11 Personality disorders and alcohol dependence

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Personality traits describe habitual clusters of behaviour. If one cluster of behaviour is dominant (e.g. depressive or obsessional behaviours) then that may justify the description of a personality type. Many different personality traits and types have been described by various authors. There is a debate over how constant styles of behaviour are, and how far they are influenced by situations.

Personality is likely to be determined by a mixture of genetics and life experience, particularly from childhood. In younger people the concept of personality is linked to development through stages of maturation. Beyond early adulthood theories about the maturation of personality are sparse. The core maturational task of later life has been defined by Erikson (1965) as establishing ego-integrity to avoid facing despair.

Personality disorder

Personality disorder is difficult to define. The most useful short definition, from a clinical point of view, may be a long-standing pattern of maladaptive, interpersonal behaviour (Kroessler, 1990). It is unclear whether it is best to regard personality disorder as a range of abnormality, which merges gradually from personality difficulties into mild and severe personality disorders, or to make a simple separation between those with and without personality disorder. A personality disorder is sometimes said to occur when behaviour resulting from personality causes damage to the person or others. Behaviour is an important marker of personality because it can be observed and does not have to be inferred, leading to more reliable diagnoses. In DSM–IV (American Psychiatric Association, 1994) a separate axis (axis II) is reserved for disorders of personality or development, while mental state disorders are classified as axis I disorders.
ICD–10 classification

ICD–10 (World Health Organization, 1992) defines personality disorders as deeply ingrained and enduring behaviour patterns, manifesting themselves as inflexible responses to a broad range of personal and social situations. The following points are made: (a) personality disorders start in childhood or adolescence; (b) they are not secondary to other disorders; (c) there are overlaps between different types; and (d) a diagnosis should be based on as many sources of information as possible. ICD–10 specific personality disorders are listed in Box 1.1.

Ageing and behaviour

As people age, changes in physical health reduce the likelihood of some behaviours associated with personality disorder in younger people. Impulsive behaviour, law-breaking, initiating fights, promiscuity and aggression to children are all less likely for a variety of reasons. While some behaviour which acts as a marker of disorder in younger people is less likely to be found in older people, other ‘marker’ behaviour, such as social withdrawal, may become more likely because of physical or sensory disabilities or undiagnosed illness, including depressive illness. Valliant & Valliant (1990) found that antisocial behaviour at college was not associated, 45 years later, with any important psychosocial adjustment at the age of 65.

Social expectations of behaviour also change. An old man who strikes another person is less likely to be charged with assault than a young man who does the same. An old woman who behaves histrionically is less likely to be labelled ‘hysterical’ than a young woman. There are socially conditioned expectations about what is ‘normal’ for people in different age groups, which influence where the line is drawn between ‘normal’ and ‘abnormal’. These changing standards make the concept of personality disorder particularly difficult to define in old age.

Box 11.1 Specific personality disorders in ICD–10 (World Health Organization, 1992)

- Paranoid
- Schizoid
- Dissocial
- Emotionally unstable (impulsive type and borderline type)
- Histrionic
- Anankastic
- Anxious (avoidant)
- Dependent
Personality disorders in older people

There are a number of practical problems in diagnosing personality disorders in older people:

(a) It is often difficult to trace behaviour back to childhood or adolescence.
(b) Older patients may live alone so it is difficult to find an informant.
(c) Informants, when available, may be biased in their reporting (such as long suffering partners).

Prevalence

Early studies found a community prevalence, in old age, of 4% for ‘character disorders’ including paranoid states (Kay et al., 1964). The prevalence of personality disorder is probably lower in old age than middle age, but it is associated with a higher psychiatric referral rate. Hospital prevalence has been found to be between 6 and 50%, depending upon the methodology used (Fogel & Westlake, 1990; Kunik et al., 1994). Abrams (1996) looked at 23 studies published between 1980 and 1994, and concluded that the overall prevalence rate for personality disorders in the over 50 age group is around 10%.

Association with other diagnoses

Depression

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

Schizophrenia

The relationship between personality and schizophrenia, in old age, has not been examined recently, although there is a link between paranoid personality types and the development of late paraphrenia. There is a strong association between schizophrenia and personality disorders in
younger patients. Many patients with late paraphrenia have never married and have lived alone for some time, suggesting that there may have been personality problems predating the paraphrenia.

**Somatisation disorder**

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

**Diogenes’ syndrome**

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

**Dementia**

Personality changes occur in organic disorders (Petry et al, 1989; Dian et al, 1990; Burns, 1992), although these changes are not classified as personality disorders. Negative personality changes are reported by relatives in two-thirds of people with dementia. Four patterns of personality change have been reported: alteration at onset of dementia, with little subsequent change; ongoing change with disease progression; regression to previously disturbed behaviours; and no change.

Negative personality traits such as being more out of touch, reliant on others, childish, listless, changeable, unreasonable, lifeless, unhappy, cold, cruel, irritable and mean, tend to be attributed to people with dementia. Some of these perceived changes may be due to other person’s reaction to
Personality disorders and alcohol dependence

the illness; some might be directly determined by organic change; and others may mark a reaction of the person, with dementia, to their experience.

Management of personality disorder

When a personality disorder is associated with a functional mental illness, the first concern must be to treat the latter. Many personality ‘traits’ will resolve with treatment of the underlying functional disorder (Peselow et al, 1994). However, when a patient has persistent or residual symptoms of a personality disorder, a consistent approach from an experienced therapist will bring most benefit. As with younger patients, forming a therapeutic alliance with a patient whose early life experience may have taught him or her to distrust authority figures is difficult (Norton, 1996). Supportive, dynamic and cognitive approaches can all play a role, depending on present symptoms. It is particularly important to ensure a consistency of approach between involved professionals, and this requires good communication. Efforts may also be helpful at modifying the reaction of significant other people to unwanted behaviour.

When changes of personality are secondary to dementia, the increased dependence of the person with dementia on the environment, including care-givers, means management is often through changing that environment. This could involve an analysis of unwanted behaviour and contingency management. More general advice can be given to care-givers to help them become more aware of changes in personality and the best ways of dealing with them (see Chapter 6). Management is summarised in Box 11.2.

Outcome

Abnormal personality traits, by definition, are relatively stable. However, since they represent maturational defects they might be expected to resolve with age. Longitudinal studies show that while personality tends

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<th>Box 11.2 Management of personality disorders</th>
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<td>Treat any mental state disorder</td>
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<td>Consistent, long-term approach</td>
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<td>Form a therapeutic alliance</td>
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<td>Supportive, dynamic or cognitive psychotherapy</td>
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<td>Good communication between professionals</td>
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<td>Involve significant others</td>
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to be stable throughout life, introversion increases with age (Howard & Bergmann, 1993). Changes in the health of the individual, or changes of environment (e.g. moving to residential care), may sometimes precipitate maladaptive behaviour that is taken to signify personality disorder. Personality may also continue to develop abnormally with increasing age, perhaps undergoing a transformation into frank illness, as in the development of paraphrenia in someone with a previous tendency to be isolated and suspicious of others. Borderline personality disorder, in later life, may involve an inability to formulate future plans or pursue goal directed activity, and elderly patients with severe personality disorders may disrupt nursing homes and other service delivery systems.

Sexuality
Research into the important topic of sexual behaviour in old age is still limited. A steep decline in marital sexual activity occurs in extreme old age (Marsiglio & Donnelly, 1991). Attitudes and health are likely to contribute to this as much as simple ageing. There is a place for sexual therapy with older couples which include such practical remedies as hormone replacement therapy, intracavernosal prostaglandins and vaginal lubricants. The place of the new drug sildenafil has yet to be established. Other considerations include the treatment of remedial disorders (like depression) and an exploration of the relationship and inhibitions.

Problems may occur with inappropriate sexual activity in older people in residential and nursing home care (Barker & Wattis, 1991). Of course, whereas public masturbation is unlikely to be acceptable, a sexual relationship between unattached older people may only be a problem because of staff and family disapproval. Sympathetic understanding is the basis of all management, whether behavioural or pharmacological (Seymour, 1990).

Alcohol dependence

Definition
Alcohol is a unique drug in terms of its ready availability ‘over the counter’ and its social acceptability. Many terms have been used to describe those who come to harm through the use of alcohol but ‘alcohol dependence’ (Edwards & Gross, 1976) and ‘harmful drinking’ are perhaps the most useful. Alcohol dependence is defined as a serious medical and psychiatric disorder, characterised by certain features (Box 11.3). Harmful drinking is defined as a pattern of alcohol use that causes damage to physical or mental health. There is considerable overlap between the two terms.

ICD–10 includes the following clinical conditions within the classification of mental and behavioural disorders due to psychoactive
substance use, acute intoxication, harmful use, dependence syndrome and withdrawal state.

**Effect of ageing on alcohol metabolism**

The College guidelines for ‘safe’ drinking are 14 units of alcohol a week for women and 21 units a week for men (Chick & Cantwell, 1994). These upper limits take no account of age, and such drinking may harm an older person. With age, body water content declines and body fat content increases, so that lean body mass decreases by about 10% between the ages of 20 and 70. This results in altered distribution and increased blood alcohol levels for a given dose of alcohol (Vestal et al., 1977). Ageing organs, including the brain, are less able to withstand the toxic effects of alcohol. Drug interactions with benzodiazepines (Cook et al., 1984), neuroleptics or opiates are more common.

**Epidemiology**

Surveys, in the elderly, are limited by several factors:

(a) under-reporting of current consumption occurs because of cultural factors;
(b) ‘retrospective bias’ is stronger in older people;
(c) screening tools may not be appropriate for old age;
(d) the heaviest drinkers may be missed; and
(e) broad categories, such as ‘heavy drinking’, are of limited relevance in older people.

Some research has attempted to identify problem drinkers and follow patterns of alcohol consumption longitudinally (Mishara & Kastembaum, 1992). It appears that alcohol intake remains relatively high in the 65–75 age range but falls markedly in the 75–85 age range. There are large
differences in age-related intake and dependence in different cultural settings, even within the same country. Men are more likely to be regular drinkers, although if women do drink regularly, they are as likely as men to exceed ‘sensible’ limits. In some cultures, older women have higher rates of misuse than younger women (Seymour & Wattis, 1992). Community surveys such as the Epidemiological Catchment Area study (Holzer et al, 1984), probably underestimate the proportion of older alcoholism, at just under two per cent for men, and less than one per cent in women. About half the over 65-year-old population drink alcohol (Jones & Joseph, 1997).

**Trends in consumption**

The per capita consumption varies over time and between countries. Generally, there is a higher consumption of alcohol in countries that are richer. National trends conceal a multitude of cultural and ethnic effects. People born at different times may have different patterns of alcohol intake. For example, prohibition in the US may have influenced subsequent drinking habits in those people who were children or adolescents during that era, by placing a taboo on drinking during formative years (Knupfer & Room, 1970). There is a relationship between per capita alcohol consumption and the numbers of people developing alcohol-related problems (Leifman & Romelsjö, 1997).

**Aetiology**

Elderly people with alcoholism who were dependent in younger life (early onset) have different characteristics from those who started drinking heavily in later life (late onset) (Atkinson et al, 1990). Early-onset dependent drinkers are more likely to have a family history of alcohol misuse, a history of smoking and a greater alcohol intake. Late-onset drinkers are more likely to have an obvious precipitant for drinking; a milder, more circumscribed drink problem; and greater premorbid psychological stability. Drinking may start or escalate after a bereavement. Sometimes elderly people resort to alcohol to help them sleep or mask pain.

**Medical complications**

All systems of the body may be affected by alcohol (Box 11.4). A direct causal link between alcohol dependence and pathology is clear in some conditions (e.g. pancreatitis (Singh & Simsek, 1990) and liver cirrhosis (Groover, 1990)), but less clear when the aetiology is complex and multifactorial. For example, high alcohol intake is linked with hypertension.
Personality disorders and alcohol dependence (Marmot et al., 1994), but other risk factors may be involved such as smoking, obesity, family history, diet or exercise. Smoking is a particular confounding factor. Many people who drink heavily also smoke, and many of the pathological processes caused or exacerbated by alcohol are also caused or exacerbated by smoking (e.g. peptic ulcers or ischaemic heart disease).

**Nutrition**

Alcohol dependence is associated with poor nutrition in older people. Factors include a neglected diet; poor appetite due to medical complications; malabsorption; the increased dietary demands of metabolising large quantities of alcohol; and the toxic effects of alcohol on cell metabolism. Alcohol dependence can lead to severe deficiencies of vitamins, most notably vitamins C and B group (Barburiak & Rooney, 1985).

**Immune system**

Heavy drinking impairs the immune system, resulting in increased susceptibility to infection, including tuberculosis. The mechanisms are complex, and at present poorly understood, although alcohol probably affects T cells and cell-mediated immunity. Alcoholic liver disease further impairs immunity (Dunne, 1989).

**Cancer**

Excess alcohol is a known risk factor for cancer in most regions of the gastrointestinal tract. Alcohol is also implicated in the aetiology of breast cancer (Bowlin et al., 1997), perhaps mediated by reduced immune surveillance.

**Liver disease**

Alcohol dependence results in a spectrum of liver disorders, ranging from fatty liver to cirrhosis. Liver cirrhosis is a disease of the late middle aged, or slightly older, and prognosis is worse in old age (Potter & James, 1987).

**Heart disease**

Dependence is associated with higher mortality from hypertension, haemorrhagic stroke and cardiomyopathy (Peacock, 1990). High alcohol intake (above safety guidelines) is probably associated with increased ischaemic heart disease. It remains unclear whether a small intake of alcohol has a cardioprotective effect.
Drug interactions

Alcohol has an additive, sedative effect to benzodiazepines, barbiturates, chloral hydrate and tricyclic antidepressants. Alcohol reduces their metabolism and raises their serum concentrations. There may also be pharmacodynamic interactions. Conversely, the metabolism of barbiturates, tolbutamide, phenytoin and warfarin may be increased as the result of enzyme induction in the liver, or reduced by liver damage. Alcohol influences compliance with medication. Elderly people may omit medication as they fear an interaction with alcohol, or elect not to take medication at all if they want to carry on drinking.

Neuropsychiatric complications

Acute intoxication

Older people rarely present in an alcoholic coma. An elderly patient presenting to casualty in a coma and smelling of alcohol may have concurrent pathology, for example, a drug overdose or a subdural haematoma. Pathological drunkenness is rare, but may occur in older people, especially men with brain damage who can behave completely out of character after a small amount of alcohol.

Withdrawal syndrome

A withdrawal syndrome, ranging from anxiety to fully developed delirium tremens with epileptic fits and coma, can largely be prevented by good management. Delirium tremens is a medical emergency demanding immediate sedation and the possible use of anti-epileptic drugs (CRAG/SCOTMEG, 1994).

Wernicke–Korsakoff syndrome

Wernicke’s encephalopathy is characterised by the clinical triad of: ophthalmoplegia, ataxia and delirium. It is caused by an acute deficiency of thiamine (vitamin B1) (Perkin & Hondler, 1983). Wernicke’s
encephalopathy is a medical emergency which requires intravenous administration of thiamine. Treatment delay increases the risk of permanent damage with Korsakoff's psychosis (Anonymous, 1990). Even with treatment only a fifth of patients with Wernicke's encephalopathy fully recover, and over half are left with Korsakoff's psychosis.

Korsakoff's psychosis is characterised by apathy, the inability to learn or form new memories, loss of insight and confabulation. Patients are otherwise mentally intact and may survive many years into old age. On CT scan, frontal brain shrinkage is particularly pronounced, suggesting a dual aetiology: thiamine deficiency and a direct neurotoxic effect of ethanol on the brain, particularly the frontal lobes. With time, up to a quarter of Korsakoff's patients make a complete recovery and half show some improvement.

Alcoholic cerebellar degeneration

This condition tends to arise in binge drinkers and so called 'skid row' populations of deteriorated long-term misusers of alcohol, and is not commonly diagnosed in the elderly (Victor et al, 1959). The clinical picture is identical to subacute cerebellar degeneration secondary to carcinoma of the bronchus, so a chest X-ray should always be performed in the elderly. There is a progressive ataxia of gait (without incoordination of the limbs), dysarthria and gaze-evoked nystagmus. Cerebellar damage probably arises from the direct toxic effect of very high levels of alcohol rather than a nutritional effect, as alcohol produces (lesser degrees of) cerebellar ataxia in normal subjects and there is a poor response to treatment with thiamine.

Alcoholic hallucinosis

These are persistent auditory hallucinations, usually derogatory or hostile in nature, in the context of prolonged heavy drinking. Alcoholic hallucinosis is rare in old people.

Morbid jealousy

This usually occurs in men and is characterised by paranoid delusions concerning infidelity. The delusions may be refractory to neuroleptics and stopping alcohol. Patients are often a danger to their partner or ex-partner. It is rare for this condition to arise de novo in old age, but it may persist into old age.

Alcoholic dementia and cortical atrophy

Increasing age is a major risk factor for alcoholic dementia. Alcohol in large quantities causes a decrease in brain size, widening of sulci and
enlargement of ventricles. There is neuronal loss affecting principally neocortex, basal ganglia, hippocampus and reticular activating system: the same areas affected principally in normal ageing. This macroscopic and microscopic brain damage is reflected in impaired performance on tests of cognition and motor skills (Lishman, 1990).

So-called 'social drinking' within the safety guidelines may affect cognitive function (Robertson, 1984). Problem-solving, abstraction abilities and memory and psychomotor abilities have been shown to be affected. There may be a continuum of cognitive deficit directly related to alcohol intake, ranging from barely detectable or no deficit (social drinking) through to Korsakoff's psychosis (very high alcohol intake). Brain damage may also result indirectly from alcohol misuse. For example, hypertension and other cardiovascular changes resulting from alcohol misuse, may cause a vascular dementia. Whenever alcohol misuse and a dementing illness coexist they pose particular problems, since the patient's impaired memory and judgement make it impossible to control his own alcohol intake. Neuropsychiatric complications are summarised in Box 11.5.

Presentation

Alcohol dependence, in older age, often presents indirectly with confusion, falls, self-neglect or associated medical problems (Wattis, 1981, 1983). Alcohol problems are often undetected as appropriate questions are not asked of older people. Information on alcohol intake must be sought, it is rarely volunteered. Patients may underestimate their weekly intake, be unaware of harmful effects or deny the link between alcohol and harmful effects. A history from an informant is vital, although the informant may have a vested interest in minimising consumption, especially if he or she is also a heavy drinker. The CAGE questionnaire (Ewing, 1984) is a useful short screening instrument (see Chapter 1).

Box 11.5 Neuropsychiatric complications of alcohol dependence

Acute intoxication
Withdrawal syndrome and delirium tremens
Wernicke-Korsakoff syndrome
Cerebellar degeneration
Alcoholic hallucinosis
Morbid jealousy
Dementia
Physical examination may reveal the medical complications of alcohol misuse. Laboratory results including a raised mean corpuscular volume or liver function tests should alert the physician to the possibility of alcohol misuse. Hyperuricaemia, hypertriglyceridaemia and hypoglycaemia may be caused or exacerbated by alcohol misuse.

Management of alcohol dependence

The principles of management are the same in the elderly as they are for younger age groups. They include the recognition of a problem (by patient, carers, doctor); the acceptance of treatment; detoxification; treatment of concurrent psychiatric and medical disorders; rehabilitation; and continuing support. Management is summarised in Box 11.6.

Therapeutic nihilism should be avoided. ‘It’s too late for her to change her drinking habits now’ or ‘beer is one of his few pleasures left in life’ are ageist statements. Older alcohol misusers may find it particularly difficult to change their drinking habits if there are younger alcohol misusers colluding with them. Hospital admission is often necessary. It breaks the pattern of consumption; enables full medical assessment; treatment of any complications; assessment of mood and cognitive functioning; and the supervised initiation of treatment for concurrent psychiatric disorders.

Withdrawal regime

Admission to hospital for detoxification is often necessary as out-patient detoxification can be hazardous. Sometimes the person refuses hospital admission. Compulsory admission under the mental health legislation is often not appropriate (the Mental Health Act specifically excludes alcohol misuse as a reason for compulsory admission). In that case attempts should be made to build a relationship with the person until the need for change is accepted or the home situation deteriorates to the point that hospital admission becomes inevitable.

The alcohol withdrawal regime pays particular attention to fluid and electrolyte balance, and concurrent medical conditions. Shorter acting sedatives, such as chlormethiazole, are recommended for old people, often in reduced doses, rather than longer acting benzodiazepines such as chlordiazepoxide, although opinion is divided (CRAG/SCOTMEG, 1994). Phenytoin should be used prophylactically if there is a history of epilepsy or withdrawal fits, in which case the duration of the withdrawal regime may need to be slightly extended. Vitamin supplements are important, especially thiamine which should be given orally or parenterally with suitable precautions for anaphylaxis where Wernicke’s encephalopathy is suspected.
After detoxification, rehabilitation is essential and increased social contacts may prevent recurrence. Education about the alcohol content of different drinks is necessary and a switch to low or no alcohol beers may help. Local facilities (e.g. day centres, and visits from members of the multi-disciplinary team) may provide alternatives to drinking. Alcoholics Anonymous can offer considerable support and there are related support groups for partners and children. At this stage, the emphasis is on social intervention rather than on medical treatments, such as disulfiram (antabuse), which may be dangerous in older people. For a fuller review of alcohol dependence in old age see A Handbook of Nutrition in the Elderly (Wattis & Seymour, 1993).

Other drug dependence

The therapeutic use of narcotics increases with age, but non-therapeutic misuse declines (Dunne, 1994). It may be that the non-therapeutic use of drugs in old people will increase as the ‘hippies’ and ‘flower people’ of the 1960s grow older (cohort effect). For now, a more urgent problem is the number of older people who are dependent on benzodiazepine, usually prescribed as sleeping tablets, but sometimes as anxiolytics (Dunne, 1994; McInnes & Powell, 1994). The longer-acting hypnotics have ‘hang-over’ effects on cognitive function and some of the benzodiazepines appear to interfere

Box 11.7 Withdrawal of benzodiazepines

- Educate and inform the patient, and other involved individuals
- Change to a long-acting benzodiazepine
- Gradually reduce over several weeks
- Closely monitor the patient
- Offer therapeutic help including relaxation therapy
Personality disorders and alcohol dependence with memory. Evidence is emerging that benzodiazepine dependence is associated with increased hospital admissions and length of stay. Withdrawal regimes are available, the principles of which are in Box 11.7.

Conclusion

Personality disorder, sexual problems and alcohol dependence present differently in older people. This is partly due to social and cultural differences and partly due to age-related changes in the body, including the central nervous system. In particular, physical illness and drug interactions are more common in older people and these are often important. Although it is obvious that older people have these problems, they have traditionally been neglected. Now that a growing body of research has demonstrated their significance to old age psychiatry, they may be taken more seriously.

References