Do borderline personality disorder and epileptic personality overlap?

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In a previous paper, a complex case of a severe psychomotor agitation and clinical motor manifestations with dysmetric movements was described in a patient who was diagnosed with an adult presentation of Rasmussen Syndrome (di Michele et al., 2021). This Syndrome is characterized by drug-resistant focal seizures that can manifest as *epilepsia partialis continua*.

In the emergency room the psychomotor agitation was characterized by violent behavior, combative attitude, inappropriate behavior without clear purpose, hyperreactivity to stimuli, inability to remain quiet, exaggerated gesticulation, facial tension and angry expression, raised tone of voice, altered emotional state with appearance of anxiety, irritability and hostility, verbal and/or physical aggression against self and others and objects. Moreover, fluctuations in the levels of consciousness, tempo-ro-spatial disorientation, low frustration tolerance, difficulty in anticipating consequences, persecutory ideation, tachycardia, tachypnoea, sweating, tremor, and neurological signs such as difficulty walking, difficulty in opponent movements and pointing were observed (di Michele et al., 2021).

Interestingly, during the interview this patient reported in his history a previous diagnosis of Borderline Personality Disorder (BPD). However, our team hypothesized that the aforementioned psychiatric symptoms were more consistent with a cluster of personality traits observed in individuals with chronic epilepsy (especially temporal lobe epilepsy), termed epileptic personality (di Michele et al., 2021). Indeed, a pervasive pattern of instability of interpersonal relationships, self-image and affects, irritability, selfishness, increased neuroticism, impulsivity, reduced self-directedness and cooperativeness, have been proposed to characterize an epileptic personality (Yazici et al., 2013) that overlaps with BPD. Moreover, a deficit in social cognition (with impaired emotional recognition) has been reported in both epileptic personality and in BPD (Harris et al., 2002).

In my clinical experience, stress related dissociative behavior or transient paranoia which characterizes BPD can also be present in epileptic personality. I have often found a disruption in the integration between ideational and affective components of awareness (ideo-affective dissociation). Moreover, manipulative behavior, emotional instability, chronic feeling of emptiness and inappropriate anger, usually associated with BPD, have also been reported in epileptic personality.

A trait which distinguishes the two is viscosity, i.e., circumstantiality and stickiness in speech and behavior, with hypergraphia, which are typical of epileptic personality. Moreover, individuals with epileptic personality are usually harm avoidant while those with BPD have an increased self-injurious behavior secondary to their marked impulsivity. Further, decreased sexual interest has been described in epileptic personality, although this is not specific. Moreover, fluctuations in level of consciousness, such as a crepuscular state is frequently associated with intercritic epilepsy (Blumer, 1999; Broicher et al., 2012).

However, the notion of a unique epileptic (epileptoid) personality is controversial and has been criticized as being poorly defined as a distinct clinical syndrome (Devinsky & Najjar, 1999).

Nevertheless, the presented case well fits with the characteristics of an epileptic personality, having been previously confused with BPD. Research is needed to determine whether these two clinical entities share neurobiological substrate.

In the psychiatric clinical practice, it is commonplace for only the psychiatric aspects to be considered in epileptic patients, with the focus on cluster B personality traits and comorbidity with axis I disorders (dissociative, psychotic, depressive, or anxiety diseases), while the epileptic pathology is referred to a neurologist. Instead, it be preferable for psychiatrists and neurologists to cooperate in the assessment and care of such patients to better understand their complexity and jointly select the best tailored treatment.

Another example of neuropsychiatric disease that deserves a cooperation among neurologists and psychiatrists is the non convulsive status epilepticus, where semiology is heterogeneous and includes variable degrees of impaired consciousness, cognitive dysfunction, disturbances of language, subtle motor signs (myoclonus, automatisms and nystagmus), and psychiatric disturbances, such as anxiety, impulsivity, psychosis, catatonia (Cativo et al., 2022).

Therefore, building a team of psychiatrists and neurologists (mental health professionals) for such cases is highly recommended.

Moreover, in a view of a larger mental health care, implementing a multiagency approach including education and involving ancillary services, to create a support network would

be useful to address the needs of such patients as well as their families and care givers.

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