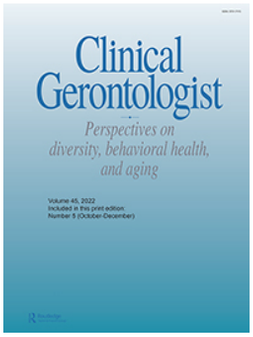
Clinical staging as a novel approach for selecting psychological treatment levels for older adults with borderline personality disorder



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Clinical Staging as a Novel Approach for Selecting Psychological Treatment Levels for Older Adults with Borderline Personality Disorder

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ABSTRACT

Objectives: In this paper, a novel approach is presented for selecting psychological treatment levels for older adults with borderline personality disorder (BPD). BPD tends to be a lifelong disorder persisting into old age, with a specific presentation of BPD symptoms in later life, which is illustrated by three different clinical cases.

Methods: Recently, a clinical staging and health management model for BPD was presented to assist in selecting appropriate treatment approaches.

Results: We combined this clinical staging model for BPD across the lifespan with psychotherapeutic treatment levels for older adults with personality disorders.

Conclusions: This may allow for a more accurate treatment selection for older adults with BPD and was applied to the three clinical cases. Finally, implications for research and clinical practice are discussed.

KEYWORDS

Clinical staging; borderline personality disorder; treatment; psychotherapy; older adults

Introduction

In this paper, a novel approach is presented for selecting psychological interventions for the treatment of older adults with borderline personality disorder (BPD). It is based on the clinical staging model for BPD throughout the lifespan (Hutsebaut, Videler, Verheul, & Van Alphen, 2019), and psychotherapeutic treatment levels for older adults with personality disorders (PDs) (Rosowsky, Young, Malloy, Van Alphen, & Ellison, 2018; van Alphen et al., 2012). The presentation of BPD in later life is illustrated by three cases, to which the new model is applied. Finally, implications for research and clinical practice are discussed.

Borderline personality disorder in later life

BPD is characterized by impulsivity, self-harm, suicidality, and emotional and interpersonal instability (American Psychiatric Association, 2013). Manifestation of BPD changes across the lifespan (Videler, Hutsebaut, Schulkens, Sobczak, & van Alphen, 2019). BPD emerges in adolescence in vulnerable children when exposed to a wide range of social, psychological, and biological risk factors. In adolescence, BPD manifests in impulsive behaviors, identity issues, and affective instability. In adulthood, the manifestation of BPD shifts toward maladaptive interpersonal functioning and enduring functional impairments, while the severity of symptoms fluctuates across time. Empirical know-ledge on the manifestation of BPD in older adults is limited. A cross-sectional study showed that throughout the life course, some BPD symptoms, such as impulsivity, unstable relationships, affective instability, and intense anger, seem to decline more than other features, such as abandonment fears (Guitierez et al., 2012). Large-scale IRT analyses on data of more than 34,000 people showed that older BPD patients appeared to differ in 2 out of the 9 DSM-IV criteria of BPD (McMahon et al., 2019). With increasing age, women were less likely to report suicidal and self-harm symptoms and in both men

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and women unstable interpersonal relationships appeared to discriminate BPD severity better in younger people than in the oldest people.

The 21 experts in an American Delphi study (Rosowsky, Lodish, Ellison, & Van Alphen, 2019) agreed that it is even possible that the first appearance of PDs occurs later in life. Experts in two other Delphi studies, with 35 Dutch and Belgian experts and a cross-validation with 21 international experts, respectively (Rosowsky et al., 2018; van Alphen et al., 2012), agreed that a specific manifestation of cluster BPDs in later life consists of less aggressive and impulsive behavior, more psychosomatic and depressive complaints or passive aggressive, and addictive behavior. The experts also agreed that late appearance (late onset) of BPD can occur after a change in the ability to use coping strategies (for example, due to the development of a somatic disorder) or a change in social circumstances (for example, the death of a supportive partner or moving into a care home). Videler et al. (2019) concluded that, depending on contextual and developmental factors from childhood up to old age, most BPD patients demonstrate periods of remission and relapse throughout adult life, while some showing stable remission. However, the associated psycho-social disability and psychopathology are often chronic and persistently invalidating (Hutsebaut et al., 2019; Newton-Howes, Clark, & Shanen, 2015). The fluctuating nature of BPD should have a major impact on our assessment and treatment of BPD throughout the life span and especially in late life, as illustrated in the following three cases.

Case 1: late appearance of BPD

Mrs. A., 68 years old, has coped with her emotional dysregulation by working in a catering company and training dogs in her spare time. She has had occasional suicidal thoughts and trouble keeping peer relationships, but never met the threshold for BPD. After being forced to take care of her husband, who was suffering from dementia, she could no longer cope with her affective instability. She started drinking alcohol excessively, became increasingly suicidal, and clashed with everyone around her. For the first time in her life, she meets the threshold criteria for BPD.

Case 2: chronic, reemerging BPD

Mrs. B is an 76-year-old woman with BPD and avoidant PD. She presents with low self-esteem and depressed mood, feeling worthless. As a child she experienced sexual abuse by her father. When becoming widowed after 49 years of marriage, relationships with her children became troublesome but had been better in the past. She has a very limited social network, and experiences multiple stressors, for example ongoing physical disorders, and dealing with health-care professionals, severe financial problems, and an unequal partner relationship.

Case 3: irreversible BPD

Mrs. C is a 78 year old woman with BPD. She had been married for 40 years until her husband died. She has two children. Her first child was born before she was married, and the father is unknown. She has not been able to finish her education, nor to keep a job, and was supported by her husband's income and social services. All her life there have been difficulties in anger management, anxiety, and depression. She suffers from severe medical illnesses, such as diabetes mellitus type II and a heart-condition, for which she does not adjust her unhealthy life style and is non-compliant in using medication. She has little social contacts, and her contacts are mainly with health-care professionals, and with the healthcare nurses, who visit her every day for medical reasons. She is most unsatisfied and often angry with the healthcare nurses.

Methods

Clinical staging model for BPD

In each case we applied a clinical staging model. This model offers the possibility to take into account the fluctuating nature of BPD in assessment and treatment. Clinical staging models originated in medicine and are used as a framework for clinical reasoning. For example, in the treatment of malignancies. When these models are applied to mental disorders, they provide a more refined form of diagnosis, and "try to define the extent of progression of disease at a particular point in time" (McGorry, Hickie, Young, Pantelis, & Jackson, 2006). It gives a detailed description of the stage a person is in along the continuum of a disease that tends to progress. Firstly,

underlying ideas are that patients in earlier stages of the disorder show better responses to treatment and better prognosis than patients in later stages. The second underlying idea is that treatments offered in earlier stages should be more benign and more effective. Ideally, the clinical staging model should use a biopsychosocial definition, using clinical features (including relapse), psychological and social functioning, as well as objective measures that link to pathophysiology to differentiate between stages. Knowledge of biological, psychological, and social risk factors for progression and regression between stages is needed, including whether these factors are influenced by (preventive) interventions (McGorry et al., 2006).

Clinical staging models have been developed for several mental disorders and support for their reliability and validity has been found, e.g. for bipolar disorder (de la Fuente-tomás et al., 2020), anxiety, depression, and/or psychotic symptoms (Hickie et al., 2013; McGorry et al., 2006), schizophrenia (Fountoulakis et al., 2019), depression (Verduijn et al., 2015), and anxiety disorders (Bokma, Batelaan, Hoogendoorn, Penninx, & van Balkom, 2020).

Recently, a clinical staging model for BPD has been presented (Hutsebaut et al., 2019). This model takes into account the patient's life span by proposing five stages of BPD, based on the extent, severity and duration of BPD features, the degree and severity of comorbid mental disorders and the degree of disability in social, relational, and professional functioning. This clinical staging model for BPD will need further empirical support to determine the psychological, social, and additionally also biological risk factors to differentiate between the stages, i.e. for profiling. So far, only a recent literature review was able to identify potential psychological, social, and biological risk factors that may predict prognosis in young people with BPD (Hutsebaut & Aleva, 2021). No specific risk factors for the progression and regression between stages for older adults with BPD have been published yet.

Clinical staging model combined with treatment levels in older adults

In all international guidelines, psychotherapy is the first choice of treatment for BPD (e.g. Oldham, 2005; National Institute for Health and Care Excellence, 2015). However, when the clinical staging model is applied to older adults, it is relevant to take the capability and motivation for psychotherapeutic interventions into consideration. The experts in two Delphi studies (Rosowsky et al., 2018; van Alphen et al., 2012) agreed that placing treatment intervention for older adults with PDs on a continuum of treatment levels is useful. Three levels of psychological treatment were differentiated, (1) treatment that provides support and structure, (2) treatment focused on adaptation enhancement and (3) treatment with the focus on personality change. Selection criteria were specified in terms of capability and motivation for treatment (see van Alphen et al., 2012). The three different treatment levels and their specific selection criteria were explored in case studies for guiding the selection of treatment (Videler et al., 2015). In addition, pharmacotherapy was agreed to be selected in case of cognitive perceptual symptoms, serious affective dysregulation, and severe impulse control issues.

In most older patients, BPD has progressed through the early clinical stages, because their PD has developed decades ago and preventive or early interventions were not available when the current cohort of older BPD-patients reached adulthood.

Results

The clinical stages may match to the levels of treatment in the following way, see Table 1. In the threshold stage (stage II) of the clinical staging model, CBT and emotion regulation training is advised, which might match the adaptation enhanced approach of the levels-of-treatment model, in patients without the motivation or ability for psychotherapy, but who are able to make some adjustments on a behavioral level. In the chronic stage of the clinical staging model (stage III), standard psychotherapeutic treatment is advised. This matches the advice in the levels-of-treatment model for patients who have motivation and ability to engage in personality-changing psychotherapy. And in the irreversible stage of the clinical staging model (stage IV), long-term supportive or mediation interventions are advised, which matches the

Table 1. Clinical staging model combined with the levels of treatment for borderline personality disorder in later life.

Clinical staging model				Level of treatment
Stage	Description	BPD features	Health management approaches	
0	Premorbid stage	Self-regulation (irritability, hypersensitivity and excessive self-soothing) and interpersonal functioning (relational aggression)	Psycho-education	
I	Subthreshold stage	Affective and impulsive symptoms (self-injurious behavior, mood swings, temper outbursts) in limited extent, duration and severity	Emotion Regulation Training	
II	Threshold stage	First episode of full BPD, triggered by age specific stressors, with significant problems in the four core areas of affect regulation, impulsivity, identity and interpersonal functioning Late appearance BPD	Emotion Regulation Training and CBT	Adaptation enhancing treatment for clients who are willing to change behavior but are not willing or able to enter personality changing treatment (See also case 1)
III	Chronic stage	During the life course at least 2 years of full BPD and reemerging episodes of remission and relapse, with interpersonal dysfunctioning, loneliness and emptiness. Current relapse triggered by age-specific stressors	Standard psychotherapeutic treatment, including DBT, MBT, TFP, ST	Personality changing treatment for clients who are willing and able (discipline and persistence, self-reflection and toleration of disorganizing effects of psychotherapy) (See also case 2)
IV	Irreversible stage	Chronic full BPD with severe problems in all areas: affect regulation, impulsivity, identity and interpersonal functioning	Long-term supportive and outreaching treatment or cognitive-behavioral therapy involving caregivers and staff (f.i., Cognitive Model for Behavioral Interventions*)	Supportive-structuring treatment for clients with limited or overloaded social support systems, and who are not able or willing to change behavior (See also case 3)

DBT = Dialectical Behavior Therapy; MBT = Mentalization-Based Treatment; TFP = Transference-Focused Psychotherapy; ST = Schema Therapy. *Ekiz, Videler, and van Alphen (2020).
Source: Hutsebaut et al. (2019) and Conjaerts et al. (in preparation).

supportive-structuring approaches in the levels-of-treatment model for patients who are either unwilling or unable to change behavior.

Case 1: threshold stage (stage II) and adaptation enhancing treatment

The level of adaptation enhancing treatment could be selected in the threshold stage of the clinical staging model (stage II), for the previously mentioned late appearance of BPD. At this stage, adaptation to age-specific stressors is aimed for. Case 1 is an example of a patient with BPD who meets the threshold stage for the first time in her later life.

As previously mentioned, Mrs. A. could no longer apply her coping strategy for her emotional dysregulation by keeping busy with work, as she had to care for her husband, who was suffering from dementia. She started drinking alcohol excessively, became increasingly suicidal, and clashed with everyone around her. She was motivated to change her behaviors, such as emotion regulation and coping, but did not want to make the effort for long-lasting personality changing psychotherapy. Adaptation on a behavioral level to the new phase in her life, with the least amount of emotional disorganization, seemed to be her goal. Therefore, we decided to treat her with brief CBT, which involved learning emotion regulation skills and taking time for herself to reduce her stress. This resulted in a reduction of alcohol use, of suicidal thoughts and more stable interactions with family and friends.

Case 2: chronic stage (stage III) and personality changing treatment

In the chronic stage of the clinical staging model (stage III) psychotherapeutic interventions are recommended, in accordance to the treatment level of personality changing treatment. At this stage, willingness to enter therapy, sufficient self-discipline, a reasonable level of self-reflection, and an ability to tolerate the disorganizing effects of psychotherapeutic treatment is required. Case 2 gives an example of a patient with reemerging BPD in the chronic stage. She was treated at the personality changing treatment level.

Mrs. B, the woman with BPD and avoidant personality disorder, had only received long term supportive and outreaching treatment. There were

some periods in her life in which she participated in social relationships, in which she managed to function at a reasonable level and some borderline symptoms were in remission. Additionally, she was able to reflect on the impact of previous experiences on her current behavior and she was more motivated for psychotherapy. She was offered schema therapy, aimed at acceptance and expression of emotional needs and improvement of social contacts in order to feel socially appreciated. We added the supportive interventions of a psychiatric nurse to help Mrs. B to cope with her emotions that became activated during the schema therapy. She improved her ability to express her emotions and needs assertively, resulting in positive interactions with health-care professionals and neighbors (that had previously been problematic), and was able to develop a stable and equal new partner relationship. The heavy mental burden that she had been carrying disappeared and she was able to work through the sadness when reviewing her life that had been full of problems.

Case 3: irreversible stage (stage IV) and supportive-structuring treatment

In the final, irreversible clinical stage (stage IV), the level of treatment selected is long-term supportive and outreaching treatment, which applies to patients with irreversible BPD and severe problems in all areas. In older BPD patients, this commonly includes medical problems and being dependent on medical and life supporting care. Case 3 gives an illustration of a patient with BPD who is in an irreversible stage and for whom long-term supportive-structuring and outreaching treatment from the levels-of-treatment model has been selected.

Mrs. C has had difficulties in anger management, anxiety, and depression during her entire life. Interaction was difficult with the healthcare nurses, who visited her every day for medical reasons. When discussing her problems, she lacked the ability to take her own behavior into consideration, she stated that her problems are other people's fault. In her view all the people with whom she had difficulties needed treatment, but she did not. She was not willing or able to consider her own emotions, thought-processes, and behavior. Therefore, long-term supportive and outreaching treatment, including mediation therapy, was offered, aiming at improving the relationship with healthcare professionals by giving them guidance to cope with this patient. This resulted in less problematic interactions with health care professionals.

Discussion

The application of the clinical staging model for BPD to older adults seems to be promising for selecting feasible and effective interventions. This clinical staging model can be combined with the three psychological treatment levels, adaptation enhancing, personality changing and supportive-structuring treatment for the threshold (II), chronic (III) and irreversible (IV) clinical stages, respectively. It seems very relevant to reconsider these psychotherapeutic treatment options for older BPD patients. In the end, the lack of treatment for older people with PDs in the last decades might give the impression that every older BPD patient is at an irreversible stage (stage IV), where supportive and outreaching treatment is often provided as treatment as usual, while at the threshold (II) and chronic (III) stages other psychotherapeutic interventions might be more applicable and efficacious (Penders, Peeters, Metsemakers, & van Alphen, 2020). Typically, the decision about an intervention should be a shared decision-making process between patient and therapist. Not every older patient in the chronic stage is willing to commit to a standard psychotherapeutic treatment. The proposed model aims to contribute to careful decision making and personalized, more cost-efficient treatments.

More research is needed to determine the specific psychological, social, and biological risk factors to differentiate between the stages for older adults, which may allow for profiling and therefore better predict treatment outcome. Research should focus on the question of which factors predict the progression and regression between the stages, specifically in later life.

In addition, research should address the question whether substages are needed to the clinical staging model of BPD, similar to other clinical staging models for other mental disorders and somatic

illnesses. This would enable further differentiation of profiles. A Delphi study has recently been conducted to gather expert-consensus on these indicators and substages (Conjaerts, Videler, Schepman, Elfeddali, & Van Alphen, in preparation). As BPD is highly stigmatized among mental healthcare providers, specifically in that it is viewed as untreatable (Ring & Lawn, in press), a less stigmatizing name for stage IV, the irreversible stage, could be considered at the same time. Furthermore, research into the reliability and validity of the clinical staging model of BPD in clinical practice is needed. A tool for allocating older PD patients to clinical stages and corresponding levels of treatment is currently being constructed (Conjaerts et al., in preparation), and interrater reliability and criterion validity will be studied empirically by our research group. Retrospective patient records review studies, case studies and, ultimately, randomized controlled trials can add to our knowledge to allocate patients to the most appropriate clinical stage, based on social, psychological and biological risk factors. This will likely contribute to the efficacy and cost effectiveness of interventions for older patients with BPD. Moreover, a clinical staging model has been developed for BPD, and an extension to other personality disorders could contribute to the effectiveness of assessment, treatment, and health management of all personality disorders across the lifespan and into old age.

Clinical implications

- We suggest using a clinical staging model for BPD to consider specific treatment options for older BPD patients.
- Reconsider the psychotherapeutic treatment options for older patients with BPD as these might not have been previously offered to this cohort.
- Take adaptation enhancing treatment interventions into consideration for late appearance of BPD.

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