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Differences between older and younger adults with Borderline Personality Disorder on clinical presentation and impairment

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ABSTRACT

Background: Borderline Personality Disorder (BPD) is well-known to be a clinically severe and impairing diagnosis. Research shows that BPD symptoms decrease in severity over time. However, a subset of patients with BPD continue to meet criteria for the disorder in older adulthood. Little is known about this subset. Perception of BPD as a young-person's diagnosis could lead to under recognition in older patients. As such, the objective of the present report is to provide the first direct comparison between older and younger adults with BPD on demographics, clinical presentation, and functional impairment.
Method: Over 3000 psychiatric outpatients were evaluated with semi-structured diagnostic interviews. Forty-six older adults (age 45–68) and 97 younger adults (age 18–25) met criteria for BPD.
Results: Both groups reported high levels of functional impairment and Axis I comorbidity. Older adults were more likely to endorse chronic emptiness, and less likely to endorse impulsivity, self-harm, and affective instability. Older adults also reported fewer substance use disorders, more lifetime hospitalizations and higher social impairment.
Conclusion: Older adults with BPD had a significantly different clinical presentation from younger adults with BPD, including differences in likelihood of endorsing specific BPD criteria, social impairment, and comorbid substance use. It is important to assess less prototypic features of BPD to avoid overlooking borderline personality features in this population.

1. Introduction

Borderline Personality Disorder (BPD) is associated with high functional impairment (Zimmerman et al., 2012) and is also an expensive disorder with respect to public health costs (Bender et al., 2001). There is also a general belief that the impairment and characteristics of BPD decrease over time, including in diagnostic manuals (APA, 2000). This belief is well-supported in the cross-sectional, community prevalence literature. For example, BPD criteria counts were shown to decrease with age in a large, British household population (Ullrich and Coid, 2009). Engels et al. (2003) also reported significantly less BPD symptomology in older (age $\geq$ 50 years) as compared to younger community members and patients. Importantly, in both studies BPD symptoms were reported at all ages despite being less prevalent in older populations.

1.1. Longitudinal findings for BPD symptoms

The majority of research on BPD diagnosis and age is longitudinal rather than cross-sectional, with follow-up ranging from 2 to 25 years. Taken together, these studies show that BPD symptoms are less prevalent over time within subjects, and thus less likely in older adults. For instance, Stone (1990) followed individuals diagnosed with BPD or borderline traits for 10–25 years. Most patients, by the time they reached their 30s or 40s, were rated as either "good" or "recovered" (GAF > 70). Rate of remission from BPD was reported in the 80–90% range in at least two, large-scale studies with ten-year follow ups (Gunderson et al., 2011; Zanarini et al., 2006). Similar studies show remission at 99% at sixteen-year (Zanarini et al., 2012) and 94% at 27-year follow-ups (Paris and Zweig-Frank, 2001).

Reduced incidence over time was replicated with respect to several specific BPD criteria. One such study examined impulsivity, affect disturbance, identity disturbance, and intense, unstable relationships in 123 BPD outpatients (Stevenson et al., 2003). A significant, negative correlation was found between age and impulsivity. Another report showed lower relationship instability

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over time (Paris et al., 1987). Finally, studies show that both self-injury (Zanarini et al., 2011b) and substance abuse (Zanarini et al., 2011a,b) decrease significantly at 10-year follow-up with BPD patients.

1.2. Longitudinal findings and functional impairment

Although "functional impairment" is required to make a diagnosis on both Axis I and Axis II, there is no generally accepted, operational definition for impairment (see Ro and Clark, 2009; Uston and Kennedy, 2009). As such, authors vary in their use of this term, but generally define functional impairment as dysfunction in social and/or occupational activities. Functioning is also frequently confounded by symptoms, and may include variables used to track clinical progress, plan treatment, or predict treatment outcomes (Uston and Kennedy, 2009).

Functional impairment by many definitions has also been addressed longitudinally with BPD patients. In his classic follow-up, Stone (1990) identified a small number of individuals who remained chronically angry, and appeared to experience a decrease in functioning across multiple domains in their mid-40s'. Similarly, a study of 81 BPD patients found that those entering the study in their 50s' showed poorer functioning (as defined by employment status, social activities, and ongoing psychiatric symptoms) at 15-year follow-up than did those with an earlier entry age (McGlashan, 1986). In a report from the Collaborative Longitudinal Personality Disorders Study (CLPS), psychosocial impairment increased for the oldest BPD cohort only (age 35–45 at intake) over six year follow-up (Shea et al., 2009). However, the CLPS results only addressed changes in global functioning using two broad functioning measures rated from 0 to 100 (Global Assessment of Functioning and Range of Impaired Functioning), and did not report more specific group differences.

Evidence showing lower rates of BPD in older adults leads many researchers to conclude that PD symptoms "burn out," "fade," or "disappear" as patients age (Paris, 2003). Nonetheless, some studies report that functional impairment persists even when full criteria for a PD is no longer met (Moffit et al., 2002). For instance, Drake and Valliant (1988) reported that although specific behaviors required to meet a PD diagnosis diminish over time, interpersonal impairment continues throughout the lifespan. Thus, it is possible that PD presentation changes over time, but continues to have a negative impact on psychosocial functioning. However, it is currently unclear to what degree this is true for PDs generally or for BPD specifically (Balsis et al., 2009; Trappler and Backfield, 2011).

1.3. Clinical presentation in older adults with BPD

Perhaps due to the low prevalence of BPD in older adults, very few studies present demographic information, clinical descriptions, or clinical correlates for this sample. Trappler and Backfield (2011) report on 3 older adults (>50 years) with BPD, noting that all three patients presented with a broad range of BPD traits. Similarly, Rosowsky and Gurian (1991) compared 8 elderly patients (age 64+) with BPD to controls matched for age, gender, and residence. The authors reported less identity disturbance and impulsivity (including self-harm, risk taking, and substance use) in older adults. However, both studies were based on very small sample sizes, and did not conduct statistical testing. Other studies typically group patients into broad "PD/no PD" categories (Stevenson et al., 2011), or compare their results to other published data rather than conducting comparisons within one study (Ames and Molinari, 1994).

1.4. Cross-sectional comparisons of older and younger adults with BPD

We only identified two direct comparisons of younger and older age groups of BPD patients. First, Shea et al. (2009) divided patients into three age groups based on age at study entry: 18–24, 25–34, and 35–45. The patients were followed for 6 years for improvement in both psychosocial functioning and BPD symptoms. Here, younger and older subjects showed roughly equal improvement, although the oldest age group showed a change in direction from improvement to worsening functioning midway through the six-year follow-up. In this case, the authors suggested the change constituted a reappearance of difficulties with advancing age generally, rather than only in a subgroup as originally suggested by Stone (1990). However, analyses emphasized differences in course rather than fundamental differences at baseline such as specific criteria met; results also did not assess differences in specific aspects of functional impairment. A second study (Stepp and Pilkonis, 2008) evaluated group differences between patients with BPD, with other PDs, and with no PDs in three age groups: 20–30, 31–40, and 41–50. Results showed less suicidality and impulsivity in older groups, but comparable levels of distress and anxiety for BPD at all ages. However, patients older than 50 were not included in these analyses. Demographic differences, Axis I comorbidity, or differences in functional impairment also were not assessed. Thus, it remains unclear what clinical qualities might uniquely characterize older BPD patients at intake.

1.5. The current study

Taken together, it is clear that BPD symptoms decrease in severity over time at the population level. However, it is also clear that a small subset of BPD patients continue to meet criteria for the disorder in older adulthood. Little is known about this subset. To date, nearly all studies of BPD and age are longitudinal, and the two studies that compared age groups with PD presented either longitudinal analyses or limited analysis to a small number of variables. As such, it is currently unclear whether older adults with BPD differ from their younger counterparts with regard to any variable other than prevalence. The perception of BPD as a young-person's diagnosis could lead to under recognition in older patients. For example, if the more salient features of BPD such as impulsivity and self-injurious behavior—which are touchstones for clinicians in identifying BPD (Commons Treloar and Lewis, 2009)—are less frequent, then other BPD symptoms may be overlooked in older patients.

This study is the first study to our knowledge to directly compare younger and older adults with BPD with respect to Axis I comorbidity, frequency of specific BPD criteria, and functional impairment in a variety of domains. We hypothesized that older adults will be less likely to endorse problematic substance use or impulsivity (BPD criteria 4). We also predicted that older adults with BPD would not differ significantly from younger adults in psychosocial impairment across all tested domains.

2. Method

2.1. Participants

Participants were 3280 outpatients in the Rhode Island Hospital Department of Psychiatry outpatient practice. The practice predominantly treats individuals with medical insurance (including Medicare but not Medicaid) on a fee-for-service basis. Participants were 18 years or older. Participants who displayed difficulties in communicating in the English language or who had a history of developmental disabilities were excluded from the study. Of the

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