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VIEW POINT

Borderline personality disorder management - a descriptive online survey of indian psychiatrists

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Abstract

Background: Borderline personality disorder (BPD) is increasingly being recognized in clinical practice in India. This study aims to understand the diagnostic and management practices of psychiatrists in India concerning BPD. We also examined the practice of sharing the diagnosis with patients and caregivers and the factors influencing this.

Methods: The study was conducted as an online cross-sectional survey using a convenience sampling method among practicing psychiatrists across India. A purpose-built online questionnaire was designed and circulated by email and social media groups.

Results: 296 psychiatrists completed the survey. The reported diagnostic and management practices were consistent with the latest guidelines. The psychiatrists felt confident in diagnosing BPD but less confident in managing it. While most of them gained experience in diagnosing and managing the disorder during their training period, they also gained skills and knowledge through other means like continuing medical education events and workshops. The participants of the survey strongly believed in a need for specialized services and more focused practical training in this field.

Conclusions: The discrepancy between confidence in the diagnosis and management of BPD indicates the need for hands-on training in management practices.

Keywords: borderline personality disorder, India, psychiatrist, online survey, diagnosis and management

Introduction

The Diagnostic and Statistical Manual of Mental Disorders the fifth edition (1) describes Borderline personality disorder (BPD) as "a pervasive pattern of instability of interpersonal relationships, self-image, and marked impulsivity, beginning in early adulthood and present in a variety of contexts." BPD is diagnosed in about 6% of primary care patients (2) and in community-based samples with a prevalence of 15–20% of patients in psychiatric hospitals and outpatient clinics (3).

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Despite increased awareness, evidence suggests that a sizable proportion of individuals with BPD remain misdiagnosed, undiagnosed, and under-treated (4, 5). Studies show that persons meeting symptoms of BPD and seeking psychiatric treatment may be diagnosed and treated for Axis 1 comorbidity alone or are told that they have a disorder other than BPD, such as bipolar disorder (4).

The importance and relevance of disclosing the diagnosis is immense. One study found that when individuals diagnosed with BPD are educated about the disorder and given new coping strategies, the severity of symptoms decreases over 16 weeks (6).

There have been few studies investigating the extent to which psychiatrists disclose a diagnosis of BPD to their patients. A study examined how psychiatrists disclosed several psychiatric diagnoses and showed that there was a reluctance to disclose BPD compared to other conditions, such as bipolar, panic, and depressive disorders (7). A study by Clafferty and colleagues (8) compared disclosure practices across several diagnoses and found that 90–98% felt comfortable disclosing unipolar depression, bipolar disorder, anxiety disorder, and substance use disorders. However, only a minority (42%) revealed the diagnosis of personality disorder.

Studies on personality disorders have come a long way from justifying their existence in the Indian context (9) to disorders that are acknowledged to be causing significant morbidity (10). However, research into personality disorders in India is still at a nascent stage. In the International Pilot Study of Personality Disorders (IPSPD), the personality disorders frequently seen in the clinical sample in South India were schizotypal (19.1%) and borderline (14.7%) (11). To our knowledge, there are no studies on the diagnostic and management practices for BPD in India as yet.

This study aims to understand the BPD diagnostic and management practices and the practice of sharing diagnoses with patients and caregivers by psychiatrists in India, including the factors influencing this.

Material and methods

Study design and setting

An online cross-sectional descriptive survey was conducted among practicing psychiatrists and psychiatry trainees across India. The data was collected from August to November 2021.

Sample

Practicing and trainee psychiatrists currently working in India were invited to participate and complete the survey after giving online consent.

Questionnaire

A brief survey (version 1) was designed based on a literature review, which was modified (version 2) after discussion amongst the research team. The version 2 survey was piloted with 17 clinicians with expertise in BPD. With their feedback, the survey was further revised and finalized (version 3) for circulation. The survey contained 30 items, including demographic details, clinical practice details, borderline personality diagnostic and management practices, and participants' perception of the need for further training.

Study procedure

An email explaining the study and a link to the SurveyMonkey form were sent to psychiatrists across the country using as many forums as possible (e.g., 5,000 email addresses from the Indian Psychiatric Society (IPS) Directory, psychiatrists registered in a Google group, and reaching out to psychiatrists through various social media groups). All the members listed in the directory were sent the survey along with subsequent reminders. Weekly reminders were sent for 4 weeks, inviting participants to participate in the research. The participants were also requested to share the survey link with their contacts to maximize reach.

Consent for the study

The online survey form had a face sheet providing the study description, confidentiality, and the right to withdraw. The participants were asked to 'click-if-you-agree' to participate before completing the survey.

The Survey Monkey account was password protected, and data was extracted and stored on password-protected computers, and data access was available only to the research team. SurveyMonkey also did not allow duplicate entries thereby reducing the risk of this affecting the data.

The study was approved by the Institutional Ethics Committee. The study was approved by the Institutional Ethics Committee of Schizophrenia Research Foundation (India) with ethics approval number: SRF-CR/12/JUL-2021.

Statistical analysis

Demographic data was analyzed using descriptive statistics, including the mean with standard deviation (SD) for continuous variables and frequencies and percentages for categorical variables. The chi-square test was performed to determine the association between categorical variables and the outcome (e.g., sharing a diagnosis with persons: Yes vs. No groups). Continuous variables were compared

across the groups using an independent t-test. Data was analyzed using STATA version 16.1 software (12).

Report writing

We used the STROBE checklist (13) when writing our report.

Results

A total of 302 participants completed the online survey. Six responses were excluded as the participants were not currently practicing in India.

Table 1 describes the demographic and clinical practice details of the participants.

The respondents had a mean age of 40.93 ± 10.56 with a slight male preponderance (54.7% male), with 13.97 ± 10.53 years being the mean duration of clinical practice. Only 6.1% were trainees, and the rest were all practicing psychiatrists. As seen in the figure (see supplementary material), many participants were from the states of Tamil Nadu, Karnataka, Kerala, and Maharashtra, which are in the southern half of India.

TABLE 1 | Participant demographics and clinical practice details.

	N = 296
Age mean ± SD	40.93 ± 10.56
Gender n (%)	
Male	162 (54.7)
Female	133 (44.9)
Prefer not to say	1 (0.3)
Work status	
Trainee in psychiatry n (%)	18 (6.1)
Practicing psychiatrist n (%)	278 (93.9)
Qualifications n (%)	
MD	198 (66.9)
DPM	35 (11.8)
DNB	37 (12.5)
Foreign qualifications	8 (2.7)
Trainee in psychiatry	18 (6.1)
Duration of experience in years mean ± SD	13.97 ± 10.53
Percentage of borderline personality disorder (BPD) in the caseload reported by the participants	13.4 ± 24.5
Practice setting - rural vs urban	
Rural	5.7%
Urban	76%
Both	18%
Type of clinical practice	
Teaching	126 (42.6%)
Non-teaching	170 (57.4%)

TABLE 2 | Diagnosis sharing practice.

Timing of sharing diagnosis	N (%)
In the first visit	44 (15)
After a few visits	180 (61.4)
After psychometric tests	63 (21.5)
Sharing diagnosis with families	
Mostly	212 (72.1%)
Sometimes	59 (20.1%)
Rarely/never	23 (7.8%)
Sharing diagnosis with persons with BPD	
Mostly	164 (56.4%)
Sometimes	98 (33.7%)
Rarely/never	29 (10%)

Current borderline personality disorder diagnostic and management practices

The psychiatrists reported using clinical history from the person or the family or both as the most common way of arriving at a diagnosis of BPD. One-third of the psychiatrists also use psychometric testing to help diagnose BPD. The psychiatrists mostly shared the diagnosis with the persons and their families after a few visits, and they shared the diagnosis almost equally with persons and families, as seen in Table 2.

Reasons for sharing/not sharing diagnosis

The commonest reasons reported by the participants for sharing the diagnosis with persons and families are for families to support persons better (255/296), explain the need for follow-up and long-term treatment (243/296), help persons understand what is happening to them (237), discuss management (227), and for medicolegal reasons (67).

The three most commonly cited reasons for psychiatrists not sharing diagnoses in descending order of frequency are uncertainty about diagnosis (119/296), worry about misuse of diagnosis by persons with BPD and families (80/296), and stigma (64/296).

Management practice

Medications (86.1%) and psychological therapies (86.8%) are the most commonly used treatment options, followed by the

respondents. Psychiatrists provide self-harm management (73.3%) and crisis management (70.9%). Inpatient treatment (27.7%) and referral to other practitioners (8.8%) are the other management practices adopted by the psychiatrists.

Therapies

Psychiatrists have various options to choose from for therapies like supportive psychotherapy (n = 189; 63.9%), dialectical behavior therapy (DBT) (n = 177; 59.8%), cognitive behavior therapy (CBT) (n = 133; 44.9%), and family therapy (n = 126; 42.6%). Eclectic therapy (n = 87; 29.3%), mentalization based therapy (MBT) (n = 41; 13.9%) and psychodynamic psychotherapy (n = 41; 13.9%) are also available. Just under 50% of the participants (n = 143) reported that therapies were delivered by both themselves and the psychologists. Other respondents either delivered therapy themselves (n = 61; 20.6%) or referred to a psychologist (n = 85; 28.7%) for therapy.

Confidence level of psychiatrists in diagnosing and management of BPD

The psychiatrists who completed the survey were more confident in diagnosing BPD compared to managing BPD, as shown in Table 3.

Challenges encountered by psychiatrists when managing persons with BPD that affect their diagnostic and management practice included dysfunctional coping (72%), self-harm (69.6%), family conflicts (67.6%), countertransference (48%), and mistrust (42.9%). The other less reported challenges include idealization (23.6%), splitting staff (25%), devaluing people (29.4%), and trauma (26.4%).

TABLE 3 | Confidence level of psychiatrists in diagnosing and management of BPD.

Extent of confidence	N (%)
Confidence in diagnosing BPD	
Extremely/very	192 (65.5)
Somewhat	91 (31.1)
Not confident	10 (3.4%)
Confidence in managing BPD	
Extremely/very	85 (29%)
Somewhat	136 (46.4%)
Not confident	72 (24.6%)

Expectations regarding future for borderline personality disorder services and training

Many respondents (88.5%) felt the need for specialized services for managing persons with BPD.

The experience that the respondents gained in diagnosing and managing BPD was reported to be mainly during postgraduate training (68.2%) and through clinical experience (81.8%). Conferences (30.7%), workshops (21.3%), and continuing medical education programs (36.1%) were the other sources of training. The participants preferred future training to be practical, of whom 74.7% reported wanting practical workshops and 60.1% wanted more hands-on practical training during postgraduation. Participants also wanted more case discussion forums, training programs in specific therapies for BPD, and continuing medical education lectures on BPD management.

As shown in Table 4, psychiatrists who reported sharing the diagnosis tended to report greater perceived helpfulness of disclosure and higher confidence in diagnosing and managing BPD ($p < 0.001$). Other characteristics such as age, gender, years of practice, and proportion of BPD cases in clinical practice did not show meaningful differences between the groups.

Discussion

To the best of our knowledge, this is the first study in India to explore the diagnostic and management practices of psychiatrists for BPD. While there are reservations about using online surveys (14), this was the best way to reach out to psychiatrists in different parts of the country, given the limitations of having a contact list for all the psychiatrists in the country in one place. Further restrictions were posed by the COVID-19 pandemic, rendering postal services unreliable for the study.

The clinical practice guidelines (15) advise using structured interviews or assessment scales to diagnose personality disorders. Our study shows that around one-third of psychiatrists use psychometric tests to diagnose, while the remaining rely on clinical history from the patient and their family. The guidelines also say that psychotherapeutic options should be at the center of the management of patients with BPD. Our survey shows that psychiatrists do use psychotherapeutic modalities themselves or practice collaboratively by referral to psychologists. Because most respondents were from an urban background, access to resources like psychologists might have been better. MBT and psychodynamic psychotherapy are reported to be used less commonly compared to other therapies like DBT. The lesser use of the above therapies might be due to the non-availability of certified professionals, lack of training,

TABLE 4 | Association and mean comparison between the share diagnosis groups (yes/no) and independent variables.

Variables	Share diagnosis with patient		
	Yes N (%)	No N (%)	p-value
Gender			
Male	138 (55.4)	13 (46.4)	0.365
Female	111 (44.6)	15 (53.6)	
Psychiatrist category			
Trainee in psychiatry	14 (5.3)	5 (17.2)	0.03
Practicing psychiatrist	248 (94.7)	24 (82.8)	
Location of practice			
Rural	15 (5.7)	2 (6.9)	0.641
Urban	201 (76.7)	20 (69)	
Both	46 (17.6)	7 (24.1)	
Timing of diagnosis sharing			
In the first visit	41 (15.8)	3 (10.3)	<0.001
After a few visits	164 (63.1)	13 (44.8)	
After psychometric tests	55 (21.2)	7 (24.1)	
Never	0 (0)	6 (20.7)	
Perceived need for specialized BPD services			
Yes	234 (90)	24 (82.8)	<0.001
No	26 (10)	5 (17.2)	
Practice of sharing diagnosis with families			
Mostly	198 (75.6)	13 (44.8)	**<0.001**
Sometimes	55 (21)	3 (10.3)	
Rarely/never	9 (3.4)	13 (44.8)	
Practice of sharing diagnosis with patients			
Mostly	164 (62.6)	0 (0)	**<0.001**
Sometimes	98 (37.4)	0 (0)	
Rarely/never	0 (0)	29 (100)	
Perceived helpfulness in sharing diagnosis			
Extremely/very	163 (62.2)	7 (24.1)	**<0.001**
Somewhat	89 (34)	9 (31)	
Not so/	10 (3.8)	13 (44.8)	
Confidence in BPD diagnosis			
Extremely/very	180 (69.2)	10 (34.5)	**<0.001**
Somewhat	73 (28.1)	16 (55.2)	
Not so/	7 (2.7)	3 (10.3)	
Confidence in managing BPD			
Extremely/very	83 (31.9)	2 (6.9)	**<0.001**
Somewhat	125 (48.1)	7 (24.1)	
Not so/	52 (20)	20 (69)	
	Mean ± SD	**Mean ± SD**	
Age	41.1 ± 10.3	38.1 ± 10.6	0.143
Number of years of practice as a psychiatrist	14 ± 10.2	12.5 ± 12.2	0.468
Reported average number of patients of all diagnosis	292.2 ± 573.2	252.9 ± 291.6	0.721
Reported average number of patients with BPD	12.7 ± 18.8	8.8 ± 12.1	0.279
Proportion of BPD in percentage (BPD caseload/all diagnosis caseload*100)	13.4 ± 24.2	14.9 ± 29.4	0.768

Note: p-values indicate statistical significance. Results were significant at $p < 0.001$.

and cost and time involved in training and delivering the interventions. Uptake of therapies, even if available, might also have been a challenge.

The report of the use of medications in persons with BPD appears relatively high. The reasons for the higher use of medications will need to be explored through further studies to understand the reasons behind this. They could be addressed through specific training in BPD assessment and management.

While the clinicians appear to be very confident in diagnosing BPD, the confidence seems to be less in managing the disorder. The clinicians who participated in the study reported that their main training in BPD was during the psychiatry residency period. As postgraduate trainees report less adequate training and supervision in BPD (16), this might be why the confidence level in management could be lower in the study respondents.

The Clinical Practice Guidelines for Assessment and Management of Patients with BPD (15) also recommends that sharing a diagnosis is important for a therapeutic relationship and to support psychoeducation. With collaborative decision-making and a patient-participatory approach to treatment being recognized as necessary, the findings of our study indicate that psychiatrists in India are sharing diagnoses with their patients most of the time in keeping with the guidelines. Psychiatrists who are more confident in diagnosing and managing BPD and when they perceive the sharing to be helpful are more likely to share the diagnosis with patients. Clafferty et al. (8) found the rate of disclosure of personality disorder as a diagnosis was 42% as compared to 90-98% of other Axis 1 psychiatric illnesses. Studies done by McDonald-Scott in 1992 (7) reported that 55% of American psychiatrists and 16% of Japanese psychiatrists would inform patients of a BPD diagnosis. The disclosure rates in our study are similar to those of American psychiatrists (56.4%).

The significant reasons indicated as to why the diagnosis could not be shared were uncertainty about the diagnosis, stigma, and worry about misuse of the diagnosis by persons with BPD and their families. A survey of 134 psychiatrists conducted in the US (2) found that uncertainty about diagnostic validity and stigma were the two leading causes of not disclosing or documenting a diagnosis of BPD. A review of literature by Lequesne et al. (17) done in 2003 reported that uncertainty regarding the validity of the BPD diagnosis, the feeling that the diagnosis is too negative to divulge (stigma), and worries that such a diagnosis would have deleterious effects on the patient's health and morale were major reasons for not disclosing the diagnosis. While the factors cited by psychiatrists in our study are not dissimilar to other studies, the unique factor of worry about misuse of diagnosis by families is reflective of the cultural aspects of medical care in India.

The surveyed psychiatrists are seeking increased emphasis on practical hands-on workshops aimed at the diagnosis and management of BPD in the future. Masland et al. (18) found that even a 1-day training event on general psychiatric management changed the attitude of clinicians towards BPD.

While many surveyed psychiatrists expressed a demand for specialized services to handle BPD cases, the small number of respondents necessitates further surveys among psychiatrists and psychiatric trainees to know if this need is widely felt.

Limitations

Key limitations of the study include reliance on self-reported data from the participating psychiatrists, a primarily regional focus on the southern states leading to issues with generalizability to the whole of India, and a potential selection bias due to the respondents' urban background and their interest in BPD, which may explain the high level of confidence and access to therapies. The authors acknowledge that a study of this nature requires multiple sources of contact, which introduces these biases. Responses may be indicative of people who are more confident with BPD thereby adding to the bias.

Conclusions

This study contributes to the BPD research about Indian psychiatrist practices in diagnosis and management. The discrepancy in the confidence level of diagnosing and managing BPD can be bridged by conducting good quality practical hands-on workshops focussed on the management of BPD for trainees and practising psychiatrists. Practical workshops will ensure that psychiatrists are able to provide good quality care to persons with BPD. As the responses predominantly reflect practices in South India, further studies are required to determine whether patterns are similar in other parts of India. Future research should also explore patient perspectives on diagnosis and management practices.

Data availability

The data supporting the findings of this study are available from the corresponding author upon reasonable request.

Ethics statement

SRF-CR/12/JUL-2021

Author contributions

All authors have contributed significantly to this work.

Consent to participate and publish

Obtained electronically from all participants.

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

AI declaration

Grammarly was used solely for spelling and grammar checks. The authors take full responsibility for the content.

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