Do older adults presenting with “late-onset” personality disorders (PD) have experiences consistent with PD prior to their first contact with services?

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Chapter 1

Schema Therapy for Older Adults with Personality Disorders: A Systematic Review and Meta-Analysis of Emerging Evidence

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Abstract

Objective

Personality disorders in later life are increasingly recognised as persistent and clinically significant; however, psychological interventions specifically adapted for older adults remain limited. Schema therapy has shown emerging promise for this population, however the empirical evidence base remains under-synthesised. This systematic review and meta-analysis aimed to synthesise available research examining treatment outcomes and methodological quality of schema therapy in older adults with personality disorder.

Methods

Following PRISMA guidelines, systematic searches were conducted across PsycINFO, Psychology and Behavioural Science Collection and MEDLINE from database inception to 19 October 2025, and supplemented by forward and backward citation searching. Records were screened against predefined eligibility criteria for studies assessing the effects of schema therapy for older adults with personality disorder. A total of 138 records were identified, of which nine met eligibility criteria. Methodological quality was appraised using the JBI Checklist for Quasi-Experimental Studies. Meta-analyses were conducted on seven studies. Given most studies employed uncontrolled and single-arm study designs, meta-analyses synthesised within-group pre-post effects using random-effects models.

Results

Across studies, schema therapy was associated with consistent within-group improvements in schema severity and psychological symptom severity. Quantitative synthesis of within-group effects indicated a small-to-moderate improvement in schema outcomes (Hedges' g = 0.34) with low heterogeneity (I^2 = 0%), and a moderate improvement in symptom severity (g = 0.54) with low heterogeneity (I^2 = 22%).

Conclusion

Schema therapy was associated with promising improvements in schema severity and psychological symptoms among older adults with personality disorder; however,

limited sample sizes and the scarcity of randomised controlled trials restrict the strength of conclusions. Further high-quality, large-scale research is required to strengthen the evidence base for this under-represented clinical population.

Keywords: systematic review, meta-analysis, older adults, personality disorder, schema therapy

Introduction

Personality disorders (PD) are characterised by enduring patterns of emotion dysregulation, interpersonal difficulties and impaired functioning, often resulting in complex mental health and social care needs across the lifespan. Psychological intervention is recommended as the primary treatment for PD, particularly borderline personality disorder (Simonsen et al., 2019). Psychological therapies, such as dialectical behaviour therapy, mentalisation-based therapy, and schema therapy, have shown substantial progress in demonstrating a reduction in distress and improved interpersonal, social, and occupational functioning (Storebo et al., 2020). In older adulthood (aged 60 and above), the presentation and impact of PD may shift in intensity and expression due to age-related biological, psychological, and social changes, with potential consequences for distress, functional decline and service use (van Alphen et al., 2015). Despite this, psychological interventions specifically adapted for older adults with PD remain limited (van Alphen et al., 2015).

Experts in the treatment of PD in older adults reached a consensus that evidence-based interventions for younger adults—such as schema therapy for those under 50—are equally applicable to individuals over 60 (van Alphen et al., 2012; Rosowsky et al., 2018). Schema therapy (Young, 1990) is an integrative model targeting entrenched maladaptive patterns through cognitive, experiential and interpersonal techniques. Schema therapy has shown to be effective in the younger adult population (Giesen-Bloo et al., 2006; van Dijk et al., 2023), and holds potential for addressing other complex disorders, such as post-traumatic stress disorder, depression and obsessive-compulsive disorder (Cockram et al., 2010; Malogiannis et al., 2014; Thiel et al., 2016).

To date, there has not been a systematic review focusing on the effectiveness of schema therapy in the older adult population. In a review of 8 randomised controlled trials (RCTs) evaluating the efficacy of schema therapy in the general adult population, Zhang et al. (2023) found that schema therapy was an effective treatment for PD, producing a moderate effect size in reducing PD symptoms, and a moderate improvement in quality of life. Notably, group-based schema therapy demonstrated larger effects than individual formats, although results varied across PD types.

Indeed, there is emerging evidence supporting the effectiveness of schema therapy in older adults (Videler et al., 2014, 2018, 2021). In particular, studies suggest that schema therapy can be feasibly adapted for later life, incorporating modifications such as a slower therapeutic pace, greater emphasis on positive schemas and sensitivity to age-related experiences of loss, autonomy and identity (Videler et al., 2018). A multiple-baseline study of schema therapy in older adults with personality disorder reported large reductions in early maladaptive schemas and psychological distress, with seven of eight participants no longer meeting diagnostic criteria at post-treatment (Videler et al., 2018). More recently, the first randomised controlled trial demonstrated that group schema therapy combined with psychomotor therapy significantly reduced psychological distress in adults aged 60 years and older compared with treatment as usual, with a moderate effect size (Cohen's d = 0.42) at six months (Veenstra-Spruit et al., 2024). Despite this, an initial appraisal of the literature indicates that the evidence base is small and methodologically heterogeneous, with much of the available evidence derived from non-randomised and single-arm study designs.

Rationale

PDs in older adults are a significant yet often under-recognised mental health concern, with clinical presentations shaped by age-related psychological, cognitive and social changes. Emerging literature suggests that PD presentations in later life may be heterogeneous, encompassing chronic, re-emergent and late-onset variants (Rosowsky et al., 2019; D'Agostino et al., 2022). In addition, relational and contextual factors may influence the expression of personality pathology over time. For example, Bangash (2019) highlights how significant others may buffer, bolster, or bind maladaptive patterns, potentially contributing to periods of relative stability across adulthood.

Alongside this, there is increasing recognition that traditional diagnostic frameworks may not fully capture the developmental and contextual complexity of PDs in later life. Recent clinical staging models have been proposed to integrate severity of personality dysfunction with life-course trajectories, offering a more developmentally informed approach to assessment and treatment planning (Hutsebaut et al., 2019; Conjaerts et al., 2025).

Despite these advances, older adults with PDs remain underrepresented in research and treatment development. Given the complexity of PD presentations in later life, and the potential for both longstanding and later-life manifestations of difficulty, it is important to evaluate whether Schema Therapy is feasible, acceptable and effective for this population. The present review aims to address this gap by systematically evaluating and synthesising the available research on schema therapy for older adults with PD across study designs, with particular attention to treatment outcomes and methodological quality.

Objectives

This systematic review and meta-analyses aimed to:

i. Identify and synthesise all available empirical research trials reporting outcomes associated with schema therapy for older adults with a personality disorder.
ii. Quantitatively synthesise changes in early maladaptive schemas and general psychological symptom severity following schema therapy in older adults with personality disorders.
iii. Narratively synthesise evidence relating to changes in personality disorder diagnostic status following schema therapy in later life, where reported.
iv. Critically appraise the methodological quality of included studies to inform interpretation of findings and identify priorities for future research.

Methods

Search Strategy

This systematic review was conducted in accordance with the Preferred Reported items for Systematic Reviews and Meta-Analyses updated guidelines (PRISMA; Page et al., 2021; Appendix 1.1). A protocol for this review is registered on Prospero: https://www.crd.york.ac.uk/PROSPERO/view/CRD420251155425.

A systematic search was carried out on the 19 October 2025. The electronic databases PsycINFO and Psychology and Behavioural Science Collection were accessed using EBSCOhost, and MEDLINE accessed using OVID. These databases were selected to ensure coverage across psychological, behavioural and broader mental health literature relevant to schema therapy and personality disorder in older adults.

Inclusion criteria were selected to ensure alignment with the review aim of evaluating schema therapy for older adults with PD. Given the emerging nature of the evidence base, a broad range of study designs were included to capture all available empirical data, such as randomised controlled trials (RCTs), feasibility studies, multiple baselines studies and single-case experimental designs.

Inclusion Criteria

All studies were screened based on the following criteria:

Table 1 Eligibility criteria for study selection

Inclusion Criteria	Exclusion Criteria
▪ Studies recruiting people over the age of 65 with a diagnosis of personality disorder, as defined by standard operational criteria ▪ Studies that directly assess the effects of schema therapy (no limits to intervention style e.g. 1:1, group, online), and/or reporting on adaptions to schema therapy in older adults ▪ Studies primarily or secondarily investigating clinical outcomes, including changes in schema severity, psychological distress and or/PD remission status	▪ Schema therapy is not the primary intervention ▪ No empirical data relating to clinical outcomes, feasibility or intervention delivery ▪ Studies not in English

A search strategy was developed using the eligibility criteria, and related keywords were identified from an initial scoping search. The specificity and sensitivity of the search strategy was altered where necessary through a scoping review of results and ensuring the key papers were captured. The final search terms are outlined in Appendix 1.2: Search Terms.

Search Process

Search results were exported to Mendeley Reference Manager and de-duplication was completed. Titles and abstracts were screened by the first author (CB) and those that did not satisfy the eligibility criteria were eliminated. A second reviewer (DA) independently screened 20% of the papers (n= 32) and there was a 100% agreement, indicating good inter-rater reliability. At this stage, the full texts of studies were read in full and screened against the eligibility criteria.

Data Collection and Extraction Process

The eligible studies were included within the review and data extracted using a standardised data extraction template on Microsoft excel. The data extraction table captured key study characteristics: author(s) and year of publication, country, design, schema therapy format, sample size, diagnosis, primary aim/objectives and key outcome measures used.

Quality Assessment and Risk of Bias

Methodological quality was assessed using the JBI Critical Appraisal Checklist for Quasi-Experimental Studies (Joanna Briggs Institute, 2020), following guidance from Barker et al (2024) on application and interpretation. The checklist evaluates design quality and potential sources of bias, including whether the intervention and outcomes are clearly defined, comparability of groups where relevant, consistency of treatment exposure, adequacy and reliability of outcome measurement, completeness of follow-up and appropriateness of statistical analysis. This tool was selected due to its suitability for evaluating quasi-experimental and non-randomised designs, providing a structured framework for assessing internal validity across heterogeneous methodologies while allowing flexibility where comparator groups were absent.

Reviewers CB and DA independently appraised methodological quality. Each criterion was rated as Yes, No, Unclear, or Not applicable, with brief justifications recorded. Reviewers demonstrated 96% agreement, with minor discrepancies – primarily relating to distinctions between “Unclear” and “Not applicable” – resolved through discussion until consensus was reached. Studies meeting the eligibility criteria were retained irrespective of quality rating, in light of reviewing the emerging evidence base. A formal reliability coefficient was not calculated; therefore, agreement estimates should be interpreted cautiously.

Synthesis Methods

To address the multifaceted nature of the research aims, a comprehensive framework for data synthesis was adopted. Data pulled from eligible studies were categorised into qualitative or quantitative outcomes, the former being outlined in a narrative synthesis, and the latter presented within the findings of the meta-analysis.

Narrative Synthesis

Where quantitative pooling was not possible, findings were synthesised narratively in accordance with established guidance for narrative synthesis in systematic reviews (Popay et al., 2006). Studies were grouped according to outcome domain (e.g., schema severity, symptom severity and diagnostic status), and findings were summarised across studies with attention to direction and consistency of effects.

Patterns were examined in relation to study design, intervention characteristics and methodological quality, allowing integration of heterogeneous evidence.

Meta-Analysis

Studies were eligible for inclusion in the meta-analysis if they provided sufficient data e.g. mean, SD, sample size. Where standard error scores were not provided, the primary researcher calculated scores independently. Analysis was performed using SPSS through initially computing and pooling effect sizes. In view of heterogeneity among studies, a random effect model was used. For outcome measures, effect size and standard error were used to determine within-group pre-post comparisons. Hedges' g was chosen as it adjusts for biases caused by small sample sizes (Cuijpers, 2016). Where studies provided multiple outcome measures targeting a similar construct (e.g. YSQ and SMI), the measure with the most consistent use across studies was selected.

Assessment of Heterogeneity

Statistical heterogeneity was examined using Cochran's Q, τ^2 and the I^2 statistic (Higgins et al., 2003). Cochran's Q assesses whether observed variation in effect sizes across studies is greater than would be expected by chance alone, with a significant Q statistic suggesting variability in effects across studies. The I^2 statistic estimates the percentage of total variability attributable to between-study heterogeneity rather than sampling error, with values of 0%, 25%, 50% and 75% typically interpreted as indicating no, low, moderate and high heterogeneity, respectively (Higgins et al., 2003). As random-effects models were used, τ^2 was also reported as an estimate of between-study variance.

Publication Bias

Publication bias occurs when studies with non-significant or unfavourable results are less likely to be published, which can inflate pooled effect estimates (Borenstein et al., 2009). Formal assessment of publication bias using funnel plots and Egger's regression test is generally not recommended when meta-analyses include a smaller number of studies, as these methods have limited power and may produce unreliable or misleading results (Sterne, et al., 2011). As formal assessment was not appropriate,

potential bias was explored through visual inspection of forest plots, examining the distribution and consistency of effect sizes, and the presence of outliers.

Sensitivity Analysis

Sensitivity analyses were conducted to evaluate the robustness of the pooled effects. In particular, where visual inspection of the forest plot suggested a potentially influential outlying effect, analyses were repeated with the influential study removed to determine whether conclusions were sensitive to its inclusion (Higgins et al., 2023). This approach allowed the stability of the overall symptom severity estimate to be examined when excluding a study that differed methodologically from others included in the synthesis.

Results

Study Selection

The study selection process is summarised in the PRISMA flow diagram (Figure 1). Database searches identified 135 records, of which five were duplicates and removed. Titles and abstracts of the remaining 130 records were screened against the eligibility criteria, resulting in the exclusion of 121 records. Nine studies met the inclusion criteria following full-text screening and were included in the review. These studies were taken forward to descriptive, narrative, and quantitative synthesis as appropriate.

Study Characteristics

The characteristics of the nine included studies are presented in Table 2. Studies were published between 2014 and 2025 and were all conducted in the Netherlands. Designs included feasibility studies (n = 4), multiple-baseline designs (n = 3), a mixed-methods or single-case study (n = 1) and one randomised controlled trial (n = 1). Schema therapy was delivered in both individual and group formats, including adapted group-based interventions and combinations with psychomotor therapy. Sample sizes ranged from 1 to 51 participants; for the randomised controlled trial, only participants allocated to the schema therapy condition were included in the present analyses**.** Mean ages were typically in the mid-to-late 60s. Most studies focused on Cluster C personality disorders, although several included mixed Cluster B and C presentations. Early maladaptive schemas were most commonly assessed using the Young Schema Questionnaire (YSQ or YSQ-L2), while general psychological distress was typically measured using the Brief Symptom Inventory (BSI) or Symptom Checklist (SCL-90). One study (van Dijk et al., 2020) examined the rapid adaptation of schema therapy to an online format during the COVID-19 pandemic, providing preliminary insights into feasibility and acceptability in older adults; however, as no empirical outcome data were reported, it was not included in the quantitative or outcome-focused narrative synthesis.

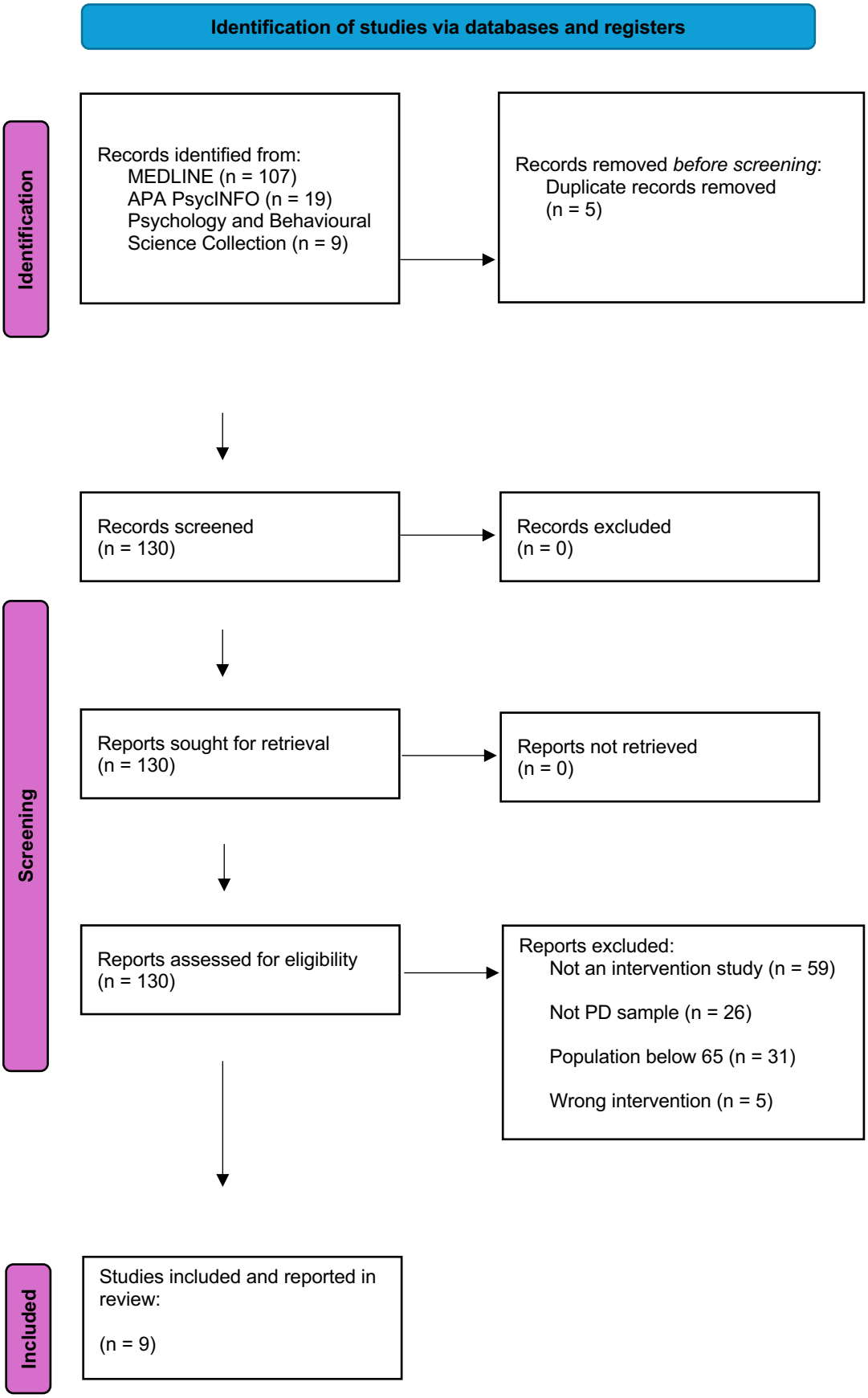

Figure 1: PRISMA 2020 flow diagram for new systematic reviews which included searches of databases, registers, reference searches and forward citation searches

Table 2: Characteristics of included studies

Study Citation	Country	Design	ST format	Sample size	PD diagnoses	Aim/Purpose	Age, years (M SD] or range)	PD Measure	Schema Measure	Symptom Measure
Videler et al. (2014)	Netherlands	Feasibility study	SCBT-g	31	Cluster C	Feasibility and preliminary effectiveness of ST in PD	67 (range 60-78)	SCID-II	YSQ	BSI
Videler et al. (2017)	Netherlands	Single-case design	Individual ST	1	Cluster C	Single-case evaluation of adapted individual ST	65 (single case)	SCID-II	YSQ	SCL-90
Videler et al. (2018)	Netherlands	Multiple baseline design	Individual ST	8	Cluster C	Effectiveness of ST	69.3 (SD 3.8)	SCID-II	YSQ	SCL-90
Van Dijk et al. (2020)	Netherlands	Feasibility study	Online gST	4	Cluster C	Feasibility and acceptability of online gST	Range (64 - 70)	Patient and therapist experience	YSQ (not reported)	SMI (not reported)
Videler et al. (2021)	Netherlands	Feasibility study	Adapted brief gST	29	Mixed Cluster B and C	Outcomes of adapted gST in PD	66 (range 58-70)	SCID-II	YSQ	BSI
Van Dijk et al. (2022)	Netherlands	Feasibility study	gST combined with psychomotor therapy	19	Mixed Cluster B and C	Impact of ST on schema modes and psychological distress	65 (range 60-70)	SCID-II	YSQ-L2	MANSA (not meta-analysed)
Kasho et al. (2023)	Netherlands	Multiple-baseline design	Individual ST	5	Cluster B	Feasibility and preliminary outcomes of positive schema interventions within ST	64.6 (SD 3.6)	SCID-5-P	YSQ	BSI
Veenstraspruit et al. (2024)	Netherlands	Randomised controlled trial	gST combined with psychomotor therapy	51 (ST arm only)	Mixed Cluster B and C	Comparison of gST + PMT versus TAU	69 (IQR 63 – 71)	SCID-5-P	YSQ (not extractable)	BSI
Van Donzel et al. (2025)	Netherlands	Multiple-baseline design	Individual ST	10	Cluster C	Effects of integrating positive schema interventions into ST	65.3 (range 62-71)	SCID-5-P	YSQ	BSI

Notes. SCBT-g = short-term group schema cognitive behavioural therapy; ST = schema therapy; gST = group schema therapy; PMT = psychomotor therapy; TAU = treatment as usual. Cluster C = avoidant, dependent, and obsessive–compulsive personality disorders; Cluster B = borderline personality disorder. For the randomised controlled trial (Veenstra-Spruit et al., 2024), only participants allocated to the ST condition were included in quantitative analyses. Only outcomes relevant to schema severity and general symptom severity were included in meta-analyses; diagnostic outcomes were synthesised narratively. For studies marked as not reported, outcome measures were administered but quantitative results were not reported in a form suitable for extraction and inclusion in meta-analyses. Outcome measures that were reported in a single study only (e.g. MANSA) were not included in meta-analyses due to lack of comparable data. Not extractable indicates that outcomes were assessed but quantitative data were not available for meta-analysis.

Quality Appraisal

Methodological quality was assessed using the JBI Critical Appraisal Checklist for Quasi-Experimental Studies and was rated as moderate overall. Across studies, interventions and outcome measures were generally well defined (Q1), with most studies employing repeated pre–post assessments (Q5) and validated outcome measures (Q6–Q7). Statistical analyses were typically appropriate to study design, with studies using methods such as mixed-effects models for repeated measures and analytical approaches suited to multiple-baseline designs, supporting a “Yes” rating for statistical analysis (Q9) in most effectiveness-focused studies.

Common methodological limitations were largely design-related. The inclusion of non-randomised and single-case designs reflects the early stage of research in this area; however, it limits the strength of causal inference. The majority of studies did not include a comparator group (Q2), and items relating to between-group comparability (Q3) were therefore not applicable to single-group and single-case designs. Control of concurrent care was variable (Q4), particularly where treatment-as-usual or medication changes could not be standardised. Follow-up was generally reported transparently (Q8), although attrition and missing data were relevant in several studies. These quality considerations informed interpretation of pooled effects as within-group changes rather than causal treatment effects**.** A visual summary of individual study quality ratings is presented in Figure 2.

Note * indicates studies not included in the meta-analysis. Reasons for exclusion; no quantitative data

Figure 2: Visual overview of methodological quality using the JBI Critical Appraisal Checklist for Quasi-Experimental Studies

Results of Synthesis

For a subset of these studies, a meta-analysis was conducted. A total of 7 studies were included in the meta-analysis, with a total of 153 participants. To examine the effects of schema therapy in accordance with aims, two random-effects meta-analyses were conducted, with six papers respectively for each analysis: one examining changes in schema (k = 6) as the outcome, and the other with changes in symptoms (k = 6) as the outcome.

Measures assessing the same underlying constructs were combined for meta-analysis. Schema outcomes were pooled across studies using the Young Schema Questionnaire (YSQ) and YSQ–Long Form (YSQ-L2), while general symptom severity

outcomes were pooled across studies using the Brief Symptom Inventory (BSI) and Symptom Checklist (SCL-90).

Schema Meta-analysis

A random-effects meta-analysis was conducted to examine within-group pre–post change in schema severity following schema therapy, using outcomes measured by the YSQ and the YSQ-L2. Across the six included studies, schema therapy was associated with a statistically significant improvement in schema severity (Hedges g = 0.34, SE = 0.10, 95% CI [0.14, 0.54], p < .001), representing a small-to-moderate effect. Heterogeneity was negligible (I^2 = 0%, τ^2 = 0.00; H^2 = 1.00), indicating highly consistent effect sizes across studies and suggesting that observed variability was likely due to sampling error rather than meaningful between-study differences. A forest plot of study-level effects and the overall pooled estimate is presented in Figure 3.

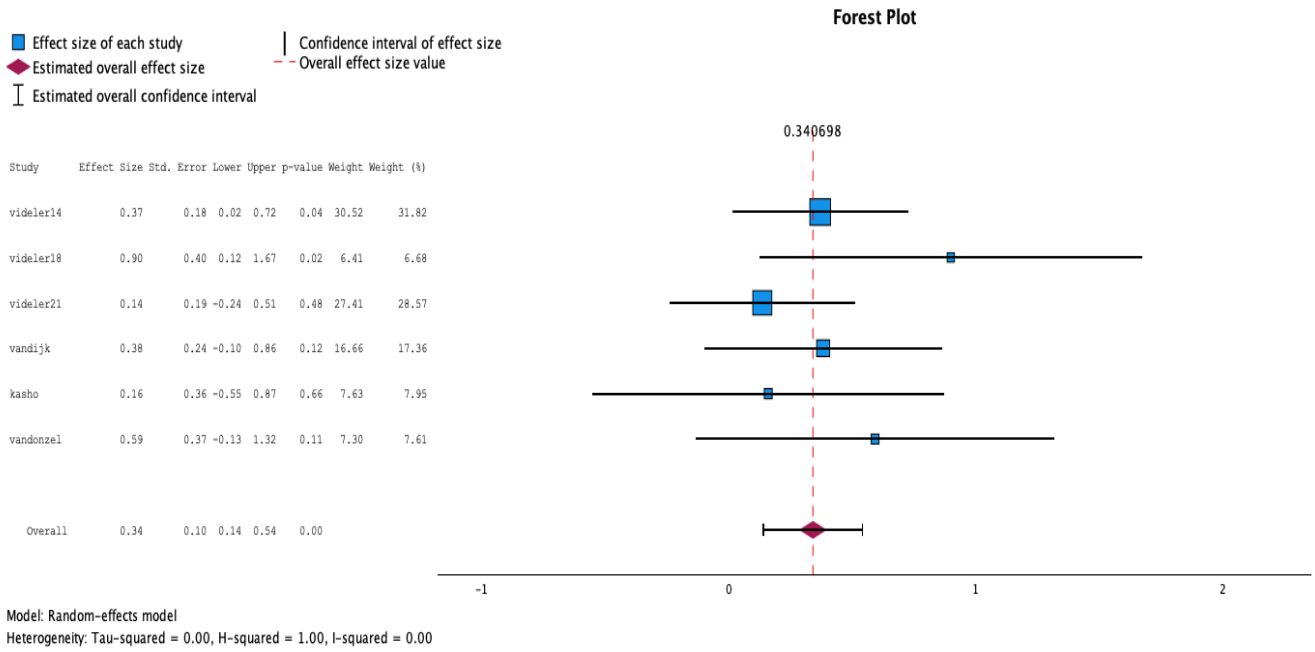

Figure 3: Forest plot of the random-effects meta-analysis of schema severity outcomes

Although heterogeneity was estimated at zero (I^2 = 0%, τ^2 = 0.00), this should be interpreted cautiously given the relatively small number of studies. However, the findings indicate no clear evidence of meaningful between-study differences in effect size within the current dataset.

Symptom Severity Meta-analysis

In addition to schema-level change, treatment outcomes were also examined in terms of psychological symptom severity. A second random-effects meta-analysis was performed using symptom measures (BSI and SCL-90) to estimate pooled pre–post change following schema therapy. Across the included studies, schema therapy was associated with a statistically significant improvement in symptom severity (Hedges g = 0.54, 95% CI [0.32, 0.76], $p < .001$), representing a moderate effect. Heterogeneity was low ($I^2 = 22\%$, $\tau^2 = 0.02$; $H^2 = 1.28$), indicating that effect sizes were broadly consistent across studies, with only a small proportion of variability attributable to between-study differences.

Notably, the pooled effect for symptom severity (g = 0.54) was larger than that observed for schema severity outcomes (g = 0.34).

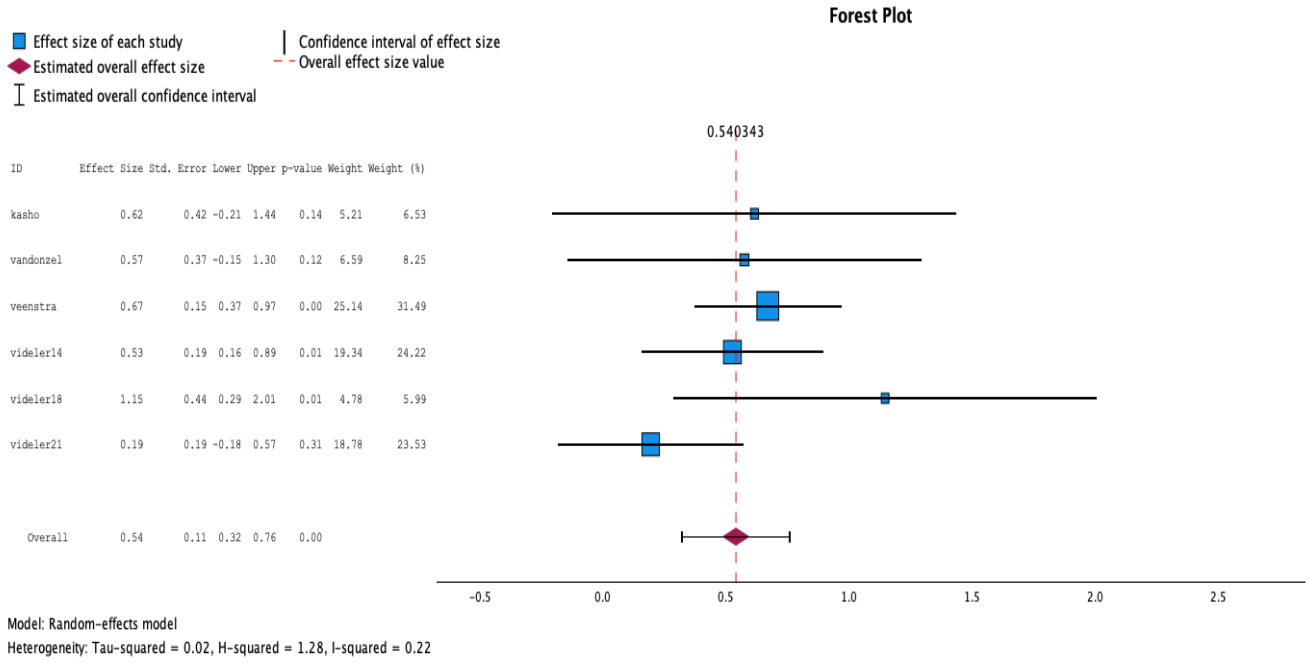

Figure 4: Forest plot of the random-effects meta-analysis of symptom severity outcomes

Sensitivity Analysis

Visual inspection of the forest plot suggested one potentially influential effect (Videler et al., 2018). Given the study's multiple-baseline design and the use of model-based predicted means, a sensitivity analysis was conducted excluding this study to examine its impact on the pooled estimate. Excluding Videler et al. (2018) resulted in a

comparable pooled effect (g = 0.50, 95% CI [0.28, 0.72]), suggesting the results were not unduly influenced by this potentially outlying study (Appendix 1.3: Sensitivity Analysis excluding Videler et al. (2018)

Narrative Synthesis of PD Change

In addition to schema and symptom outcomes, three studies reported post-treatment changes in PD status following schema therapy assessed using structured clinical interviews (e.g. SCID-II, SCID-5-P). As diagnostic outcomes were reported categorically (e.g. remission vs persistence) rather than as continuous change scores, findings were synthesised narratively.

In a single-case study, the participant no longer met criteria for any personality disorder following individual schema therapy (Videler et al., 2017). In a multiple-baseline study of older adults with Cluster C personality disorders, remission was reported in seven of eight participants (Videler et al., 2018). Similarly, a recent multiple-baseline study integrating positive schema interventions reported loss of DSM-5 personality disorder diagnosis in all assessed participants at post-treatment (van Donzel et al., 2025).

Feasibility studies and the RCT focused primarily on schema, symptom and functional outcomes and did not report post-treatment diagnostic status (Videler et al., 2014; Videler et al., 2021; van Dijk et al., 2022; Veenstra-Spruit et al., 2024).

Overall, where diagnostic reassessment was conducted, schema therapy was associated with loss of categorical personality disorder diagnosis in a proportion of older adults. These findings, while derived from small and predominantly uncontrolled studies, provide important clinical context for the dimensional improvements in schema and symptom outcomes observed across studies.

Discussion

Summary of Findings

This systematic review and meta-analysis synthesised the emerging evidence on schema therapy for older adults with PD across nine studies, which included a single case design, feasibility trials, multiple-baseline designs, and one randomised controlled trial. Schema therapy was associated with significant within-group improvements in both schema-level outcomes and symptom-level distress. Meta-analytic findings indicated a small-to-moderate effect on early maladaptive schemas (Hedges' g = 0.34, I^2 = 0%) and a moderate effect on general psychological symptoms (Hedges' g = 0.54, I^2 = 22%). These effects remained stable in sensitivity analyses excluding smaller or methodologically distinct studies, reflecting a consistent pattern of improvement across heterogeneous designs. Taken together, these findings provide preliminary support for the clinical utility of schema therapy in later life, while underscoring the early-stage nature of the evidence base.

Using benchmarks derived from schema therapy research conducted predominantly with younger adults, the pooled effect for schema outcomes (g = 0.34) falls within the small-to-moderate range, while the pooled effect for symptom severity (g = 0.54) falls within the moderate range (Cohen, 1988). Although these estimates derive from within-group analyses and should therefore be interpreted cautiously, they are broadly consistent with treatment effects reported in systematic reviews of schema therapy for younger adult populations with personality disorder (e.g., Zhang et al., 2023). This suggests that the magnitude of change observed among older adults may be comparable to that reported elsewhere across the lifespan.

This review extends the existing literature by providing the first quantitative synthesis of schema and symptom outcomes for schema therapy, specifically in older adults with PD. Overall, findings suggest that schema therapy is associated with improvements in schema severity and psychological symptoms, with evidence of meaningful reductions in psychological distress, alongside smaller but consistent improvements in maladaptive schemas. Although the evidence base remains methodologically limited, results are encouraging and support the continued development and evaluation of age-sensitive schema therapy interventions. As the population of older adults

presenting with complex personality pathology continues to grow, schema therapy represents a promising approach for addressing an important and historically neglected clinical need. In addition to symptom and schema change, the narrative synthesis indicated that dimensional improvements may, in some cases, translate into loss of categorical personality disorder diagnosis in later life. While this finding should be interpreted cautiously, it is in alignment with emerging perspectives that personality pathology may show greater plasticity in older adulthood than previously assumed, with growing recognition of shifting symptom expression and potential for change across the lifespan (van Alphen et al., 2015; Rosowsky et al., 2018; D'Agostino et al., 2022). Indeed, van Dijk et al. (2020) highlighted that schema therapy can be flexibly adapted for older adults across delivery formats, including online provision.

Findings in Relations to Existing Research

Consistent with the conclusions of Taylor, Bee and Haddock's (2017) systematic review of schema therapy across adult mental health populations, the present review found that schema therapy was associated with improvements in early maladaptive schemas, but larger and more consistent effects on overall symptom outcomes. Taylor et al. (2017) highlighted that although most studies reported concurrent schema and symptom change, formal evidence supporting schema change as a causal mechanism of symptom improvement was lacking, with no mediation analyses and only limited correlational data available. The current findings extend this observation quantitatively, suggesting that while schema change appears to be an important therapeutic outcome, symptom improvement may occur through additional or parallel processes rather than being solely driven by direct modification of early maladaptive schemas.

Several strands of the broader literature further contextualise these findings. As previously noted by Taylor et al. (2017), formal tests of schema change as a mechanism remain scarce, with few studies examining temporal or mediational relationships. More recent comparative evidence reinforces this limitation: in the first randomised trial directly comparing schema therapy and dialectical behaviour therapy for borderline personality disorder, Assmann et al. (2024) reported large and sustained symptom improvements in both treatments, yet did not assess schema change, precluding conclusions regarding schema-specific mechanisms. Within older adult

populations, available studies suggest that schema therapy is feasible and associated with meaningful symptom improvement (e.g. Videler et al., 2014; Videler et al., 2021; Khasho et al., 2023), though these studies are predominantly uncontrolled and vary in the extent to which schema outcomes are examined. Indeed, the evidence base is limited but emerging. Collectively, the existing body of evidence aligns with the present meta-analysis in indicating that while schema therapy demonstrates promising outcomes across age groups (Zhang et al., 2023), the relationship between schema modification and symptom improvement remains insufficiently specified, particularly in later life.

Considerations and Limitations

Several limitations should be considered when interpreting these findings. First, the evidence base remains small and is dominated by uncontrolled designs, limiting causal inference. Second, sample sizes were modest, and heterogeneity across PD clusters complicates conclusions regarding differential effectiveness. Third, intervention formats and outcome measures varied considerably, reflecting the exploratory stage of this research area.

Long-term follow-up data were limited, and it remains unclear whether observed improvements—particularly at the schema level—are sustained over time. Although attrition was generally well reported, the influence of concurrent treatments and medication changes could not always be fully controlled. At the meta-analytic level, reliance on pre–post effect sizes may overestimate treatment effects due to regression to the mean or non-specific therapeutic factors. However, the low levels of heterogeneity and consistency across sensitivity analyses mitigate some of these concerns.

Although the review was not restricted by PD subtype, the included studies predominantly focused on Cluster C presentations. Given differences in clinical profile and treatment complexity, findings should be interpreted with caution when considering generalisation to cluster B presentations. Finally, all included studies were conducted in the Netherlands and by a small number of researchers, resulting in a geographically concentrated evidence base and limiting generalisability to other healthcare systems and cultural contexts, and the potential of therapeutic allegiance.

Importantly, the meta-analysis synthesised within-group pre-post change rather than between-group treatment effects. Consequently, improvements cannot be attributed solely to schema therapy and may reflect non-specific therapeutic factors, regression to the mean, spontaneous improvement, or concurrent interventions. Findings should therefore be interpreted as evidence of change following schema therapy rather than evidence of treatment effectiveness.

Future Research

Future research should prioritise well-powered controlled trials, including pragmatic randomised controlled designs that reflect real-world service delivery. Studies explicitly examining mechanisms of change—such as schema modes, positive schemas, and interpersonal functioning—are needed to clarify how schema therapy exerts its effects in later life. Longer follow-up periods are also essential to determine the durability and sustainability of treatment effects, in line with recommendations from the MRC Complex Interventions Framework (Skivington et al., 2021).

Given emerging interest in late-onset PD and clinical staging models, future research may benefit from distinguishing between lifelong and later-emerging personality pathology, as these groups may differ in treatment responsiveness (D'Agostino et al., 2022; Hutsebaut et al., 2019; Rosowsky et al., 2019). The integration of qualitative methodologies could further enhance understanding of patient experience, acceptability, and perceived mechanisms of change, in line with recommendations for complex intervention research (Skivington et al., 2021).

Conclusion

Overall, these findings are broadly consistent with the theoretical framework of schema therapy, in which changes in maladaptive schemas are expected to occur alongside reductions in broader psychological distress. However, the limited number of studies and reliance on within-group designs mean that conclusions should be interpreted cautiously. While several studies suggest that clinically meaningful diagnostic change can occur in later life, it should be noted that there are currently no validated diagnostic tools specifically designed to assess PD in older adults, raising

important questions about the accuracy and stability of categorical PD outcomes in this population.

In summary, schema therapy appears to be a promising intervention for older adults with PD, offering meaningful improvements in psychological distress alongside more modest schema change. While conclusions are constrained by the early-stage evidence base, this review provides an important foundation for future mechanism-focused and age-sensitive intervention research.

Declaration of interest

None.

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Chapter 2

Major Research Project

"Do older adults presenting with "late-onset" personality disorders have experiences consistent with PD prior to their first contact with services?"

A Qualitative study

Prepared in accordance with the author requirements for the

Journal of Geriatric Psychiatry and Neurology (JGPN)

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Plain Language Summary

Title: Do older adults presenting with “late-onset” personality disorders have experiences consistent with PD prior to their first contact with services?

Background: Borderline Personality Disorder (BPD) is the most prominent and well recognised of all current personality disorder (PD) categories. However, little is known about the development of BPD across the lifespan and into later life. It is believed by some that people can develop BPD for the first time in later life, which has been referred to as “late onset” BPD. However, there is evidence to suggest that these traits may be pre-existing and were being contained throughout the person’s life in a number of ways, for example through the support of a significant other. It may be that the loss of this support brings these traits to the surface. Speaking to individuals and their family members can help us understand this. Therefore, there is a need to explore whether older adults presenting with BPD have experiences consistent with PD prior to significant first contact with services later in life, and whether there is evidence of it being contained.

Aims: This project has 2 main aims:

1. Explore whether older adults presenting with features consistent with personality disorder experienced emotional, relational, or interpersonal difficulties earlier in life, prior to significant mental health service involvement.

2. To find out whether there is evidence of containing factors (a relationship, job, caregiving role) that supported them across the lifespan, and what might have changed in later life that contributed to increased distress or contact with services.

Methods: Interviews were conducted with 11 participants, including older adults and significant others (such as partners and adult children) recruited through Older Adult Mental Health Services in NHS Greater Glasgow and Clyde. They were asked 8 questions related to experiences across the lifespan, including relationships, emotional wellbeing, coping, family experiences and contact with services. Common words and phrases from the interview answers were grouped together into themes.

Main findings: Participants rarely described emotional difficulties as beginning suddenly in later life. Instead, many described longstanding experiences of emotional vulnerability, relational difficulties, shame, emotional suppression, trauma, or instability that appeared present across much of adulthood. However, these difficulties were often managed or contained through relationships, caregiving responsibilities, work, routine, family roles, and social connection. In many cases, later-life deterioration followed significant losses or changes, including bereavement, retirement, declining health, social isolation, or changes within family relationships. Participants also described experiences of emotional invalidation, misunderstanding, and mental health support that focused mainly on medication or crisis management rather than emotional understanding. Overall, the findings suggest that later-life presentation may often reflect increasing visibility of longstanding emotional vulnerability rather than entirely new difficulties developing for the first time in older adulthood.

Why this matters: This study supports our understanding of mental health across the lifespan and create more equitable access to treatment. The findings highlight the importance of understanding older adults' emotional difficulties within the context of their life experiences, relationships, and wider social circumstances. This suggests that services may benefit from moving beyond crisis-focused or purely medical approaches by considering the role of relationships, loss, caregiving, trauma, and social support across the lifespan. The study also challenges assumptions that personality-related difficulties necessarily begin for the first time in later life.

Abstract

Objective

To explore whether older adults presenting with features consistent with borderline personality disorder (BPD) and their significant others recognised emotional and interpersonal difficulties prior to significant later-life service contact, and whether relational and structural forms of containment buffered difficulties across adulthood.

Methods

Semi-structured interviews were conducted with 11 participants (five older adults; six significant others) recruited through Older Adult Mental Health Services. Data were analysed using Reflexive Thematic Analysis within a critical realist framework.

Results

Four interconnected themes were generated: ‘relational vulnerability’, ‘continuity and concealment across adulthood’, ‘relational and structural containment’ and ‘disruption of containment’. Participants described longstanding emotional vulnerability that frequently remained buffered through relationships, caregiving roles, work, routine, and social connectedness. Later-life deterioration often followed disruption to these systems through bereavement, declining health, retirement, and social isolation.

Conclusion

Later-life presentation appeared better understood as increased visibility of longstanding emotional vulnerability rather than entirely new onset pathology.

Introduction

Personality disorders (PDs) have traditionally been conceptualised as enduring disturbances in self-organisation and interpersonal functioning that emerge during adolescence or early adulthood and remain relatively stable across the lifespan (D'Agostino et al., 2022). Developmental accounts of personality organisation emphasise the early construction of relational templates and regulatory capacities (e.g., Stern, 1938), suggesting that personality architecture is shaped through repeated relational experience. Contemporary lifespan personality research similarly indicates that while traits demonstrate gradual normative change across adulthood, core dispositional tendencies show considerable rank-order stability (e.g., Back et al., 2018). Within this framework, personality pathology is typically understood not as an episodic condition, but as a relatively stable pattern of relating and regulating.

Over the past decade, however, research has encouraged a more differentiated view of personality disorder trajectories in later life. Epidemiological, longitudinal, and consensus-based studies describe heterogeneity in life-course patterns, including chronic, re-emergent, past, and late-onset variants (Debast et al., 2014; Rosowsky et al., 2019; D'Agostino et al., 2022). In particular, the concept of late-onset personality disorder — where clinically significant personality dysfunction exceeds diagnostic threshold for the first time in older adulthood — has received increasing scholarly attention. A Delphi study has suggested that such a presentation may be conceptually plausible, while also emphasising the need for further empirical investigation (Rosowsky et al., 2019).

Alongside these developments, concerns have been raised regarding the application of categorical diagnostic systems to older adults. DSM-based criteria may insufficiently account for developmental context and age-related shifts in expression, potentially contributing to both over- and under-identification (Balsis et al., 2007; Van Alphen et al., 2013). Dimensional approaches, including the Alternative Model for Personality Disorders (AMPD), emphasise severity of personality functioning and maladaptive traits, and may offer a more developmentally sensitive framework (Morey & Hopwood, 2013; Stone & Segal, 2021). Extending dimensional perspectives, clinical staging models have been proposed to integrate severity and life-course progression into assessment and treatment planning (Hutsebaut et al., 2019). Conjaerts et al. (2025)

recently advanced a staging model specifically for older adults with PD, incorporating both severity of personality dysfunction and life-course variants — chronic, re-emergent, late-onset, and past PD. While supported by expert consensus, the model remains largely conceptual and would benefit from empirical exploration of how such trajectories are experienced and understood.

Clinical observation and case-based literature add further nuance to considerations of later-life presentation. Indeed, features of borderline personality disorder (BPD) have been reported to intensify in the context of significant life transitions, including bereavement, relational loss, retirement and social contraction (Beatson et al., 2016). Bangash (2019) proposes that significant others may serve three interrelated functions in the lives of individuals with personality disorder: buffering, by mediating interactions with external stressors; bolstering, by augmenting adaptive traits and compensating for vulnerabilities; and binding, by inhibiting the expression of maladaptive behaviours. Within this containment framework, personality-related vulnerabilities may persist across adulthood while being stabilised or moderated by relational and contextual structures.

From this perspective, later-life diagnostic threshold crossing may reflect altered visibility of longstanding patterns rather than the emergence of entirely novel pathology. Individuals may function for decades with subthreshold or compensated dysregulation, meeting full criteria following the loss of stabilising relational or environmental supports. Retrospective clinical audits are broadly consistent with this possibility. For example, Jo et al. (2023) reported that individuals identified as presenting with late-manifestation BPD demonstrated attachment disruptions and trauma-related vulnerabilities similar to those documented in younger BPD cohorts (Gunderson, 2009; Zanarini et al., 2002; Porter et al., 2020). Such findings suggest continuity of developmental antecedents, even where earlier dysfunction may not have been formally recognised.

At present, much of the literature concerning personality disorder in later life has drawn predominantly on diagnostic frameworks, epidemiological patterns, clinical observation, and expert consensus. While these approaches have contributed important insights regarding prevalence, presentation, and treatment, there remains comparatively limited qualitative research examining how older adults and their

significant others themselves understand the trajectory of emotional and interpersonal functioning across the lifespan. To the authors' knowledge, no previous qualitative study has specifically explored whether individuals presenting with apparent "late-onset" personality pathology in later life, alongside those close to them, retrospectively recognise earlier relational and emotional patterns consistent with longstanding vulnerability. In particular, the relational and contextual processes that may stabilise, amplify, obscure, or alter the expression of vulnerability over time have received limited empirical attention. Individuals and those close to them are uniquely positioned to reflect upon early relational experiences, enduring responses to distress, and the role of significant others or wider systems in supporting, buffering, or containing difficulties across the lifespan.

The present study therefore adopts a qualitative, life-course approach to explore how older adults presenting with features consistent with borderline personality disorder, and their significant others, understand emotional and interpersonal patterns across time. This informs the initial research question:

- Do individuals presenting with traits of BPD and/or their family members recognise experiences that are consistent with PD prior to significant first contact with services in later life?

To address this further, the study will explore:

- In later life presentations of PD, are there patterns of emotional, interpersonal and social difficulties and dysfunction throughout the lifespan that occur in the absence of contact (or minimal contact) with mental health services?
- Is there evidence of bolstering, buffering and binding and/or other containing experiences throughout the lifespan? Was there loss of a protective factor preceding contact with services?

Methods

Ethical Approval

Ethical approval was obtained from the West of Scotland Research Ethics Service (reference: 25/WS/0099, IRAS: 354703; Appendix 2.1) and management approval obtained from NHSGGC Research & Innovation (reference: UGN25MH227; Appendix 2.2) in August 2025.

Epistemological Stance

This study is situated within a critical realist ontological framework. Critical realism assumes that psychological phenomena, such as patterns of personality functioning, exist independently of individual perception, while recognising that our understanding of these phenomena is shaped by social, cultural, and historical contexts. Personality disorder is therefore understood as reflecting enduring patterns of emotional and interpersonal organisation, interpreted through situated meaning-making.

Epistemologically, the study adopts an interpretivist position, viewing knowledge as co-constructed between researcher and participant. Participants' accounts are treated as contextually situated narratives rather than objective reconstructions of past events.

The researcher's professional background as a trainee clinical psychologist informed sensitivity to developmental and relational formulations of personality difficulty. In line with reflexive qualitative practice, ongoing attention was given to how theoretical familiarity with constructs such as attachment and trauma might shape interpretation, while remaining open to alternative meanings.

Experts by Experience (EbE)

Consultations were conducted with experts by experience (EbE), members of a UK-wide borderline personality disorder support group, to gain perspectives on use of language and pitching of the interview guide.

Recruitment

The following criteria was applied to capture a purposeful sample

Table 3: Edibility Criteria

Inclusion Criteria for Older Person	**Exclusion Criteria for Older Person**
• Older persons aged ≥ 65 years • Fluent or proficient in English • Presenting with symptoms of borderline personality disorder (with or without diagnosis) • First presentation at MH services in later life or prior contact did not result in diagnosis of, nor treatment for BPD. • Currently open to an NHS GGC mental health team. • Deemed as psychologically well enough to participate (as determined by their care team). • Patient preferably has a significant other and has provided consent for significant other (partner, family member) to be involved in the project, but will not be excluded on the basis of not having a significant other. Participant can also nominate a significant other, and not participate themselves.	• Those lacking the capacity to consent (as determined by their care team) • Current significant suicidal ideation
Inclusion Criteria for Family Member	**Exclusion Criteria for Family Member**
• Must be over 18 years old • Fluent or proficient in English • Must be an individual who the older person identifies as a close significant other • Self-identify as a family member/close person • Must independently give consent to participate	• Under the age of 18 • Do not have sufficient knowledge of their loved ones history or have had limited contact • If they are legally restricted from contacting or discussing their loved one (e.g. restraining order, legal guardianship issues)

The research team disseminated information about the study through team meetings and via professional leads in psychology and psychiatry across older adult inpatient and community mental health services within NHS Greater Glasgow and Clyde. Individuals who were deemed appropriate were approached by their keyworker, and

if they provide consent to be contacted, the clinical keyworker contacted the researcher directly. Provisional participants were then provided with detailed participant information sheets and had the opportunity to ask questions before providing informed consent to participate.

Procedure

Potential participants were initially identified by members of the clinical team, who provided brief information about the study and assessed suitability. With permission, contact details were shared with the principal researcher, who provided further information and arranged interviews. Written informed consent was obtained prior to participation.

Where appropriate, older adults were invited to identify a significant other (e.g., partner, family member, friend, or carer) with knowledge of their emotional and interpersonal functioning across the lifespan. Significant others were required to be aged 18 years or over and able to provide independent informed consent. Older adults and significant others were interviewed separately to ensure independent accounts.

Semi-structured interviews were conducted by the principal researcher. Most interviews took place in person at NHS or University sites, with one conducted via Microsoft Teams in line with participant preference. Interviews lasted approximately 60 minutes and followed a consistent topic guide, which was not modified during data collection. All interviews were audio-recorded using a University-approved digital recorder or Microsoft Teams software, where applicable.

Participants

The study included 11 participants across six relational systems/cases. Data included one triad interview set, three dyads and two monadic cases. Five older adults participated directly, alongside six significant others, including spouses and adult children. One significant other participated independently due to the older adult partner lacking capacity to consent to interview participation. Formal diagnostic status varied across older adult participants. No participants withdrew following consent. A summary of the case figurations is presented in Table 2 below.

Table 4: Overview of Case Configuration

Configuration (*name)*	Relationship(s)	Older adult interviewed?	Family member interviewed?
Monad – *Andrew**	Husband	No	Yes
Monad – *Suzanne*	~	Yes	No
Dyad – *Anna, Dan**	Mother, son	Yes	Yes
Dyad – *Louise, Chris**	Mother, son	Yes	Yes
Dyad – *Audrey, Ian**	Wife, husband	Yes	Yes
Triad – *Angela, Michael*, Rosie**	Wife, husband, daughter	Yes	Yes

Note. An asterisk (*) denotes a family member

Justification of Sample Size

The sample size was considered appropriate for an in-depth qualitative study, guided by the concept of information power (Malterud et al., 2016). This approach suggests that the adequacy of a sample is determined not by size alone, but by the extent to which the data hold relevant information in relation to the study aims. Information power is influenced by factors including the specificity of the sample, the focus of the research question, the use of established theory, the quality of dialogue, and the analytic strategy.

Analysis

Interviews were transcribed using Microsoft Teams' automated transcription function. All participant names and identifying details were anonymised to protect confidentiality. Each transcript was subsequently checked against the original audio recording by the principal researcher to ensure accuracy and to correct transcription errors. Emotional markers (e.g., pauses, laughter, tearfulness) were retained where relevant to meaning.

Data were analysed using Braun and Clarke's (2006; 2019; 2022) six-phase Reflexive Thematic Analysis (RTA), selected for its flexibility and suitability for exploring subjective experience within an interpretivist framework. Analysis commenced once

all interviews had been completed and transcripts finalised, allowing immersion in the dataset as a whole.

Familiarisation

The principal researcher engaged in repeated reading of all transcripts to develop familiarity with the breadth and depth of the dataset. Early analytic reflections and observations were documented in a reflexive journal to capture initial impressions, emotional responses, and developing interpretations.

Coding

Coding was conducted using NVivo (version 15) to organise and manage the dataset. NVivo was used as a tool to support data organisation, retrieval, and comparison; analytic decisions remained interpretative and researcher-led.

Transcripts were coded line-by-line, generating approximately 150 initial codes across the dataset. Coding captured both semantic content and underlying patterns of meaning relevant to the research questions.

The analysis was primarily inductive, allowing patterns to develop from participants' accounts rather than applying a pre-determined coding framework. However, the research questions and interview schedule were informed by existing conceptualisations of containment (e.g., bolstering, buffering, binding), meaning that the analysis was theoretically sensitised. These concepts functioned as sensitising ideas rather than fixed analytic categories. Reflexive bracketing was employed to remain aware of professional assumptions, particularly those related to attachment and trauma, while maintaining openness to alternative interpretations.

Coding was conducted across the entire dataset rather than separating older adults and significant others in the initial phase. Participant position was noted within NVivo to enable later consideration of convergences and divergences in perspective, particularly within dyadic and triadic cases.

Constructing Themes

Codes were iteratively reviewed and clustered into candidate themes through an interpretative process. Themes were developed as meaning-based interpretative stories that captured patterned responses across the dataset, rather than descriptive topic summaries. The dataset included relationally linked accounts (one triad and three dyads) as well as standalone perspectives. The analysis attended to both shared narratives and tensions within relational groupings. A thematic map was developed to visually represent the relationships between themes and subthemes and to refine the conceptual structure of the analysis (see Figure 5). Additionally, cross-case thematic patterning across participants is presented in Appendix 2.9 to illustrate the distribution and relative prominence of themes across the dataset.

Researcher Reflexivity

Reflexivity was embedded throughout the analytic process. The principal researcher maintained a research log documenting analytic decisions, evolving interpretations, and awareness of how professional training as a clinical psychologist may shape attention to constructs such as attachment, trauma, and containment. Regular supervision sessions provided space for critical reflection and conceptual development, while analytic ownership remained with the principal researcher. Consistent with reflexive TA, no inter-rater reliability procedures were employed. Themes are understood as constructed through engagement between researcher and data, rather than discovered as objective entities within the dataset.

Results

The reflexive thematic analysis generated four interconnected themes that together illustrated a developmental and relational lifespan process underpinning later-life presentation. Although each participant's narrative was unique, highly consistent emotional, interpersonal, systemic, and developmental patterns emerged across the dataset, including across individual, dyadic, and triadic accounts. Participants frequently described early relational vulnerability characterised by emotional insecurity, invalidation, shame, instability, trauma, and unmet emotional need that appeared to remain psychologically active across adulthood. However, these vulnerabilities were often partially concealed, privately endured, or buffered through relational and structural forms of containment including intimate relationships, caregiving roles, work, routine, family systems, and social connectedness. Across interviews, later-life deterioration frequently appeared associated with disruption to these previously stabilising systems through bereavement, declining health, retirement, social isolation, cumulative strain, and changing relational dynamics. As containment weakened or became increasingly unsustainable, longstanding emotional difficulties appeared to become more visible, difficult to manage, and more emotionally understood within broader developmental and relational contexts.

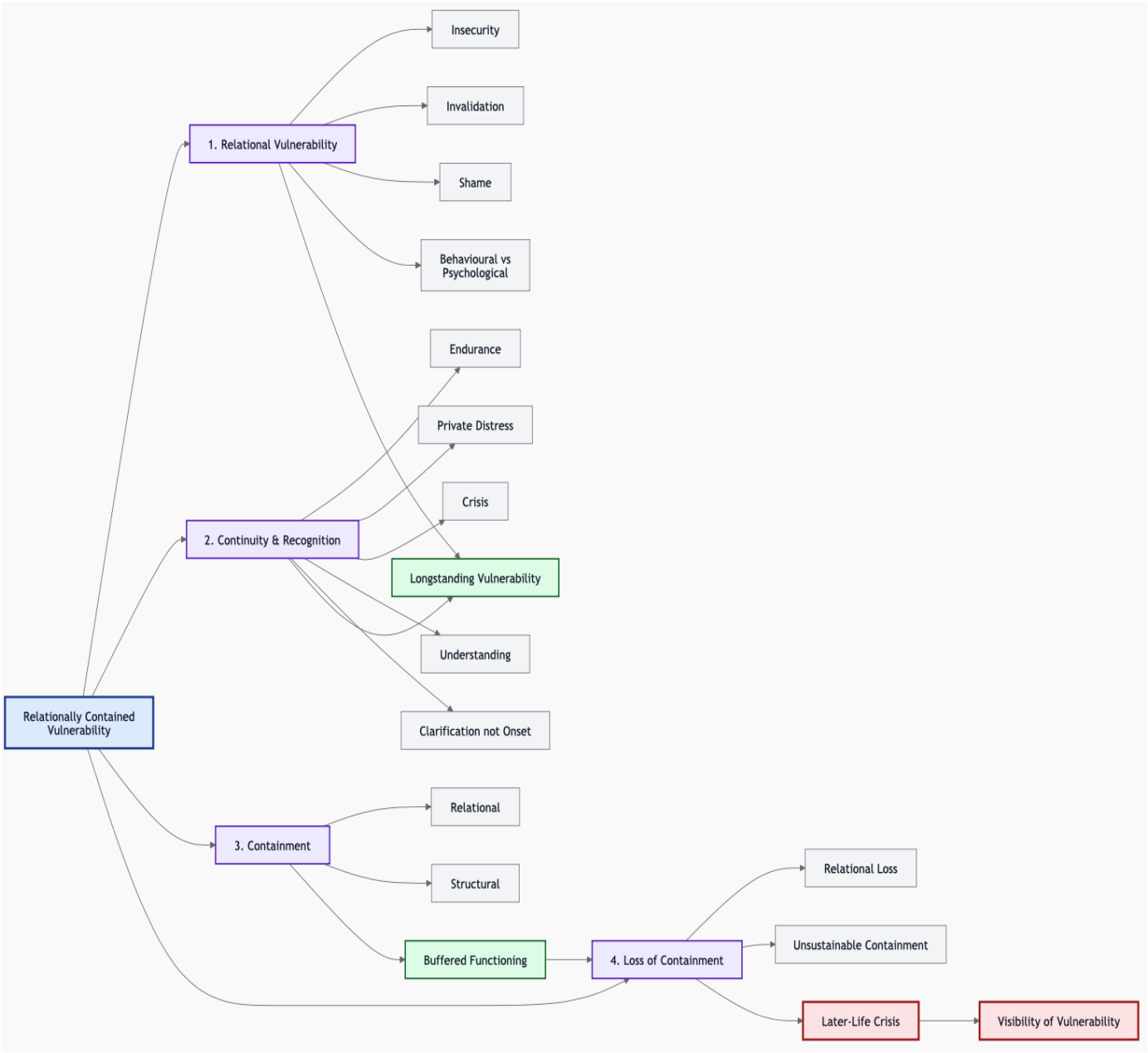

Figure 5: Thematic Mind Map (Mermaid Live Editor)

1. Foundations of Relational Vulnerability

Participants' accounts suggested that later-life emotional difficulties were situated within broader histories of longstanding relational vulnerability, often characterised by emotional insecurity, invalidation, shame, instability, abuse and cumulative adversity across the lifespan. Difficulties were rarely described as isolated events or as emerging abruptly in older adulthood. Rather, participants and relatives repeatedly reflected upon relational environments that appeared to shape experiences of

emotional safety, trust, attachment, support and self-worth across many decades. Across accounts, vulnerability frequently appeared cumulative and relationally organised, with emotional suffering developing through repeated experiences of emotional absence, fear, coercion, loss and unmet emotional need over time.

1.1 Relational Insecurity and Instability

Across several interviews, participants described early relational environments as emotionally unstable, demanding, frightening, or insufficiently protective. Importantly, emotional vulnerability was rarely discussed as emerging through isolated experiences alone. Rather, participants frequently reflected upon broader family and relational systems characterised by emotional inconsistency, criticism, absence, role pressure, caregiving burden, or lack of emotional safety across childhood and adolescence. Across accounts, participants often appeared to develop within environments in which emotional needs were insufficiently recognised, contained, or responded to, shaping enduring expectations regarding trust, safety, closeness, and emotional belonging across the lifespan.

Several participants described experiencing significant emotional responsibility within their family systems from an early age. Angela reflected upon her mother becoming severely unwell during childhood, describing how she became increasingly responsible both emotionally and practically within the family environment:

“I stayed off school so that I could go and visit my mother every afternoon because I was so terrified she was going to die and I was going to be left with him [her father].”

This account appeared particularly important in illustrating how emotional insecurity frequently developed within environments characterised by fear, lack of protection, and premature emotional responsibility. Angela’s account suggested a childhood organised not around safety and care, but around vigilance, anxiety, and attempts to emotionally manage overwhelming family circumstances. Michael similarly reflected retrospectively that Angela:

“She was never treated like a normal child or had a normal child’s upbringing. She was just left on her own.”

Across interviews, participants repeatedly described growing up within relational environments in which emotional care, guidance, or containment appeared limited or inconsistent, often leaving participants to manage distress privately or adapt prematurely to adult emotional responsibilities. Several accounts suggested that early relational experiences became organised around caregiving, emotional responsibility, or maintaining relational stability for others despite significant internal distress themselves.

Several accounts additionally reflected relational environments characterised by criticism, emotional invalidation, or conditional approval. Andrew reflected that his wife's father believed that *"Anything she did, was never good enough.*" While also describing how "*He would never compliment her on anything."* Similarly, Louise reflected an early relational environment characterised by emotional responsibility, limited emotional containment and pressure to continue functioning despite distress. Across her interview, difficulties were rarely framed explicitly as traumatic or neglectful. Instead, experiences were often minimised, normalised or contextualised within broader generational expectations. Louise also described how emotional and practical responsibility within the household often shifted:

"When dad went unwell… I had to look after things. I just wanted to be good for my mum and dad"

These accounts suggested early experiences of caregiving and responsibility within the family system, with participants appearing to adapt through helping roles, expectation and continuing to "manage" despite emotional strain. This pattern appeared to continue into adolescence during periods of significant emotional distress to perform well academically, which led to early psychiatric intervention, in this case electroconvulsive therapy (ECT). Louise recalled: "*She would take me up there… and then I was on my own."* This illustrates the coexistence of practical caregiving alongside emotional distance or lack of psychological containment. Louise additionally reflected upon the emotional inaccessibility of her mother, stating: *"She couldn't seem to explain things to me…and would say "I have other things to do".*

Importantly, several participants additionally described experiences of sexual abuse, exploitation, or boundary violations within childhood and adolescence, including abuse

occurring within family or trusted relational systems. Across these accounts, such experiences were rarely discussed in isolation, but instead appeared embedded within broader relational environments characterised by limited protection, emotional silence, fear, shame or lack of emotional safety. In some interviews, participants described these experiences only retrospectively or following many decades without disclosure, while others reflected upon not fully understanding or processing the experiences at the time they occurred. Across accounts, these early relational violations appeared to contribute to enduring patterns emotional suppression, mistrust, shame and difficulties experiencing emotional and relational safety across adulthood.

Taken together, these findings suggest that many participants developed within relational environments experienced as emotionally insecure, demanding, unstable, critical, abusive or insufficiently protective. Across interviews, these early relational conditions appeared to contribute to enduring patterns of emotional vigilance, relational insecurity, fragile self-worth, and fear of inadequacy that remained psychologically active across adulthood.

1.2 Invalidation, Lack of Support, and Emotional Silencing

Accounts also reflected longstanding experiences in which emotional needs were not consistently recognised, responded to or emotionally contained. Across interviews, participants frequently described managing distress privately or in isolation, often within relational environments where emotional expression did not feel safe, understood or meaningful. Emotional suffering therefore appeared internalised rather than openly communicated or emotionally processed. After becoming a mother, Suzanne reflected that "*I had nobody for support and nobody to turn to… I was terrified"* detailing how she felt emotionally overwhelmed but also demonstrating the continuation of poor emotional scaffolding she had received from her family through her life.

Across interviews, participants repeatedly described feeling emotionally alone within overwhelming emotional experiences, often without consistent reassurance, understanding or opportunities for emotional expression. Audrey described years of silence surrounding domestic abuse as a young woman:

"I never told my mother and I never told anybody, because you're ashamed."

This account appeared particularly important in illustrating how emotional suffering frequently became associated with shame, secrecy, and emotional self-containment. Across interviews, participants often described learning to suppress, minimise, or privately manage distress rather than seek emotional support or understanding from others.

In some accounts, participants described experiences of feeling actively misunderstood, confused or invalidated within psychiatric systems themselves. Reflecting upon an inpatient admission, and whether her admission would be prolonged or not, Angela recalled being told: *"You can either be bad or you can be good. That's it."* In relation to receiving electroconvulsive therapy (ECT) as a teenager, Louise reflected: *"It seems to be a lot they were giving me. I was frightened of it. I didn't want to be there. It felt like they were experimenting on me".*

This, understandably, led to further suppressing and internalising experiences for both participants. These accounts appeared particularly striking in illustrating how emotional distress could at times be framed behaviourally or morally rather than psychologically understood. Across interviews, participants frequently described experiences in which emotional suffering felt insufficiently recognised, validated or meaningfully explored within systems of care.

Taken together, this subtheme highlights how emotional silencing, lack of emotional containment, and experiences of invalidation contributed to patterns in which distress remained internalised, longstanding, and often managed symptomatically rather than psychologically understood across the lifespan.

1.3 Early Relational Experiences

Across interviews, participants' accounts suggested that early relational experiences frequently contributed to enduring patterns of shame, negative self-beliefs and conditioning that remained psychologically active across adulthood. Emotional suffering was often experienced not only as distress, but as evidence of something fundamentally flawed, defective, or inadequate within the self.

Several participants described deeply internalised beliefs relating to badness, inadequacy, or self-blame. In relation to her father, Andrew recalls his wife frequently

saying*: "I think I've inherited his badness… it's with me every minute of the day*". Similarly, in response to being asked by why she self-harmed, her response was: *"Because I'm bad."* These accounts appeared particularly important in illustrating how emotional pain or ongoing criticism frequently became internalised into enduring beliefs regarding personal defectiveness and shame. Across interviews, these beliefs were often linked to their formative years. Rosie, reflecting on the lack of nurture in her Mother's (Angela's) childhood, commented that *"…there is not one single picture of my mum as a child, how do you think that must feel?"* and another adult child (Chris) had the insight, when reflecting on his mother's (Louise) early years *"I think the core of the issue…was the way she was treated by her mum".*

These accounts, expressed by adult children in relation to their respective parent, were often expressed with considerable compassion and insight, with family members retrospectively linking later emotional difficulties to longstanding experiences of emotional neglect, criticism, invalidation or lack of affirmation earlier in life, particularly now having become parents themselves. Adult children engaged in processes of understanding and reinterpreting their parents' distress as rooted within broader developmental and relational histories. These emotional patterns remained psychologically active across adulthood, and were not only reflected within participants' own narratives, but were identified by family members, particularly adult children. These findings appear to suggest that early relational experiences contributed to enduring patterns of shame and inadequacy that shaped participants' sense of self across the lifespan.

1.4 Behavioural Versus Psychological Understandings of Distress

A notable cross-case pattern involved differing understandings of emotional distress within relationships, families, and systems of care. Across interviews, some accounts framed distress primarily behaviourally — in terms of mood, conflict, personality or difficulty — while others increasingly interpreted emotional suffering through relational, developmental, and psychological frameworks involving trauma, shame, grief, emotional deprivation or unmet emotional need.

In some dyadic accounts, markedly different understandings of distress co-existed within the same long-term relationships. Reflecting upon his wife's emotional difficulties, Ian stated:

"You don't know if it's that or just in a bad mood or something like that."

In contrast, Audrey herself reflected: *"I think it's maybe a trauma that brings it back or something."*

These contrasting accounts appeared particularly important in illustrating how emotional distress could be conceptualised very differently within the same relational system. While some family members appeared to understand difficulties primarily through observable behaviour, mood, or interpersonal conflict, participants themselves often described more psychologically complex narratives involving trauma, grief, coercion, emotional suppression, and unmet relational needs. Across interviews, emotional distress therefore appeared variably understood depending upon relational position, emotional proximity, and psychological formulation.

2. Continuity, Concealment and Recognition Across Adulthood

Participants' accounts suggested that emotional vulnerability frequently persisted across adulthood despite many individuals continuing to function within expected social, relational and occupational roles. Across interviews, longstanding distress often appeared partially hidden, privately managed or accommodated within family systems, relationships, caregiving roles and routines. Emotional suffering frequently coexisted alongside employment, parenting, caregiving and outward competence, contributing to difficulties remaining insufficiently recognised across much of the lifespan.

At the same time, participants' accounts suggested that later-life presentation was often accompanied by increasing recognition and reinterpretation of longstanding emotional difficulties. Experiences that had previously been normalised, minimised, behaviourally framed or privately endured increasingly came to be understood within broader relational, developmental and psychological contexts.

2.1 Endurance, Accommodation and Emotional Suppression

Across several interviews, participants described continuing to fulfil expected social and relational roles despite experiencing underlying struggles. Indeed, practical responsibilities frequently continued alongside depression, shame, trauma, emotional exhaustion or relational instability.

Reflecting on her marriage, Angela said:

"I feel guilty because he was a decent person. He trusted me because I was able to put on an act that I was intelligent enough to get married and have a family and look after him, and a home, but I was not able."

This quote appeared to capture the contrast between inner and outer worlds and longstanding feelings of inadequacy in not feeling able to fulfil expected relational roles. On balance, it also represents a sense of resilience and endurance in being able to perform an expected role while managing underlying struggles.

This account appeared strongly connected to broader relational patterns evident across the dataset in which participants described longstanding fears regarding inadequacy, failure, or inability to successfully fulfil expected relational roles. Across interviews, emotional vulnerability frequently appeared organised around fears of not being emotionally "good enough" for others.

Several accounts additionally reflected broader generational cultures of stoicism, perseverance and emotional suppression:

"You just had to get on with it back then."

– Suzanne

"I think that's what you did – you just kept going."

– Michael

Similarly, Louise described *"having to keep pushing on".*

Several women additionally contextualised these experiences within broader gendered and generational expectations and relational inequality surrounding emotional endurance and silence. For example, reflecting upon their early adult lives, Anna and Suzanne independently described this period as *"a man's world"* stating:

"It was just how things were… it was a man's world. Women didn't get support the way they do now."

And

"I think back now, it was a man's world, that was real"

These accounts suggested that emotional suffering, abuse, overwhelm and relational inequality were often normalised within broader social contexts in which women were expected to endure difficult circumstances privately while continuing to maintain caregiving and relational roles.

Importantly, functioning itself sometimes appeared to contribute to under-recognition of emotional distress. Dan, Anna's son, reflected critically upon services focusing primarily upon outward capability:

"She IS capable… she was able to function, and that seems to be the factors that they consider. Not really her mental health."

There were also several accounts of families and relationships gradually adapting around longstanding distress over time, which was accommodated within everyday relational systems and woven into family life. Rosie reflected:

"We've grown up with it… it was just how things were. When she was happy you could tell because she was singing at the top of her voice, when she was down you could tell because she was very depressed and critical and very kind of expressing that."

Reflecting upon periods in which their mother (Louise) was unable to work or care for them, Chris (son) stated:

"I think basically she just went to bed and either just lay there and my dad would look after us and look after her basic needs and we just got on with it… eventually she

would just get out of bed and that would be it, back to relatively normal life. We just got on with it."

Across interviews, continuation of everyday roles and responsibilities often appeared less reflective of emotional wellbeing and more indicative of adaptation, passive endurance and relational accommodation of longstanding distress within systems.

2.2 Managing Distress Privately

Several participants' accounts suggested that emotional distress was frequently managed privately through withdrawal, contained within the family system and selective disclosure. Across interviews, participants repeatedly described carrying distress internally for many years, with little opportunity for emotional expression or understanding.

Emotional suffering often appeared visible privately within family systems. Michael reflected:

"She only unloaded her problems onto our daughter (Rosie)… I don't know if she didn't want to talk to me to the same extent."

This quote is particularly significant in illustrating how emotional disclosure could become relationally specific, with certain family members gradually occupying emotionally containing roles. Across several dyadic interviews, family members held markedly different understandings of the same emotional difficulties depending upon their relational proximity and emotional role within the system.

Several participants additionally described prolonged periods in which emotional suffering remained privately endured despite significant internal distress. Rosie reflected upon attempting to emotionally support her mother during adolescence:

"I could sit for hours with her in the evening and feel I was talking sense into her… we'd go to bed, and the next morning she was depressed again."

These accounts highlighted the extent to which relatives often became emotionally containing figures themselves, reorganising their own roles, boundaries and emotional responses around the management of parental distress.

Emotional suffering also frequently appeared associated with shame, secrecy and emotional self-containment. Audrey, reflecting upon domestic abuse in early adulthood, shared:

“I never told my mother and I never told anybody, because you're ashamed.”

Across interviews, participants often described learning to suppress, minimise or privately manage distress rather than seek emotional support or understanding from others.

Taken together, emotional distress frequently remained contained within close family and relational systems rather than openly communicated or psychologically processed more broadly.

2.3 Crisis, Escalation and Partial Recognition

Across interviews, participants’ accounts suggested that emotional difficulties were often not fully recognised by themselves, family members or services across much of adulthood. Continued functioning, emotional suppression, relational accommodation and endurance frequently appeared to contribute to delayed recognition of underlying emotional vulnerability.

Several participants described emotional suffering becoming visible primarily during periods of escalation, crisis or withdrawal. Chris reflected about his mother (Louise):

“She would spend a couple of months, maybe three, either in hospital or in her bed.”

This appeared to reflect a pattern in which emotional distress remained suppressed, accommodated or insufficiently recognised until periods of escalation occurred, often resulting in crisis-driven intervention with limited opportunity for sustained emotional exploration or psychological understanding.

Across accounts, distress was often recognised at the level of symptoms, behaviour or risk rather than understood relationally or developmentally. Participants and family members reflected upon mental health support that focused predominantly upon medication and symptom management, with Rosie reflecting:

"…it was all tablets, there was no talking therapy…"

And:

"one antidepressant after another… this has been going on almost all of our life."

- Michael

These accounts suggested that emotional suffering was often recognised symptomatically without being fully understood within broader relational, developmental or psychological contexts. Of note, this was also the case when emotional distressed was explicitly witnessed or disclosed via help seeking. Two participants, Angela and Louise, described periods in early adulthood during which emotional distress became sufficiently severe that it was disclosed to others or expressed through suicidal thinking and behaviour. In one account, a participant described developing a suicide plan which was disclosed to her GP, while another reflected upon a suicide attempt where she was helped by a member of the public. These experiences suggested that, although emotional suffering was often privately endured across long periods of time, distress did at times become externally visible. As previously notes, across accounts, such episodes frequently appeared responded to at the level of immediate crisis, risk or symptom management via medication rather than understood within broader relational, developmental or psychological contexts.

At the same time, some accounts reflected isolated moments of emotional attunement within services. Rosie remembered her mother describing a GP during a period of acute post-partum distress:

"Someone realised she just needed to speak, and even offered for the secretary to look after her baby while they had a chat in her clinic. It sounds so simple, but it was really novel back then, a medical professional recognising that she just needed someone to speak to."

Reflecting retrospectively on another difficult period, Angela shared:

"…if there was only somebody to talk to…"

These accounts suggested that opportunities for emotional understanding were often experienced as rare, partial or fleeting.

2.4 Recognition Through Emotional Understanding and Shared Experience

Several participants described experiences of feeling emotionally understood later in life, often following decades of silence, shame, suppression or emotional isolation. Across interviews, emotional recognition was facilitated through therapy, recovery communities, reflective conversations or opportunities for emotional disclosure that had previously been unavailable.

Audrey joined a recovery group for support with alcohol use, and appeared to benefit from the shared recognition of difficulties:

“It’s wonderful… I cannot tell you how wonderful it is.”

“At first, it's very hard when you go, but then you feel as if you're accepted, because these people have got the same scabs as you and they understand it.”

Here, emotional understanding appeared grounded in mutual recognition, shared experience and reduced isolation.

Michael also described important shifts occurring when emotional difficulties were understood within a broader relational and developmental context rather than solely managed symptomatically. He reflected upon the impact of his wife beginning psychological therapy in later life:

“He (clinical psychologist) is the first person who has really stopped to ask Angela the question of why she feels the way she does.”

“He’s got her coming to realise that she's not had a normal upbringing… and that is in her thoughts and her mind all the time.”

These accounts appeared particularly important in illustrating how emotional difficulties became increasingly understandable when connected to earlier relational experiences rather than experienced solely as illness, weakness or personal failure.

Incidentally, participation in the research itself appeared to provide opportunities for emotional disclosure and recognition:

“I’ve never spoken to anybody before, but I decided today to tell the truth today, and it’s making me feel better.”

- Audrey

Across interviews, emotional understanding frequently appeared connected not only to insight or explanation, but the experience of feeling witnessed by another person.

2.5 Late Presentation as Clarification Rather Than Onset

Across the dataset, later-life presentation appeared to reflect processes of clarification, recognition and increased visibility rather than entirely new onset psychological difficulty. As already highlighted, participants described longstanding emotional vulnerability that had remained buffered, adapted around, privately endured or partially hidden across adulthood until later-life disruption, cumulative loss, reduced containment or opportunities for emotional reflection increased visibility of underlying distress. More specifically, a participant described his wife’s earlier emotional pain resurfacing more visibly in later life. Andrew reflected on his wife:

“Everything seemed fine for 30 years. What happened when she was young, it all came back when she was older.”

This account suggested that later-life deterioration reflected longstanding emotional difficulties becoming increasingly difficult to continue containing through routine, caregiving, work, endurance or emotional suppression alone.

Taken together, the findings suggest that later-life presentation may be better understood as reflecting increased visibility and reinterpretation of longstanding emotional and relational vulnerability rather than the emergence of entirely new psychological difficulties in older adulthood.

3. Relational and Structural Containment

Participants' accounts suggested that stability across adulthood was frequently maintained through relational and structural forms of containment that buffered, organised and absorbed emotional distress over time. Across interviews, periods of relative stability rarely appeared to reflect resolution of underlying emotional difficulties. Rather, participants described relationships, routines, caregiving responsibilities, work, social connection and practical roles as important systems through which vulnerability was managed, organised or partially held across adulthood.

3.1 Relational Containment

Across interviews, emotional wellbeing appeared closely tied to the presence of emotionally significant relationships and family systems. Partners, children, parents, extended family members and social networks often appeared to function as stabilising systems that buffered emotional vulnerability and enabled continued functioning despite enduring psychological difficulties.

Dan reflected upon the stabilising role played by his grandmother within the family system stating that *"…it was probably her that held the whole thing together."* This reflection appeared particularly important in illustrating how emotional stability was often maintained through key relational figures who might have maintained family cohesion and buffered instability. Indeed, when Michael was asked what most helped his wife during periods of emotional difficulty, he responded:

"What helped her? Myself. I helped, Rosie (daughter) helped, and the wee activities she went to at the time. That's when things were good."

Here, emotional stability appeared closely tied to the presence of consistent relational scaffolding, shared activity and externally organised social connection.

Across several interviews, adult children described gradually absorbing emotionally regulating and caregiving roles within the family system over time. In one case, this responsibility appeared redistributed between relatives as family members passed

away, became overwhelmed or withdrew from caregiving positions. Following the withdrawal of another caregiving family member, Dan shared:

"That's when I started talking to [name of nurse] and the doctors… I was like, it's really just gonna be me. I took over that role, it was on me"

Here, emotional containment appeared increasingly carried by family members themselves, with adult children reorganising their own roles, routines and emotional availability around the ongoing management of parental distress.

Taken together, this subtheme suggests that emotional stability across adulthood was frequently maintained relationally, with family systems and close relationships functioning as important forms of containment that buffered vulnerability and absorbed distress. Of note, the data highlighted a cross-case pattern in which partners frequently appeared to provide practical or behavioural forms of containment, while adult children more commonly demonstrated emotional attunement and reflective understanding of their parent's distress.

3.2 Structural Containment

Alongside relational support, participants repeatedly described routines, responsibilities, work, significant roles and structured activity as important forms of emotional organisation and containment across adulthood. Across interviews, practical structure frequently appeared to regulate emotional distress by providing routine, identity, distraction, social connection, purpose and continuity within everyday life.

Michael reflected positively upon periods in which he and his wife shared routine and structure through work:

"That period of our life was great. We worked together at [name of organisation]. We both went to work at the same time, came home at the same time, so that was fine."

Similarly, when asked what might have helped her Mother (Angela) throughout her life, Rosie reflected:

“I think being out and being active, contributing to society and having that routine would have helped her… having a purpose in society would have been the best therapy for her.”

When reflecting on periods of relative stability, Anna reflected:

“I went and trained to be a teacher, and I was teaching for years after that, and I remember, you know, I was really quite happy. I was probably quite busy, and I really enjoyed it”

In this case, work and routine appeared to function not just as practical responsibilities, but as emotionally regulating systems that organised daily life and reduced emotional overwhelm. At the same time, several accounts suggested that emotional difficulties became increasingly visible following the disruption or loss of these containing structures. In these accounts, deterioration appeared linked not simply to the loss of activity itself, but to the breakdown of externally organised purpose, identity and routine that had previously enabled continued functioning. Reflecting on the loss of her teaching role, Anna also reflected:

“I just felt as if I was stripped of everything. I didn’t want to carry on anymore”

This subtheme highlights how routines, roles and responsibilities frequently functioned as forms of structural containment that enabled participants to continue functioning alongside longstanding emotional vulnerability.

4. Disruption of Containing Factors

While many participants have engaged with services across their life, predominantly their primary care physician, many accounts suggested that later-life presentation to mental health services was preceded by disruption or collapse of previously stabilising systems of relational and structural containment. Importantly, these changes did not appear to create entirely new vulnerabilities, but rather appeared to expose or intensify longstanding emotional difficulties.

4.1 Loss of Relational Containment

Across interviews, emotional deterioration frequently appeared associated with relational loss, relational transitions and distancing within family systems. Participants described emotionally significant relationships functioning as stabilising systems across adulthood, with disruption to these systems associated with increased distress, instability and emotional overwhelm.

Dan reflected upon the impact of his grandmother's death within the family system:

"Once she'd gone, it was just a kind of free for all."

Similarly, he reflected on this event as being a catalyst to the deterioration of his Mother's (Anna's) mental health:

"I kind of think that when Gran died, that's probably when it all started happening."

These accounts appeared particularly important in illustrating how emotional vulnerability often remained buffered within relational systems until key containing figures were lost.

This also appeared to be the case during points of transition, for example a child leaving home for the first time. Rosie reflected on her Mother's (Angela's) response when she made the decision to move out:

"Her life was over in a way, because everything she'd ever kind of felt was her purpose was disappearing…"

"She was faced with having to redefine herself, 'what now? Sort of thing"

At times, participants also reflected upon how attempts to seek reassurance, connection or emotional support through crisis could unintentionally contribute towards further relational distancing. Chris reflected on his Mother's (Louise) tendency to seek closeness through emotional escalation, which often had the opposite effect relationally, contributing towards increasing distance and relational strain:

“Her tendency to seek attention through crisis is the very thing that pushes people away”.

“That’s why I put the manly hard exterior up.”

These accounts appeared particularly important in illustrating how cycles of distress, dependency and emotional escalation could gradually strain relational systems over time, with family members simultaneously experiencing compassion, exhaustion and increasing emotional withdrawal.

Taken together, these findings suggest that emotionally significant relationships frequently functioned as important forms of containment across adulthood, buffering distress, maintaining stability and supporting continued functioning over time. Across interviews, emotional deterioration often appeared to emerge following bereavement, separation, relational distancing or cumulative strain within family systems, with vulnerability becoming increasingly exposed as these containing relationships weakened, changed or were lost.

4.2 Containment Becoming Unsustainable

Participants’ accounts suggested that ageing, cumulative stress, emotional exhaustion and reduced coping capacity contributed to later-life deterioration. Later-life presentation frequently appeared to reflect a point at which previously effective systems of containment became insufficient to manage emotional distress.

Participants described experiences of emotional collapse or following decades of endurance, emotional suppression and cumulative strain. Anna reflected:

“I think I just pushed through everything for years, but then suddenly it just all sort of fell apart.”

Here, deterioration appeared less reflective of a sudden emergence of distress, and more suggestive of longstanding emotional difficulties becoming increasingly difficult to continue containing through activity, routine and endurance alone.

Similarly, participants described earlier emotional pain resurfacing in later life, such as Andrew’s previously stated account (theme 2.5) of his wife’s deterioration after 30

years of relative stability. Again, this account illustrates that longstanding feelings could remain psychologically present across the lifespan, resurfacing more visibly in later life as previously containing systems weakened or became increasingly difficult to sustain.

Taken together, this subtheme suggests that later-life presentation may be understood less as sudden onset psychological difficulty and more as a point at which longstanding relational and emotional vulnerability became increasingly difficult to contain.

Discussion

Overview of Findings

The present study explored how older adults presenting with features consistent with traits of personality disorder, alongside their significant others, understood emotional and interpersonal difficulties across the lifespan. Across interviews, participants rarely described later-life distress as representing entirely novel psychological difficulties emerging in older adulthood. Instead, accounts frequently reflected longstanding patterns of emotional vulnerability, relational insecurity, shame, emotional suppression, and interpersonal instability that appeared psychologically active across much of the lifespan. However, these vulnerabilities often remained partially concealed, accommodated within relationships, or buffered through wider relational and structural systems including intimate partnerships, caregiving roles, employment, routine, family systems and social expectations.

Later-life deterioration frequently appeared associated with disruption to these containing systems through bereavement, retirement, social contraction, role changes and transitions or cumulative relational exhaustion. Taken together, participants' accounts may therefore be understood less as reflecting de novo onset personality pathology and more as illustrating how longstanding emotional vulnerability becomes increasingly visible once previously stabilising relational and contextual systems weaken or collapse. The findings support developmental and relational understandings of personality pathology while raising broader questions regarding how emotional distress in later life is conceptualised and responded to within contemporary adult mental health systems (Fonagy & Bateman, 2008; Gunderson, 2009; Hutsebaut et al., 2019).

Developmental Continuity and Lifespan Vulnerability

Across interviews, participants frequently situated later-life emotional difficulties within broader histories of relational adversity, emotional insecurity, shame, invalidation, instability, trauma and unmet emotional need. Difficulties were rarely described as emerging abruptly in older adulthood. Rather, emotional suffering appeared cumulative, relationally organised, and embedded within longstanding interpersonal

environments that shaped experiences of attachment, safety, trust and self-worth across many decades (Fonagy & Luyten, 2009; Linehan, 1993).

These findings align with developmental perspectives that conceptualise personality organisation as shaped through repeated relational experiences across early life (Stern, 1938), alongside contemporary lifespan models suggesting continuity in emotional and interpersonal functioning across adulthood (Back et al., 2018). Participants' accounts also appeared consistent with attachment-informed understandings of personality pathology, whereby early relational insecurity may contribute to enduring patterns of emotional dysregulation, shame, abandonment sensitivity and interpersonal vigilance (Fonagy & Bateman, 2008; Levy et al., 2005).
Importantly, however, participants' narratives rarely reflected static or deterministic understandings of pathology. Emotional vulnerability instead appeared dynamically shaped through ongoing interaction with wider relational and contextual systems across the lifespan. In this sense, the findings may align more closely with dimensional and developmental understandings of personality functioning than categorical models of fixed disorder. Contemporary approaches, including the Alternative Model for Personality Disorders (AMPD), increasingly emphasise impairments in personality functioning and maladaptive relational processes rather than discrete diagnostic categories (Morey & Hopwood, 2013; Stone & Segal, 2021). Similarly, emerging staging models within older adult personality disorder research have attempted to account for heterogeneity in developmental trajectories, including chronic, re-emergent and late-manifestation presentations (Conjaerts et al., 2025).

Across interviews, participants and family members frequently identified longstanding emotional and interpersonal patterns that appeared to predate significant service involvement by many decades. Importantly, however, these patterns often remained insufficiently recognised, psychologically formulated or clinically understood across adulthood. Participants were therefore not necessarily describing previously absent vulnerability suddenly emerging in later life, but rather longstanding emotional difficulties that had remained partially hidden, normalised, accommodated or privately endured until later-life circumstances rendered them increasingly difficult to contain.
At the same time, caution is warranted in avoiding retrospective over-pathologisation. The findings do not demonstrate that personality disorder was necessarily present

throughout the lifespan in all cases. Rather, participants frequently described enduring emotional and interpersonal patterns that retrospectively appeared consistent with later formulations of personality-related vulnerability. Maintaining this distinction is important both methodologically and clinically given the retrospective and interpretative nature of the accounts provided.

Containment, Compensation, and Relational Buffering

A particularly striking finding concerned the extent to which emotional stability across adulthood appeared dependent upon wider relational and structural systems of containment. Participants frequently described functioning within caregiving roles, employment, intimate relationships, parenting responsibilities and family systems despite substantial underlying emotional distress. In many cases, continued functioning itself appeared to contribute to under-recognition of vulnerability, both by others and by services (Balsis et al., 2007; Van Alphen et al., 2013).

Bangash's (2019) containment framework appeared especially useful in understanding these processes. Across interviews, relationships and wider structures frequently functioned as forms of buffering, bolstering and binding. Significant others often absorbed distress, scaffolded functioning, reinforced adaptive roles or mediated emotional crises. Similarly, employment, caregiving identities and routines appeared to provide predictability, structure, meaning and emotional organisation across adulthood. These findings therefore support Bangash's proposition that personality-related vulnerability may remain partially stabilised through external relational and contextual systems over time.

Importantly, however, these systems rarely appeared to resolve underlying vulnerability entirely. Rather, they appeared to compensate for, contain, or externally regulate distress. Several participants described relationships in which family members gradually adapted around longstanding emotional difficulties, reorganising routines, caregiving responsibilities, and relational boundaries over many years. In some cases, adult children appeared to occupy emotionally containing roles within the family system, retrospectively demonstrating considerable understanding regarding their parent's emotional difficulties and developmental experiences.

These findings may also be understood through broader systemic and attachment-informed perspectives (Fonagy & Bateman, 2008). Psychological stability rarely appeared achieved through individual coping processes alone. Instead, emotional regulation frequently appeared distributed across wider relational systems. From this perspective, later-life functioning may be understood not solely as an intrapsychic achievement, but as relationally scaffolded through participation in interpersonal and social environments capable of supporting emotional organisation and continuity of identity over time (Fonagy & Bateman, 2008; Pearce & Pickard, 2010).

From Containment to Crisis

Later-life deterioration frequently appeared associated with disruption to previously stabilising systems of containment. Bereavement, retirement, declining physical health, social isolation, caregiving changes and loss of meaningful roles repeatedly emerged as significant contextual shifts preceding escalation in distress. Participants often described emotional vulnerability becoming increasingly difficult to manage once previously containing systems weakened or collapsed. These findings align with literature suggesting that later-life transitions may intensify personality-related vulnerabilities through loss of attachment figures, reduced social structure and disruption to established identities and routines (Beatson et al., 2016; D'Agostino et al., 2022). However, the present study extends this literature by illustrating how such transitions were experienced relationally and developmentally within participants' lived narratives.

Importantly, participants frequently appeared to enter services not at the onset of difficulty, but at points of relational or structural breakdown. Across accounts, service contact often followed prolonged periods of compensation and private suffering once previously stabilising systems had become insufficient to contain distress. This distinction may hold important clinical implications. If services predominantly encounter individuals at points of collapse rather than at the developmental origins of vulnerability, crisis presentations may risk being interpreted as representing sudden emergence of pathology rather than the culmination of longstanding relational and emotional processes.

From a developmental-relational perspective, later-life crisis may therefore be understood less as the appearance of entirely new pathology and more as the increased visibility of longstanding vulnerability once compensatory systems weaken. This interpretation appeared broadly consistent across the dataset, where participants repeatedly described emotional and relational difficulties that predated later-life service involvement despite remaining psychologically unrecognised across adulthood.

Endurance and Emotional Silence

Several participants additionally contextualised their experiences within broader generational and gendered expectations surrounding emotional endurance, silence, and caregiving (Ussher, 2011). Women in particular reflected upon growing up within what two participants independently described as “a man’s world”, where emotional suffering, abuse, relational inequality and self-sacrifice were frequently normalised and privately endured. Emotional expression often appeared constrained by shame, fear of judgement or assumptions that distress should be managed quietly within the family system.

These findings suggest that delayed recognition may not solely reflect individual avoidance or service-level failures, but also be shaped by wider sociocultural contexts surrounding gender, emotional expression and help-seeking. Several women appeared to describe lives organised around caregiving, relational responsibility, endurance and adaptation to difficult interpersonal circumstances, where emotional suffering became secondary to maintaining family functioning or fulfilling expected social roles.

More broadly, such findings resonate with feminist and sociocultural critiques of personality disorder diagnosis, which have highlighted the historical gendering and pathologising of women’s emotional distress through diagnostic frameworks such as “hysteria” and, more recently, borderline personality disorder (Shaw & Proctor, 2005; Ussher, 2011). Contemporary scholars have further argued that BPD diagnoses may, at times, risk obscuring the interpersonal, traumatic and sociocultural contexts in which distress develops and is expressed (Becker, Grilo, Edell, & McGlashan, 2002; Sansone & Sansone, 2011). While the present study did not explicitly examine

diagnostic practices themselves, participants' accounts nevertheless highlighted the extent to which emotional suffering may remain obscured within broader systems of social expectation, relational endurance and gendered roles.

Implications for Clinical Practice

The findings of the present study may have important implications for how later-life presentations associated with personality disorder are conceptualised and responded to clinically. Across cases, participants' emotional wellbeing appeared closely shaped by the presence or absence of relational and structural forms of containment, including intimate relationships, caregiving roles, family systems, work, routine, social connectedness and meaningful roles within wider communities. Periods of relative stability often appeared less reflective of the absence of vulnerability and more indicative of the extent to which emotional distress was buffered, scaffolded or absorbed within these systems. Conversely, later-life deterioration frequently emerged following disruption to these containing structures through the loss of these protective mechanisms. Taken together, these findings suggest that emotional difficulties may be insufficiently understood when conceptualised solely as intrapsychic pathology located within the individual. Rather, the data support a more developmental, relational, and systemic understanding in which longstanding emotional vulnerability is continually shaped, maintained, buffered, or destabilised through interaction with wider relational systems across the lifespan.

Within this context, the findings raise questions regarding the extent to which existing interventions for older adults with personality disorder remain overly individualised, frequently emphasising medication management or individual psychotherapy in relative isolation from the relational and systemic environments in which distress both develops and is sustained. Participants repeatedly described early attachment insecurity, emotional invalidation, trauma, coercion and chronic unmet emotional needs occurring within interpersonal systems, while later stability often appeared contingent upon healthier relational structures that provided emotional regulation, predictability, belonging and meaning.

Assessment approaches that attend to relational histories, attachment experiences, coping patterns, caregiving systems, and previous sources of containment may therefore support more meaningful and contextually grounded formulations (Johnstone & Dallos, 2014). Similarly, the findings may support the development of more explicitly systemic and relational approaches to intervention in later life (Carr, 2019), including greater attention to family systems, indirect psychological approaches supporting family members, caregiving dynamics, social connectedness, community participation and psychologically informed environments (Haigh, 2013). In this sense, healing may be understood not solely as symptom reduction within the individual, but as occurring through participation in healthier relational systems capable of supporting emotional understanding, revised internal narratives and increased security within relationships, especially when there is risk of a primary attachment figure being lost.

More broadly, the findings challenge the predominantly reactive structure of contemporary adult mental health systems. Across interviews, service involvement frequently appeared to occur only once distress had escalated significantly or systems of containment had already deteriorated. In contrast, child and learning disability services more routinely incorporate systemic and preventative approaches that recognise the relational embedding of emotional difficulties across developmental contexts. The present findings suggest that similar approaches may hold value within older adult services, particularly during predictable periods of systemic vulnerability including bereavement, retirement, caregiving transitions, social isolation or declining physical health.

At the same time, implementing more preventative and systemic approaches raises important ethical and practical considerations. Mental health services are not currently configured to provide ongoing anticipatory intervention in the absence of acute need. There are also risks associated with over-pathologising normative dependence upon relationships or inadvertently undermining autonomy through excessive professional involvement. Nevertheless, the findings suggest that continued reliance upon crisis-driven and highly individualised models of care may remain insufficiently aligned with the developmental, relational and systemic nature of the difficulties described by participants. Lastly, although findings were interpreted primarily through attachment and systemic frameworks, individual psychological models such as CBT and Schema

Therapy may also offer useful explanatory perspectives, particularly in association with foundations of relational vulnerability and concealment across adulthood, which may be understood through a schema lens.

Strengths and Limitations

A key strength of the present study lies in its qualitative life-course approach, which enabled detailed exploration of how emotional and interpersonal difficulties were retrospectively understood across time. The inclusion of significant others provided important relational perspectives that enriched understanding of how emotional vulnerability was recognised, accommodated, and interpreted within wider family systems. The use of reflexive thematic analysis within a critical realist framework additionally supported nuanced interpretation that acknowledged both subjective experience and broader relational and contextual influences (Braun & Clarke, 2006, 2019, 2022; Willig, 2013).

A further strength and novel contribution of the present study lies in its focus upon the lived experience and perceived developmental trajectories of personality-related difficulties in later life directly from the perspectives of older adults and their significant others. Much of the existing literature surrounding personality disorder in older adulthood has relied upon diagnostic debates, epidemiological approaches, clinician-rated presentations or theoretical discussion, with relatively limited qualitative exploration of how such difficulties are subjectively experienced and understood across the lifespan by those living them. The study also contributes to a relatively limited qualitative literature exploring later-life presentations associated with personality disorder from a developmental and relational perspective. By integrating attachment-informed, systemic and lifespan perspectives, the findings offer a more nuanced account of later-life emotional vulnerability than categorical diagnostic approaches alone may provide.

Several limitations should nevertheless be acknowledged. Recruitment proved challenging, partly due to the requirement that participants presented with personality disorder-related difficulties within older adult services. This may have introduced sampling bias, including potential gatekeeping by clinicians concerned regarding

participant vulnerability or diagnostic appropriateness. The sample also consisted primarily of individuals already engaged with services, limiting transferability to those who may remain outside formal mental health systems entirely.

The retrospective nature of participants' accounts additionally introduces the possibility of reinterpretation over time. Participants and family members were reflecting upon experiences spanning many decades, often through the lens of current understanding, therapy, relational change or service involvement. However, within reflexive thematic analysis, such reinterpretation remains meaningful in itself, reflecting how participants currently make sense of their emotional and relational histories.

Finally, while the study focused upon participants presenting with features consistent with BPD, caution is required regarding diagnostic assumptions. The study did not seek to retrospectively confirm diagnoses or establish definitive developmental trajectories. Rather, it explored how emotional and interpersonal difficulties were experienced and understood across the lifespan by older adults and those close to them.

Future Research and Conclusion

Future research may benefit from prospective longitudinal approaches examining how relational and structural forms of containment shape trajectories of emotional vulnerability across adulthood and into later life. Greater exploration of systemic intervention models within older adult mental health services may also prove valuable, particularly approaches that incorporate relational formulation, caregiving systems and preventative support during periods of transition and loss.

Overall, the findings suggest that later-life presentations associated with personality disorder may be more accurately understood not as entirely new pathology emerging in older adulthood, but as the increasing visibility of longstanding emotional vulnerability once previously stabilising relational and structural systems weaken or collapse. In doing so, the study supports developmental, relational, and systemic understandings of personality-related vulnerability across the lifespan, leaning towards a late-presentation understanding vs late-onset, and challenging

predominantly individualised and crisis-driven conceptualisations of emotional distress within older adult mental health care.

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Appendix 1.1: PRISMA 2020 Checklist

Section and Topic	Item #	Checklist item	Location where item is reported
TITLE			
Title	1	Identify the report as a systematic review.	Abstract and methods
ABSTRACT			
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	Abstract
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	Introduction
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	Introduction
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	Methods
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	Methods
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	Appendix 1.2
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.	Methods
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.	Methods
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	Methods
	10b	List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	Table 1
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.	Methods
Effect measures	12	Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.	Methods
Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)).	Methods
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions.	Methods
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	Figure 2, 3 and 4
	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used.	Methods
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression).	Results, Data analysis

Section and Topic	Item #	Checklist item	Location where item is reported
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized results.	Results, Appendix 1.3
Reporting bias assessment	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).	Results
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	N/A
RESULTS			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	Methods, figure 1, results
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	Table 1, methods
Study characteristics	17	Cite each included study and present its characteristics.	Table 2
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	Figure 2
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.	Table 2
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	Figure 2
	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	Results, figure 3, figure 4
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	Results, discussion, Appendix 1.3
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	Results, discussion, Appendix 1.3
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	Table 2, results, limitations
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	Table 2, results, discussion
DISCUSSION			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	Discussion
	23b	Discuss any limitations of the evidence included in the review.	Discussion – limitations
	23c	Discuss any limitations of the review processes used.	Discussion – limitations
	23d	Discuss implications of the results for practice, policy, and future research.	Implications
OTHER INFORMATION			

Section and Topic	Item #	Checklist item	Location where item is reported
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	Methods
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	Methods
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	Methods
Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review.	Funding and Conflicts of Interest
Competing interests	26	Declare any competing interests of review authors.	Funding and Conflicts of Interest
Availability of data, code and other materials	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	Appendix 4, 5

Appendix 1.2: Search Terms

1. OVID MEDLINE

1.	exp Aged/
2.	(older adult* or elderly or senior* or aged or ageing or aging or geriatric* or late life or later life or old age or advanced age).ti,ab,kw
3.	1 or 2
4.	exp Personality Disorders/
5.	(personality disorder* or borderline personalit* or BPD or antisocial personalit* or narcissistic personalit* or avoidant personalit* or obsessive compulsive personalit* or schizoid personalit* or schizotypal personalit* or paranoid personalit* or histrionic personalit* or dependent personalit* or emotionally unstable personalit* or dissocial personalit*).ti,ab,kw
6.	4 or 5
7.	exp Schema Therapy/
8.	(schema therap* or schema-focused therap* or schematherapy or schema-based therap* or schema mode* or maladaptive schema* or early maladaptive schema* or schema intervention* or schema-focused cognitive therap*).ti,ab,kw
9.	7 or 8
10.	3 and 6 and 9

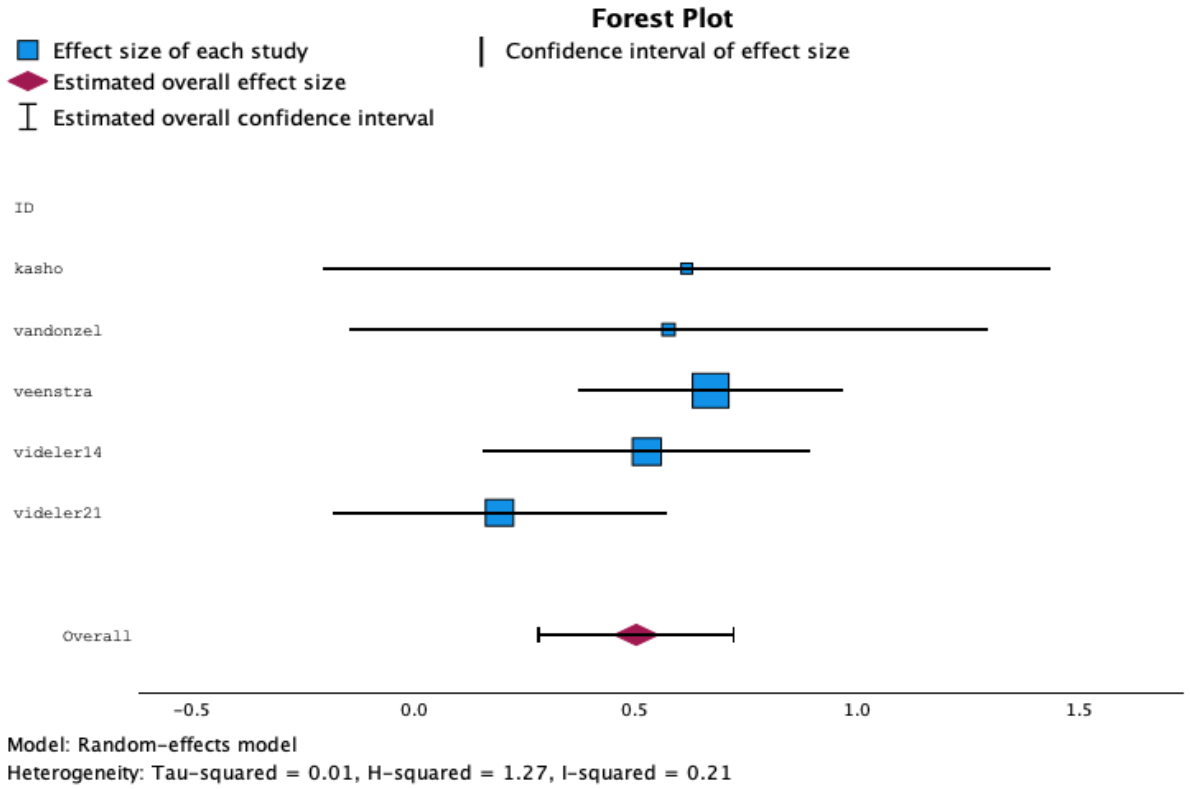
2. EBSCOhost APA PsycInfo

S1	DE “aging”
S2	TI (older adult* or elderly or senior* or aged or ageing or aging or geriatric* or late life or later life or old age or advanced age) OR AB (older adult* or elderly or senior* or aged or ageing or aging or geriatric* or late life or later life or old age or advanced age) OR KW (older adult* or elderly or senior* or aged or ageing or aging or geriatric* or late life or later life or old age or advanced age)
S3	S1 OR S2
S4	DE "Personality Disorders"
S5	TI (personality disorder* or borderline personalit* or BPD or antisocial personalit* or narcissistic personalit* or avoidant personalit* or obsessive compulsive personalit* or schizoid personalit* or schizotypal personalit* or paranoid personalit* or histrionic personalit* or dependent personalit* or emotionally unstable personalit* or dissocial personalit*) OR AB (personality disorder* or borderline personalit* or BPD or antisocial personalit* or narcissistic personalit* or avoidant personalit* or obsessive compulsive personalit* or schizoid personalit* or schizotypal personalit* or paranoid personalit* or histrionic personalit* or dependent personalit* or emotionally unstable personalit* or dissocial personalit*) OR KW (personality disorder* or borderline personalit* or BPD or antisocial personalit* or narcissistic personalit* or avoidant personalit* or obsessive compulsive personalit* or schizoid personalit* or schizotypal personalit* or paranoid personalit* or histrionic personalit* or dependent personalit* or emotionally unstable personalit* or dissocial personalit*)
S6	S4 OR S5
S7	DE "Schema Therapy"
S8	TI (schema therap* or schema-focused therap* or schematherapy or schema-based therap* or schema mode* or maladaptive schema* or early maladaptive schema* or schema intervention* or schema-focused cognitive therap*) OR AB (schema therap* or schema-focused therap* or schematherapy or schema-based therap* or schema mode* or maladaptive schema* or early maladaptive schema* or schema intervention* or schema-focused cognitive therap*) OR KW (schema therap* or schema-focused therap* or schematherapy or schema-based therap* or schema mode* or maladaptive schema* or early maladaptive schema* or schema intervention* or schema-focused cognitive therap*)
S9	S7 OR S8
S10	S3 AND S6 AND S9

3. EBSCOhost Psychology and Behavioural Science Collection

S1	SU “older people”
S2	TI (older adult* or elderly or senior* or aged or ageing or aging or geriatric* or late life or later life or old age or advanced age) OR AB (older adult* or elderly or senior* or aged or ageing or aging or geriatric* or late life or later life or old age or advanced age) OR KW (older adult* or elderly or senior* or aged or ageing or aging or geriatric* or late life or later life or old age or advanced age)
S3	S1 OR S2
S4	SU “personality disorders”
S5	TI (personality disorder* or borderline personalit* OR BPD or antisocial personalit* or narcissistic personalit* or avoidant personalit* or obsessive compulsive personalit* or schizoid personalit* or schizotypal personalit* or paranoid personalit* or histrionic personalit* or dependent personalit* or emotionally unstable personalit* or dissocial personalit*) OR AB (personality disorder* or borderline personalit* OR BPD or antisocial personalit* or narcissistic personalit* or avoidant personalit* or obsessive compulsive personalit* or schizoid personalit* or schizotypal personalit* or paranoid personalit* or histrionic personalit* or dependent personalit* or emotionally unstable personalit* or dissocial personalit*) OR KW (personality disorder* or borderline personalit* OR BPD or antisocial personalit* or narcissistic personalit* or avoidant personalit* or obsessive compulsive personalit* or schizoid personalit* or schizotypal personalit* or paranoid personalit* or histrionic personalit* or dependent personalit* or emotionally unstable personalit* or dissocial personalit*)
S6	S4 OR S5
S7	“schema therapy”
S8	TI (schema therap* or schema-focused therap* or schematherapy or schema-based therap* or schema mode* or maladaptive schema* or early maladaptive schema* or schema intervention* or schema-focused cognitive therap*) OR AB (schema therap* or schema-focused therap* or schematherapy or schema-based therap* or schema mode* or maladaptive schema* or early maladaptive schema* or schema intervention* or schema-focused cognitive therap*) OR KW (schema therap* or schema-focused therap* or schematherapy or schema-based therap* or schema mode* or maladaptive schema* or early maladaptive schema* or schema intervention* or schema-focused cognitive therap*)
S9	S7 OR S8
S10	S3 AND S6 AND S9

Appendix 1.3: Sensitivity Analysis excluding Videler et al. (2018)



Appendix 2.1: Ethics Approval: West of Scotland REC

WoSRES
West of Scotland Research Ethics Service

NHS
Greater Glasgow and Clyde

Dr David Grinter
Clarice Pears Building
University of Glasgow
90 Byres Road
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West of Scotland REC 1
West of Scotland Research Ethics Service
Admin Building, Level 2
Gartnavel Royal Hospital
1055 Great Western Road
Glasgow G12 0XH
www.nhsggc.org.uk
Date 06 August 2025
e-mail ggc.wosrec1@nhs.scot

Dear Dr Grinter

Study title:	**Do older adults presenting with "late-onset" personality disorders have experiences consistent with personality disorders prior to their first contact with services?**
REC reference:	**25/WS/0099**
Protocol number:	**1**
IRAS project ID:	**354703**

Thank you for your letter of 31 July 2025, responding to the Research Ethics Committee's (REC) request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Alternative Vice-Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Good practice principles and responsibilities

The UK Policy Framework for Health and Social Care Research sets out principles of good practice in the management and conduct of health and social care research. It also outlines the responsibilities of individuals and organisations, including those related to the four elements of research transparency:

1. registering research studies
2. reporting results
3. informing participants
4. sharing study data and tissue

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of

Appendix 2.2: Ethics Approval: NHS R&I GG&C Board Approval

Coordinator/administrator: Rozanne Suarez
Telephone Number: NA
E-Mail: Rozanne.Suarez2@nhs.scot
Website: https://www.nhsggc.org.uk/about-us/professional-support-sites/research-innovation

Research & Innovation
Gartnavel Royal Hospital
Admin Building, Level 2
1055 Great Western Road
Glasgow, G12 0XH
Scotland, UK

11/08/2025

Miss Katie Briggs
NHS Greater Glasgow & Clyde
Trainee Clinical Psychologist
Glasgow

NHS GG&C Board Approval

Dear Miss Briggs

Study Title:	Do older adults presenting with late-onset personality disorders have experiences consistent with PD prior to their first contact with services?
Principal Investigator:	Katie Briggs
GG&C HB site	Older People Psychology Services across NHS Greater Glasgow and Clyde
Sponsor	University of Glasgow
R&I reference:	UGN25MH227
REC reference:	25/WS/0099
Protocol no: (including version and date)	V.04 – 28.07.2025

I am pleased to confirm that Greater Glasgow & Clyde Health Board is now able to grant **Approval** for the above study.

Conditions of Approval

1. **For Clinical Trials** as defined by the Medicines for Human Use Clinical Trial Regulations, 2004
   a. During the life span of the study GGHB requires the following information relating to this site
      i. Notification of any potential serious breaches.
      ii. Notification of any regulatory inspections.

It is your responsibility to ensure that all staff involved in the study at this site have the appropriate GCP training according to the GGHB GCP policy (www.nhsggc.org.uk/content/default.asp?page=s1411), evidence of such training to be filed in the site file. Researchers must follow NHS GG&C local policies, including incident reporting.

2. **For all studies** the following information is required during their lifespan.
   a. First study participant should be recruited within 30 days of approval date.
   b. Recruitment Numbers on a monthly basis
   c. Any change to local research team staff should be notified to R&I team

Appendix 2.3: Link to MRP documentation (Open Science Framework)

Additional information relevant to chapter 1 is available to view at:
https://www.crd.york.ac.uk/PROSPERO/view/CRD420251155425.

All relevant documentation related to chapter 2 i.e. final approved proposal, participant information sheet, consent form, interview schedule, participant debrief sheet, are available to view at:
https://osf.io/ufqnh/overview?view_only=9022d05656424e7a9bfa68f23f117cb1

Internet Archive Link
https://archive.org/details/osf-registrations-hrys8-v1

Registration DOI
10.17605/OSF.IO/HRYS8

Appendix 2.4: Data Analysis Plan: Reflexive Thematic Process

Overview

Data were analysed using Braun and Clarke's (2006, 2019, 2022) Reflexive Thematic Analysis (RTA) within a critical realist framework. Analysis was recursive and iterative rather than strictly linear, with movement occurring back and forth between stages throughout the analytic process. The six phases of analysis are summarised below.

Phase 1: Familiarisation With the Data

Interviews were transcribed verbatim using Microsoft Teams transcription software and subsequently checked against audio recordings for accuracy. Transcripts were read and re-read alongside audio recordings to facilitate immersion within the dataset. Initial observations, emotional responses, reflexive thoughts, and early interpretative ideas were recorded throughout this stage. Particular attention was paid to emotional tone, relational dynamics, repeated patterns, contradictions, and developmental narratives across the lifespan.

Phase 2: Generating Initial Codes

Coding was conducted inductively using NVivo. Semantic and latent codes were generated across the full dataset, capturing emotionally, relationally, and developmentally meaningful features of participants' accounts. Coding focused not only on explicit content, but also underlying meanings, relational processes, emotional patterns, and systemic influences underpinning participants' narratives. Codes were continually refined, expanded, collapsed, and revisited throughout analysis.

Phase 3: Constructing Initial Themes

Codes were then reviewed and grouped into broader patterns of shared meaning. Candidate themes were developed through consideration of conceptual relationships between codes across interviews, with attention paid to recurring developmental, relational, emotional, and systemic processes underpinning later-life presentation. At

this stage, thematic maps and visual diagrams were used to explore relationships between themes and subthemes.

Phase 4: Reviewing and Refining Themes

Themes were reviewed against both the coded data extracts and the dataset as a whole to ensure coherence, distinctiveness, and analytic depth. This stage involved revisiting transcripts repeatedly, refining thematic boundaries, collapsing overlapping themes, and strengthening the evidential basis underpinning each theme. Particular attention was given to ensuring themes captured patterned meaning across participants while also retaining complexity, nuance, and divergence within accounts.

Phase 5: Defining and Naming Themes

Themes were further refined and clearly defined to capture their central organising concepts. Theme names were revised iteratively to ensure they accurately reflected both the descriptive and interpretative aspects of the analysis. At this stage, themes were conceptualised as interconnected components within a broader developmental and relational lifespan process underpinning later-life presentation.

Phase 6: Producing the Report

The final stage involved integrating themes into a coherent analytic narrative situated within existing literature relating to personality disorder, attachment, lifespan development, and systemic perspectives. Data extracts were selected to illustrate thematic patterns while preserving participants' voices and contextual meaning. The final analysis aimed to move beyond descriptive summary towards interpretative understanding of how participants experienced and understood emotional vulnerability, containment, and later-life presentation across the lifespan.

Example of Cross-Case Thematic Patterning Across Participants

Participant	Foundations of Relational Vulnerability	Hidden Continuity Across Adulthood	Relational & Structural Containment	Disruption of Containment in Later Life	Recognition & Reinterpretation of Lifespan Patterns
Participant 1	✓✓	✓✓✓	✓✓✓	✓✓	✓
Participant 2	✓✓✓	✓✓✓	✓✓	✓✓	✓
Participant 3	✓✓	✓✓	✓✓✓	✓✓✓	✓✓✓
Participant 4	✓✓✓	✓✓✓	✓	✓✓	✓
Participant 5	✓✓	✓✓	✓✓	✓✓	✓✓✓
Participant 6	✓✓	✓✓✓	✓✓✓	✓✓✓	✓
Participant 7	✓	✓	✓✓✓	✓✓✓	✓✓
Participant 8	✓✓✓	✓✓	✓✓✓	✓✓✓	✓
Participant 9	✓✓✓	✓✓✓	✓	✓✓	✓
Participant 10	✓✓✓	✓✓✓	✓✓	✓✓✓	✓✓✓
Participant 11	~	✓	✓	✓	~

Note. ✓ = theme present; ✓✓ = strongly present; ✓✓✓ = central organising feature within participant account; ~ = minimally present or indirectly referenced.

Example of Reflexive Thematic Analysis Process: Coding Clusters and Emerging Themes

Code group/cluster	Initial code	Participant theme (interpretative)	Data extract	Relevance to research question(s)
Early vulnerability & onset	Postnatal onset; early distress; absence of psychological input/emotional support; early adversity; overwhelm following motherhood	A life lived under the surface	"Soon after the birth… *[PATIENT NAME]* suffered from postnatal depression… one antidepressant after another… this has been going on almost all of our life."	Evidence of longstanding vulnerability prior to late life presentation at MH services (Primary RQ)
Pre-existing personality features	Low self-esteem; indecisiveness; difficulty expressing needs; chronic dissatisfaction; rigid thinking	Fixed ways of being: identity, rigidity, resistance	"She's never happy with anything… I'd ask what is it you want… but she wouldn't express an opinion, but still have a problem"	Enduring personality patterns across lifespan (Primary & Secondary RQ)
Relational patterns	Emotional offloading; selective disclosure; difficulty maintaining relationships; suspicion; stigma sensitivity	Difficulties in relating: closeness, distance and strain	"She only unloaded her problems onto *[NAME OF DAUGHTER]…* I don't know if she didn't want to talk to me to the same extent."	Lifelong interpersonal difficulties (Secondary RQ)
Relational and contextual containment	Husband support; daughter as emotional container; routine; structured roles; social engagement	"Held together" by others and structure	"what helped her? Myself. I helped, [NAME OF DAUGHTER], and the wee activities she went to at the time"	Evidence of buffering, bolstering, binding (Secondary RQ)
Loss of a protective factor	Loss of routine; reduced social contact; daughter moving away; physical decline; isolation	When the structure disappears	"That all gradually faded… she's hardly ever out the house now."	Deterioration following loss of containment (Secondary RQ
Pre-existing personality features	First psychological input; persistence; challenging avoidance; alternative narrative emerging	Opening up to a different narrative	"He sits and talks to her… he doesn't let her away with anything… brings it back."	Change linked to accessing psychological intervention later in life

Appendix 2.5: COREQ (Consolidated criteria for reporting qualitative studies): 32 item checklist

Adapted from Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. International Journal for Quality in Health Care, 19(6), 349–357.

No.	Item	Guide Questions / Description	Reported on Page No.
1	Interviewer/facilitator	Which author conducted the interview or focus group?	45
2	Credentials	What were the researcher's credentials?	43, 48
3	Occupation	What was their occupation at the time of the study?	43, 48
4	Gender	Was the researcher male or female?	98
5	Experience and training	What experience or training did the researcher have?	43, 48, 98
6	Relationship established	Was a relationship established prior to study commencement?	44-45
7	Participant knowledge of interviewer	What did participants know about the researcher?	45, 48
8	Interviewer characteristics	What characteristics were reported about the interviewer?	43, 48, 98
9	Methodological orientation	What methodological orientation underpinned the study?	43, 46-48
10	Sampling	How were participants selected?	44-45
11	Method of approach	How were participants approached?	44-45
12	Sample size	How many participants were included?	45
13	Non-participation	How many people refused or dropped out?	45
14	Setting of data collection	Where was the data collected?	45
15	Presence of non-participants	Was anyone else present besides participants and researchers?	45

16	Description of sample	What are the important characteristics of the sample?	45-46
17	Interview guide	Were questions/prompts provided and pilot tested?	43, 45
18	Repeat interviews	Were repeat interviews carried out?	N/A
19	Audio/visual recording	Did the research use audio or visual recording?	45-46
20	Field notes	Were field notes made during or after interviews?	46, 48
21	Duration	What was the duration of interviews?	45
22	Data saturation	Was data saturation discussed?	46
23	Transcripts returned	Were transcripts returned to participants?	No
24	Number of data coders	How many data coders coded the data?	46-47
25	Description of coding tree	Did authors provide a description of the coding tree?	47, Appendix 2.4
26	Derivation of themes	Were themes identified in advance or derived from the data?	46-47
27	Software	What software was used to manage the data?	46
28	Participant checking	Did participants provide feedback on the findings?	EbE – 43
29	Quotations presented	Were participant quotations presented?	49-69
30	Data and findings consistent	Was there consistency between data and findings?	49-69
31	Clarity of major themes	Were major themes clearly presented?	49-69
32	Clarity of minor themes	Was there discussion of diverse cases or minor themes?	49-69

Note. Page numbers refer to Chapter 2 of the thesis document and associated appendices where relevant. Items relating to participant checking and saturation are interpreted in line with Reflexive Thematic Analysis principles (Braun & Clarke, 2021/2022).

Appendix 2.6: Researcher Reflexivity and Reflective Practice

Consistent with Braun and Clarke's (2006, 2019, 2022) reflexive thematic analysis approach, reflexivity was understood as an ongoing and active process throughout all stages of the research. Rather than attempting to bracket out subjectivity entirely, the researcher acknowledged that analytic interpretation was inevitably shaped by their professional background, emotional responses, assumptions, relational positioning, and interactions with participants and wider systems surrounding the research process. Reflexive practice therefore formed an integral component of the study design and analytic development.

The researcher entered the project as a Trainee Clinical Psychologist with previous professional experience working with individuals presenting with emotional dysregulation, relational trauma, personality disorder diagnoses, and complex mental health difficulties across a range of NHS settings. Prior clinical experiences had already highlighted the stigmatising attitudes often directed towards individuals perceived as having "personality disorder traits", particularly within inpatient and crisis-based systems. These prior experiences influenced both the researcher's interest in the topic and sensitivity to relational and systemic patterns emerging throughout recruitment, interviewing, and analysis.

Reflexive awareness became particularly important during recruitment. Recruitment proved substantially more difficult than initially anticipated, with multiple organisational and interpersonal barriers emerging across services. Because the recruitment pathway required clinical teams to first approach potential participants before researcher contact could occur, the process became heavily influenced by clinicians' perceptions of patient suitability and risk. Across multidisciplinary discussions, the researcher became increasingly aware of stigmatising narratives surrounding older adults perceived to display personality disorder traits. Participants were at times described informally as "manipulative", "difficult", or unlikely to benefit from psychological input. Simultaneously, clinicians often appeared reluctant to formally identify individuals as potentially meeting criteria for personality disorder, particularly

where there was no documented earlier diagnosis. This created a notable tension within recruitment processes. Some individuals were described colloquially as “a bit PD” within clinical discussions, yet subsequently deemed ineligible for recruitment due to the absence of a historical diagnosis.

The researcher became increasingly aware that this dynamic risked reproducing the very phenomenon under investigation within the study; namely, the possibility that longstanding relational and emotional difficulties may have remained historically unrecognised, misunderstood, or diagnostically obscured across adulthood. Reflexive notes documented growing awareness of potential gatekeeping processes within services, including concerns among staff that discussing personality disorder-related experiences with older adults might be harmful, destabilising, or stigmatising. At times, the researcher experienced frustration and concern that participants’ voices risked being filtered through professional anxieties and assumptions before they were given the opportunity to decide for themselves whether they wished to participate. Recruitment therefore became analytically meaningful in its own right, highlighting broader systemic tensions surrounding the conceptualisation of personality disorder within older adult services.

Throughout interviews and analysis, the researcher experienced a range of emotional responses to participants’ narratives. Many interviews involved detailed accounts of trauma, coercion, abuse, emotional deprivation, loss, relational instability, and prolonged emotional suffering. Reflexive journaling documented moments of sadness, protectiveness, anger, helplessness, admiration, frustration, and deep emotional resonance with participants’ experiences. In particular, the researcher became aware of strong emotional reactions while listening to women describe experiences of abuse, coercive relationships, emotional silencing, and systemic invalidation across earlier adulthood. Several participants described existing within social and relational environments in which emotional suffering had been minimised, normalised, or endured privately within broader gendered expectations regarding caregiving and emotional endurance. The researcher noted periods of anger and frustration on participants’ behalf, particularly when participants described being disbelieved, silenced, morally judged, or managed behaviourally within psychiatric and relational systems.

At times, the researcher additionally became aware of shifting internal responses towards participants during interviews themselves. Reflexive notes documented moments of feeling highly emotionally pulled towards participants, wanting to “rescue”, protect, reassure, or advocate for them, alongside awareness of frustration, uncertainty, confusion, or emotional distancing at other moments. In some interviews, participants’ communication styles, storytelling patterns, emotional avoidance, or apparent contradictions generated fluctuating emotional reactions within the researcher, including feelings of being simultaneously drawn towards and pushed away from participants. These reactions were explored reflexively through supervision and reflective journaling, not as evidence of participant “difficulty”, but as potentially meaningful relational and interpersonal dynamics occurring within the research encounter itself.

The researcher also became increasingly aware that their own clinical lens shaped patterns of attention within analysis. Although the analysis was conducted inductively and grounded closely within participants’ accounts, the researcher recognised being theoretically sensitised to relational concepts including emotional containment, attachment, trauma, caregiving roles, emotional invalidation, and loss. Reflexive supervision therefore became important in monitoring assumptions, avoiding over-pathologising understandable responses to adversity, and ensuring themes remained grounded in participants’ accounts rather than solely clinical interpretation. Particular attention was paid to distinguishing between emotional responses that reflected empathic engagement with participants’ suffering and moments where the researcher risked moving too quickly towards formulation-driven interpretations.

Reflexive practice was maintained throughout all phases of analysis via reflective journaling, analytic memo writing, supervision discussions, and repeated revisiting of transcripts. Reflexive notes often captured evolving interpretations, emotional responses, tensions, uncertainties, and shifts in understanding over time. Importantly, reflexivity was not treated as a separate stage occurring after analysis, but as an ongoing process woven throughout interviewing, coding, theme development, interpretation, and writing. Consistent with Braun and Clarke’s reflexive approach, themes were therefore understood not as passively “emerging” from the data, but as actively constructed through engagement between participant accounts, researcher

interpretation, theoretical positioning, and the wider relational and systemic contexts surrounding the study.

Appendix 2.7: Data Availability Statement

The author confirms that additional information for the systematic review is openly available at:

PROSPERO | https://www.crd.york.ac.uk/PROSPERO/view/CRD420251155425.

The supplementary material for the empirical study is openly available at:

OSF | **10.17605/OSF.IO/HRYS8**

Written and verbal consents were obtained from participants; however, this did not include permission for their data to be shared for public access. Therefore, supporting data, such as scanned transcripts, are not publicly available due to concerns that despite the data being pseud-anonymised, there may still be information that could compromise the privacy of research participants. Additional requests may be made to the corresponding author, DC, for access to supporting data.

All data was securely stored on the researcher's University of Glasgow OneDrive server and in adherence to University and NHS GGC policy will be available for ten years.