haringsma, & Van Putten, 2003). It is, however, possible that this apparent lower prevalence of cluster B PDs in older adults reflects the limitations of the DSM to identify these disorders in this population.

Despite the relatively time-consuming nature and lack of operational guidelines for interpreting contradictory information, the LEAD standard was

regarded to be very suitable in geriatric psychiatry. Furthermore, agreement was reached on a stepwise and multidimensional test diagnostic approach in clinical practice. Besides the classification of three levels of psychological treatments and pharmacotherapy for PDs in later life, the experts also agreed on specific criteria for each level of treatment in clinical practice. To our knowledge, no specific inclusion and exclusion criteria have been proposed for psychological treatment levels of PDs in the literature.

A strength of this study was the careful selection of the panel members by EPO. Almost every expert who was selected, agreed to participate, and the Delphi panel included the most experienced ones on the topic throughout the Netherlands and Belgium. In addition, the response rate was high and there was a high level of agreement across experts. Agreement, for our purpose, was taken to mean that at least two-thirds of the respondents (≥67%) "agreed" or "fully agreed" with an assumption. In the literature the consensus range for Delphi studies is between 50% and 100%; the choice of a two-thirds majority was made because of the explorative character of this study (Fink, Kosecoff, Chassin, & Brook, 1984).

This study has also some limitations. First, the panel was limited to Dutch and Belgian experts. Thus, the results can be regarded as being representative only of Dutch and Belgian geriatric psychiatry and nursing home care. Replication of this study in other countries is warranted to further validate its findings. Second, Delphi research relies on level III evidence, though actually it is recognized as an excellent starting point for further scientific inquiry (Wollersheim, 2009). Third, representing the current knowledge regarding the diagnosis and treatment of PDs in older adults in only 21 statements is doubtful. Fourth, some statements could elicit socially desirable responses. For example, asking experts in the field of PDs about the value of a specific mental health program for PDs. Fifth, several therapeutic assumptions for personality-changing psychotherapy and pharmacotherapy are not specific to older adults

and thus are not particularly novel. Besides, the data on pharmacotherapy of older adults with PDs are sparse and one must use caution in giving any psychopharmacologic agent to such patients without evidence of a comorbid mental disorder.

Further research concerning diagnosis of PDs can be suggested, including cross-validation studies of these Delphi statements in other countries, the implications these may have for diagnostic assessment, and the implications for the design of specific mental health programs. Other suggestions for further work would include longitudinal research on the course of PDs in older adults and research on the reliability and validity of the LEAD standard in geriatric psychiatry.

Considering further research into treatment of PDs in later life, studies on the efficacy of different intensities of treatment in older adults with PDs, and of behavior management for their informal as well as formal (i.e. professional) caregivers are suggested. Moreover, research on the applicability and efficacy of personality-changing psychotherapy with this population is of importance. Some authors believe that changing pathological aspects of personality is not feasible in older adults (e.g., De Leo, Scocco, & Meneghel, 1999; Segal et al., 2006). This Delphi-study however, has led to consensus among experts that existing evidence-based therapies for PDs in younger adults are applicable with older cohorts. Especially schema therapy is promising for this treatment level, as this treatment model seems to connect to the psychotherapy expectations of older adults, because it incorporates psychoeducation and is structured, skill-enhancing and problem-focused.

However, it is recommended that age-specific aspects are integrated. The efficacy of psychotherapy at the personality-changing treatment level for older adults could possibly be enhanced by integrating the gerontological aspects, concerning which the experts reached consensus in this study. First, the changing life perspective can cause an actualization of dysfunctional schemata as one is

reviewing one's life; the process of life review can lead to evaluating certain aspects of one's own life (extremely) negatively. The second gerontological aspect concerns the beliefs about – and consequences of – somatic ailments. For example, the core belief of an older dependent woman that she "won't make it on her own," can be actualized by macular degeneration; the prospect of a waning eye sight causes her to see the future as threatening. A disturbing consequence of a somatic ailment is when a narcissistic older man becomes immobile because of peripheral vascular disease, which causes him to give up his appraisal generating role as president of an organization for senior citizens. Third, cohort beliefs and the sociocultural context could be integrated into schema therapy of PDs. Cohort beliefs are beliefs held by groups of people born in similar time periods, which tend to have a significant impact on the therapeutic alliance (Laidlaw et al., 2003), especially as they combine with dysfunctional core beliefs. The sociocultural context refers to people's attitudes to their own aging and can include internalized negative stereotypes about growing old. A fourth important gerontological aspect to be considered in schema therapy, is change in role investment. This concerns the extent to which an older adult remains involved in personally meaningful activities and interests. Older people with personality pathology are significantly less able to adapt to new roles. Finally, intergenerational linkages, in interaction with dysfunctional cohort beliefs, can cause tensions in intergenerational relationships. Older adults consider continuity and the transmission of values to younger generations as important, whereas younger adults view independency and autonomy as more important. This can cause disagreement between older parents and their children on, for example, notions of caregiving. Besides this, possibly integrating wisdom enhancement (Knight & Laidlaw, 2009) and worth enhancing beliefs (James, 2008), which have been suggested to provide useful gerontological targets in the treatment of depression and anxiety, may also have a positive effect on the schema therapeutic treatment of PDs in the elderly.

Call for evidence

In conclusion, as evidence on treatment of PDs in later life is lacking, it is recommended to first conduct explorative research to examine the applicability of the treatment levels in clinical practice. The most prejudice is surrounding the personality-changing treatment level in older adults. Especially schema therapy is promising for this treatment level, as this treatment model seems to connect to the psychotherapy expectations of older adults. Therefore, conducting a feasibility study into schema therapy in later life would be useful.

If schema therapy appears feasible, then exploring the effectiveness of schema therapy for the treatment of PDs in older adults would be the next step towards evidence-based therapy for PDs in later life. Such a first test of efficacy can be conducted using a multiple baseline design (Ferron & Scott, 2005; Kazdin, 2010) with a series of case studies, in which schema therapy is applied to older adults with a PD. To account for the increasing inter-individual variability and multiple morbidity as people age, such a study could focus on cluster C PDs, as this cluster probably is the most stable across the life span (Gutiérrez et al., 2012). Because the inter-individual variance in this design is smaller, the same power can be reached with this type of research. Such a design yields findings especially pertinent on how therapeutic change unfolds individually (Borckardt et al., 2008). This can also shed light on relevant age-specific aspects that can be used to adapt schema therapy to a treatment protocol that is molded for older cohorts. This adapted treatment protocol can ultimately be studied for its efficacy with older adults in a RCT.

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Chapter 3

Psychotherapeutic treatment levels of personality disorders in older adults

Abstract

Treatment of personality disorders (PDs) in older adults is a highly underexplored topic. In this chapter, the clinical applicability of the findings from a recent Delphi study regarding treatment aspects of PDs in older adults is explored. This concerns the relevance of three psychotherapeutic treatment levels for PDs in later life: 1) personality-changing treatment, 2) adaptation-enhancing treatment, and 3) supportive-structuring treatment. By means of three cases concerning the three levels, all from a cognitive behavioral perspective, namely 1) schema therapy, 2) cognitive behavioral therapy, and 3) behavioral therapy, we illustrate the usefulness of the different levels in the selection of treatment for older adults with PDs. Throughout all treatment levels, attention to specific age-related psychotherapeutic topics - such as loss of health and autonomy, cohort beliefs, sociocultural context, beliefs about and consequences of somatic comorbidity, intergenerational linkages, and the changing life perspective - is crucial, as they often cause an exacerbation of personality pathology in later life. Suggestions are discussed as to how to adapt existing treatments within a cognitive behavioral framework in order to better mold them to the needs and experiences of older adults with PDs.

Introduction

Treatment of personality disorders (PDs) in older adults is a highly underexplored topic (Van Alphen et al., 2015). The number of publications on this subject is scant. Possibly, this stems from a therapeutic nihilism, very similar to the pessimism regarding the treatability of PDs in younger cohorts until the end of the last century. Currently, there is accumulated evidence for the efficacy of several kinds of psychotherapeutic treatments of PDs up to the age of fifty with respect to reducing symptomatology and improving social functioning (Verheul & Herbrink, 2007).

As far as we know, there are only two treatment studies into PDs in older adults over the age of 60 (Lynch et al., 2007; Videler, Rossi, Schoevaars, Van der Feltz-Cornelis, & Van Alphen, 2014). The first study was a small randomized controlled trial on 37 depressed older patients with a comorbid PD, who were randomized to either antidepressant therapy alone or antidepressant therapy combined with dialectical behavior therapy (DBT). The combined treatment was superior with respect to improved interpersonal sensitivity and interpersonal aggression compared to antidepressant treatment alone. Remarkable is that in both conditions about half of the PDs were in remission after treatment, as pharmacotherapy has not been proven efficacious in treating PDs itself (Ingenhoven, Lafay, Rinne, Passchier, & Duivenvoorden, 2010). Probably, the diagnoses of the PDs were confounded by the comorbid depressions. The second study (Videler et al., 2014), which evaluated short-term schema group therapy for 31 older outpatients suffering from chronic depression and/or a PD (or PD features) within a pre-post design with repeated measures, found a medium treatment effect on the reduction of depressive symptoms, dysfunctional schemas and schema modes. Furthermore, the reduction in symptoms was mediated by a change in dysfunctional schemas, which supports the efficacy of schema therapy (ST) for older adults. However, both studies

concern treatment of PDs and comorbid mood disorders. Research into treatment of PDs in later life as the main focus of therapy is lacking.

The outcomes of these studies do suggest that a cognitive behavioral approach, in various forms, may be an effective avenue for the treatment of PDs, as the main focus of therapy, in older adults. Cognitive behavior therapy (CBT) has been proven efficacious for the treatment of depression and anxiety disorders in older adults (Gould, Coulson, & Howard, 2012a; 2012b; Laidlaw & Thompson, 2014; Pinquart, Duberstein, & Lyness, 2007; Scogin & Shah, 2012). Furthermore, case studies and empirical reviews indicate that CBT and schema therapy (ST) are applicable for the treatment of PDs in later life (Bizzini, 1998; Dick & Gallagher-Thompson, 1995; James, 2003, 2008; Van Alphen, 2010; Van Alphen et al., 2012; Van Alphen et al., 2015).

In a Delphi study among Dutch and Belgian experts in the field of PDs in older adults (Van Alphen et al., 2012), diagnostic and treatment aspects of PDs in older adults were explored. For a better understanding, the outcomes of this Delphi study concerning treatment are briefly summarized here.

Regarding the selection of treatment, the expert panel agreed that the various psychological interventions for PDs can be seen as lying along a continuum of personality-changing treatment, adaptation-enhancing treatment and supportive-structuring treatment. Treatment aimed at personality change is focused on changing the pathologic aspects of the personality. Treatment at this level consists of forms of psychotherapy, which have been proven effective for younger adults, such as ST (Young, Klosko, & Weishaar, 2003), DBT (Cheavens & Lynch, 2008), or transference focused psychotherapy (TFT; Clarkin, Yeomans, & Kernberg, 2014).

Treatment focused on adaptation enhancement can be selected for older adults who are motivated for treatment, yet are limited in their ability to change, for example, because of poor introspection and capacity for empathy. At this level, treatment focuses on helping the patient to adapt to his or her changing

environment, particularly to age-specific problems. Treatment at this level includes, for example, CBT, interpersonal psychotherapy (Hinrichsen & Clougherty, 2006), as well as other psychotherapies addressing the interpersonal functioning of the patient such as family therapy (Qualls, 2014).

The last treatment level, supportive-structuring treatment, can be selected when a patient is not able to change, or cannot benefit from direct psychological treatment because of, for example, severe cognitive disorders. Possible interventions at this treatment level are behavioral activation, advising and supporting the patient and his or her family. Another option is to use less direct interventions, such as behavioral therapy (BT) aimed at specific behavioral disturbances, by changing the intermediate behavior of the patient's informal or formal (i.e. professional) care providers and context of care.

In our opinion, a cognitive behavioral perspective seems interesting as it provides treatment interventions on all three treatment levels, that is ST for personality-changing psychotherapy, CBT for adaptation-enhancing treatment and BT for supportive-structuring treatment.

Besides consensus on the usefulness of the three psychotherapeutic treatment levels, the experts also agreed about specific psychotherapeutic topics in the treatment of PDs in later life (Van Alphen et al., 2012). There was agreement that features of the gerontological perspective on treatment of PDs are particularly loss experiences, which are often prominent in the life of older adults. As people with PDs age, as a consequence of their history of life-long maladaptive coping, they have more trouble than older adults with a healthy coping repertoire, facing these age-related loss experiences, such as loss of health (related to the beliefs about – and the consequences of – somatic ailments), loss of significant others and loss of autonomy (Knight, 2004; Segal, Coolidge, & Rosowsky, 2006; Van Alphen et al., 2015). Besides the loss experiences, there are the cohort beliefs, the sociocultural context and changes in role investment. Cohort beliefs are those beliefs held by groups of people born in similar times,

which tend to have a significant impact on the therapeutic alliance, especially as they may combine with dysfunctional core beliefs (James, 2008; Laidlaw, 2003; Laidlaw & Thompson, 2008). The sociocultural context refers to people's attitudes to their own aging and can include internalized negative stereotypes about growing old (Laidlaw & Thompson, 2008; Laidlaw, 2009). For example, older adults might be reluctant to seek psychotherapy because "one can't teach an old dog new tricks." Changes in role investment refers to the loss of social roles and the trouble older PD patients tend to have in acquiring new meaningful roles. The changing life perspective is also an important psychotherapeutic topic in older adults with PDs as this can cause an actualization of dysfunctional cognitive schemas as one is reviewing one's life. While life review is a normal psychological task in older age (Butler, 1974; Erikson, 1963), there are indications of increased risk for older adults with PDs in that they might develop psychiatric symptoms that correlate with the actual life review process. The process of life review can lead to evaluating certain aspects of one's own life (extremely) negatively, and sometimes trigger traumatic experiences from the past. Finally, intergenerational linkages and the transmission of values to younger generations are important topics in psychotherapy of older adults (Laidlaw, 2003), perhaps especially with those with PDs, as they often combine with their dysfunctional core beliefs. The chances of intergenerational tensions occurring are much greater for older adults with PDs, as difficulty with interpersonal relationships due to intergenerational and interpersonal conflicts is a hallmark of PD pathology in later life.

Aims of this study

As no exploratory study has been performed yet on the clinical relevance and applicability of the findings by Van Alphen and colleagues (2012), three case studies will be described that explore the three treatment levels from a cognitive

behavioral perspective, as well as the specific psychotherapeutic topics in this patient group.

Case reports

Case 1. Treatment aimed at personality change: Schema therapy

Mrs. A, 65 years old, was referred by a psychiatrist, and suffered from recurrent depressive episodes. She received antidepressant medication at referral. Twenty years earlier, she was diagnosed with PD Not Otherwise Specified (NOS) with avoidant, dependent and obsessive-compulsive traits. At the time, she was only treated for her mood disorder. Although there was some response to the antidepressant medication, Mrs. A reported she still was inactive and felt depressed. She was diagnosed with a major depressive episode and again with a PD NOS with mainly avoidant traits on the Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II; First et al., 1997). Mrs. A had been treated for a melanoma eighteen months earlier, and at the time she was very anxious about dying; this anxiety was still present. One year before referral, her aunt died, whom she referred to as her favorite aunt. Her mother, who died when Mrs. A was 24 years old, once told her she was an unwanted child. Her aunt's death activated her dysfunctional core beliefs "I am not worthwhile" and "I loose everyone." Thus, the loss of her aunt, combined with the confrontation with her own mortality, evoked the earlier loss through a changing life perspective; this activated maladaptive cognitive schemas. As a consequence of these schemas, Mrs. A had avoided intimacy with others throughout her life, which maintained the depression, although the relationship with her husband and children was generally satisfactory.

Treatment selection

Mrs. A matched the inclusion criteria for personality-changing treatment (see table 3 in chapter two). She was motivated to overcome her current depression and to prevent the risk of relapse. She understood that her avoidant behavior was based on the core belief "I am not worthwhile," and that this contributed to her depression. Mrs. A possessed the discipline and persistence to invest in psychotherapy. She also had sufficient social support. Therefore personality-changing treatment was selected, in this case ST (Young, Klosko, & Weishaar, 2003).

Treatment focus

The goal of ST was changing her dysfunctional core belief, or early maladaptive schema (EMS), about the self ("I'm not worthwhile") into a functional core belief. This EMS was formed in her youth, especially in interaction with her mother. Her mother owned a rather successful store but was unavailable as a sensitive parent. By re-experiencing the (traumatic) situations that gave rise to this EMS, and then changing its meaning, Mrs. A could develop a functional core belief. This experiential technique, called imagery rescripting, is one of the most powerful techniques in ST (Edwards & Arntz, 2012). In guided imagery, Mrs. A was helped to re-experience situations with her mother, in which she developed the EMS by speaking in the I-form and the present tense. Next, she was guided to rescript these experiences by taking a healthy adult perspective and re-enacting these experiences. The influence of the memories of these traumatic experiences waned. Mrs. A thus discovered that her aunt repeatedly gave her the feeling: "I'm worthwhile," a functional core belief. Homework was assigned in which she daily described a positive situation in a logbook which served as proof for the functional core belief. Mrs. A took this "positive logbook" to subsequent sessions in order to strengthen her positive self-belief. Subsequently, the fear of

losing others diminished and she was able to practice more appropriate social behavior. This led her to lessen her avoidance of intimate relationships.

Treatment results

ST led to a solid functional self-belief and diminished avoidant behavior. Mrs. A no longer met the criteria for PD NOS. The depressive mood was in remission. In total, the therapy consisted of 35 weekly sessions, with 5 additional monthly booster sessions.

Case 2. Adaptation-focused treatment: Cognitive behavioral therapy

A couple, Mr. and Mrs. B, he 70 years old and she 65, were both avid tennis players. Both were referred by their GP. The immediate reason for the request for help was a fierce discussion the couple had in front of other tennis players. Mr. B thought that his partner let him down. An escalating argument ended in him leaving the premises. Mrs. B followed, ashamed because of his behavior and refused to talk about it. Following this, Mrs. B chose another tennis partner. Her husband demanded her to give up this new tennis partner, which she refused.

In the past, there had been several escalating arguments in different tennis clubs. Because of this, Mr. B associated his cardiac complaints as stress induced by the relational tensions. Furthermore, the current problems were reinforced by the retirement of Mr. B, who had continued his job as tax consultant up to the age of 69. He strongly suggested Mrs. B to go and talk with an "outsider," to which she agreed. Mr. B sent an email to the therapist to "hear his opinion in short notice."

Mr. B suffered from cardiac problems and Mrs. B from hearing problems. The recent death of her two sisters led Mrs. B to review her life. While the relationship with their children was deemed satisfactory, she reappraised the relationship with her husband and wondered whether to continue the marriage. Mr. B was diagnosed as having a narcissistic PD using the SCID-II. Mrs. B had,

at the most, two histrionic traits, so no PD diagnosis, and had functioned well as a social worker. Mr. B had had a long career as a tax consultant, and in the first two decades of his career there were many conflicts with superiors, and he abused alcohol periodically. After he started his own consultancy, his functioning improved, although he remained extremely vulnerable to criticism.

Treatment selection

Personality-changing treatment was not feasible for Mr. B, but he matched the inclusion criteria for adaptation-enhancing treatment (see table 4 in chapter two) at referral. Mr. B only asked for the opinion of the therapist regarding the relational conflict. The therapist assessed that a willingness for behavior change would occur during the initial phase of treatment, although mainly caused by the pressure that Mrs. B placed on him. Adaptation-enhancing treatment was selected, and given by means of CBT, applied in a treatment model by Everly (1996).

Treatment focus

The rationale of this treatment model, which is an elaboration of brief CBT for PDs, is that the reinforcer of the dysfunctional behavior pattern is used to motivate the patient for therapy, in general, and behavior change, specifically. People with PDs rigidly pursue specific reinforcers. For example, dependent PD patients are in need of support by others for their psychological survival, as they consider themselves incompetent. In brief adaptation-focused CBT for PDs, the therapist agrees with the necessity of pursuing the reinforcer, in order to establish a therapeutic alliance. The goal of the behavior change is a more adequate adaptation to changing circumstances, which in later life commonly concerns age related stressors and life transitions. The dominant dysfunctional core belief of Mr. B was that he had special rights because of his self-perceived special status. The therapist agreed with the importance of the reinforcer, being unlimited

appraisal and prevention of humiliation. In the first two treatment sessions, it became apparent that Mr. B. had paid little attention to his wife during his working years, and after retirement, had assumed himself as a helper to her. Mrs. B was encouraged to verbalize that she was not in need of help, but wanted to be appreciated as a wife. In the third session both partners agreed that the escalations in the relationship because of his behavior and her reactions were painful for both. So maintaining the relationship, including the appraisal of his wife and lessening his feelings of humiliation because of her criticism, became the specific reinforcer in the therapy. There was a mutual agreement between the partners and the therapist to work on the dysfunctional behavior of Mr. B and her reaction to this, with their common goal to maintain the marriage. In the next sessions, the focus was on adaptation of dysfunctional behavior patterns which were aimed at this goal. The therapist appealed to the expertise Mr. B had acquired during his work with - sometimes difficult and critical - clients as a tax consultant, and how to apply this expert knowledge to the relationship with his spouse. In the fifth session, Mr. B decided to be nicer, and Mrs. B would guard her reaction. In the sixth session, there was stabilization of the behavior based on their common goal. Mr. B, showed nicer behavior, like complementing his wife and proposing activities, which Mrs. B found enjoyable. Mrs. B stopped directly criticizing him. Instead of this, the couple learned a form of negotiation and giving feedback, which was acceptable for both.

Treatment results

This brief CBT treatment, which only took six two-weekly sessions and one follow-up session a month later, led to an improved relationship. Of note, the PD was not treated itself, as is not the focus of adaptation-enhancing treatment. The treatment goal was adjustment to the retirement of Mr. B. As a result of treatment, both spouses were more able to adjust their behavior to the changes in their marriage after the retirement of Mr. B. Mrs. B had adjusted her behavior

to the sensitivity for criticism of her husband. And Mr. B was motivated to change his abasing behavior by appealing to the expertise he had acquired during his career.

Case 3. Supportive-structuring treatment: Behavioral therapy

Mrs. C, 74 years old, was referred by her GP because of suicidal behavior after the loss of her spouse two years earlier. She was ambivalent about the possibilities for help. On the one hand, Mrs. C longed for rest and wanted to be admitted to a psychiatric hospital. On the other hand, she thought she could not be treated and wanted to die. Mrs. C avoided stimuli which reminded her of her husband, such as pictures, music and the cemetery. When the therapist asked questions about her husband, she cried, and acutely became suicidal: "My husband was an angel and without him I cannot live." According to her daughter, Mrs. C idealized her husband. However, during their marriage, there were repetitive arguments between her parents. She described her mother as vulnerable and capricious. Towards others, she alternated between claiming their attention and dismissing them. Her two brothers had stopped having contact with their mother a year ago. The daughter was emotionally exhausted. Mrs. C was diagnosed with complicated grief, with a score of 72 on the Inventory for Complicated Grief (Prigerson et al., 1995), and a borderline PD, meeting five out of nine criteria on the SCID-II. Impulsive behavior, mood swings, and also alternating between claiming and dismissing others had been present throughout the patient's life. But from around the age of 40 until the retirement of her husband, Mrs. C had functioned better. After the retirement, there were escalating rows between the spouses. The daughter thought her mother felt abandoned at the time by her father when he went out for a game of billiards. Since his death, the patient appealed strongly to her daughter.

Treatment selection

Personality-changing treatment and adaptation-enhancing treatment could not be selected, but Mrs. C met the selection criteria for supportive-structuring treatment (see table 5 in chapter two), in this case BT. She lacked activities and was sometimes suicidal; her daughter was overburdened after the death of her father. Furthermore, Mrs. C was not willing to engage in any kind of therapy.

Treatment focus

Goals of the treatment were to prevent suicidal behavior and acquire an adequate pattern of activities, and also to relieve the daughter. Because of the underlying attachment problems, in-patient admission was not chosen for as this would aggravate the suicidal behavior. Instead, psychiatric day treatment was offered. Also a written crisis plan was agreed upon, which outlined what Mrs. C would do or ask for if she experienced suicidal thoughts. Options were a short admittance up to three nights, or calling her daughter. The daughter was given psycho-education and support, in which she was educated on borderline PD. She was also taught, as a mediator for behavior change of her mother, how she could talk to her mother when in crisis, in a neutral tone. In fact, by intermittently talking to her mother in an emotional way or by not answering the phone, she had been intermittently reinforcing her mother's core belief "I will be abandoned by others," thereby increasing the amount of phone calls and the suicidal behavior. In response to treatment, the relationship between mother and daughter improved. Interestingly, after being stabilized emotionally, Mrs. C was able to confront her feelings of grief. Music therapy appeared to be a way of expressing her strong feelings of anger and sadness over the loss of her husband, and also to give up the idealized image of him. Sessions on drums (anger) and xylophone (sadness) were recorded so that she would be able to listen to them at home, as a form of grief exposure therapy.

Treatment results

This supportive-structuring treatment led to a better relationship between mother and daughter. The PD itself was not treated, but as a result of the behavior change of the daughter and the support Mrs. C received, the suicidal behavior waned and Mrs. C was able to mourn the loss of her husband; her score on the Inventory for Complicated Grief lessened to 26. Treatment consisted of 12 weekly BT sessions with the daughter, psychiatric day treatment, a crisis management plan, and 24 weekly music therapy sessions.

Discussion

Aim of these case studies was to explore the clinical relevance and applicability of the three treatment levels and the specific psychotherapeutic topics, as were found in the Delphi study by Van Alphen and colleagues (2012). These three case reports indeed illustrate the applicability of the three different treatment levels and their specific selection criteria guiding the selection of treatment and the operationalization of feasible treatment goals.

A cognitive behavioral approach of PDs in later life appeared useful at all three levels of treatment. At the personality-changing treatment level, ST led to a solid functional self-belief and diminished avoidant behavior and Mrs. A no longer met the criteria for PD NOS. At the adaptation-enhancing level, CBT led to an improved adjustment to retirement; although the PD was not treated itself, the relational crisis due to the exacerbation of the narcissistic PD, was at ease. Finally, at the supportive-structuring treatment level, behavior change of the daughter through BT and supportive treatment caused the suicidal behavior to wane and Mrs. C was able to mourn for the loss of her husband.

The case reports furthermore emphasize the importance of recognizing and integrating specific psychotherapeutic topics of PDs in older adults.

A cognitive behavioral approach of levels of treatment

A cognitive behavioral framework provides treatment interventions on all three treatment levels, namely schema therapy (ST) for personality-changing psychotherapy, cognitive behavioral therapy (CBT) for adaptation-enhancing treatment, and behavioral therapy (BT) for supportive-structuring treatment.

In case A, the patient was treated with ST at the personality-changing treatment level. ST emerged as an effective treatment for PDs and other patient groups such as chronic mood and anxiety disorders in adults up to the age of fifty (Bamelis, Bloo, Bernstein, & Arntz, 2012; Bamelis, Evers, Spinhoven, & Arntz, 2013). In ST, besides cognitive and behavioral techniques, experiential

techniques are important and powerful in changing EMS; experiential techniques are imagery rescripting, role-play and chair work (Arntz & Van Genderen, 2009; Kellogg, 2014). Nevertheless, the efficacy of individual ST in older adults remains to be explored further (Videler et al., 2014).

For adaptation-enhancing treatment, as in the case of Mr. B, CBT applied in a treatment model for PDs by Everly (1996), "brief personologic psychotherapy," appears promising. In this treatment the dysfunctional core beliefs and maladaptive behavior patterns are identified. The goal of the treatment is not to change these core beliefs, but rather to adapt the behavior pattern in such a way that the same reinforcers are achieved, leading to a more adequate adaptation to changing circumstances, such as age related stressors.

For supportive-structuring treatment, BT is an interesting treatment modality, as we saw in the case of Mrs. C. Especially, as many older patients are realistically dependent on others for supportive and life-sustaining care, this throws the elderly person with PD into unavoidable, intense interpersonal interactions. Since the core of the difficulties that those with PDs encounter, are in the interpersonal sphere, management of PDs in late life poses specific and important challenges for family and professional care providers (Van Alphen, Derksen, Sadavoy, & Rosowsky, 2012). Psychosocial interventions based on BT aimed at behavioral disturbances, by changing the intermediate behavior of caregivers or nurses (LeBlanc, Raetz, & Feliciano, 2011), can be useful for older adults with PDs in care settings.

Specific psychotherapeutic topics

The case reports underline the importance of recognizing the gerontological topics in psychotherapy with PDs in later life, which the experts agreed about in the Delphi study by Van Alphen et al (2012). These aspects caused an exacerbation of the personality pathology in later life. In the case of patient A, the melanoma and the loss of a loved one induced a changing life perspective,

and this reviewing her life activated a dysfunctional core belief. This exacerbated her avoidant PD. In patient B, a change in role investment after retirement and somatic complaints, in combination with the changing life perspective of the spouse, caused an aggravation of relational distress, superimposed on a narcissistic PD. Furthermore, the cohort belief of patient B, "a wife should stand by her man," amplified his narcissistic idea that his wife should obey him. In the treatment of patient C, the grief because of the loss of her husband and his supportive and structuring role, led to an exacerbation of the borderline PD. Furthermore, her internalized stereotyped cohort belief about growing old, "aging is dying alone," coincided with her dysfunctional core belief that she could not live without her husband, which led to clinging behavior towards her daughter and complicated her grief.

Strengths and limitations

This is the first study exploring the applicability of the three treatment levels for the selection of treatments regarding PDs in older adults in actual case studies. In terms of the usefulness of a cognitive behavioral approach to the treatment levels and also the relevance and integration of specific psychotherapeutic topics, this provides us with innovative results. Case studies are very relevant in this phase of scientific knowledge gathering, as explorative research is a useful first step (Bromley, 1986; Morley, 1989). As Balsis and colleagues (2011) pointed out, a first starting point for a better understanding of PDs in older adults is the presentation of rich, clinical descriptions in case studies.

Of note, the patients in the case reports were all under 75. It can be expected that, as people with PDs age, comorbidity of PDs with somatic ailments and cognitive disorders increases, as well as the dependency on others for care, and BT on a supportive-structuring treatment level will be selected more often.

Obviously, the results of these case studies have limited generalizability and further empirical research into the validity of the selection criteria for the

three treatment levels and the differential integration of age-specific psychotherapeutic aspects in later life is needed.

Implications for research

The Dutch-Belgian expert results (Van Alphen et al., 2012) are currently being examined by Rosowsky and colleagues in a United States Delphi replication study concerning age-specific aspects of diagnosis and treatment of PDs in later life. If the selection criteria for the treatment levels are indeed replicated, it would support the usefulness of constructing and validating an instrument based on these criteria for the selection of treatment for older adults with PDs. A next step would be an implementation study of this selection-instrument.

Furthermore, conducting empirical research into augmenting the efficacy of a cognitive behavioral approach for PDs in older adults - at all three treatment levels - is of great importance (Videler et al., 2014). Currently, research is being carried out in the Netherlands in which ST is applied to older adults with a PD in a multiple baseline case series design (Videler, Van Royen & Van Alphen, 2012). Time-series analysis can shed light on how therapeutic change unfolds individually. Furthermore, this study explores qualitatively which relevant age-specific aspects can be used to adapt schema therapy to a treatment protocol that is better molded for older cohorts.

As Laidlaw & McAlpine (2008) pointed out, little has been written about how the efficacy of CBT, which is developed for adults in their working age, could be enhanced for older adults. Some authors have pointed out that the outcome of CBT can probably be increased by using gerontological theories of aging to identify process factors, which can be used as vehicles for change. Interesting targets for CBT with older adults have been suggested, like wisdom enhancement and attitudes to aging (Knight & Laidlaw, 2009; Laidlaw, 2009; Laidlaw & Thompson, 2014). However, these suggestions were made for CBT for depression and anxiety in later life. This raises the question whether and how

ST, CBT, and BT for the treatment of PDs in older adults can be better molded to the context of aging by integrating gerontological theory.

Wisdom in the theoretical perspective of Baltes and Staudinger (2000) is conceptualized as expert knowledge about the fundamental pragmatics of human life. Wisdom enhancement in CBT is helping people to contextualize their current problems within a lifespan perspective by asking them how they have coped with problems successfully earlier in their life. Laidlaw (2009, 2013) describes a useful therapeutic technique, in which the client is asked to construct a timeline, on which he or she puts all meaningful events from his or her life. By means of Socratic questioning, the client is helped to discover what wisdom can be gained from reviewing past experiences, thus guiding the client to a more self-accepting stance. Wisdom enhancement could also be an interesting augmentation of the CBT framework for PDs in older adults, both at the personality-changing treatment level and at the adaptation-enhancing level. At the personality-changing treatment level, the treatment goal is to change the maladaptive aspects of the personality and thus to increase the resilience of the patient to cope with age-related changes and challenges. Re-experiencing and rewriting the narrative of the PD patient's life is an important element of ST. The schema changing technique described by Padesky (1994), the historical test of schema, has much in common with the wisdom enhancing time-line technique as described by Laidlaw (2013). Therefore, our hypothesis is that this technique is especially applicable and helpful for older adults as it helps the patient to take a life span perspective. Possibly, in selecting the personality-changing treatment level, the ability for retrospection is as important as the ability for introspection.

At the adaptation-enhancing treatment level, the focus of treatment is helping the older PD patient to change his or her behavior in order to achieve a better fit between the changed environment and his or her PD. Possibly, the concept of wisdom enhancement can often be used as a vehicle for behavior change at this treatment level. As Gibson (2011) suggested, deliberately focusing

on experiences of triumph and success, could be a useful strategy in psychotherapy with older narcissistic and histrionic PD patients. It could be especially helpful for behavior change in older adults with these specific PDs, as it connects to their core beliefs of superiority and being special. However, older adults with PDs commonly have less positive experiences to look back on, and most of them will be more reluctant to review their life as looking back can be painful.

Furthermore, attitudes to aging have been suggested as a target for CBT in older adults with depression and anxiety (Laidlaw, 2009; Laidlaw & Thompson, 2014). Societal attitudes about aging are internalized from a young age and can become negative self-stereotypes, which operate similarly to early maladaptive schemas. These are activated by the negative mood congruent attentional bias in depression, resulting in older depressed adults attributing their problems to aging instead of to depression or anxiety. CBT should help older depressed and anxious patients to challenge these negative attitudes to aging. We hypothesize that in older adults with PDs these negative self-stereotypes are more - or even continually - active in later life, and are relevant at all three treatment levels. Also, in older PD patients, these negative attitudes to aging are less prone to therapeutic change, even at the personality-changing level. However, recognizing the unconscious role of the attitudes to aging is equally important in psychotherapy with older PD patients, as they might reinforce negative core beliefs in later life.

Another interesting option to enhance the efficacy of ST and CBT in older adults could be to take into account the action of premorbid positive, or functional, schemas as James (2008) has suggested. James called these functional schemas "worth enhancing beliefs" (WEBs) which used to be nourished by for instance social roles. If a person ages and loses these nourishing roles, positive self-beliefs are less triggered and dysfunctional schemas can become more influential. While traditional CBT therapists tend to focus on dysfunctional

schemas, attention to these positive WEBs seems promising for enhancing treatment of older adults. In treatment of PDs in later life, we want to stress that even PD patients have WEBs. Using these WEBs is promising, especially for those who have functioned better in some earlier life stage. In our opinion the use of WEBs is congruent with the brief personologic therapy model for CBT at the adaptation-enhancing treatment level.

Whether and how the efficacy of psychotherapy of PDs in older adults within a CBT framework can be augmented by integrating wisdom enhancement, attitudes to aging and WEBs, deserves further empirical research.

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Chapter 4

Schema group therapy in older outpatients:
A proof of concept study

Abstract

Short-term group schema cognitive behavior therapy (SCBT-g) showed improvements in overall symptomatology, early maladaptive schemas (EMS) and schema modes, both in adults and adolescents with personality disorder (PD) features and long-standing mood disorders. However, no research has yet been carried out on the effect in older adults. Therefore, in a proof of concept study, we explored the effect of SCBT-g in older outpatients with PD features and longstanding mood disorders. Thirty-one older outpatients, aged 60-78 years with PD features and/or longstanding mood disorders were included in a proof of concept study with pre-mid-post design. Primary outcome was psychological distress (Brief Symptom Inventory) and intermediate outcomes were EMS (Young Schema Questionnaire) and schema modes (Schema Mode Inventory). Paired samples *t*-tests were conducted, and Cohen's *d* effect sizes reported for pre-, mid- and post-treatment. As proof of concept analysis, hierarchical regression analyses with residual change scores were used to analyze whether early process changes in EMS (intermediate outcomes) predicted later outcome changes in symptoms. SCBT-g led to significant improvement in all three measures of psychological symptoms, EMS and modes with medium effect sizes. Pre-treatment to mid-treatment changes in schema severity predicted symptom improvement from mid- to end-of-treatment. This proof of concept study shows that SCBT-g has potential to change EMS and to show significant effect at symptom level in older outpatients with PD features. A control condition in a randomized controlled trial is a necessary step for further research.

Introduction

There is a substantial body of evidence showing that older adults respond well to a variety of forms of psychotherapy, both individual and group psychotherapies, to a degree comparable with younger age groups (American Psychological Association, 2013). Efficacy has especially been demonstrated for individual cognitive-behavioral therapy (CBT) in the treatment of depression and anxiety disorders (Pinquart, Duberstein, & Lynness, 2007; Hendriks, Oude Voshaar, Keijsers, Hoogduin, & Van Balkom, 2008), and for life review therapy and group psychotherapy in the treatment of depression (Scogin, Welsh, Hanson, Stump, & Coates, 2005; Krishna et al., 2011).

Nevertheless, the efficacy of schema therapy (ST) in older adults remains to be explored. ST was originally developed by Young (1990) as an individual psychotherapy for the treatment of PDs, especially the borderline PD, and has recently been elaborated for the treatment of other complex psychiatric disorders (Edwards & Arntz, 2012). In younger cohorts (18-50 years), ST has emerged as an effective treatment for personality disorders (PDs) and other patient groups such as chronic mood and anxiety disorders (Bamelis, Bloo, Bernstein, & Arntz, 2012; Bamelis, Evers, Spinhoven, & Arntz, 2013). ST integrates elements of CBT, object relations theory, gestalt therapy and attachment theory into one unified, systematic approach of treatment (Young, Klosko, & Weishaar, 2003). ST focuses on early maladaptive schemas (EMS) and how they influence daily life and interpersonal relationships. EMS are defined as self-defeating core themes that pertain to one's view of the self, others and the world. They form the core of one's self concept and are formed in childhood and adolescence. Schema domains contain several EMS related to different clusters of unfulfilled emotional needs (Young et al., 2003). Schema coping styles are developed in order to cope with the early environment that led to the development of EMS. Three main categories of coping can be identified: surrendering (acting as if the EMS is completely true), avoidance (blocking thoughts, feelings, emotions linked

to the EMS), or overcompensating (acting as if the opposite of the EMS is true). Schema modes are conceptualized as groups of EMS and schema coping styles that are active together and thus reflect a particular emotional state.

ST teaches patients to respond more from "a healthy adult" perspective and to cope in a more adaptive manner when schemas are triggered in daily life by events that are linked to unfulfilled needs (Young et al., 2003). ST consists of three stages. Assessment is the first phase, in which EMS, schema coping styles and schema modes are identified, commonly with the help of questionnaires. Secondly, the emotional awareness and experiential phase follows, wherein patients get in touch with these EMS and learn how to spot them when they are operating in their day-to-day life. Thirdly, behavioral and schema change becomes the focus, during which the patient is actively involved in replacing negative, habitual thoughts and behaviors with new, healthy cognitive and behavioral options. In this third phase of therapy, besides cognitive and behavioral techniques, experiential techniques seem to be powerful, especially imagery rescripting (Arntz & Van Genderen, 2009). In guided imagery the patient is helped to re-experience the situations which were crucial in forming their EMS, and express his or her emotions that are linked to these situations. In rescripting the outcome, the patient can give a different meaning to these experiences. Other experiential techniques with the same objective are role-play and chair work (Arntz & Van Genderen, 2009).

ST has been modified for a group-focused approach, which is promising as a cost-effective alternative for individual treatment (Farrell, 2012). Even a short-term group schema cognitive behavior therapy (SCBT-g; Broersen & Van Vreeswijk, 2012) is associated with improvements in overall symptomatology, EMS and schema modes, both in adults with PD features and long-standing mood disorders (Van Vreeswijk, Spinhoven, Eurelings-Bontekoe, & Broersen, 2012) and adolescents with PD features (Renner et al., 2013). SCBT-g is primarily indicated for relapsing mood, chronic adjustment and anxiety disorders which

are intermingled with comorbid PDs or PD features. SCBT-g focuses in particular on the cognitive behavioral techniques of ST.

A recent expert study on treatment of PD in older adults has led to consensus among Dutch and Belgian experts that existing evidence-based therapies for PDs in adults up to the age of 50, such as ST, are also applicable to older adults over 60 years of age (Van Alphen et al., 2012; see chapter two). However, no research has yet been carried out on the effects of individual, nor group ST in older adults (Van Alphen, Derksen, Sadavoy, & Rosowsky, 2012). Providing ST in a short group format like SCBT-g might be interesting, because SCBT-g seems to connect to the psychotherapy expectations of older adults, as it places emphasis on psychoeducation, is highly structured, skill-enhancing and problem-focused (Laidlaw & Thompson, 2008). It also provides social support, which tends to diminish as people age (Zarit & Zarit, 2011).

The aim of this study is to evaluate, as a proof of concept, whether SCBT-g is effective in older adults with relapsing mood and chronic adjustment disorders and comorbid PDs or PD features. We hypothesized that symptom, EMS and mode severity decreases after SCBT-g treatment. A proof of concept seeks to confirm a concept by evaluating intermediate outcomes that seem relevant for the mechanism and outcome of the intervention (Lawrence Gould, 2005). In terms of the proof of concept, because ST is supposed to diminish EMS in order to mediate changes in symptoms, we explored whether changes in EMS indeed mediated changes in symptomatic distress as intermediate outcome. We hypothesized that changes in EMS in the first phase of SCBT-g treatment predict changes in symptomatic distress in the second phase of this treatment.

Methods

Participants

Forty-two participants, age 60 years of age and over, with a multidisciplinary consensus diagnosis of a longstanding mood disorder or a chronic adjustment disorder with comorbid PDs or PD features, that had previously been treated by evidence based or best practice based therapy without significant improvement, were included. Exclusion criteria were: (I) patients who suffered from neurodegenerative diseases, (II) patients suffering from major physical illness to such an extent that it could affect participation, (III) patients with a diagnosis of a learning disability and (IV) patients with hearing or vision problems that affected participation in a group.

Study design

To investigate whether SCBT-g is effective in older adults and whether changes in EMS mediate changes in symptomatic distress, this study was designed as a proof of concept study. A proof of concept study is very common in medicine. It has been developed to test the feasibility of a new intervention or drug in a small trial with patients (Lawrence Gould, 2005), and is becoming more popular for other interventions than pharmacotherapeutical ones. Such a trial investigates the activity of the intervention on the assumed therapeutic process by evaluating the effect on intermediate outcomes related to the presumed mechanism of the intervention working on the outcome, and is a preliminary phase to a randomized controlled trial (RCT) (Van der Feltz-Cornelis et al., 2014).

The DSM-IV (American Psychiatric Association, 2000) diagnosis was based on a multidisciplinary consensus diagnosis. The outpatients participated in five consecutive schema groups of 8 to 10 participants. Measurements of symptomatic distress and EMS were conducted at pre-treatment, mid-treatment

(session 10) and end-of-treatment (2 months after session 18). Measurement of schema modes was administered at pre-treatment and end-of-treatment.

The Medical Ethic Committee of the South of Holland and local research ethics committees granted ethical approval. Informed consent was obtained from all participants.

Treatment intervention

SCBT-g (Broersen & Van Vreeswijk, 2012) is a short-term group therapy of 20 sessions (18 sessions of 90 minutes weekly and 2 follow up sessions of 90 minutes, one and two months after termination of treatment respectively). The highly structured protocol has a special emphasis on cognitive and behavioral techniques of ST. In accordance with the protocol, in the first stage of the therapy (session 1-9), patients were educated about the schema model, specifically in relation to their own three most prominent EMS and modes. All patients had their own schema workbook in which cognitive techniques were applied to help them test and challenge the distorted views associated with their EMS. In the second stage (session 10-20), patients were tempted to respond to situations that triggered their EMS in a more adaptive manner, using their workbook exercises and role-playing. During the entire course of therapy, the group was encouraged to explore EMS triggering as it occurred naturally in the group setting and to discuss it openly. All sessions were recorded on DVD and patients who missed any sessions were required to watch the DVD before the next session. The therapists received supervision of an experienced schema psychotherapist and co-author of the treatment protocol (Broersen). During SCBT-g, no individual psychological treatment took place. Participants who were on medication, mainly antidepressants, continued it throughout treatment.

Measures

Psychological symptoms

The primary outcome variable was the score on a symptom checklist, the Brief Symptom Inventory (BSI; De Beurs, 2011; translated from Derogatis, 1975a). The BSI is a shorter version of the Symptom Checklist-90 (SCL-90; Derogatis, 1975b), and consists of 53-items. The reliability of the Dutch BSI scales is good and the convergent and divergent validity has been found to be satisfactory (De Beurs, 2011). Moreover, the BSI is validated for older adults and preferable for this age group because it is less lengthy than the SCL-90 (Van Alphen, Derksen et al., 2012).

Early maladaptive schemas

The Young Schema Questionnaire (YSQ L-2; Young & Brown, 1994; Dutch translation Sterk & Rijkeboer, 1997) is the most commonly used EMS measure. The list consists of 205 items, which are phrased as a negative core belief and rated along a 6-point scale. It measures 16 core beliefs as defined by Young et al. (2003): abandonment/instability, mistrust/abuse, emotional deprivation and social isolation/alienation (schema domain 1: disconnection and rejection); dependence/incompetence, enmeshment/undeveloped self and failure (schema domain 2: impaired autonomy and performance); entitlement/grandiosity, and insufficient self-control/self-discipline (schema domain 3: impaired limits); subjugation and self-sacrifice/approval seeking/recognition seeking (schema domain 4: other directedness); and emotional inhibition and unrelenting standards/hypercriticalness (schema domain 5: overvigilance and inhibition). The Dutch YSQ has good reliability and convergent and discriminant validity (Rijkeboer et al., 2005).

Schema modes

The Schema Mode Inventory (SMI; Dutch translation Lobbestael, Van Vreeswijk, Arntz, Spinhoven, & `t Hoen, 2005) measures 16 modes. These modes can be divided into 4 types of modes: healthy modes, parent modes, child modes and coping modes. This test consists of 270 items, which are rated along a 6-point scale. The Dutch SMI has excellent test-retest reliability and the convergent and divergent validity of the subscales are satisfactory (Lobbestael, Van Vreeswijk, Spinhoven, Schouten, & Arntz, 2010).

Statistical analyses

Strength of outcome was measured by calculating within subjects effect sizes Cohen's d (Cohen, 1988)*,* based on the BSI and YSQ for the pre-, mid- and end-of-treatment measurements and based on the SMI for pre- and end of treatment measurements (as SMI scores were only available at pre- and end-of-treatment). According to conventional criteria, $d < 0.20$ is considered a small effect size, $d = 0.50$ a medium effect size and $d > 0.80$ a large effect size.

Treatment success was determined by the classification of patients as recovered, improved, unchanged or deteriorated by Lambert, Hansen, & Bauer (2008). We first calculated changes between the BSI pre-treatment to post-treatment and assessed these changes for statistically reliable change. Next, it was determined whether patients who showed reliable change also passed the clinical cut-off point (reliable change scores were 18 for men and 19 for women and clinical cut-off points 35 for men and 37 for women, based on norm group data provided in the Dutch manual of the BSI by de Beurs (2011)). After these two steps each patient could be classified as recovered (reliable change and below the cut-off), improved (reliable change and above cut-off), unchanged (no reliable change) or deteriorated (reliable change in a negative direction).

Intermediate measures analysis

To examine whether pre-treatment to mid-treatment change in EMS mediated mid-treatment to end-of-treatment change in symptoms, cross-lagged correlations among residual change scores were calculated in treatment completers (Finkel, 1995). Hierarchical regression analyses were used to investigate whether early process changes in EMS predicted later outcome changes in symptoms after controlling for autocorrelation (the correlations of pre-treatment to mid-treatment with mid-treatment to end-of-treatment on BSI residual change scores and YSQ residual change scores) and synchronous correlations (the correlations between pre-treatment to mid-treatment or mid-treatment to end-of-treatment changes on the YSQ and the BSI, respectively). Inverse associations were also determined by regression analysis. The Statistical Package for the Social Sciences version 19 for Windows (SPSS Inc., Chicago, USA) was used. All the analyses were two-tailed with a significance level of 5%, unless stated otherwise.

Results

In total 31 out of 42 included older outpatients completed the therapy and filled out all measures. Of the eleven dropouts, 6 patients refused to participate in SCBT-g after completion of the questionnaires at pre-treatment (pre-dropouts). During the course of this study another 5 patients (dropouts) terminated this therapy before the last session: 1 patient was admitted to a psychiatric hospital, 1 patient reported an excess of fear in the group, 1 patient left the group after a heated dispute with the other members of the group, 2 patients refrained from participation because of unknown reasons. Dropout patients were offered an alternative treatment. Table 1 gives an overview of the baseline characteristics of the patients that remained in treatment and those who left treatment prematurely. Average age of the patients who completed treatment was 68 years (range: 60-78 years); 22 were female (71%), 9 were male (29%). Ten patients were diagnosed

with a PD (32%; 6 patients with PD not otherwise specified, 3 with dependent PD and 1 with paranoid PD), of whom 6 had a comorbid mood disorder and 3 a comorbid adjustment disorder; 12 patients were diagnosed with PD features (39%; of whom 7 had a comorbid mood disorder and 5 a comorbid adjustment disorder); 9 patients were diagnosed with a longstanding mood disorder without a comorbid PD or DSM-IV PD features (29%).

Patients who stayed in treatment (N = 31), were significantly more diagnosed with a mood disorder than the 11 patients who dropped out (N = 11) ($\chi^2(1) = 5.061$, $p < 0.05$). Patients who dropped out, did not differ ($\chi^2(9) = 16.094$, $p = 0.065$) in global assessments of functioning (GAF, DSM-IV), or in the amount of symptomatic distress at pre-treatment from those who completed treatment ($t = 1.143$, df = 40, $p = 0.130$). Nor did dropouts differ in EMS compared to the patients who completed treatment ($t = 0.324$, df = 40, $p = 0.374$). There were no significant differences between dropouts and treatment completers in all schema modes, with the exception of the healthy modes on which dropout patients did score significantly higher on the SMI ($t = 2.736$, df = 36, $p < 0.05$).

Table 1. Baseline characteristics

	Treatment completers (N=31)		Dropout patients (N=11)	
	M	SD	M	SD
Age	68	4,6	67	5,3
	N	%	N	%
Women	22	71	9	82
Men	9	29	2	18
Higher education	4	13	1	9
Higher secondary with vocational training	10	32	4	36
Elementary school with lower vocational training	12	39	3	27
Elementary school	5	16	3	27
PD	1	3	0	0
PD + Mood disorder	6	19	2	18
PD features + mood disorder	7	23	5	45
Mood disorder	9	29	0	0
PD + adjustment disorder	3	10	1	9
PD features + adjustment disorder	5	16	3	27
GAF at pretreatment 35-40	1	3	1	9
GAF at pretreatment 45	3	10	0	0
GAF at pretreatment 50	5	16	5	45
GAF at pretreatment 55	6	19	1	9
GAF at pretreatment 60-65	15	48	2	18
GAF at pretreatment 70	1	3	2	18

PD = personality disorder; GAF = Global Assessment of Functioning.

Effect of treatment

Symptomatic distress was the main outcome variable and decreased significantly from pre-treatment (M = 63.58, SD = 28.62) to end-of-treatment (M = 48, SD = 28.31). Total EMS, the most important process variable, also decreased significantly from pre-treatment (M = 42.04, SD = 11.36) to end-of-treatment (M = 38.42, SD = 10.11), as did all schema domain scores. Dysfunctional schema modes decreased significantly (Parent modes from M = 39.27, SD = 12.19 to M= 34.85, SD = 12.96; child modes from M=31.24, SD = 10.45 to M = 28.39, SD = 11.19; coping modes from M = 30.59, SD = 8.67 to M = 27.99, SD = 9.76). Healthy modes increased significantly (from M = 45.57, SD = 11.71 to M = 49.65, SD = 12.29).

The means, SDs and effect sizes of changes in symptomatic distress, EMS and modes are presented in table 2. Almost all effect sizes, including those of decrease in symptomatic distress and total YSQ score were medium. Exceptions were the effect sizes of change in schema domain 3 (impaired limits) and schema domain 5 (overvigilance/inhibition), which were small.

Table 2. Means, standard deviations, and effect sizes (with paired samples t-tests significant at p < 0.05) in the BSI, EMS, schema domains and mode domains

	Pre-treatment		Mid-treatment		End of treatment		Effect sizes
	M	SD	M	SD	M	SD	
BSI	63,58	28,61	52,45	25,94	48,00	28,31	0,41/0,15/0,54
YSQ total	42,04	11,36	39,77	9,94	38,42	10,11	0,30/0,11/0,38
YSQ domain 1	2,65	0,86	2,45	0,74	2,40	0,76	0,25/0,07/0,31
YSQ domain 2	2,42	0,71	2,29	0,62	2,21	0,58	0,20/0,13/0,32
YSQ domain 3	2,47	0,77	2,47	0,75	2,30	0,69	0/0,24/0,23
YSQ domain 4	3,17	0,85	2,97	0,74	2,86	0,77	0,25/0,15/0,38
YSQ domain 5	2,60	0,82	2,51	0,80	2,43	0,81	0,11/0,10/0,21
Healthy modes	45,57	11.71	Na	Na	49,65	12,29	Na/Na/-0,34
Coping modes	30,59	8,67	Na	Na	27,99	9,76	Na/Na/0,28
Parent modes	39,27	12,19	Na	Na	34,85	12,96	Na/Na/0,35
Child modes	31,24	10,45	Na	Na	28,39	11,19	Na/Na/0,26

BSI = Brief Symptom Inventory total score. YSQ = Young Schema Questionnaire. Effect size values are based on the difference in scores from pre-treatment to mid-treatment (x/), from mid-treatment to end-of-treatment (/x/) and form pre-treatment to end-of-treatment (//x) divided by the mean of the corresponding standard deviation. For modes a single effect size is given because these were assessed only at pre-treatment and end-of-treatment. Na = Not available

There was a small difference in effectiveness between patients with a PD (N = 10; d = 0,69 on symptomatic distress and d = 0,58 on total EMS) and patients with a mood disorder without a comorbid PD or PD features (N = 9; d = 0,45 on symptomatic distress and d = 0,34 on EMS), although all effect sizes were medium.

Calculation of the clinical significance of change using the BSI reliable change scores and clinical cut-off scores, showed that 26% of the patients recovered, 16% improved, 52% remained unchanged and 6% deteriorated.

Intermediate outcome analysis: Mediation effects

Residual change scores were calculated for the BSI and the YSQ total score (see table 3). There was no significant auto-correlation for the BSI and the YSQ total, implying that early treatment changes in these variables were unrelated to late treatment changes in the same variables. Synchronous correlations showed a significant association of pre-treatment to mid-treatment changes in YSQ scores with pre-treatment to mid-treatment BSI changes. The mid-treatment to end-of-treatment changes in YSQ scores were also significantly associated with mid-treatment to end-of-treatment changes in BSI scores. This suggests that changes in EMS co-occur with changes in symptomatic distress. As the synchronous correlations are significant, the cross-lagged correlations ought to be treated with caution. The cross-lagged correlations showed no significant association between pre-treatment to mid-treatment YSQ change and mid-treatment to end-of-treatment BSI change. The converse correlations were also non-significant.

Table 3. Zero-order correlations of residual change scores

	Pre-treatment – mid-treatment BSI	Mid-treatment – end-treatment BSI	Pre-treatment – mid-treatment YSQ	Mid-treatment – end-treatment YSQ
Pre-treatment – mid-treatment BSI	___			
Mid-treatment – end-treatment BSI	-0,216	___		
Pre-treatment – mid-treatment YSQ	0,585**	0,191	___	
Mid-treatment – end-treatment YSQ	-0,241	0,700**	-0,050	___

**. Correlation is significant at the 0.01 level (2-tailed).

To analyze whether pre-treatment to mid-treatment YSQ change was a significant predictor of mid-treatment to end-of-treatment BSI change after controlling for variance due to pre-treatment to mid-treatment changes on BSI, and for mid-treatment to end-of-treatment changes on the YSQ, hierarchical regressions were performed (see table 4). Pre-treatment to mid-treatment YSQ change appeared to be a significant predictor of mid-treatment to end-of-treatment BSI changes, accounting for an additional 10% of the variance apart from the variance due to pre-treatment to mid-treatment changes on BSI and for mid-treatment to end-of-treatment changes on the YSQ. The converse lagged association proved to be non-significant.

Table 4. Summary of hierarchical regression analysis

Variable	β	SE β	R²	ΔR² of step
Mid-treatment to end BSI				
Step1				
Pre-treatment – mid-treatment BSI	-0,289	0,157		
Mid-treatment – end-of-treatment YSQ	0,649	0,128	0,492	0,492**
Step 2				
Pre-treatment to mid-treatment YSQ	0,393	0,153	0,592	0,100*
Mid-treatment to end YSQ				
Step1				
Pre-treatment – mid-treatment YSQ	-0,225	0,178		
Mid-treatment – end-of-treatment BSI	0,754	0,148	0,524	0,524**
Step 2				
Pre-treatment to mid-treatment BSI	0,053	0,179	0,526	0,002

Note: variables are residualized change scores. *p<0,05, **p<0,001

Discussion

The primary aim of this proof of concept study was to investigate the feasibility of SCBT-g in older adults with PDs, PD features or longstanding mood disorders by assessing the effect on changes in global symptomatic distress. As proof of concept intermediate analysis, we investigated whether SCBT-g led to changes in EMS, and whether this mediated changes in symptoms. Our results showed that SCBT-g led to significant improvement in symptomatic distress ($d = 0.54$) from pre-treatment to post-treatment. Besides, changes in schemas seemed to co-occur with changes in symptomatic distress. Further analysis showed that pre-treatment to mid-treatment EMS change appeared to be a significant predictor of mid-treatment to end-of-treatment BSI changes. This implies that EMS change as process variable probably mediates changes in the outcome variable of ST, symptomatic distress. This was also found in the study of Van Vreeswijk et al. (2012) in a younger cohort. This finding can be seen as a proof of concept that SCBT-g decreases EMS and thus lessens symptomatic distress in our sample of older adults.

The BSI effect size in this study is comparable to the medium effect size found on the SCL-90 by Van Vreeswijk et al. (2012) in 48 adults with an average age of 39 ($d = 0.66$). Renner et al. (2013) found a large effect size ($d = 0.81$) on the SCL-90 in a sample of 26 adolescents with an average age of 22.5. Effect size on EMS was significant in our study ($d = 0.38$). However, it was smaller than the large effect sizes found in younger age groups (Van Vreeswijk et al.: $d = 0.75$; Renner et al.: $d = 0.88$). In the current study, 26% of the patients recovered, 16% improved, and 52% remained unchanged. Van Vreeswijk et al. (2012) found a larger proportion of recovery (47%). To explain the difference of effect between the sample of adolescents (Renner et al., 2013) and the sample of adults (Van Vreeswijk et al., 2012), Renner and colleagues proposed that EMS in younger adults are more flexible and changeable during treatment. This same explanation

could clarify the differences found in the current sample of older adults, in comparison to younger adults and adolescents.

Nevertheless, SCBT-g should be made more powerful where possible, in order to generate better treatment effects. We suggest some adaptations in the SCBT-g protocol (Broersen & Van Vreeswijk, 2012) to meet the needs of older patients. They probably need more time to learn the schema language and to recognize the triggering of schemas and modes in their personal life. Therefore, they may substantially benefit from having several individual ST sessions (e.g., five) prior to the start of SCBT-g. Also simplifying a number of cognitive techniques in the workbook, illustrated with examples that fit their experiential world, might improve therapy outcome.

Furthermore, offering ST individually, and providing more therapy sessions, can lead to better treatment effects in older adults, given the fact that RCTs with 50 individual sessions (40 ST sessions in the first year and 10 booster sessions in the second year) have shown higher treatment effects in adults up to the age of 50 (Bamelis et al., 2013; Giesen-Bloo et al., 2006). Future studies on individual ST in older adults should also integrate experiential techniques (e.g., imagery rescripting), as they are thought to be more powerful at changing EMS (Arntz & Van Genderen, 2009).

Another explanation for the differences in treatment effect in our sample, compared to the younger age groups, is that ST could probably be improved for older adults by integrating age-specific aspects into the treatment protocol, as was found in the expert study by Van Alphen et al. (2012). Examples of age-specific aspects are the changing life perspective, the beliefs about – and consequences of – somatic ailments, cohort beliefs and the sociocultural context, change in role investment and intergenerational linkages (Videler, Van Royen, & Van Alphen, 2012). Besides diminishing the effects of EMS, in ST with older adults, the action of premorbid positive, or functional, schemas should also be taken into account as James (2008) has suggested. James called these functional

schemas "worth enhancing beliefs" (WEBs) which used to be nourished by for instance social roles. If a person ages and loses these nourishing roles, positive self-beliefs are less triggered and EMS can become more influential. We further refer to James (2008) for a more elaborate description of how these WEBs can be used in psychotherapy with older adults. In fact, this use of WEBs shows similarities with elements of adaptation-focused treatment as described by Van Alphen et al. (2012).

Limitations and strengths of the study

Some limitations of this study need to be addressed. Firstly, the lack of a control group limits the generalizability of our findings. However, as a proof of concept, the findings are very useful, as the next step can be a RCT with a control condition (Lawrence Gould, 2005). Secondly, considering the assessment, a multidisciplinary consensus diagnosis was used to establish inclusion criteria and not a semi-structured clinical interview for DSM Axis I and Axis II diagnosis. On the other hand, both DSM criteria and DSM assessment are mostly based on younger adult groups and are not adequately attuned to the living situations and experiences of older adults (Oltmanns & Balsis, 2011; Van Alphen et al., 2012). For instance 29% of the DSM criteria for PDs led to measurement errors in older adults (Balsis, Woods, Gleason, & Oltmanns, 2007). However, a recent study showed the age neutrality of EMS by investigating differential item functioning (i.e., bias in item endorsement) of the Young Schema Questionnaire across age groups (Pauwels et al., 2014). Thirdly, the results of this study are based on a relatively small group of participants (N = 31), consisting of a heterogeneous group of patients with longstanding mood disorders or chronic adjustment disorders with comorbid PDs or PD features. In future research it is interesting to further differentiate the efficacy in more homogeneous samples of only PDs, or only mood disorders. The current sample size restricted the number and types

of analyses that could be carried out. On the other hand, such a group of participants is common in a proof of concept study.

Despite these limitations this is the first research on ST in older adults. It provides support for the concept that ST in a short group format like SCBT-g is effective in reducing EMS in older adults and thus mediates changes in symptomatic distress. Furthermore, as studies of efficacy of treatments for PD and related problems are sorely lacking (Van Alphen et al., 2012), this study contributes to the current best practice regarding the treatment of PD and longstanding mood disorders in older outpatients.

Conclusion

The current proof of concept study supports the idea that ST in a short group format, like SCBT-g, is effective in reducing EMS in older adults and thus mediates changes in symptomatic distress. This finding might suggest that the belief that little can be done for older adults with PD or related psychopathology, proves to be an expression of unfounded therapeutic nihilism. ST is promising for our aging population in western and Asian countries. Still, further research is needed to fine-tune ST for use in older adults.

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Chapter 5

Schema therapy for personality disorders
in older adults:
A multiple-baseline case series study

Abstract

As no studies have been conducted yet into the effectiveness of treatment of personality disorders in later life, this study is a first test of the effectiveness of individual schema therapy as a treatment for cluster C personality disorders in older adults. We applied a multiple-baseline design with eight cluster C personality disorder patients with a mean age of 69 years old. After a baseline phase with random length, schema therapy treatment was given during the first year, followed by follow-up sessions during the next six months. Participants weekly rated the credibility of dysfunctional core beliefs. Symptomatic distress, early maladaptive schemas, quality of life and target complaints were assessed every six months and personality disorder diagnosis was assessed before baseline and after follow-up. Data were analyzed with mixed regression analyses. Results revealed significant linear trends during treatment phases, but not during baseline and follow-up. The scores during follow-up remained stable and were significantly lower compared to baseline, with high to very high effect sizes. Seven of eight participants remitted from their personality disorder diagnosis. We conclude that the results corroborated that schema therapy is an effective treatment for cluster C personality disorders in older adults.

Introduction

The prevalence rate of personality disorders (PDs) among older adults over the age of 65-years-old was 8% in US community samples (Schuster, Hoertel, Le Strat, Manetti, & Limosin, 2013). Moreover, PDs appeared strongly associated with disability, somatic problems and mental disorders (Schuster et al., 2013). Notwithstanding, there are no effectiveness studies into the treatment of PDs in later life as the main focus of therapy: only two studies have been conducted into the treatment of depression with comorbid PDs (Van Alphen et al., 2015). One small randomized controlled trial (RCT) in 37 older adults explored the effectiveness of dialectical behavior therapy combined with pharmacotherapy for depression and comorbid PDs, compared to pharmacotherapy as stand-alone treatment (Lynch et al., 2007). The combined treatment did not improve depressive symptoms over medication alone. And - remarkably - about half of the PDs were in remission in both conditions. As pharmacotherapy is not efficacious for treating PDs themselves (Ingenhoven, Lafay, Rinne, Passchier, & Duivenvoorden, 2010), probably the PD diagnoses were confounded by comorbid depressions (Van Alphen, Tummers, & Derksen, 2007). The second study examined short-term group schema therapy (SCBT-g) in 31 older adults with depression and comorbid PDs or PD-features with a pre-mid-post design (Videler, Rossi, Schoevaars, Van der Feltz-Cornelis, & Van Alphen, 2014; see chapter four). A medium effect size was found for reduction of depressive symptoms and of early maladaptive schemas (EMS), and a small effect size was found for schema modes. However, treatment effect on the comorbid PD diagnosis was not assessed. Furthermore, this SCBT-g treatment did not involve experiential techniques, like imagery rescripting and chairwork, which are considered more powerful at achieving change at an emotional level than cognitive-behavioral techniques and thus at influencing EMS (Arntz & Van Genderen, 2012; Kellogg, 2004). In sum, these two studies do show the feasibility

of psychotherapy for comorbid PDs in later life, but they shed no light on psychotherapy for PDs as the main focus of treatment in older adults.

Case studies indicate that schema therapy (ST) is applicable as a treatment of PDs in older adults (Videler et al., 2015). Videler and colleagues (2014) advocated that ST connects to the psychotherapy expectations of older adults, as it incorporates psychoeducation and is structured, skill-enhancing and problem-focused. ST is an integrative treatment, which combines cognitive behavior therapy (CBT), object relations theory, gestalt therapy and attachment theory into a systematic model for the treatment of PDs (Edwards & Arntz, 2012; Young, Klosko, & Weishaar, 2003). In this model, EMS are considered core elements of PDs. The goal of treatment is to decrease the impact of these EMS and to replace negative coping responses and schema modes with more healthy alternatives, so that patients succeed in getting their core emotional needs met (Rafaeli, Bernstein, & Young, 2011). In ST, besides CBT techniques, experiential techniques have a central place (Edwards & Arntz, 2012). There is accumulating evidence for the efficacy of ST in younger age groups, both in treating borderline (Giesen-Bloo et al., 2006; Farrell, Shaw, & Webber, 2009; Nadort et al., 2009) and cluster C, paranoid, narcissistic, and histrionic PDs (Bamelis, Evers, Spinhoven, & Arntz, 2014), but the effectiveness in older adults is unknown.

The aim of the present study was to assess the effectiveness of individual ST as a treatment for PDs in older adults using a multiple-baseline design (MBD; Kazdin, 2010) with eight patients with a PD diagnosis.

We chose the MBD for several reasons. Often, as a first evaluation of a treatment an open trial is done. A MBD has the advantage over an open trial that if offers experimental control over time versus intervention effects. Furthermore, this design has some advantages over a RCT. The most important advantage of a MBD over RCTs is that this design requires fewer participants, because participants act as their own controls, thus increasing power. Nevertheless, like a RCT, a MBD can demonstrate significant change and also that this change is the

result of the intervention and not of time (Hawkins, Sanson-Fisher, Shakeshaft, D'Este, & Green, 2007; Onghena, 2005). A MBD is less suitable for comparing two or more treatments. For such studies, between-group designs are more appropriate, like case-control studies or RCTs. A MBD is more suited for problems that are stabilized, like PDs in older adults, than for problems with a tendency for natural recovery, as there is no strong time effect during baseline. Because the course of cluster C PDs appears to be more stable throughout the life span than that of cluster B PDs (Cooper, Balsis, & Oltmanns, 2014; Gutiérrez et al., 2012), we decided to examine ST in cluster C PDs. As our aim was to test the effectiveness of ST in later life, without comparing ST to another potentially powerful treatment, we considered the MBD to be a good option.

MBDs require dependent variables that are frequently assessed and are highly sensitive to change, to study the time and intervention effects on a microscopic level (Kazdin, 2010). Such variables should represent a core aspect of the disorder that is addressed by the treatment (i.e. short-term treatment effects). The frequent assessments make it possible to distinguish time and treatment effects, and allow that each case is its own control. Thus, the high number of assessments of this central variable compensates for the relatively small number of participants. As central variable we chose the strength of belief participants had in their personal core beliefs, which they viewed as central to their PD problems. This idiosyncratic measure represented the EMS that are assumed to underlie the patient's PD problems according to the ST model.

Our hypothesis was that ST would lead to a decrease of dysfunctional core beliefs, symptomatic distress and EMS, and an increase of quality of life in cluster C PDs.

Method

Participants

Participants were four patients from the department of geriatric psychiatry of Breburg, and four patients from the department of geriatric psychiatry of Mondriaan, both mental health institutes in the Netherlands. Inclusion criteria were: 1) primary diagnosis of a cluster C PD or PD not otherwise specified with cluster C traits, as assessed with the Dutch version of the Structured Clinical Interview for DSM-IV PDs (SCID-II; Weertman, Arntz, & Kerkhofs, 2000); 2) age 60 years old or older; 3) willingness to participate in the study. Exclusion criteria were: 1) severe depression; 2) bipolar disorder; 3) psychotic disorder; 4) IQ under 80; 5) substance dependence; 6) cognitive disorder (Mini Mental State Examination (Folstein, Folstein, & McHugh, 1975) under 25). No other treatment was allowed and medication was kept constant during the study. The eight participants were recruited from nine patients screened for participation; one declined participation in the study. Fig. A presents the patient flow. Table A gives an overview of the characteristics and the treatments of the participants. The study was approved by the ethical committees of the Maastricht University Hospital, Breburg and Mondriaan.

Fig. A CONSORT Flow Diagram
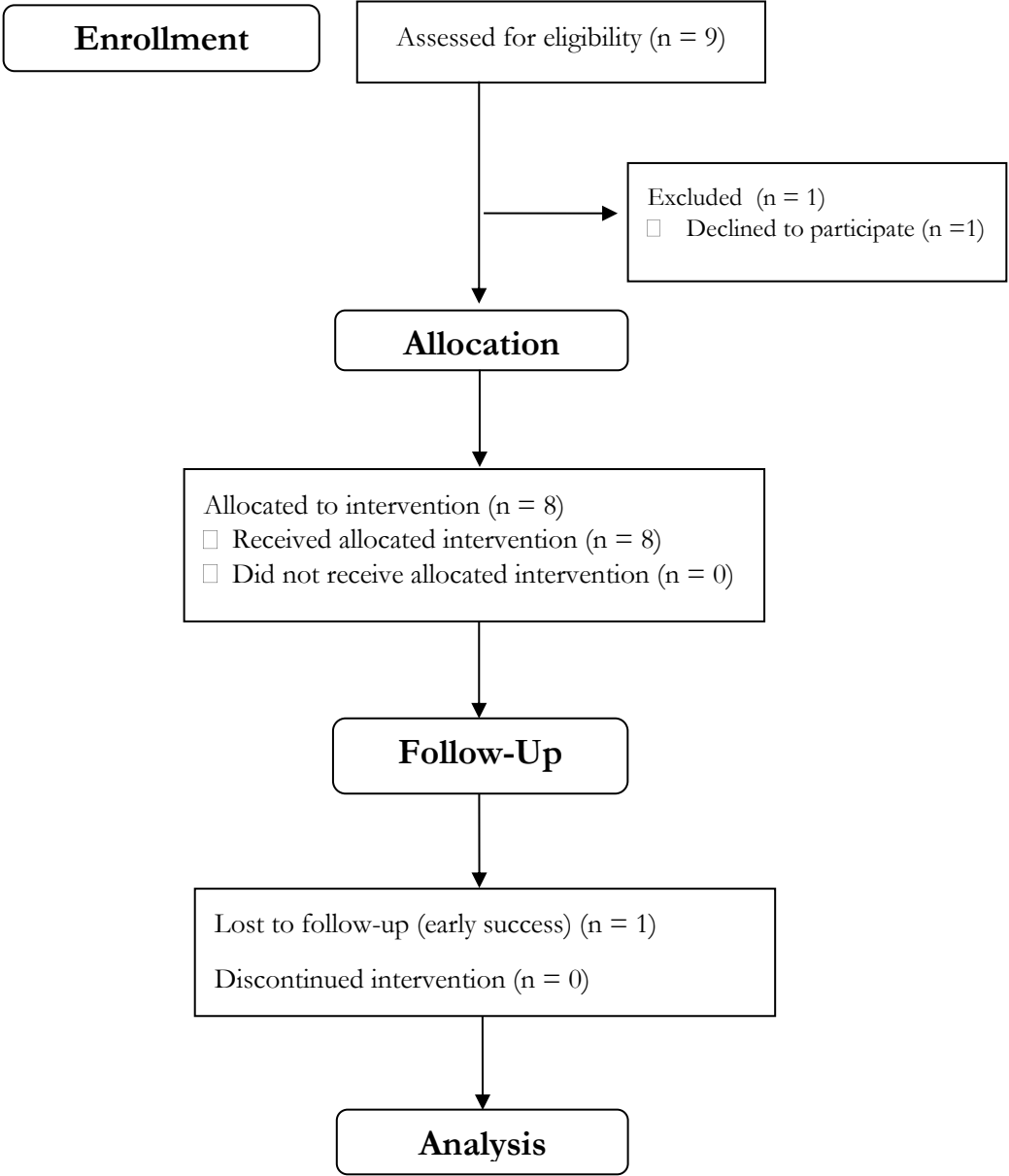
Table A. Demographic data and treatment of participants (N = 8)

Participants	1	2	3	4	5	6	7	8	Mean/ *SD*
Age	68	65	67	72	76	69	62	75	69.3/3.8
Gender[1]	F	M	M	F	F	F	F	F	
Educational level[2]	1	2	1	1	1	1	2	1	
PD diagnosis[3]	Avoi	Avoi	NOS	Avoi	OC	NOS	NOS	Dep	
Secondary diagnosis[4]	Depr	Adh	Depr	Soc	Pan	Depr	Depr	Depr	
Medication[5]	AD	-	AD	Benz	AD	AD	-	AD	
Treatment duration prior to study (years)	0.8	6	0.8	0.3	2	4	0.5	0.6	1.9/2.1
Baseline sessions	6	6	5	4	8	6	8	6	6.1/1.4
CBT sessions	6	8	13	18	8	6	6	15	10/5.1
Experiential sessions	28	28	22	-	26	25	32	17	25.4/5.3
Booster sessions	10	10	10	-	9	8	8	6	8.7/1.5
Total number of sessions	44	46	45	18	43	39	46	38	39.9/9.3

[1]M = male, F = female; [2]1 = elementary school with lower vocational training, 2 = higher secondary with vocational training; [3]Avoi = avoidant PD, OC = Obsessive-compulsive PD, Dep = Dependent PD, NOS = PD Cluster C Not Otherwise Specified; [4]Depr = Depression, Adh = Attention Deficit Hyperactivity Disorder, Soc = Social phobia, Pan = Panic disorder; [5] AD = Antidepressant, Benz = Benzodiazepine; medication was constant in all participants throughout treatment.

Design

We used a non-concurrent MBD (Kazdin, 2010), consisting of four phases. The first phase was a baseline phase varying in length from three to eight weeks in which core beliefs and target complaints were identified. The variation in baseline length offers the possibility to differentiate between time effects and experimental effects of the treatment. After baseline, weekly ST treatment sessions were given. To explore the effectiveness of experiential techniques for older adults, we divided treatment into two phases, a CBT phase, with cognitive and behavioral techniques, and an experiential phase, where the latter was defined by the use of experiential techniques. The two treatment phases differed in length between participants according to the ST methods described by Young and colleagues (2003): based upon each patient's case conceptualization, the therapist decided when to introduce experiential techniques, in order to match the individual aspects of the patient's problems. Maximum duration of baseline, CBT and experiential phases together was 40 sessions. Finally, a six months follow-up phase with 10 booster sessions followed to help maintain and assess the effects of ST. During all study phases, outcomes (described in assessments) were repeatedly assessed.

Assessments

As primary outcome, strength of idiosyncratic beliefs was assessed weekly. To formulate these beliefs, participants were interviewed with a semi-structured procedure to elicit three to five idiosyncratic dysfunctional beliefs they felt to be central to their PD problems. These dysfunctional core beliefs were then rated weekly by the participants on a visual analogue scale (VAS) on 0-100% credibility. The ratings of the participants were put in an envelope by them and given to the research team directly, so these ratings were unknown to the therapists, in order to minimize demand effects. Core beliefs were chosen as the primary outcome as they can be frequently assessed, are sensitive for short-term change, and are

viewed in cognitive models as important representations of schemas deemed to underlie the PD problems (David & Freeman, 2014). The average of the ratings per assessment was taken as dependent variable (range 0-100).

The Dutch SCID-II (Weertman et al., 2000) was used to assess DSM-5 (American Psychiatric Association, 2013) PDs as secondary outcome, before baseline and after follow-up. Items are rated on a 3-point scale as absent, subthreshold or threshold. Interrater agreement appeared excellent in adults with an average age of 35.5 years (range 18-61), with a mean value of Cohen's kappa of .84 (Lobbestael, Leurgans, & Arntz, 2010).

Symptomatic distress, another secondary outcome, was assessed with the Dutch version of the Symptom Checklist 90 (SCL-90; Arrindell & Ettema, 2003) four times, before baseline, after six months of treatment, at the end of treatment, and after follow-up. The SCL-90 is a 90-item self-report measure of overall psychological distress. Items are scored on a 5-point Likert scale from "not at all" to "always." The reliability of the Dutch SCL-90 is good, the convergent and divergent validity are satisfactory and no age effect was found for older adults with an average age of 73.5 years (Arrindell & Ettema, 2003). It appeared sensitive to change in clinical settings.

Idiosyncratic target complaints, as secondary outcome, were discussed with all participants in the baseline phase by the therapists and assessed on a Likert-scale of 1-9, ranging from "not at all' to "can't be worse." Target complaints are the primary complaints of a patient and for which there is mutual consent between therapist and patient that these are the primary goals of treatment (Battle et al., 1966). Both Hoehn-Saric and colleagues (1964) and Shorer (1970) reported considerable correlations (.61 and .71 respectively) between global assessments of improvement and improvement on target complaints. Test-retest reliability was .76 (Frey, Heckel, Salzberg, & Wackwitz, 1976). Target complaints were rated four times, in the baseline phase, after six months of treatment, at the end of treatment, and after follow-up.

Quality of life (QOL), also a secondary outcome, was assessed with the Dutch World-Health-Organization-Quality-Of-Life, brief version (WHOQOL-BREF; Trompenaars, Masthoff, Van Heck, Hodiamont, & De Vries, 2005). The WHOQOL-BREF is a 26-item self-report measure, which is rated along a 5-point Likert scale. In two samples of older adults, with mean ages of 73 and 76 years, reliability was good and the construct validity satisfactory (Kalfoss, Low, & Molzahn, 2008). The WHOQOL-BREF was rated four times, before baseline, after six months of treatment, at the end of treatment, and after follow-up.

EMS, as final secondary outcome, were measured using the Dutch Young Schema Questionnaire (YSQ; Sterk & Rijkeboer, 1997). The questionnaire consists of 205 items, which are phrased as negative core beliefs and rated along a 6-point Likert scale. The YSQ showed good reliability and convergent and discriminant validity in a clinical sample with a mean age of 33.9 years (range 18-74; Rijkeboer & Van den Berg, 2006), and was rated four times, before baseline, after six months of treatment, at the end of treatment, and after follow-up.

Procedure

Patients with a primary multidisciplinary diagnosis of a cluster C PD, who met the inclusion criteria, were approached by the first author, until four participants were included at both sites. Potential participants were fully informed about the study and gave written consent to participate. One patient with an obsessive-compulsive PD decided not to participate; he preferred medication over ST. The SCID-II was applied to assess PD diagnosis. In the treatment phases ST, according to the methods described by Young and colleagues (2003), was provided in weekly sessions by two therapists (with 6 and 15 years of experience). Treatment integrity was monitored by means of supervision by the third author, a certified ST supervisor. To provide feedback, the treatment of each participant was discussed in supervision at least ten times and of each participant at least

four therapy sessions were filmed and viewed by supervisor and psychotherapist together. In the CBT phase, underlying EMS were targeted by cognitive and behavioral techniques. The experiential phase started with the use of experiential techniques such as imagery rescripting and chairwork. The number of treatment sessions was maximized at 40 sessions, although start of the booster sessions was allowed earlier if therapist and participants agreed treatment goals were reached; thus mean length of treatment was somewhat shorter than 40 sessions (see table A). During the booster phase, in the last six months of treatment, a maximum of 10 sessions were dedicated to stabilize the progress the participants had made.

Statistical analysis

Core beliefs

Mixed regression analyses were used to assess the differences between the treatment and follow-up phases on the one hand, and baseline on the other hand, in average scores and linear change. The fixed model part consisted of 1) a general linear time effect, starting with time = 0 when the first assessment was taken for an individual, and 2) dummy indicators for the CBT, experiential and follow-up phases (thus contrasting each to baseline), and 3) four centered time-within-condition covariates, one for every phase, to assess time-by-phase interaction, that is, changes in the time effect across phases (cf. Arntz, Sofi, & Van Breukelen, 2013; Vlaeyen, De Jong, Geilen, Heuts, & Van Breukelen, 2001). The random model part consisted of an AutoRegressive-Moving-Average model (ARMA11) for the within-subject covariance structure. Random slopes to allow inter-individual variation in time and condition effects led to reduced fit of the model or convergence problems, and were therefore not included. The analytic strategy was to first test for a general time effect, next to assess the full model with all predictors entered, and then to delete in backward fashion the time-by-phase interactions that were nonsignificant. If the main time effect was nonsignificant, it was deleted at the last step. The time effect within baseline was

also tested separately for the baseline assessments only. Cohen's *d* for the core beliefs were calculated as effect size of change at the end of a phase with respect to baseline: *d* = the mean outcome difference between baseline and current phase, derived from the fixed part of the mixed regression divided by the standard deviation of the residual outcome variance (the patient-specific outcome mean per phase has as variance random intercept (between subject variance) + (residual (within-subject) variance/number of measurements per phase); the square root of this subject-specific variance is the denominator for *d*.

Other measures

For the analysis of symptoms, target complaints, QOL and EMS, an unstructured model fitted better for the within-subject covariance structure. For these measures, Cohen's *d* were similarly calculated, but only as effect size of the change between follow-up and baseline, with standard deviation of the baseline as denominator.

Results

Attrition

Participant 4 was considered recovered by herself and the therapist after the CBT phase and declined participation in the follow-up phase. She did fill out all measures four times however, but did not participate in the final SCID-II interview.

Core beliefs

The individual VAS-scores of the credibility of dysfunctional core beliefs during the different phases are shown in figure B. During baseline, the time effect was nonsignificant, $F(1, 4.83) = 1.75$, $p = .25$. Visual inspection suggests decreases in

credibility of dysfunctional core beliefs during the treatment phases in all 8 participants, and lower scores during follow-up than during baseline in all but participant 4. Mixed regression revealed a significant linear effect of time when tested as single predictor, $t(37.67) = -7.37$, $p < .001$. With all predictors entered, the time-within-baseline and time-within-follow-up effects appeared to be nonsignificant, p's $>.35$. After stepwise deleting, the main effect of time appeared to be nonsignificant and was therefore also deleted. Table B presents the final results of the mixed regression analysis. The main effect of treatment (i.e., the change at the middle of both treatment phases compared to baseline) was significant, as was the main effect of follow-up (as compared to baseline). The time-within-treatment effect was significant, showing a steep decrease of credibility of core beliefs, both in the CBT phase and in the experiential phase. Effect sizes of treatment versus baseline, and follow-up versus baseline were very high; note that these represent not the middle point of phases but the end point of phases. Figure C depicts the predicted means from the analysis.

Figure B. Individual averaged credibility ratings of core beliefs during time
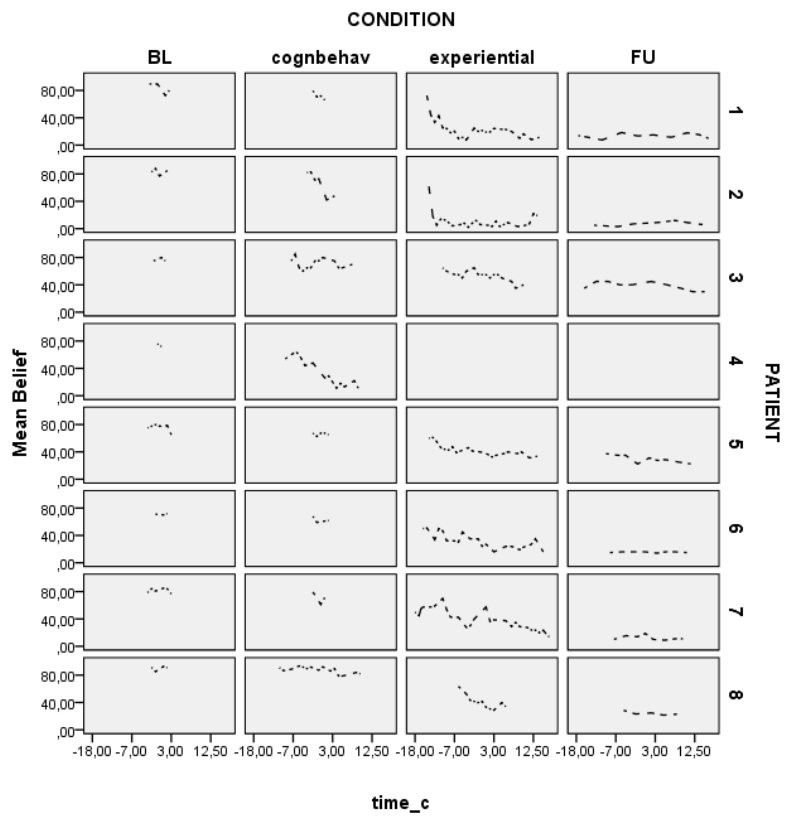
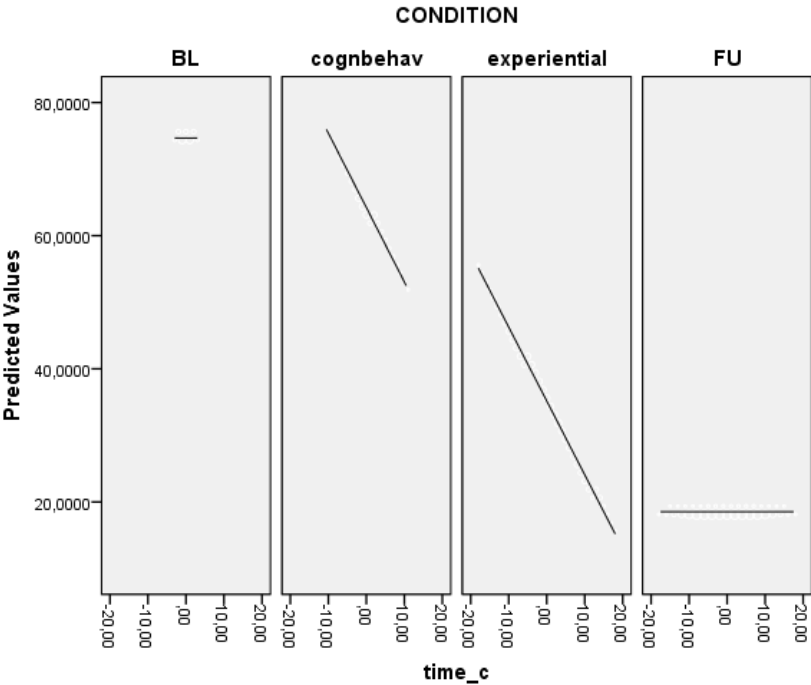Note. Time-c is the centered time per condition.

Table B. Results of mixed regression analyses

	Para-meter	β	Std. error	df	t	p	Eff. size[1]
Core beliefs	Intercept	74.678	4.934	020.397	15.135	<0.001	
	CBT phase	-10.455	2.531	171.282	-4.130	<0.001	2.136[a]
	Exp. phase	-39.515	4.275	070.895	-9.243	<0.001	5.03[a]/ 7.17[b]
	Follow-up	-56.146	6.031	041.700	-9.310	<0.001	0.41[a]/ 7.58[b]
	Time CBT	-1.117	0.348	152.619	-3.212	00.002	
	Time exp.	-1.109	0.215	074.991	-5.166	<0.001	
SCL-90	Intercept	203.00	14.294	7.000	14.202	<0.001	
	CBT phase	-26.625	13.749	7.000	-1.937	0.094	
	Exp. Phase	-47.000	12.944	7.000	-3.631	0.008	
	Follow-up	-52.125	8.961	7.000	-5.817	0.001	1.29
Target complaints	Intercept	7.519	.219	7.000	34.387	<0.001	
	CBT phase	-2.335	.644	7.000	-3.623	0.008	
	Exp. phase	-3.273	.630	7.000	-5.191	0.001	
	Follow-up	-3.626	.555	7.000	-6.535	<0.001	5.86
YSQ	Intercept	2.753	.191	7.000	14.393	<0.001	
	CBT phase	-.176	.118	7.000	-1.497	.178	
	Exp. Phase	-.526	.219	7.000	-2.391	.048	
	Follow-up	-.595	.232	7.000	-2.564	.037	1.01
WHO-QOL	Intercept	81.125	6.460	7.000	12.558	<0.001	
	CBT phase	7.750	3.016	7.000	2.569	.037	
	Exp. phase	9.500	5.057	7.000	1.879	.102	
	Follow-up	11.500	3.470	7.000	3.315	0.013	.63

[1] Effect sizes (Cohen's *d)* calculated as change with respect to baseline, with baseline *SD* as denominator. [a] Effect size based on end of phase estimated value minus estimated baseline value, with *SD* based on mixed regression ARMA11 variance of the baseline values. Reported phase effects (CBT, Experiential, Follow-up) are mid-phase effects. [b] Effect size based on end of phase estimated value minus end of previous phase estimated value, with *SD* based on mixed regression ARMA11 variance of the baseline values.

Figure C. Predicted means of the credibility of core beliefs

Note. Time-c is the centered time per condition.

Symptomatic distress

The individual scores of the participants on the SCL-90 are given in figure D.1. Visual inspection suggests that all scores decreased, except those of participants 2 and 4. All changes appeared significant including that of participant 2. Participant 4 left treatment after the CBT phase. Figure D.2 shows the predicted means from the analysis. Effect size of treatment from baseline to follow-up was high (1.29).

Figure D.1 Individual SCL-90 total scores during time
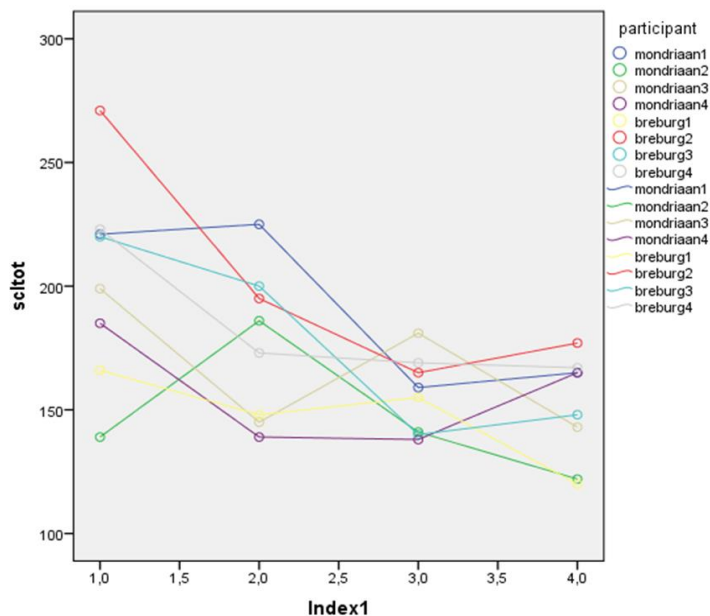
Figure D.2 Predicted means of the SCL-90
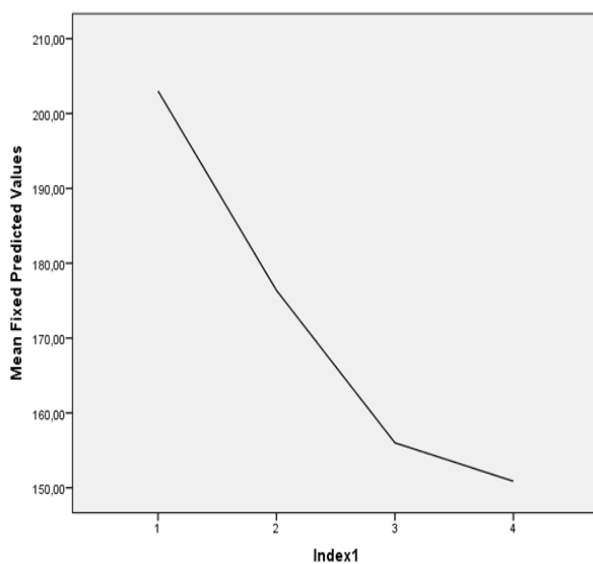
scltot = SCL-90 total score; index1 = assessments at: 1 = baseline, 2 = after six months of the treatment, 3= after treatment, 4 = after follow-up.

Target complaints

The individual target complaints are shown in figure E.1. Again, visual inspection suggests a decrease in target complaints scores in all participants but one, participant 2. This participant had three target complaints and his mean target complaint's score remained high, probably because one of those was unaffected as it was determined by his comorbid ADHD. The predicted means from the analysis are shown in figure E.2. Effect size of treatment from baseline to follow-up was very high (5.864).

Figure E.1 Individual averaged target complaints during time
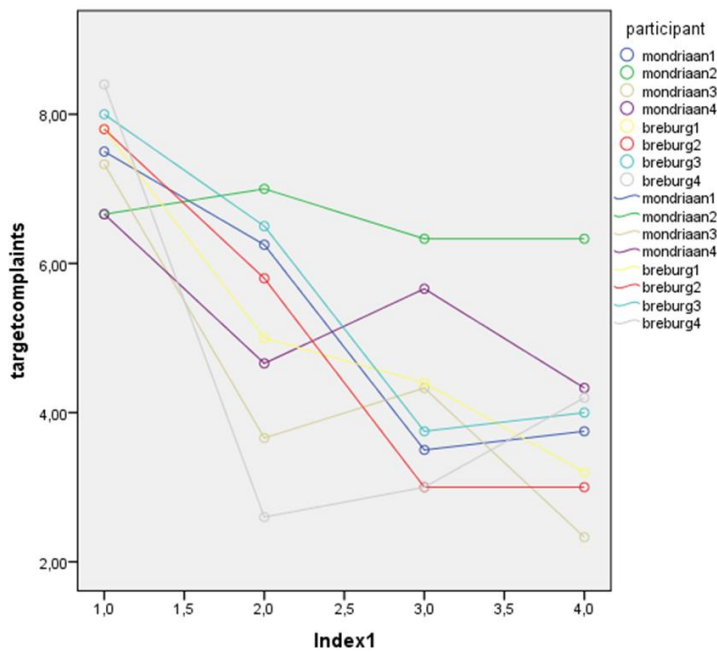

index1 = assessments at: 1 = baseline, 2 = after six
months of the treatment, 3= after treatment, 4 = after follow-up.

Figure E.2 Predicted means of averaged target complaints

index1 = assessments at: 1 = baseline, 2 = after six
months of the treatment, 3= after treatment, 4 = after follow-up.

Quality of life

Individual scores on the WHOQOL-BREF are shown in figure F.1. All scores
improved, except for participant 5. The predicted means from the analysis are
shown in figure F.2. Effect size of treatment from baseline to follow-up was
medium (0.629).

Figure F.1 Individual total WHOQOL-BREF scores

Figure F.2 Predicted means WHOQOL-BREF
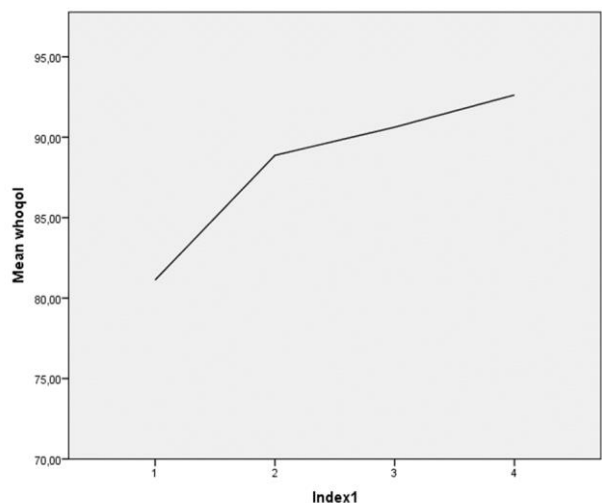
index1 = assessments at: 1 = baseline, 2 = after six
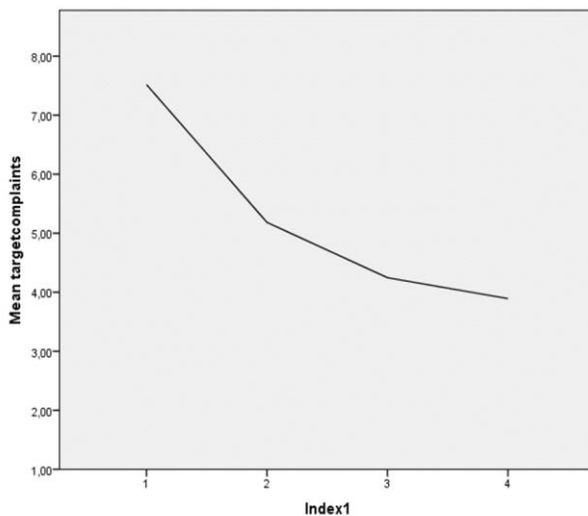months of the treatment, 3= after treatment, 4 = after follow-up.

Early maladaptive schemas

Scores on the YSQ are shown in figure G.1. Visual inspection suggests the scores of five participants improved, and the scores of three participants did not change (participants 1, 3 and 4). The predicted means from the analysis are shown in figure G.2. Effect size of treatment from baseline to follow-up was very high (1.01).

Figure G.1 Individual total YSQ scores during time
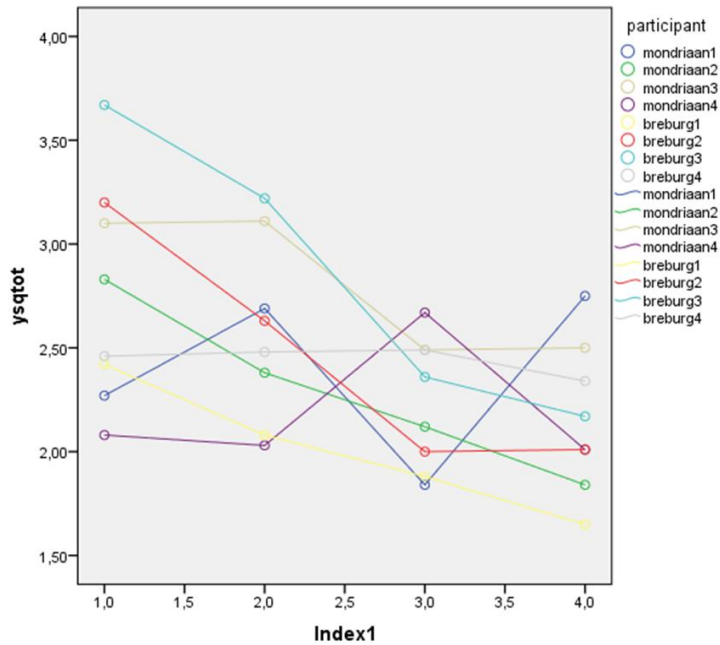
index1 = assessments at: 1 = baseline, 2 = after six months of the treatment, 3= after treatment, 4 = after follow-up.
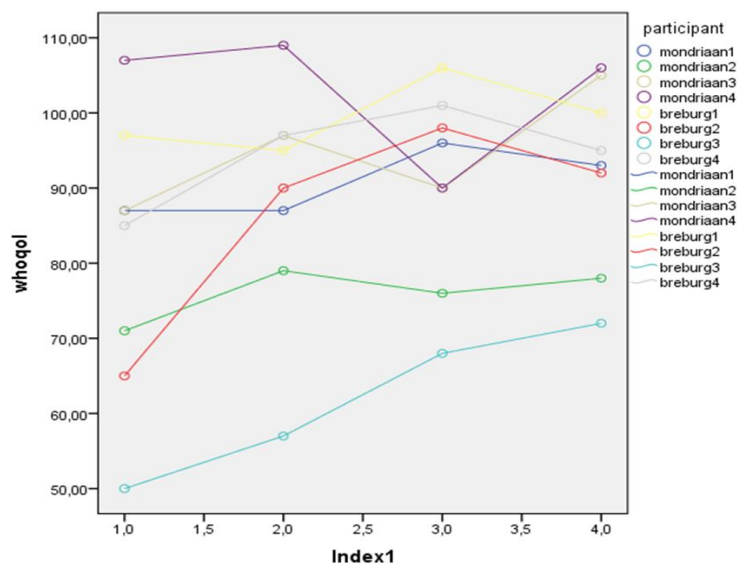
Figure G.2 Predicted means of the YSQ
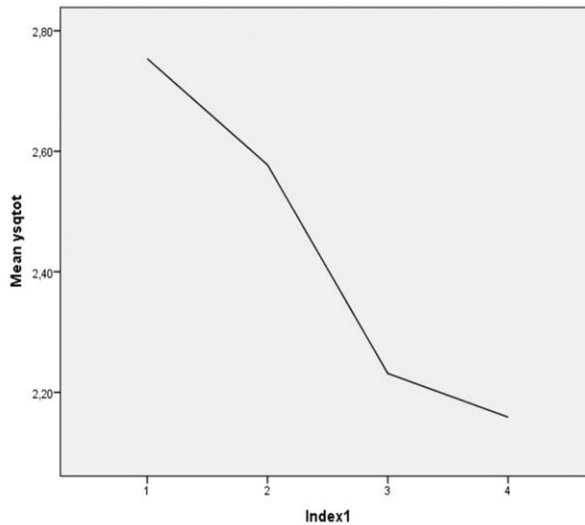
index 1 = assessments at: 1 = baseline, 2 = after six
months of the treatment, 3= after treatment, 4 = after follow-up.

PD diagnosis

All seven participants, whose PD diagnosis was assessed both at baseline and at follow-up, did not meet full criteria for a DSM-5 PD diagnosis anymore at follow-up, using the cut-off for each PD according to DSM-5. The mean number of PD criteria decreased from baseline to follow-up from 13.71 with a *SD* of 2.69, to 4.57 with a *SD* of 2.44 ($t = 5.959$, df = 6, $p < 0.01$), with a very high effect size ($d = 3.56$).

Discussion

We investigated ST as a treatment for PDs in older adults, using a MBD. We found strong effects of ST on the credibility of dysfunctional core beliefs, symptoms, QOL and EMS. Mixed regression analyses revealed no evidence for significant time effects within baseline and follow-up phases, whereas the linear time effect during ST was strong, indicating that ST already had a positive impact on outcome during treatment. The general time effect disappeared after treatment conditions were entered into the model, indicating that it is highly unlikely that effects can be attributed to a time effect. Of the seven participants reassessed with the SCID-II at follow-up, all remitted from PD diagnosis. Our finding, that ST has a considerable positive effect on PDs in later life provides us with innovative results. This is the first study exploring the effectiveness of psychotherapy, in this case ST, for PDs as the main focus of treatment in older adults.

Participant 4, who was not reassessed concerning her PD diagnosis, did also improve concerning her core beliefs and target complaints, but she showed no improvement at follow-up on symptomatic distress, QOL and EMS. She was considered an early success by herself and the therapist and although she filled out all questionnaires, she stopped rating the credibility of her dysfunctional core beliefs and did not cooperate in the second PD assessment. This patient was diagnosed with severe social phobia as well as avoidant PD. Possibly, the social phobia had improved, but not the underlying avoidant PD. In retrospect, she might be considered a drop-out.

Participants 1 and 3 improved on all measures, except their YSQ-scores. The initial YSQ-score of participant 1 was rather low, possibly reflecting her avoidant coping style. In the course of treatment, she improved to a more active coping, and avoided negative feelings much less; in her own words: "I learnt to feel much better, which was hard at first." Other studies found that treatment-related changes on the YSQ tend to be smaller than on other measures central to

the patient's problems (Renner et al., 2013; Nadort et al., 2009). Possible explanations are that not all EMS are reported at the start of treatment, and secondly, some items are insensitive to change as they describe issues that cannot change (e.g., "In my youth,...").

Some limitations of the present study should be mentioned. First, although the patients were recruited randomly from referred patients who met explicit in- and exclusion criteria, we cannot exclude some form of selective sampling as in all open trial and case series studies. Second, there were individual differences between responses to, and length of, the two treatment phases, the CBT and the experiential phases. We divided ST into two treatment phases in order to explore the effect of experiential techniques in older adults, as some authors - and many clinicians - assume that the aim of changing pathological aspects of personality is not possible in older PD patients, because of the rigidity of lifelong dysfunctional patterns (e.g., De Leo, Scocco, & Meneghel, 1999; Segal, Coolidge, & Rosowsky, 2006). They believe that focusing on skills and symptoms is more attainable, like in CBT. The present data suggested that both sets of techniques contributed to the effectiveness of the full treatment. This is also an advantage of the ST treatment model, as there are different techniques available to match individual aspects of a patient's problems. There was no evidence for superiority of CBT or experiential techniques, but as in younger cohorts, individual patients might differ in how much they change with these techniques (Weertman & Arntz, 2007). Third, all participants had cluster C PDs, and we don't know whether similar effects would have been found in other PDs. As said, we chose to include cluster C as they are more stable whereas cluster B PDs have a different expression in later life (Van Alphen et al., 2015; Cooper et al., 2014). Furthermore, three of the participants were diagnosed with PD NOS, which are usually less severe than 'pure' cluster PDs. The three participants with PD NOS in this study however, met more PD criteria than the other participants did, so their PDs were possibly even more severe than those of the other five

participants. A final limitation concerns the randomization of the length of the baseline phase; it would have been better if randomization to baseline length was determined by an independent person, as we cannot exclude that characteristics of participants' presentations at the screening (e.g., severity, motivation for treatment, etc.) could have impacted the moment of the introduction of the treatment, thereby introducing bias into the data. However, start of treatment was determined by coincidence, mainly the agendas of the therapists, and checked for variance by the first author before the start of treatment. So we do believe length of baseline was actually determined by random factors.

A possible criticism concerning this study could be its sample size of N = 8 which seems small, compared to RCTs which are much larger because of power considerations. However, it were these same power considerations, but applied to MBDs, which led us to choose for this sample size in the first place. In the statistical literature it has been estimated that samples as small as N = 4 are sufficient to demonstrate treatment effects in MBDs (Onghena, 2005). The reason for this is that the frequent assessment of the primary outcome (in this study core beliefs) and the use of each participant as his/her own control, compensates for the smaller sample size.

Some strengths of the current study also deserve to be acknowledged. All questionnaires were taken by an independent psychologist at Mondriaan and by the first author at Breburg, thus minimizing a demand effect of the participants towards their therapists. For the same reason, the ratings of the core beliefs were blind to the therapists. The findings on the self-report measures were validated by an independent assessment of the PDs, using the SCID-II. Finally, medication was constant in all participants throughout treatment, so medication did not interfere with the outcomes.

Conclusions

Our study provides evidence for therapeutic optimism concerning the effectiveness of ST in the treatment of PDs in later life. This study also replicated a previous finding that in adult populations on average there is no evidence for superiority of CBT or experiential techniques, but that individual patients might differ in how much they change with these techniques (Weertman & Arntz, 2007). Also in older adults, the effectiveness of ST was supported by using cognitive, behavioral and experiential channels to bring about change.

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Chapter 6

Adapting schema therapy for personality disorders in older adults

Abstract

Schema therapy (ST) is an evidence-based treatment for personality disorders (PDs). The first research into ST with older adults in a short group format demonstrated its applicability for this population, although with lower efficacy than in younger age groups. This raises the question whether ST can be optimized for older adults. Therefore we conducted a mixed quantitative/qualitative case study of individual ST of a 65 year old man with a cluster C PD, to explore possible adaptations of ST for older adults. We assessed symptomatic distress, early maladaptive schemas, PD diagnosis and the quality of the working alliance. The patient improved on these parameters and no longer met PD criteria. Five domains of adaptations emerged for possibly enhancing the outcome of ST for older adults: the ST language, the case conceptualization diagram, imagery rescripting, chairwork, and contextualizing to a life span perspective by incorporating wisdom enhancement and reinforcing positive schemas.

Introduction

Schema therapy (ST) is an integrative treatment, which incorporates cognitive behavior therapy (CBT), object relations theory, gestalt therapy, and attachment theory into a systematic treatment model (Edwards & Arntz, 2012; Young, Klosko, & Weishaar, 2003). Over the past decade, research corroborated the efficacy of ST in the treatment of borderline and cluster C personality disorders (PDs) (Arntz & Jacob, 2013; Bamelis, Evers, Spinhoven, & Arntz, 2013). There is initial evidence for the effectiveness of ST for chronic depression (Renner, Arntz, Peeters, Lobbestael, & Huibers, 2016). According to the ST model, stable and enduring early maladaptive schemas (EMS) are core elements of PDs. The goal of ST is to decrease the impact of EMS and to replace negative coping responses and schema modes with more healthy ones, in order to help patients get their core emotional needs met (Rafaeli, Bernstein, & Young, 2011). In ST, besides CBT techniques, experiential techniques have a central place (Edwards & Arntz, 2012). Experiential techniques, like imagery rescripting and chairwork, are being considered more important for achieving change in EMS than cognitive techniques (Arntz & Van Genderen, 2009; Kellogg, 2004). The therapeutic relationship itself is also a vehicle for change in ST: Young and colleagues (2003) emphasized the importance of "limited reparenting" as a caring attitude and dealing with whatever comes up in the relationship as a good parent would.

ST was developed for adults up to middle-age and different technical approaches and protocols of ST for adults and adolescents are described in the literature (Arntz & Jacob, 2012; Arntz, Sofi, & Van Breukelen, 2013; Arntz & Van Genderen, 2009; Bernstein et al., 2012; Rafaeli et al., 2011; Van Vreeswijk, Broersen, & Nadort, 2012; Young et al., 2003), yet an adaptation for older adults is lacking.

Treatment of personality disorders in later life

PDs are still prevalent in later life with a rate of 8% among community-dwelling older adults over the age of 65 in the US, and they are associated with disability as well as medical and mental disorders (Schuster, Hoertel, Le Strat, Manetti, & Limosin, 2013). However, treatment of PDs in older adults remains relatively unexplored (Van Alphen et al., 2015). Videler, Rossi, Schoevaars, Van der Feltz-Cornelis and Van Alphen (2014) suggested ST as a treatment option for older adults as it places emphasis on psychoeducation, is structured, skill-enhancing and problem-focused. Their research into the efficacy of ST in a short group format in older adults showed that ST led to a decrease of symptomatic distress, EMS, and schema modes. However, the effects were smaller than in two studies in adults with an average age of 39 (Van Vreeswijk, Spinhoven, Eurelings-Bontekoe, & Broersen, 2012) and 23 (Renner et al., 2013), raising the question how to specifically adapt ST techniques so that they are better molded for older patients?

The current study therefore explores possible adaptations of ST for older adults by examining the process of individual ST on a microscopic level in a case study of a 65-year old man with a cluster C PD. By discussing the emerging possible adaptations of ST, we want to contribute to improving the applicability of ST in older adults and ultimately enhance its outcome for use in later life.

Method

Design

We conducted a mixed quantative/qualitative case study. As case studies are very relevant to explore research questions of how and why certain phenomena occur (Yin, 2013), we chose the case study design to shed light on our research question of exploring possible adaptations of ST for older adults.

We describe the treatment process in three phases, the case conceptualization phase (session 1- 7), the treatment phase (session 8-40), and the booster sessions (session 41-50).

Participants

Psychotherapist

Mrs. H, the fourth author, conducted the psychotherapy. She had 15 years of experience in psychotherapy with older adults. In accordance with the clinical trials in younger age groups, ST dosage was 40 weekly sessions in the first year, followed by 10 booster sessions in the next six months.

Patient

We selected a patient who was 65 years old and whose PD was the primary focus of treatment. As the course of cluster C PDs appears to be more stable throughout the life span than of cluster B PDs (Cooper, Balsis, & Oltmanns, 2014), we selected a patient with a cluster C PD. The patient, Mr. B, a white male, was referred because of depressive complaints, compulsive scratching and social anxiety. These complaints had become worse following retirement. While Mr. B was working as a bookkeeper, he was able to maintain structure in his daily life and had some social contacts with colleagues. After retirement, he withdrew from social life and spent long hours behind his computer. Mr. B evaluated his life as a failure and the prospect of aging alone increased his hopelessness. He was born as the middle one of seven children. Father owned a small textile factory; Mr. B described him as fierce and dominant. He was occasionally beaten by his dad, as a form of punishment. Mother was described as gentle and caring. During his youth, he didn't have any close friends. He had some short courtships with women, but no sexual relationships, and wasn't able to keep a long term relationship. He never married and lived alone his entire life. He didn't have any friends, and only had contacts within his family. Because of the lack of response

to an earlier CBT treatment for the excoriation disorder, we decided to opt for treatment of the underlying PD as the main focus of treatment. Mr. B was assessed by a geriatric psychiatrist and fulfilled DSM-5 criteria (American Psychiatric Association, 2013) for social phobia, generalized anxiety disorder, excoriation disorder and avoidant PD. He provided informed consent for the discussion of his case in this article and for filming and audiotaping therapy sessions.

Measures

Presence of PDs was assessed at beginning and end of treatment with the Structured Clinical Interview for DSM-IV PDs (SCID-II; First, Spitzer, Gibbon, Williams, & Benjamin, 1997). Interrater agreement appeared excellent in adults with an average age of 35.5 years (range 18-61), with a mean value of Cohen's kappa of .84 (Lobbestael, Leurgans, & Arntz, 2010).

As outcome assessments we measured symptomatic distress and EMS four times, at the beginning of treatment, after 6 months, 12 months and at the end of treatment. Symptomatic distress was assessed with the Symptom Checklist-90 (SCL-90; Derogatis, 1975).The reliability of the Dutch SCL-90 in older adults is good and the convergent and divergent validity are satisfactory (Arrindell & Ettema, 2003). Positive correlations were reported with other symptomatology measures and it was sensitive to change.

EMS were measured using the Young Schema Questionnaire (YSQ; Young & Brown, 1994). The YSQ has good reliability and convergent and discriminant validity (Rijkeboer & Van den Berg, 2006). The SCID-II, SCL-90 and YSQ were administered by an independent psychologist.

We assessed the therapeutic alliance with the Working Alliance Inventory-Observer-Short version (WAI-O-S; Tracey & Kokotovic, 1989). The WAI-O-S can be rated reliably (Myers & Hayes, 2006), and the observer-rated

alliance appeared a stronger predictor of therapy outcome than the therapist-rated alliance (Horvath & Symonds, 1991).

Procedure

Psychotherapy process

Treatment integrity was monitored by means of 17 supervision sessions by the second author, a certified ST supervisor. The treatment process was documented based on the psychotherapist's session notes and on the supervision notes of the supervisor and psychotherapist. We sent intermediate versions of the manuscript to the psychotherapist and the supervisor for review and discussed the therapy process extensively.

Process measure ratings

The WAI-O-S was rated by three psychologists, experienced in psychotherapy with older adults. They received the manual and were instructed how to score the WAI-O-S S by rating an educational film on CBT for older adults, before they rated the filmed sessions independently. The segments (beginning, middle, end) were randomly presented. We assessed interrater agreement using the $r_{wg(j)}$ (James, Demaree, & Wolf, 1984).

Data synthesis

We examined change from pre-treatment to mid-treatment, end-of-treatment and post-treatment by calculating the effect sizes of change on the quantative measures. We also calculated the reliable change index (RCI; Jacobson & Truax, 1991). The RCI provides a z-score, where higher scores indicate improvement and the threshold for significant improvement (at $p < .05$) lies at a z-score < 1.96. For the SCL-90 we used the reliability coefficients and standard deviations obtained in a Dutch sample of psychiatric outpatients (Arrindell & Ettema, 2003). For the YSQ we used a Dutch sample of PD patients (Rijkeboer & Van

den Bergh, 2006). Effect sizes (Cohen's *d*) were calculated as the difference between pre-treatment and post-treatment means divided by the standard deviations of the SCL-90 and YSQ from the normative samples mentioned above.

Results

Patient pre-treatment assessments

On the SCID-II, Mr. B met five traits of avoidant PD, three traits of depressed PD, two traits of schizoid PD and one trait of schizotypal PD. On the SCL-90, Mr. B scored a total of 189, with high scores on interpersonal sensitivity, hostility and depression (see table 1). The highest scores of Mr. B on the YSQ concerned the EMS Failure, Lack of self-control and Alienation. Scores on Subjugation and Defectiveness/shame were also high.

Case conceptualization phase (first 7 sessions)

In the initial phase of treatment, the main goals are forming a therapeutic alliance and constructing a case conceptualization. Mr. B expressed that he felt despondent about his ability to improve.

Mr. B: Don't think I can get better. Always felt like this. Now I stopped working, it's gotten worse…

Mrs. H: Your problems are on a deeper level. That's why we chose for ST. Are you willing to give it a try?

Mr. B: (Sighs and nods) *I'm not sure, at my age and all.*

Not only did Mr. B look hopeless, he also induced strong feelings of hopelessness in the therapist. Most psychotherapists who are not used to working with older adults, might have unconsciously reinforced Mr. B's ageism. However, Mrs. H. was optimistic about the possibility for change in later life and she assumed that Mr. B's negative attitude towards aging strengthened his Failure EMS.

Case conceptualization

All relevant information concerning the problems, symptoms, interpersonal patterns and biographical elements were assessed, which led to a case conceptualization. This identifies the targets for intervention, and also helps the patient to feel validated, thus strengthening the therapeutic alliance (Kuyken, Padesky, & Dudley, 2009). Furthermore, it helps the patient to view his continuity in experience from a life span perspective (Rafaeli et al., 2011).

There are different models for case conceptualizations charts: a model for EMS or a schema mode model (Arntz & Jacob, 2012) or an extended combination of both (e.g. Van Genderen, 2012). An extended combination of both EMS and modes gives more information but can be rather complicated to understand for many older adults. Therefore, Mrs. H used a concise model of EMS and modes, which gave short, concrete information of both, see figure 1. In this chart she included concrete situations of the daily life of Mr. B which demonstrated the EMS and modes in his own personal language. By connecting his current complaints to both the EMS, modes and the life span, this chart became very recognizable for Mr. B.

Language

Although it is common in ST with younger age groups to first teach patients the "language" of EMS and modes, Mrs. H used the individual, spontaneous language of Mr. B. In her experience with older adults with PDs, the use of the spontaneous language of the patient appears to result in better rapport and greater compliance.

Mr. B: Last Saturday my sister gave me advice, like first doing something, and then rewarding yourself afterwards. Made me feel bad.

Mrs. H: Made you feel bad?

Mr. B: Awful. Everyone gets frustrated because of me.

The therapist and Mr. B went through several situations in which he felt similarly bad about himself. Another situation was where Mr. B sat behind the computer scratching his arm. He thought to himself: *I failed again*, which made him feel bad, inducing him to continue scratching.

Mrs. H: Do you remember having thoughts about being a failure, when you were young?

Mr. B: (quiet, thinking)…*my dad…he always punished me. I was a failure to him. I am an outsider.*

By talking through several problematic situations and linking these to Mr. B's history, Mrs. H helped him, by using the downward arrow technique (Burns, 1980), to identify dysfunctional core beliefs in his own personal language. Mr. B agreed on the following core beliefs about himself: *I am adrift, I am a failure* and *I am an outsider.* Core beliefs concerning other people were *Others are better at living than I am, Others condemn me* and *People are selfish.* His core belief about the future was *It's all downhill from now on.* They also identified his dominant conditional assumptions, which were referred to in therapy as "rules of life," which helped Mr. B cope with these core beliefs, and the compensatory strategies to avoid feeling distressed. Rules of life were *I can never do it my own way* and *It doesn't matter what I do, it always goes wrong.* The dominant coping strategies were withdrawing from social life and doing things alone, which in fact were forms of surrendering to the EMS of failure. Other coping strategies were postponing tasks, hiding behind the computer, scratching and eating too much.

This assessment culminated in a case conceptualization, put in the personal language of the patient. Of this written conceptualization, the therapist presented a chart to Mr. B to visualize his "story" (see figure 1).

Fig. 1. Case Conceptualization Diagram

Relevant childhood experiences:

- busy, chaotic and impulsive as child

- mother was sweet and caring, also very anxious; could not enjoy life

- father was fierce and punishing, he was "king of the house"

Core beliefs:

About the self

I am adrift

I am a failure

I am an outsider

About the other

Others are better at living than I am

Others condemn me

People are selfish

About the world

It's down the hill from now on.

Rules of life:

If I don't adapt to others, I am alone
I can't do things my own way
It doesn't matter what I do, It's always wrong

Strategies:

Withdrawing from social life

Scratching

Postponing

Waiting for guidance from others

Only doing things alone

Treatment phase (sessions 8-40)

Although Mrs. H assessed that the dominant EMS mode was the detached protector, by postponing activities and hiding behind the computer, she decided to wait sharing this with Mr. B, as he would take this as proof of being a failure, now as a patient in therapy. Because the Failure EMS, which originated in the relationship with his father, was the most dominant EMS, she decided to focus on further building the therapeutic relationship and then introducing experiential techniques to address this EMS.

But before turning to experiential techniques, in this case imagery rescripting, Mrs. H and the supervisor believed it to be more helpful for older adults to start exploring positive schemas. In doing so, it's possible to avoid diagnostic imagery; we will explain this later on. It's important that often older PD patients have functioned relatively better for some period in their lives, under different circumstances, which served as a sort of "niche," in which the problematic personality traits were embedded by social roles or compensating others. The so-called "healthy adult mode," often very weak in young adults with PDs, has been more active, usually after their forties. This was also the case with Mr. B, who had functioned better while working as a bookkeeper. At the time, he maintained some structure in his daily life and had social contacts with colleagues. In order to formulate a positive schema, Mrs. H used the cognitive technique of multidimensional evaluation in session 9. Mr. B eventually agreed with *I am a realist and that's ok* as a positive schema, which he rated as 85% true, although he could not feel this emotionally.

Imagery rescripting

In session 12, Mrs. H introduced imagery rescripting, one of the most powerful techniques of ST (Edwards, 2007; Holmes, Arntz, & Schmucker, 2007). In guided imagery the patient is helped to re-experience the situations which were crucial in forming his EMS. In rescripting the outcome, the patient gives a

different meaning to this experience. This changed memory with different emotional value and meta-cognitive aspects is reconsolidated in a different form (Hackmann et al., 2011). In younger adults, diagnostic imagery is usually the first imagery intervention. Goal of diagnostic imagery is to help therapist and patient discover how current problems, feelings or modes are connected to childhood memories. In the clinical experience of Mrs. H and the supervisor, diagnostic imagery alone, without rescripting, is often not necessary for older adults. Diagnostic imagery is less suited as it does not bring a positive alternative for the patient within that same session and leaves the patient with only the negative experience. Older adults tend to have a more restricted social network and especially older PD patients lack sufficient social support, like Mr. B. Therefore, Mrs. H decided to use the full imagery rescripting technique with Mr. B.

However, before introducing imagery rescripting, Mrs. H payed attention to the possibility of the so-called "loyalty issue." Loyalty to parents (and authorities) tends to be stronger among older adults, in line with their cohort beliefs (James, 2008). Such beliefs, held by groups of people born in similar times, tend to have a significant impact on the therapy, especially as they combine with dysfunctional core beliefs (James, 2008). In the rescripting, the patient has to stand up against the opponent. Also with younger adults this can be an issue, especially if the healthy adult mode is weak, but it is a greater problem with older adults who were socialized to a much greater extent than younger generations, to obey parents and authorities. Although Mr. B thought negatively about his father, when going back to childhood memories, he would probably again feel that he should obey him, as his generation was taught to do. Therefore, Mrs. H decided it would be helpful to discuss the father as a person, by means of Socratic questioning, in an early stage of the technique.

Mrs. H: *How do you think about your father now?*

Mr. B: *I make up excuses for how he behaved. He was raised that way.*

Mrs. H: *Yes, but….even so, what do you think of this now, as a 65-year old?*

Mr. B: (blushes)… *You don't do this to children…*(wet eyes).

With this healthy perspective activated, Mrs. H started imagery rescripting with an image of a current situation. Mrs. H asked him to go back in his memories where he felt the same. An image came up, in which his father angrily puts his fingernails in his arm.

Mrs. H: What do you think of that?

Mr. B: I make up excuses why he does this. He was raised this way.

(Loyalty issue comes up)

Mrs. H: Okay, but what do you think of that now?

Mr. B: (silence) ….You don't do this to children….

Mrs. H: What do you want to say to him?

Mr. B: (blushing, stuttering) Keep your hands of me….what kind of father are you! You make us all scared with your behavior.

This imagery rescripting session was the first of several to help Mr. B develop the more solid positive schema: *I am realist and that's OK.*

Chairwork

By session 17, Mr. B kept reviewing his life as a failure, as he never had a relationship. He realized that he had avoided failures with women, and kept his *curtains closed,* as he put it. Mr. B reviewed his life through the filter of his failure EMS, even though his current behavior improved. It appeared that a punitive parent mode was active, which they referred as *the negaholic*, which in fact reinforced his negative life review. Mrs. H introduced chairwork to challenge this negative mode. Chairwork is an experiential technique, stemming from gestalt therapy, which helps patients to distinguish and experience the feelings and needs associated with their modes (Kellogg, 2004). Mrs. H assessed that introducing different chairs for different modes would be confusing for him, so she only used two chairs: one for the "negaholic" and one for the healthy adult mode. This helped Mr. B to fully experience the emotions, cognitions and emotional needs

correlated with these modes. It took several chairwork sessions to strengthen the healthy adult mode of Mr. B.

Strengthening positive schemas

In the last 12 sessions of the treatment phase, most attention was directed at strengthening the positive schema, which was reformulated into *I'm worthwhile*. Mrs. H decided to direct attention to memories of past experiences, in which Mr. B felt worthwhile, as most older PD patients have had some period in their lives, in which positive schemas were more active (Videler et al., 2015). Specific, lively memories appeared helpful for Mr. B.

Mrs. H: What memories do you have in which you felt worthwhile?

Mr. B: I think of my mother. She used to say 'You are a fantastic boy, but I should have had you alone'.

Mrs. H: How do you feel, when you imagine your mum saying this to you?

Mr. B: That she loves me.

Mrs. H: And what else comes up?

Mr. B: She sees me as worthwhile.

Other positive images which helped him feel the positive schema, were memories of his work as a bookkeeper. Although his forced retirement had hurt him and hurt him still, he mostly felt angry at his former employer, as he considered himself as competent at his job. Giving computer lessons to elderly people nourished this sense of competence and the correlating positive schema of being worthwhile.

At session 40, after one year of treatment, Mr. B was able to both see ànd feel himself as worthwhile. He was able to organize his life better and avoided intimacy with peers less.

Booster phase (sessions 41-50)

The final 10 sessions during the last six months of treatment were dedicated to maintaining the progress Mr. B had made and addressing remaining difficult situations.

Therapy was terminated in session 50. Mr. B had made serious progress, which he acknowledged himself and was proud of. His detached protector mode and punitive parent mode were much less active. He had developed solid positive schemas.

Quantative assessment of therapy outcome

Table 1 provides the scores at pre-, mid-, posttreatment and after the booster sessions on the SCL-90 and YSQ, the reliable change indices, and effect sizes.

Symptomatic distress

Total symptomatic distress decreased significantly from pre-treatment till after the booster sessions, with a large effect size and a significant RCI.

Early maladaptive schemas

The scores on the YSQ decreased significantly and with large effect sizes and significant RCI's during treatment on: Dependence/incompetence, Social undesirability, Failure, Social isolation, Defectiveness/shame and Insufficient self-control.

Personality disorder

On the SCID-II after treatment, Mr. B scored 3 traits of avoidant PD, one trait of depressed PD, two traits of schizoid PD and one trait of schizotypal PD, thereby no longer meeting the criteria for a PD.

Process measures rating

The working alliance

Interrater agreement for the WAI-O-S total score was high (0.99). Scores on the WAIO-S ranged between 4.86 and 6, indicating the coders observed positive indicators of the working alliance. The total alliance score, and that of the Bond and Task subscale, were already high after three months. The score of the Goal subscale improved during treatment. This might reflect that the failure EMS became less active during treatment, which led to a stronger goal-directed alliance.

Table 1. Scores on the YSQ, SCL-90 and WAI-O-S

Measure	Pretreatment	Mid treatment	After treatment phase	After booster sessions	RCI	ES
SCL-90 total score	189	186	141	122	4.58*	1.12
YSQ Total score	2.83	2.38	2.12	1.84	2.30*	0.92
Dependence/ incompetence	3.00	2.20	1.93	1.40	3.77*	1.6
Social undesirability	3.67	2.67	2.56	2.44	1.98*	1.22
Failure	4.33	2.67	2.56	2.50	3.38*	1.51
Social isolation	4.00	2.30	2.20	2.22	3.36*	1.42
Defectiveness/ shame	2.60	1.40	2.13	1.47	2.46*	1.04
Abandonment	1.72	1.50	1.17	1.00	1.60	0.69
Emotional deprivation	2.11	2.11	1.44	1.33	1.42	0.60
Mistrust/ abuse	2.00	2.24	1.82	1.59	0.93	0.39
Insufficient self-control	4.20	3.40	3.80	3.00	2.55*	1.25
Entitlement	1.91	2.18	1.73	1.45	0.87	0.62
Unrelenting standards	2.22	2.06	1.94	1.50	1.50	0.70
Emotional inhibition	2.22	2.56	2.11	1.33	1.39	0.83
Self-sacrifice	2.56	3.44	2.82	2.25	0.69	0.34
Subjugation	3.60	3.10	2.00	2.70	1.75	0.84
Enmeshment	2.00	1.00	1.09	1.00	1.92	0.90
Vulnerability	3.07	3.43	2.57	2.29	1.59	0.78

Working alliance total and subscale Mean scores and SD during psychotherapy

Total		5.31 (0.00)	5.62 (0.07)	5.96 (0.10)		
Bond		5.64 (0.06)	5.89 (0.14)	6.00 (0.25)		
Task		5.44 (0.06)	5.67 (0.09)	5.86 (0.03)		
Goal		4.86 (0.02)	5.31 (0.02)	5.88 (0.08)		

Information concerning table 1 on page 154

RCI = Reliable Change Index; ES = Effect size; $*$ $p < .05$. The RCI is calculated as: $(X2–X1)/\sqrt{(2(SD\sqrt{1-a})^2)}$ where X1 is a subject's pretreatment score and X2 the posttreatment score (or reversed if lower scores on the measure mean better functioning as for the YSQ). The SD is the standard deviation for the measure or a subscale of a sample at pretreatment. The internal consistency (Cronbach's alpha) is used as a reliability coefficient for the measure or subscale. The specific RCI computations for the measures are as follows: SCL-90, the RCI is calculated as: $(189–122)/\sqrt{2(51.68.\sqrt{1-0.96})^2} = 4.58$; YSQ total: RCI $= (2.83-1.84)/\sqrt{(2(1.05\sqrt{1-.92})^2)} = 2.30$; Dependence: RCI $= (3.00-1.40)/\sqrt{(2(1.00\sqrt{(1-.91)})^2)} = 3.77$; Social undesirability: RCI $= (3.67-2.44)/\sqrt{(2(1.01\sqrt{1-.81})^2)} = 1.98$; Failure: RCI $= (4.33-2.50)/\sqrt{(2(1.21\sqrt{1-0.90})^2)} = 3.38$; Social isolation: RCI $= (4.00-2.22)/\sqrt{(2(1.25\sqrt{1-.91})^2)} = 1.98$; Defectiveness: RCI $= (2.60-1.47)/\sqrt{2(1.09\sqrt{1-.92})^2)} = 2.46$; Abandonment: RCI $= (1.72-1.00)/\sqrt{(2(1.05\sqrt{1-.91})^2)} = 1.60$; Emotional deprivation: RCI $= (2.11-1.33)/\sqrt{(2(1.29\sqrt{1-.91})^2)} = 1.42$; Mistrust: RCI $= (2.00-1.59)/\sqrt{(2(1.03\sqrt{1-.91})^2)} = .93$; Self-control: RCI $= (4.20-3.00)/\sqrt{(2(.96\sqrt{1-.88})^2)} = 2.55$; Entitlement: RCI $= (1.91-1.45)/\sqrt{(2(.74\sqrt{1-.74})^2)} = .87$; Unrelenting standards: RCI $= (2.22-1.50)/\sqrt{(1.03\sqrt{1-.89})^2)} = 1.50$; Emotional inhibition: RCI $= (2.22-1.33)/\sqrt{(2(1.07\sqrt{1-.82})^2)} = 1.39$; Self-sacrifice: RCI $= (2.56-2.25)/\sqrt{2(.92\sqrt{1-.88})^2)} = .69$; Subjugation: RCI $= (3.60-2.70)/\sqrt{(2(1.07\sqrt{1-.86})^2)} = 1.75$; Enmeshment: RCI $= (2.00-1.00)/\sqrt{2(1.11\sqrt{1-.89})^2)} = 1.92$; Vulnerability: RCI $= (3.07-2.29)/\sqrt{2(1.00\sqrt{1-.88})^2)} = 1.59$.

Discussion

This case study is the first extensively described ST process of an older adult with a PD. The patient improved with large effect sizes concerning symptomatic distress and EMS. He no longer met DSM-criteria of avoidant PD. We conclude that the ST process of this older adult is different from ST in younger age groups. After comparison with the existing literature on ST in adults, we found five areas of differences. These differences are possible adaptations of ST, which might enhance the outcome of ST in older adults: the case conceptualization diagram, the use of the language of the ST model, the imagery rescripting technique, chairwork and contextualizing to a life span perspective.

Concerning the case conceptualization diagram, a concise model of EMS and modes, which gives short, concrete information of both, seemed to most adequately fit to the experiential world of Mr. B. In younger age groups, different and more extended models for case conceptualization charts are used (Arntz & Jacob, 2012).

In this case study, it appeared advantageous to use the patient's spontaneous language instead of the precise ST terminology. In ST with younger patients, they are usually first educated in the ST language (Van Genderen, 2012). The spontaneous language of the patient has a representational impact and includes memories which are full of perceptual and motor experiences (Zwaan & Radvansky, 1998). In this situational language, the patient recalls and revives his world of emotions and images. Because language has a representational impact, it elicits mental imagery, which is more emotional than verbal processing of the same material (Hackmann, Bennett-Levy, & Holmes, 2011; Holmes et al., 2007; Holmes, 2010). Emotional effects of imagery are greater than those of alternatively based representations (Hackmann et al., 2011; Holmes, 2010). By using the patient's spontaneous language, we reach these images. Especially when working with experiential techniques, it is crucial to preserve this emotional context by the use of the spontaneous language of the patient. This might hold

especially true for older adults as the language in which they describe their imagery stems from at least six decades ago.

Furthermore, we found modifications to the imagery rescripting technique. Some therapists hesitate to use this technique in older adults, because they feel it too emotionally disrupting or intrusive, or they might consider EMS less changeable in later life. This technique appeared very suited for Mr. B. Diagnostic imagery, often used in adults without rescripting (Weertman, 2012), was not necessary in this ST process. The healthy adult mode of Mr. B could easily be activated during the rescripting. We believe that the majority of older PD patients have gathered more "wisdom of their years," and developed a relatively stronger healthy adult mode (Videler et al., 2015), which can be activated more easily than in younger patients. Another adjustment of imagery rescripting for Mr. B considered the loyalty issue. Loyalty to parents and authorities was very strong in Mr. B, as it tends to be stronger among most older adults, in line with their cohort beliefs (James, 2008). Therefore, Mrs. H discussed the person of the opponent with Mr. B in an early stage of the technique, and tackled the loyalty issue in advance. Although Edwards, a pioneer in imagery rescripting, already proposed this in 1990, this is a difference with ST in adults.

Simplifying chairwork helped Mr. B to challenge his negative child modes. In working with younger PD patients, using more chairs can be helpful when many modes are active and the patient switches from one mode to another (Arntz & Van Genderen, 2009). However, Mr. B tended to get confused when using more than two chairs or when asked to switch chairs too much. This might be similar for most older adults.

Finally, addressing the negative life review of Mr. B by contextualizing to a life span perspective, might have enhanced the outcome of this treatment. This is in line with the literature on enhancing CBT for older adults, which was also originally developed for younger adults. Wisdom enhancement has been suggested as a process factor for enhancing the outcome of CBT in later life

(Knight & Laidlaw, 2009; Knight & Pachana, 2015; Laidlaw, 2010; Laidlaw & Thompson, 2014). We found similar process factors in the ST treatment of Mr. B. We will discuss the integration of wisdom enhancement, of positive schemas and negative attitudes to aging respectively.

Baltes and Staudinger (2000) defined wisdom as expert knowledge about the fundamental pragmatics of human life. Wisdom enhancement in psychotherapy means helping older people to contextualize their current problems within a lifespan perspective and next asking them how they have coped with problems successfully earlier in life. In the treatment of depression life review has been shown highly effective in older adults (Bhar, 2014). Older adults are more inclined to take this positive perspective than younger people as this refers to the psychological task of life review in older age (Butler, 1974). By utilizing this perspective, Mr. B's healthy adult mode could readily be activated. This might be the case for most older adults, as it helps them to take a life span perspective from their healthy adult mode.

Another way in which the efficacy of ST might have been enhanced in this case study, was by focusing on positive schemas. Mr. B had functioned somewhat better in midlife, while working as a bookkeeper. After retirement, he looked back at his life as a failure. His punitive parent mode aggravated this. For Mr. B, redirecting attention to his positive schemas helped him reviewing his life more positively. James (2008) called these positive schemas "worth enhancing beliefs" (WEBs), and he theorized that these WEBs tend to have been more active in older adults earlier in their lives, when these positive schemas were nourished by specific social roles. As social circumstances change while a person ages and loses these nourishing roles, positive self-beliefs will be less triggered and EMS become more influential. Directing attention in therapy to these WEBs, can help strengthen positive schemas and can also help change a negative life review. When working with PDs in older adults, patients tend to review their life through the filter of their EMS, just as Mr. B reviewed his life as a failure. For

Mr. B, helping others with administration and computers resembled his functioning while working as a bookkeeper, which strengthened his WEB of being worthwhile.

Finally, negative attitudes to aging, which have been suggested as a target for CBT in older adults with depression and anxiety (Laidlaw & Thompson, 2014), were an initial barrier for Mr. B as well. Recognizing the role of his attitude to aging which coincided with his EMS of being a failure and an outsider, and not reinforcing his ageism was important in motivating Mr. B for therapy.

Limitations

First, the findings of this case study cannot be generalized to all older adults with PDs. We opted for a case study design for exploring possible adaptations of ST for older adults as the purpose of case studies is to expand and generalize theories (Yin, 2013).

One could argue that some of the proposed adaptations could also be of clinical value for some younger patients, like the concise case conceptualization diagram, the use of spontaneous language and simplifying chairwork. This might indeed be the case, but we still think that they are especially advantageous when working with most older adults. Integrating wisdom enhancement and WEBs seem to be exclusively useful moderators for enhancing ST in later life.

Implications for practice and research

This study indicates that individual ST can be powerful in the treatment of complex PD patients in later life. Currently, the question whether individual ST is efficacious in the treatment of PDs in older adults is being examined (Videler, Van Royen, & Van Alphen, 2012). Another research question is whether the modifications we found in this case study, will indeed increase the efficacy of ST in later life. This can be studied by conducting a randomized clinical trial in which ST with these modifications is compared with "standard" ST.

Conclusions

The ST process of the older adult in this case study is different from ST in younger or middle-aged adults. We found five areas of modifications for possibly enhancing the outcome of ST in later life, concerning the use of the terminology of the ST model, the case conceptualization diagram, the imagery rescripting technique, chairwork and incorporating wisdom enhancement and positive schemas.

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Chapter 7

General discussion

Introduction

This dissertation focused on a hitherto highly unexplored subject, the treatment of PDs in older adults. In clinical geropsychology and geriatric psychiatry, until nowadays, this topic has been surrounded by prejudice and therapeutic nihilism. In fact, the current situation has much in common with the late nineteen eighties when similar therapeutic nihilism prevailed regarding the treatment of PDs in young and middle-aged adults (Livesley, Dimaggio, & Clarkin, 2016). The central aim of this dissertation was to explore the flagging field of inquiry that the treatment of PDs was until recently. Or rephrased into a main question, whether there is reason for more optimism concerning the treatability of PDs in later life? This main question was further divided into three research questions, that is:

1) How to determine the optimal choice of intervention for older adults with PDs?

2) Whether existing evidence-based treatments for PDs in younger age groups from a cognitive-behavioral perspective are feasible and effective in later life?

3) What adjustments to psychological treatments for PD would possibly enhance their outcome in later life?

These research questions were approached from several different perspectives. Considering the enormous gap in our scientific knowledge, as a first step, in chapter two, the selection of treatment and the role of age-specific factors in the treatment of PDs in older adults were explored, using a consensus method among experts, the Delphi method (Fink, Kosecoff, Chassin, & Brook, 1984). Next, in the third chapter, three case studies were performed to examine the clinical relevance and applicability of the three different treatment levels which were derived from the Delphi study, using a cognitive-behavioral framework. The next studies focused on the personality-changing treatment level. In a proof

of concept study (Lawrence Gould, 2005), described in chapter four, the feasibility of short schema group therapy in later life was examined. In chapter five, the first test of the effectiveness of individual schema therapy (ST) for PDs as the main focus of treatment in older adults was described. In chapter six, possible adaptations of ST for older adults were explored by examining the process of individual ST on a microscopic level in a case study of an older PD patient.

In this final chapter the most important findings of the studies in this dissertation are summarized and discussed from a broader perspective. Several general limitations of the studies are described. Possible directions for further research are discussed, after which implications for clinical practice are dwelled upon.

Summary of findings

Optimal choice of intervention

The first research question, concerning the optimal choice of intervention for PDs in older adults, was addressed in chapter two and chapter three. The Delphi-study, described in chapter two, yielded consensus concerning several age-specific diagnostic and therapeutic considerations. Concerning diagnosis, agreement was reached upon the concept of the late onset PD and the distinct behavioral expression of PDs in older adults. The LEAD standard combined with a stepwise, multidimensional test diagnostic approach was considered the best suitable procedure for diagnosing PDs in geriatric psychiatry. Concerning treatment, the experts agreed that a specific mental health program for PDs in older adults is clinically valuable. A classification of three treatment levels was regarded useful for the selection of psychological treatments for PDs in later life, that is the personality-changing, the adaptation-enhancing and the supportive-structuring treatment levels.

Furthermore, specific in- and exclusion criteria for these treatment levels were agreed upon. These treatment levels allow for matching older patients to treatments, which is valuable considering the increasing heterogeneity among older people with age (Kessler, Kruse, & Wahl, 2014). This heterogeneity is determined by their level of cognitive functioning, social circumstances, somatic comorbidity and psychological features, the latter of which, for example, concern the capability for self-reflection and the ability to tolerate the disorganizing effects which can derive from treatment. Finally, consensus was reached that psychological treatment of older adults with PDs requires some adjustments to fit better to their specific needs and experiential world. It was recommended to integrate specific gerontological aspects into therapy, such as beliefs about – and consequences of – somatic ailments, beliefs determined by cohort and sociocultural context, intergenerational linkages and the loss of social roles. In addition, the changing life perspective was considered an important topic in therapy.

The three treatment levels and their specific selection criteria appeared applicable in the three case reports that were described in chapter three. Furthermore, they were helpful for guiding the selection of treatment and the operationalization of feasible treatment goals. A cognitive behavioral approach appeared a useful avenue for the treatment of PDs in later life, as cognitive behavioral therapy (CBT) connects to the psychotherapy expectations of older adults (Laidlaw & Thompson, 2014), and it provides interventions on all three treatment levels, that is ST for personality-changing psychotherapy, CBT for adaptation-enhancing treatment, and behavioral therapy for supportive-structuring treatment. At the personality-changing treatment level, ST, which has emerged as an effective treatment for PDs in adults up to middle age (Arntz & Jacob, 2013; Bamelis, Bloo, Bernstein, & Arntz, 2012), led to an improved functioning and a remission of the PD. This treatment model encompasses both CBT techniques and experiential techniques, the latter of which are considered

especially powerful in changing underlying maladaptive schemas (Arntz & Van Genderen, 2009; Edwards & Arntz, 2012; Kellogg, 2014). At the adaptation-enhancing level, CBT, applied in a brief treatment model for PDs by Everly (1996) appeared helpful at adjusting to age-specific role changes. In this treatment model, the dysfunctional core beliefs and maladaptive behavior patterns are identified. The goal of the treatment is not to change these core beliefs, but rather to adapt the behavior pattern in such a way that the same reinforcers are achieved, inducing a more adequate adjustment to changing circumstances, such as age related stressors. Finally, at the supportive-structuring treatment level, behavioral therapy appeared to be an interesting treatment modality. Behavioral therapy induced intermediate behavior change of the caregiving daughter and caused the suicidal behavior of the patient to wane. Especially, as many older patients are realistically dependent on others for care, this throws them into unavoidable and intense interpersonal interactions. Since the core of the difficulties that those with PDs encounter, are in the interpersonal sphere, management of PDs in late life poses specific and important challenges for family and professional care providers (Van Alphen, Derksen, Sadavoy, & Rosowsky, 2012). Psychosocial interventions based on behavioral therapy aimed at behavioral disturbances, by changing the intermediate behavior of caregivers or nurses (LeBlanc, Raetz, & Feliciano, 2011), might be very useful for older adults with PDs in care settings.

Feasibility and effectiveness of cognitive-behavioral treatment

The second research question, whether existing evidence-based treatments for PDs in younger age groups from a cognitive-behavioral perspective are feasible and effective in later life, was addressed in two empirical studies in chapter four and five. In these studies, the ideas were challenged that changing pathological aspects of personality is not possible in older adults (e.g., De Leo, Scocco, & Meneghel, 1999; Segal, Coolidge, & Rosowsky, 2006).

In chapter four, as a proof of concept study, the feasibility of short group schema therapy (SCBT-g) was investigated in older adults with PDs, PD features and longstanding mood disorders, in a pre-mid-post design. As proof of concept intermediate analysis, it was investigated whether SCBT-g led to changes in early maladaptive schemas (EMS), and whether this mediated changes in symptomatic distress. The results showed that SCBT-g led to significant improvement in symptomatic distress with a moderate effect size from pre-treatment to post-treatment. After analysis, pre-treatment to mid-treatment EMS change appeared to be a significant predictor of mid-treatment to end-of-treatment changes in symptomatic distress. This implied that EMS change as process variable probably mediated changes in the outcome variable of SCBT-g, symptomatic distress. As this was also found in the study of Van Vreeswijk, Spinhoven, Eurelings-Bontekoe and Broersen (2014) in a younger cohort, this finding was considered a proof of concept that SCBT-g also decreases EMS and thus lessens symptomatic distress in older adults.

However, the effect sizes in this study on EMS and symptomatic distress were lower than the effect sizes found by Van Vreeswijk et al. (2014) in 48 adults with an average age of 39 and the effect sizes found by Renner et al. (2013) in a sample of 26 young adults with an average age of 23. Furthermore, in the current study, 26% of the patients could be considered as recovered on the symptomatic distress measure, whereas Van Vreeswijk et al. (2012) found a larger proportion of recovery (47%). One possible explanation of the differences in effect between the samples of young adults (Renner et al., 2013), the sample of adults (Van Vreeswijk et al., 2012), and our sample of older adults could be that EMS in younger adults are more flexible and changeable during treatment. Another explanation holds that this short group schema therapy needs adaptations to meet the needs of older patients by integrating age-specific aspects into the treatment protocol, as was found in the studies described in chapter two and three. A third explanation could be that this SCBT-g treatment is not powerful

enough for effecting EMS change in later life, and therefore it was proposed to offer ST individually, like in the studies into ST in younger age groups, with a higher treatment dosage and integrating experiential techniques, as these techniques are considered to be more powerful at changing EMS (Arntz & Van Genderen, 2009).

Such a ST study was described in chapter five. This being the first test of individual ST as a treatment for PDs in older adults, a multiple baseline design was used. ST was examined in cluster C PDs, as these are more stable throughout the life span than cluster B PDs (Cooper, Balsis, & Oltmanns, 2014). ST generated strong effects on the credibility of dysfunctional core beliefs, and on symptoms, quality of life and EMS. Mixed regression analyses revealed no evidence for significant time effects within baseline and follow-up phases, whereas the linear time effect during ST was strong, indicating that ST already had a positive impact on outcome during treatment. The general time effect disappeared after treatment conditions were entered into our model, indicating that it is highly unlikely that these effects could be attributed to a time effect. Most effect sizes were high to very high. Of the participants reassessed for PD diagnosis at follow-up, all remitted from their PD diagnosis. The mean number of PD criteria also decreased from baseline to follow-up with a very high effect size. The finding, that ST has a considerable positive effect on PDs in later life, was considered highly innovative as this was the first study exploring the effectiveness of psychotherapy, in this case ST, for PDs as the main focus of treatment in older adults. Moreover, this study provided evidence for therapeutic optimism concerning the effectiveness of ST in the treatment of PDs in later life.

Enhancing the outcome of treatment in later life

The final research question, what adjustments to psychological treatment of PDs would possibly enhance its outcome in later life, was examined in chapter two, three and six. As was described above, in the Delphi study described in chapter

two, consensus was reached that psychological treatment of older adults with PDs requires some adjustments to fit better to their specific needs and experiential world. The age-specific factors concerned beliefs about – and consequences of – somatic ailments, beliefs determined by cohort and sociocultural context, intergenerational linkages, the loss of social roles and the changing life perspective. The case reports, described in chapter three, also emphasized the importance of recognizing and integrating these age-specific topics into the treatment of older PD patients. Furthermore, elaborating on these case reports it was hypothesized that the outcome of CBT and ST for treating PDs in later life might be increased by using gerontological theories of aging to identify process factors, which then could be used as vehicles for change. Specific targets were suggested, like wisdom enhancement (Knight & Laidlaw, 2009; Laidlaw & Thompson, 2014), attitudes to aging (Laidlaw, 2009) and integrating the action of premorbid positive schemas (James, 2008).

In chapter six, five areas of differences were found as possible adaptations of ST, which might enhance its outcome in older adults: the case conceptualization diagram, the use of the language of the ST model, the imagery rescripting technique, chairwork and contextualizing to a life span perspective. Concerning the case conceptualization diagram, a concise model of EMS and modes might most adequately fit to the experiential world of older adults. Furthermore, it appeared advantageous to use the patient's spontaneous language because especially when working with experiential techniques, it is crucial to preserve this emotional context by the use of the spontaneous language of the patient. This might hold especially true for older adults as the language in which they describe their imagery, stems from at least six decades ago. Concerning the technique of imagery rescripting, diagnostic imagery, often used in adults without rescripting (Weertman, 2012), was not necessary in this ST process, as the healthy adult mode could be activated easily during the rescripting. This corroborated the idea that the majority of older PD patients, for whom personality-changing

treatment can be selected, have gathered more "wisdom of their years" and developed a relatively strong healthy adult mode, which can be activated more easily than in younger patients by using wisdom enhancement. Another adjustment of the imagery rescripting technique concerned the loyalty issue, which tends to be stronger among most older adults, in line with their cohort beliefs (James, 2008). Simplifying chairwork was considered helpful for most older adults. Finally, contextualizing to a life span perspective might enhance the outcome of ST as this is a form of wisdom enhancement (Knight & Pachana, 2015; Laidlaw & Thompson, 2014). Wisdom enhancement in psychotherapy means helping older people to contextualize their current problems within a lifespan perspective and next asking them how they have coped with problems successfully earlier in life. Older adults are more inclined to take this life span perspective than younger people as this refers to the psychological task of life review in older age (Bahr, 2014). By utilizing this perspective in ST, the healthy adult mode can be activated more readily. Finally, the efficacy of ST might be enhanced by focusing on positive schemas. Many older PD patients, especially those selected for personality-changing treatment, but probably also those selected for adaptation-enhancing treatment, have functioned somewhat better in midlife, in which their positive schemas were more active. James (2008) called these "worth enhancing beliefs" (WEBs), which, at the time, were nourished by specific social roles. As social circumstances change while a person ages and loses these nourishing roles, positive core beliefs are less triggered and EMS become more influential. Directing attention to these WEBs in ST and CBT for PDs could help strengthen these positive schemas, induce EMS to become less influential and it might also contribute to a more positive life review.

General limitations

Specific limitations of the studies were already presented at the end of each chapter. However, there are also some general, overarching limitations to be discussed here.

First of all, the level of evidence of the studies in this dissertation is limited. The level of evidence varies from expert opinion (chapter two), through case studies (chapter three and chapter six) and an open trial (chapter four) to a multiple baseline design (chapter five). The multiple baseline design is the only design that is truly capable of showing the effectiveness of an intervention. Considering the absolute lack of evidence for the treatment of PDs we set out from, the current designs were chosen in order to make a first important and highly needed exploration of the flagging field of inquiry that was described in chapter one. The aim was to contribute to theory and clinical practice and generate further research questions. The methods of a Delphi study and evidence-based case studies are especially relevant dealing with topics about which empirical data are sparse and to explore research questions of how and why certain phenomena occur (Fink, Kosecoff, Chassin, & Brook, 1984; Wollersheim, 2009; Yin, 2013). The general contributions to clinical practice and for guiding further research will be discussed in the next paragraphs.

A second general limitation was the way PDs were diagnosed. This was done by multidisciplinary consensus diagnoses in chapter three and four, and using the Structured Clinical Interview for DSM-IV PDs (SCID-II; First, Spitzer, Gibbon, Williams, & Benjamin, 1997) in chapter five and six. Both have their limitations concerning their reliability and validity. It would have been better if the multidisciplinary consensus diagnoses had been combined with the LEAD standard. The SCID-II is based upon the polythetic DSM-IV model that is identical to that of the DSM-5, concerning which several limitations have been found, when applied to older adults. As mentioned in the introductory chapter, several DSM-criteria are not appropriate for older adults, and measurement

errors were found in nearly a third of the diagnostic criteria of the DSM when applied in later life (Balsis, Gleason, Woods, & Oltmanns, 2007; Oltmanns & Balsis, 2011). The alternative DSM-5 model for PDs, described in Section III of DSM-5, is more promising, as dimensional models are likely to be more fruitful than categorical ones for assessing PDs in later life (Van Alphen, Rossi, Segal, & Rosowsky, 2013; Rossi, Debast, & Van Alphen, 2016). Instruments used to measure dimensional PD qualities show less measurement bias among older adults than instruments measuring dichotomous PD features. These instruments also allow for a more nuanced analysis of PD symptom presentation across the life span than categorical PD measures (Debast et al., 2015), which seems more helpful for treatment planning. However, when the studies in this dissertation were planned, the alternative DSM-5 model was not available yet.

Another limitation of the studies in this dissertation is that the participants were mainly "young old," i.e., under 75 years of age. Older adults are very heterogeneous (Kessler et al., 2014), and there are many differences between the "young old" and the "oldest old," also referred to as the "third age" and the "fourth age" (Higgs & Gilleard, 2015). In the fourth age, older adults become increasingly complex, with multiple comorbidities and frailty. Especially, PD patients in their fourth age are difficult to include in large-scale studies due to the complexities of their multimorbidity, unwillingness to participate, high dropout rates, or incapacity to give informed consent (Van Alphen et al., 2015). Still, this group of the oldest old is growing rapidly; the amount of people over 80 years of age will triple worldwide from 125 million in 2015 to 434 million in 2050 (United Nations, 2015).

A final limitation concerns the focus on personality-changing treatment from a ST perspective in chapters four, five and six. Obviously, there are much more perspectives to explore on the treatment of PDs in later life, both concerning the other treatment levels as well as other treatment models. This will be elaborated upon in the next paragraph.

Directions for future research

This dissertation can be considered a first step of many more to come towards the development of feasible and effective treatments for PDs in older adults. There are several possible avenues, and corresponding directions for further research, to optimize the treatment of PDs in later life. Some of the most important directions will be discussed here. First, the expansion of the level of evidence of the findings of the studies in this dissertation is discussed. Next, other perspectives on the treatment of PDs will elaborated upon, after which research directions concerning other treatment levels than the personality-changing level are discussed. Finally, the development of more appropriate instruments for assessing treatment effects is described.

A first direction for further research concerns the expansion of the level of evidence of the findings in these studies. An obvious route would be to replicate the findings of the multiple baseline design concerning the effectiveness of individual ST in a RCT. In such a trial, it would be highly relevant to explore the enhancing effects of integrating age-specific adaptations of ST, which were proposed in chapter three and six. This could be done by including dependent variables that are frequently assessed and are highly sensitive to change, to study the time and intervention effects on a microscopic level (Kazdin, 2010). Possible dependent variables are dysfunctional core beliefs, like in chapter five, but also positive core beliefs, which can then be analyzed by means of time series analysis to explore the added effect of the age-specific adaptations. Thus, it can be explored whether the adjustment of experiential techniques generates more effect, but also whether the integration of wisdom enhancement and positive schemas contribute to the efficacy. A RCT would also allow for enough power to explore the differences of effect of ST between groups, like cluster B and cluster C PDs. Besides, efficacy research on possible differences between the

young-old and the older-old PD patients is needed. The latter design would thus allow for examining the role of the amount of cognitive and somatic limitations, which have been shown to limit the effect of CBT for depression in later life (Pinquart, Duberstein, & Lyness, 2007).

Another interesting option would be to explore the added value of integrating systemic interventions into ST treatment. This could be done by adding family therapy sessions with family or even professional caregivers to the treatment protocol. These sessions could be added to the case conceptualization phase, the treatment phase and the booster sessions.

Concerning short group schema therapy, it would be useful to examine the added value of integrating age-specific adaptations and of adding experiential techniques to the SCBT-g protocol (Broersen & Van Vreeswijk, 2012) to meet the needs of older patients and enhance the outcome. After all, group therapy has the advantages over individual therapy of supplying social support for patients and it also provides the opportunity for practicing with group members (Zarit & Zarit 2011). Furthermore, it is likely to be a cost-effective alternative for individual treatment (Farrell, 2012).

Another area of future research is to explore other perspectives on treatment of PDs in later life, both concerning other treatment models as well as other treatment levels. Concerning other treatment models at the personality-changing treatment level, the question rises whether other specific manualized treatments than ST would be feasible in older adults, like mentalization-based treatment (Bateman & Fonagy, 2011), transference focused therapy (Clarkin, Yeomans, & Kernberg, 2014) or dialectical behavior therapy (Pederson, 2015). However, we already know from the extensive research in PDs in younger age groups that no major differences have been found in effectiveness between different psychotherapeutic treatment models (Dimaggio & Livesley, 2012; Livesley, Dimaggio, & Clarkin, 2016). Therefore, it can be advocated to focus future research on an integrated treatment of PDs, also in older adults, in which

empirically-supported strategies and techniques are selected from different traditions (Dimaggio & Livesley, 2012). Given the enormous heterogeneity of older adults, it is probably more fruitful to improve treatment through component analysis studies to aid in treatment matching to the older PD patient.

Concerning the other treatment levels, it is relevant to study treatments for the adaptation-enhancing and the supportive-structuring level. Especially for the growing and highly complex group of oldest-old PD patients, who are in the "fourth age," the development of feasible and effective treatments is needed. At the adaptation-enhancing treatment level, exploring the effectiveness of CBT, applied in a treatment model by Everly (1996), as described in chapter three, can be recommended. Maybe, interpersonal psychotherapy (Hinrichsen & Clougherty, 2006) could be feasible for helping PD patients to adapt to their changing environment, particularly to age-specific problems. But also brief dynamic interpersonal therapy, which is based upon expert consensus identifying key components drawn from manualized psychoanalytic and dynamic therapies (Lemma, Target, & Fonagy, 2011), is promising for older adults as it is a structured brief intervention with a focus on interactive patterns from a life span perspective. Furthermore, family therapy (Qualls, 2014) could address the difficulties that those with PDs encounter in the interpersonal sphere. For PDs in adolescents, there is evidence for the efficacy of functional family therapy (Sexton, 2015), which would most likely need adaptations for PDs in later life. One adaptation would be to include not only family members but also professional caregivers, as disruption of both family and professional care systems are common (Van Alphen et al., 2012).

At the supportive-structuring treatment level, a specific treatment model is lacking for addressing the majority of problems PD patients face in later life. In chapter three, we proposed behavioral therapy, which seemed feasible for treating the behavioral problems PD patients have. The feasibility of such a behavioral therapeutic treatment for behavioral and psychological symptoms of

dementia among patients with maladaptive personality traits, based upon the cognitive model of PDs by Beck (Beck, Davis, & Freeman, 2015), is currently being examined in the Netherlands. But furthermore, there is also an urgent need for a more elaborate treatment model to treat the other problems PD patients face, and their family and professional caregivers encounter, like not adhering to medical treatments or to life-sustaining care, and social isolation.

Concerning the selection of treatment, combining the treatment levels with a clinical staging model could be helpful, because PDs have a chronic but also fluctuating course across the life span (Oltmanns & Balsis, 2011; Debast et al., 2014). In later life, changes in the individual's circumstances and reduced positive reinforcement of WEBs in subthreshold stages of PDs can lead to a decrease in adaptation to environmental factors, which then causes the maladaptive personality traits and limitations in personality functioning to become manifest (Van Alphen et al., 2015). After all, the biopsychosocial aspects of aging place great demands on the individual's capacity to cope with and adapt to changing circumstances, especially in the vulnerable group with subthreshold PDs. This can cause a reemergent PD or even a late onset PD. The clinical staging model, widely used in clinical medicine, is a more refined form of diagnosis which can improve the logic and timing of interventions in PDs, just as it does in many complex and serious medical and mental disorders (McGorry, Hickie, Yung, Pantelis, & Jackson, 2006). Interventions could then be evaluated in terms of their ability to prevent or delay progression from earlier to later stages of PD. Clinical staging with an explicit operationalization of criteria for extent and progression of PDs, could be explored as a heuristic strategy for the development and evaluation of earlier, safer, and more effective clinical interventions. Such a model identifies four stages: stage one is the latent or non-existent stage; in stage two there is an increased risk of a PD, for instance in adolescence or of a subthreshold PD in middle-age where early interventions could be helpful; in stage three, the acute phase of the PD, treatment of the PD

itself is indicated; in the fourth stage, the most severe or chronic stage, continuous care is necessary. For PDs in later life, personality-changing treatment could be selected in the acute stage, and supportive-structuring treatment in the chronic stage. Possibly, adaptation-enhancing treatment should be selected for milder stages and for the late onset PD.

As a final direction for future research, developing and validating appropriate instruments for assessing treatment effect is relevant. Probably, criterion A of the DSM-5 alternative model, and the corresponding measures such as the Severity Indices of Personality Problems – Short Form (SIPP-SF) (Rossi, Debast, & Van Alphen, 2016) or the Semi-Structured Interview for Personality Functioning DSM–5 (STiP-5.1; Hutsebaut, Kamphuis, Feenstra, Weekers, & De Saeger, 2016) are more intricate and also more sensitive for change than those measures based on DSM-IV and DSM-5 section II. The SIPP-SF is currently being validated for older adults, and the STIP-5 needs to be examined for its application in later life.

Recommendations for clinical practice

The studies in this dissertation provide ground for preliminary therapeutic optimism concerning the treatability of PDs in later life. This is in sharp contract with the severe under-treatment of PDs in current clinical practice in geriatric psychiatry. In a clinical staging model, especially in the acute stage of the disorder - also in later life - PDs should be treated to prevent progress of the disorder to a chronic stage. This is relevant, not only to prevent chronic distress and suffering in PD patients and their social environment, but also from a cost-effectiveness perspective, as personality pathology appeared a relevant predictor of greater medical resource utilization into later adulthood and is an important risk factor for costly overuse of healthcare resources among older adults (Powers, Strube, & Oltmanns, 2014). Therefore, for PD patients in stage three of a clinical staging model of PDs, including the late onset PD, personality-changing treatment should be considered as the first treatment option. The current evidence for the effectiveness of ST suggests that this form of psychotherapy for now is the first choice of treatment, pending evidence for other treatment modalities. If treatment at the personality-changing level is not effective or not possible, adaptation-enhancing treatment should be considered next.

At both the personality-changing and the adaptation-enhancing treatment levels, integrating moderators for change, like wisdom enhancement, attitudes to aging and integrating the action of premorbid positive schemas deserves recommendation. But also in the chronic stage of PDs in later life, the action of premorbid positive schemas should be taken into account. One relatively simple way to do this, is to ask patients and their family and professional caregivers in what period in life and under what circumstances they have functioned (somewhat) better. This directs the attention of the PD patient, their environment, and the clinician towards the action of positive schemas and the interaction with social circumstances. Also at the supportive-structuring treatment level, this positive attitude can help build the therapeutic alliance,

which could be the most important ingredient of successful treatment of these PD patients with severe attachment problems.

Concerning the organization of mental healthcare for PDs in later life, it can be recommended to further develop feasible and effective treatments in clinical centers of excellence, after which they can be implemented in regular mental health care. Adaptation-enhancing treatment should be made more readily available in regular mental healthcare. Despite the preliminary optimism concerning the effectiveness of ST, personality-changing treatment in older PD patients is still an innovative treatment, which should be developed further in clinical centers of excellence. Besides this, the supportive-structuring treatment level mainly concerns a highly complex patient group, with many symptoms and problems across diagnostic categories, for whom the assessment of treatment options needs highly qualified professionals with expertise in both PDs in later life as well as geriatric psychiatry. Therefore, in many cases these patients should typically be thoroughly assessed for treatment options in clinical centers of excellence. Many older PD patients have never had adequate treatment earlier in life and thus have progressed to the final clinical stage. Possibly, some patients can be stabilized to such an extent that the clinical stage of their PD could diminish to the acute stage, in which ST or adaptation-enhancing treatment can be selected.

Finally, the most important implication for clinical practice is that the still prevailing therapeutic nihilism concerning the treatability of PDs in older adults should be abandoned.

Conclusion

This dissertation was devised to pioneer the field of treatment of PDs in later life. It set out to explore a highly undiscovered terrain, the "badlands" of PDs in older adults, like the South Dakota Badlands, depicted on the cover of this dissertation. Central theme and motivation of this dissertation research is the great need for feasible and effective treatments for personality pathology in older adults. Although in large part explorative, the initial findings of the empirical studies in this dissertation are of impeccable valuable for clinical practice. Treatment of PDs appears feasible and can be effective in later life, especially when molded for older adults. Moreover, these studies will contribute to and inspire further research in the field, such as RCTs and the development of a clinical staging model with an explicit operationalization of criteria for extent and progression of PDs in the third and fourth age. Until now, therapeutic nihilism prevailed concerning the treatment options of PDs in later life. This dissertation can be considered as a first step beyond this therapeutic nihilism towards a more positive stance to the treatability of PDs in older adults.

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Acknowledgements
(Dankwoord)

Bij deze ben ik aangekomen aan het meest persoonlijke deel van mijn proefschrift, mijn dankwoord. Een dankwoord is bedoeld om degenen te bedanken die mij hebben geholpen en geïnspireerd, maar het is ook een goede gelegenheid om te reflecteren op de sociale impact van mijn promotietraject. Immers, een belangrijke leerervaring die ik heb opgedaan in het hele proces, is dat promoveren in combinatie met een fulltimebaan alleen mogelijk is, als geregeld van alles opzij gezet wordt. Zij die de dupe waren, zijn geprezen! In het bijzonder en vooral mijn eigen gezin: Monique, Anna en Joris. Ontzettend bedankt voor de ruimte en de steun! Ook vrienden en verdere familie kwamen geregeld op de tweede plaats. Daarom behalve dank ook een mea culpa - hoewel ook een beetje: scientiae culpa.

Ik kijk met plezier en voldoening terug op de samenwerking met mijn promotoren. We vormden een goed team. Hoewel ik normaliter dames voor laat gaan, wil en moet ik eerst jou bedanken, Bas. Zonder jou was ik nooit gepromoveerd! Sinds het ISSPD-congres in New York in 2009 heb je me stelselmatig lastig gevallen met het idee om te promoveren. Jarenlang heb ik volgehouden dat het er misschien ooit van zou komen, maar dat persoonlijkheidsstoornissen bij ouderen eerst en vooral een hobby was. Maar de hobby liep gaandeweg uit de hand. In 2013 sloeg je de handen ineen met Christina en Gina - achter mijn rug nota bene - en creëerden jullie het perspectief om werktijd te kunnen besteden aan onderzoek. Zeer aantrekkelijk en daarmee was dit promotietraject geboren. Ik was om en ik glimlach als ik nu er op terugkijk. Typisch jij, Bas, gedreven op het thema persoonlijkheidsstoornissen bij ouderen en bovendien enthousiasmerend, zoals niemand dat kan zoals jij. We hebben de afgelopen tien jaar heel veel samen gedaan, zoals onderwijs, congressen, EPO, onderzoek, noem maar op. Ik ben jou enorm dankbaar voor alles wat je voor me hebt betekend - en nog betekent - en ik kijk uit naar onze verdere samenwerking de komende jaren, waarin we de diagnostiek en

behandeling van persoonlijkheidsstoornissen bij ouderen verder ontwikkelen, jij vanuit Mondriaan en ik vanuit GGz Breburg.

Christina, ontzettend veel dank voor je inspiratie en steun. Als ik één ding zou moeten noemen, waar jij in uitblinkt – en dat zijn vele zaken – dan is dat toch je vermogen om out-of-the-box te denken. Je vindt altijd een weg naar je doel, al denkt menigeen dat deze weg er niet is. Dat neem ik ook mee vanuit dit promotietraject. We gaan binnen de context van Breburg verder met onze samenwerking om de wetenschap nog beter op de kaart te zetten.

Gina, ik ben je enorm dankbaar voor onze samenwerking. Je was en bent zo ontzettend betrouwbaar, steunend en altijd positief. Ik heb veel geleerd van je over statistiek en methodologie. Maar ik bewonder ook je passie voor ons vak. Gaandeweg ontdekte ik dat we ook de liefde delen voor het harde muziekgenre. Onze samenwerking rondom persoonlijkheid en ouderen gaat gewoon door. Ik kijk er naar uit!

Verder wil ik de coauteurs bedanken. Allereerst Arnoud Arntz, veel dank voor je hulp bij het multiple baseline design, een statistisch kunststukje. Ik vond het een eer samen te mogen werken met het Europese boegbeeld van de schematherapie.

Mariska Schoevaars en Sylvia Heijnen, ook jullie bedankt voor jullie medewerking.

Erlene, I am turning to English, so you can understand this acknowledgement. As pioneer in the field of personality disorders in later life, you have been - and still are - an inspiration to me, and I feel so privileged to work with you!

Rita, jij bent behalve coauteur veel meer voor mij geweest. Sinds ik je ontmoette in je rol als supervisor aan het einde van mijn psychotherapieopleiding in 2003, hebben we de handen ineen geslagen rondom persoonlijkheidsstoornissen bij ouderen. Net als Erlene ben jij een pionier op het gebied van persoonlijkheidsstoornissen. Wetenschap moet altijd een klinische

betekenis hebben, althans dat vinden jij en ik, en sindsdien zijn we samen opgetrokken. Helaas, helaas, de VUB kent het concept paranimf niet, want ik was vastbesloten jou als paranimf te vragen, onder meer om mijn symbolische dank te tonen voor de inspiratie en de steun al die jaren.

Charles, mijn grote broer, ook jou had ik bedacht als paranimf. Helaas geldt voor jou dus hetzelfde.

Ik wil ook diegenen bedanken die niet met naam en toenaam hier aan de orde komen. Want er zijn velen die bewust of onbewust een bijdrage hebben geleverd aan dit traject. Bijvoorbeeld collega's bij GGz Breburg, die klinisch werk uit handen namen, waardoor ik ruimte kreeg voor de wetenschap. Maar zeker ook de patiënten met een persoonlijkheidsstoornis die me door de jaren heen hebben gefascineerd en geïnspireerd, en meer in het bijzonder de patiënten die anoniem hebben meegewerkt aan de studies in dit proefschrift.

Verder wil ik GGz Breburg bedanken, en in het bijzonder de directie en de raad van bestuur, voor de onvoorwaardelijke steun die ik gekregen en gevoeld heb bij mijn promotietraject en mijn plannen en ambities op het gebied van persoonlijkheidsstoornissen bij ouderen.

Ten slotte wil ik mijn ouders bedanken voor het leggen van de basis die dit promotietraject mogelijk heeft gemaakt. Jammer dat jullie dit niet meer mee mogen maken. Ik troost me te weten dat jullie zo ongelooflijk trots zouden zijn geweest.

Curriculum Vitae

&

Publications

Curriculum Vitae

Arjan Videler was born on September 10th, 1968, in Putte, the Netherlands. He graduated from secondary school (Gymnasium) at the Juvenaat in Bergen op Zoom in 1986. After studying Political Science for one year, and Psychology at the Radboud University Nijmegen, in 1993, he received his master's degree in Clinical Psychology. At the time, he was already working as a psychologist at the department of geriatric psychiatry at the RIAGG Breda, a mental health care institute in the Netherlands.

Since 2003, Arjan is working as a psychotherapist and psychologist at GGz Breburg, department of geriatric psychiatry in Tilburg. Currently, he is head of PersonaCura, clinical center of excellence in personality disorders in older adults. Besides his clinical work, Arjan is certified supervisor of the VGCt, the Dutch association of cognitive-behavioral therapy, and teaches psychotherapy in older adults and assessment of personality disorders in older adults at RINO Zuid in Eindhoven and RINO Group in Utrecht, both institutes for continuing education in mental health. He is also a senior researcher at PersonaCura and chair of the committee for scientific research at GGz Breburg. Since 2006, Arjan is an active member of the Expert panel Personality in Older adults (EPO), a Dutch-Belgian research group into personality disorders in later life.

Throughout his clinical work, teaching and research activities, Arjan has always been intrigued by personality disorders in later life, and enhancing the outcome of psychotherapy for older adults.

This PhD project concerned a joint-doctorate, an international cooperation between Tilburg University, Tranzo Department, in the Netherlands, and the Vrije Universiteit Brussels (VUB), Department of Clinical and Lifespan Psychology, in Belgium.

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