

EMOTIONALLY UNSTABLE PERSONALITY DISORDER IN PRIMARY CARE: A THEMATIC REVIEW AND NOVEL TOOLKIT

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SUMMARY

Emotionally Unstable Personality Disorder (EUPD) causes significantly impaired personality functioning to include feeling of emptiness, lack of identity, unstable mood and relationships, intense fear of abandonment and dangerous impulsive behaviour including severe episodes of self-harm. The vast majority of EUPD patients are managed in the community, and have less contact with specialist psychiatric services when compared to patients with other mental illnesses. Despite the burden of this condition on primary care, the academic literature focuses on EUPD in psychiatric inpatients. This paper therefore aims to redress this balance through, first, establishing the key themes present in the available body of work on EUPD in the community, and second, highlighting areas for future research. Further, in the spirit of reducing stigma surrounding mental illness, the authors present a novel and non-pejorative toolkit for the recognition of EUPD in primary care.

Key words: Emotionally Unstable Personality Disorder - psychiatric services - community - stigma

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INTRODUCTION

Emotionally Unstable Personality Disorder, also known as Borderline Personality Disorder, is defined as causing 'significant impairments in personality functioning with one or more pathological personality traits' (APA 2013). Those with EUPD demonstrate – most notably – intense and unstable interpersonal relationships, dysregulation of emotions and impulses and an inconsistent sense of self (Beatson & Rao 2013). Such personality traits persist across time and place, causing affected individuals marked functional impairment such as high rates of unemployment and social exclusion (Javaras et al. 2017).

Despite this, it is well documented that fewer personality disorder patients make contact with psychiatric services when compared to those with other conditions such as depression or schizophrenia (Andrews et al. 2001). This can be at least partially explained by the absence of evidence based and effective pharmacotherapy for EUPD, as well as the prevalence of stigma associated with the diagnosis felt by patients and practitioners alike (Beatson & Rao 2013, Wehbe-Alamah & Wolgamott 2014). The net result is that the vast majority of personality disorder patients reside in the community with only occasional contact with secondary psychiatric care, usually in the form of psychotherapy (Beatson & Rao 2013). Thus personality disorders represent a significant burden on primary care (Moran et al. 2000).

The high prevalence of personality disorders in patients attending primary care has been quantified as up to 4.4% of the general household population (Moran et al. 2000, Coid et al. 2006). Yet the academic literature on emotionally unstable personality disorder is lar-

gely focused on the condition in psychiatric inpatients and thus confers limited value to the vast majority of patients contending with the challenges of 'real world functioning' in the community (Javaras et al. 2017).

This paper therefore aims to redress this balance through, first, establishing the key themes present in the available body of work on EUPD in the community, and second, highlighting areas for future research. Further, in the spirit of reducing stigma surrounding mental illness, the authors present a novel and non-pejorative tool for the recognition and diagnosis of EUPD in primary care.

METHODS

Design

This paper employed a systematic, thematic analysis of the academic literature accessible via the online repository PubMed, relating to emotionally unstable personality disorder in the community. The authors agreed upon the following search terms and combinations to locate a total of 30 related works (Table 1).

Data Selection and Analysis

Once the 30 papers had been retrieved, the authors independently reviewed the abstracts, excluding works that had no clear link to primary care in the UK, including papers based on findings from non-comparable healthcare systems. The authors discussed excluded papers and underlying rationale to produce the final set of 17 papers of clear relevance to emotionally unstable personality disorder as encountered in the UK primary care setting.

Table 1. Search Terms

Key Words	Combined Search Terms	No. Papers Retrieved
EUPD, Emotionally Unstable Personality Disorder	-	-
BPD, Borderline Personality Disorder	-	-
Community	EUPD + Community BPD + Community	24
General Practice	BPD + General Practice EUPD + General Practice	1
Primary Care	BPD + Primary Care EUPD + Primary Care	5

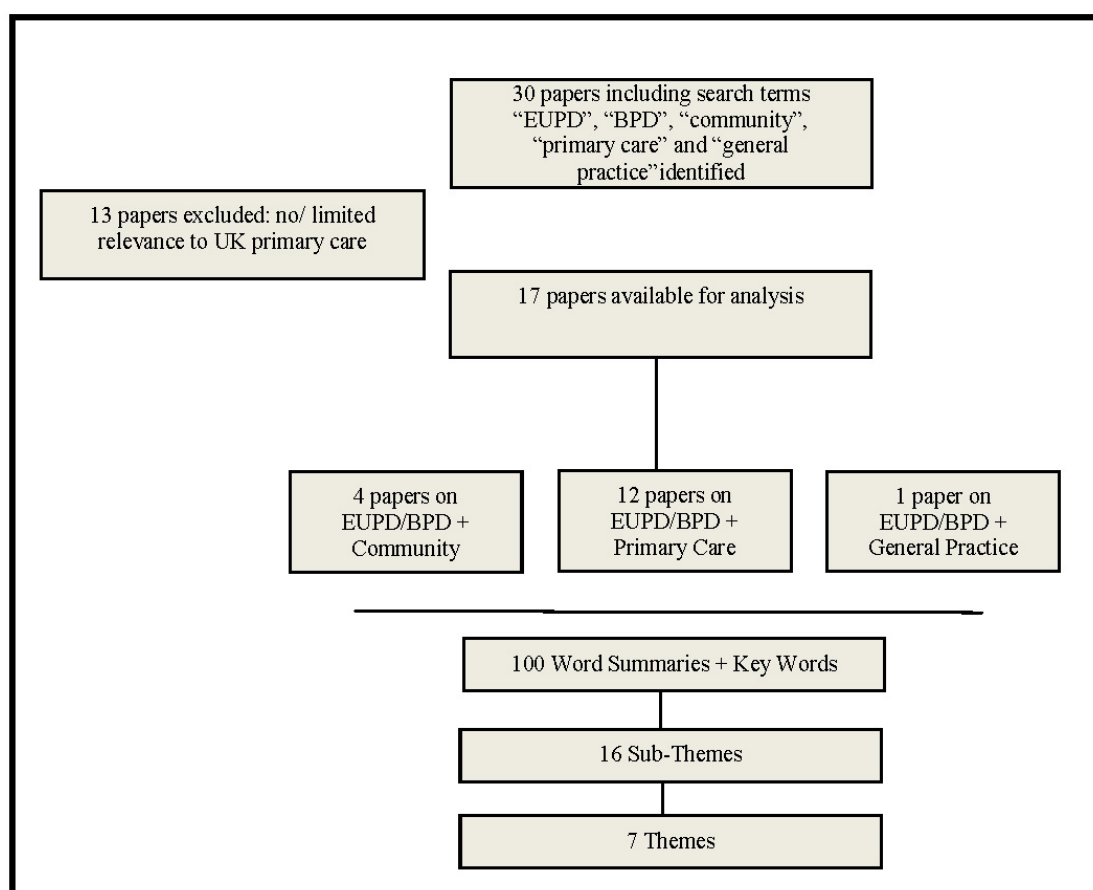


Figure 1. Flow chart of process for data selection and analysis

The authors carried out inductive thematic analysis to generate and refine emerging trends upon reading the papers making up the final data set, using methods described by Braun and Clarke (2006). For each paper, the authors independently produced a summary of up to 100 words, and then from the summary selected key words. The next level of analysis involved a collaborative effort to produce 16 sub-themes from the key words, before the sub-themes were subsumed into the final set of seven themes. The process for data selection and analysis is summarised in Figure. 1.

RESULTS

Inductive thematic analysis revealed 16 subthemes, which were subsumed into a total of seven broader themes characterizing the patient and practitioner

experiences of emotionally unstable personality disorder in the community setting. The themes include therapeutic relationships, psychiatric and medical comorbidities, patient functioning and EUPD prevalence, recognition, and management in primary care. The seven themes are displayed along with exemplar quotes from the existing literature in Table 2.

DISCUSSION

EUPD Prevalence in Primary Care

EUPD is not an uncommon psychiatric diagnosis in patients looked after by their GP. The proportion of patients cared for in the community with EUPD has been variably reported as between 4-6% (Sievwright et al. 1991, Gross et al. 2002, Coid et al. 2006). Personality disorder is particularly common in urban areas,

Table 2. Themes, Subthemes and Exemplar Literature

Theme	Subthemes	Exemplar Literature
The Thera- peutic Relation- ship	Stigma	<p>“ There may be no psychiatric diagnosis laden with more stereotypes and stigma than borderline personality disorder” (Nehls 2000)</p> <p>" Clinicians perceive patients with BPD as being manipulative and difficult" (Nehls 1998)</p> <p>" Recent ethnographic work has demonstrated that nurses show less sympathy for them than patients with other mental illnesses" (Rogers & Dunne 2011)</p> <p>"This paper identifies that patients with an overt diagnosis of personality disorder are believed to be harder to manage by clinicians than those with a covert diagnosis of personality disorder." (Tyrer et al. 2008)</p>
	Communication & Boundaries	"Doctors who exhibit judgmental attitudes when dealing with demanding complex patients may validate the sense of abandonment experienced by BPD patients" (Holm et al. 2009, Raven 2009)
Psychiatric Comorbidity	Depression	<p>"Major depressive disorder (MDD) commonly co-occurs with BPD. The lifetime prevalence of major depression in the course of BPD was 83% in one large study"</p> <p>"The consensus of informed opinion over many years has been that depression co-occurring with BPD does not respond as well to antidepressant medication as depression in the absence of BPD" (Beatson & Rao 2013)</p>
	Substance Misuse	<p>"Chronic pain is also particularly important in patients with BPD because of the risk of prescribing opioids in this population. Patients with BPD have a high degree of substance use disorder comorbidity, although the rates of comorbidity decrease significantly over time" (Trull et al. 2000, Choi-Kainet al. 2010)</p> <p>"In psychiatric, primary care and internal medicine clinics, there are high rates of prescription medication abuse among patients with BPD" (Sansone et al. 2010)</p> <p>"GPs have a potentially key role to play in intervening with patients diagnosed with PD, particularly in the presence of comorbid alcohol misuse, which may help reduce suicide risk." (Webb et al. 2016)</p>
Medical Comorbidity	Pain	<p>"A German clinical sample of patients with chronic pain found that 58% of patients had a diagnosis of BPD" (Sansone et al. 2010).</p> <p>"Patients with BPD are more likely to experience pain and rate their pain as more severe than patients with other personality disorders" (Fischer-Kern et al. 2011)</p> <p>"Patients with BPD experience significantly more pain disorders, such as chronic fatigue syndrome, fibromyalgia and temporomandibular disorders, than patients with other personality disorders." (Frankenburg & Zanarini 2004)</p>
	Vomiting	"Patients with borderline personality disorder often are found and treated in psychiatric settings following episodes of self-mutilation, such as wrist-slashing (...) but in primary care settings wrist-slashing or other physical mutilation is a less common presenting problem. Frequently these patients complain of such symptoms as nausea and vomiting" (Johnson 1993)
Prevalence in Primary Care	Demography	<p>"EUPD patients account for 6% of the patients seen in routine clinical practice" (Gross et al. 2002) "personality disorder was diagnosed in 5.3% by the GP" (Sievewright et al. 1991)</p> <p>"Cluster B disorders were more prevalent in urban environments, in younger age groups, in men, separated or divorced people, those of lower social class and those renting their accommodation" (Coid et al. 2006)</p>
	Healthcare Utilization	<p>"Patients with BPD who have not remitted use significantly more health-care services than patients with other personality disorders" (Frankenburg & Zanarini 2004)</p> <p>"patients with personality disorders were only more expensive if they had psychiatric comorbidity" (Rendu et al. 2002).</p>
Functioning in the Community	Motherhood	"Some women with BPD may begin to dysregulate in pregnancy if, for example, their body feels invaded, physical discomfort unsettles, memories of past sexual abuse are triggered, or partner problems are highlighted" (Sved Williams & Apter 2017)
	Socio-economic status	"...less than one-half of community-based participants with BPD experienced good overall functioning (steady, consistent employment and at least one good relationship), in contrast to over three-quarters of community-based participants without BPD." (Javaras et al. 2017)

Table 2. Continues

Theme	Subthemes	Exemplar Literature
Diagnosing EUPD in Primary Care	Recognition	"Some red flags that may alert a primary care provider to possible diagnosis of BPD comprise (...) an excessive interest in the PCP's personal life as well as attempts to test or invade professional boundaries" (Carlat 1998, Gross et al. 2002, Sansone & Sansone 2010)
	Discussion	"...every clinician in my sample acknowledged the particular stigma of this label and worried that the diagnosis would do more harm than good." (Sulzer et al. 2016) "The vast majority of patients in the sample expressed relief and feeling a sense of belonging as well as understanding. "It finally makes sense why I've been the way I've been for so many years". As one patient shared, "I've had it for at least 20 years; it's a relief to finally be diagnosed". Many viewed the diagnosis as a crucial step toward getting effective treatment and information" (Sulzer et al. 2016)
Management in the Community	Treatments	"The principal treatment for BPD is psychosocial - that is, some form of psychotherapy, which may be combined with psychotropic medication aimed at specific symptoms" (Beatson & Rao 2013).
	Patient Coping Strategies	"Online support communities provide an additional venue for BPD sufferers, friends, families, and significant others, to learn about the disorder and identify resources for treatment." (Wehbe et al. 2012)

with Cluster B disorders (including EUPD) are more prevalent in younger age groups, in men, separated or divorced people, those of lower social class and those renting their accommodation (Coid et al. 2006). Additionally, EUPD is associated with functional psychosis and affective or anxiety disorders, and these individuals are more likely to be unemployed, have criminal convictions (including time in prison) and to have been in local authority care as children (Coid et al. 2006).

Analysis of the literature revealed a commonly held belief that EUPD patients utilize healthcare services, and primary care in particular, at higher rates than other patients (Hueston et al. 1999, Bender et al. 2001, Jackson & Burgess 2004). However, further research suggests that after adjusting for comorbidity and demographic variables, including socio-economic status, the evidence that those with personality disorders consult services much more frequently than other patients 'disappeared' (Coid et al. 2006). Further, the suggestion that personality disorders are associated with higher mean total healthcare costs failed to remain statistically significant following multivariate analysis – instead, patients with personality disorders were only more expensive if they had psychiatric comorbidity (Rendu et al. 2002).

The Therapeutic Relationship

The idea that there 'may be no psychiatric diagnosis laden with more stereotypes and stigma than borderline personality disorder' immediately suggests potentially difficult relationships between those with EUPD and those making and managing their diagnosis (Nehls 2000). Indeed, Nehls (1998) explained that 'clinicians perceive patients with BPD as being manipulative and difficult' which is mirrored in the inpatient setting where 'recent ethnographic work has demonstrated that nurses show less sympathy for them than patients with other mental illnesses' (Rogers & Dunne 2011). It

would follow, then, that the quality of the therapeutic relationships between EUPD patients and their healthcare providers is inversely proportional to the level of felt or enacted stigma around the condition. It is also commonly suggested in the literature that 'doctors who exhibit judgmental attitudes when dealing with demanding complex patients may validate the sense of abandonment experienced by BPD patients' (Holm et al. 2009, Raven 2009). These findings indicate that the attitudes of healthcare professionals towards the EUPD diagnosis and the patients affected by the condition are a potential source of iatrogenic harm.

Diagnosing EUPD in Primary Care

The oft-quoted 'red flags' that may alert a clinician to a possible EUPD diagnosis include a history of doctor shopping, legal action against healthcare professionals, suicide attempts, several brief marriages or unsuccessful intimate relationships, an immediate idealization of the latest doctor as the most "wonderful doctor" in comparison to any previous practitioners, and most importantly, an excessive interest in the PCP's personal life as well as attempts to test or invade professional boundaries (Carlat 1998, Gross et al. 2002, Sansone & Sansone 2010). Analysing the therapeutic relationship for a potential EUPD diagnosis is an approach to be employed with caution. It is well documented that doctors who lack compassion and tolerance, or exhibit judgmental attitudes when dealing with 'demanding, complex patients may validate the sense of abandonment and lack of trust experienced by BPD patients (Holm et al. 2009, Raven 2009).

That is not to suggest, however, that making an EUPD diagnosis ought to be avoided altogether. The stigma associated with the condition can cause clinicians to be 'worried that the diagnosis would do more harm than good', yet the 'vast majority' of patients given the EUPD diagnosis 'expressed relief and feeling

a sense of belonging as well as understanding'; one interviewed patient said "it finally makes sense why I've been the way I've been for so many years" and the diagnosis was seen as a 'crucial step' towards accessing effective treatment (Sulzer et al. 2016).

EUPD Management in the Community

The mainstay of EUPD management in hospital and community settings alike is psychosocial intervention; most commonly a referral for psychotherapy (Beatson & Rao 2013). Psychotropic medication is generally restricted; there is no evidence that such medications provide long-term benefit (Chanen & Thompson 2016). However, psychotherapy may be combined with psychotropic medication if aimed at specific symptoms of comorbid affective disorders, for instance (Beatson & Rao 2013). However, clinicians may need to 'exercise caution' in prescribing lithium for patients with BPD and MDD, in light of the 'significant risk (about 25%) of self-harm through overdose of prescription medication in patients with BPD' – and in any event, 'treatment of BPD with specific psychotherapies tends to result in remission of co-occurring MDD' (Beatson & Rao 2013).

It is increasingly common for individuals with EUPD to develop coping strategies outside of the medical domain, too. Indeed, 'internet blogging may have important implications in care'; online communities provide an additional 'venue' for learning about the disorder and resources for treatment, and can be places of significant support 'in the form of hopeful messages, resources, educational material, and sharing of personal stories and experiences with BPD', as well as a 'coping mechanism or form of therapy'. While largely positive, the dangers of unregulated online communities cannot be ignored: in particular, blogging may normalise dangerous behaviours and 'coping mechanisms shared by BPD bloggers may delay treatment' (Wehbe-Alamah & Wolgamott 2014). An awareness of the existence of such online communities serves as a reminder of the crucial importance of effective therapeutic relationships between healthcare providers and EUPD patients in order to develop appropriate and successful management strategies for patients in the community.

Psychiatric Comorbidity

The lifetime prevalence of major depressive disorder in patients with a diagnosis of EUPD has been reported as high as 83% (Beatson & Rao 2013). As such, it is absolutely crucial that primary care practitioners are aware of the condition and the subtleties in managing co-morbid depression in patients with EUPD. The consensus of the academic literature is that 'depression co-occurring with BPD does not respond as well to antidepressant medication as depression in the absence of BPD' (Beatson & Rao 2013, Gunderson et al. 2004). Further to this, the quality of depression in patients with EUPD differs from the general population (Silk 2010).

Most notably, these patients are rarely melancholic but rather display instability of negative affect with feelings of loneliness, emptiness, clinging dependency on significant others and a sense of 'inner badness' accompanied with merciless attack on the self, expressed also via increased suicidal ideation and behaviours (Beatson & Rao 2013). The idea that 'combined depression and personality disorder is associated with a poorer outcome than depression alone' is widely accepted, and highlights the need for effective treatment (Newton-Howes et al. 2006). The recommendation is therefore that 'psychotherapy should take priority' in patients with comorbid EUPD and major depressive disorder, since 'once the BPD abates, so will the depression' (Gunderson et al. 2004).

A second psychiatric comorbidity is widely reported in the literature on EUPD: substance misuse. Put simply, 'in primary care...there are high rates of prescription medication abuse among patients with BPD' (Choi-Kainet al. 2010). While conceding that the rates of substance misuse comorbid in the EUPD community 'decrease significantly over time' following diagnosis and support, Trull et al. (2000) suggest that it is particularly risky to prescribe opioid medication to this patient population. This bears particular relevance to EUPD since pain is often a chief medical complaint of this cohort.

Medical Comorbidity

It is well documented in the literature that patients with EUPD are 'more likely to experience pain and rate their pain as more severe than patients with other personality disorders' (Fischer-Kern et al. 2011). In addition, when compared to patients with other personality disorders, those with EUPD 'experience significantly more pain disorders, such as chronic fatigue syndrome, fibromyalgia and temporomandibular disorders' (Frankenburg & Zanarini 2004). An additional study by Sansone et al. (2010) demonstrated that 58% of patients with chronic pain 'had a diagnosis of BPD'. While the exact aetiology remains unknown, it has been suggested that chronic pain 'may be a manifestation of a self-regulatory disturbance among some patients with BPD' (Sansone et al. 2001). Further, there are three reported predictors of the severity of pain in those with BPD: older age, major depressive disorder, and the severity of childhood abuse (Biskin et al. 2014). Taking a thorough social and psychiatric history from EUPD patients presenting with chronic pain in general practice is therefore crucial, since 'a focus on the management of medical and psychiatric comorbidities may improve their long term functioning' (Biskin et al. 2014).

Similarly, persistent and unexplained nausea and vomiting may not be an obvious presentation of psychopathology, yet vomiting has been described as 'a primary care analogue of self mutilation in some patients with borderline personality disorder' (Johnson 1993). As such, the importance of taking a careful history in

the primary care setting cannot be overstated. Indeed, obtaining a history of, for instance, childhood abuse in patients presenting with unexplained vomiting 'should not only mitigate extensive, costly and invasive gastrointestinal system evaluations but also suggest more effective treatment strategies' in those with emotionally unstable personality disorder (Johnson 1993).

Patient Functioning in the Community

A careful history in the primary care setting can also be used to elicit the degree of functional impairment a community-dwelling patient with EUPD might experience. Javaras et al. (2017) report that 'less than one-half of community-based participants with BPD experienced good overall functioning (steady, consistent employment, at least one good relationship), and in contrast to over three-quarters of community-based participants without BPD.' Further, the study warned that even for the 38% of those with EUPD in the community who 'appear to be functioning well' in educational, occupational, social and recreational domains, EUPD still has a detrimental effect on quality of life.

It is possible that the impact of EUPD on functioning in women may be exacerbated by new motherhood. Pregnancy might be a trigger – due to unsettling physical discomfort, feelings of bodily invasion, memories of past sexual abuse – for some women with EUPD to 'dysregulate'. This typically involves 'feelings of inadequacy as a parent, self-hate and sometimes self-harming behaviours to relieve her inner tensions' and the patient may describe her infant as demanding, or indeed hateful, and disclose fears of harming her child' (Sved Williams & Apter 2017). Eliciting such concerns is paramount: not only would primary care be a key source of support and gateway to treatment for the mother, GPs play a 'crucial role in identifying burdened children and ensuring their follow-up', in particular with access to mental health support (Hafting et al. 2019).

Areas for Future Research:

The etiology of EUPD remains unclear, though the current view implicates deficient co-regulation and social communication in infancy, as leading to emotional dysregulation and social cognition deficits in later development (Winsper 2018). Indeed, there is a high incidence of personality disorder, particularly EUPD, in those who have been in local authority or institutional care, suggesting that 'preventative and treatment strategies in this population could have a major influence on public health' (Coid et al. 2006). Adolescence is considered a 'crucial' developmental phase in those at risk of EUPD, and nonsuicidal self-injury is a 'promising target' for intervention (Hessels et al. 2018). However, more work is required to systematically characterize the risk factors and full range of early presentations signaling EUPD development in order to facilitate early detection and intervention in at-risk adolescents.

EUPD: A NOVEL TOOLKIT

Often, the literature discussing EUPD contains the sentiment that it is 'one of the most challenging mental health disorders to treat' (Wehbe-Alamah & Wolgamott 2014). This paper has highlighted the importance of the therapeutic relationship for successfully managing EUPD in the community, as well as the risks that negative perceptions of the condition held by healthcare professionals might reinforce 'fears of stigmatization and prejudice' (Markham 2003, Trull et al. 2010). To assist with the diagnosis of EUPD, a simple tool in the form of the I DESPAIRR mnemonic was developed to highlight the 'hallmarks and red flags that identify a person as potentially having BPD' (Carlat 1998). While this tool is certainly of value in the primary care setting, the language used directly references the sense that 'BPD has historically been difficult to diagnose and laden with stigma' (Sulzer et al. 2016). Stigma may be a particular problem for patients with EUPD since a central tenet of the condition is an intense fear of abandonment or rejection, and therefore stigmatisation from healthcare professionals 'can present obstacles to effective caregiving' (Knaak et al. 2015). Indeed, Beatson & Rao (2013) hold that the key to successful management of EUPD is a respectful, cooperative, collaborative, active, open and non-judgmental relationship with the patient.

In light of the clear barrier to such therapeutic relationships with the I DESPAIRR mnemonic, we would like to put forward a novel mnemonic designed for use as a diagnostic tool for EUPD in the primary care setting. It is designed to be simple and non-pejorative, employing the EUPD acronym to cover the major presenting complaints associated with the disorder. The 'core dimensions of psychopathology' underlying EUPD are characterised as disturbance in self-image, pervasive affective instability, unstable interpersonal relationships, fear of abandonment and impulsivity (Kulacaoglu & Kose 2018, Palihawadana et al. 2018). These defining features are incorporated in our novel EUPD diagnostic tool, displayed in Figure 2.



Figure 2. Novel EUPD Diagnostic Tool

CONCLUSIONS

The quality of the therapeutic relationship is key to the successful management of EUPD in the community. General practitioners must have an awareness of the

demographics of the EUPD population and an understanding of their social circumstances – including degree of functional impairment and support structures, include online communities – in order to best support those affected. A key challenge for primary care is accurate and timely recognition of EUPD. A thorough history is essential to elicit potential personality disorder triggers, as is an awareness of the subtle presentations of EUPD, including unexplained vomiting and chronic pain. Perceived or enacted stigma from healthcare professionals can deter patients from accessing services, and so this paper has contributed a novel diagnostic tool in the form of the EUPD mnemonic (Figure 2), as a small step toward cultivating a more positive and collaborative approach to EUPD diagnosis and management in primary care. Further research is required to elicit the precise etiology of EUPD, and to evaluate the options for early detection and thus intervention in at-risk individuals.

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Contribution of individual authors:

The literature search and analysis was carried out by Chloe Gamlin & Amie Varney.

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