International Journal of Multidisciplinary Research And Studies

Available online at https://ijmras.com/

INTERNATIONAL JOURNAL OF MULTIDISCIPLINARY RESEARCH AND STUDIES
ISSN: 2640 7272
Volume:04; Issue:01 (2021)

Page no.- 15/15

FACTORS CONTRIBUTING TO MULTIPLE PERSONALITY DISORDER ONSET

Menka kumari
M.Phil., Roll No.: 141740 Session-2014-15
Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India
E-mail: menkaakumari@gmail.com

Abstract

Multiple personality disorder is a complex mental condition that is most likely brought on by a combination of factors, such as chronic stress, exposure to traumatic events, and prolonged participation in abusive relationships. As a direct result of the ailment itself, the individual who is afflicted with multiple personality disorder may, on occasion, have been put in precarious situations when they were still developing as a child and adolescent. An individual's personal history of traumatic events, particularly those that were experienced repeatedly, were overwhelming, or threatened their lives when they were children, can almost always be traced back to the development of multiple personality disorder in that individual. This is the case in approximately 99% of all cases.

Keyword: traumatic events, overwhelming, chronic stress,

Introduction

Multiple personality disorder is distinct from other mental conditions in a number of significant respects, including the fact that the individual affected by the disorder demonstrates characteristics that are shared by two or more identities and that the individual's various personality states completely dominate their behaviour. Other mental conditions

Menka Kumari *, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: menkaakumari@gmail.com

include schizotypal personality disorder, dissociative identity disorder, and schizoaffective disorder. Having said that, not everyone goes through their MPD in the same way. As a consequence of having MPD, certain individuals could, for instance, have an altered or transformed identity with regard to their own age, sex, or race. Every one of a person's fictitious personas will have their very own particular method of talking, as well as their very own particular attitude and gestures. This will be the case regardless of who the individual is.

A person whose behaviour has recently changed raises some legitimate concerns since, in some cases, the characteristics of an animal or a violent person might be inferred from that person's altered behaviour. The act of shifting between one identity and another is referred to as "switching," and it may also be an adjective. It might take as little as a few seconds or as long as several minutes to switch from one person's persona to another. A person who suffers from multiple personality disorder may have a variety of symptoms, including but not limited to headaches, amnesia, and "out of body" experiences.

Some persons who have multiple personality disorder show a tendency toward self-harming behaviours such as self-punishment, self-sabotage, and even aggression at times. Self-persecution occurs when a person treats himself in an unfair and severe manner. Self-persecution can have a variety of causes. People who have major depressive disorder (MDD) may, for instance, discover that they participate in behaviours that they would not normally engage in, such as driving at full speed, stealing money from other people, or committing crimes.

According to the theory that underpins multidimensional personality disorder (MPD), a person is said to be suffering from this illness when they are unable to adequately integrate the many aspects of their identity and consciousness into a single multidimensional self. A person who has MPD may go through a variety of psychological changes as a direct result of the condition. Some of these changes include amnesia, identity confusion, identity alteration, and depersonalization. This individual could possibly have prior experience with their current living arrangements. Out of body experience is another word for depersonalization, which defines the feeling that an individual has of being separate from his or her own body. Depersonalization is also known as an out of body experience. On the other side, the individual who is having difficulty piecing together his or her identification will also have difficulty piecing together their own identity, which will lead to even more ambiguity. When a person has difficulties defining the areas of their life that most capture their attention, this

Menka Kumari *, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: menkaakumari@gmail.com

might be an indication that they are having problems finding their identity and settling into it. People who suffer from amnesia will have a tough time memorising their own personal information, and they also won't be able to remember every conversation that took place between themselves and other people.

In order to make an accurate diagnosis of MPD, it is necessary for the person being examined to satisfy all of the criteria mentioned below, which are taken from the DSM 5 manual. The first requirement is that there be two or more different characters connected with that individual, and each of those characters must have a unique method of experiencing and thinking about how the environment around them affects them. The conviction that this person has had an experience of possession is necessary in order to meet this requirement. The second requirement is the appearance of forgetfulness, which suggests that the individual in question will have amnesia at each and every occurrence, and not merely as a response to traumatic events that have already taken place in the past.

Thirdly, in order to correctly identify a person as having MPD, it is imperative that we take into account the fact that the symptoms that person is experiencing are not the direct result of the substance's influence on the physiological processes of the body. This is so that we can correctly diagnose the condition. Take, for example, the intoxicating effects of alcohol, which can lead a person to act in an erratic manner In addition, a person may only be given a diagnosis of MPD if the disturbance that they are experiencing does not have any connection to the practises of their culture or religion.

It is well knowledge that a person may have more than one personality at the same time (MPD). According to ICD-10 (WHO, 1992), it is described as the existence of two or more separate personalities within a single human, with only one of them being evident at any given moment. This definition was established by the World Health Organization in 1992. Nevertheless, at any given time, only one of these personas will really show itself. Each person's personality is completely developed, complete with their own own memories, habits, and interests. The premorbid condition, in which there was only ever one personality, stands in sharp contrast to this. In the most common form of having two personas, one and the other are almost totally unaware of the presence of the other personality. In the first scenario, the change from one personality to another takes place all of a sudden and is closely associated with an experience that was painful. Throughout the course of several decades, various examples have been reported coming from the majority of the world's continents, one of

Menka Kumari *, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: menkaakumari@gmail.com

which is India (Verma et al., 1981; Adityanjee et al. 1989). The discussion of whether or not it really does exist is still continuing strong today. ICD-10 is more sceptical than DSM-IV regarding the presence of this condition (DSM-IV refers to it as dissociative identity disorder), and it places this condition under the section of other dissociative disorders (F44.8). Recent discoveries in the domains of phenomenology, epidemiology, psychobiology, and treatment all provide support to the theory that this state does in fact exist. It has been described in the paediatric and teenage population, in addition to the adult population, which it has also been described in (Putnam FW, 1991; Hornstein NL & Putnam FW 1992; Eldar Z et al., 1997). An estimated prevalence rate of 1% has been observed in settings in which patients are undergoing psychiatric care, despite the fact that it has been suggested that the incidence of MPD varies from nation to nation. (Ross 1991). According to Hornstein and Tyson (1991), the rate for children is 3%, but the number for adolescents is 16%. (Ross, 1996). This case report of MPD from Northern India is being presented with the intention of drawing attention to the peculiar characteristics that are associated with this disorder.

PATHOPHYSIOLOGY

The pathophysiology of an individual's brain, such as the changes in the hippocampus and orbitofrontal cortex and the reduction in blood flow and functioning of orbitofrontal cortex, is a contributing factor that is leading for an individual to get MPD. This is the cause of MPD in a person and the way that it manifests in their body. The majority of persons who suffer from serious depressive illness are more likely to also have schizophrenia or bipolar disorder, as indicated by the findings of numerous studies that have been conducted on the topic.

The individual suffering from schizophrenia will exhibit both positive and negative symptoms at various times. The outcomes of the research indicate that a person's mental health is in a significantly worse state if they have positive signs of schizophrenia than if they have major depressive disorder (MPD). According to the information that is now available, individuals who are diagnosed with schizophrenia have greater levels of brain abnormalities in virtually all of the lobes, including the occipital lobe. This suggests that there is a direct relationship between the mental condition known as schizophrenia and MPD.

The level of stress experienced by an individual is the single most crucial factor in predicting whether or not they may develop MPD at a younger age. There are several circumstances in which stress might bring about a reduction in the overall volume of the hippocampus. The hippocampus is a key component in the processes of both learning and the storage of

Menka Kumari *, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: menkaakumari@gmail.com

memories. Childhood trauma is another factor that may play a role in the development of MPD; however, it is not yet established whether or whether childhood trauma may create changes in the volume of the hippocampus. The presence of childhood trauma is a contributing factor.

People who suffer from MPD may have a reduced blood flow in the contralateral orbitofrontal cortex, which is the second of two probable causes. If there is insufficient blood flow to the orbitofrontal cortex of an individual's brain, which is the region of the brain that is involved in decision making for that person, it can result in impulsive behaviour and the development of new personality traits, such as an inability to make good choices. For instance, the individual does not demonstrate any indicators of dread whenever they make a decision that could have unfavourable effects on their lives.

THE MANAGEMENT AND TREATMENT OF

There are no treatments for multiple personality disorder that are accessible at this time; however, there are antidepressant medications, anti-anxiety drugs, and antipsychotic pharmaceuticals that can aid in reducing the mental health symptoms that are linked with dissociative disorders. The therapy of MPD issues for patients tries to ease symptoms and protect the safety of those individuals by merging the numerous personalities of a single individual into a single integrated and well-functioning personality. This process is known as "integration." These are the objectives that the therapy intends to accomplish.

Psychotherapy, which may also be known as talk therapy, counselling, or psychosocial therapy is the most common alternative method of treating multiple personality disorder that does not include the use of pharmaceuticals. One kind of treatment is having a conversation about the illness with a trained mental health expert. One of the safety precautions that should be taken into account is finding the appropriate therapist who has a great deal of experience working with patients who suffer from mental diseases. The therapist is going to talk about the severity of the ailment as well as the traumatic events that have been gone through in the past.

DESCRIPTION

Multiple personalities can range from being so mild that they are considered to be part of the normal experience range to being so severe that they cause problems for the person who is experiencing the dissociation. Multiple personalities can be mild enough to be considered

Menka Kumari *, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: menkaakumari@gmail.com

part of the normal experience range. Multiple personalities exist along a continuum. An example of everyday dissociation that is moderate is when someone is travelling for a significant length of time on an interstate and takes many exits without being able to recall where they got off. When dissociation has progressed to the point that it is severe and incapacitating, a person may experience a loss of knowledge of major aspects of his or her identity. The degree of impairment can range from mild to severe, and the consequences may include suicidal thoughts or attempts, self-inflicted wounds, aggressive behaviour, or the use of illegal narcotics. A person just needs to have two distinct identities or a personality state in order to be diagnosed with multiple personality disorder (MPD). Having said that, there have been cases in which an individual has been reported as having 100 different alternate personas, also known as alters. Five out of every ten patients who suffer from multiple personality disorder have less than 11 distinct identities. As a result of the alters taking turns controlling the patient's cognition and actions, the patient who is impacted by this condition suffers from lengthy memory lapses. These lapses are far longer than the typical cases of amnesia that occur in individuals who do not suffer from multiple personality disorder (MPD). The modifications are referred to by their respective names and are distinguished in a variety of ways. They are easily distinguished from one another due to the fact that everyone possesses a unique personality, set of likes and dislikes, manners in which they express themselves, and even physical characteristics such as posture and body language. Patients diagnosed with MPD may come with shifting gender identities, sexual orientations, ages, or nationalities. Patients may also report with multiple personality disorder. This kind of thing happens rather frequently.

REVIEW OF LITERATURE

Purnima Shanmugam 2018. Dissociative identity disorder, which was formerly known as multiple personality disorder, is thought to be a complex mental condition that is most likely caused by a combination of factors, one of which is severe trauma experienced during early childhood, typically in the form of extreme, repetitive physical, sexual, or emotional abuse. It was formerly known as multiple personality disorder. We hope to be able to arrive at a conclusive diagnosis of DID and MPD by following the lead provided by the bio signals. The bio signal that was examined and collected from MPD patients has been referred to as having typical bio values. This was because the signal was taken from individuals who had MPD. A biosignal that was obtained from the LIE DETECTOR with the assistance of p300 in order to

Menka Kumari *, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: menkaakumari@gmail.com

provide conclusive evidence that DID was responsible. For the purpose of making a diagnosis of DID, biosignals such as EEG and ECG are gathered and analysed. The treatment for dissociative identity disorder (DID), at least as it is now practised, consists of many periods of counselling. The effective completion of treatment is wholly contingent on alterations in a patient's behaviour. Despite the fact that there may be some parallels between the two groups of patients, our study demonstrates the differences that exist between those who are diagnosed with DID and those who are malingering.

Santosh K. Chaturvedi is the one who authored this piece. 2009. It is considered that the prevalence of dissociative disorders, in addition to the kind of ailment, changes not just throughout the course of time but also between the many civilizations that have existed. The participants in the study were people who had sought treatment in psychiatric hospitals over the course of a decade, and the aim of the study was to explore the prevalence of dissociative disorders among those people. The sample, which was gathered between the years 1999 and 2008, consisted of both inpatients and outpatients of a psychiatric institution. An analysis was performed on the data relevant to the subjects who were found to have dissociative disorders. We used a proforma that had a layout that was semi-structured so that we could collect information on demographic particulars and diagnosis. There have been a total of 893 persons who have been recognised as having dissociative disorder during the past ten years, 591 (or 66%) of whom were deemed to be outpatients, and 302 (or 34%) of whom were regarded to be inpatients. Inpatients had a proportion of patients diagnosed with dissociative disorders ranging from 1.5 to 15.0 per 1,000, whereas outpatients had a proportion of patients diagnosed with dissociative disorders ranging from 1.5 to 11.6 per 1,000. The majority of patients were diagnosed with dissociative motor disorder (43.3% of outpatients and 37.7% of inpatients), which was followed by dissociative convulsions (23% of outpatients and 27.8% of inpatients), which was the second most prevalent diagnosis. There found a preponderance of females across all subtypes of dissociative disease, with the exception of dissociative fugue, which was reported to have a male majority. Diagnosing individuals with dissociative disorders is still considered standard practise, and this applies to both inpatient and outpatient care settings. Dissociative motor disorders and dissociative convulsions are two of the most common forms of dissociative diseases. The high prevalence of possession states in the Indian population demonstrates that there is a cultural gap in the diagnosis of dissociative identity disorders. [Cross-cultural disparity in the diagnosis of dissociative identity disorders]

Menka Kumari *, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: menkaakumari@gmail.com

Dissociative identity disorders, on the other hand, were not widely acknowledged in Western medicine.

Margaret Mcallister 2000. A review of the previous research on the topic of dissociative identity disorder is going to be presented as part of this investigation. The diagnosis of this disease, which was traditionally referred to as multiple personality disorder, is becoming increasingly common. This is happening in part because diagnostic tools have become more specific, but it is also happening because more people are getting help for the long-term effects of abusing and neglecting their children when they were children. In other words, diagnostic tools have played a role in this, but the other factor is that more people are getting help. In the research that has been done on dissociative identity disorder, the illness has been approached from a variety of different theoretical perspectives. Each of these discourses has a unique perspective on how problems might be understood as well as a unique strategy for their management. The discourses of a number of different academic fields, including psychiatry, psychology, corporealities, feminism, social constructivism, anthropology, and postmodernism, have been investigated in this article. The study comes to a close with a discussion of prospective routes for future nursing research into this delicate facet of mental health, as well as a review of the nursing research that has been done in the past. This brings the total number of things covered in the study to a total of 10.

RESEARCH METHODOLOGY

According to Denzin and Lincoln (2000), a research design is "a plan, structure, and strategy of investigation to obtain answers to research questions or problems that puts paradigms of interpretation into motion" on how to move forward in gaining an understanding of "a phenomenon in its natural setting" (Ary et al., 2002). It is an all-inclusive plan or agenda for the research (Kerlinger, 1986). The design explains the steps that will be taken to carry out the study, including the times, places, and circumstances under which the data will be collected. Its goal is to supply the research questions with responses that are as accurate and credible as they can possibly be (McMillan & Schumacher, 1993).

An efficient research design lays out the specified objective of the study, ensuring that there is coherence between the research questions and the methodologies or approaches that are offered, so producing data that is trustworthy and verifiable (McMillan & Schumacher, 2001).

Menka Kumari *, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: menkaakumari@gmail.com

Both qualitative and quantitative approaches can be taken when designing a research study. 'Qualitative research is an inquiry process of knowing based on diverse methodological traditions of inquiry that study a social or human challenge,' writes Creswell (1998). The researcher constructs a multifaceted and comprehensive image, does word studies, provides in-depth accounts from informants, and carries out the research in a natural environment. While a quantitative research design adheres to the positivist philosophy of knowing, which places a focus on objectivity through the utilisation of numbers, statistics, and experimental control to quantify phenomena, qualitative research designs adhere to the subjectivist philosophy of knowing (McMillan & Schumacher, 1993). Because it will have a high clinical usefulness, examining the clinical picture of any sickness or problem should be done using a combination of qualitative and quantitative methodologies. This is the method that is most highly recommended. As a result, a multi-method approach to both the gathering of data and its subsequent analysis was utilised in this particular research endeavour.

The inclusion of qualitative data allows for a variety of different interpretations to be offered for the quantitative findings.

ANALYSES AND RESULTS

Both qualitative and quantitative approaches to data analysis were utilised in the processing of the gathered clinical and questionnaire information. The analysis consisted of the following three stages:

In the first section, we concentrated on qualitative assessments (thematic and content analysis).

The second section focused on descriptive analysis, including means and standard deviations, base rate (BR) scores, frequency distributions, and percentage breakdowns.

The inferential statistical analysis was the focus of the third section (Logistic Regression Analysis)

QUALITATIVE ANALYSES

A qualitative analysis is a method of study that aims to construct a comprehensive and, for the most part, narrative account of a social or cultural phenomena in order to further inform the researcher's knowledge of that phenomenon. The term "qualitative research" was coined by McMillan and Schumacher (1993), who described it as "mainly an inductive process of

Menka Kumari *, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: menkaakumari@gmail.com

organising data into categories and discovering patterns (relationships) within categories" (p. 479). This term suggests that facts and meaning develop "organically" from the setting in which the study was conducted. It entails determining meaning, classifying it, and integrating it into a whole. These are all connected processes. The qualitative method of research is conducted in their natural environments through a combination of participant observation and interviewing.

Logical analysis ensured the study's internal validity by providing complete descriptions of the research location and participants, as well as the instruments and processes for data collection. This allowed for accurate data gathering.

Interpretive validity and trustworthiness are two tactics that may be utilised when arguing for the internal validity of a study:

1. The degree to which the interpretation of the data and the conclusions drawn from it are thought to be correct in order to accurately reflect the subjects' or phenomenon's "reality" is what is referred to as the level of interpretive validity. There are four aspects that go into determining the interpretative validity; the larger the degree, the more of acceptance by other researchers, the original researcher's interpretation is deemed to have a higher level of validity (Altheide and Johnson, 1994).

(1) Applicability: applicability is measured by how well the report educates readers and inspires them to conduct more study.

(2) Contextual Completeness: This relates to the extent to which the description of the report (often in the form of a narrative) is comprehensive and detailed.

(3) Research Positioning: Given the essential role that the researcher plays in qualitative techniques, qualitative researchers have been referred to as "data collecting machines" in the past. Therefore, it is necessary for the researcher to document both their direct and indirect impacts on the research site(s), participants, and so on.

(4) Reporting Style: This refers to the extent to which the description provided by the research report writers is viewed as authentic.

All four aspects of interpretive validity have been ensured by doing the following: • Obtaining the information about the client from their treating clinicians, despite the fact that very little information could have been obtained; • Discussing about the clients' problems

Menka Kumari *, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: menkaakumari@gmail.com

with other clinicians; • Describing the full range of information of each client in detail; • Analyzing qualitative data at three levels of analysis, by clubbing the information of individual clients into themes and sub themes, then analysing those themes and sub themes; and • Discussing

TRUSTWORTHINESS

When data analysis and conclusions are triangulated, a study's "trustworthiness" is raised. When participants' views are validated in a systematic manner, and when a project's data chain of evidence is formed, a study's "trustworthiness" also increases (Gall, Borg, & Gall, 1996)

(a) Triangulation refers to the process of establishing the validity of findings through the utilisation of numerous data gathering devices, sources, analysts, etc. A deeper and more in-depth knowledge of the research subject may be achieved by the combination of several approaches that are used to explore a phenomena. This goal has been accomplished through the utilisation of a multi-method approach to the data collecting process.

(b) Chain of Evidence: The logical link between research questions, research techniques, raw data, and outcomes should be such that a reasonably prudent individual would arrive at the same or comparable conclusions. This is referred to as the "gold standard." A score of five

The following two procedures for establishing the chain of evidence for the data have been followed in this research:

(1) An outlier analysis was performed, in which examples that were extremely distinct to one another were compared and the discrepancies were explained. This helped add to the integrity of the findings that were strengthened as a result. It was possible to distinguish between common and individual symptoms presented by customers.

(2) Pattern Matching: This technique is quite similar to the approaches that focus on the achievement of goals in order to evaluate a project. In this part of the study, the expected advantages of an intervention were compared to those that were discovered. When such criteria are satisfied, the case for "trustworthiness" receives a significant boost.

Content analysis is a methodology for doing qualitative research that is commonly used for the subjective interpretation of the content of text data. This is accomplished via the methodical categorization process of coding and the identification of themes or patterns.

Menka Kumari *, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: menkaakumari@gmail.com

There are three main techniques to content analysis: the conventional, the guided, and the summative. In order to interpret meaning based on the contents of the text data, all three methods were utilised, and in doing so, the naturalistic paradigm was adhered to. The primary distinctions between the techniques are the coding schemes, the origin of the codes, and the dangers to the reliability of the information.

Coding categories are often produced directly from the text data in traditional approaches to content analysis. The analysis of a guided approach begins with a theory or pertinent counting and comparisons, which are often important words or content, and is then followed by the interpretation of the underlying context. The process of producing the segments of data using symbols, descriptive phrases, or the category name is referred to as coding. After compiling a comprehensive list of codes, those codes are then applied to fresh sections of data whenever an acceptable section of data is discovered. Inductive codes are generated by the researcher by direct examination of the data, whereas a priori codes are developed in advance of studying the data that is now available. The codes were derived from the DIB-R symptoms as well as the symptoms that were discovered in the transcripts.

In order to become familiar with the data, the tape recorded interview data were transcribed, and this was done so that the data could be listened to on cassettes and reread from the transcripts (with due regard to confidentiality issues). Following three stages of analysis allowed for further reduction of the copious amounts of data.

1. The information gathered from each client was subjected to an individual analysis, during which themes, subthemes, and main reactions or traits that are characteristic of the themes were determined.

2. The information pertaining to each and every customer was categorised, or clubbed, in accordance with the overarching themes, underlying themes, and features. By comparing the various screenplays' treatment of these issues, we were able to develop notions that went beyond being straightforward and descriptive.

3. After the data were coded at the third level, additional themes appeared. These themes were then integrated and categorised into major and relevant regions or domains. It was determined how frequently each of the symptoms occurred. Following the identification of the first-person stories or narratives of those symptoms included within the transcripts, a concise description of each symptom is provided.

Menka Kumari *, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: menkaakumari@gmail.com

The method of analysis that was used was one that focused on themes, substance, and narratives.

The following Tables of qualitative analysis part of findings presents the key categories/themes and sub themes that were produced from the content analysis of the case history material.

CONCLUSIONS

The current research sought to identify people suffering from BPD in order to better design therapies for such patients. The identification of patients was carried out using a variety of techniques of evaluation, and it was determined which characteristics and symptoms were shared by BPD patients in North India. According to the analysis of the demographic data, there were significantly more men (66%) than there were females. According to findings from earlier studies, females make up 75% of the total number of patients. This disparity raises questions about gender differences in the aetiology and development of borderline personality disorder (BPD), as well as in differential outcomes and impairment for men and women caused by traits and features associated with BPD. Specifically, this disparity raises questions about whether or not BPD is more likely to affect women than men.

Anger, tension, anxiety, despair, sorrow, irritability, attempted suicide, related changes in sleep, food, and somatic symptoms, and mental disease among family members were found as the common clinical characteristics of BPD patients in case histories and MSE studies. Their states of mind were erratic, unstable, and difficult to predict or influence in any way. These symptoms led to poor performance, a lack of interest in job or studies, poor memory and forgetfulness, frequent arguments, few friends, isolation, and substance abuse. In addition, these symptoms caused the individual to withdraw from social situations. Early on, the climate at home was either very rigid or quite liberal, and there were also concerns over money and marriage. During their childhood, patients had poor academic performance, were truants, were stubborn and belligerent, and were able to manipulate the situation to their advantage. They were singled out, shunned, and punished by others around them. They were unsure and uncertain about things, and they had only a limited or no understanding of how their mental illness affected them.

The attitudes of these patients' families suggested that their members were unaware of the problem, that they rejected and hid the difficulties from others, and that they were unwilling to seek professional assistance. Stigma was another significant obstacle that labelled the

Menka Kumari *, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: menkaakumari@gmail.com

client as "crazy" or having a "disturbed mind," which led to the client withdrawing within themselves or isolating themselves. The sick was looked down upon and shunned as a symbol of society's sentiments toward them. They were excluded from society because they did not conform to the norms of society. There was both denial and uncertainty on their part. a state of bewilderment on the part of the sufferers in reference to their own actions (stigmatizing the self).

REFERENCES

1. Aaronson, C. J., Bender, D. S., Skodol, A. E., & Gunderson, J. G. (2006). Comparison of attachment styles in borderline personality disorder and obsessive-compulsive personality disorder. Psychiatric Quarterly. 77:
2. Agrawal, H. R., Gunderson, J. G., Holmes, B. M., & Lyons-Ruth, K. (2004). Attachment studies with borderline patients: A review. Harvard Review of Psychiatry, 12,.
3. Ahnemark, E., Hultén, A., & Åsberg, M. (2004). Vad vet vi om flickor som skär sig? En kunskapsöversikt om självskador hos unga, Socialstyrelsen, rapport:
4. Akiskal, H. S. (2004). Demystifying Borderline personality disorder: critique of the concept and unorthodox reflections on its natural kinship with the bipolar spectrum. Acta Psychiatrica Scandinavia; 110:
5. American Psychiatric Association. (APA; 2013). Diagnostic and statistical manual of mental disorders (5^{th} ed.). Washington, DC.
6. Andreasen, N. & Black, D. W. (2001). Introductory textbook of psychiatry. Arlington,VA: American Psychiatric Publishing.
7. Arntz, A., Van der Hoorn, M., Cornelis, J., Verheul, R., Vanden Bosch, W., & De Bie, A. (2003). Reliability and Validity of the borderline personality disorder severity index. Journal of Personality disorders; 17,
8. Baer, R. A., Peters, J. R., Eisenlohr-Moul, T. A., Geiger, P. J., & Sauer, S. E. (2012). Emotion-related cognitive processes in borderline personality disorder: A review of the empirical literature. Clinical Psychology Review; 32(5),
9. Barnow, S., Stopsack, M., Grabe, H. J., Meinke, C., Spitzer, C., Kronmuller, K., et

Menka Kumari *, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: menkaakumari@gmail.com

al. (2009). Interpersonal evaluation bias in borderline personality disorder. Behaviour Research and Therapy; 47(5),

10. Bateman, A., & Fonagy, P. (2009). Randomized controlled trial of outpatient mentalization-based treatment versus structured clinical management for borderline personality disorder. American Journal of Psychiatry; 166:

11. Belhekar, V. M., & Padhye, A. A. (2009). The Borderline Personality: Exploring the role of affective instability and the five factor model neuroticism. Journal of Psychological researches; 53(2),

12. Bender, D. S., & Oldham, J. M. (2005). Psychotherapies for borderline personality disorders. In: J. G. Gunderson and P. D. Hoffman (Eds.), Understanding and Treating Borderline Personality Disorder: A Guide for Professionals and Families, pp. 21-41. Arlington, VA: American Psychiatric Publishing, Inc.

13. Black, D. W., Blum, N., Pfohl, B., & Hale, N. (2004). Suicidal behavior in borderline personality disorder: prevalence, risk factors, prediction, and prevention. Journal of Personality Disorders; 18:

14. Black, D. W., Gunter, T., Allen, J., Blum, N., Arndt, S., Wenman, G., & Sieleni, B. (2007). Borderline personality disorder in male and female offenders newly committed to prison. Comprehensive Psychiatry; 48

15. Bohus, M., Limberger, M. F., Frank, U., Sender, I., Gratwohl, T., & Stieglitz, R. D. (2001). Entwicklung der Borderline-Symptom-Liste (Development of the borderline symptom list). Psychotherapy Psychosomatic Medical Psychology; 51

16. Bradley, R., Conklin, C., & Westen, D. (2005). The borderline personality diagnosis in adolescents: Gender differences and subtypes. Journal of Child Psychology and Psychiatry; 46(9):

17. Bradley, R., Zittel, C., & Westen, D. (2005). Borderline personality disorder in adolescence: Phenomenology and subtypes. Journal of Child Psychology and Psychiatry; 46.

Menka Kumari *, *Department of Psychology, B.R.A. Bihar University, Muzaffarpur, India.*
E-mail: menkaakumari@gmail.com