

## LETTERS

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### Schema therapy with older adults: call for evidence

Although there is a considerable body of evidence supporting the efficacy of psychotherapy for personality disorders (PD), as yet, effect studies focusing on treatment of PD in older adults are lacking. In a literature search (1980–2011) with Pubmed Medline and PsycINFO with the terms “personality disorders,” “psychotherapy,” “treatment,” “elderly,” and “older adults,” it appeared that no randomized and controlled effect studies have been conducted on the treatment of PD in later life. Just one study examined the efficacy of dialectical behavior therapy (DBT) in a small randomized clinical trial among older people with comorbid depression and PD ( $N = 35$ ; Lynch *et al.*, 2007). However, it is surprising that the number of PD in remission (in total 16 out of 35) was almost the same with medication treatment alone ( $n = 7$ ) compared to combined treatment of medication and DBT ( $n = 9$ ). Moreover, this study was not exclusively focused on the treatment of PD.

A recent Delphi-study has led to the consensus among Dutch and Belgian experts that existing therapies for PD in younger adults are applicable with older cohorts, such as schema therapy (van Alphen *et al.*, 2012). However, it is recommended that age-specific aspects are integrated.

#### Age-specific therapeutic aspects

The efficacy of schema therapy for older adults can probably be improved by integrating several gerontologic aspects into the treatment protocol. First, the changing life perspective can cause an actualization of dysfunctional schemata as one is reviewing one’s life; the process of life review can lead to evaluating certain aspects of one’s own life (extremely) negatively.

A second gerontologic aspect is formed by the beliefs about – and consequences of – somatic ailments. For example, the core belief of an older dependent woman that she “would not make it on her own” can be actualized by macular degeneration; the prospect of waning eyesight causes her to see the future as threatening. A disturbing consequence of a somatic ailment is when a narcissistic older man becomes immobile because of peripheral vascular disease, which causes him to give up his appraisal-generating role as president of a senior organization.

Third, cohort beliefs and the sociocultural context can be integrated into schema therapy of PD. Cohort beliefs are beliefs held by groups of people born in similar time periods, which tend to have a significant impact on the therapeutic alliance, especially as they combine with dysfunctional core beliefs. The sociocultural context refers to peoples’ attitudes to their own aging and can include internalized negative stereotypes about growing old.

A fourth important gerontologic aspect to be considered in therapy is change in role investment. This concerns the extent to which an older adult remains involved in personally meaningful activities and interests. Especially, elderly with PD are less able to adapt to new roles.

Finally, intergenerational linkages, in interaction with dysfunctional cohort beliefs, can cause tensions in intergenerational relationships. Older adults consider continuity and the transmission of values to younger generations as important, whereas younger adults view independency and autonomy as more important. This can cause disagreement between older parents and their children on, for instance, notions of caregiving.

Possibly, integrating worth-enhancing beliefs (James, 2008), which have been suggested to provide useful gerontologic targets in the treatment of depression and anxiety, may also have a positive effect on the treatment of PD in the elderly with schema therapy.

#### Call for evidence

As evidence on treatment of PD in later life is lacking, we recommend conducting explorative research with a series of case studies in which schema therapy is applied to older adults with a PD. This can shed light on relevant age-specific aspects that can be used to adapt schema therapy to a treatment protocol that is molded for older cohorts. A study could focus on cluster C PD to account for the increasing inter-individual variability and multiple morbidity as people age, as this cluster is the most stable across the life span. Furthermore, it is possible to conduct a meta-analysis with a number of studies, which have been conducted in a similar way, using a multiple baseline case series design (Ferron and Scott, 2005). Because the inter-individual variance in this design is smaller, the same power can be reached with this type of research. Such a design yields findings especially pertinent on how therapeutic change unfolds individually (Borckardt *et al.*, 2008). In addition, a semi-structured interview is applied to

participants to explore possible modifications for older adults. This adapted treatment protocol can then be studied for its efficacy with older adults in a randomized controlled trial.

We are aiming to start a study on schema therapy for older adults with PD using the case series design in 2011 in Breburg Hospital, Tilburg, and Mondriaan Hospital, Heerlen, both in the Netherlands. This study investigates the efficacy of schema therapy in older adults and also explores qualitatively which relevant age-specific aspects can be used to adapt schema therapy to a treatment protocol that is molded for older cohorts. This is a unique study in that it aims to answer the need for evidence of treatment of PD in older adults.

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## Screening of autism spectrum disorders in the elderly: a contribution to a psychometric approach

Autism spectrum disorders (ASDs) in older adults have been neglected for a long time. As far as we know only five papers have been published. No empirical research in this area was found. Four papers were case studies of men diagnosed with an ASD (James *et al.*, 2006; Naidu *et al.*, 2006; van Alphen and Heijnen-Kohl, 2009; van Niekerk *et al.*, 2011), and the fifth one was an opinion paper concerning the diagnosis of ASD in the elderly and the difficulties arising in this (Heijnen-Kohl and van Alphen, 2009).

Nevertheless, all publications emphasize the importance of the detection of ASD to reduce patient burden and improve care delivery. Children, adolescents, and adults suffering from ASD benefit, for example, from psycho-education and a more structured day and week program (Volkmar *et al.*, 2000). Furthermore, the diagnosis of an ASD probably also directs the referrals and requirements for the most optimal living arrangements. Empirical evidence concerning older adults is thus urgently needed.

Diagnosing ASD in later life is complicated for several reasons. First, the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV) criteria for ASD (American Psychiatric Association, 2000) are developed for children without any information given on age-sensitive interpretations. Second, criteria focusing on the earliest years of life cannot be applied reliably. Informants have usually passed away and the patient's memories about their youth may not be accurate (van Alphen and Heijnen-Kohl, 2009). Third, there are no specific measures for ASD that are suitable for older people. The existing assessment is developed for diagnosing ASD in children, and therefore substantial items refer to early childhood (van Niekerk *et al.*, 2011). Fourth, diagnosing ASD in general is difficult because the actual assessment relies mainly on self-report, and it has been confirmed that individuals suffering from an ASD can have a distorted view about their own functioning and behavior (van Niekerk *et al.*, 2011).

In their case-series, van Niekerk and colleagues (2011) stress the importance of informant-based information for diagnosing ASD. If true, diagnosing ASD in older adults may significantly improve if informant-based information can be gathered in more reliable way. For this reason we initiated the research project to detect ASD in later life by structured informant information based on