Borderline Personality: An Illness in Obscure Darkness, Exploring Psycho-social Factors of BPD Through Narratives and Case studies.

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Abstract
Objective – To explore the aetiology, pathogenesis, and symptomatology of borderline personality disorder (BPD) in relation to childhood traumas through case study and narrative approach.
Methodology – The study was qualitative in nature. The data was collected from two individuals with BPD using semi structured interview guide. Semi-structured interviews with three psychiatrists with significant clinical experience in treating individuals with BPD was conducted focussing on clinical approaches, treatment approaches and treatment challenges.
Result- Societal shifts in Kerala, characterized by reduced parental care, a focus on nuclear families, and a decline in social support systems, are creating an environment that is detrimental to child development. Childhood traumas have a strong relation in causation of BPD**.**
Discussion-Psychiatric social workers play a crucial role in supporting individuals with Borderline personality disorder (BPD) and their families. They bridge the gap between patients and the healthcare system, addressing the unique challenges faced by individuals with BPD, such as stigma, relationship difficulties, and family dynamics. By providing support, education, and guidance to both patients and their families, social workers contribute significantly to improving treatment outcomes and enhancing the overall quality of life for individuals living with BPD.

Introduction
Borderline Personality Disorder (BPD) belongs to Cluster B personality disorder. Cluster B includes three maladaptive personalities, characterised by overly dramatic, emotional, erratic nature and the theme of their personality as having a general lack of empathy for others. Patients with borderline personality disorder are thought to suffer the most out of every person with a Cluster B personality disorder diagnosis (Hoch & Polatin, 1949). Extreme sensitivity to perceived rejection from others, an unstable sense of self, strong and unpredictable emotionality, and impulsive actions that are typically self-destructive are characteristics of borderline personality disorder (BPD).
In this article, the authors want to provide a contemporary understanding of borderline personality disorder (BPD) based on psychoanalytic theory, existing research and through the narratives of experts from the mental healthcare field. The interviews of two eminent psychiatrists, Dr. C.J John of Medical trust hospital, Kochi Kerala and Dr. Femi Abdulla from Futurace hospital, Kochi Kerala, and two case studies of BPD are used to support and substantiate the author's observations. The pathogenesis, the causes, and treatment of the disorder are specifically addressed.

Aetiology
In the nineteenth century, Sigmund Freud, Pierre Janet, Jean-Martin Charcot, and others used the term "hysteria," which means "wandering uterus" in Greek, to refer to a variety of physiological issues,

**Sigmund Freud used the term subconscious in 1893 to imply links and impulses that are outside of human consciousness. Psychology define subconscious, as the part of our mind that is not currently in focal awareness, where information is stored for later retrieval.*

most of which affected women. These issues included somatoform disorders, BPD, PTSD, dissociative disorders, and some sorts of psychosis. Psycho analysts, whose views are largely based on psychodynamic theories (Psychodynamic refers to the mental process of development or progression) given by Sigmund Freud and Erik Erikson, Postulates on the role that early life events have in shaping an individual's personality. Thus Children who were abused, neglected, or had gone through trauma as young children may grow up to have a personality disorder.

Pierre Janet was the first person documented to explore the connection between traumatic memories and dissociation in an attempt to explain symptoms of hysteria. (Van der Kolk &

Van der Hart, 1989). As per Janet's word's Traumatic events and the "fierce emotions" they produced, become detached from normal consciousness and functioned "subconsciously," unable to be properly or emotionally unified*. But in most psychoanalytic literature, the term "dissociation" was eventually substituted with "splitting," and the initial focus on trauma and dissociation was either disregarded or ignored. Thus, traumatic incidents caused unfulfilled emotions which could not expressed or integrated with normal emotions, resulting in splitting or dissociation. This was thus the first observation recorded about hysteria, from which a group of disorders were subdivided and allotted their own special place as borderline personality organization (BPO).

By the 1950s and 60s, borderline conditions had been recognised, but was linked to schizophrenia. It was further later, they were given their own unique classification, known as borderline personality organisation (BPO), a group of disorders that has similarities to both psychosis and neurosis but were not the same as either (Kernberg, 1975).

The term 'borderline' was first used by Adolf Stern in 1938. The term began to gain attention and be widely used after Robert Palmer Knight's (1953) article "Borderline states" . Knight reported individuals with 'BPD' as those who displayed characteristic neurotic symptoms despite of having intact functional domains (such as memory and "habitual performances") but whose capacity to establish steady, long-lasting connections and adjust to changing circumstances was seriously jeopardised. Cleckley,(1941) Described patients with BPD as those who aren't psychotic, but wear a "mask of sanity."

BPD patients constantly struggle to balance their overwhelming need for human connection with their distrust, hostility, and dread of being alone, which frequently pushes people away. From a dynamic standpoint, borderline patients may need to rely on another person to manage and regulate their own emotions. This concept is called - The lack of "evocative object constancy" that is, their incapacity to self-soothe by relying on recollections, pictures, or experiences with soothing others—this was first noted by Adler and Buie in 1979. According to Adler and Buie's conceptual terms, this deficit develops as a result of childhood

experiences with abusive, uncaring, or inattentive parents who fail to demonstrate to their kids how to control their emotions.

Features and symptomatology

Table 1. Emotion regulation and emotional

a)	Has difficulty identifying or recalling anything pleasant while depressed: everything seems horrible when depressed.
b)	Frequently experiences negative feelings, such as melancholy, worry, guilt, etc. deeply

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	prone to feeling too much or being scattered by feelings
c)	When upset or annoyed they have a tendency to act out against others and turn needy, reliant, and clinging.
d)	Is prone to temper tantrums and outbursts of rage when disappointed or frustrated
e)	Is prone to feel depressed or dissatisfied Tends to feel concerned or worried and ponder or endure on worries
f)	has trouble understanding other people's viewpoints when their emotions are intense can waver between clinging to and pushing away from others when upset.

(The data are modified and summarised from Zittel, Bradley, and Westen (in press) using the Affect Regulation and Experience Questionnaire (Westen et al., 1997)

According DSM V, Borderline Personality Disorder is defined as “A pervasive pattern of instability of interpersonal relationships, self-image, and affects,
and marked impulsivity, beginning by early adulthood and present in a variety of contexts,
as indicated by five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
3. Identity disturbance: markedly and persistently unstable self-image or sense of self
4. Impulsivity in at least 2 areas that are potentially self-damaging, for example, spending, substance abuse, reckless driving, sex, or binge eating
5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
6. Affective instability due to a marked reactivity of mood, for example, intense episodic dysphoria, anxiety, or irritability, usually lasting a few hours and rarely more than a few days
7. Chronic feelings of emptiness
8. Inappropriate, intense anger or difficulty controlling anger, for example, frequent displays of temper, constant anger, or recurrent physical fights
9. Transient, stress-related paranoid ideation or severe dissociative symptoms

**Taken From DSM-V (2013) Issued By the American Psychiatric Association (APA), Page no: 663 [301.83 (F60.3)].*

At least two potentially self-damaging areas of impulsivity are displayed by people with borderline personality disorder. They could gamble, spend carelessly, overeat, do drugs, have risky relationships, involving unprotected or reckless sexual relationships, and may drive haphazardly. People with this illness frequently act self-destructively, make threats or gestures, or self-mutilate. Threats of rejection or separation from a romantic partner, are what typically set off these self-destructive behaviours.

Dr Femi Abdulla, working at Futarace hospital, Kerala observes that main presenting symptom of BPD is suicide ideation. Some patients while being presented with self-harming tendencies or suicidal ideation when analysed further, BPD was found to be the root cause of their constant suicidal thoughts. *"When a patient presents themselves with constant marital conflicts, Involving self harm or suicidal threats, they are initially send with their spouse or partner for marital counselling, In some such cases, one partner were found to be suffering from BPD."*

Pathogenesis.

There is no singular factor known to be the causative element of BPD. Studies have found that interplay of both genetic and environmental factors can cause BPD. There have been studies showing a strong correlation between childhood traumas and development of BPD. Linehan (1993) proposes that interactions between biological and psychological elements particularly those involving unpleasant and traumatic childhood experiences and temperamental vulnerabilities, may result in BPD. Children acquire essential knowledge about who they are, how to control their inner feelings, and how to behave in ways to other people through their early attachment styles. A realistic and balanced image of oneself and others may be compromised by experiencing parental/caregiver's abuse or neglect (Critchfield, 2008). Prolonged and recurrent trauma, especially during younger years,can lead to a persistent incapacity to control emotions, which can lead to BPD-like behavioural patterns.(van der Kolk, 1994) A path breaking discovery was made when Mary Zanarini, a professor of Psychology at Harvard Medical School and Director of McLean Hospital's Laboratory , who found that, 40% to 76% of adults with BPD report childhood sexual abuse; 25% to 73% report childhood physical abuse.(Zanarini, 2000).More than any other personality disorder, BPD is linked to child abuse and neglect with a range of 30 to 90% in BPD patients.(Battle CL, Shea MT et.al ,2004).The above mentioned study was conducted using data from the Collaborative longitudinal personality disorder study (CLPS), from four U.S research sites. The total sample of the said study was 600 and the final sample of this research investigation had 600 individuals of which 517 people were adults with one or more personality disorders. (BPD, n= 214). Among the participants, the rates of reported childhood abuse and neglect were usually high: around 73% indicated a history of some type of abuse throughout childhood, with 34% reporting sexual abuse by either a parent or non-caretaker. Furthermore, 82% of respondents said they had been the victim of one or more of the seven categories of childhood neglect that were being evaluated in the study.

Soloff et al.'s (2002) study with a mixed sample of BPD inpatients and outpatients showed that 45.9% of the sample reported to experience childhood sexual abuse. The sample of the study involved 11 males and 50 females, who met full diagnostic criteria for BPD as per DSM - III. The results showed that 16.4% BPD patients reported being sexually abused in childhood, 19.7% experienced some form of physical abuse and 29.5% were reported to have experienced combined abuse (physical, sexual and emotional abuse) during their childhood. It was also found that 51 patients (83.6%) had a past history of suicide attempt.

Shedler & Westen, (2004), Westen & Shedler, (1999), Zittel & Westen (2005), Using a scale called 'SWAP-200', provides evidence through their studies that "those with BPD are unable to soothe themselves, they often found to be simultaneously in need of intimacy or caring but tends to reject it when offered and is inclined to feel victimised, disrespected or misjudged". [Psychologists Drew Westen and Jonathan Shedler devised the 'Shedler-Westen Assessment Procedure (SWAP-200)'. It is a psychological test for personality evaluation and clinical case development. While using SWAP-200,

a mental health practitioner fills up this scale based on their observations along with their comprehension of a patient, client, or assessment subject. Given that the clinician completes SWAP-200, test results cannot be falsified and diagnostic conclusions are independent of the authenticity of the information participants provide about themselves. Thus increasing the empirical nature and scientific validity of the above mentioned study].

How Childhood Traumas Cause BPD- a Very Short Overview:

One of the essential components in the human stress response system is serotonin(Dell'Osso,2006).Serotonin regulates emotions,(mood and affect), behaviours,(like aggression and impulsivity), cognitive functions and many other physiological process (Lesch,1998)(Siever,2008).Serotonin plays a key role, especially during early stages of brain development, in regulating morphogenetic processes, which include cell migration, proliferation, and differentiation.(Lauder,1993).Serotonin is found to be dysregulated after trauma.(Lesch 2000). Studies conducted in rodents have been shown to prove that decreased serotonin levels can cause an increase in aggressive behaviours. Thus Early trauma affects serotonin and the genes which control and regulates it along with having an effect on behaviour patterns and personality. Another hormone, Oxytocin released by the pituitary gland, plays a crucial relationship in how someone perceives and manages interpersonal relationships. This hormone controls a person's sexual response and milk production. It also controls a broader variety of social interactions, such as attachment, social cognitive skills, identifying emotions, and empathy.(Bartz,2011).In "The enduring effects of abuse and related adverse experiences in childhood: a convergence of evidence from neurobiology and epidemiology", the author noted that abnormalities in the way oxytocin regulates during social attachments in childhood might result in elevated oxytocin levels and, consequently, results in developing quick and less constrained personal bonds in later life.(Anda,2006).

Magnetic resonance imaging (MRI) scans of patients with BPD showed some interesting findings. There were 3 parts of the brain which showed size difference or unusual levels of activity compared to normal brain- Amygdala, Hippocampus and orbitofrontal cortex. Studies found decreased volumes in amygdala and hippocampus in those subjects with BPD as opposed to normal volumes in the control group without BPD or any other personality disorder. (Driessen et al., 2000, Rusch et al., 2003, Schmahl et al., 2003, Tebartz van Elst et al., 2003). It is well established from various scientific researches that life experiences during early years have an impact on how certain brain regions grow. For majority of prenatal brain development, genetic process are found to be dominant, (Morgane et al, 1993) but the brain development in post-natal period relies heavily on one's experiences. (Thompson et al, 2009; Boksa, 2010) The above-mentioned parts of the brain play crucial role in controlling mood and behaviour, which could explain to some extent, the issues of people with BPD especially in intimate relationships. However more studies are needed in this field to find how precise treatment and therapies can be custom tailored to each patient as per the structural abnormalities of the brain.

Case example: 1

Miss X (name changed for confidential purpose) An accountant by profession[Bangalore],Currently 26 years old and hailing from an upper middle class family has been taking treatment for BPD from past 3 years.

Childhood history: She says she had trouble coping up with stressors "as long as she could remember''. Her aggressive behaviours peeked around the age of 14 as she recalls it. She said that

whenever she got upset or moody, she had trouble controlling her anger and would say extremely hurtful things, which she would regret later. She stated that she came from a very conservative family, her mother was an ardently religious person whereas her father used to drink frequently and was often physically abusive. She mentioned that whenever her father wasn't being drunk , he would shower her and her 2 other siblings with love and buy toys and food for them. But whenever he was drunk, he would be irritable and abusive and X remembers as if 'walking on eggshells' to avoid disappointing him. Her mother would lock the kids in a room so that their father wouldn't interact with them when he was drunk. Even though she mentioned

Relationship patterns and diagnosis : She had her first long term relationship at the age of 21 and recalls having fits of rage whenever her then partner wouldn't be available for her. Once during an argument miss X exhorted to continuously hit her head on the wall to make her partner show assurance to her. After a couple of similar arguments which lead to extremely unpleasant conversations and actions, her partner broke off the relationship which made miss X even more depressed and irritable. She recalls that her partner and close friends identified her to be demanding and short tempered. The relationship had lasted over 8 months. Miss X remembers that she desperately tried to connect with people, through social media, trying to find a romantic partner. She dated multiple men at the same time, but without revealing to each other so that 'she could choose the best out of them'. Soon at the age of 22, she got into another relationship. Even though things went smooth at first violent fights began to happen and X was often physically and verbally assaulted by her partner. During this same period, She mentions that she got jealous seeing the relationship between her best friend and her male partner and tried to flirt with him in order to get into a romantic relationship with her friend's partner. This incident took into serious turn of other events leading to be ostracised and later, X consulted a psychiatrist on her own initially suspecting depression, but was diagnosed with BPD.

Treatment: She is currently taking medications to manage BPD but feels like therapist or psychiatrist is not fully able to understand her. She refused to talk about her further treatment details.

Current status: she currently has a good relationship with her mother and father, she still fears him and is unable to bond well with him. X being the middle child, has one elder and younger sibling, both offering unwavering support for her and keeping track of her treatment progress even when she displays some of the worst symptoms of BPD. She credits them for being her hope to survive BPD. She is currently not in any romantic relationship but wishes to be in one if possible. She experiences quick mood swings, sometimes shifting from one to another extreme just in a couple of hours. She says that reading news about Zoraya ter Beek, a 28-year-old woman from Netherland who is sanctioned to undergo euthanasia as she was diagnosed with BPD, austism and depression made her feel that 'may be i shoul die too'. X says that people with personality disorders cannot lead fulfilling lives and feels as if they are cursed to live lonely.

The Psycho-social Aspects Of BPD: Through the narratives of a psychiatrist

Psychiatrist Dr. C. John, one of the most eminent psychiatrists of Kerala, who currently works as senior consultant psychiatrist at Medical Trust hospital, Ernakulam, Kerala, is known to have paved the way in mental health care in Kerala as a socio-medical activist. With an experience spanning over four decades, he is recognized for his compassionate nature and dedication to the overall well-being of both patients and the community, Dr John is one of the pioneers of the anti-suicide movement in Kerala and a member of the State Mental Health Authority.

(i) How is BPD identified?

It is usually when a family member presents issues such as anger outbursts and excessive irritability, self harm for the smallest issues, jumping from one relationship to another and trying to get connected quickly with another romantic partner without much thought or exhibiting behaviours such as to be highly unstable in relationships and appearing promiscuous, he/she is usually brought for treatment as these behaviour can be embarrassing to the near and dear ones. Some cases displaying the said symptoms will be diagnosed to have BPD upon further assessment. Compared to earlier years, the number of patients with BPD are on the rise.

(ii) What could be possible causes for increasing prevalence of BPD, can you elaborate on the psychosocial factors from your viewpoint?

Over the period of time our social structures have undergone drastic changes. The availability of Safe secure environments, and parenting quality have reduced over the years. Nowadays, it seems that parents don't have much time for children and the space for intimacy and communication is also reducing. Parental neglect is becoming more and more common. The instances where very young children are abused, be it physically, emotionally or even sexually, are on the rise. There has been a psycho social shift in family structures of Kerala. We are moving towards a money-driven, pleasure-oriented society. Also, there is a scarcity of 'healing avenues' within our social structures. Like if an issue or trauma happens, safe spaces to share and heal it have reduced, thus increasing vulnerability. Also, children growing up in an environment, where the parents' marriages are 'psychologically broken', may develop narcissistic or borderline personality disorders, or antisocial personalities.

(iii) Which could be the stronger agent in the increasing BPD cases, genetic or psycho social?

There is a link a genetic link between bipolar disorder and borderline personality disorder. But if personality disorders like BPD were to have a more genetic nature, the prevalence rates of BPD among different generations should show some kind of consistency. In my opinion more than genetic transmission it is the changing psycho - social factors, and the scars it leaves in evolving personality is the main contributing factor for developing BPD.

(iv) How difficult is it to address the said issues of a client with bpd?

Since they lack emotional control, the chances of them leaving the treatment process halfway in the earlier phase itself, can be high. They also exhibit suicidal tendencies on the most minor issues and this can be as traumatic and stressful for the healthcare provider. They can easily get frustrated and resort to deliberate self-harm, especially when in fear of abandonment from a partner. Addressing their issues in a therapeutic setting, as they have severe emotional dyscontrol with self-harming tendencies, can be very challenging for the health care provider to teach them better coping mechanisms or skills for improving frustration tolerance.

Dr C.J John's observations can be best read along with M.M Linehan's biosocial model for the development of borderline personality disorder. Linehan postulated that heightened emotional reactivity, enhanced emotional sensitivity, and a delayed return of emotional arousal to baseline account for BPD patients' emotional vulnerability. (Linehan,1993). According to Linehan, BPD arises from interaction between people who have biological vulnerabilities and certain environmental influences which then leads to emotional dysregulation. Linehan's theory conceptualises BPD from a lifespan developmental perspective. Biosocial theory interprets BPD as a result of several interrelated risk factors, involving various dynamic processes. This paradigm looks at the causes and mechanisms behind emergence of BPD, as of how, its psychopathology is influenced by interactions between people. Dysfunctional interpersonal relationships, as per this theory, increases the likelihood for

developing BPD. Linehan proposes that children from invalidating family environments are at higher risk of BPD. Linehan suggests that emotional dysregulation can lead to dysfunctional or heightened unwanted responses during events that can be challenging. An 'invalidating environment' can be understood as one which teaches a child, that emotional displays are undesirable, (but at the same time reinforcing extreme expressions of emotion) and that they should handle their emotions on their own without any assistance from their parents. As a result of this belief, a child learns to fluctuate between high emotional lability and emotional suppression rather than learning to comprehend, categorise, control or deal with their natural emotional reactions. The child also fails in addressing the issues that cause these responses.

Treatment and challenges

Psychiatrists who treat individuals with borderline personality disorder may experience considerable stress. For instance, these patients may respond negatively and fiercely, and these reactions may be instantly aroused. Suicide accounts for up to 10% of BPD patients death.(Nelson-2012, Soloff 2012).It has been observed that BPD patients typically disregard treatment recommendations, use services erratically, and repeatedly cancel therapy. Many medical professionals are apprehensive about treating individuals with BPD and have low expectations for the effectiveness of their care. Therapists that work with BPD patients have demonstrated significant degrees of burnout.Dr. Femi Abudulla says treatment of people with BPD can be quite challenging. It is difficult to establish a therapeutic relationship with them as they have black or white thinking. "They will shower you with praises for supporting and treating them, but if an instance happens which feels unfavourable to them, they will easily blackmark the you. They have compliance issues and it is difficult to draw boundaries with them. Some patients get dependent on you while you are in the treatment process and they might call you up even at odd hours when faced with the slightest stress or an emotional difficulty."

Psychiatrists have often avoided disclosing the BPD diagnosis to their patients until recently. (Gunderson,2011)Apart from apprehension about unfavourable responses from a BPD patient, especially if the patient feels abandoned, some psychiatrists have been worried that disclosing this diagnosis may increase stigma, or even crush patient hope. However, it is becoming more recognised that BPD patients can generally benefit from psychiatrists who share this diagnosis (Sanislow et.al, 2012).

C.J John says that it is important to disclose their diagnosis to the patient and their family. He says "In this era of the internet a lot of people google their symptoms online. A small percentage of people have turned themself in for treating, suspecting borderline personality, from their search online based on their insight of their experiencing symptoms".

Psychiatrists can also discuss with patients having BPD that the interpersonal difficulties that are having, are partially hereditary and result from anatomical variations in their brains which is what makes them more susceptible to reacting violently to interpersonal stress. (Gunderson 2011, New A.S et.al 2012). This knowledge may relieve, to some extent, shame or guilt of a patient and that what has gone wrong in their lives wasn't entirely their fault. Also, assurance from the psychiatrist about methods of treatment and how medications and therapies can alleviate their distress, might create a new profound hope for those with BPD. According to recent researches, hope may be just as vital as anything else—if not more important—for suicidal patients. (Bruffaerts,2012).

Case 2 ; A triumph over BPD

Priya (name changed), 30 year old female, currently doing Masters In managerial course in Prague (Czech Republic) was diagnosed with BPD in 2019.

Childhood history : When asked about her childhood, Priya says both her parents were loving and nurturing towards both her and her sister. But she recalls that her parents used to fight a lot and in many instances, Priya witnessed her mother being beaten up by her father. As a child, she would always try to break up the fight and calm the parents and often used to act as a 'mediator' between them. She says she had to 'keep things to herself', and handle her hard times alone as she thought she should not trouble anyone. When studying in 9th grade, she was raped but had to keep this hidden from her parents as she felt rape happened due to her fault. She says that she never spoke to her parents freely.

Relationship patterns & Diagnosis: In 2019, Priya was in a relationship with a man who pursued her for nearly 8 years. Prior to this relationship Priya dated many men but couldn't progress in any of those relationships as she could not connect with any of them emotionally. She said that constant fights used to happen and her partner used to say that her emotions are extreme and called her a woman who was difficult to handle. She herself admits that her emotions are always extreme, she says she will go to any extent while in love with a person. Good or bad, there was never an intermediary level for her emotions. It was her partner who suggested her to a psychiatrist.

Treatment: Currently she is not under any medications. She says the medications made her severely depressed and she felt like unable to even get out of her bed. Priya also says that therapy doesn't work for her. The reason being her first therapist, as soon as he learnt about her diagnosis, said to Priya "It is difficult to work with people like you as you keep criticising us without any good reasons". This made her feel that even when she is trying to work things and make a change, due to her diagnosis she is being villainized without any other reason.

Current status: Priya says she has made peace with the fact that BPD can mostly never be cured. She feels that moving abroad to a different country and culture, studying while doing a part-time job and learning to live alone there has given her great deal of confidence. She says " i am learning to live my life alone. I love being around people but when i get into a relationship i become very needy and feel like i want to be around that person always. It can be extremely difficult for the other person" The researcher observes that she has good insight and a positive outlook on life. She is able to accept her condition, realise her negatives and strengths and channel that into things that works for her. She currently goes to gym and does yoga religiously and believes following a routine and sticking to it whenever possible, helps her get through tougher times. She journals everyday in order to track her thoughts and actions. She is also active in social media and uses her platforms to create awareness about BPD.

Discussion- Social work with BPD : Role of psychiatric social workers

People who have borderline personality disorder (BPD) may face serious barriers to social integration as well as substantial societal costs, such trouble sustaining relationships in both their personal and professional lives. BPD is among the mental health disorders that carries the worst stigma. The literature indicates that even medical professionals frequently categorise people with BPD as manipulative or attention-seeking. The majority of the symptoms are related to mood control issues and frequently involve self-harm displays, which can be stressful for clients and their family to handle. This is made more difficult by the fact that, although BPD though in spite of having a higher

prevalence, the mental health system is usually not built for those with this disorder (Gunderson, 2011).In comparison to patients with MDD(Major Depressive Disorder), BPD clients were reported to exhibit more aggressive, narcissistic, non-compliant, uncertain, and sexualized interpersonal behaviours(Bourke and Greyner ,2013). In a meta-analysis study ,Sasone and Sasone (2013) found that Mental health professionals have a lot of unfavourable stereotypes about individuals with BPD. First of all, individuals with interpersonal behaviours that may be extremely hurtful are what physicians deal with while treating BPD. Since BPD patients may go quickly from being highly supportive and actively participating in therapy to exhibiting hurtful and rejecting relationship behaviours towards their therapists or doctors. However, the majority of healthcare workers are not educated in providing appropriate treatment for those with BPD, and as a result, they may feel unprepared to handle their patients' feelings of surprise, frustration, and anger.

In order to help patients and their families and overcome the above-mentioned barriers and stigma to receiving treatment, social workers are frequently required. A social worker can bridge the gap between a doctor and a patient. For example, a social worker can help a patient to develop more insight about their own condition and also act as a mediator if the patient unnecessarily harbours personal grudges against the treating psychiatrist. The natural systems working around the patient can be identified, supported and strengthened by a social worker which can contribute significantly in improving the efficiency of the treatment process as well as to support the partners of people with BPD. When a patient is diagnosed with BPD their parents may be vilified since most studies show BPD to a disorder arising out of childhood traumas. Well intentioned and genuine parents may find it difficult to accept that they have mistreated their child in some way It is important that frontline workers, such as psychiatric social workers give support and guidance through counselling, to both patients and their families.Given that roughly half of the BPD cases develop without any physical or sexual abuse or psychiatric disorders, it is important to see that the relationship between the patient and their parents, especially when the parents are still their primary caregivers, are not further strained due to diagnosis. Borderline patients may feel conflicted about asking for assistance when they need it. As a result, families may be too or underly involved. On the other hand, a needy, dependent patient who freely asks her parents for advice on everything may encourage such a parent to be overbearing. A social worker can effectively guide the patient and their parents through this process and help both the patient and the family draw healthy boundaries. Incase of married persons with BPD, it can be quite challenging for the spouse. Over one third of patients with BPD are in long standing relationships. (DSM-V, 2013). According to studies, between 30 and 44 percent of people with BPD have romantic relationships going at any given moment. However, very little research has focussed on their partners' experiences. (Greer,2018). This is even more sparse in Indian context given the stigma towards mental health and how less personality disorders are diagnosed. In research conducted in the UK, most partners who underwent interviews, said they felt misinformed, ignored, and neglected by the mental health system (Dunne et.al,2013). Psychiatrists or other doctors may not have enough time to address the concerns of a client’s partner or parents. Social workers can ensure that patients' family's or partner's inquiries are addressed. In addition to providing information, social workers encourage the family to continue receiving treatment (since the ones with BPD may not be consistent in treatment by themselves).Thus, Social workers can play an important role to assist people, as well as their families in managing stress and maintaining a healthy therapeutic relationship between the healthcare provider and the client. As patients go through several stages of treatments and display characteristic borderline symptoms, the coordination and communication among the treatment team becomes crucial. This is

where the role of a social worker steps in. Psychiatric social workers may organise group therapies for those with BPD where clients can be taught how to take care of themselves, so that people with BPD can develop the interpersonal, economical, and social skills necessary for enjoying their lives.
Future researchers should focus on how custom tailored treatment can be developed for BPD patients.

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