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Article

Can sociocultural and historical mechanisms influence the development of borderline personality disorder?

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Abstract

Borderline personality disorder (BPD) is a common and severe clinical problem. While cross-cultural research suggests that this condition can be identified in different societies, indirect evidence suggests that BPD and some of its associated symptoms (suicidality and self-harm) have a higher prevalence in developed countries. If so, sociocultural and historical mechanisms may have influenced the development of the disorder. While the vulnerabilities underlying BPD are broad and nonspecific, specific symptoms can be shaped by culture. The mechanisms involve the influence of a "symptom bank," as well as the role of social contagion. These trends may be related to a decrease in social cohesion and social capital in modern societies.

Keywords

borderline personality disorder, historical context, personality disorder, sociocultural context, symptom bank

It is well known that mental disorders can present with different symptoms in different cultures (Gone & Kirmayer, 2010). It is less well known that the symptoms of mental disorders may present differently in different historical periods. There are three ways in which historical changes in a culture can influence and shape the clinical presentation of psychopathology. The first concerns the choice of symptoms through which distress is expressed. At any given time, dysphoria can be communicated to others by an implicit choice from clinical presentations that are "out there" in the community, or what Shorter (1997) has called a "symptom bank." The related concept of *pathoplasty* (Jaspers, 1999; Mulder, 2004) describes

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the way that coexisting forms of psychopathology can shape observable clinical features.

A second mechanism involves social stressors that reduce thresholds for the development of psychopathology. While the symptoms of mental disorders derive from a complex interaction between biological vulnerability, individual psychological experience, and sociocultural context, social stressors can bring the interaction between risk factors to a tipping point at which distress emerges as overt symptomatology (Wexler, 2006).

A third mechanism concerns discrepancies between social demands and individual temperament at different historical periods and in different social settings (Alarcón et al., 2009). Behaviors that can be acceptable in one culture may be seen as pathological in another (Alarcón, Foulks, & Vakkur, 1998). Since personality disorders, by definition, describe a failure to meet social expectations, these conditions might be expected to show a higher degree of cultural sensitivity, i.e., responsiveness to variable sociocultural conditions (Paris, 2004).

Personality disorders and personality traits

Personality disorders (PDs) lie on the interface of trait vulnerability, individual experience, and social expectations. As defined in DSM-IV (American Psychiatric Association, 2000), and in the proposals for DSM-5 (www.dsm-5.org), PDs represent a failure of adaptation that leads to behavioral, affective, and cognitive symptoms, affecting individuals in many contexts and over extended periods of development. Personality trait profiles underlie these disorders, constituting vulnerability factors for their development (Siever & Davis, 1991), and determining what kind of disorder is likely to develop (Paris, 1997). However, unusual trait profiles do not require that a PD will necessarily develop.

There is a controversy in the literature as to whether trait profiles can fully describe personality pathology: some experts view PDs as extremes on trait dimensions (Costa & Widiger, 2012; Krueger et al., 2011; Skodol, 2010), while others view them as qualitatively different, particularly when patients present prominent symptoms not readily accounted for by traits (Gunderson, 2011; Paris, 2008). In either case, dimensional trait profiles do not consistently predict the presence of symptoms.

Everyone has a trait profile that can be associated with some kind of vulnerability. While dimensions of personality have been shown in behavioral genetic research to be heritable, they are also influenced by a large component of unshared environmental factors (Livesley, Jang, & Vernon, 1998), and very similar patterns have been found in behavioral genetic studies of personality disorders (Torgersen et al., 2000). Moreover, a number of prospective and retrospective studies have consistently found childhood adversity to be a risk factor for PDs, both in antisocial PD (Luntz & Widom, 1994), and in borderline PD (Widom, Cjaza, & Paris, 2009; Zanarini, 2000). It therefore seems likely that the environment plays an important role in determining whether traits develop into disorders.

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Another complication in defining personality disorder is the comorbidity problem. Most patients diagnosed with PDs meet criteria for other mental disorders. BPD shows a particularly wide range: the most frequent comorbid diagnoses are major depression, anxiety disorders, and substance use disorders (Zanarini et al., 1998). However, comorbidity is largely an artefact of a diagnostic system that encourages multiple diagnoses. PD is an overarching construct that describes a complex symptomatic picture rooted in personality.

Borderline personality disorder

Most personality disorder research has focused on the borderline category (Gunderson, 2011; Gunderson & Links, 2008; Paris, 2008). BPD is a common clinical problem in North America and Europe, and has been found to have a community prevalence of about 1%, both in the USA (Lenzenweger, Lane, Loranger, & Kessler, 2007) and in the UK (Coid, Yang, Tyrer, Roberts, & Ullrich, 2006). Since BPD patients are help-seeking, its clinical prevalence is higher (Zimmerman, Rothschild, & Chelminski, 2005). About half of all patients coming to emergency rooms with recurrent suicide attempts meet criteria for this diagnosis (Forman, Berk, Henriques, Brown, & Beck, 2004).

The BPD diagnosis describes patients with severe emotion dysregulation, a wide range of impulsive behaviors, and unstable interpersonal relationships (American Psychiatric Association, 2000). Its primary clinical features are unstable affect, impulsive behaviors such as overdoses and self-harm, and unstable interpersonal relationships. The personality traits underlying the clinical picture are affective instability and impulsivity (Crowell, Beauchaine, & Linehan, 2009; Siever & Davis, 1991). The most effective treatment consists of specialized forms of psychotherapy (Bateman & Fonagy, 2006; Linehan, 1993).

BPD is influenced by culture, but is not a culture-bound syndrome. In a study sponsored by the World Health Organization (Loranger et al., 1994), the diagnosis was found to be recognizable in multiple clinical sites across the world. It has been described in clinical populations of suicide attempters in India (Pinto, Dhavale, Hemangee, Nair, Patil, & Dewan, 2000), in China (Leung & Leung, 2009; Zhong & Leung, 2007, 2009), and in Turkey (Senol, Dereboy, & Yüksel, 1997).

Determining the influence of culture on psychiatric disorders requires data from epidemiological studies. Unfortunately, the community prevalence of BPD in less developed countries is unknown. The most relevant data thus far come from a WHO survey conducted in 13 countries (Huang et al., 2009). The results showed that 1–2% of people in most of these countries studied met criteria for a "Cluster B" PD (i.e., a group of diagnoses defined by DSM-IV and characterized by impulsive behavior patterns). Cluster B diagnoses were more common in the young, but cross-national differences were inconsistent, possibly reflecting sampling variation. Unfortunately, BPD was not examined separately, and the results are difficult to generalize because Cluster B also includes the more prevalent category of dissocial (antisocial) personality disorder. These results show that this group of

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disorders is common across all countries, but the methods did not allow for a test of cross-cultural difference in prevalence.

This paper presents the hypothesis that BPD is less common in non-Western than in Western societies. There are several reasons to entertain this idea (Paris, 2004). BPD patients have a wide range of culture-specific impulsive behaviors, but the most characteristic symptoms consist of parasuicidal behaviors under interpersonal stress. Such problems fall within the broader category of externalizing disorders. This construct, introduced by Achenbach and McConaughy (1997) for the classification of psychopathology in children, contrasts with that of internalizing disorders, in which suffering is expressed through inner distress rather than through impulsive behaviors. ''Externalizing'' is a factor analytically defined dimension that cuts across many diagnoses in psychiatry (Eaton, South, & Krueger, 2010; Krueger et al., 2011), describing behaviors such as criminality, substance abuse, eating disorders, and suicide attempts. All these problems have been found to be increasing in prevalence over the last several decades (Paris, 2004).

These observations might therefore be generalized to BPD, which has a very wide range of impulsive symptoms that separates it from other PDs (Zanarini, Gunderson, & Frankenburg, 1989). It must be acknowledged, however, that BPD is a complex construct that shows features of both externalizing and internalizing disorders (Eaton et al., 2010). It is well-established that BPD patients are high in the personality trait of neuroticism (Costa & Widiger, 2012). Thus, the self-harm behavior often seen in these patients can be understood both as an action, and as a way of regulating dysphoria (Brown, Comtois, & Linehan, 2002).

In the absence of community studies of the cross-cultural prevalence of BPD, one can make use of indirect measures, i.e., symptoms associated with the diagnosis. Many of these have been increasing in prevalence in developed societies, most particularly self-harm and suicidal attempts (Bland, Dyck, Newman, & Orn, 1998). While these symptoms represent only one part of the larger picture of BPD, they are more readily measurable in epidemiological surveys. It has been suggested that these changes in prevalence, occurring largely since the Second World War, could be due to a loss of social cohesion (Millon, 1993; Rutter & Smith, 1995). If so, one might expect to see differences in the prevalence of BPD in different societies.

BPD in historical context. Prior to a pioneering paper by Stern (1938) that described BPD in a readily recognizable way for modern clinicians, there were no published descriptions of the disorder. The clinical features seen in BPD were not the basis of formal diagnosis until the latter half of the 20th century (Berrios, 1993; Stone, 1997). One does not have to go far in the historical literature to find descriptions of psychosis or severe depression. In contrast, it is difficult to find historical evidence that chronic self-harm or repetitive suicidal behaviors were common 100 years ago. It is therefore possible that this clinical picture is a relatively recent development.

Even so, the traits underlying BPD could have been as prevalent in the past as they are now. As shown by cross-cultural studies, personality dimensions do not

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show large cross-cultural differences (McCrae & Costa, 1997), but the symptoms associated with these traits could have been different in the past. It is possible that such problems were not medicalized and/or not recognized. However, while people have always committed and attempted suicide, there are no reports in the older medical literature, or descriptions in the historical literature, of a pattern of mood instability, recurrent overdoses or self-harm, and unstable relationships. In fact, deliberate self-harm, in the form of superficial cutting of the wrist, was first described less than fifty years ago (Graff & Mallin, 1967; Pao, 1967). While some religious rituals are associated with cutting (Favazza, 1987), that behavior has an entirely different motivation.

When societies modernize, symptom banks change, and one set of symptoms can be replaced by another. The underlying trait vulnerabilities behind BPD lie in affective instability and impulsivity (Crowell et al., 2009), but these traits could find expression in other ways. For example, it is possible that patients with these dimensions can be associated with classical forms of depression. It is also possible that, as has been suggested by historians (Shorter, 1992), abnormal mood could have presented with somatic symptoms. Another possibility is that these traits could have produced "hysterical" or conversion symptoms. These clinical presentations were one of the main concerns of 19th-century psychiatry, but have become relatively rare in Western societies (Merskey, 1997), even as they remain common in traditional societies (Littlewood, 2002). Clinical presentations with physical symptoms have been understood as functioning to mobilize family and community to deal with mental distress (Kirmayer & Young, 1998).

An interesting study from a rural area in West Bengal (Nandi, Banerjee, Nandi, & Nandi, 1992) could illustrate this point. Researchers found a high frequency of conversion symptoms when a primary care population was first surveyed, but when they returned to the same site 15 years later, these symptoms had become rare, while overdoses had become much more common. In a kind of historical "fast forward," this sequence could reflect changes that have already occurred in the symptom bank of Western society over the last century. Thus, when the main form of expression for distress was somatic, physicians diagnosed patients with conversion and neurasthenia. Today, impulsive symptoms are among the most common ways for distress to be expressed among adolescents and young adults (Rutter & Smith, 1995).

Symptom banks and social contagion

Shorter's (1992, 1997) concept of a "symptom bank" is essential for understanding how history and culture shape psychopathology. It describes that while psychological distress occurs at all times and all places, at any given historical moment or social context, the environment shapes symptoms by offering specific options to express distress. Thus similar vulnerabilities and psychosocial risk factors can lead to different clinical pictures. The concept goes beyond the familiar cultural coloring of psychopathology, as in the specific content of psychotic delusions. Instead,

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diagnoses that are currently considered to be in entirely different groups can be transformed into another pattern by social influences.

This paradigm is further reinforced by the construct of *social contagion*, in which symptoms are spread either through personal contact or through the media (Rodger, Rowe, & Buster, 1998). These mechanisms correspond to what Dawkins (1976) and Blackmore (1999) have described as *memes*. Clinical studies suggest that patients can learn about self-harm behaviors through social contagion, learning about wrist-cutting from peers and from media reports (Nixon & Heath, 2008). For example, it has been observed that patients without a history of self-harming admitted to a hospital ward alongside self-harming patients often began to self-mutilate (Taiminen, Kallio-Soukainen, Nokso-Koivisto, Kaljonen, & Helenius, 1998). In current times, influenced by the power of the Internet, there are new ways for patients to learn how to harm themselves.

In summary, BPD is a disorder that could be of relatively new historical onset, and that has been described most often in Westernized societies. Its specific symptoms can be spread through social contagion, and the culture's symptom bank contains the signs and symptoms clinicians know and look for. It is also possible that people in developing societies are less likely to somatize than previously, and more likely to express their distress by self-cutting and suicidal attempts.

Social sensitivity, social cohesion, and social capital

Millon (1993) hypothesized that BPD develops in the presence of social risk factors that are associated with modern or modernizing societies, and that the behaviors associated with this diagnosis are suppressed in traditional social settings. The evidence supporting this idea is indirect but suggestive. Traditional societies have strong structures and norms that tend to limit the conditions for the development of impulsive symptoms. For example, a large-scale epidemiological study in Taiwan conducted in the 1980s found very few cases of antisocial PD (Hwu, Yeh, & Change, 1989). In contrast, societies where there is a predominance of individualistic values, coupled with a lack of support for those who have a greater need for community, could make impulsivity more prevalent (Caldwell-Harris & Ayçiçegi, 2006). Theorists attempting to account for BPD have also proposed that modern society makes the modulation of dysphoric affects more difficult, due to a relative absence of consistent social support (Linehan, 1993).

Millon (1993) suggested that rapid social change, particularly after the Second World War, made BPD more prevalent by interfering with social and community support mechanisms. Rutter and Smith (1995) also invoked this hypothesis, noting that in spite of unprecedented affluence, impulsive behaviors and suicidality increased in young people over this time period.

The strongest evidence for sociocultural factors in any mental disorder comes from epidemiological research demonstrating changes in prevalence over time. When the frequency of a disorder increases over a few decades, the explanation must be social. Research from cohort studies shows that several forms of mental

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disorders have greatly increased in prevalence since the Second World War: substance abuse, antisocial personality, as well as depression among adolescents and young adults (Rutter & Smith, 1995). The prevalence of suicidality in the young increased over the same time period (Bland et al., 1998). In personality disorders, research on antisocial PD provides a precedent for cohort and cross-cultural studies of BPD. This disorder greatly increased in prevalence in North America between 1950 and 1980 (Robins & Regier, 1991). Antisocial personality disorder can also be rare in traditional societies (Hwu et al., 1989). While BPD has not been studied in the same way, its associated symptoms have become more common.

Another line of evidence comes from observations suggesting that patients who have not suffered from BPD in their country of origin can develop this condition once they immigrate to the West (Paris, 1996). One possible explanation is that when one grows up in a more traditional society, behavior is more closely monitored, and emotional stability is promoted by having provided social roles, associated with the support of extended families and a tightly knit community.

The mechanisms by which social factors affect the development of BPD could also depend on "social sensitivity," a construct that describes the likelihood that individuals will respond symptomatically to social change (Paris, 2004). Many socially sensitive disorders (e.g., substance abuse, eating disorders, antisocial personality, borderline personality) have prominent externalizing symptoms that may be particularly responsive to social context.

Another clue to the role of social factors in BPD is that this diagnosis, as well as other externalizing disorders, begins in adolescence, a developmental stage that can be stressful, at least for some. Adolescence is in part a social construction (Furstenberg, 2000), since throughout most of history, young people assumed adult roles earlier in life. But in a modern society, where adolescents have to find their own path, this stage can be stressful, particularly for those who are temperamentally vulnerable (Paris, 1997). Thus young people who are at risk because of temperamental vulnerability and exposure to psychological adversity could be more likely to develop symptoms under conditions of low social cohesion. This hypothesis might be tested by conducting surveys specifically examining the prevalence of BPD under different social conditions.

Another unanswered question is whether BPD could show a difference in prevalence between urban and rural settings. While research in the UK (Paykel Abbott, Jenkins, Brugha & Meltzer, 2000), and in the USA (Robins & Regier, 1991) has found differences in the prevalence of mental disorders between urban and rural areas, these findings do not necessarily show that urban life is more stressful. However, in some studies, a rural residence has been associated with improved recovery from mental illness, both in terms of decreasing symptomatology and improved life skills (Tirupati, Conrad, Frost, & Johnston, 2010). What we do not know is whether these observations would apply to BPD. Pinto et al. (2000) suggested that the absence of case reports or prevalence estimates of BPD in India

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prior to the late 1990s might suggest that the "close-knit" Indian culture may be protective against BPD. These authors thought that if they had examined patients in a rural rather than an urban setting, they would have found fewer cases than in their study, conducted in Mumbai. However, it is possible that such cases might not have been recognized. At this point, almost all research on the clinical prevalence of BPD in less developed countries comes from academic centers located in cities.

Another mechanism that could help account for differential prevalence of BPD is differences in the accumulation of *social capital*. This construct, introduced to sociology a century ago by Hanifan (1916), and later expanded by Putnam (2000), reflects the tradition developed by Emil Durkheim (1897/1997), whose concept of "anomie" describes the absence of social supports. Hanifan (1916, p. 132) defined social capital as "that in life which tends to make these tangible substances count for most in the daily lives of people, namely, goodwill, fellowship, mutual sympathy and social intercourse among a group of individuals and families." Social capital may be higher in rural communities than in urban environments, since members of smaller populations are more likely to form significant relationships with the people they know and see each day.

Social cohesion and social capital, as well as support from nuclear and extended family, are known to be generally protective against mental disorder (Gone & Kirmayer, 2010). Giordano and Lindström (2011) have argued that "generalized trust," trust in the people and community around oneself, is the element of social capital that is most important for determining mental health outcomes, and that this sense of trust is fostered much more in a rural setting. These factors could help explain why BPD could be more prone to develop in less traditional settings, and why recovery from the disorder can sometimes be problematic. For the most chronic patients, who have lost all their social capital, the mental health system can become the only social network they can trust. However, more research is needed to substantiate this relationship.

Conclusion

The hypothesis put forward in this paper cannot yet be supported by solid data, although it could be tested by cross-cultural epidemiological studies. Indirect evidence suggests that BPD is socially sensitive, occurs in specific social contexts, and is more likely to develop when social cohesion and social capital are compromised. Patients with a BPD diagnosis might therefore be considered, at least in some ways, as casualties of modernity and the rise of individualistic values.

Understanding the historical and cultural context of a disorder may be helpful in developing treatment plans. BPD patients have been shown to benefit from psychotherapy, but also need sociotherapy. Clinicians who treat these cases should help patients to develop wider social networks, to build social capital and to find useful social roles.

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