Psychiatry Research 258 (2017) 44–50

Contents lists available at ScienceDirect

Psychiatry Research

journal homepage: www.elsevier.com/locate/psychres

Differential symptomatology and functioning in borderline personality disorder across age groups

Álvaro Frías[a,b,*], Carol Palma[a,b], Laia Solves[b], Bárbara Martínez[b], Ana Salvador[a,b]

[a] Facultad de Psicologia, Ciencias de la Educación y el Deporte Blanquerna, University of Ramon-Llull, Barcelona, Spain
[b] Consorci Sanitari del Maresme, Department of Psychiatry, Hospital of Mataró, Mataró, Spain

ARTICLE INFO

Keywords:
Aging
Aggression
Suicide attempts
Depression
Anxiety
Somatization

ABSTRACT

There is increasing research aimed at addressing whether patients with borderline personality disorder (BPD) may exhibit variations in symptomatology and functioning according to their chronological age. The current study consisted of 169 outpatients diagnosed with BPD, who were divided into four age groups as follows: 16–25 years (n = 41), 26–35 years (n = 43), 36–45 years (n = 45), and 46 and more years (n = 40). Age groups were compared for symptomatology, normal personality traits, psychiatric comorbidities, functioning, and treatment-related features. The younger group had significantly higher levels of physical/verbal aggression and suicide attempts relative to the older group. Conversely, the older group had significantly greater severity of somatization, depression, and anxiety symptoms. In addition, the older group showed significantly greater functional impairment overall and across physical/psychological domains, specifically when compared to the younger group. Overall, these findings may suggest that age-related symptoms should be considered when diagnosing BPD. Also, functional impairments should be the target interventions for older BPD patients.

1. Introduction

Borderline personality disorder (BPD) is a psychiatric disorder characterized by emotional dysregulation, behavioral dyscontrol, interpersonal disturbances, and an unstable self-image (Skodol et al., 2002). Over the 20th century, it was suggested that one of the cardinal features of the personality disorders (PDs) in general and BPD in particular was their *enduring* nature. Also, it was assumed that *consistent* longitudinal symptomatology was a key element in establishing true diagnoses of any PD (American Psychiatric Association, APA, 1994).

Until recently, these assumptions have influenced clinical decision analysis for recognizing BPD. However, current research is progressively confirming to what extent these premises were erroneous. Regarding the first issue, recent data from large prospective longitudinal studies converge in the finding that PDs in general are not as enduring as once thought. Concretely, research on BPD has shown that over 55–95% of treated patients do not meet criteria for this psychiatric pathology after 6, 10, 16, 17, and 27 years of follow-up. Specifically, rates of remission were usually greater among older patients at intake and also for those studies using a longer period of assessment (Paris and Zweig-Frank, 2001; Zanarini et al., 2003, 2012; Gunderson et al., 2011; Alvarez-Tomás et al., 2016; Kjaer et al., 2016). Regarding the second issue, ongoing cross-sectional and longitudinal research has found that symptomatic consistency is the exception rather than the rule in those meeting criteria for BPD at long-term. In fact, it has been proposed that some BPD features may be more transient, while others may be more trait-like and temperamental. Particularly, research on this issue has usually found that impulsiveness, self-harm, and anger criteria diminish over time, and most of the elderly BPD patients do not have these clinical characteristics. Conversely, interpersonal disturbances (e.g., demandingness, entitlement), emotional dysregulation, and affective symptoms (depression, anxiety, somatization) tend not to decline in late life among BPD patients (Stevenson et al., 2003; Zanarini et al., 2003, 2017; Hunt, 2007; Blum et al., 2008; Stepp and Pilkonis, 2008; Choi-Kain et al., 2010; Gunderson et al., 2011; Arens et al., 2013; Morgan et al., 2013; Alvarez-Tomás et al., 2016; Beatson et al., 2016; Wedig et al., 2013). Based on these findings, some authors have suggested that the latter clinical characteristics may be core BPD features and, as such, relatively resistant to change. In contrast, the former BPD symptoms may spontaneously resolve relatively early in life. Overall, longitudinal symptomatic heterogeneity in BPD may ultimately indicate that effects of maturation may exert a role in the pathoplasty of BPD (Fonagy et al., 2015). Beyond BPD symptomatology, some of these studies have also focused on delineating whether functioning and comorbidity change over time among BPD patients. First, it has been observed that functioning is more impaired when BPD patients are older (McGlashan,

* Correspondence to: Facultat de Psicologia, Ciències de l`Educació i l'Esport Blanquerna, Císter st. 34, 08022 Barcelona, Spain.
E-mail address: afrias@csdm.cat (Á. Frías).

http://dx.doi.org/10.1016/j.psychres.2017.09.081
Received 5 April 2017; Received in revised form 24 September 2017; Accepted 26 September 2017
Available online 28 September 2017
0165-1781/

1986; Blum et al., 2008; Shea et al., 2009; Morgan et al., 2013). Second, substance use disorders (SUDs), eating disorders (EDs), and post-traumatic stress disorder (PTSD) are more prevalent among younger BPD patients, while major depression disorder (MDD) and dysthymia are the opposite of those (Zanarini et al., 2003, 2010, 2011a, 2011b; Morgan et al., 2013; Beatson et al., 2016). The fact noted above that some clinical phenomena (e.g., impulsiveness, self-harm behaviors) reduce over time while functioning may be more impaired later in life may suggest that symptomatic improvement is not necessarily accompanied by functional recovery over time. Also, this may reflect that core BPD symptoms (e.g., emotional dysregulation, interpersonal disturbances) may be ultimately responsible for functional impairment at long-term.

The current study sought to extend prior research on the differential characteristics of BPD from adolescence to elderly stages. Specifically, we aimed at addressing whether BPD patients differed in clinical features, psychiatric comorbidities, functioning, and treatment-related variables across age groups. To this end, this research was intended to solve some methodological limitations commonly encountered thus far. First, BPD patients under 18 years were included, since ongoing research is devoted to the diagnosis of BPD in youth. Second, functioning was not merely focused on assessing global but also multi-dimensional areas that may be differentially affected over time (e.g., social, physical). Third, following a hybrid diagnostic model of PDs in general, trait measures of normal personality were also included to compare them to BPD symptomatology over time (Samuel and Widiger, 2008; Hopwood et al., 2009; Hopwood and Zanarini, 2010; Fonagy et al., 2015).

2. Materials and methods

2.1. Participants

Clinicians at the Outpatient Mental Health Center of Mataró (Barcelona, Spain) referred patients to us between January 2015 and March 2017. Inclusion criteria were: (i) lifetime diagnostic criteria for BPD, according to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) (APA, 1994) and (ii) aged 16–65 years. Exclusion criteria were: (i) lifetime comorbidity with a psychotic disorder and/or pervasive developmental disorder, (ii) current episode (hypo)manic according to DSM-IV criteria, (iii) diagnosis of intellectual disability (IQ < 70), as recorded by the clinical charts, and (iv) idiomatic barriers for reading/speaking Spanish or Catalan languages. Because of the great prevalence of current SUD among BPD patients, only those who manifested symptoms of intoxication or substance withdrawal at the time of testing were excluded. Referred patients received naturalistic psychological treatment consisting of individual and/or group psychotherapy based on Schema Focused Therapy (SFT) (Young et al., 2003). Also, they attended naturalistic psychopharmacological treatment.

Of the 181 potentially suitable outpatients, seven declined to participate, mainly because they did not want to respond to sensitive issues in the questionnaires. Another five patients did not meet lifetime criteria for BPD. Akin to other related studies, the final sample of 169 BPD patients was divided into four age groups: *16–25* (n = 41), *26–35* (n = 43), *36–45* (n = 45), *46 and more* (n = 40) (Blum et al., 2008; Arens et al., 2013; Morgan et al., 2013). On average, participants attended one session of two hours in order to complete the hetero-administered questionnaires and the semi-structured interviews. All participants were interviewed directly by the authors of the manuscript, who are doctoral-level clinicians, clinical psychologists, or psychiatrists widely experienced in personality disorders. The degree of agreement between interviewers for the diagnosis of BPD was high (Cohen's *Kappa* = 0.87). One week later, self-administered questionnaires were completed by the participants in a second session, in which, if required, interviewers resolved any doubt regarding the items.

The hospital's Institutional Review Board approved the study, and all patients gave informed consent after a full explanation of the nature of the study.

2.2. Assessment instruments

The Spanish translation of the Structured Clinical Interview for DSM-IV Axis I Disorders, Research Version, Patient Edition (SCID-I/P) is a semi-structured interview that was used for making current DSM-IV Axis I diagnoses of ED, SUD, MDD, and PTSD (First et al., 1995). In addition, the Spanish translation of the SCID-II was used for making lifetime DSM-IV Axis II personality disorder diagnoses in general and, specifically, BPD (First et al., 1997).

The Spanish validation of the 13-item short form of the Beck Depression Inventory (BDI) was used (Beck and Beck, 1972; Conde and Useros, 1975). The Spanish validation proved a reliable instrument for assessing the severity of depressed mood (Cronbach's alpha = 0.90).

The Spanish translation of the Scale for Suicidal Ideation (SSI) was used to assess the greatest severity of suicidal ideation over the last 12 months. This hetero-administered scale consists of 19 items. Responses are based on a 3-point Likert scale (0 − 2). Thus, the total score ranges from 0 to 38. The higher the score, the greater the seriousness or intensity of suicidal intent. An additional item also registers previous suicide attempts over the last 12 months as follows: 0 = *None*; 1 = *One*; 2 = *Two or more*. The SSI has an adequate internal consistency (Cronbach's *alpha* = 0.89) and inter-rater reliability (Cohen's *Kappa* = 0.83) (Beck et al., 1979).

The Spanish validation of the Symptom CheckList Revised (SCL-90-R) was used to assess general psychopathology (Derogatis, 1977; Robles et al., 2002). The SCL-90-R consists of 90 items, comprised of nine dimensions of psychopathology: somatization, obsessive-compulsive, depression, anxiety, phobic anxiety, hostility, interpersonal sensitivity, paranoid ideation, and psychoticism. Patients are asked to answer using a 6-point Likert scale (0 − 5). Spanish validation of the SCL-90-R has adequate psychometric properties (Cronbach's *alpha* = 0.70–0.89).

The Spanish validation of the Buss and Perry Aggression Questionnaire (AQ) was used to assess aggression (Buss and Perry, 1992; Andreu et al., 2002). The AQ is made up of 29 items and is comprised of four subscales: physical aggression, verbal aggression, anger (physiological arousal and preparation for aggression), and hostility (feelings of ill-will and injustice). A 5-point Likert scale (1 − 5) is used to answer each item. The higher the score is, the greater the severity of aggression. The Spanish validation of the AQ has adequate psychometric properties (Cronbach's *alpha* = 0.72–0.88).

The Spanish validation of the NEO Personality Inventory Revised version (NEO PI-R) was used to assess trait measures of normal personality based on the FFM (Costa and McCrae, 1985; Sanz and García-Vera, 2009). The NEO PI-R is a self-reported questionnaire consisting of 240 items. It has five basic scales, each consisting of 48 items, which correspond to the basic dimensions of personality: Openness to experience (O), Conscientiousness (C), Extraversion (E), Agreeableness (A), and Neuroticism (N). In addition to assessing the five overall personality dimensions, the NEO PI-R also measures six facets of each of the five dimensions. Patients are asked to answer using a 5-point Likert scale (0 − 4). The higher the score is, the greater the agreement with the statement. Similar to other studies (Sutin et al., 2012), an Impulsivity index was created, based on the average score of four impulsivity-related facets of the NEO-PI-R: Impulsiveness (N5), Excitement-Seeking (C5), Self-Discipline (C5), and Deliberation (C6). The Spanish validation of the NEO PI-R has an adequate internal consistency (Cronbach's alpha > 0.85).

The Spanish validation of the World Health Organization Quality of Life, Short-Form (WHOQOL-BREF) is a self-reported questionnaire used to assess functioning (Lucas-Carrasco et al., 2011). It is comprised of 26 items – 24 items covering four domains (physical health, psychological health, social relationships, and environment) and two global questions about overall functioning and satisfaction with health. Each item is