Emotionally Unstable Personality Disorder: An In-Depth Analysis in Clinical Practice

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Abstract

Emotionally Unstable Personality Disorder (EUPD), formerly known as Borderline Personality Disorder (BPD) is a multifaceted mental health condition affecting approximately 1.6% of the general population and 20% of psychiatric inpatients. This disorder manifests in intense and unstable relationships, emotional dysregulation, impulsivity and an inconsistent sense of self. Individuals with EUPD often face challenges in daily life, including conflicts, fear of abandonment and difficulties in occupational and educational pursuits. This paper presents a comprehensive literature review on EUPD, focusing on its clinical presentation, diagnosis and treatment approaches. The DSM-V and IDC-11 criteria are discussed, highlighting common features and differences. Various psychotherapeutic approaches, such as Dialectical Behavioural Therapy (DBT), Mentalisation-Based Treatment (MBT), Schema-Focused Therapy (SFT) and Transference-Focused Psychotherapy (TFP) are explored. Pharmacotherapy, including antidepressants, anticonvulsants, antipsychotics, mood stabilisers, Cannabis-Based Medicinal Products (CBMP) and Omega-3 Fatty Acids are examined. Challenges in clinical practice, such as diagnosis disclosure, referral to specialist therapy and involuntary hospitalisation are addressed. The paper concludes by emphasizing the importance of understanding recovery and quality of life for individuals with EUPD. It acknowledges the promising prospects of CBMPs and Omega-3 Fatty Acids in treatment, urging further research. Furthermore, the study contributes to the broader understanding of EUPD, guiding future research and clinical efforts.

Key words: EUPD, BPD, diagnosis, Dialectical Behavioural Therapy, pharmacotherapy, quality of life

An Overview on Emotionally Unstable Personality Disorder

Emotionally Unstable Personality Disorder (EUPD) is a complex mental health condition characterised by a significant negative impact to one's personality, leading to at least one pathological personality trait. Some surveys estimated the prevalence of 1.6% of the total general population to have this disorder, as well as 20% of the psychiatric inpatient population (1). People who have this disorder demonstrate 'intense and unstable interpersonal relationships, dysregulation of emotions and impulses and an inconsistent sense of self' (2). This can lead to noticeable consequences in a person's daily life and social functioning, such as high levels of conflict, a fear of abandonment and dependency and a general sense of instability (3). Some symptoms may manifest as self-destructive impulsive behaviours such as self-harming, often pronounced with co-morbidities like feeding and eating disorders (FEDs) (4), alcohol use disorder (AUD) (5) and substance misuse (6). Individuals with EUPD generally have a poorer level of occupational and educational outcomes than others do (6). They may also encounter 'difficulties with the healthcare system due to stigma', unfortunately barring access to necessary treatments (7, 8). In fact, there is ample documentation which states that patients with personality disorders consult psychiatric

services less, compared to individuals with 'other conditions such as depression or schizophrenia' (9). From a study based on the Netherlands Mental Health Survey and Incidence Study-2, an attempt was made Disorder Examination. From the total population studied, 25.2% had 1-2 EUPD symptoms and 4.9% had over three symptoms (10). It was also discovered that the number of symptoms had a positive relationship vis-à-vis living with partner, unemployment and/or having the aforementioned comorbidities of substance use, mood or anxiety disorders (10). This particularly highlights the importance of being well-informed and aware of the presence of this disorder in the community. Despite its clinical utility, the term "Borderline Personality Disorder" has often been associated with stigma surrounding this disorder. The word "borderline" can imply a sense of ambiguity or 'being on the edge', which can perpetuate misconceptions and negative stereotypes, while "emotionally unstable" personality disorder places more emphasis on the core features of the condition. By centering the term around these key characteristics, individuals diagnosed with the condition are more accurately represented and it is a crucial step forward in promoting greater empathy towards them.

EUPD patients have been found to be at an increased morbidity and mortality, when compared to the rest of the population, underlining the importance of studying and monitoring this disorder's presence in the community (11).

Methodology

A literature review was conducted across academic databases including PubMed and Science Direct, utilising keywords such as "EUPD", "BPD", "aetiology", "pharmacotherapy", "treatment" and "challenges". The search encompassed articles mainly published within the past decade, written in English and focused on the various aspects of EUPD, its definition, diagnosis and treatment modalities.

Articles were screened based on their titles and abstracts to identify potentially relevant studies. Full-text review was then performed for articles meeting the following criteria:

1. Relevance to Emotionally Unstable Personality Disorder and its ties to Clinical Practice
2. Availability in the English language
3. Original research articles, reviews and clinical trials.

Key data points were extracted from selected studies, including study objectives, methodology employed, participant demographics and numbers, key findings and the conclusion drawn by the authors.

The extracted data was then synthesized according to theme to identify the common patterns, trends and gaps in the literature pertaining to EUPD. This involved categorising the studies based on the focus areas mentioned above. Through this process, a comprehensive understanding of the current landscape of EUPD research was achieved in this review, allowing for insights and implications for clinical practice and public health initiatives.

Clinical Presentation and Diagnosis

Both the Diagnostic and Statistical Manual 5th edition Text Revision (DSM-V-TR) and the International Classification of Diseases 11th revision (ICD-11) attempt to create a set of criteria for EUPD (referred to as BPD at the time of publication). The DSM-V-TR refers to it as BPD, while the ICD-11 refers to it as EUPD.

Common Features of the description of EUPD in DSM-V-TR AND ICD-11

- An impairment in inter-personal functioning, causing a struggle with forming and maintaining healthy relationships.

- Identity disturbance, such as an unstable self-image, a general sense of uncertainty a general feeling of emptiness.

- Affective instability: Emotional dysregulation and intense mood swings are pivotal features for the diagnosis. This can also be the cause for the co-morbidities seen in EUPD such as anxiety and depression – with patients suffering from EUPD having a range of 71-83% rate of lifetime depression comorbidity, and a rate as high as 88% for anxiety disorder (12).

- Impulsive behaviours: Potentially harmful impulsive behaviours such as substance abuse, gambling and sexual promiscuity (13).

Differences of the Description of EUPD in DSM-V AND ICD-11

- Terminology: While the DSM-V-TR uses the term "Borderline Personality Disorder", the ICD-11 uses the term "Emotionally Unstable Personality Disorder".

- Criteria: The DSM-V states nine criteria for diagnosis of EUPD as follows (14):

    1. Frantic efforts to avoid real or imagined abandonment
    2. A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation and devaluation
    3. Identity disturbance: markedly and persistently unstable self-image or sense of self
    4. Impulsivity in at least two areas that are potentially self-damaging
    5. Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour
    6. Affective instability due to a marked reactivity of mood
    7. Chronic feelings of emptiness
    8. Inappropriate, intense anger or difficulty controlling anger
    9. Transient, stress-related paranoid ideation or severe dissociative symptoms

The DSM-V requires meeting five out of nine criteria for a diagnosis of BPD (14). After recognising and characterising a number of these trait domains, one can also further differentiate the personality disorder by adding a "Borderline Pattern Specifier", which is based on the nine DSM-V-TR BPD diagnostic criteria, as stated above (19).
In contrast, the ICD-11, first diagnoses the impairments to personal functioning, both to the self and to other people, and classifies them according to their severity: Mild, Moderate or Severe Personality Disorder (15). Additionally, the patient can be assigned a 'sub-threshold' Personality Difficulty Code. Trait domains are used to further sub-specify the individual features that contribute to the disorder, these being:

- Negative Affectivity - A personality trait encompassing experiences of negative emotions and a diminished self-concept including anger, disgust, fear and anxiety (16).

- Detachment: The disengagement or disconnect from other people, which manifests both physically and emotionally (17).

- Dissociality: This includes negative variability in emotional states such as trust, compassion and respectfulness (18). Disturbances can be marked by transient symptoms or episodes such as paranoia in situations of elevated emotional arousal (19).

- Disinhibition: The inability of self-regulation or control over one's own behaviour. High disinhibition is displayed as spontaneity and a lack of consideration to long-term consequences that may potentially arise from their actions (20).

- Anankastia: Anankastia is etymologically derived from anankatikos – a Greek word meaning "compulsion". This trait encompasses perfectionism, stubbornness and preservation (18).

Aetiology in EUPD

EUPD has been found to have a significant genetic component, with twin studies indicated a heritability rate of over 50%, surpassing that of major depressive disorder (21). Environmental factors also play a crucial role, notably childhood maltreatment such as physical, sexual or neglectful experiences, found in up to 70% of individuals with EUPD. Theories suggest that a lack of resilience to stressors, invalidating environemtns and disturbances in early maternal relationships contribute to its development. Neuroimaging studies indicate differences in brain regions and misattribution of emotions in EUPD patients, alongside impared serotonin function (22).

Treatment Approaches to EUPD

Psychotherapy

Once thought untreatable, advancements in treating EUPD involve outlining generalist care models versus specialist treatments, and recognising crucial elements of psychotherapy such as Dialectical Behavioural Therapy (DBT). DBT is an evidence-based treatment for EUPD that originated from the efforts to address suicidal behaviour in multi-problematic women.

It incorporates cognitive-behavioural interventions, emphasizing acceptance and change-oriented strategies within a dialectical philosophy. The functions DBT aims to challenge are (23):

1. Enhancing and generalising capabilities
2. Improving motivation
3. Maintaining therapist capabilities
4. Structuring the environment

DBT conceptualises the challenges associated with EUPD as arising from the interplay between individuals inherently sensitive to emotions and "invalidating environments". These environments, represented by people or systems such as families and the workplace, are characterised by an inability to comprehend, perceive and effectively respond to the vulnerabilities of individuals with such a high emotional sensitivity.

DBT uses mindfulness and acceptance interventions to help the patient manage their emotions, showing promise in cases involving substance abuse disorders, binge-eating disorders and even depressed elderly patients (23).

While research on pharmacological interventions is limited, no specific medications have been proven to offer standalone treatment (24).
Some of the other treatments for EUPD include:

1. Mentalisation-Based Treatment (MBT)

Focuses on enhancing the individual's ability to mentalise, which involves understanding thoughts and feelings in one's own and others' minds to navigate interpersonal interactions. For those with EUPD, MBT addresses symptoms stemming from a breakdown in mentalisation, leading to distorted perceptions, a disconnection from reality and heightened attachment distress. MBT aims to stabilize EUPD issues by reinforcing patients' capacity during stress, using a therapeutic approach that prioritises curiosity, uncertainty and patient-driven exploration (24).

2. Schema-focused therapy (SFT)

An integrative form of psychotherapy developed for treating personality disorders, particularly EUPD. It incorporates concepts from cognitive behavioural therapy, attachment theory, gestalt therapy and psychodynamic perspectives, focusing on Early Maladaptive Schemas (ESM) and schema modes to understand and address dysfunctional patterns of thoughts, behaviours and emotions developed during childhood. This is done with the goal of improving self-understanding and emotional regulation in individuals with EUPD (25).

3. Transference-focused psychotherapy (TFP)

A psychanalytically informed treatment primarily designed for patients with EUPD. It works by exploring and understanding the patterns of emotions, thoughts and behaviours that individuals with EUPD may experience in their relationships, as a result of internal conflict in the working models of relationships (24) The therapy focuses on the concept of "transference" where feelings and attitudes from past relationships are unconsciously transferred onto the therapist. By addressing these patterns and emotions into the therapeutic relationship, indivudals gain insight into their interpersonal difficulties and learn healthier ways to relate to others. Overall, the goal is to improve self-awareness, emotional regulation and interpersonal functioning (26).

4. Systems Training for emotional predictability and problems solving (STEPPS)

A psychotherapeutic model applied to severely affected patients with EUPD or personality disorders with significant borderline features with a mood disorder. STEPPS focuses on emotional predictability and problem-solving, emphasizing stable settings, defined therapeutic goals and an active role for the therapist in addressing emotional and behavioural dysregulation in these individuals. (27)

It is important to note that STEPPS, although not designed as a stand-alone treatment, some research indicates that STEPPS' group sessions can enhance concurrent EUPD treatments (26).

Pharmacotherapy

There has been about three decades of research on treating EUPD with pharmacotherapy, and yet, there has not been a single medication that has been approved as a 'stand-alone' treatment by the national drug authority (24, 28). However, despite the lack of evidence, the use of pharmacotherapy remains commonly used to help EUPD patients for symptom control, with up to 90-95% of patients with EUPD receiving pharmacotherapy (29).
Classes of drugs used in EUPD:

1. Antidepressants

Selective serotonin reuptake inhibitors (SSRIs) have been found to have a minimal effect on the impulsive aggression in EUPD. However they may have modest effects in decreasing symptoms such as depression, anxiety and mood swings – such as with Paroxetine, which showed a possible decrease in suicidal tendencies, or fluvoxamine, which showed a mild improvement in affective impulsivity (31)

2. Anticonvulsants
Anticonvulsants are used in EUPD due to their therapeutic benefits in managing mood swings, impulsivity and aggression. These medications stabilise excitatory neurotransmission by modulating the activity of neurotransmitters, such as glutamate, and affecting the balance of signalling pathways in the brain. While there were earlier indications of lithium's efficacy, its limitations and associated risks have reduced its clinical utility. Affective instability in EUPD shares some similarities with rapid-cycling bipolar disorder, leading to the exploration of alternative mood stabilisers. Valproate, lamotrigine and topiramate are considered more beneficial for treating affective instability and impulsivity,

with anticonvulsant medications showing moderate or better effects on impulsive aggression and overall functioning. The specific mechanisms of therapeutic response in EUPD for these medications remain unclear, and long-term risk-benefit analysis needs to be determined on a case-by-case basis, considering the potential teratogenicity risks for women of childbearing age. (31)

3. Antipsychotics

Antipsychotics are used in EUPD to help manage emotional stability, agitation, aggression and psychotic symptoms, such as brief episodes of psychosis and paranoia. There are two types of antipsychotics:

1. The first-generation antipsychotics (Dopamine Receptor Antagonists)
2. The second-generation antipsychotics (Dopamine and Serotonin Blockers) (30)

While antipsychotics have shown efficacy in managing cognitive-perceptual symptoms, the prevalence of adverse side effects often leads to their preference for exclusively use in acute relapse treatment. Olanzapine, a frequently studied antipsychotic, has demonstrated effectiveness in reducing impulsivity, hostility, psychotic symptoms and affective instability in EUPD. However, its use is associated with metabolic side effects, impacting tolerability. Limited research also suggests the potential benefits of aripiprazole and haloperidol in treating EUPD, particularly in managing symptoms of anger (31). Other antipsychotics such as quetiapine, respiradone and olanzapine are also regularly used to treat EUPD (32, 33).

4. Mood stabilisers

Mood stabilisers including lamotrigine, topiramate, lithium and valproate are identified as effective for managing impulsivity, aggression and behaviour control in EUPD.

Lithium, in particular, demonstrates effectiveness in preventing suicide in EUPD patients, although its usage is limited due to significant side effects such as cognitive dulling, nausea, diarrhoea, polyuria, tremor, weight gain and sexual dysfunction (34). Preliminary evidence suggests omega-3 fatty acids as a potential adjunct to primary medication treatment, especially when combined with mood stabilisers to prevent recurrent self-harm. Meta-analyses also highlight that mood stabilisers and low-dose antipsychotics are more effective than antidepressants for addressing affective dysregulations in individuals with EUPD (11).

5. Cannabis-Based Medicinal Products (CBMP)

In a case study of seven EUPD-diagnosed participants treated with CBMPs by Sultan et al (2022), the participants underwent an initial assessment and were followed up one month after CBMP prescription. The findings indicate that CBMPs were both effective and well tolerated, with six participants reporting noticeable improvements in symptoms and functioning. No adverse side effects were reported, contributing to potential medication adherence, a significant factor in EUPD treatment. The study acknowledges the need for further research to determine the long-term tolerability, efficacy, and dosing strategy for CBMPs in EUPD. While promising, the study emphasizes the preliminary nature of the results due to the inherent limitations of the case series design and the small number of participants. The potential benefits of CBMPs are suggested to complement psychological therapies rather than replace them, acting as an initial catalyst for symptom control and fostering hope for clinical improvement. Despite encouraging findings, rigorous research in controlled clinical settings is advocated to further explore the use of CBMPs as a potential treatment alternative for EUPD (35), since there is not enough research available to warrant CBMP an affirmed position as treatment for EUPD.

6. Omega-3 Fatty Acids

Omega-3 fatty acids are essential polyunsaturated fats found in certain fish and algae. In a study by Bellino et al (2014), 43 patients with a DSM-IV diagnosis of BPD were recruited. Two treatment groups were established one receiving a combination of eicosapentaenoic acid (EPA) and docosahexaenoic acid (DHA), two omega-3 fatty acids, and the other undergoing monotherapy with valproic acid, a medication used in the treatment of various medical and psychiatric conditions, such as manic episodes associated with bipolar disorder, epilepsy, agitation, impulsivity and aggression (36). Valproic acid doses ranged from 800mg/day to 1300mg/day. After 12 weeks, 79.07% of the patients completed the trial, with both treatment modalities showing similar efficacy in addressing global symptoms, EUPD-related symptoms, anxiety, depressive symptoms and social functioning. The combined therapy, however, demonstrated superiority in reducing impulsivity, anger and self-mutilating behaviours. Adverse effects were mild, with gastrointestinal disturbances more prevalent in the combined therapy group. While encouraging, the study has limitations, including a small sample size and a lack of a placebo group (37).

Challenges in Clinical Practice

Managing individuals with EUPD poses unique challenges in clinical practice, particularly in secondary care mental health services where the prevalence of EUPD is estimated at 20% (38). The wide spectrum of symptoms presented by EUPD patients can significantly influence the therapeutic process. Addressing these challenges requires a comprehensive understanding of the disorder, tailored treatment approaches, and a recognition of the complex interplay between psychological and pharmacological interventions.

In navigating the intricacies of EUPD care, clinicians encounter hurdles related to treatment adherence, comorbidities and the balance between symptom relief and long-term therapeutic goals. The potential for self-harm, particularly with lithium prescriptions, demands cautious prescribing. Additionally, medical comorbidities, such as chronic pain and unexplainable symptoms, further complicate diagnosis and management (10).

One of the first challenges faced by clinicians is the disclosure of an EUPD diagnosis, as well as the associated risk, such as the increased risk of suicide. It is a historically debated issue in psychiatry, rooted in the belief that the disorder carried a negative prognosis. However, contemporary understanding suggests that sharing the diagnosis and all relevant information can be beneficial for patients (39). It serves as a guiding label for treatment, helping patients comprehend their suffering. Transparency about the genetic and neurobiological factors contributing to interpersonal problems in EUPD is a sign of respect to the patient and fosters trust in the psychiatrist. Some psychiatrists involve patients in reviewing the diagnostic criteria, allowing self-identification and promoting engagement in the treatment process. Sharing this information instils hope, a crucial factor, particularly for suicidal patients. Overall, the shift towards openness about diagnoses aligns with improved treatment outcomes and patient well-being (39).

Another conflicting challenge faced in clinical practice is the question on whether or not the patient needs to be referred to specialist psychological therapy. A significant number of patients are not deemed ‘ready’ for specialist treatments, leading to missed opportunities for improving functioning and reducing suffereing (41). Clinicians face the difficulty of managing patients in community mental health teams (CMHTs) that may exhibit chaotic and risky behaviour, posing obstacles to treatment. Patient perspectives

6highlight feelings of being passed around services, emphasising the need for effective strategies to enhance readiness for therapy. The lack of specific guidelines on increasing readiness adds to the complexity, necessitating a nuanced approach that considers the trans-theoretical model of change and incorporates various interventions to support patients at different stages (41). The trans-theoretical model of change is a theory that health behaviour change involves six stages through which one must progress. These six stages are:

1. Pre-contemplation
2. Contemplation
3. Preparation
4. Action
5. Maintenance
6. Termination (41)

Being able to assess the stage the patient is in could ultimately aid healthcare workers in their referral (41)

Coordination with personality disorder services, addressing external factors, and promoting continuity of care are crucial aspects of managing these challenges in clinical practice.

Furthermore, when managing patients with EUPD, psychiatrists must address the complex issue of involuntary hospitalisation when the patient's well-being is at risk. Recognising factors that elevate imminent risks, such as specific subtypes of EUPD with higher suicidal tendencies, is crucial. Psychiatrists may initiate a dialogue with patients, emphasizing their expertise and the possibility that, during stressful periods, patients may struggle to assess their needs accurately. Establishing early agreement on the potential for the psychiatrist to "know best" in certain hospitalisation decisions can facilitate future interventions.

Despite concerns about legal liability, psychiatrists are cautioned against acting solely for self-protection.

Collaborative decision-making with colleagues, along with thorough documentation, provides a more defensible position. Ethically, it is acknowledged that chronic suicidal patients diagnosed with EUPD may experience better outcomes without hospitalisation, despite remaining with a level of risk (39).

Recovery and Quality of Life

In examining the complex landscape of EUPD, a critical focal point emerges – the interplay between recovery and the quality of life experienced by individuals contending this disorder.
A comprehensive PRISMA (2016) guided systematic search dedicated to researching the recovery from EUPD had a number of interesting findings (42). The review considers perspectives from consumers, clinicians, family and carers. Qualitative studies reveal three key themes in consumer perceptions of recovery.

1. The active willingness to engage in the journey of recovery
2. Improvement in clinical characteristics of EUPD
3. The conceptualisation of recovery

A multitude of factors such as vocation and motivational drive activate willingness to recovery, while an enhanced emotional regulation, identity development and interpersonal skills are essential for clinical improvement. The review also highlights gaps in literature, urging further exploration of family, carer and clinician perspectives on recovery.
On remission, recurrence and diagnosis retainment, it was discovered that varied definitions and methodologies contributed to differences. Factors like diagnostic tools, patient drop-out rates and the follow-up duration influence outcomes. The stability of EUPD over time is noted, with higher remission rates in the longer follow up periods.

In another study by Katsakou, C. et al (2012) (43), the perspectives on recovery of individuals with EUPD. Out of the 54 invited participants, 48 were interviewed. The findings revealed key themes related to recovery:

1. Personal Goals and Achievements

Accepting oneself and building self-confidence were primary goals, with participants expressing a desire to understand their problems and develop a positive self-image. Moreover, taking control of emotions, moods and negative thinking was crucial, emphasizing the importance of managing emotions without the use of harmful behaviours. Practical achievements and employment were seen as essential for boosting confidence and a sense of normalcy.

2. Balancing Personal Goals and Service Targets

Some participants felt a tension between their personal recovery goals and the focus of therapeutic interventions, which often concentrated on specific issues, potentially neglecting other important aspects. One participant believed that they had made no progress following treatment, stating "I'm just fat… I look at myself and I go, what … have I become?" (43)

3. Stages of recovery

Participants described varied states of recovery, ranging from feeling no progress to experiencing fluctuations in recovery. Many reported progress but not full recovery. This was only emphasised by the fact that some participants found the term 'recovery' to be problematic, perceiving it as implying a binary distinction between having problems and being fully recovered. They expressed concern about unrealistic expectations and the potential for relapse.

Conclusion and implications for clinical practice

This review article underscores the importance of diagnosis disclosure, referring patients to specialist therapy and managing involuntary hospitalisation while navigating the complexities of comorbidities. Emphasising recovery, this study highlighted the active willingness and clinical improvement crucial for individuals contending with EUPD. As research progresses, avenues such as CBMPs and Omega-3-Fatty Acid use in treating EUPD offer promising prospects, urging further investigation. The Netherlands Mental Health Survey's additional insights into the positive correlation between EUPD symptoms and various life factors contribute to the broader understanding of this challenging disorder, ultimately guiding future research and clinical endeavours in addressing EUPD. In closing, one can only hope for an increased focus on EUPD, particularly within the Maltese Healthcare System, with more research papers delving into the specific nuances and challenges faced by individuals in Malta grappling with this complex mental health condition, since there is dearth of literature available on the Maltese context regarding EUPD. This warrants attention to give policy makers sufficient perspective to improve on the healthcare provided to people with EUPD.

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