Quality of Life in Elderly Patients with Cluster C Personality Disorder

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Introduction: Epidemiological studies have found reduced health-related quality of life (QoL) in patients with personality disorders (PDs), but few clinical studies have examined QoL in elderly patients with cluster C PDs. Our objective was to evaluate QoL in elderly patients with cluster C PDs admitted to the Psychiatric Clinic No II Tîrgu Mureș in all four domains related to QoL: physical health, psychological health, social relationships and environment.
Material and method: Elderly patients with cluster C PDs filled in the World Health Organization Quality of life (WHOQoL-Bref). An independent psychiatrist diagnosed cluster C PDs and Axis-I disorders by structured interviews (SCID II) and rated the Global Assessment of Functioning (GAF).
Results: Cluster C PD patients showed high co-morbidity with Axis I mental disorders, and they scored significantly lower on all the WHOQol dimensions. The WHOQoL physical health and social functioning were significantly associated with the GAF.
Conclusions: Elderly people with a cluster C PD have globally poor QoL and were more vulnerable to late-life distress, especially those with more than one diagnosis. In keeping with the results, widowhood, divorce hood, and living alone appear to be variables able to negatively influence QoL in this population.

Keywords: cluster C personality disorder, elderly, quality of life

Received: 20 April 2009

Introduction

Advances in medical technology and improvements in health behavior have greatly increased the proportion of people who survive into old age (over 65 years old). Consequently, identifying environmental and behavioral factors that enhance or protect the health and functional capacity of older adults is an important goal.

There is mounting evidence that personality disorders (PD) are no less prevalent in late life than in adulthood, and that the presence of PDs is associated with poor treatment outcomes and disability [1].

Personality disorders represent some of the most insidious and challenging psychiatric conditions that clinicians encounter, often creating unwarranted and unwanted conflicts in a clinical setting. The reasons for these conflicts lay at the core of the pathology of PD, namely, a fundamental impairment in interpersonal relationships that leads to a variety of maladaptive, inappropriate or outrageous behaviors, that the affected person seems incapable of fully understanding and controlling [7].

Research suggests that the majority of personality disorders evidenced in late life are Cluster C PDs, particularly obsessive-compulsive PD, followed by Cluster A disorders [2]. These disorders are typically characterized by excesses in emotional reactivity [6], particularly anxiety in the case of Cluster C disorders and hostility in the case of Cluster A disorders.

Cluster C PDs could be compensated by psychological spontaneity patterns represented by interpersonal, familial, professional and socio-cultural activities. The aim of this study is to assess the impact of cluster C PDs on the subjective assessment of QoL in a sample of elderly psychiatric patients.

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Material and method

Patients

The study included elderly patients (over 60 years old) with cluster C PDs from the Psychiatric Clinic No II Tîrgu Mureș, recruited from January 1, 2009. Patients have been diagnosed clinically and anamnestically with DSM-IV and SCID II, by the therapeutic team of the clinic.

Eligible patients were those aged over 60 years old and diagnosed with cluster C PDs. They received oral and written information about the study from their therapists.

Exclusion criteria were: mental retardation, lifetime psychosis and bipolar disorder, organic mental disorder, current intense suicidal ideation.

Measures

Professional-rated

The Structured Clinical Interview for DSM-III-R Personality Disorders (SCID-II) is a clinician-administered semi structured interview for diagnosing the Axis II personality disorders of the Diagnostic and Statistical Manual of Mental Disorders (3rd ed., rev.), plus the Appendix category self-defeating personality disorder. The SCID-II is unique in that it was designed with the primary goal of providing a rapid clinical assessment of personality disorders without sacrificing reliability or validity. It can be used in conjunction with a self-report personality ques-

Table I. Demographical and psychopathological features in elderly patients

Variables	Obsessive-compulsive	Avoidant	Dependent
Age (mean, years)	63.5	67	72.5
Gender (n, %)			
Male	3 (15%)	1 (5%)	3 (15%)
Female	2 (10%)	5 (25%)	6 (30%)
Marrital status			
Married	3 (15%)	0	1 (5%)
Widowed	2 (10%)	3 (15%)	8 (40%)
Divorced	1 (5%)	2 (10%)	0
Educational level			
Primary education	1 (5%)	2 (10%)	4 (10%)
Secondary education	5 (25%)	2 (10%)	5 (25%)
University	0	1 (5%)	0
Traumatizing events	2 (10%)	3 (15%)	8 (40%)
GAF (mean)	57.5	52	41.5
WHO-QL (mean)			
Domain 1	62.5	53.5	42.25
Domain 2	50	44.5	42.25
Domain 3	62.5	59.5	50.25
Domain 4	66	62.5	53.25

tionnaire, which allows the interview to focus only on the items corresponding to positively endorsed questions on the questionnaire, thus shortening the administration time of the interview.

The Global Assessment of Functioning (GAF) is a rating scale for the current evaluation of the overall functioning of a subject, on a continuum from severe mental disorder to complete mental health, that was defined as Axis V of the DSM-IV. The scale values range from 1 (sickest individual) to 100 (the healthiest person). The scale is divided in ten equal intervals from 1–10 to 91–100. The GAF is a reliable instrument, and the cut-off score for "minimal impairment" has been set at 70 points or higher and for "serious mental disorder" at lower than 60.

Patient-rated

The WHOQoL-Bref is an abbreviated version of the WHOQoL-100 quality of life assessment. It produces scores for four domains related to QoL: physical health, psychological, social relationships and environment. It also includes one facet on overall QoL and general health. It contains 26 items, and the scores of the four domains have a range of 1–100. The WHOQoL-Bref has demonstrated sensitivity to change, and score changes can be interpreted as change in the health-related QoL of the patient.

Table III. Somatic comorbidities

PDs	None	Somatic comorbidities
Obsessive-compulsive	5	1
Anxious-avoidant	0	5
Dependent	0	9
Total (n, %)	5 (25%)	15 (75%)

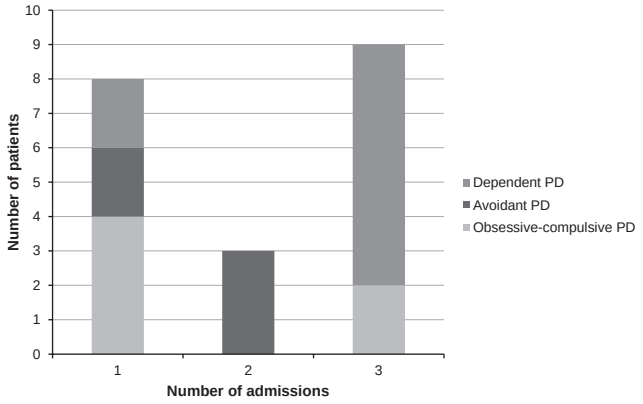

Fig. 1. Number of admissions during the study

Results

Our sample was formed of 20 elderly patients with cluster C PDs: 30% obsessive-compulsive, 25% avoidant, and 45% dependent. The demographic characteristics of the patients are presented in Table I. Psychiatric co-morbidities found in our sample are presented in Table II. Somatic co-morbidities, such as elevated blood pressure, spondylopathy, diabetes, cardiopathy are presented in Table III.

The majority of patients had more than one admission during our study, as it can be seen in Figure 1.

Discussions

The main finding of our study is that QoL in elderly patients with cluster C PDs is significantly low.

Dependent PD scores were low in all four domains related to QoL: physical health (WHOQoL-Bref score = 42.25), psychological health (score = 42.25), social relationships (score = 50.25) and environment (score = 53.25). In case of the obsessive compulsive and avoidant PD, QoL scores were lower in psychological health, in concordance with data from the literature [9]. The lower scores on the WHOQoL are correlated considerably with the professional-rated measure, GAF (for the dependent personality disorder GAF= 41.5).

The presence of comorbid Axis I disorders (depressive disorders 60%, obsessive-compulsive disorders 40%, anxi-

Table II. Psychiatric comorbidities

	None	Anxiety disorders	Depressive disorders	Social phobia	Obsessive-compulsive disorder	Total
Obsessive-compulsive	1	0	3	0	2	6
Anxious-avoidant	0	0	2	1	2	5
Dependent	0	2	7	0	0	9
Total (n, %)	1 (5%)	2 (10%)	12 (60%)	1 (5%)	4 (40%)	20 (100%)

ety disorders 10%) explained also a significant part of those scores, especially physical health. This is in accordance with the findings of other clinical studies on patients with anxiety disorders, depression, and substance dependence [8], and also with the findings of an Australian study [5].

In keeping with the results, widowhood (65% in our study), divorce hood (15%), and living alone appear to be variables able to negatively influence QoL in this population [3].

Conclusions

Our results suggest that elderly people with a personality disorder are more vulnerable to late-life distress, especially those with more than one diagnosis.

The indicators of QoL are less affected in the case of obsessive-compulsive PD than in the case of avoidant PD, confirming superior adaptive capacities for those with obsessive-compulsive PD. They can be more easily integrated in existential roles and rules. The level of moral attributes, although undermined by a disharmonic structure of character, may facilitate in case of obsessive-compulsive PD a satisfactory level for the QoL.

Although our preliminary study has certain limitations, our results underscore that female gender, a history of traumatizing events, widowhood, psychiatric and somatic comorbidities all have negative effects on the QoL of elderly patients with cluster C PD. Therefore, psychiatric interventions, targeting the patients, who are considered as a risk group, social programs (governmental or not), in order to improve their quality of life and to reduce their disability, will be useful.

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