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Borderline Personality Disorder in Older Adults: A Review of the Diagnostic and Treatment Dilemma

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Abstract

A borderline personality disorder is one of the most common personality disorders encountered in psychiatric practice and medicine overall, yet it is poorly understood. Emotional lability, impulsivity, unstable relationships, and chronic emptiness are just some of the symptoms of this complex disorder. This review aims to understand the diagnosis and treatment of borderline personality disorder in older individuals. Based on our review, we have noticed that diagnosing and treating borderline personality disorder in older individuals can be particularly challenging, but a combination of dialectical behavioral therapy (DBT) and pharmacotherapy, especially antidepressants, has been shown to be effective for most individuals.

This topic is vastly misunderstood and understudied. By bringing together various articles as a part of this review, we have attempted to bridge this gap to a certain degree.

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Introduction

Borderline personality disorder (BPD) is a complex mental illness that affects an individual's feelings, mood, and thought processes, which reflect on their interpersonal relationships and behavioral patterns. Therefore, it is characterized by intense, unstable, and conflict-ridden interpersonal relationships, impulsive and self-harming behavior, chronic feelings of emptiness and boredom, repeated suicidal thoughts or actions, and visualizing people as all good or bad. According to the DSM-5, the presence of five or more of these symptoms leads to a diagnosis of borderline personality disorder. Lack of proper management of this condition often leads to the loss of many vital relationships in patients, and most patients also go undiagnosed. Comprehensive research into the diagnosis and treatment of this disorder will enhance physicians' confidence in addressing this complex personality disorder.[1]

In this review, we discuss the treatment protocols for older adults who are diagnosed with BPD. It is estimated that about 1.6% of the adult population worldwide has BPD, with 20% of the psychiatric in-patient population

affected. It is more common in older women than in men.[2] According to Pinto *et al.*, BPD is believed to occur globally, but there is limited epidemiological research on BPD outside the Western world.[3] Coid *et al.* conducted a methodologically rigorous survey on a random sample of 626 British householders and reported a weighted prevalence of 0.7% for BPD. Similarly, Samuels *et al.* found a prevalence rate of 0.5% in a random sample of 742 American households. Torgersen *et al.* surveyed 2,053 community residents in Norway and reported a prevalence rate of 0.7% for BPD. These studies suggest that the prevalence of BPD is relatively consistent across Western cultures and is prevalent among older adults who are about 65 years of age.[3]

The exact cause of BPD remains unknown; however, studies indicate that genetic, environmental, and neurological elements may play a role in its onset. Environmental factors may include childhood trauma, abuse, neglect, or abandonment, while neurological factors may involve changes in the activity or structure of brain regions that regulate emotions and impulse control.[4]

BPD can be challenging to manage, but with the right treatment, individuals with this disorder can make significant progress in reducing their symptoms and improving their quality of life. With the help of a mental health professional and a supportive network of friends and family, individuals with BPD can work to develop healthy relationships, reduce impulsive behavior, and find stability and happiness.[5]

The symptoms of BPD can be highly distressing and disruptive to an individual's daily life. Some of the most common symptoms are intense and unstable interpersonal relationships, marked by rapidly shifting emotions and constant conflict. They may idealize someone for one moment, only to devalue and discard that person the next. BPD can lead to impulsive and hazardous behaviors, such as substance abuse, binge eating, reckless driving, or risky sexual behavior.[6] People with BPD may engage in self-harm or suicidal behavior, make repeated suicide attempts, and struggle with intense thoughts of death. They have a chronic feeling of emptiness, which predisposes them to anxiety and depression. This stems from an unstable sense of self, with frequent changes in beliefs, values, and goals, and may cause one to have difficulty trusting others. Distrust can lead to paranoia and brief periods of dissociation, in which people feel disconnected from reality.[6] For the diagnosis of BPD, a variety of precursor syndromes have been suggested, but none have considered the likelihood that these individuals will satisfy the criteria as adults.

Several theories have been proposed about BPD's persistent emptiness. According to Kernberg, an absence of integrated representations leads to a lack of "self-feeling" since the link between the self and object relations has been lost or disturbed. Similar theories have been put forth claiming that emptiness is caused by deficiencies in upholding stable object relations and the failure to ingrain secure attachment with the caregiver (i.e., the lack of internalized positive and nurturing experiences). This lack leads to an unstable object, self-representation, and a sense of inner emptiness.[7]

Barnow *et al.*, Reinelt *et al.*, and found empirical evidence for theories on the relationship between parental psychopathology, particularly maternal BPD, and the potential precursor to BPD in children and adolescents. It was noted that the likelihood of adolescents having BPD themselves is enhanced when there is positive maternal psychopathology, which leads to a disrupted mother-child relationship. This instability reflects on the offspring's self-image and identity.[8,9]

Diagnosing BPD can be challenging, as we mentioned earlier, as the symptoms of this disorder often overlap with those of other mental illnesses, such as depression, anxiety disorders, or bipolar disorder. A comprehensive evaluation by a mental health professional, including a psychiatric interview, is necessary to make a definitive diagnosis.[10] Stepp *et al.* highlighted various risk factors like lack of interpersonal support, cohesiveness, conflict between a parent and child, and a parent's psychiatric history. They proposed a multivariate model of assessment to identify all the predisposing factors for BPD.[11]

Over the past two decades, several studies have focused on the progression of individuals with BPD. It was noted that most of the patients achieved remission over time. A reduction in all symptoms was observed; however, impulsivity and behavioral signs of BPD tend to subside more quickly than internal, mainly affective experiences. The behav-

ioral manifestations were often less consistent over time than the personality features linked to BPD. However, the chance of death by suicide persisted even after an early decrease in suicidal and self-harming tendencies.[12]

Even though the course of BPD is primarily favorable, some individuals do eventually have relapses. Though most therapies for BPD are time-limited, lasting between one and three years on average due to the exhaustive use of resources, Hence, several professionals believe that intermittent psychotherapy would be a preferable model of treatment for both new BPD patients and to prevent relapse. Patients who get periodic care may be able to address several setbacks at various stages of their lives.[13] It's crucial to remember that the stigma associated with BPD keeps people from getting the assistance they require. To lessen stigma and increase access to high-quality care for individuals with BPD, we must educate people and raise awareness about this condition among older adults.

Even though it's generally accepted that BPD symptoms decrease with age, a significant portion of people continue to have BPD symptoms well into old age. Unfortunately, older people sometimes go undiagnosed because the current diagnosis is thought to primarily affect young people. The purpose of this research is to examine effective treatment strategies for adult individuals diagnosed with BPD. The majority of research tends to overlook the fact that older people also frequently have this psychological disease, with an emphasis on treating the disorder in young adults. Because of its overlap with other personality disorders, BPD can go unnoticed at times, and older adult patients are less likely to report symptoms or view the disorder as a medical issue.[14]

A growing number of senior residential care facilities and psychiatric institutions are seeing a surge in the prevalence of BPD, according to case studies and clinical experience, as a result of environmental changes exacerbating some characteristics of the disorder as people age. Because of their poor interpersonal functioning, many elderly BPD patients are cut off from their family and former acquaintances. This could set off recurrent episodes of insecure attachment-type problems and feelings of abandonment when kids need care. In contrast to other personality disorders and traits within the normal range, trait neuroticism and BPD symptoms were the only ones that were found to be significantly associated with increased suicidal ideation in older adults.[15]

According to the International Classification of Diseases 11th Revision (ICD-11) guideline, a person with a personality disorder in their twenties may no longer me*et a*ll criteria by middle age, which expressly states that personality disorders are only "relatively" stable after young adulthood. However, ICD-10 believes that personality disorders tend to be stable over time.[16,17] Sometimes, a person might live their entire life without being diagnosed with a personality disorder. There is sometimes a correlation between the development of personality disorders in older adults and the absence of social support that had previously helped to compensate for personality instability.[15]

Hence, a lifespan approach to BPD may have significant implications. BPD characteristics are dynamic, and their expression depends on environmental and developmental circumstances from childhood up to old age, as opposed to having a fixed collection of BPD symptoms that are unchanging across the life span. Throughout adulthood, most BPD patients have a waxing and waning profile of impairment, with periods of remission and relapse. However, others exhibit sustained remission. This fluctuating nature of BPD should have a significant influence on how we assess and treat BPD throughout a person's lifetime.[15]

Professional skills in understanding the suffering experienced by individuals with BPD and the critical situations in which healing takes place are essential. People's experiences may not match how symptoms and suffering are portrayed in any diagnostic literature. Hence, it was proposed that subjective data must be included in the diagnostic methodology.[18]

Classically, the management of BPD involves a combination of psychotherapy and psychopharmacology (Table 1). Psychotherapy is a cornerstone of BPD treatment and is effective in improving symptoms in older adults. Dialectical behavior therapy (DBT) is a type of cognitive-behavioral therapy that

Table 1: Various pharmacotherapies used for the management of BPD

Medication class	*BPD-associated symptoms*
Anticonvulsants	Affective dysregulation (e.g., mood lability, temper outbursts, suicidal thoughts and behavior, rejection sensitivity), impulse behavioral dyscontrol (e.g., aggression, anger, hostility, impulsiveness, self-injury)
Antidepressants	Affective dysregulation (e.g., depression, anxiety, mood lability, suicidal thoughts and behavior), impulse behavioral dyscontrol (e.g., aggression, anger, hostility, impulsiveness, self-injury)
Antipsychotics	Affective dysregulation (e.g., anger, mood lability, suicidal thoughts, and behavior), cognitive-perceptual disturbance (e.g., illusion, paranoid ideation, ideas of reference), impulse behavioral dyscontrol (e.g., aggression, impulsiveness, hostility, self-injury), psychoticism
Opioid agonists/antagonists	Self-injurious behaviour
Sedative-hypnotic medications	Sleep disturbance

has shown promising results in older individuals with BPD.[13,15] DBT aims to help individuals regulate their moods, feelings, and affect through mindfulness and emotional regulation skills. Therefore, one must form a stable relationship with oneself and others. Cognitive-behavioral therapy (CBT) is another type of psychotherapy that has also been used to treat BPD in older adults. It can help change negative behavioral thought patterns.[19]

Psychotherapies are often combined with psychopharmacotherapy, such as antidepressants, mood stabilizers, and antipsychotics, for individuals with BPD. Medications provide a symptomatic approach to treatment by managing BPD symptoms.[13]

Second-generation antipsychotics (like aripiprazole, olanzapine, and quetiapine) highlighted moderate improvement in anger and impulsivity.[20] Antidepressants also showed minimal improvement in depressive symptoms; however, amitriptyline showed significant improvement.[21] Mood stabilizers like topiramate, lamotrigine, and valproate show strong improvement in BPD. Additionally, topiramate and lamotrigine are effective in treating aggressive symptoms.[21] Other medications like opioid antagonists and naltrexone showed early improvement in dissociative symptoms, impulsivity, self-harm, and interpersonal functioning.[22,23] However, there is little evidence to support the effectiveness of these drugs in treating BPD in older adults, and these patients may also be more susceptible to side effects. As a result, close monitoring is necessary while using medication to treat BPD in older people.[24]

An integrated treatment approach combining psychotherapy and pharmacotherapy is effective in treating BPD in older adults. This approach can be tailored to the individual needs and circumstances of the older adult and can lead to improved outcomes.[25]

Conclusion

BPD is a pervasive, chronic, and debilitating personality disorder that causes significant distress and disruption in the patient's and caregiver's lives. The exact cause of BPD is unknown and is a combination of genetic, environmental, and neurological factors. Still, with proper treatment and support, individuals with BPD can make significant progress in managing their symptoms and improving their quality of life. The treatment of BPD in older adults can be quite challenging, but effective treatment options do exist. Psychotherapy, especially dialectical behavioral therapy, and adjuvant medications are proven to be effective ways to improve symptoms in older adults with BPD. In addition to psychotherapy and psychopharmacology, social support and self-care practices can also play an essential role in the recovery process for individuals with BPD. This can be ensured by further research to develop a multifactorial diagnostic and management approach.

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