

## **BOOK REVIEW**

### **Borderline Personality Disorder in Older Adults: Emphasis on Care in Institutional Settings**

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Although borderline personality disorder (BPD) has a prevalence of ~ 6% in the primary care setting, the condition easily can be misdiagnosed or missed altogether by non-psychiatrists in older patients. Debilitating symptoms associated with BPD can be ameliorated with a combination of psychotherapy and pharmacotherapy, although data for the efficacy of individual drugs are based on small clinical trials and observational studies. Failure to recognize BPD and to collaboratively develop effective interventions not only may prevent gains in quality of life, but may subject vulnerable patients to inappropriate, potentially harmful treatments and deprive family and institutional caregivers of the tools they need to effectively care for the patient, as well as to handle the negative transference that commonly occurs.

#### **Barriers to Recognition**

*The hazards of specialty-driven "illness scripts:"* The constellation of affective dysregulation, anger outbursts, black-and-white thinking, poor decision-making, self-neglect, failure to thrive, and strained interpersonal relationships can be attributed to conditions other than BPD that are more commonly seen in older patients, such as dementia, isolated depression, multi-organ chronic illness, and elder mistreatment. Primary care providers are trained to take an organ-system approach to acute and chronic illness and may not explore psychosocial issues unless raised by the patient. Constrained by short visit times, they rely on "illness scripts," which are patterns of clinical presentation that trigger specific differential diagnoses and set priorities for diagnostic and therapeutic interventions. Although geriatrics emphasizes the incorporation of functional and psychosocial issues into clinical decision-making, geriatricians, too, rely on their own set of "illness scripts" as a shortcut to diagnosis and management. If an older patient appears not to be taking her medications, is losing weight, and making frequent visits to the emergency department, concern for self-neglect would be raised. In the Chicago Health and Aging Project, the prevalence of self-neglect in persons aged 65+ had a prevalence of 2.4% in whites and 13.2% in blacks, was present in 14.7% of seniors with less than a high-school education, and was found in 21.7% of seniors with an annual income of < 15,000 U.S. dollars.(1) Our illness scripts for self-neglect might prompt an assessment for depression or cognitive impairment, but likely would not include BPD unless the patient already carried the diagnosis. If a functionally dependent older adult with BPD claims that her children refuse to help her, the "illness script" of elder abuse might surface, prompting a referral to an adult protective services agency that could further strain relationships within the family and potentially damage the family's therapeutic alliance with the doctor. The patient's BPD as the root cause of the strained relations might go unrecognized.

*Time spent on mental-health concerns in primary care:* In observed encounters with older patients, primary-care physicians in a variety of practice settings discussed mental-health topics 22% of the time, but only spent an average of 2 minutes per encounter on the mental-health issues.(2) Given the short amount of time devoted to behavioral health in primary care, the rate of prescription of psychotropic medications is disproportionately high. The Third National Health and Nutrition Examination Survey (1988-1994) revealed that 9.9% of patients age 60+ received one or more prescriptions for a psychotropic

medication, most often for an anxiolytic, sedative, or hypnotic.(3) These data suggest that, as a group, primary-care physicians readily treat symptoms associated with behavioral health disorders, but may be missing or misdiagnosing complex behavioral disorders like BPD.

*Barriers in long-term care:* Recognition of BPD in skilled nursing facilities is hampered by poor training of staff and the often-superficial nature of the mandated monthly visits by physicians and nurse practitioners/physician assistants. Required training for nursing assistants in assisted living facilities is even less. Staff complaints of "agitated behavior," often poorly characterized, frequently are accompanied by requests for tranquilizers. For behavioral disturbances, missing information about the frequency and severity, associated factors, effective and ineffective management strategies, and patterns of interaction with staff hamper correct diagnosis and proper management. It is unknown how often institutionalized patients who have angry outbursts and "agitated" behavior related to BPD are lumped in with all other patients with disruptive behavior. A lack of accessible and accurate information about patients is considered a severe problem in nursing homes, based on the average rating by respondents to a survey of medical directors.(4). Antipsychotic drugs are prescribed to about a third of patients in U.S. nursing homes who are diagnosed with dementia. Facilities with higher use of antipsychotics tend to be larger, urban, and understaffed.(5, 6) In a study of facilities with access to psychiatric consultation, the use of antipsychotics varied two-fold among consultant groups (range 12.2% to 26.4%), even after adjusting for resident case-mix and facility characteristics.(7) To the geriatrician or primary-care physician, this variation in practice patterns should be unsettling. Some of the variation could be explained by differences in the quality of patient information made available by the facility and the family to the consulting psychiatry group.

*Access to mental health services for older patients in the U.S.:* In the 2004-2005 Community Tracking Study, 66.8% of non-federal primary-care physicians surveyed reported that they were unable to obtain high-quality outpatient mental-health services for their patients, compared to 33.8% for inability to obtain high-quality specialist referrals.(8) Starting in January, 2014, Medicare required 100% parity in the percent reimbursed to mental-health professionals of allowed charges, compared to the percent reimbursed to other specialists. However, the formulae for reimbursement heavily weight the higher overhead of proceduralists compared to the cognitive specialties, resulting in overall lower reimbursement rates for psychiatrists and psychologists. Medicare's payments to clinical psychologists declined a cumulative 24% between 2007 and 2013,(9) creating a disincentive to provide psychotherapy to Medicare recipients outside of managed care plans. Psychotherapy, an important element in the treatment of BDP in the older patient, may be difficult to obtain in some communities.

*Fragmentation and the loss of continuity of care:* In the present U.S. health-care system, care is fragmented between the hospital, outpatient clinic, emergency department, and the nursing home, especially in metropolitan areas. Outpatient specialty care adds to the fragmentation, with treatment often initiated and modified by specialists instead of recommended to the primary-care provider, the traditional coordinator of care. Acute-care clinicians tend to focus on the acute illness and may miss clues to an underlying BPD unless there is documentation in the patient's institutional medical record, which often does not include mental health records.

*A 61-year-old man is admitted to the orthopedic service from a nursing home after standing up from his wheelchair and losing consciousness, sustaining a right shoulder fracture. He has a history of type 1 diabetes mellitus that has been poorly controlled due to medication non-adherence.*

*Complications include severe autonomic neuropathy with profound orthostatic hypotension, despite severe supine hypertension. As an inpatient, he intermittently refuses his insulin despite blood sugars over 400 mg/dl, refuses to wear compression stockings despite several pre-syncopal episodes from orthostatic hypotension, walks to the bathroom alone against physician orders, and routinely becomes hostile to and "fires" some of his doctors and nurses, while remaining polite to others. At the nursing facility he had been placed on olanzapine because of frequent agitation and angry outbursts, and carried a diagnosis of schizoaffective disorder. Family reported that he abused marijuana and alcohol at the facility. A psychiatric consultation is called in the hospital to assess him for BPD. He is somewhat hostile to the consulting psychiatrist and declines to discuss his background or current psychosocial situation. The psychiatrist finds him to have limited judgment and insight, concrete thinking, no delusional beliefs, and no evidence of homicidal or suicidal ideation, but considers him to be mildly depressed. The psychiatrist is concerned about delirium and a substance-abuse disorder, and recommends low-dose olanzapine and follow-up with the psychiatric consultant to the nursing home "who knows him better." No diagnosis of BPD is made.*

The acute-care setting, in which the older patient may be very ill, delirious, or under the influence of opiates, anticholinergics, or other medications that could affect cognition, can be a poor environment in which to evaluate a patient for BPD. In primary care it is not uncommon for patients to be pinned with an inaccurate diagnosis ("chart lore") that sticks with them and which treating physicians accept as truth, thereby perpetuating the misdiagnosis and hampering re-analysis of the symptoms. It is likely that the same applies to complex psychiatric disorders like BPD. In the modern era, these patients transition from one primary-care provider to another, from one health system to another, and from one acute-care setting to another. In a fragmented healthcare environment, the continuity of care that allows symptoms that arise over time to be connected into a pattern fitting the diagnosis of BPD may never occur. As in this patient, certain behavioral disorders may emerge that label the patient as having one or more psychiatric illnesses, but the dots revealing the classic signs and symptoms of BPD never are connected.

As this book reveals, recognition of BPD in older patients may be particularly challenging. It is a diagnosis to which primary-care physicians, hospitalists, and emergency-room physicians -- not just psychiatrists -- need to be attuned. For general internists and family physicians interested in mental health issues (and all should be), this book provides valuable information about clues to making the diagnosis and insight into its optimal management in the older patient. Even though the length of continuity of care today may be measured in years, rather than decades, primary-care physicians have the greatest opportunity to pick up valuable clues that would place BPD on their list of differential diagnoses, if they were educated about its presentation. Providing the psychiatrist with these clues, gathered over months to years of longitudinal follow-up, could facilitate making a formal diagnosis and instituting appropriate therapy.

Psychotropic medication has the potential for serious complications in older patients, ranging from an increased risk of all-cause mortality with antipsychotics to an increased risk of falls with serotonin agonists and gait instability from anticonvulsant mood stabilizers. The types and doses of psychotropic medication should be determined based on a close collaboration with primary-care providers and shared medical records, rather than selected and started in isolation. Integrated psychiatric and primary care may increase the number of primary-care visits but reduces costly visits to the ED,(10) and represents a model

for the management of BPD. Those who furnish medical care to older patients and confront their mental as well as physical illnesses will find this book informative and a valuable reference.

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