

## Emotionally Unstable Personality Disorder with Comorbid Binge-Eating Disorder — A Comprehensive Review

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### ABSTRACT

**Background:** Borderline Personality Disorder (BPD) is a severe psychiatric condition characterised by affective instability, interpersonal dysfunction, and impulsivity. Binge-Eating Disorder (BED), the most prevalent eating disorder, involves recurrent binge episodes with loss of control and psychological distress. Despite growing evidence of substantial comorbidity between BPD and BED, this overlap remains underrecognized and undertreated. **Methods:** A narrative synthesis of peer-reviewed studies, meta-analyses, and clinical guidelines was conducted, focusing on epidemiological trends, shared mechanisms, clinical features, and treatment approaches relevant to the dual presentation of BPD and BED. **Results:** Epidemiological findings indicate that up to one-third of individuals with BED exhibit borderline features, while 20–30% of those with BPD meet criteria for an eating disorder. Shared etiological mechanisms include chronic emotion dysregulation, impulsivity (particularly negative urgency), and early-life trauma, with neurobiological evidence implicating fronto-limbic and reward circuitry. The co-occurrence of BPD and BED is associated with earlier onset, greater functional impairment, elevated suicidality, and poorer treatment response compared with either disorder alone. Psychotherapies such as Dialectical Behaviour Therapy (DBT) and Cognitive-Behavioural Therapy (CBT) show efficacy, though integrated, trauma-informed, and multidisciplinary interventions are increasingly recommended. Pharmacological treatments may provide symptomatic relief but are not first-line strategies. **Conclusions:** Comorbid BPD and BED represent a clinically significant yet under-addressed challenge. Improved recognition, integrative care models, and precision treatment are essential to enhance outcomes. Future research should prioritise large-scale epidemiological studies, mechanistic investigations, and clinical trials of hybrid or stepped-care interventions.

**Keywords:** BPD, EUPD, Binge-Eating Disorder, Emotion Dysregulation, Impulsivity

Borderline Personality Disorder (BPD), also referred to in some classification systems as Emotionally Unstable Personality Disorder, is a chronic and typologically heterogeneous illness defined by pervasive affect instability, unstable self-image, unstable relationships, and extreme impulsivity<sup>1</sup>. Central features of emotion dysregulation and impulsive behaviour underpin many of the disorder's most impairing expressions,

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including self-mutilation, suicidal acts, and dysfunctional interpersonal relationships, and are major targets of current psychotherapies<sup>2-4</sup>.

Eating problems, and in particular binge-eating behaviour, are often seen in individuals with BPD. Prevalence estimates vary based on samples and context, but studies and reviews report significantly greater rates of eating disorders and disordered eating behaviour in individuals with BPD compared to the general population, and the presence of disordered eating symptoms in individuals with BPD is prominent enough to recommend routine evaluation in clinical settings<sup>5</sup>. In turn, personality disorders, most frequently BPD, are among the commonly observed co-occurring conditions in samples with Binge-Eating Disorder (BED), suggesting a bidirectional and clinically significant comorbid condition<sup>5-7</sup>. Multiple overlapping mechanisms offer a compelling explanation for the frequent, comorbid overlap of BPD and binge-eating pathology. Numerous studies consistently identify emotion regulation difficulties, maladaptive coping (for example, eating to cope with negative affect), and aspects of impulsivity (for example, urgent/rash action while distressed) as common vulnerabilities, which not only lead to binge episodes but also serve to maintain borderline symptoms<sup>8,9</sup>. That is, these are transdiagnostic processes that suggest comorbidity is not simply additive; rather, the disorders interact to create more severe, treatment-resistant presentations with resulting greater functional impairment and risk for self-directed harm and medical complications<sup>10,11</sup>.

Having both BPD and BED at the same time increases the complexity for diagnosis and treatment. The typical single disorder treatment trajectories have the potential for fragmented care, drop-out, or evidence of symptom remission at the end of treatment, but incomplete symptom coverage, with the two disorders. In contrast, interventions that are either integrated or modified or adapted to treat BPD and BED and directly target emotional regulation, distress tolerance, and impulsivity are increasingly discussed in the literature and show promise for treatment. Current BPD treatment guidelines specify psychotherapy as first-line treatment (with Dialectical Behaviour Therapy and Mentalization-Based Therapy as the two strongest evidence-based psychotherapies), and increasing attention has been paid to modifying these approaches or integrating them with evidence-based ED treatments when BED co-occurs with BPD<sup>1,3,12</sup>.

This review integrates the empirical literature on the epidemiology, shared aetiology and maintenance mechanisms, clinical presentation, assessment challenges, and evidence-based treatment approaches for individuals with BPD and binge-eating disorder. Our goals are to (1) clarify prevalence and patterns of comorbidity across clinical and/or community settings, (2) map psychological and neurobehavioral mechanisms potentially linking BPD and binge eating disorder, (3) assess outcomes and adaptations of evidence-based treatments for comorbid presentations of BPD and binge eating disorder, and (4) determine boundaries and priorities for future research and/clinical practice. Through synthesising and integrating findings across epidemiological, psychological, and neurobehavioral studies, and treatment studies on this comorbidity, we hope to present a cohesive framework for clinicians and researchers to facilitate detection, treatment personalisation, and ultimately improve morbidity related to this challenging comorbidity.

### ***Epidemiology and Comorbidity***

The estimated prevalence of BPD is 1 - 2% in the general population<sup>13</sup>. However, rates can be significantly higher in clinical populations, particularly in psychiatric inpatient samples,

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where they range from 10% to 20%. BPD is associated with psychosocial dysfunction, chronic instability in functioning, and higher rates of healthcare utilisation<sup>14,15</sup>. Binge-eating disorder, which is a diagnosis recognised in the DSM-5, is the most common eating disorder globally. Lifetime prevalence estimates in community samples are 1 - 3%, and rates are higher for individuals seeking treatment for obesity, weight loss, or psychiatric disorders. BED is characterised by recurrent episodes of eating uncontrollably without engaging in any compensatory behaviours, and often leads to obesity, metabolic complications, and psychological distress<sup>16,17</sup>.

The co-occurrence of BPD and eating disorders has been consistently reported. Research suggests that 20–30% of patients with BPD meet criteria for an eating disorder and that those with borderline disorder exhibit higher levels of binge-eating and bulimia behaviours<sup>18–20</sup>. In the opposite direction, in a BED sample, borderline features are among the most typically co-occurring personality traits, and it has been reported that one-third of patients diagnosed with BED met criteria for BPD or demonstrated clinically significant borderline symptomatology<sup>8</sup>.

While BPD is diagnosed more often in women, BED has a relatively equal distribution in gender compared with anorexia nervosa or bulimia nervosa. Women with BPD are at particularly high risk for the development of BED, but recent information indicates that men with BPD might be underdiagnosed as well, and this implies that more gender-sensitive assessment is warranted in treatment and clinical settings<sup>21</sup>. The co-occurrence of BPD and BED is associated with earlier onset of psychiatric symptoms, increased chronicity of illness, and higher rates of comorbid affective and anxiety disorders. Patients with co-occurring BPD and BED present with more severe dysregulation of emotions, impulsivity, and functional impairment<sup>22–25</sup>. Critically, comorbidity is associated with greater suicidality and more refractory clinical presentations, indicating the importance of a thorough assessment and integrated approaches to treatment<sup>26</sup>.

### *Aetiology and Shared Mechanisms*

Emotion regulation is a significant mechanism for understanding the association between BPD and binge-eating disorder.<sup>27</sup> Individuals with BPD appear to be more reactive to emotional cues, have an exaggerated emotional response to emotional events, and take longer to recover from experiences of emotional distress.<sup>28</sup> Similarly, individuals with BED often describe binge episodes as maladaptive ways of coping with negative moods, such as shame, sadness, and anxiety. Therefore, binge eating can be a helpful (but ultimately short-lived) way to regulate emotional intensity and continue to contribute to the worsening of negative emotion regulation. Impulsivity is another area of significant shared vulnerability<sup>29,30</sup>. Impulsivity manifests in BPD across a range of domains, including substance use, risk-taking, and self-harm<sup>31,32</sup>. In BED, impulsivity manifests as negative urgency, or acting rashly when experiencing emotional distress. Both BPD and BED have increased sensitivity to reward and decreased capacity for inhibition, which often leads to binge-eating patterns and other maladaptive coping strategies.<sup>31,33</sup>

Experiencing adverse events in the earlier part of a person's life, particularly childhood trauma<sup>34,35</sup>, neglect, and ineffective attachment, is well-recognised as highly correlated with BPD and BED. When a person has been trauma-exposed, escape (e.g., alcohol or drugs) may lead to ongoing difficulties with emotion regulation and impaired self-concept and interpersonal functioning. In BED, exposure to trauma correlates with disordered eating as a

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form of self-soothing to manage distress. Overall, these findings point to the need for trauma-informed care for individuals with comorbid diagnoses.<sup>34,35</sup>

Recent neurobiological studies have found shared neurobiological pathways in BPD and binge eating disorder.<sup>36–39</sup> The alterations in the fronto-limbic circuits involved in the regulation of emotions constitute the common symptomatology group of both diseases, more concretely, one of the results of the mentioned circuits' dysregulation is that the affected individuals have the amygdala highly activated and at the same time little prefrontal control, which means both emotional regulation and inhibitory control problems<sup>40–42</sup>. Additionally, the shared feature between these disorders might be the malfunction of the dopaminergic pathways related to reward, which causes the patients to become more susceptible to the occurrence of impulsive binge eating behaviours, which also strengthens the parallel of impulsivity and affectivity instability in BPD<sup>41,43,44</sup>.

One of the main aspects of BPD symptoms is the presence of cognitive distortions, which not only include those mentioned in the title of the text but also a general set of distortions that strongly interact with the symptoms of BPD, alongside distortions of interpersonal relationships. Dysfunctional beliefs about food, weight, and self-worth not only work alongside cognitive vulnerabilities, but they also become the main source of disordered eating behaviours that eventually lead to BED. Symptoms of both BPD and BED indicate the presence of cycles of maladaptive coping, shame, and symptom escalation, which suggests that some cognitive-behavioural interactions are similar in these two disorders, affecting the degree of their chronicity<sup>41,45,46</sup>.

### ***Clinical Presentation and Assessment***

BPD and BED have many similarities that overlap in their symptomatology, which may change the way they present in a clinical setting. Both disorders talk about the impulsivity of a person, the increased sensitivity towards the surroundings, and insufficient use of the same distress and emotional regulation-like strategies. BPD is known by the occurrence of symptoms that are its main features, among them is recurring self-injury and at the same time unstable relationships with others, as well as the feeling of emptiness that lasts for a very long time<sup>8,47</sup>. BED is also about the repeated binge-eating episodes that come along with an absence of inhibitive or corrective actions. In the case of comorbid disorder, these patients can become more impulsive, their mood changes can be more extreme and as severe as they can become, and so on, thus making a vicious circle of recurrences of various symptomatology. In fact, such patients not only become more complex but also more severe in regard to symptomatology. Comorbidity is one of the biggest obstacles to achieving diagnostic clarity<sup>48–53</sup>. Emotional eating, bingeing episodes, or other impulsive behaviours that might be present could be simply misunderstood and misinterpreted as impulsivity. In the case of a BPD diagnosis, affect dysregulation is probably not as clear when only assessing BED. Standardised diagnostic assessments may not take into consideration the effects of personality pathology on eating behaviours. Consequently, clinicians have to rely on standardised assessments and their own clinical judgment when evaluating comorbid eating disorders, in which case clinical significance and dimensional assessments can be particularly useful for accurate identification of both disorders from a more dimensional and categorical approach (including structured interviews, SCID-5-PD for personality disorders, and the EDE for eating disorders)<sup>54–56</sup>.

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The combination of BPD and BED is associated with an earlier onset of psychopathology, longer duration of illness, and worse overall prognosis compared to either disorder alone. Patients with comorbidities demonstrate lower adherence to treatment, higher relapse rates, and greater use of healthcare resources. Patients with suicidality, which is high because of BPD, are further burdened by eating disorders and the medical complications that accompany them, including being overweight, experiencing diabetes, and cardiovascular risk<sup>47,57–59</sup>.

Each disorder separately limits social, occupational, and interpersonal functioning, even more so when combined. Patients may struggle with trust and boundaries in interpersonal settings (BPD) while simultaneously facing shame or secrecy surrounding their eating (BED). In many cases, this combination leads to social isolation, diminished quality of life, and economic burden due to missed work and medical complications<sup>58,60</sup>.

Since symptoms are interacting with each other in a complicated way, a complete and multidisciplinary assessment has to be conducted. As an instance, regular eating disorder check-ups may be disregarded in BPD patients, while personality pathology assessments may be included for BED patients. An effectively integrated approach, which combines psychological, medical, and nutritional assessments, can open the door for clinicians to recognise comorbidity at the early stages and tailor treatments that are more efficacious and individualised.<sup>41,44,57</sup>

### ***Treatment and Management***

DBT is the most prominent treatment studied for Borderline Personality Disorder (BPD) and has emerged as a potential treatment for co-occurring Binge-Eating Disorder (BED). It focuses on the improvement of emotion regulation, distress tolerance, and mindfulness, and specifically targets transdiagnostic mechanisms for both binge-eating disorder and self-harm. As of yet, DBT for eating disorders (DBT-ED) has reduced binge frequency, improved emotion regulation, and resulted in greater retention in treatment in randomised trials<sup>61–63</sup>.

Mentalization-Based Therapy (MBT) is a treatment approach that focuses on increasing patients' capacity to reflect upon and make sense of internal mental states of self and others<sup>64</sup>. By enhancing interpersonal function and reducing emotional instability, MBT may, in turn, reduce binge episodes when such episodes are related to relational distress. Although the existing evidence for MBT is less extensive than DBT, it may be a valuable option for patients with comorbid disorders, especially with interpersonal triggers for eating disorders<sup>62,64–77</sup>. Cognitive-Behavioural Therapy (CBT) is the first-line treatment for BED, and includes restructuring maladaptive food-related and body image-related cognitions, enhancing participants' self-esteem, and developing behavioural tools to interrupt binge episodes. In presentations with comorbidity, CBT alone may not suffice for treatment of dynamic core borderline disorder pathology (e.g., self-harm or interpersonal instability). Subsequently, it's increasingly recommended to integrate CBT with DBT or MBT when there is BPD and BED comorbidity.<sup>65,78–82</sup>

Pharmacological approaches are not first-line treatments in either BPD or BED and may serve as adjunctive options to modalities based on psychotherapy. Selective serotonin reuptake inhibitors (SSRIs) have shown modest efficacy in reducing binge frequency and mood symptoms.<sup>83</sup> For BPD, pharmacotherapy focuses on symptom clusters (e.g., mood

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lability, impulsivity, or concurrent depression/anxiety), versus core pathology in BED populations. There are emerging data on the efficacy of lisdexamfetamine, a novel medication that is FDA-approved<sup>83–85</sup> for the treatment of BED, to reduce binge-like episodes; however, the safety concerns for using these medications in BPD populations with high levels of impulsivity or substance use are warranted for consideration. The complexities of comorbidity make the need for an integrated treatment model for all persons appropriate. Integrated treatment models include psychotherapy, nutrition counselling, medical monitoring, and psychiatric support. Collaborative care models improve adherence, reduce relapse, and better account for the psychological and physical health consequences of both disorders (e.g., obesity/metabolic complications). In BPD and BED, the significant prevalence of early adversity calls for a model of trauma-informed care, which allows for incorporation in treatment planning and intervention.<sup>85–90</sup>

Individuals diagnosed with BPD and BED comorbid often have lower rates of engagement and treatment retention than individuals diagnosed with a single disorder. Factors that can contribute to this include trust issues, ambivalence towards change, and a greater sensitivity to perceived rejection in the therapeutic alliance. Clinicians might focus on therapeutic alliance, employ motivational interviewing techniques, and develop flexible and more patient-centred approaches to increase engagement.

### DISCUSSION

The co-occurrence of BPD and Binge-eating disorder presents a significant clinical issue, characterised by greater severity of illness, earlier onset, and a worse prognosis compared to either condition alone. The overlap between BPD and BED raises important questions regarding shared mechanisms (e.g., emotion dysregulation, impulsivity, maladaptive coping), which provide a transdiagnostic perspective for understanding their comorbidity, and these concepts complicate assessment and treatment planning. Patients with co-occurring BPD and BED often have lower rates of treatment engagement, more frequent relapses, and greater levels of functional impairment, suggesting the need for models of care to address both conditions.<sup>22,23,25,27,28,34,36,37,41,42,48,51,91,92</sup>

#### *Future Research Directions*

Create and assess integrated therapies that include evidence-based components from treatments for BPD and BED (e.g., DBT + CBT-E) with an individual's symptom profile. Explore stepped-care approaches to maximize resource use, progressing flexibly from lower-intensity treatment when appropriate to higher-intensity or specialized treatment if severity or comorbidity warrants. Take advantage of digital health technology like mobile apps and telehealth to improve patients' access to care and continuity of care for patients with lower engagement. Explore biological targets (e.g., dopaminergic reward circuits, stress-response systems) for possible adjunctive pharmacological intervention. Recognize the significance of trauma-informed care with both research and practice, given the high rates of early adversity across both BPD and BED samples.

### CONCLUSION

BPD and BED often co-occur, and a complicated clinical presentation poses a significant threat to patients' psychological, medical and social functioning. Despite promising findings demonstrating shared mechanisms and informing the adaptation of evidence-based therapies, other treatment outcomes remain subpar for the majority of patients with comorbidities. The key to improving outcomes for this high-risk population lies in increased focus on

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integrated, personalised, and trauma-informed care, combined with thorough investigation into the mechanisms of the common and multiple clinical presentations or models of treatment.

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### ***Conflict of Interest***

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