

## **Psychotherapeutic treatment levels of personality disorders in older adults**

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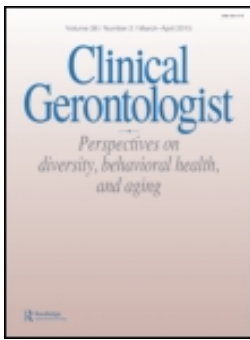
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## Psychotherapeutic Treatment Levels for Personality Disorders in Older Adults

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## CLINICAL COMMENT

# Psychotherapeutic Treatment Levels for Personality Disorders in Older Adults

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*Treatment of personality disorders (PDs) in older adults is a highly underexplored topic. In this article 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: (a) personality-changing treatment, (b) adaptation-enhancing treatment, and (c) supportive-structuring treatment. By means of three cases concerning the three levels, all from a cognitive behavioral perspective, namely (a) schema therapy, (b) cognitive behavioral therapy, and (c) behavioral therapy, we illustrate the usefulness*

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*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 changing life perspectives—is crucial, as they often cause an exacerbation of personality pathology in later life. Suggestions 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 are discussed.*

**KEYWORDS** *older adults, personality disorders, psychotherapy, treatment levels*

Treatment of personality disorders (PDs) in older adults is a highly underexplored topic (Van Alphen, Derksen, Sadavoy, & Rosowsky, 2012; 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. Presently, there is accumulated evidence for the efficacy of several kinds of psychotherapeutic treatments of PDs up to 50 years of age 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. Probably, the diagnosis of the PDs was confounded by the comorbid depression. 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 treatment of PDs, as the main focus of therapy, in older adults. CBT has been proven efficacious for the treatment of depression and anxiety disorders (Gould, Coulson, & Howard, 2012a; 2012b; Laidlaw & Thompson, 2014; Pinquart, Duberstein, & Lyness, 2007; Scogin & Shah, 2012) in older adults. Furthermore, case studies and empirical reviews indicate that cognitive behavioral therapy (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, that was reported extensively earlier in this journal (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 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 (TFP; Clarkin, Yeomans, & Kernberg, 1999).

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. Moreover, as people with PDs age, as a consequence of their history of lifelong maladaptive coping, they have more trouble than older adults with a healthy coping repertoire, facing 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 among 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.

## STUDY AIMS

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, a 65-year-old woman, was referred by a psychiatrist due to a history of 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 SCID-II (First et al., 1997). Mrs. A had been treated for a melanoma 18 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, once told her she was an unwanted child. Her aunt's death activated the core cognitions "I am not worthwhile" and "I lose 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 core cognitions, 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 Van Alphen et al., 2012). She was motivated to overcome her current depression and to prevent the risk for 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 by changing its meaning, Mrs. A could develop a functional core belief. This experiential technique, called guided imagery and 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 so-called "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, were both avid tennis players. He was 70 years old, and she 65. 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 appraised 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 (First et al., 1997). 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 Van Alphen et al., 2012) at referral. Mr. B only asked for the opinion of the therapist regarding the relational conflict. The therapist assessed that willingness toward 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. 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 that were aimed at this goal. The therapist appealed to the expertise Mr. B had acquired during his work—which was sometimes difficult and critical—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 complimenting his wife and proposing activities that Mrs. B found enjoyable. Mrs. B stopped directly criticizing him. Instead of this, the couple learned a form of negotiation and giving feedback that 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, who was 74 years old, was referred by her GP because of suicidal behavior after the loss of her spouse 2 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 that 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 the 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 (First et al., 1997). 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 Van Alphen et al., 2012), 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, inpatient admission was not deemed appropriate, 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 overidealized 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 for Mrs. C.

#### DISCUSSION

The aim of this case study 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 1, the patient (Mrs. A) 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 50 (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 guided imagery and 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 care givers or nurses (LeBlanc, Raetz, & Feliciano, 2011), can be useful for older adults with PDs in care settings.

### Specific Psychotherapeutic Topics

These 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 and colleagues (2012). These aspects caused an exacerbation of the personality pathology in later life. In the case of Mrs. A, the melanoma and the loss of loved one led to a changing life perspective, and this reviewing her life activated a dysfunctional core belief. This exacerbated her avoidant PD. In Mr. 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 Mr. B, “a wife should stand by her man,” amplified his narcissistic idea that his wife should obey him. In the treatment of Mrs. 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 years of age. 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 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 ageing 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 ageing (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 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 patients 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 ageing 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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