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Personality Disorders in the Indian Culture: Reconsidering Self-Perceptions, Traditional Society and Values

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Abstract Until recently, personality disorder research in India has been a largely neglected area. A small body of epidemiological research reveals lower prevalence rates for personality disorders in India than seen globally. The present study aims to examine personality disorders within the lens of family of origin and values, thereby providing a culturally relevant framework to understand this heterogeneous and complex clinical condition. The participants were recruited over a 2-year time period and comprised of 20 adults with personality disorders who, using a matched case-control design, were compared with 20 participants from the community. A total of three focus groups were conducted to develop themes for an in-depth interview that highlighted four context specific themes relevant to personality disorders (mood states that impact the self, significant life experiences, impact of family of origin and procreation, and value organization). The study revealed several key findings. Like previous studies, borderline and avoidant personality disorders were more common. Interestingly, participants were brought to the clinical setting in their late twenties. Internalized emotional reactions were predominant. The family acted as both a source of stress, abuse and support, with ties being maintained with extended family such as grandparents, siblings and spouse. Dissonance between individual values and existing pluralistic Indian cultural belief system was experienced. The findings highlight the requirement for expanding on cultural models of personality disorders in South Asian settings and integrating them into mainstream psychosocial assessment and interventions.

Keywords Personality disorders · Cultural values · Self-perception · Family functioning · India

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Introduction

Personality disorders (PD) have been understood as dysfunctions in personality and the presence of pathological personality traits that are relatively stable over time, consistent across situations and which deviate markedly from an individual's culture. The research section of the current edition of the Diagnostic and Statistical Manual of Mental Disorders broadly defines PD as impairments in constructs of self in terms of identity (view of oneself as unique with clear boundaries between self and others), self-direction (pursuit of goals with capacity to self-reflect) and interpersonal relationships including empathy and intimacy (DSM-5, American Psychiatric Association, 2013). Furthermore, the diagnosis of a PD requires the presence of maladaptive personality traits such as negative affect, detachment, antagonism, disinhibition and psychoticism in varying degrees. Based on these criteria, there are ten distinct PD types including paranoid, schizoid, schizotypal, borderline, narcissistic, antisocial, histrionic, obsessive–compulsive, dependent and avoidant (DSM-5, 2013).

Until recently, studies on personality disorders in psychiatric healthcare facilities in India have been largely neglected. The small body of research that exists has focused primarily on the low PD prevalence in India, which although relevant does not encapsulate the underlying phenomenology (Gupta & Mattoo, 2010; Sharan, 2012).

More specifically, verbalization of distress and identity disturbances are rooted in sociocultural experiences, interpretation of which shape help-seeking behaviors, values, religious practices and self-definition (Kleinman & Benson, 2006). It would therefore be useful to have knowledge of the malleable nature of personality variables across different contexts such as family, the larger society and the representation of values to have a deeper understanding of PD in Indian culture.

Urban India is witness to a rapidly evolving sociocultural transition, and as participation between the community and mental organizations in healthcare delivery rises, there is a growing need to provide culturally relevant formulations of PDs. Over 31.2% of the population lives in urban settings, in contrast to 27.8% in 2001 (Census, 2011). This is evidenced with mental healthcare services having been integrated into general medical clinics across more than 127 districts (Murthy, 2011). While in traditional society, a stereotyped Indian is viewed largely as group oriented and interpersonal, embedded within a matrix of relationships from which a sense of self is derived (Roland, 1988; Sinha & Verma, 1987; Triandis, 1995), the urban shifts and its impact on personality disorders have not been researched. There is a long-researched history suggestive of the Indian self, that comprises of coexisting individualistic and relational aspects that are domain specific and determined largely by culture (Kapoor, Huges, Baldwin, & Blue, 2003; Mascolo, Misra, & Rapisardi, 2004; Sinha & Tripathi, 2001; Sinha, Vohra, Singhal, Singhal, & Ushashree, 2002). The urban Indian landscape has moved from being viewed as being traditional and conforming, with predictable social roles and high cohesion, to one that is more fluid. This gives salience to the person in the place they live, the roles they lead, their family life and individual beliefs, the shared notions of illness, rather than that of a stereotypical "patient" with a fixed set of traits (Kleinman & Benson, 2006). Moreover, in her sociocultural descriptions on personhood in relation to aging and gender in India, Lamb (1997) suggests dichotomizing Eastern versus Western notions provides an oversimplified explanation to the complex, multifaceted self. In this context, rather than viewing relational and autonomous aspects of the self as mutually exclusive, a deeper interpretation of the ways in which they interact with one other may provide a deeper understanding of personality in the Indian setting.

Along a similar vein, personality of Indians, particularly their self-perceptions and identity have been theorized to be interlinked with family ties and values. Family is not just viewed as deriving self-identity but also as a source of support. The cultural beliefs of India instill a value of "seva" (duty) where family members, including sick members, are provided extensive care and love, often at the cost of one's own needs (Brijnath, 2012). How this translates to PD has not been studied, although it would provide useful insights into the cultural manifestation of this complex mental health condition. However, till date, research on the interaction between cultural and family level variables and personality disorders is limited globally and absent in India.

The aim of the current paper is to study individuals with personality disorders as they present to the clinical setting in India. Moreover, using a combination of questionnaires, focus groups and in-depth interviews, the study seeks to provide a culturally relevant formulation for personality disorders. Specifically, it attempts to formulate personality disorders through self-perceptions and its relationship with emotional states, family of origin and value systems.

Method

Study Setting and Participants

The study was conducted in Bangalore city, the capital of Karnataka, which, with a population of over 8.5 million (Census, 2011), is the third most populated city in India. Participants were recruited from the inpatient and outpatient departments of National Institute of Mental Health and Neuro Sciences (NIMHANS). This is the largest psychiatric tertiary care facility in India and was therefore considered ideally suited to screen for PDs, which are often overlooked in routine practice. The sample comprised of 20 participants with a first-time diagnosis of PD. Individuals with substance dependence (but not substance use/abuse), who were currently psychotic, those with major depressive disorder and individuals who were less than 20 years of age were excluded from the study. While we understood that comorbid PD such as antisocial personality disorder is often seen with substance dependence, they were excluded primarily to minimize bias due to the severity of the symptom presentation. The decision on sample size was made on an *apriori* basis in accordance with the information obtained from the Medical Records Section of the hospital on the number of patients seen with an Axis II diagnosis over the past 3 years. Corresponding to this, another study had revealed that between 1996 and 2006, out of over 18,000 psychiatric diagnoses received in another similar tertiary care hospital in northern India, only 173 received a PD diagnosis (Gupta & Mattoo, 2010). The diagnosis of PD was made by a trained mental health professional followed by the primary author, who also had the mandatory training required to make the diagnosis. Two-thirds of the participants were inpatients, and comorbidity was highest with mild depression and substance use.

A case-control design was used, and the participants were matched on age and sex with 20 adults from the general community who visited the hospital. All participants were residents of urban Bangalore, from a middle social economic background, and had at least high school level of education. More than half were graduates with varied employment background including being researchers, software professionals, physiotherapists, teachers and homemakers. Written informed consent was taken from all participants. They were assured confidentiality and anonymity. Ethical clearances were obtained for the procedures from the hospital. The duration of data collection was 2 years. The language of interviewing was English, which is the second official language in Karnataka, and the predominant mode of linguistic communication in South Indian urban settings. All participants were interviewed individually in the outpatient therapy rooms of the hospital. Interviews were coded based on their primary themes by the main authors who are both clinical psychologists with postgraduate level experience in qualitative research methods.

Tools and Qualitative Method

The clinical assessment of PD was done using a structured interview schedule (Personality Diagnostic Questionnaire-4+; PDQ-4+; Hyler, 1994). The PDQ4+ is a 99-item questionnaire which assesses the presence of 12 personality disorders of the Diagnostic and Statistical Manual of Mental Disorders-1V. These include paranoid, schizoid, schizotypal, histrionic, borderline, narcissistic, antisocial, avoidant, dependent, obsessive–compulsive, negativistic and depressive. Scores ranged from 0 to 79, with scores greater than 30 indicating the presence of personality disturbance, and a score of 20 and below found in healthy personalities. To reduce the number of false positive responses, we administered the Clinical Significance Scale, which is preceded by a brief interview to confirm the diagnosis. The tool has been used in the Indian setting (Tandon, 2004). Internal consistency of the tool was found to be adequate ($\alpha = 0.83$). Test–retest reliability over 4 weeks for the total PDQ mean score was found to be 0.91.

In-Depth Interview

The cultural context of personality disorders was examined through an in-depth interview schedule that was developed for the study. The themes for the interview schedule were piloted through three focus group discussions in the community setting that examined perceptions that participants held in relation to personality, family functioning and individual values. This included one all male group ($N = 7$), one all female group ($N = 6$) and one mixed group ($N = 8$). One mediator with a psychiatric social work background apart from the primary author participated in the focus group discussion, each of which lasted for about 3–4 h. The aim of the focus groups was a synergistic participation of group members, who clarified, commented, critiqued, prompted and triggered responses from one another. This spontaneous interaction generated insights that were socially anchored and reflected themes of identity, ruptures and their shared cultural meanings. All emergent data were audio-recorded, and based on this information, the in-depth interview was developed.

The interview comprised of four specific thematic items with self-perception as the central theme. These included: (1) mood states that impacted the self; (2) significant life experiences that shaped the self; (3) role of family of origin; (4) value organization. All interviews were audio-recorded and written verbatim. Thematic codes were underlined from the transcripts to identify common patterns, and content analysis was carried out. The interviews were conducted in a single session lasting for about one to 2 h.

Results

The demographic details of the PD group indicated that the participants were their late twenties (Table 1; mean age = 28.90 years; SD = 6.09). Gender was equally distributed. A small number ($N = 4$) were unemployed. They were predominantly Hindu in their religious orientation in accordance with the religious distribution in India. Almost fifty percent of the PD group comprised of married participants. This is important in terms of the implications of personality dysfunction on the family of procreation. Similarly, most of them were currently living with their families ($N = 17$), which was either nuclear ($N = 11$) or joint ($N = 9$). Majority of them had one sibling. The community sample differed significantly from the PD group in terms of education and employment. Higher education was greater in the community sample. This might indicate that in some participants in the PD group, college education was disrupted due to their dysfunction. In keeping with this, there were a larger number of homemakers and unemployed respondents in this group as compared to the community sample. On the other hand, similarities between the clinical and community sample on all other demographic domains suggest a similar socio-cultural and religious background.

Table 2 shows the total score obtained on the Personality Diagnostic Questionnaire-4 + by the PD group and the community sample. The table indicates that respondents in the PD group had obtained a significantly higher

Table 1 Socio-demographic details of the personality disorder group and comparison with the community group

Variable	Personality disorder group ($N = 20$)	Community group ($N = 20$)	χ^2/t value
Age			
Mean	28.90	27.15	0.95
SD	6.09	6.15	
Gender			
Male	10	10	**NS**
Female	10	10	
Education			
High school	**05**	**00**	**NS**
Graduation	**11**	**10**	
Post-graduation	**04**	**10**	
Occupation			
Student	05	08	**NS**
Employed	08	12	
Unemployed	04	00	
Homemaker	03	00	
Marital status			
Single	10	12	**NS**
Married	09	06	
Divorced/separated	01	02	
Place of residence			
Home	**17**	**11**	**5.58***
Other	**03**	**09**	
Religion			
Hindu	18	16	0.78
Other	02	04	
Family type			
Nuclear	11	13	0.96
Joint/extended	09	07	

Highlighted numbers designate significant difference between the two groups on that variable or specific values which are not significant but have implications

*$p < 0.05$

total score than the community group, suggesting the presence of personality dysfunction. It is seen that the mean scores obtained by respondents in the PD group were above the cutoff for Borderline PD, and slightly below the cutoff for avoidant and depressive PD, suggesting a mixed personality disorder profile. As expected, the community sample had obtained low mean scores across all subtypes of personality disorders. An intriguing observation about the PD group was that the mean age of individuals who were brought to the hospital setup due their dysfunction was on the higher side. This may reveal a cultural phenomenon wherein problems are kept within a family until the requirement for medical help is high.

Qualitative Interview Themes

The purpose of the interview was exploratory and to conceptualize PDs within a cultural framework. The following themes emerged:

1. Mood states that impacted the self

The pervasive negative mood states common across the PD interviews were anger directed at family members, feeling misunderstood and used especially in heterosexual relationships prior to marriage, having ambivalent feelings toward others, feeling lonely, experiencing self-disgust, having a fear of forming deep bonds with people versus getting into emotionally abusive relationships, being reassurance-seeking, especially with respect to beauty and love, and wanting gratification immediately. These highlight the mixed profile of the personality dysfunction seen. One respondent (PD Female 3) reported, “I realized my mind works too much and thinks all kind of negative thoughts. So, I thought, if I sleep, these thoughts would not come to my mind. That’s when I started taking sleeping pills.” Another (PD Male 4) stated, “I don’t let people come close to me. There is a level at which I cut off all communication. I have many walls to climb before I can reach out to others.” This focus on disconnection from others was a common theme, along similar lines as the inhibition that is associated with avoidance. On the other hand, the presence of statements such as (PD Male 20), “I would like to interact better with people, be more forthcoming, more sociable, more gregarious, less paranoid,” suggests a need for a relational self in accordance with the Indian context.

In contrast, the interviews revealed that participants from the community were more accepting of themselves and others and showed greater trust. For instance, one community participant (CS Male 16) who had undergone a traumatic divorce reported, “Today when I look back, I don’t think that everything that happens is for the good, but it’s good that I am out of it. I look forward to a soul mate, and then the past chapter will be closed.” Another participant (CS Male 18) reflected on his career choice of being a researcher, “Earlier when I would see my friends who had a computer science background earning much more than me I would feel bad. But I want my self-respect. I do not want to shift my career just to earn money. If I want to do something, I will definitely work for it.” Talking about her personality, one participant who worked as a college principal (CS Female 13) reported, “I don’t hold grudges. If people change, I change as well.” She also stated that “I always thought I was very strict with my students. Yet, there must be something nice about me, because they always come and share their problems with me. I enjoy making decisions for them, especially with a smile.”

Table 2 Distribution of personality disorders in the sample and difference between the PD group and the community group

Variable	Cutoff Score	Mean/SD	PD group ($N = 20$)	Community group ($N = 20$)	t value
PDQ total (cutoff = 29)	–	Mean	**38.35**	**23.00**	3.98***
		SD	12.05	12.26	
Cluster A					
Paranoid	4	Mean	3.30	2.10	2.65*
		SD	1.56	1.29	
Schizoid	4	Mean	**2.50**	**1.15**	**3.82*** **
		SD	1.05	1.18	
Schizotypal	5	Mean	2.10	1.75	0.62
		SD	1.92	1.65	
Cluster B					
Histrionic	5	Mean	3.80	2.80	1.61
		SD	2.12	1.79	
Narcissistic	5	Mean	3.20	2.40	1.30
		SD	2.17	1.70	
Borderline	5	Mean	**5.90**	**2.95**	**3.79** **
		SD	2.71	2.19	
Antisocial	3	Mean	2.40	1.55	1.43
		SD	2.26	1.39	
Cluster C					
Avoidant	4	Mean	**3.95**	**1.75**	**3.49** **
		SD	2.19	1.77	
Dependent	5	Mean	**3.20**	**1.65**	**2.45***
		SD	2.12	1.84	
Obsessive–Compulsive	4	Mean	2.25	3.00	1.60
		SD	1.71	1.21	
Negativistic	4	Mean	**2.85**	**1.45**	**3.23** **
		SD	1.57	1.15	
Depressive	5	Mean	**4.75**	**1.45**	**7.54*** **
		SD	1.48	1.28	

Cut-off scores represent the value above which a pesonality disorder is present

Values in bold represent significant difference between the two groups in that value

PDQ (Personality Disorder Questionnaire)

*$p < 0.05$; **$p < 0.01$; ***$p < 0.001$

Elaborating on her interactions with different people, a participant (CS Female 7) said, "When I was in high school, one of my class mates spread a rumor that I was having an affair with a boy. My father was very upset and wanted to marry me off. But my mother and uncle believed in me, and let me continue my education. If someone does bad things to me, I cannot think ill of them, I need to avoid them. Now I have close friends and am no longer in a shell. I write articles for websites, I love to cook, do yoga and read about Vedic lifestyles. My past changed my present." These statements highlight the ability of the community participants to deal with difficulties in different life spheres and develop adaptive personality mechanisms. It also reveals their capacity to develop relationships despite ruptures in the past.

2. Significant life experiences

Common themes of broken heterosexual relationships, divorce, interpersonal conflicts and work stress were reported by both groups. Among both groups it was found that major decisions about career were based on a combination of one's self-interest and advise of seniors, while that of marriage are primarily based on advice of family members. However, perceptions of these experiences and their impact varied among them. For example, a participant (PD Male 5) reported, "My past relationships have all failed, so I might as well do as my parents want." This passivity shows resignation over one's decision, and a need to gain parental approval by acceptance of their wishes. Participants in the PD group revealed a poor body image,

often associated with peers having made fun of the person in the past. On the other hand, optimistic responses were also present in the interviews, such as, (PD Female 14) “I am not bad, though what happened to me was not good.” Themes of caring for others, transforming psychological pain into creativity through dance, art, exercise, reading, developing a routine and accessing a social network were also seen. These reveal the use of external methods of coping with their problems, possibly due to a lack of inner psychological resources.

3. Role of family of origin and procreation

Common themes of unavailability of one or both parent, remarriage of the father, witness to parental discord, severe mental illness in parents or in siblings, being a silent spectator to abuse faced by mother from her in-laws, experiencing a lack of privacy in a joint family structure and a controlling child rearing style, especially by the father in the presence of a submissive mother were seen. Across more than ten interviews, physical or sexual abuse in varying degrees, mainly by the father or uncle, was expressed. Themes of suicide in a sibling, abuse faced by a sibling or by other relatives were also seen. For example, one participant (PD Female 1) reported, “My mother would act as if dead when my father hit me. She would just lie down and do nothing.” Another woman (PD Female 19) said, “My mother endured all the beatings my father gave her and me because she felt a child needed both parents.” Another participant reported (PD Female 9), “My father would do things to me sexually. My mother knew it but told me never to tell anyone. To forget about it, I would dream that I was in a hilly place which was full of people I loved. During all those years, my father supported me academically…I don’t know if I hate him or not.” This suggests the presence of family secrets and a lack of control over what was happening, which may have had an impact in shaping the self.

The lack of availability of parents came across as another equally key factor. One respondent (PD Female 14) said, “My parents gave me all the freedom I wanted, but they were so busy with their own lives. I was all alone. I lived in a house but not a home.” Another (PD Female 10) reported, “My father treated me mechanically, like I was a maid.” Highlighting the impact of her father in developing a heterosexual relationship, one participant (PD Female 8) stated, “My mother was so beautiful, yet my father stayed away from her and spent all his time working. He never said anything bad to her or us, but he was never there for us either. That made me feel, if a woman as beautiful as my mother could not hold the attention of a man, what chance did an obese person like me have.” The passivity of the mother may have been another factor that contributed to allowing others to manipulate them, and a feeling of being used without taking any active measures against it. Being criticized for thinking independently for oneself was also reported by some. In this context, one participant (PD Male 4) reported, “My parents were too protective of me, and that prevented me from facing society confidently.”

The interviews have highlighted the multiple relationships between family and personality in such individuals, which have an impact on shaping the way they perceive their self. Commenting on getting distanced from his family members and becoming self-reliant, a participant (PD Male 7) reported, “My mother was not very emotional and my father was very strict. When I got molested as a child, I could never speak to them because I felt they would not understand. I grew up with a “yuck” feeling about myself that did not allow me to form deep bonds with anyone. Sometimes, I feel I am part of a privileged minority, who can do anything, since I no longer believe I have to answer to my parents or others. I dance, paint, write poetry, know different languages, travel and have enough money to go by.” On the other hand, the statement “I am not a man” (PD Male 4) reflects a lack of belief in one’s capacity to be self-efficacious. This participant claimed, “I had psoriasis as a child and went into a cocoon. My parents never drew me out of it. Today I share a very superficial relationship with them.”

A desire to live cooperatively with others in society but being unable to do so was also reported. Reflecting on this, one participant (PD Male 16) said, “My mind became like a thief because my parents never taught me how to understand other people.” Thus, although there is a need for being self-directed and cooperative, they reveal how maladaptive parental dimensions contribute to a tendency to withdraw from social contact versus investing excessively in a particular relationship, which may act as deterrents in the development of one’s self.

Despite these irregularities, almost all the interviews also highlighted the presence of family buffers in terms of extended relatives, mainly the support of maternal grandparents, an elder sibling who acted as a confidante and one of the parents (either father or mother) taking on the caregiving role when the other is abusive.

In comparison with the clinical sample, the community participants elaborated on themes of being cared for in the family, perceiving parents and uncles as role models, receiving advice about career, having frequent intellectual discussions, the family being open to new ideas and providing higher education to women. While they reported difficulties in the family domain, they also perceived it as a cohesive unit. For example, one respondent (CS Female 4) said, “My father constantly told me that he wished I were a doctor. But I would tell him I am doing well in my profession.” Another participant (CS Male 18) stated, “My mother said she would rather I die than face society when I

did not get an engineering seat. But looking back, I do not feel so bitter. She did not really mean it." Another (CS Male 17) said, "My parents never knew what was best for me, so I made my own choices." Reflecting on coming together as a group, one participant (CS Female 1) reported, "My father, mother, sister and I live in our own individual clouds. But whenever there is a crisis, we get united." This indicates that individuals in the community sample (CS) could view the limitations of their families more objectively while maintaining adequate connection with each other. In accordance with this, one participant (CS Female 2) reflected, "When I was younger, I wanted to get away from home. Now I want to go back."

It was found that the death of a parent, grandparent or sibling (seen in 7 interviews) changed the worldview of the community respondents and brought an increased sense of responsibility, with greater priority to the needs of the family, sometimes, at the cost of their own desires. One respondent (CS Male 8) stated, "All my life I saw my father as very influential and powerful. But the night he collapsed in a railway platform, he looked so helpless. I realized everything in life is temporary." It was also seen that despite tensions in the family or any indifference or rejection faced in adulthood, the opinions of the parents were considered important in major life decisions, including marriage and career.

4. Value organization

The values that emerged as significant across the PD interviews were love, self-direction and benevolence. In contrast, the community group endorsed self-enhancement, openness to change and autonomous values. Ambivalence over both, the traditional Indian cultural value system, as well as modern urban values was reported across PD interviews. They reported agitation over societal double standards such as men and women mingling freely on the one hand, while on the other, women being asked to wear a "ghunghat" (Purdhah system followed by traditional society for married women in India who are required to cover their head). Reflecting on holding unconventional values but having difficulty with the consequences, a participant (PD Female 3) reported, "I formed a love contract with a man for nine months. We had great sexual compatibility and were good friends. But then I wanted to get married to him, and he refused. Now I feel violated." A common theme associated across the interviews was values on the taboo linked with heterosexual relationships. Another participant (PD Female 1) stated, "An emotional relationship can be so much more damaging than a sexual one. You can wash off the smell of a person from your body, but not the scars of what he does to your heart. Yet, the Indian culture condemns a sexual relationship and is indifferent to an emotional one." These highlight the opinions of the PD group on the contrasts that exist in the Indian value system, and their distress associated with it. It also highlights that although there is an ideological shift in thinking, they may have difficulty balancing it within the confines of social acceptability.

In contrast to the PD group, the community sample provided more positive themes about the Indian cultural value system such as greater choice in getting married and having children later in life, and in permitting women to do both house work and hold a career. In terms of family, they provided statements reflecting passing down of knowledge through stories and folklore down the generations and a respect for looking after elders. They reported a discomfort on being excessively career minded and self-oriented, something that had led to an increased number of old people's homes and less focus on personal relationships. Thus, although a shift in the value system was seen in the community group as well, integration of traditional practices of the past into the present, and allowing for their individuality to be expressed in an adaptive manner was more prevalent.

Examining religious values, participants from the PD group provide themes of opposing ritualistic practices. For instance, one respondent (PD Male 7) stated, "I am spiritual, but I don't believe in practices such as Ganasha drinking milk" (a religious belief that on an auspicious day if the idol of a Hindu God is worshipped with milk, it will receive it). In contrast, participants from the community spoke on the acceptance of all religious ideologies in India, for example, one respondent (CS Male 19) said, "I am a Christian, but my parents allow me to go to temples and even eat prasadam" (offering made during a Hindu worship). Some reported religion as a binding force, for instance, (CS Female 7) reported, "Maybe a Gauri Ganesha festival (a Hindu festival) is not celebrated for the reason behind it by most people, but it still carries the tradition of bringing people together." Similarly, themes associated with not just promotion of religious values, but having the knowledge of rituals, traditional practices, religious books, reasons for fasting and the value behind mantras, as well as why festivals are celebrated were elaborated in greater depth in the community sample. This shows a deeper connection with religion among the community participants. Research linking values to PD is lacking in India. The Indian culture promotes relational values and communal harmony, and as such is noted as a traditional society. However, the urban setting is experiencing marked contextual shifts with individualist and collectivist values coexisting. These preliminary findings suggest that respondents in the community were able to integrate different value priorities within their belief system with lesser conflict while the PD group experienced ambivalence, cultural dissonance and poorer integration of values.

Discussion

Our attempt in the present study was to examine personality disorders in the Indian clinical setting and to anchor the sense of self in a culturally meaningful way to their family of origin and values. The study revealed some distinctive findings that need to be stated. Firstly, extreme personality pathology was not evident (Table 1; Mean PDQ score = 38.35; SD = 12.05; cutoff criterion met only for borderline PD; avoidant features also present). This might point toward utilizing structured interview measures of personality disorders to capture the complete range of pathology with key observer reports to supplement the information. The absence of substance dependence and major depression in the present population further cautions researchers from generalizations regarding manifestation of severe personality disorders. While depressive, avoidant and paranoid personality symptoms were also reported, suggestive of a mixed profile, as is often seen in clinical settings, these findings would be more appropriately represented by incorporating multiple measures of personality disorders (Alnaes & Torgersen, 1989; Pfohl, Conyell, Zimmerman, & Stangl, 1986). Secondly, the age at which the participants were brought to the hospital setting was in the latter part of twenties' (mean age = 28.90; SD = 6.09). Would this be a phenomenon unique to urban India, where pathology is contained within a family till need for medical intervention is high? Or more to the point, would there be an underlying cultural phenomenon that could be at play? Our findings lead us to think this might possibly be the case, with a good backing by larger population based South Asian studies [See Sharan (2012) for a review]. It does appear that in India, the typical age when adults are first brought to a psychiatric institution for intervention for a mental disorder generally, and, more specifically, for a personality related dysfunction, is higher than that found globally. Researchers suggest that the family, which still plays a pivotal role in caregiving in India, often view help-seeking and going to a psychiatric treatment facility as a final resort, as also espoused by the participants in this study (Avasthi, 2010).

The study revealed over-representation of internalized emotions in the form of anxiety and sadness among the participants. In a pluralistic culture like India, which promotes conformity and tradition, these preliminary findings may suggest that rather than acting out or aggressive behaviors, emotional distress was kept confined within social sanctions. As research develops in this area, it might be useful to identify if individual expressions of emotions in PD occur more within the relational domain, in the backdrop of coexisting collectivist and individualist self-priorities.

The study has indicated that the family of origin was viewed as both a source of dysfunction and support. Recurrent themes of abuse, illness, trauma and parental control and neglect emerged. On the other hand, long-term care provided by one parent when the other was abusive, as well as by grandparents, siblings and extended relatives was reported. While the role of family breakdown is well documented in relation to PD, studies have shown that children who develop alternative supports tend to be more resilient, either through extended family or social networks (Masten & Garmezy, 1985). The findings obtained reveal that the Indian culture places a strong value on family, marriage and kinship ties in the process of caregiving. Almost fifty percent of the participants were married, while there was only one participant who was divorced (Table 1). Urban India is fast moving toward a nuclear family structure, with smaller household units (Census, 2011). However, extended family networks allow for greater cooperativeness, help with mate selection, marriage and career decisions, thereby revealing the preserved collective nature of nuclear Indian family.

An important finding of the study was that individual values in participants with personality disorders were at dissonance with that of the prevailing Indian cultural system. Values are guiding principles that underlie choices and behaviors (Schwartz, 1992), and this ambivalence would have a significant impact on wellbeing, efficacy and mood states. The present study revealed that both groups, that is, the community participants as well as the PD group reported a coexistence of self-enhancement and conservation values. However, while participants from the community balanced and moved between religion, career, benevolent, achievement and self-oriented values with relative ease, the same generated uncertainty in the PD group. Distress over rules imposed by society has been found to an indicator of poor mental health, as found in the present study (Sagiv, Roccas, & Hazan, 2004). In this connection, studies on the social context of collective cultures such as South Asia have revealed that mental health of individuals is largely impacted by context sensitive social cues from which they derive satisfaction irrespective of self-goals (Suh, 2002). Furthermore, research suggests that when there is congruence between personal values and those of the prevailing environment, it is associated with positive mood states as was reported by our community participants (Sagiv et al., 2004). The findings underscore the relevance of developing a deeper understanding of cultural values in therapeutic work with PD individuals and strive to balance these with their own individual values in a congruent manner. Current PD assessments in India are restricted to clinical epidemiological studies, with an overreliance on tools that have been adapted from Western countries (Sharan, 2012). While these provide useful insights into PD, an interpretation of the local environment and the cultural traditions, and its impact on the personality configuration is important for

developing a context sensitive approach toward assessment.

The present findings of this study should be viewed in light of the existing literature on PDs in India. This is the first study as far as we are aware, that presents information relevant to the cultural underpinnings of personality disorders in India. The key to successful treatment lies, at least, in part, to being culturally aware of how this complex clinical condition plays out in India. However, we are bound by a primarily urban middle class, English-speaking population, which has greater healthcare access and wherein, the stigma of visiting a hospital is lower. While we are limited in our scope with a small sample size, a study such as this can provide a platform for larger mixed methods studies with rigorous qualitative methods anchored in socially grounded theories relevant to South Asian settings. Even with these challenges certain strengths of the study need to be restated. The study suggests that clinician guided diagnoses and interventions need to be sensitive to personality pathology in Indian settings and incorporate contextual variables in their treatment priorities. Personality disorders have been largely neglected and poorly conceived in India, with explanatory models borrowed from Western concepts, and the findings of this study have revealed the interplay between cultural and family variables with personality.

In conclusion, our study has highlighted a mixed personality disorder profile wherein extreme personality pathology was not evident. Borderline and avoidant personality disorders were more common. The mean age at which the participants were brought to the hospital setting was in their late twenties. In terms of their self-perceptions, it was found that internalized mood states were more common. The family emerged as a source of stress as well as support, with the extended family, especially grandparents, siblings and the family of procreation emerging as important social networks. Dissonance between individual values and the Indian belief system was apparent, and individuals with personality disorders had difficulty balancing self-enhancement and conservation values that coexist in a pluralistic society such as India. As assessment for personality disorders become more sophisticated in India, developing culturally embedded interventions to treat this complex clinical condition would be the next step.

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Compliance with Ethical Standards

Conflict of interest The authors declare that they have no competing interests.

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