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Short Communication

Getting Old and Character Maladies: A Second Look

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Introduction

Clinically, a personality malady is a mental health state that is characterized by persistent behaviors, thoughts, and feelings that are considered maladaptive, rigid, and inflexible. As is known, character ailments usually develop during the teenage years or early adulthood and may fluctuate in strictness over time depending on many parameters, like life experiences, coping skills, physical health, stress levels, and more [1]. In addition, the diagnosis of a character syndrome necessitates a persistent pattern of behavior and inner experience that stems distinctly from the outlooks of the person's culture, which is revealed in at least two of the following zones: interpersonal functioning, impulse control, affect, and cognition [1]. Considering that aged persons' characters may become less bendable in terms of how they behave and think, it looks that personality complaints are not rare among elders [2]. In this regard, a meta-analysis of eleven studies revealed an incidence of 10% of personality disorder in adults over 50 years of age, in comparison with 21% in the younger group [3]. But though some researchers believe that prevalence of personality disorders may rise with increasing age [4], other scholars consider that frequency of character syndrome declines with increasing age [5,6]. Essentially, in spite of the massive number of writings on health care of elder persons, character ailments in late life have been given slight attention. On the other hand, clinicians usually do not like to assign this diagnosis to elderly people due to the restricted amount of study of this topic [7].

Likewise, there is inadequate inquiry regarding character syndromes in seniors, which are mostly in the form of editorials, reviews, case reports, and comments due to a conjecture that some types of personality complaints may fade away over the lifecycle [8]. On the other hand, though character ailment diagnoses, which are seen in late life, usually consist of the histrionic, obsessive-compulsive, dependent, schizoid, avoidant, and paranoid types, some studies suggest that these diagnoses may remain unchanging over the lifecycle or may even increase [8]. It is interesting that according to some studies, personality disorders may take four different courses through life: 1) starting in early life and having a long duration; 2) the disorder no longer meets diagnostic standards in older age; 3) temporary remission of symptoms in mid-adulthood, which is followed by a re-emergence in old age; and 4) personality disorder may emerge in old age, which was not evident in early life [8]. Available research suggests that maybe parameters like imprisonment, accidents, which may result in shorter life expectancy, and poor coping mechanisms, which may result in dropping out of research projects, in addition to social, financial, and physical restrictions, may have a role in the expression of personality disorders in the elderly [9]; which may have led to an undervaluation of personality disorders in seniors [10]. In addition, in differential diagnosis of character problems, while it can be difficult to ascertain whether the clinical picture is a result of a primary personality disorder, a neurocognitive impairment, a medical condition or medication, or a difficult doctor-patient relationship, one should consider physiological effects of aging, environmental aspects, cultural roles, eccentricities, and situation-specific behaviors, as well [11].

Anyhow, as it may be deduced from the abovementioned studies and debates, a contradiction exists regarding the quantitative or qualitative changes of personality disorders among aged people. So, while it has been declared that personality disorders or traits, which usually appear during adolescence and the young period of life, may be vanished or modified after getting old, for instance with regard to borderline personality disorder, which constitutes a remarkable percentage of referred or hospitalized cases in mental health clinics or psychiatric wards, respectively, some scholars believe in an opposite process and have faith in the increment of primary character problems during old age. Nevertheless, the former optimistic faith may convince some apprentices that, at least if there is no clear-cut management for persons with personality disorders who, according to current classification systems, cause continuous or recurrent distress, based on their habitual and behavioral algorithms, for their relatives, colleagues, or communities, may improve naturally, due to getting old and advancement of personal experience or enrichment of social feedback, etc. But is such a supposition really credible when lots of therapeutic maneuvers, like simple, hybrid, and major psychotherapeutic techniques and available biological methods or psychotropic medications, usually fail to induce substantial improvement in the thought, psyche, and behavior of such a group of people or patients? On the other hand, as is evident, while the sturdiest antipsychotic preparations may break the toughest delusions, they may not influence the slenderest ideas, and the problem of persons with personality disorder lies in their stereotypical, distinct, and steady cognitive configuration, not episodic behavioral and/or cerebral oddity.

Similarly, while the earlier physiognomies may constitute a trait, which is typically constant and inflexible, the later features may constitute a state, which is characteristically unstable, flexible, and dependent on circumstances. Alternatively, while surroundings may have the most important role in orchestrating a state due to unavoidable reactions, feed-backs, or inferences, a trait is the outcome of reciprocal interplay between environment and genes. So, punishment, tutoring, and role-modeling, though they may impact, meaningfully, the said states, may not influence,

readily, the aforesaid traits, and may not, straightforwardly, correct or adjust their genetic expression. Unfortunately, in clinical psychiatry, differentiation between a state and a trait, which may be, phenotypically, very similar to each other, is not at all times stress-free; a phenomenon which is similar to difficulty regarding clear differentiation between idea, preoccupation, over-valued idea and delusion, between imagination, illusion, pseudo-hallucination, and hallucination, or between euthymia, hyperthymia, cyclothymia, and mania, or, likewise, between depressive personality trait, dysthymia, and depression. Consequently, the cross-sectional profile of signs or symptoms may not be analyzable without integration with their longitudinal course of development or chronological account. Therefore, while the said premise may be equally applicable to personality eccentricities, ignoring that may result in inferences that may not be generalizable or conclusive. No doubt, many psychiatrists have seen or visited a lot of seniors with different personality disorders or traits, which could be, clinically, diagnosable, or, socially, problematic for themselves, their families, or other people around them, who are obliged to deal with lots of daily and unescapable stresses or struggles.

Then, it seems that mitigation of cognitive or behavioral presentations of previously fixed traits in aged people with personality disorder may be the result of dissolution of a series of states, not real traits, in a person who could be diagnosed more fittingly after sufficient chronological investigation, or loosening of pathoplastic linkage (the influence of personality and psychopathology on the presentation, appearance, or expression of one another) [12], or removal of substances or preparations with psychoactive properties, or control of addiction in patients with comorbid psychiatric complications, or, finally, management of medical illnesses that may induce behavioral changes. Anyhow, though the said amendments may not be applicable easily in aged people with personality disorders, which may, on the other hand, pave the way for further physical or psychological complications, their timely diagnosis may reduce, at least, the risk of overestimation of complaints, which may be expressed melodramatically, due to the existence, for example, of histrionic or narcissistic traits or odd anticipations of antisocial or paranoid seniors. On the other hand, while some scholars believe that the major mitigation may occur in eviler characters, like borderline personality disorder, deep-rooted and dynamic glitches, like impaired object constancy and awkward self-image, and unconscious defense mechanisms, like projective identification, do not seem to be, naturally, improvable.

Undoubtedly, biological changes of aging may restrict the frequency or intensity of morbid conduct by means of an unavoidable alteration in energy and stamina during the elderly period, though it may not be accounted for as a shatterproof occurrence, and many intervening parameters, like monetary and social position, may be involved in the final outcome. Also, personality disorders with more cognitive elements, like paranoid, schizoid, and schizotypal traits, in comparison with emotional elements in borderline, hysterical, or narcissistic traits, seem to be more enduring and resistant because they rely less on physical exhibitions than perceptive stances. Characters of cluster C, as well, like avoidant, dependent, and obsessive-compulsive traits, seem to be more similar to cluster A characters, though they have more anxious elements than other clusters, which may be increased even more than younger periods due to increased physical debilities or social complications. Anyhow, it may not be surprising that ego-syntonic charisma of personality traits and their underlying dynamic grounds have made them impervious against customary therapeutic maneuvers, others' reproaches, social encounters, and legal intimidations. Moreover, though some qualities, like antisocial, negativism, or sadistic traits, may become less noticeable after, for example, retirement, imprisonment, or forced social withdrawal, their craving or temptation seems to be everlasting and indestructible, like desire to psychoactive substances in substance-related and addictive disorders or pathological gambling in gambling disorders. Besides, by the same token, spontaneous disappearance of innate or configured temperament and traits due to aging seems to be as questionable as the primary formation of them during the elderly.

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