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Borderline personality disorder: a review of Indian studies

Abstract

Borderline personality disorder (BPD) is a serious mental disorder characterizing impulsivity and instability in interpersonal relationships, self-image and moods. The study explores the scope of BPD research in the eastern cultures with reference to India. The paper first explores the cultural manifestations of BPD in different cultures such as eastern and western. The paper further illustrates a critical review of studies conducted in Indian clinical population and the awareness of the disorder in India. Researches in cultures like India were found to be very few, based on small sample cases with limited efforts to understand the disorder. Hence, the need to study the disorder comprehensively and empirically in India is emphasized. The focus on the directions for more research in the field of personality psychopathology and its diagnosis has been identified. It was found that the appropriate identification of BPD is needed in India as the disorder is gaining popularity and there has been an increase in the epidemiology of the disorder in the western countries so the concern is to do more empirical studies, including epidemiological studies in eastern cultures also.

Keywords: borderline personality disorders, BPD in India, disorder profile, BPD research

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Introduction

Personality characteristics are persistent forms of recognizing, connecting to, and thinking about oneself and the environment around him or her. These characteristics or traits are displayed in a variety of settings. In case these traits are maladaptive and lead to severe personal distress and functional impairment in an individual, they represent a personality disorder. Personality disorders are often manifested and identified during adolescence and continue throughout life. BPD is widely studied and prevalent of all the personality disorders (PDs) described in the fourth edition of the *Diagnostic and StatisticalManual of Mental Disorders* (DSM-IV; American Psychiatric Association [APA], 1994). Patients with BPD show difficulty and impairment in their day to day functioning of life. They exhibit dysfunctional personality patterns which cause severe distress to themselves and to those around them.

BPD in Eastern Cultures

The diagnosis of a personality disorder (PD), along with the definition of what constitutes a "normal personality" is a cultural and social construct. Culture plays a role in the definition of the self, in the expectations on the orientation of the person (towards the individual or the social group) and in the definition of how a normal personality is made and expresses itself. The difference between a normal and an abnormal personality depends on culture which directs and governs social norms declaring normal behavior patterns. The concept of PD is based on the western notion such as the individual being unique and independently functioning. Its applicability to people from cultures with different definitions of the individual's "normal" characteristics is thus open to debate and criticism. While eastern notions of self emphasizes on the individual's identity as embedded in his society. Hence, the society is more representative of one's self.

Researchers have addressed that socially acceptable behavior is variable between societies and over time. The significance placed on behavior supposed to be deviant may be related to whether the behavior is seen as threatening to the prevailing social order.[1] Young (1990) emphasized on social process where values of the dominant group and their experience is viewed as a universal norm while groups which differ from this are viewed as inferior, deviant or abnormal. Tanaka-Matsumi & Draguns[2] highlighted the contextual analyses of psychopathology and the links between the major dimensions of culturally differentiating behavior (such as the dimension of individualism-collectivism and the selforientation dimension of interdependent-independent self) and modes of expression of psychopathology.

Reports on BPD focus on its occurrence in different cultures around the world.[3] Currently, BPDhas been found to be less prevalent in Asian cultures and few studies on BPD phenomena using Asian populations exist. The DSM-IV does not include certain phenomena in the case of BPD which has been reported in Asian cultures. These phenomena are: a.) the impact of misperceived acculturation, b.) passivity, c.) suicidal like behaviors, d.) identity, e.) adjustment issues, and f.) religious traditions on the presentation of people which resemble those that fall into the BPD category.[4,5]

Thus, there is a need to study different conceptualizations of BPD in different cultures as the DSM in its very definition of personality disorders, emphasizes on the presentation of the disorder differently in different cultures.[6] A theoretical illustration of cultural influences on psychiatric disorders such as BPD has also been explained with reference to Indian cultural context.[7] Keeping this in view, the present study highlights major studies done in India and reflects on the future directions of research in the area as elicited from those studies.

Indian Researches on BPD

Research on PDs is a growing field in India. Researchers have mainly focused on the area of PDs in general without studying specific PDs. Very few studies on BPD have been done in the Indian context. Despite its huge attention in the West, there are few studies on Indian clients. Some studies have found the occurrence of BPD, while others have reported very limited research indicating the need for more inquiry into this growing field. To begin with major attempts at studying BPD in India, a meta-analysis of 13 psychiatric epidemiological studies (n =33, 572) was conducted. This study

provided an estimated prevalence rate of 5.8 % for all psychiatric disorders with organic psychosis (0.04 %), alcohol/drug dependency (0.69 %), schizophrenia (0.27 %), affective disorders (1.23 %), neurotic disorders (2.07 %), mental retardation (0.69 %) and epilepsy (0.44 %) without reporting any prevalence of PDs.[8] A study by Latha et al.,[9] has presented a prevalence rate of PD which was 12 % without any incidence of BPD. Other studies have identified the prevalence of PDs among psychiatric outpatients and reported that such prevalence was very low as compared to the research literature. The sample had a PD prevalence of 1.07% and contained more students or unemployed single young men. Borderline and anxious-avoidant PDs were the most common. The borderline group were younger (mean age 24.44 years), had more women (60%), housewives (28%) and had patients more with a lower-income background (80%).[10]

Earlier studies focusing on the occurrence of BPD in India have rarely reported significant information about the disorder. In a study by Paris,[11] a patient of Indian descent as a case was used. She developed BPD after migrating to Canada,. Paris elaborated the hypothesis that BPD appears to be highly sensitive to the socio cultural context and insisted that risk factors underlying BPD exist in developing countries and that some traditional cultures such as India provides protective factors that suppress the overt expression of BPD symptoms.

Other studies have mainly focused on the study of suicide and its comorbidity with personality disorders with a few cases reporting the prevalence of BPD. One such study by Gupta &Trzepacz,[12] focused on the characteristics of serious suicide attempters who overdosed (poison) and were admitted to a general hospital, comparing them with those who used non-overdose methods and with medically ill patients who had suicide ideation. They reported that prior psychiatric contact was high in all groups; DSM-III-R[13] diagnoses of depression, adjustment disorders, and substance abuse were common in each group; and the overdose group contained significantly more borderline and female patients.

There are few reports of BPD from developing countries like India. This led to study of a small sample (as very few cases could be identified) from a very narrow segment of suicide attempters who presented to a charitable hospital in a city. Out of 75 suicide attempters, 13 (8 Males and 5 Females) patients were found to have BPD. This report suggests that BPD exists in India and may be under diagnosed in the clinical setting.[14]Another study by Sharan[15] was conducted as part of his doctoral dissertation at the Post Graduate Institute of Medical Education and Research (PGIMER), Chandigarh. However, in that study the application of International Personality Disorder Examination (IPDE) led to the emergence of emotionally unstable PD (impulsive and borderline) as the most common PD. Chandrasekaran, Gnanaseelan, Sahai, Swaminathan, &Perme,[16] found that among 341 patients who attempted suicide, PD was identified only in 7% with 0.58% cases of BPD and all suffered from a comorbid psychiatric illness. Nath et al.,[17] aimed to identify the type of PD commonly associated with deliberate self harm. It was found that the commonest disorder was emotionally unstable (both borderline and impulsive type, 28.6%) in young people. This was more common in females than in males.

Recent studies on BPD in India have begun to focus on its relationship with other psychological constructs and its comparison/ comorbidity with other disorders. In a review of 13 studies on attachment and BPD, Agrawal et al[18] concluded that there was a strong association between insecure forms of attachment and BPD. Aaronson[19] found that patients with BPD were more likely to exhibit (vacillate between) angry withdrawal and compulsive care-seeking. These patients also scored higher on the dimensions of lack of availability of the attachment figure, feared loss of the attachment figure, lack of use of the attachment figure, and separation protest.[20] A study by Belhekar & Padhye[21] explored the relationship of BPD with affective instability and FFM neuroticism and found affective instability as a core component of BPD.

An unpublished thesis reported a study investigating the relationship between BPD and ADHD and further checked whether cultural differences between India and Kuwait affect the symptomatology and comorbidity of these two disorders. It was found that there was a strong partnership of BPD and ADHD, they predicted each other with absolute significance, hut in individual samples there were differences among cultures. In India, BPD and ADHD were predicted indirectly through anger, impulsivity and mood swings, whereas in Kuwait ADHD and BPD were direct predictors of each other accompanied by anger in predicting ADHD.[22] Another study by Mitra & Mukherjee[23] explored whether Bipolar Affective Disorder and BPD fall under the same spectrum or they represent separate categories. Both group of patients showed features of immaturity and instability. A co-relational analysis indicated the probable pathway of development of psychopathology. The parallels of the findings to Kernberg's concept of Borderline Personality Organisation (BPO) have been discussed.

Case studies on BPD have also been done in order to gain a deeper understanding of presentation of the sympromatology. A case study presented a BPD patient with difficulties in living and poor living conditions and quality of life. An intervention for enhancing his quality of life was proposed.[24]Another case reported clinical profile of BPD patient with specific features such as suicidal tendencies, substance abuse, disturbed emotions and difficulty in controlling emotions. Dialectical Behavior Therapy Intervention plan was suggested to this patient who eventually was a dropout .[25] A recent study by Choudhary and Thapa[26] has examined specific features in BPD patients in 8 cases of BPD. A list of commonly found defining characteristics or features of BPD were substance abuse, suicidality, academic failure, social dysfunction, dependency on others and personal distress. The results also indicated that marked impairments exist in significant areas of the patients' life, such as intimate relationships and occupational functioning. A major problem encountered in Indian clinical population was that the family attitude was a major barrier in seeking therapy. Choudhary and Thapa (2014)[27] also presented a social and cultural viewpoint of borderline personality disorder They illustrated that the disorder can be construed according to the cultural perspective and that it is perceived and maintained in the society according to the views of people. The family and society contribute to the manifestation and maintenance of the disorder Choudhary and Thapa 2017[28] also presented a profile concerning the evaluation of cognitive and emotional functioning in BPD. They proposed that emotional functioning is very erratic with sudden shifts in moods while there is mild deficit in cognitive functioning due to intense emotions.

A review paper on Indian scales and Inventories identified several measures for assessing different aspects of human behavior and personality. The paper highlights the Indian adaptations of several measures assessing personality, cognition, social aspects and diagnosis of a psychiatric illness with a very few measures for identifying specific mental disorders.[29] Choudhary[30] has attempted to adapt a few measures for identifying BPD in Hindi speaking states

of India. No attempt has been made at developing a comprehensive diagnostic measure for BPD.

The above mentioned studies on BPD in India do not present a comprehensive clinical picture of the disorder. They only proposed a surface level explorations whereas a thorough investigations concerning the presentation, manifestation, diagnosis and treatment of the disorder is required. Hence, there is a need to study the disorder in detail. In depth interviews and case analysis of BPD patients will render a clear picture of the disorder and will help in understanding the severity and complexity of the disorder.

Implications and directions for research in BPD

BPD, a prevalent mental disorder, lacks consensus about assessment and diagnosis. Incorrect diagnosis can lead to ineffective treatment and may be detrimental to the clients. The epidemiological studies present a shift in incidence and gender ratio. This shift corresponds to the increase in prevalence of BPD and relatively equal gender diagnosis. Relatively recent researches show that the lifetime prevalence of BPD was found to be 5.9% in the general population, occurring in 5.6% of men and 6.2% of women.[31] Hence, the general population between 1.2% and 6% is estimated to meet diagnostic criteria for BPD and this population includes approximately 10-15% of individuals using outpatient psychiatric services and approximately 20% of those in inpatient psychiatric care.[32,33] The varying data on prevalence of BPD requires more epidemiological studies conducted using appropriate diagnostic measures as well as by considering the cultural constructs or factors into account.

The presence of any 5 out of the 9 criteria of the DSM-IV-TR and DSM-5[6] certifies a diagnosis. The clinical definition of BPD is very broad. It is defined in terms of nine criteria of which 5 or more are indicative of the disorder resulting in 126 possible combinations of symptoms that would result in a diagnosis. Moreover, the high rate of concurrent comorbid psychiatric disorders and physical health problems leads to complications that must be considered when providing treatment or designing a research study for this population.[31,34] Within these combinations, there are high functioning borderlines that operate well in society and are not very obvious to new acquaintances or the casual observer. In these combinations, there are the low functioning borderlines who are often more apparent as they can't hold jobs, and they self-harm. Thus, it is very difficult to identify these patients. Formulating an accurate diagnosis of BPD in itself is difficult and is reported to have low reliability and validity, often resulting in misdiagnosis.[35]

Therefore identifying BPD is important for reasons as mentioned below.

1. The diagnosis anchors the patient's and the clinician's expectations about the course of BPD. Even when priority may be given to symptoms, behaviors, or situational crises, the perspective of a long-term seriously handicapped person sets realistic boundaries to what can be expected.

2. The diagnosis prepares clinicians for what lies ahead—including the option of referring the patient to those who may be better able to provide needed support. The diagnosis further helps therapists focus on the characteristic defensive adaptations that these patients have made (e.g., regressing, idealizing, blaming). Such a characteristic helps clinicians discriminate BPD from different Axis 1 disorders as well as other personality disorders. To facilitate identification of these complex clusters of symptoms, precise information pertaining to their definable characteristics is required. As the wide range of symptoms seen in BPD are also typical of other co-morbid disorders such as mood (depressive disorders)[1] and anxiety disorders (posttraumatic stress disorder, PTSD),[35] substance abuse, eating disorders, and narcissistic personality disorder,[37,38] patients may be felt to have one of these conditions and are thus misdiagnosed for these disorders. Patients with BPD traits frequently have a complex presentation and are more regularly co-morbidly diagnosed as compared to other diagnostic groups.[33,39] This prevalence of co-morbidity complicates the diagnostic presentation of patients and, consequently, their treatment. This calls for a need to develop more specific tools for the assessment and differential diagnosis of BPD.

3. The most central problem of any diagnostic approach is reliance on the self-awareness among a group of PD patients who are likely to have distorted views of themselves and others. Researchers have demonstrated across multiple samples that although lay informants converge remarkably well in assessing their peers' personality pathology, aggregated peer assessments tend to correlate only on the order of r=20 to 30 with self-reports.[40-43] For the more overt symptoms of BPD, such as self-mutilation and suicidal ideation, self-report biases are less likely to be problematic. For more subtle personality symptoms, and particularly for externalizing symptoms,[35] these biases may be more problematic. Such problems account for the need to devise more comprehensive measures for the identification of BPD. Another challenge is that neither structured interviews nor questionnaires correlate strongly with consensus diagnoses made using all available data collected over time by teams of clinicians who not only have access to data from other informants but also know the patients well.[44-46] There is not a single method that best assesses BPD. However, literature revealed that the Millon Clinical Multi-Axial Inventory- III (MCMI-III) and the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) was the most widely used instrument to assess PDs in general, even though each instrument is not without limitations and controversy on their validly from other researchers have been in question. Therefore, a multi-method approach to diagnosis using various diagnostic measures is preferred over single method.

4. BPD has been reported to occur in many different cultures around the world.[3] Many researchers have suggested that diagnoses included in the DSM should not be utilized universally without taking into account cultural aspects of the individual because the cultural context is inevitably prominent in shaping the development of a person's personality. The cultural context often determines the presentation and manifestations of symptomatology. Culture provides a framework for our thoughts, beliefs and behavioral styles that are specific to a particular society. BPD has a variety of features that may be specific to the Indian cultural context so there is need to study the culture specific manifestation of the disorder. Very few studies on BPD have been done in India. These studies have not focused on the clinical features of the disorder. Hence, there is a need to study the disorder comprehensively and in detail. In depth interviews and case analysis of BPD patients will provide a clear picture of the disorder and will help in understanding of the complex clinical features that constitute the disorder within this cultural framework.

5. Approximately 75–80% of borderline patients attempt or threaten

suicide, and between 8–10% are successful. If the borderline patient suffers from depressive disorder, the risk of suicide is much higher. For this reason, early identification and appropriate interventions are critical. The borderline diagnosis establishes a basis for developing a treatment alliance by offering patients a developmental and therapeutic context that they will experience as meaningful and appropriate. This information can also be used for treatment planning.

Looking at these issues related to the importance of diagnosis as well as problems encountered in the assessment and diagnosis may provide a roadmap for devising specialized measures which are effective in identifying and defining the clinical features of BPD using cultural formulations.[47-54]

Conclusions

This article is a review of BPD research in India summarizing major attempts to researches done in the country. This paper addresses the need to conduct empirical studies on the disorder as it is conceptualized on the basis of a few cases only. Limited case studies have presented the characteristic features of BPD in India. The reliance on these features or clinical profiles cannot be made as they are based on a very small sample cases. Such clinical profiles may help in the clinical diagnosis of BPD in India. Directions for more research in the field of personality psychopathology and its diagnosis have been identified. Identification of BPD is needed in India as the disorder is gaining popularity and there has been considerable research indicating its awareness and prevalence among general population in India.

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Conflicts of interest

The authors declare no conflicts of interest.

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