Is It Personal Autonomy or a Personality Disorder?

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In today’s environment of mental health issues, protecting the rights of the elderly becomes even more challenging. Understanding the role of medical and psychiatric evaluations—and critical review of the quality of such reports—is crucial to providing adequate safeguards for clients.

By Steven C. Fox

(1891) No right is held more sacred or is more carefully guarded by common law than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.

(1999) A national crisis in geriatric mental health care is emerging. The current research infrastructure, health care financing, pool of mental health care personnel with appropriate geriatric training and mental health care delivery systems are extremely inadequate to meet the challenges posed by the expected increase in the number of elderly persons with mental illnesses.

The right to make personal decisions and carry on the ordinary business of life free from interference or restraint is fundamental. This right remained unchanged and unchallenged throughout the twentieth century and still stands firm today. What changed in the twentieth century was the development of psychiatry as a field of medicine. Concurrent was the increasing human life span as a by-product of modern medicine, specifically, the unprecedented growth of the elder population, spawning the fields of geriatrics and elder law. Both fields of practice are facing a serious challenge in serving their respective and mutual clients. Consider the following study results:

- Less than twenty-five percent of older persons with moderate to severe dementia were actually identified by their primary physician as having the disease.
- Three-quarters of physicians (surveyed) felt that depression was “understandable” in

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older adults and therefore did not warrant treatment.\textsuperscript{4}

- Fifty-five percent of the internists felt confident in diagnosing depression but only thirty-five percent felt they would actually prescribe antidepressants for their older patients.\textsuperscript{5}
- Older adults who require long-term or intensive mental health care will not fare well in the era of managed care.\textsuperscript{6}

The foremost challenge to and responsibility of geriatricians is the preservation of a patient’s cognitive and functional ability. Further, the principal of clinical practice is that a physician’s diagnosis of physical and mental illness will identify the cause of cognitive and functional impairment. The physician’s knowledge of the patient as a person, and the patient’s decision-making capacity and prognosis will assist the attorney in preserving the autonomy of the client/patient and protect the client/patient from harm, undue influence, or exploitation. In the process of assessing a client/patient’s decision-making capacity and autonomy, there are four common pitfalls:

1. Underestimating the patient’s ability, that is, “age equals disability”;
2. Relying solely on a diagnosis;
3. Lack of independent assessment, that is, relying only on past records or hearsay reports; and
4. Failure to consider the patient’s life history—adaptive behaviors, social skills, values, beliefs, personality traits and characteristics, and past psychiatric history.

In reality, a significant number of assessments conducted as part of probate or involuntary mental health treatment proceedings have relied solely on one of these four pitfalls, thereby compromising the merit and usefulness of the subsequent reports. When the legal representation, adjudication, or surrogate decision-making is based upon such reports, there is an increased risk for adverse outcomes in the older patient. For example, ageist nihilism or paternalism often creates excess disability, depression, and social withdrawal in an older patient. Reports created with a reliance on a single examination, a mental status score, or a diagnosis of “senility” or “organic brain syndrome” should be viewed as suspect and their validity challenged. Conversely, the absence of a diagnosis of a mental illness or a dementia for a patient who otherwise scores well on a mental status examination and presents well, creates an equally strong risk for adverse outcomes such as self-neglect, exploitation, and undue influence.

To avoid these problems and develop standards by which to measure the quality of a physician’s report, the prudent geriatrician will incorporate the patient’s life history, adaptive behaviors, social skills, values, beliefs, personality traits and characteristics, and past psychiatric history into the comprehensive assessment.

A patient’s personality is the core element of any assessment. Personality is defined by the traits that are the binding characteristics of an individual, but are also shared by all individuals, for example, emotions, confidence, generosity, charisma and their opposites, anxiousness, dependence, parsimoniousness, and detachment. A benchmark in assessing personality is constancy in the person—that current decision making is consistent with the processes and abilities used in the past—that there is a life-long pattern of behavior. Personality characteristics are remarkably stable well into advanced age (eighty-five or older).\textsuperscript{7} If a behavior is new, it is likely due to a superimposed medical condition. Late in life changes in personality mandate a careful assessment for structural brain diseases, such as Alzheimer’s and Parkinson’s; systemic illnesses, such as hypothyroidism; or, an acute, reversible condition, such as delirium. One must also assess for overwhelming life-changing circumstances, such as the death of a spouse or child or a diagnosis of malignancy.

Personality disorders are distinguished from recent changes in personality by the persistence and exaggeration of those personality traits resulting in difficulties in personal relationships, impulse control, and impaired social and occupational functioning. There is a persistent lack of insight, a failure in the ability to comply with treatment and management regimes, and difficulty in establishing trust. Such individuals are resistive and blaming and generally cause great upset and distress in the people around them, but they cannot see the role their own behavior plays. At first blush, it may appear that virtually everybody fits this definition. In fact approximately twenty percent of the population may have a personality disorder—a well-established mental health disorder. Frequently there is misdiagnosis in such
individuals; they produce serious debilitating behavior and emotional and social problems. Suicide, substance abuse, criminality, and self-neglect often can be traced to a personality disorder.

In the older population, individuals with personality disorder often go undiagnosed due to ageism or because the physician is treating symptoms rather than restoring function. For example, a young person who exhibits self-destructive behavior, such as reckless driving, may be the older person who defiantly smokes while oxygen is being used in the room. The personality disorders that are most likely to persist into late life are the schizotypal and obsessive-compulsive disorders. It must be pointed out that obsessive-compulsive personality disorder is distinct from the more commonly referenced "OCD," which is an anxiety disease process.

Schizotypal personality disorder is distinguished by the person's oddness and eccentricity. They are uncomfortable in social situations; they may display emotions that are inappropriate to the circumstance; and they are overly suspicious. Often such individuals are subject to self-neglect, avoid health care and social assistance, and may display a great degree of religiosity. It is likely that these individuals will have a past psychiatric treatment history that must be reviewed. They are likely to have a very poor outcome if forced into highly social situations, such as a group care home, or subjected to rigid plans of care and treatment.

Obsessive-compulsive personality disorder is distinguished by the person's rigidity, lack of emotion, and focus on details and personal rules in which they insist that others do things "their way." They are very controlling, but recoil at any placement of controls on their behaviors. They are often indecisive and stingy, and they often appear to be very cognitively intact. They are miserly, hoarders and pack-rats, unable to differentiate the act of accumulating from the usefulness of the objects or money. They become irrational when confronted with any change in their environment, for example, getting rid of the accumulated materials or taking over the control of assets. A poor outcome is likely if there is a failure to establish an acceptable level of risk within their environment such as pathways for ambulating and proper food storage.

In all such cases, the aspects of autonomy coupled with the preservation of cognitive and functional ability must be weighed against the need to protect individuals from harm. Misdiagnosis and over-medication have often caused more harm than permitting such individuals to exist in their own worlds with adaptive measures implemented to protect them. Recognizing the diagnosis and implementing interventions that are adapted to their circumstances and environment can help establish an alliance with patients, thereby maximizing their autonomy. As they become more infirm or disabled, there is a greater likelihood that subsequent interventions will be acceptable and beneficial to the individual. A physician's report that incorporates this model is one that will be most valuable to the patient, to the attorney, and to the potential surrogate decision maker.

Endnotes