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Complex Case
Emergence of borderline personality features in the sixth decade of life

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Introduction

Conventional wisdom has it that borderline pathology is a 'young person's game' in that the disorder finds its most active expression in late teenage years, extending into early adulthood and begins to 'burn out' when patients hit their late 30s and early 40s. Indeed, many of the patients we are familiar with from our emergency departments and inpatient units fit this pattern. Accordingly, much of the literature on the longitudinal course of borderline personality disorder (BPD) concerns itself with prediction of remission of symptoms over the life span. One longitudinal study of baseline predictors of time to remission, for example, found an 80% remission rate for patients with BPD over a 10-year period (Zanarini, Frankenburg, Hennen, Reich, & Silk, 2006). This is consistent with Stone's earlier and oft-cited review on long-term outcomes in borderline personality-disordered patients, in which he noted that studies found that the outcome for BPD patients followed over 10–30 years was 'generally favourable', and that his own studies showed that only 25% of patients still met Diagnostic and Statistical Manual (DSM-III) criteria by the forth or fifth decade of life (Stone, 1993).

On the other hand, there is recognition from studies that some of the core features of BPD, including chronic dysphoria, emptiness and abandonment/dependency issues can be relatively stable and may contribute to an ongoing vulnerability to borderline regression in later life (Zanarini, Frankenburg, Reich, Silk, Hudson, & McSweeney, 2007). Consequently, patients can end up 'looking borderline' on the basis of symptomatic behaviours that are episodic and reactive while failing to meet full criteria for BPD at other quiescent periods in their lives despite enduring core features. This is in keeping also with Stevenson's analysis of 123 patients with BPD, in which core features of affective disturbance, identity disturbance and interpersonal difficulties were more stable with advancing age than was the BPD core trait of impulsivity (Stevenson, Meares, & Comerford, 2003). Stone, despite his observations of 'favourable' prognosis over time in BPD, also saw some patients in whom borderline traits re-emerged in later life after a period of relative dormancy in mid-life (Stone, 1993).

A model of personality pathology have been proposed by Sansone (Sansone & Sansone, 2008) that is dynamic in nature, and which describes fluctuations in symptoms as resulting from the interplay between core personality traits and inherent vulnerabilities with factors in the patient's external environment or internal world. For example, the maturation process, which hopefully

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occurs in most people as they age (Vaillant, 2003), would be seen as a positive 'internal' factor that would drive this dynamic flux towards remission of symptoms, and would account in part for the improvements in BPD symptomatology with middle age. Conversely, the development or recurrence of an Axis I disorder, such as major depression or a substance abuse disorder would represent internal factors that could disrupt a 'personality homeostasis' in the negative direction. Situational stressors and adverse events, such as interpersonal losses or the development of medical illness, are obvious negative external factors that could lead to the emergence of borderline traits at various points in a life course (Pagano et al., 2004).

All of the above is salient in the case that we will present here for discussion. Our patient appears to have shown the emergence or development of borderline behaviours and cognitions while on an inpatient psychiatric unit. This woman had been in an ongoing outpatient therapy with a competent psychiatrist who was surprised by the clinical observations we made of the patient's manner and relational difficulties on the inpatient unit. Though our patient was a bit older than the patient described in an earlier published case report as a 'late-onset borderline personality disorder' (Bernstein, Reich, Zanarini, & Siever, 2002), we are struck by the many similarities in their respective life courses and clinical presentation.

Case report

Ms. M is a 52-year old divorced Caucasian woman with a history of post-traumatic stress disorder (PTSD), major depressive disorder and alcohol dependence who was directly admitted to the inpatient psychiatric unit from the outpatient psychiatric clinic for active suicidal ideation and depression.

Circumstances of admission and recent history

The patient reported feeling that her life was a 'nightmare' and stated 'I don't recognize my life anymore'. She has had active suicidal ideation for several weeks prior to her admission. Following a long period of abstinence, the patient resumed drinking two to three beers daily during the four weeks prior to her hospitalization. Simultaneously, she had also discontinued an antidepressant regimen of buproprion, duloxetine and trazodone over her worries of their potential interaction with alcohol. She reported a suicide attempt by heroin injection in the days preceding her admission; when this was further probed in the interview, it was unclear when the use occurred or how much she had used. The patient had also begun engaging in self-abusive actions, such as slapping herself in the face. Three months previously, her beloved 28-year old son, who had been struggling unsuccessfully with substance abuse and depression, committed suicide by jumping from a window. Since that time, she had endured a significant amount of stress. During the inpatient evaluation she stated, 'I don't want to live in this world right now', and attributed this sense of hopelessness to the loss of her son.

We contacted the patient's outpatient psychiatrist, who reported that the patient had been working very well in combined psychodynamic therapy/medication management for the last few months despite the death of her son. Ms. M had attended most of their weekly therapy appointments and was reportedly working through her guilt related to his death. Furthermore, she had repeatedly denied suicidal ideation to her psychiatrist in the months following her son's death, claiming that she needed to remain alive for her grandson and daughter. However, Ms. M had missed her last appointment, and then had shown up unannounced to her psychiatrist the day of admission, at which time she was noted to be agitated and irritable. At that point, she told her psychiatrist that she was thinking about running her car into a tree, but was worried she 'would not be successful'. This was particularly worrisome to her psychiatrist, who knew that the patient had two unsuccessful suicide attempts in her past. She also admitted to resumption of drinking, despite

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years of sobriety and active attendance in Alcoholics Anonymous. Concerned about Ms M's active suicidality and overall regression, the outpatient psychiatrist encouraged her to voluntarily admit herself to the inpatient unit. She was transported from the outpatient facility to the university hospital by ambulance.

Past psychiatric history

The patient was hospitalized twice previously following suicide attempts during presumed depressive episodes. The first hospitalization, at age 41, resulted from an attempt to kill herself with carbon monoxide by running her car with her in it in a closed garage. The attempt resulted in her passing out. After she regained consciousness and realized her failed attempt, she called a friend, who brought her to a hospital. At age 45, she attempted to overdose on her sister's medications, resulting in a second admission. During the two years prior to her current admission, the patient had been seeing a psychiatrist within the university system for medication management of depression and weekly psychodynamic therapy.

In addition to the history of major depression, she also carried diagnoses of PSTD, alcohol dependence in remission and a remote history of bulimia. She has had past medication trials of fluoxetine, escitalopram, venlafaxine and buspirone. She had most recently been maintained on a combination of bupropion 200 mg twice a day, duloxetine 60 mg daily and trazodone 100 mg at bedtime.

Family and personal history

The patient has a family history of systemic lupus erythematosus, including her father, sister, paternal grandmother and uncle. Her mother has received diagnoses of both bipolar disorder and paranoid schizophrenia. Her maternal grandmother and maternal cousin also have been diagnosed with schizophrenia. The patient's deceased son suffered from both depression and substance abuse (leading to his suicide). According to the patient, her daughter has some form of anxiety disorder and possible borderline personality disorder.

The patient recalls sexual abuse at age three by her grandfather. Her mother also physically and sexually abused her. It was unclear from the patient's report and past medical records what the details of these events were, but they were likely implicated in her PTSD symptoms of flashbacks and nightmares concerning abuse. The patient married at 18 years of age and had divorced by age 26.

The patient receives disability for back pain and depression, but previously owned and ran a cleaning business. At the time of this hospital admission, she had just finished moving in with her 18-year old grandson, who had started college. It was this grandson whom she identified as the only reason she had to live.

Hospital course

On her arrival to the inpatient psychiatric unit, she presented angry and agitated. She cursed loudly at staff, including her inpatient resident psychiatrist, and refused to sign consent for voluntary admission. She received 5 mg of intramuscular olanzapine and became less agitated. Later that day, she consented to voluntary admission, but continued to be verbally assaultive, hostile and uncooperative with questions during the admission interview. Only after receiving 1 mg of oral lorazepam was she calm enough to proceed with the inpatient assessment. The patient maintained her active suicidal ideation and stated her wish to reunite with her deceased son. Ms. M denied any auditory, visual or tactile hallucinations, but stated that she often felt her son's 'presence', later clarifying this as his 'spirit'. She endorsed 'flashbacks' of his suicide, death by jumping, though she had not actually observed his suicidal act. The patient made requests not to be 'bugged' by questions from the treatment team, but did request continuous observation (1 : 1 suicide watch) with a unit patient

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worker. When interviewed once again later in the day by the treatment team, she indicated her annoyance with the physician's tone and what she termed 'the stupidity' of our questions. The patient refused to answer questions regarding her past psychiatric and social histories, so a thorough chart review was necessary to gather additional background on the patient.

On subsequent days on the unit, her cooperativeness with questions slowly improved, and the intensity of her sarcasm and easy irritability began to ease. She continued to endorse suicidal thoughts, including the strong wish to be dead. She repeatedly mentioned her intention to commit suicide by car accident if discharged. She also voiced the idea that she would likely resume heavy drinking if discharged, a prospect we took very seriously because of the heightening of suicidal risk this would entail. In her hospital room, which was located on the ninth floor, she placed numerous pictures of her son on her window along with a sign that read 'Don't do it'. She also requested that staff give her something 'to knock me out'. Many of the nursing staff who spent a good deal of time with her began to experience her suicidal threats as 'manipulative'. In part, this may have been due to what they saw as a 'disconnect' between her suicidal threats and a less than despondent affective display. A certain 'gamy' quality was present in her psychiatric sessions as well. Throughout the hospitalization, the patient was quite emotionally labile. At times, she would isolate herself in the bathroom to scream. She was selective with attendance at scheduled unit groups and activities, which generated some negative reaction from the staff as well. It appeared to staff that she hung on to the 1 : 1 sitter longer than necessary, and a gradual 'weaning' was ultimately put in place. In addition, she constantly sought attention from nursing staff. Her requests for frequent 'as needed' medications were interpreted as drug-seeking behaviour, especially when they occurred with only some slight provocation from her environment and without evidence of intense anxiety or despondency. This caused a significant consumption of nursing and other staff time. These unit personnel came to informally label her as 'borderline' and consequently began stricter limit setting with her.

The outpatient psychiatrist visited the patient on two occasions. The patient endorsed to us her appreciation and enjoyment of these visits. As rapport with the treatment team improved, it was noted that the patient highly idealized her outpatient psychiatrist. At one point, she stated that this female psychiatrist was 'like a daughter' to her. Furthermore, in subsequent discussions between the treatment team and outpatient psychiatrist, the outpatient physician indicated her surprise at the patient's behaviour on the unit, especially with the level of sarcasm directed at staff and the preoccupation with suicide. During their outpatient sessions visits, Ms. M had never threatened suicide in the aftermath of her son's death; nor had there ever been any strong indication, in their outpatient visits, of Axis II pathology during the two years of treatment.

Her home medications were restarted and titrated upwards, with final doses of sustained release buproprion 150 mg twice daily and duloxetine 60 mg twice daily. Given her positive response to olanzapine, she was started on 5 mg orally daily with 5 mg as needed that she requested two to three times daily. However, this led to marked sedation and was changed to quetiapine to allow for more frequent as needed usage. Despite her reluctance to attend groups and activities on the unit, she did socialize with other patients in unstructured milieu time. In her sessions with the psychiatrist, she seemed to benefit from a continual rehashing of the details of her son's life and tragic suicide. Given his accomplishments as an actor and musical artist, she hoped to have a memorial festival of his work.

Discharge planning

In trying to assess her suicidality and readiness for discharge, the treatment team asked the patient daily to provide a 'percentage' of how lethal she

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felt. She was 100% committed to suicide for the first seven days of her stay. When she reached 50%, the treatment team felt more confident in proceeding with more aggressive discharge planning. As part of this dispositional planning, a family meeting was held with her grandson. Prior to the meeting, the patient requested that we did not discuss the details of her relapse to alcohol. The grandson expressed confidence over the stability of their living situation and in his grandmother's ability to maintain her safety while living with him. Eventually, the patient herself was able to confidently state her future orientation, with plans to celebrate her grandson's birthday in an upcoming weekend, and intention to return to regular Alcoholics Anonymous meetings and to a survivors of suicide group. She also stated her intention to resume her weekly outpatient psychiatry appointments. The patient was discharged after 18 days of hospitalization.

Discussion

The invited consultant commentaries for the case of a 'late-onset' BPD presented by Bernstein focused in part on evidences of borderline pathology that had been overlooked in her history. The implication of this was that this was more of a case of 're-emergence' of borderline features than a de novo appearance. In our case, this could be argued as well. The patient had risk factors for BPD, chief among which was her history of sexual and physical abuse (Bandelow et al., 2005; Bradley, Jenei, & Westen, 2005). In addition, difficulty with impulse control had manifested itself throughout much of her life in the form of substance abuse and bulimia, both of which disorders are highly represented in the BPD population (Zanarini et al., 1998). This patient could be viewed as having had some protective factors in recent years that had muted the full expression of a borderline 'diathesis'. These factors would include the cessation of alcohol use, engagement in psychotherapy and treatment with psychotropic medications. One might also wonder if a switch to disability status had ameliorative effects as well. More recently, however, control of her Axis I depressive disorder had been undermined by poor compliance with medication and by the tremendous psychosocial stress imposed by the suicide of her son and her resultant sense of loss and guilt. Though patients with co-morbid depression and BPD treated with antidepressants can still have considerable mood dysregulation, antidepressants are often useful in lessening the intensity of the depressive states in these patients (Triebwasser & Siever, 2007). Relapse into a frank major depressive episode likely played a large role in the return of Axis II features (Shea et al., 2004). Finally, there is some question as to how inpatient staff's (including the psychiatrist's) initial difficulties in sorting out and responding to her various behavioural and affective manifestations of distress may have driven her towards greater expression of maladaptive defences on the unit.

Questions for the discussant

(1) Is this patient an example of someone who has a dormant personality disorder that has reached a threshold for expression due to multiple severe stressors?
(2) Can one accurately diagnose a personality disorder when an active Axis I disorder is present? (In this patient, this would include major depression and alcohol dependence.) Is there enough evidence from the history and presentation of this patient to justify consideration of a BPD diagnosis?
(3) What was the relative contribution of the staff's 'counter-transference' reactions to the patient in aggravating underlying personality vulnerability towards a more active expression of axis II phenomena? Is the concept of a 'nosocomial personality disorder' valid? Are there ways a staff can react to a patient in her situation that would mute rather than exacerbate these traits?

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(4) What is the role and goals for pharmacologic management of this patient both during the inpatient stay and post-discharge?
(5) Should the recognition of borderline traits affect the assessment and management of self-harm risk, especially when threats of suicidality are made?
(6) How does one work with an inpatient who idealizes her outpatient therapist? And relatedly, what interventions might one make with the outpatient therapist in this regard?
(7) What role did ongoing grief play in sustaining this patient's suicidal regression and depression? What special considerations would one have with patients who have BPD or traits and are grieving a significant loss?

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