Case report: euthanasia in an older adult with personality disorder

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Introduction
Personality disorders can be challenging to conceptualise and manage, particularly in the older adult.

The literature about older adults with personality disorder is scanty, and long term outcomes appear to be mixed. Some authors suggest that some types of personality disorder may become attenuated with age, and that older adults are more likely to present with Type C personality disorders (DSM IV: obsessive compulsive, avoidant, dependant), rather than Type B (antisocial, borderline, histrionic, narcissistic) which tend to be the predominant type found in general adult services.

Patients within older adult mental health services (OAMHS) with diagnoses of personality disorders can be categorised into two main groups: “graduates” who were known to a general adult psychiatric service prior to transition to OAMHS, and those with first acquaintance with mental health services over the age of 65 years. There is scope for research to identify if these groups are substantially different: i.e. are the graduates the more conventional Type B personality disorder and how do they fare with increasing age and perhaps onset of frailty? The other issue needing an evidence base is whether people with late-life diagnoses of personality disorder (new to services) have developed personality disorder traits as a marker of neurodegeneration or whether there were factors in the environment which modulated or absorbed the expression and impact of the maladaptive personality traits in earlier life.

While there is a known association of personality disorders with self harm and suicide, there are no known reports of personality disorders and euthanasia.

Case study
This paper concerns a deceased 77 year old married woman, who presented to the older adult services for the first time aged 70.

1 Consent to publication was obtained from the patient’s husband
Mrs A initially presented to the local Accident and Emergency (A and E) services having been referred by her general practitioner (GP) with anxiety and threats of self harm after her long term diazepam was reduced from 5mg four times a day to 5 mg twice daily. There was also a history of a recent family bereavement. The reduction in the dose of diazepam was mandated by a central drive to reduce all benzodiazepine use in the locality.

The patient also had a medical history of a low grade vaginal prolapse and recto-vaginal fistula, back pain and arthritis.

She was initially offered a compromise of an interim increase of diazepam to 5mg three times a day, and discharged back to the GP with grief counselling to be arranged. She self-referred to the crisis team 2 days later, threatening to harm herself unless she was seen at home that day. When the crisis team indicated that they would have to get police involved as they could not immediately attend, she retracted the threats and informed them that she was going to attend the grief counselling session which was scheduled for the following day.

At this point, she was referred to the older adult mental health services, who arranged a formal psychiatric review and allocated a care coordinator. As the older adult mental health team built up a relationship with her, it became clear that her behaviours were well established prior to contact with mental health services and that her first reported attempt of self harm happened in her twenties. She had married, raised her children and worked for about 15 years, apparently without being referred to services.

Reports from family members suggested that she was always focused on herself, and would engage in behaviour that brought her attention, even when inappropriate in the context. She was well known to the GP team, and would be very demanding of their time, often requesting appointments and home visits for what seemed to be spurious reasons.

She was diagnosed with emotionally unstable personality disorder of the borderline type after an extensive period of assessment which included 2 periods of detention under Section 2 of the Mental Health Act. There was no evidence to support the presence of cognitive impairment, or recent personality change prior to contact with services.

Mrs A was poorly compliant with treatment modalities offered, including pharmacotherapy, behavioural therapy and psychotherapy. She refused to
attend the grief counselling. She continued to engage with services and would phone, sometimes up to 20 times a day to speak to various team members. She also attended A and E regularly, even when she had been seen by the mental health team on the same day. She would phone the GP several times a day for various reasons such as back pain or the prolapse. She also phoned the ambulance services about 80 times in a 2 year period.

Her attitude to self harm seemed particularly challenging. She would threaten to drown herself and ask her husband to convey her in the family car to a suitable site, which she would then turn down as either too deep or too cold. On one occasion, she threatened to drown herself in the bath, and climbed out a few hours later because her husband had refused to call for help, and the bathwater had turned cold. On another occasion, she loudly counted out the paracetamol tablets she was taking as an overdose until she got to 16, whereupon she insisted that her husband took her to A and E to get help. She physically assaulted her husband on one occasion when he tried to reason with her demands to be taken to hospital. She agreed to have help for the vaginal prolapse, but sabotaged any attempts to have treatment, and then loudly insisted that she had seen so many doctors who had all told her it was untreatable. She would also describe, with a visible sense of enjoyment, how faecal matter would escape from the fistula, often in an attempt to derail any kind of discussion of her mental health needs.

It was difficult to understand the psychological drivers of her behaviour, but on one occasion when visited at home by her psychiatrist, she became very angry and insisted that she had a natural right to make any demands on her husband, as she was ill. She mentioned several friends of theirs who were similarly dependent on their husbands.

The OAMHS team adopted a pragmatic responsive approach which brought together GP, ambulance and the local A and E team. The management plan specified that she should have a psychiatric assessment whenever she presented to A and E, with a view to actively avoiding admission except where indicated under the Mental Health Act. It also specified that the dose of her diazepam (then 5mg twice daily) should not be altered, and no other psychotropics should be prescribed unless agreed with her core psychiatric team.

She was seen regularly in the community by her psychiatrist and CPN. Her unscheduled contacts with the various services seemed to stabilise for a few months. When she did not attend a scheduled outpatient review
with her psychiatrist, the psychiatrist requested that active inquiry should be made by her care coordinator, to which the patient intimated that she and her husband had “a plan”. When this was fed back, her psychiatric consultant queried whether the allusion to “a plan” meant the possibility of suicide / homicide. Both the patient and her husband directly denied this.

Another appointment was arranged for a few weeks later. She did not attend. Her care coordinator contacted the family home to be informed that she had died in a European euthanasia facility the previous week.

Comments
The case raises the prospect that older people with personality disorders may seek to include euthanasia in the pantheon of self harm options. It also raises issues about the processes for screening patients for euthanasia in jurisdictions that legally allow this.

Euthanasia is the ultimate expression of autonomy in our time. Whether this expression of autonomy should be extended to all who are able to voice and afford it irrespective of physical disorder is another question that we do well to consider as old age psychiatrists.