Emotionally Unstable Personality Disorder

Synonym: borderline personality disorder

Description

Emotionally unstable personality disorder is one of ten personality disorders defined in the ICD-10 classification system. It is called borderline personality disorder in the DSM-IV and DSM-5 classification system and is still sometimes referred to as such by professionals in the UK. For more information, see separate Personality Disorders and Psychopathy article. Emotionally unstable personality disorder is characterised by pervasive instability of interpersonal relationships, self-image and mood and impulsive behaviour. The term ‘borderline’ is perhaps misleading, as it implies that patients ‘almost have a personality’ disorder. In fact it is an established category of personality disorder in the American Psychiatric Association’s DSM 4th edition (DSM-IV) classification and in DSM fifth edition (DSM-5) classification.

The cause is unknown but research suggests there is an interaction between adverse life events and genetic factors. Neurobiological research suggests that abnormalities in the frontolimbic networks are associated with many of the symptoms.[2]

There is a pattern of sometimes rapid fluctuation from periods of confidence to despair, with fear of abandonment and rejection. There is a particularly strong tendency towards suicidal thinking and self-harm.

Transient psychotic symptoms, including brief delusions and hallucinations, may also be present. It is also associated with substantial impairment of social, psychological and occupational functioning and quality of life.

People with emotionally unstable personality disorder are particularly at risk of suicide.[2]

Its course is variable and, although many people recover over time, some people may continue to experience social and interpersonal difficulties.

Diagnosis

The important feature of emotionally unstable personality disorder is a pervasive pattern of unstable and intense interpersonal relationships, self-perception and moods. Impulses are poorly controlled. At times they may appear psychotic because of the intensity of their distortions.

The ICD-10 classification gives emotionally unstable personality disorder the code F60.03 and identifies two subtypes - impulsive type and borderline type.

The criteria are as follows:

The general criteria of personality disorder (F60) must be met.

F60.30 Impulsive type

The predominant characteristics are emotional instability and lack of impulse control. Outbursts of violence or threatening behaviour are common, particularly in response to criticism by others.

F60.31 Borderline type

Several of the characteristics of emotional instability are present; in addition, the patient's own self-image, aims, and internal preferences (including sexual) are often unclear or disturbed. There are usually chronic feelings of emptiness. A liability to become involved in intense and unstable relationships may cause repeated emotional crises and may be associated with excessive efforts to avoid abandonment and a series of suicidal threats or acts of self-harm (although these may occur without obvious precipitants).

Epidemiology

- Epidemiological data need to be interpreted with care, as diagnostic standards vary.
Personality disorders as a whole are common conditions. There is considerable variation in severity and in the degree of distress and dysfunction caused. Some studies estimate that personality disorder affects 4-11% of the UK population and between 60-70% of the prison population.[5] The prevalence of emotionally unstable personality disorder (which the National Institute for Health and Care Excellence (NICE) still refers to as 'borderline personality disorder') in the general population is 1%. It is less common in the elderly. NICE emphasises that 'borderline personality disorder' should not be diagnosed under the age of 18, although characteristic personality traits can be detected at an earlier age. Although overall personality disorders are distributed equally between males and females, emotionally unstable personality disorder is more common amongst females. One study reported a prevalence of 30.1% in males and 52.8% in females.[6]

Presentation[1]

Patients with the disorder can present with:

- Relationship difficulties.
- Recurrent self-harm.
- Threats of suicide.
- Depression.
- Bouts of anger.
- Impulsivity.
- Social difficulties.
- Transient psychotic symptoms. These were mooted to occur in 'borderline personality disorder' but were not included in the ICD-10 criteria.[7, 3]

Differential diagnosis

- Alcoholism.
- Mental disorders secondary to medical conditions (head injuries, seizure disorders).
- Other personality disorders.
- Anxiety disorders.
- General learning disability.
- Brief psychotic disorder.
- Post-traumatic stress disorder.
- Depression.
- Schizoaffective disorder.
- Schizophrenia.
- Ganser's syndrome.

Investigations

- Toxicology screen because substance abuse is common (as with many personality disorders). Intoxication can lead patients to present with some features of personality disorders.[8]
- Screening for HIV and other sexually transmitted diseases may be appropriate because of the poor impulse control and disregard of risk associated with personality disorder.[9]
Psychological testing may support or direct the clinical diagnosis. Those cited by NICE are:
- Diagnostic Interview for DSM-IV Personality Disorders (DIPD-IV).
- Structured Clinical Interview for DSM-IV Personality Disorders (SCID-II).
- Structured Interview for DSM-IV Personality (SIDP-IV).
- International Personality Disorder Examination (IPDE).
- Personality Assessment Schedule (PAS).
- Standardised Assessment of Personality (SAP).

Associated diseases[^10]
- Anxiety.
- Alcohol misuse.
- Drug misuse.
- Depression.
- Recurrent self-harm.
- Eating disorders.
- Post-traumatic stress disorder.
- Physical conditions:[^11]
  - Arteriosclerosis
  - Hypertension
  - Hepatic disease
  - Cardiovascular disease
  - Gastrointestinal disease
  - Arthritis
  - Sexually transmitted infections

Management[^3, 12]
NICE guidance to inform clinical commissioning groups has been published to guide the commissioning of services for people with emotionally unstable personality disorder and dissocial disorder. This draws on prevailing guidance on a large body of resources, encompassing such issues as avoiding the integration of services, wider determinants of health and reducing the delay in the provision of care and support.[^4]

General considerations
Care should involve collaboration between different agencies and professionals. Teams working with people with emotionally unstable personality disorder should develop a comprehensive multidisciplinary care plan with the service user (and their family or carers, where agreed with the person). The care plan should:
- Identify clearly the roles and responsibilities of all health and social care professionals.
- Identify manageable short-term treatment aims and specify steps that the person and others might take to achieve them.
- Identify long-term goals (including employment), which the person would like to achieve. These should underpin the overall long-term treatment strategy.
- Develop a crisis plan which:
  - Identifies potential triggers that could lead to a crisis.
  - Specifies self-management strategies likely to be effective.
  - Establishes how to access services (including support numbers for out-of-hours teams and crisis teams).
- Be shared with the GP and the service user.
Psychological treatment

Psychotherapy is a helpful mode of treatment in emotionally unstable personality disorder, although no specific type of therapy seems better than another.\[2\] It is important however NOT to use brief psychological interventions (of less than three months’ duration) for emotionally unstable personality disorder or for the individual symptoms of the disorder outside a service that has the characteristics outlined below. Psychological treatment for people with emotionally unstable personality disorder (especially those with multiple comorbidities and severe impairment) should include:

- An explicit and integrated theoretical approach used by both the treatment team and the therapist, which is shared with the service user.
- Structured care in accordance with this guideline.
- Provision for therapist supervision.
- Twice-weekly sessions (although the frequency of psychotherapy sessions should be adapted to the person's needs).

Drug treatment

- A Cochrane review concluded that mood stabilisers and second-generation antipsychotics may be effective for treating a number of core symptoms and associated psychopathology, although the overall severity of emotionally unstable personality disorder is not affected. Drugs should therefore be targeted at specific symptoms.\[13\]
- There is some support for clozapine in the literature, particularly in adolescents with emerging emotionally unstable personality disorder when other treatment options have been exhausted.\[14\]
- Consider drug treatment in the overall treatment of comorbid conditions.
- Consider cautiously short-term use of sedative medication as part of the overall treatment plan for people with emotionally unstable personality disorder in a crisis. Agree the duration of treatment with them; however, it should be no longer than one week.
- Prescribing for this indication is largely off-label and idiosyncratic. Therefore, review the treatment of those who do not have a diagnosed comorbid mental or physical illness and who are currently being prescribed drugs. Aim to reduce and stop unnecessary drug treatment.\[15\]

Management in primary care

- Recognise:
  - Repeatedly self-harmed.
  - Persistent risk-taking behaviour.
  - Marked emotional instability.

- Refer:
  - To community mental health services for assessment for emotionally unstable personality disorder.
  - If the person is younger than 18 years. Refer them to The Child and Adolescent Mental Health Services (CAMHS) for assessment.

- Crisis management: consult the patient's crisis plan (a plan devised to identify trigger factors, advise on self-help strategies and identify when the individual should seek professional help):
  - Assess problem and risk:
    - Maintain a calm and non-threatening attitude.
    - Try to understand the crisis from the person's point of view.
    - Explore the person's reasons for distress.
    - Use empathetic open questioning, including validating statements, to identify the onset and the course of the current problems.
    - Seek to stimulate reflection about solutions.
    - Avoid minimising the person's stated reasons for the crisis.
    - Wait for full clarification of the problems before offering solutions.
    - Explore other options before considering admission to a crisis unit, or inpatient admission.
    - Offer appropriate follow-up within a timeframe agreed with the person.
    - Assess risk to self or others.
    - Ask about previous episodes and effective management strategies used in the past.
    - Help to manage their anxiety by enhancing coping skills and helping them to focus on the current problems.
    - Encourage them to identify manageable changes that will enable them to deal with the current problems.
    - Offer a follow-up appointment at an agreed time.

- Refer in crisis to community mental health services especially when:
  - Levels of distress and/or the risk of harm to self or to others are increasing.
  - Levels of distress and/or the risk of harm to self or to others have not subsided despite attempts to reduce anxiety and improve coping skills.
  - Patients request further help from specialist services.

Complications\[11\]

- Suicide\[10\]
- Substance abuse
- Accidental injury
- Depression
Prognosis

The course of emotionally unstable personality disorder is variable and, although many people recover or improve over time, many continue to experience social and interpersonal difficulties.

Prevention

There is evidence that novel indicated prevention and early intervention programmes may be useful in reducing the risk of developing emotionally unstable personality disorder. Indicated prevention involves identifying individuals who exhibit early signs of early conduct problems and/or have an increased risk for a disorder but currently do not have a diagnosable disorder. Early intervention programmes involve a system of co-ordinated services that promotes a child's age-appropriate growth and development and supports families during the critical early years. This approach is promising but requires further research.

Further reading & references

- Borderline personality disorder: recognition and management; NICE Clinical Guideline (January 2009)
- Personality disorders: borderline and antisocial; NICE Quality Standard, June 2015
- Working with personality disordered offenders: A practitioners guide, 2011; Ministry of Justice
- First M et al; Clinical Guide to the Diagnosis and Treatment of Mental Disorders, 2011.
- Working with offenders with personality disorders - a practitioners guide; National Offender Management Service and NHS England (September 2015)

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