International Journal for Multidisciplinary Research (IJFMR)
E-ISSN: 2582-2160 ● Website: www.ijfmr.com ● Email: editor@ijfmr.com

Chronic Loneliness: The Extent to Which BPD (Borderline Personality Disorder) is Determined by Chronic Feelings of Loneliness

Pratosh Kamal Das[1], Ms. Shweta Sahasrabuddhe[2]

[1]Psychologist (Primary Author), Fergusson College, Pune- 411004, Maharashtra.
[2]Fergusson College, Pune- 411004, Maharashtra

Abstract
The present study aims to understand Chronic Loneliness as a determining factor in occurrence of Borderline Personality Disorder (BPD). BPD is characterized by turbulent moods, self-destructive behaviors, low perceptions of self, dissociative ideations accompanied with chronic feelings of Emptiness. Loneliness, on the other hand, is lack of proper human connections in one's life. It can be social, emotional and clinical (chronic) depending upon the quantity, quality and pathological deficits, respectively, in one's life. The methodology of the study revolves around studying the levels of loneliness (low, average, high or very high) in BPD patients. Content Analysis using Thematic Procedure and Semi-Structured Interviews were the methods used for Data Collection. In a sample size of 36 patients, results predicted that most of the patients had high levels of loneliness. In addition, findings highlight the importance of parenting and attachment styles and in occurrence of BPD.

Keywords: Social Isolation, Emptiness, Low Self-Esteem, Affective states, Suicidality, Anxiety, Depression.

1. Introduction:

1.1.Borderline Personality

It is characterized by turbulent and unstable relationships, moods, fear of abandonment and lack of control over emotions. Self-harming tendencies, suicidal gestures and chronic feelings of emptiness are also common.

BPD is one of the most common personality disorders, occurring in around 1% of our population. More significant is the occurrence of the 7th Diagnostic Criteria of these patients (as per DSM-5), "Chronic feelings of Emptiness", present in among 71-73% of BPD patients (Grilo et al, 2001; Johansen et al, 2004).

People with this personality disorder are often intense, going from anger to deep depression in a short time. Dysfunction in the area of emotions is sometimes considered one of the core features of borderline personality disorder, and one of the best predictor of suicide. The characteristic of instability (in emotions, interpersonal relationships, self-concept and behavior) is seen as a core feature with some describing this group as "stably unstable".

This instability extends to impulsivity, which can be seen in their drug abuse and self-mutilation. Although not so obvious as to why, self-injurious behavior, such as cutting, sometimes are described as

tension-reducing by the people who engage in these behaviors. Feelings of emptiness is also common among these people, who sometimes are described as chronically bored and having difficulties with their own identities. Mood disorders are also common among people with Borderline Personality Disorder, with about 20% having Major Depression and about 40% having Bipolar Disorder. Eating disorders are also common particularly Bulimia: Almost 25% with Bulimia also have Borderline Personality Disorder. Up to 67% of people with Borderline Personality Disorder are also diagnosed with at least one substance use disorder. People with Borderline Personality Disorder, however, tend to improve in their 30s and 40s, although they may continue to have difficulties moving into old age.

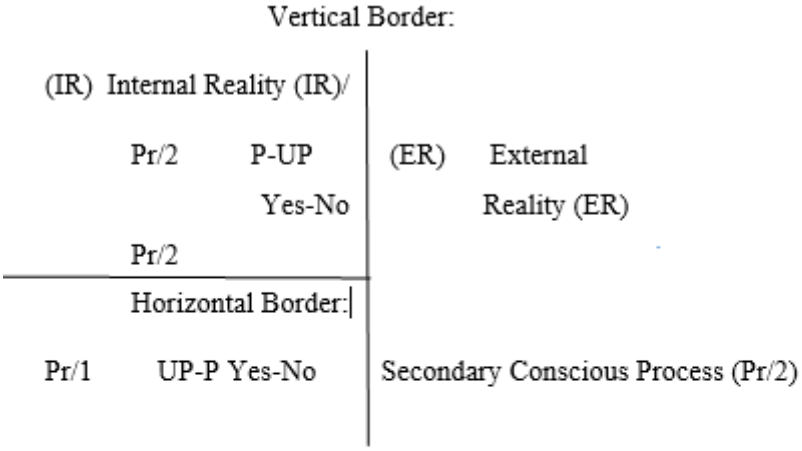
Because of substantial treatment use, people with Borderline Personality Disorder require more mental-health resources than do individuals with other psychiatric disorders.

1.2.Structural Models of BPD

1.2.1. Ego Detachment Model (Freud, Klein, Wincott, 1924)

This model states that BPD patients experience:

- Detachment of covert thoughts (sexual perversions & neurotic impulses) from external world &,
- They create a world of fantasy using symbols.



Yes [Determined by Pleasant (P)] & No [Determined by Unpleasant (UP)]

(Pr/1)

Primary Unconscious Process

*Yes-No = Inside-Outside System.

*Yes = Inside System.

[Loss of Reality & Substitutes for Reality].

1.2.2. Kernberg's Model, 1925

Structural ModelGenetic

A. Topographical Model Dynamic Model
(The overt self).

B. Hartman's Ego Psychology. A. Oral Fixation.

C. Structural derivatives of B. Pre-genital

D. Object relations.

Aggression induces premature development of Oedipal striving.

Characteristics of Borderline States:

1. Nonspecific manifestations of ego weaknesses.
2. Shift towards primary process thinking.
3. Specific defensive operations.
4. Internalization of object Relations.

1.3.Chronic Loneliness

It is the painful feeling of wanting more human contacts/connections than we have; which has lasted over a substantial period of time without showing signs of letting up. It is characterized by lack of adequate human relationships (social, emotional or both). The stereotype of a lonely person is a socially inept loser who doesn't know how to get along with others, who perhaps has little to offer to other people, who has few or no friends, and who spends most of the time alone, perhaps envying others who have friends and lovers- but recent research has begun to paint a very different picture. There are very few differences between lonely and non-lonely people. They don't differ in intelligence or attractiveness. They spend about the same amount of time interacting with other people. Thus, lonely doesn't mean alone: Loneliness is essentially independent of the quantity of relationships or social networks (Wheeler, Reis, &Nezlek, 1983).

By and large the lonely don't lack social skills, though they somehow fail to use them as much as others (they can get along well with others but they don't; Cacioppo&Hawkley, 2005). The main deficiency that has been established is that lonely people are poorer at figuring out other people's emotional states

(Pickett & Gardner, 2005). This lack of emotional sensitivity could be either a cause of loneliness (because it makes it harder to attract and keep friends), or possibly a result, or perhaps both.

Not all lonely people are the same, either. Researchers have recognized variations in loneliness. It may be quite common for people to feel temporary loneliness when they move to a new place and are separated from their friends and family. In many cases such feelings go away as soon as the person starts making more friends at the new place. Other people, however, suffer from chronic loneliness that may last for months or years. In general, when researchers speak of lonely people, they are referring to people who suffer from chronic loneliness that has lasted for a substantial period of time and is not showing signs of letting up.

These findings indicate that loneliness is much more complex than simply a failure to find other people to be with. You can be lonely living in a densely populated city like New York. You can even be lonely when married, though married people are on an average a bit less likely to be lonely than single people (Peplau& Perlman, 1982; Russell, Peplau&Cutrona, 1980). Being far from home is one strong predictor of loneliness (Cacioppo, et al, 2000), which is probably one reason that in many cultures people live their entire life close to their place of birth and are reluctant to relocate, even for a seemingly great career opportunity.

Staying close to family is one strategy that might increase perceived social acceptance, in the sense that if your family lives nearby, you have easier and readier access to some sort of social acceptance than if you live far away.

Loneliness originates in a gap between the quality of social relationships that you have with the amount or quality that you want. In principle this can be because you want a normal amount but have less than that – or because you have a normal amount and want a great deal more (Gardner, Pickett & Knowles, 2005).

In principle loneliness can also be an issue of either the quality or quantity of relationships. You might be lonely because you don't have enough contacts with others, or because the time you spend with others does not satisfies your needs. In practice, the data suggests that most loneliness stem from a lack of close, satisfying relationships. Lonely people may spend a plenty of time talking to many different people, but just talking to many different people is not good enough, and they may suffer if they feel that enough people don't care about them and want to maintain a long-term close relationship. Put another way loneliness is typically rooted in the quality rather than the quantity of social relationships (Cacioppo&Hawkley, 2005): Lonely people spend plenty of time with others, but they don't come away from these interactions feeling satisfied. To be sure, most research on loneliness has focused on people who live in large cities and universities, and people who are lonely when there are many others around who are probably suffering a lack of quality rather than quantity. Living far from others for instance, if you worked as a forest ranger in Arctic, might produce loneliness for lack of quantity of interactions. Still, in the modern world, most loneliness is linked to quality rather than the quantity of interactions.

Relationships to large groups or organizations are relevant for men, though apparently not for women. That is, a man who has no or few close friends but feels strongly but feels connected strongly to his corporation, or university, or sports team will probably not suffer from loneliness, but a women in similar circumstances will typically still feel lonely (Gardner et al.,2004).

Some people can even stave off loneliness by forming attachments to celebrities or people they see on television. Women who watch many situation comedies feel less lonely than other women who have the same number of friends and lovers but do not watch so many shows (Kanazawa, 2002). Apparently, the

televised characters come to feel like friends and family to them, especially if they watch the same shows regularly and develop feelings about the characters.

Other people fight off loneliness by forming quasi-relationships with non-human entities. For example, they might bond with a dog or a cat or treat a potted plant like a person. Some people even name their cars and treat them like family members (Gardner et al., 2005).

Loneliness takes its toll on the body. Lonely people sleep as much as non-lonely people, but the sleep is not as good or as refreshing, and they may end up feeling chronically tired. Loneliness also seems to be bad for one's physical health. Lonely people take longer than others to recover from stress, illness or injury. The poor health stems from several factors including sleep problems. A good sleep is very healthy but the poor sleep of lonely people prevents their body from getting the rest it needs. They spent the same amount of time in bed as others, but the lonely person is more prone to lie there awake or to wake up during the night (Cacioppo et al., 2002a, 2002b).

2. Literature Review:

2.1. Borderline Personality Disorder:

"The term most often is used to designate psychopathological troubles lying on the frontier between neurosis and psychosis, particularly latent schizophrenias presenting an apparent form of neurotic symptoms"(Laplanche and Pontalis, 1967).

"Borderline is a line of demarcation; but as per clinical experience, the border of insanity is not a line, it's rather a vast territory with no sharp diversions: a no man's land between sanity and insanity" (Oxford English Dictionary; Burchfield, 1972).

2.2. Chronic Loneliness

It refers to strong subjective feeling of isolation, disorientation, "lostness", aloneness; as well as hollow and empty states that leads to a strong desire for friends (groups) or intense one-on-one relationships (Francis, 1976; Younger, 1995; Portnoff, 1998; Ryan & Patterson, 1987; Austin, 1989).

Loneliness includes the subjectivity of the experience, uneasy feelings and distress, and perceptions of deficiencies in one's social relations. (Perlman &Peplau, 1981; Rubenstein & Shaver, 1982; Weiss, 1973, 1982).

2.2.1. Types of Loneliness:

+ Existential: Inborn in human beings, not related to life circumstances.
+ Pathological: Dysfunctional cognitions, affective states and psychosis.
+ Psychosocial/Ordinary/Social: Due to situational changes.

[Austin, 1989; Francis, 1976; Carr &Schellenbech, 1993].

2.2.2. Approaches to Loneliness:

Two approaches have been most dominant in conceptualizing loneliness: the attachment-cognitive approach (Bell & Gonzalez, 1988; Cramer, Ofuso, & Barry, 2000; de Jong-Gierveld, 1987, 1989; DiTommaso& Spinner, 1993, 1997; Milkulincer& Segal, 1990; Peplau& Perlman, 1982; Russell, Cutrona, Rose, &Yurko, 1984; Schmidt &Sermat, 1983; Weiss, 1973), and the temporal approach (Beck & Young, 1978; Canary &Spitzberg, 1993; de Jong-Gierveld, 1987; Rotenberg, 1998).

The Attachment-Cognitive Approach

Scholars employing the attachment approach to the study of loneliness have proposed that loneliness originates from a person's feeling a lack of strong, intimate bonds with significant others (Bowlby,

1973; Weiss, 1973). People develop psychological bonds with a number of significant others at various life stages and feel secure when these bonds remain intact. The rupture of these bonds causes intense emotional loneliness. Such emotional loneliness may lead to social loneliness because the disruption of intimate bonds is often accompanied by a change in social roles, which disturbs a person's social networks (Parkes, 1973; Weiss, 1973).

Emotional loneliness refers to the loneliness resulting from a lack of intimate relationships (Russell et al., 1984; Weiss, 1973); this void cannot be mended by increasing the quantity of social relations (de Jong-Gierveld&Raadschelders, 1982). Social loneliness refers to a perceived deficiency in social networks, or a lack of general social relations or social activities (Russell et al., 1984; Weiss, 1973). Loneliness of this type may be dealt with by increasing one's social networks and social activities.

Building on the attachment perspective, scholars (e.g., de Jong-Gierveld, 1987 ;Peplau, Miceli, &Morasch, 1982; Peplau& Perlman, 1982; Russell et al., 1984) have specified a threshold for experiencing loneliness. Loneliness is experienced when an individual's level of achieved social attachments are fewer than those desired. These social attachments may be associated with the extensivity of social relations (i.e., social loneliness) or the intensity of social relations (i.e., emotional loneliness). As compared with social loneliness, emotional loneliness is more lasting and disturbing (Weiss, 1973). In a meta-analysis of 182 studies on loneliness in older adults, Pinquart and So¨rensen (2001) found that a perceived lack of quality relationships is more closely related to loneliness than is the number of social relationships.

Various subcategories of emotional loneliness and social loneliness have been proposed. Schmidt and Sermat (1983) discriminated among family loneliness and romantic-sexual loneliness (subtypes of emotional loneliness), and loneliness in groups and friendship loneliness (subtypes of social loneliness). DiTommaso and Spinner (1993, 1997), Cramer and Barry (1999), and Cramer et al. (2000), seeking to operationalize the various types of loneliness, found that three types of loneliness (family loneliness, romantic loneliness, and social loneliness) capture the previous subcategories of emotional and social loneliness. Family loneliness (detachment or abandonment from family relations) and romantic loneliness (lacking romantic relations) are subcategories of emotional loneliness; they are similar in that they indicate a lack of intimate bonds, but they are dissimilar in that their sources and durations differ. Social loneliness occurs when a person feels that he or she has too few relations with other individuals or with the community at large (see DiTommaso& Spinner, 1993).

Although the attachment-cognitive approach has differentiated the sources of loneliness, the acute versus chronic aspect of loneliness is not taken into account by this approach. Those employing a temporal approach discuss this aspect of loneliness.

The Temporal Approach

Beck and Young (1978) differentiated between types of loneliness from a temporal perspective. They identified three types: chronic loneliness, which refers to loneliness that comes from the failure to establish satisfactory social relationships over years; situational loneliness, which refers to loneliness caused by unexpected negative events; and transient loneliness, which refers to momentary feelings of emptiness that is experienced occasionally.

Chronic loneliness (Beck & Young, 1978) is associated with enduring dissatisfaction with close or social relationships, perception of abandonment, or withdrawal from interpersonal communication (de Jong-Gierveld, 1989; Schultz & Moore, 1988). A family misfortune, such as a parental divorce or an

irresolvable conflict, contributes to children's developing feelings of loneliness that may endure into adulthood (Jones, 1992).

Situational loneliness (Beck & Young, 1978) results from traumatic experiences such as the death of a loved one or major negative changes in one's status. Bell and Gonzalez (1988) found that stress caused by negative life events moderates the relationship between perceived insufficiency in social relations and loneliness. Dykstra et al. (2005) conducted a seven-year longitudinal study of changes in loneliness among older adults and found the strongest increase in loneliness for those who lost a partner.

Transient loneliness (Beck & Young, 1978), that is, momentary feelings of emptiness, is universally experienced. For example, after a major accomplishment, a person may experience happiness and relief but also a sense of fleeting emptiness. Another example of transient loneliness is that experienced after leaving a meeting with a group (such as a reunion) or with one other—as Juliet says, ''Parting is such sweet sorrow'' (Shakespeare, 1595=2004).

Beck and Young (1978) differentiated transient loneliness from situational loneliness and chronic loneliness: Transient loneliness is ephemeral, commonly experienced, leaving as quickly as it arrives; chronic loneliness tends to be associated with a constant perception of abandonment and dissatisfaction in social contact; and situational loneliness may at times be more severe and stressful than either of the former two types of loneliness.

(Wang, Q., Fink, E. L. &Cai, D. A., 2008)

2.3. Background Research Findings:

"Chronic feelings of Emptiness", the 7th Diagnostic Criteria for Borderline Patients (as per DSM-5), is characterized by:

+ Affect states that predetermine self-injurious behavior and,

+ Other key non-psychiatric variables in non-clinical setting. One such variable identified was **"Lonely".**

(Klonsky, E. D., 2008)

Moreover, emptiness is also used by Borderline patients to deal with their disturbances in affect, cognitions, object relations, disturbed bodily experiences and lonely states. (Lafarge, L., 2015).

Evidence suggest that, this emptiness can also be a result of **emotional confusion in BPD patients.** As analyzed by Ebner-Priemer, Welch, et al. (2007) the occurrence of complex emotions and problems in identifying emotions. Compared to HCs, BPD patients reported more complex emotions (i.e., emotional responses consisting of more than one emotion simultaneously) and in particular more negative secondary emotions. Furthermore, the authors found some evidence for a more pronounced inability to identify and name emotions in those BPD patients investigated before starting dialectical behavior therapy treatment (DBT; Linehan, 1993) compared to BPD patients examined during ongoing DBT treatment and compared to HCs. This is consistent because a main target in DBT is teaching BPD patients to identify and name their emotions. In addition, Ebner-Priemer et al. (2008) addressed the relationship between psychological distress and inability to label emotions as well as the experience of complex emotions. Multilevel model analyses revealed that problems in identifying emotions and the occurrence of complex emotions are both related to heightened psychological distress in patients with BPD. However, no conclusion regarding the direction of this relationship can be made. It remains unclear whether the inability to identify and label emotions triggers distress, or whether experiencing distress impairs the ability to label emotions. In addition, Wolff et al. (2007) revealed that difficulties in

identifying emotions were significantly associated with tension intensity at a preceding assessment point (even though the correlation was very low); that is, the lower the intensity of distress, the better the ability to identify emotions 1 hour later. Contrary to the expectations, no association between the level of emotion identification and the intensity of distress 1 hour later could be found, indicating that a momentary increased ability to identify emotions does not influence later distress. However, a sampling interval of 1 hour might fail to capture rapid effects.

Suicidal tendencies is also a characteristic feature of BPD patients. 50% of BPD patients have committed at least one severe attempt of BPD and among patients with this symptom, at least three lifetime suicide attempts have been documented. The most significant link between suicide and BPD have been the repeated instances of self-injury characterized by this disorder.

Another mechanism connecting BPD to suicidality, may be emotional dysregulation. When people with BPD engage in self-harming behaviors, they donot actually intend to die; rather, they are attempting to regulate their emotions.

(Joiner T. E., Brown, J. S. & Wingate L. R.)

There have been little empirical research regarding identity disturbances, confusions and emptiness in BPD patients. Some of the researches which tried to highlight these concepts are as follows.

+ Comparison of BPD and other clinically diagnosed disorder patients on the basis of unique disruption as a part of identity experiences. (Jorgensen, 2009; Wilkinson-Ryan &Westen, 2000). They found four areas of differences between identity disturbances among BPD patients and other Clinically Disordered patients.

+ McAdams in 2001used **Conceptualization of Narrative Identity** to differentiate the identity disturbances faced by BPD patients and Normal Identity Development as proposed by Erik Erikson (1959).

3. Methodology:

3.1. Subjects:

The subjects for the study were clients diagnosed with Borderline Personality Disorder (BPD), from Mental Institutes like Chaitanya Institute for Mental Health, Pune, TezpurMental Hospital, Assam and GNRC Hospital, Assam. Even the files of the Ex-clients with BPD in these institutes were also be studied.

3.2. Study Design & Procedure:

Use of Qualitative Research Method:

Qualitative methodology suited this study because of the lack of empirical knowledge on Emptiness and Loneliness in BPD literature. In general, qualitative methodology is the appropriate scientific method for describing, understanding, and interpreting complex phenomena of psychosocial or psychological nature which have not yet been explored. Qualitative research follows an idiographic scientific approach with a variety of methods. The methods used in this study employ a descriptive-interpretative approach.

Qualitative research underlies special evaluation criteria, analogous to those of validity and reliability in quantitative research. Scientific rigor is attained by techniques such as: purposeful sampling, combination of analysis methods and the researcher's field experience, and is measured by criteria such as: presence of the participant's perspective; clarification of the study context; demonstration of relation between data and results; conceptual density of emerging categories, success of communicating the results, originality and contribution to scientific knowledge. Findings are not expected to be statistically

projectable to a wider population, but can lead to context-dependent generalizations or generalizations to a broader theory. The persons involved in a studied phenomenon (i.e., clinicians) profit from the findings by a better understanding of the field and individual cases, and can make predictions about similar cases (Elliott, Fischer, &Rennie, 1999).

The data for this study were initially collected in conjunction with an ongoing prospective investigation of personality disorders (Oltmanns& Gleason, 2011, for a detailed description of study methods, including participant recruitment and retention). From a small sample (36 patients), epidemiologically-representative, community-based sample, every participant meeting or exceeding three diagnostic criteria for BPD (as assessed through Content Analysis andSemi-Structured Interview) as par DSM-5 Personality (Pfohl, Blum, & Zimmerman, 1997) was identified. The appropriate diagnostic threshold for BPD is the subject of significant scholarly debate, with taxometric analyses indicating that the disorder is best conceived along a dimensional spectrum (e.g., Rothschild, Cleland, Halsam, & Zimmerman, 2003). Clifton and Pilknois (2007) suggested that a threshold of three BPD criteria represents a cut-off score with clinical importance. Certainly individuals meeting this number of criteria have been observed to experience significant and clinically relevant dysfunction (e.g., Clifton &Pilknois, 2007; Oltmanns& Gleason, 2011; Powers &Oltmanns, in press).

Although there was a limited population from which the present sample was drawn it is still a prospective investigation, and in light of the documented relationship between BPD and other important outcomes (e.g., Paris, 2007; Powers &Oltmanns, in press), it was possible to include data from follow-up assessments of a range of outcomes in our analyses. At both one month and two months after the baseline assessment (when the Life Story Interview was recorded). In the follow-ups however, the type of information gathered was related more to their types of negative moods, primary relationship quality and subjective perceptions of personal health. Due to lack of mobility however, these follow-ups could be conducted upon three patients only.

Four research assistants were involved, along with the Researcher and his guide, in developing the thematic units for the comparison tables through several meetings. Two of them had been involved in conducting the interviews. All disagreements were considered and discussed until the Researcher's consent was achieved.

In a second analysis stage, grounded theory coding methods were used, one of the best known qualitative research strategies (Strauss & Corbin, 1990). To enhance the level of abstraction of the patients' statements and to make meanings more explicit, codes are created in interaction with the data-text. In this way, we redefining data meanings and development of various categories were done. This kind of analysis is a cyclical process. The Researcher went through the different analysis stages several times, dropping a category or code if a more useful one was emerging (Strauss & Corbin, 1990). Ultimately, he aimed at the emergence of a complex category system. The following five categories were finally analyzed: 1. Decide level of analysis. 2. Decide how many concepts to code for. 3. Decide whether to code for existence or frequency. 4. Decide on how you will distinguish among concepts. 5. Develop rules for coding your text.

This analysis was repeated by two of the research assistants to ensure reliability. The Researcher used his expertise in analysis for the discussion of a series of cases, with his Guide and conducted the second analysis stage.

For the data collection from Borderline Patients two different approaches were used:

3.2.1. Quantitative Content Analysis (using Thematic/Conceptual Procedure)–

It was done of the information obtained from the psychiatric files of the clients.

The following steps were followed:

1. Decide level of analysis.
2. Decide how many concepts to code for.
3. Decide whether to code for existence or frequency.
4. Decide on how you will distinguish among concepts.
5. Develop rules for coding your text.
6. Decide on what to do with the irrelevant information.
7. Code the text.
8. Analyze your results.

Here, Loneliness was chosen as the concept whose presence was quantified by tallying its presence in the form of frequencies.A systematic search of the literature published related to Loneliness as a theoretical framework was conducted using Google Scholar, Medline, Proquest, Psyinfo, Social Science citation index, Sociological abstracts, and Web of Science. Studies were included in the review if they met the following criteria: (1) They had a statistically significant correlation with Loneliness, (2) They were all psycho-social factors that could exist under any cultural context, (3) included men, women or children of various age groups in data collection. Following were the exclusion reasons: (1) no variable that was associated with other disorders like mood disorders, anxiety disorders, etc.; were used for data collection and/or analysis, (2) Synonyms of Loneliness were avoided as much as possible.

Thus, after careful and specific Review of Literature, concepts related to Lonelinesswere taken into account with respect to their correlations with it. 12 Different concepts were chosen for the analysis including loneliness from the psychiatric files and other written data available. Scores were expected to be obtained for each variable with respect to their correlation with loneliness. These scores were then multiplied with the frequencies (number of times these variables were found in the psychiatric files) to obtain an overall score of that concept. The concept scores of all the variables were summed up to get the overall raw score of each subject.

The variables chosen for the study are Loneliness, negative self-concept, self-dissatisfaction, negative personal self, negative behavior, neurosis, psychosis, attention seeking, low self-esteem, anxiety, depression and social isolation.

3.2.2. Semi-Structured Interview Pattern –

Data was collected by individual, focused interviews. An interview guide was used, focusing on the following areas: (1) Experiences of symptoms, suffering and life situation before and after diagnosis. (2) If and in what way the therapeutic interventions has had impact on their suffering and life situation? (3) Their perceptions and interactions with other individuals around them. (4) Their relationships with (significant) others pre and post-diagnosis. The interview guide was used freely allowing the respondents to narrate experiences in their own words.

Questions were asked using a funnel approach starting with quite wide, open ended questions such as: “How much do you enjoy this place?,” “What was your life situation like before coming here?,” “What is your life situation like today?,” followed by more specific and personal questions, like: “How many friends do you have here?” and “Do you like company of others?”, “Do you have healthy relationships with your family?”

Background data concerning socio-demographic variables and symptoms were collected from the patients' psychiatric files, to cross-check.

A sort of interview schedule was prepared for the interview, where questions were quite flexible and not properly structured or ordered. The schedule consisted of 15 questions out of which the first 8 were asked to the Borderline Patients and the rest 7 were asked to the staff, psychiatrists, therapists who have dealt with these patients. A Marathi and Assamese version of the Interview Schedule were also standardized.

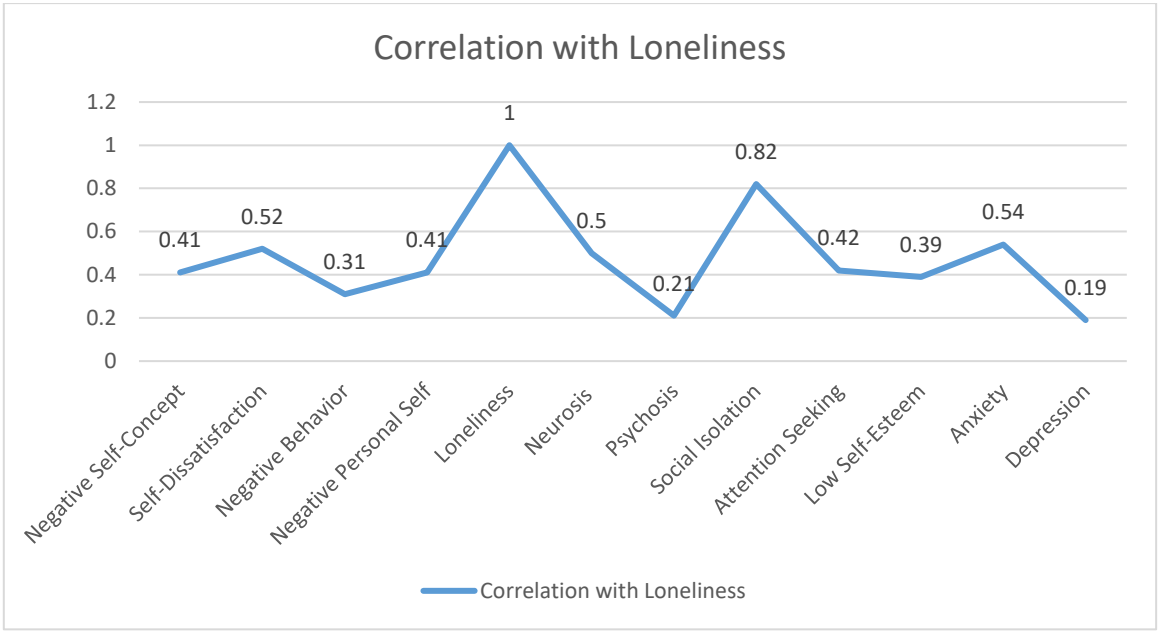
3.3. Scoring Patterns of the Responses:

3.3.1. Quantitative Content Analysis:

The marking pattern for each variable with respect to its correlation with loneliness is as follows:

Correlational Coefficient (r) of the concept with Loneliness	Scores assigned for each presence (S)
0.0-0.09	0
0.1-0.19	1
0.2-0.29	2
0.3-0.39	3
0.4-0.49	4
0.5-0.59	5
0.6-0.69	6
0.7-0.79	7
0.8-0.89	8
0.9-0.99	9

Table- 1



Graph- 1

After that, these assigned scores (S) were multiplied with frequencies of presence of the respective variable in the patients' psychiatric files to obtain the Variable Score (VS). Then the sum of all the (VS) were calculated to find the overall raw score of each patient.

3.3.2. Semi-Structured Interview:

Two types of rating systems were used to rate the responses to the questions:

Pattern-A Rating System:

This system involves questions that may have responses ranging from exact expected responses to not at all expected responses, with respect to the interviewer. Questions 1, 2, 4, 5, 8, 9, 10, 11 and 14 fall under this pattern. The marking scheme for each type of response is:

Type of Response Given	Scores Allotted
Exact Expected	3
More or less Expected	2
Less Expected	1
Not at all Expected	0

Table- 2

Pattern-B Rating System:

This system involves questions that either have a desired response or an undesired response, with respect to the interviewer. Questions 3, 6, 7, 12, 13 and 15 fall under this pattern. The marking scheme for both type of responses is:

Desired Option	Undesired Option	Scores Allotted
Completely Agree	Completely Disagree	3
Completely Disagree	Completely Agree	0
Don't Agree	Don't Agree	2
Agree	Agree	2
Prefers More	Prefers Less	1
Prefers Less	Prefers More	0

Table 3

3.4. Interpretation of Scores:

Range of Scores	Accessibility of Data based onearlier Literature	Level of Loneliness
0-9	It indicates **no assessment** of the term loneliness directly. The presence of other related variables are also **not conclusive** enough and/or correlated with loneliness to predict its level of impact.	Low levels of Loneliness.
10-19	It indicates **rare** assessment of the term loneliness directly. The presence of other related variables are **supportive** but **not definitive**. Thus the impact of loneliness is **partially predicted.**	Average levels of Loneliness.

20-29	It indicates **substantial** assessment of the term loneliness directly. The presence of other related variables also provide **conclusive evidence** to predict the impact of loneliness **demonstratively**.	High levels of Loneliness.
30 and above	It indicates **very frequent** assessment of the term loneliness directly. The presence of other related variables are also very high, indicating a **massive impact** of loneliness.	Very high levels of Loneliness.

Table- 4

Moreover, to add on; information regarding **Emptiness** (one of the diagnostic criterias of these patients) were also obtained; which is directly correlated to loneliness

4. Results& Discussions:

A sample of Thirty-six Borderline Personality Disorder Patients were observed for the study. It was found that, 50% of the subjects in the study indicated average levels of Loneliness (getting scores between 10-20). Associations between BPD criterias and loneliness were found to be high in 30.56% of the sample population. However, very few subjects fell under low and very high levels of loneliness including only 8.33% and 11.11% respectively, from the sample population.Theseare indicated in Table 5.

SERIAL NUMBER OF PATIENTS	TOTAL SCORES ALLOTTED	INTERPRETATION OF SCORES	VARIABLES OBSERVED
1	14	Average level of Loneliness	Anxiety, depression
2	11	Average level of Loneliness	Anxiety, depression
3	24	High level of Loneliness	Anxiety, depression, helplessness, loneliness
4	16	Average Level of	Anxiety, depression

		Loneliness	
5	24	High level of Loneliness	Anxiety, depression, negative behaviors
6	26	High level of Loneliness	Anxiety, depression, negative behaviors
7	19	Average level of Loneliness	Anxiety, depression, negative behaviors
8	20	High level of Loneliness	Anxiety, depression, neurosis
9	12	Average level of Loneliness	Anxiety, depression
10	13	Average level of Loneliness	Anxiety, depression, psychosis, negative behaviors
11	14	Average level of Loneliness	Anxiety, neurosis, social isolation
12	13	Average level of Loneliness	Anxiety, psychosis, depression
13	34	Very High level of Loneliness	Anxiety, loneliness, depression, negative behavior, neurosis
14	24	High level of Loneliness	Depression, anxiety
15	23	High level of loneliness	Depression, anxiety, negative behaviors
16	38	Very High level of Loneliness	Negative behaviors, anxiety, depression, neurosis, emptiness*
17	19	Average level of Loneliness	Negative behaviors, anxiety, depression
18	24	High level of Loneliness	Depression, anxiety, negative behaviors
19	21	High level of Loneliness	Negative behaviors, anxiety, depression, loneliness
20	23	High level of Loneliness	Anxiety, depression
21	17	Average level of Loneliness	Depression, anxiety
22	14	Average level of Loneliness	Depression, anxiety, negative behaviors.
23	15	Average level of	Depression, anxiety,

		Loneliness	neurosis
24	12	Average level of Loneliness	Loneliness, attention-seeking
25	9	Low level of Loneliness	Attention-seeking, neurosis
26	10	Average level of Loneliness	Attention-seeking, depression
27	9	Low level of Loneliness	Attention-seeking, anxiety
28	24	High level of Loneliness	Attention-seeking, neurosis, anxiety, loneliness
29	14	Average level of loneliness	Attention-seeking, anxiety
30	15	Average level of Loneliness	Attention-seeking, anxiety,
31	10	Average level of Loneliness	Attention-seeking, depression
32	9	Low level of Loneliness	Attention-seeking, neurosis, psychosis
33	12	Average level of Loneliness	Attention-seeking, psychosis, negative behaviors
34	24	High level of Loneliness	Psychosis, depression, anxiety, attention-seeking
35	91	Very High level of Loneliness	Psychosis, attention-seeking, anxiety, depression, neurosis, negative behaviors, social isolation, emptiness*
36	151	Very High level of Loneliness	Loneliness, anxiety, depression, negative behaviors, attention–seeking, low self-esteem, emptiness*

*Emptiness is one of the Diagnostic Criterias under DSM- 5 & ICD- 10, for BPD

Table- 5

After analyzing the loneliness variable in them through the given Methodology; the Mean (M) of scores was found to be 23.56, whereas the Standard Deviation (SD) was 25.27. Both these values fall under “High Levels of Loneliness” as per Table 4. This indicates that although Borderline patients are, at an

average, high in Loneliness; there is, at the same time, high levels of fluctuations within the sample population regarding this criteria. This fluctuation is mainly due to excessive high scores obtained by couple of patients. However, the scoring and interpretation weren't affected by these scores since, any score above thirty was considered "Very High Level of Loneliness". (Table- 4)

Still, the Mean (M), in this research, is a reliable statistical tool for predicting loneliness in BPD patients, unlike Standard Deviation (SD). Thus, a Mean (M) of 23.56 clearly shows that most of the BPD patients from the sample size have a "High Level of Loneliness".

Results of Follow-up Assessments:

A follow-up assessment was conducted upon the 34th, 35th and 36th patient, as per table- 5, 74 days after the data collection. Its results were found similar to the earlier investigation. For instance, on both occasions all three of the patients found it difficult to connect to other individuals in terms of framing conversations and making friends. Their overall dissatisfaction with their lives were also highlighted on both the occasions. However, there were a few miss-matches too, for instance, their responses regarding their relationships with their family members varied a bit. Still the responses through the follow-ups yielded enough evidence to justify the accuracy of the interviews. It also verified the authenticity of the responses and also showed that the patients weren't under any medicinal or therapeutic influence while giving their responses.

5. Conclusions & Applications:

Two sets of analysis were used to clarify the meaning and impact of loneliness in BPD patients. In Analysis- 1, key psychiatric variables highly co-related and associated with Loneliness were assessed using the given Methodology. These terms were then scored, interpreted and analyzed to give a rating of the patients' loneliness states; through a method called **Content Analysis using Thematic Procedure.** In addition to that, in Analysis- 2, a **Semi-structured Interview** was conducted on these subjects, regarding their lonely states. The scoring and interpretations of the interview responses were also done using the given methodology. Finally, the scores of Analysis- 1 and Analysis- 2 were added to give a total score of loneliness to each subject.

This study is based upon past literatures and data which reveal that loneliness as a concept has always been associated with Borderline Personality Disorders; but its relationship and impact within this disorder was very vaguely studied. So the primary aim of this research is to establish loneliness as one of the determining factors for occurrence of BPD. Eventually, this link was established as most of the Borderline subjects were assessed to have **"High Levels of Loneliness"**; shown by the Mean (M) of scores obtained by the subjects (23.56), which fell under high levels of loneliness as per the rating system, constructed by the researcher.

This study also highlights the impacts of childhood relations and experiences along with human connections [Social & Emotional Loneliness; Schmidt and Sermat (1983)]. It is also evident in the study of pathological impacts of improper attachments and parenting styles.

6. Limitations:

This study has some important limitations which may have hampered its results:

1. It doesn't try to establish any sort of Cause-Effect relationships between Loneliness and BPD. It only talks about loneliness as a predicting or determining factor in BPD.

2. It claims to make a global assessment of Loneliness but, uses only a limited number of variables to assess the concept.
3. It doesn't use any established or objective tool in measuring loneliness. Thus, scoring and interpretations in this study are subjective and elaborative.
4. The study also over-emphasizes on past literature and data to make generalizations and interpretations.
5. The Follow-up assessments weren't conducted over all the patients due to mobility and distance issues. Thus, the sample size of the follow-ups were too small, to verify the data collected through the Semi-Structured Interviews.

REFERENCES:

1. Barlow, D. H. & Durand, V. M. (2017). *Abnormal Psychology: An Integrative Approach.* CENGAGE Learning: Florida, United States of America.
2. Baumeister, R. F. & Bushman, B. J. (2008). *Social Psychology and Human Nature.* Wadsworth: Thomson Publication.
3. Bekhet, A. K.; Zauszniwski, J. A. &Nakhla, W. E. (2008). *Loneliness: A Concept Analysis*. Journal Compilation: Wiley Periodicals, Inc.
4. Cacioppo, J. T. &Hawkley, L. C. (2005). *The Anatomy of Loneliness*. Chicago, Illinois USA: Ohio State University.
5. Ellison, W. D.; Rosenstein, L.; Chelminski, I.; Dalrymple, K. & Zimmerman, M. (2015). *The Clinical Significance of Single Feature of Borderline Personality Disorder*. Psychology Department: Trinity University.
6. Joiner, T. E.; Brown, J. S.; Wingate, L. R. (2005). *The Psychology and Neurobiology of Suicidal Behavior.* Tallahassee, Florida: Annual Review of Psychology; Pro-Quest Central.
7. Klonsky, E. D. (2008). *What is Emptiness? Clarifying the 7th Diagnostic Criteria of Borderline Personality Disorder*. Guilford Press: Journal of Personality Disorders.
8. Russell, D., Peplau, L. A. &Cutrona, C. E. "*The Revised UCLA Loneliness Scale: Concurrent and Discriminant Validity Evidence".* Journal of Personality and Social Psychology: American Psychological Association, Inc. USA.
9. Wang, Q.; Fink, E. L. &Cai, D. A. (2008). *Loneliness, Gender and Parasocial Interaction.* Eastern Communication Association: Routledge.

BIBLIOGRAPHY:

1. Dammann, G., Hugli, C. &Selinger, J. (2011). "*The self-image in Borderine Personality Disorder: An in-depth qualitative Research Study".* Journal of Personality Disorders: The Guilford Press, US.
2. Adler, J. M., Chin, E. D., Kolisetty, A. P. &Oltmanns, T. F. (2012). *"The distinguishing characteristics of narrative identity in adults with features of Borderline Personality Disorder: An Empirical Investigation".* Journal of Personality Disorders: The Guilford Press, US.
3. Santangelo, P., Bohus, M. &Ebner-Priemer, U. B. (2014). "*ECOLOGICAL MOMENTARY ASSESSMENT IN BORDERLINE PERSONALITY DISORDER: A REVIEW OF RECENT FINDINGS AND METHODOLOGICAL CHALLENGES".* Journal of Personality Disorders: Guilford Press, US.
4. Perseius, K. I., O'Jehagen, A. &Ekdahl, S. (2003). *Treatment of suicide and deliberate self-harming patients with Borderline Personality Disorder using Dilectical Behavioral Therapy: The Patients'*

and the Therapists' perceptions". Elsevier Inc: Washington.

5. Iwelunmor, J., Newsome, V. &Airhihenbuwa, O. (2014). "*Framing the Impact of Culture on Health: A systematic review of Public health researches and interventions".* Informa, Ltd: Routledge, England and Wales.