 http://doi.org/10.18231/j.tjp.2020.036

Ethnoreligious identity conflict in a Malaysian patient with borderline personality disorder, a psychodynamic psychotherapy case report

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Abstract
Borderline Personality Disorder is a heterogeneous disorder involving mood dysregulation, impulse control, interpersonal relationships and identity. The feature of identity confusion can become complicated in a society with multiple ethnoreligious backgrounds, including Malaysia. This case report describes a 24-year-old Malay Muslim lady with Borderline Personality Disorder and persistent depressive disorder who struggled with her identity due to the mixed ethnicity of her parenthood. The patient achieved full functional recovery after undergoing 15 sessions of Psychodynamic Psychotherapy, which helped her to resolve her identity confusion. The dynamic of identity disturbances was discussed from the perspective of psychodynamic interpretation.

Keywords: Identity confusion, Ethnoreligious, Multi-culture, Borderline personality disorder, Psychodynamic.

Introduction
Borderline personality disorder is a heterogeneous mental disorder characterized by a pervasive pattern of instability in affect regulation, impulse control, interpersonal relationships, and self-image. Epidemiologically, this disorder affects 6% of the general population, with a prevalence of 10% of psychiatric outpatients, 20% of inpatients and 5.9% of individuals do not seek psychiatric help.[1] This poses significant burdens to the healthcare system as they are associated with severe psychosocial impairment and comorbidities.[1] Traditionally, borderline personality disorder has been seen as a chronic condition with poor prognosis, however, recent studies have shown that the understanding and treatment of this personality has significantly improved and thoroughly researched, giving hope to clients suffering from this illness.[1,2] There are many therapies dedicated for the treatment of borderline personality disorder, each having its theoretical framework, however, there is little empirical guidance to show that one therapy is superior to the other.[2]

Other components of borderline personality disorder (e.g. affective dysregulation) has been frequently studied.[2] Identity disturbance, however, can be tricky in regards to management especially in a society with various ethnic, cultural, and religious backgrounds. An individual's identity is linked to religion, ethnic and family identity.[3] To date, there is limited literature examining the influence of multicultural family background in the identity conflict of borderline personality disorder. This case report discussed the challenges faced by this patient on her ethnoreligious identity which had influenced her psychodynamic treatment direction.

Case Report
AD was a 24-year-old married lady with no family history of mental illness. She presented to the psychiatric clinic after accidentally injuring her husband during a self-harming attempt. AD suffered from chronic low mood and irritability since young, associated with occasional fatigue, insomnia, hopelessness and low self-esteem. In addition to that, since her childhood AD had been struggling with her identity, chronic feelings of emptiness, regular anger outburst, and difficulty in managing her emotion. She had been impulsive in different aspects of her life, including spending, together with repetitive self-injurious behaviour as a mechanism to physicalize her emotional pain with occasional suicidal ideation under stress. Her interpersonal relationship had been turbulent, which was reflected by her struggle with two of her past romantic but abusive relationships. There was an intense fear of abandonment in her. There were no features of bipolar disorder, psychosis or substance abuse.

AD is the eldest in her family. She had a poor relationship with her father compared to her mother. She felt her father favoured her younger sister and siblings. Her feelings of jealousy and resentment intensified when she noticed her father played with her younger sister but not her. During her primary school days, the only way she could get her father's attention was when she scored a few distinctions for her examinations to which she was rewarded with material things. She became rebellious during her secondary school days, e.g. selling pornographic material in the school. However, when caught by the school authorities, her father just scolded her and told her that she was a disappointment to him and their cultural values. It was then that she had feelings of chronic emptiness and would impulsively cut her left wrist to release the tension and feel the pain. The sense of hopelessness was always lingering around and this made her felt like "a piece of trash". Although she had occasional thoughts of passive death wish whenever she was under stress, there was no suicidal attempt thus far. She struggled with her body image during the college days where her BMI dropped from 35 to 17 within a year through chaotic food intake, including binging, purging and calorie restriction,

which required three dietitians to help her to acknowledge her eating problem. She was enthusiastic in extreme sports as she enjoyed the adrenaline rush.

Her first two relationships with her boyfriends were short-term but abusive. Each relationship was volatile, filled with trust issues and anger. While in these relationships, she remembers having screaming matches, and always fighting with them. Feeling numb, she would impulsively cut her left wrist to release the stress to 'feel' the pain. Her boyfriends were never faithful while having relationships with other women. Her father disapproved of the relationships, however, she pursued the relationships because she feared her boyfriends would abandon her. Her friends had to convince her to leave these men because she frequently sought medical attention for the abuse from the emergency department. Her third boyfriend, her current husband, was someone she impulsively married because she described him as dependable, stable, mature and 'perfect for her'. He is a personal trainer, eight years older than her. In the early months of her marriage, she said the union was 'magical', however, later on, they started having occasional arguments over finances. She admitted hitting him a few times but he will not retaliate back which frustrated her. The fights would escalate into a fistfight involving knives due to her perceived lack of attention from her husband. She would accuse him of having extramarital relationships despite there being no evidence of such. Her husband reported several instances where verbal argument rapidly escalated to her grabbing a knife to cut herself. After the fight, she would go out with her friends for alcoholic drinks and come back home intoxicated. Her husband, fortunately, remained supportive of her despite all the incidents because they would patch up after the fights.

Another major concern of AD's was her ethnoreligious identity conflict. Her mother is an ethnic Chinese Buddhist Malaysian who converted to Islam after being adopted by an influential Malay Muslim family as part of the legal requirement. Her father is an ethnically Malay Muslim man from a religious and orthodox Muslim family, who admonishes her for not following the religion seriously. Despite her official identity under the Malaysian constitution as a Malay Muslim following her father's ethnicity, she struggled with the identity of being a Malay and a Muslim. She identified better with her mother's Chinese ethnicity, i.e. a Chinese and a free thinker. Her dissatisfaction with the Malay Muslim culture and religion intensifies her dissonance in conforming to them which could not be expressed freely in her family. The struggle became more prominent as she got older and it became friction between her and her father's family conservative approach and her perception that they forced their values onto her.

Physical examinations were unremarkable other than multiple healing laceration wounds over her left wrist. Blood investigations revealed no significant abnormality. She was diagnosed with persistent depressive disorder (PDD) and borderline personality disorder based on DSM-5 criteria, with a probable diagnosis of anorexia nervosa in the past.

She was psychological-minded and motivated to make a change in her life. Her ego-strength was adequate and there was no issue with reality testing. Her Clinical Global Impression scale (CGI) for severity (CGI-S) on the first visit was 4 (Moderately ill).

Formulation and Treatment Plan

AD was prescribed tablet Sertraline 50 mg daily. As part of the psychosocial intervention for AD, collateral history from another family member other than the husband would help in the process of assessment and treatment of borderline personality disorder. Nevertheless, the AD has full capacity and she refused to consent to involve other family members except for her husband.

Short-term psychodynamic psychotherapy (STPP-15 sessions) was started to help her to address her identity issue, improve her relationship with her family, and dealing with her maladaptive defense mechanism. The STPP was constructed in three stages: the first five sessions were induction stage, the middle five sessions were core reflective stage, and the last five sessions were the termination stage.

AD's major conflicts were her conscious awareness of feelings of anger, hatred and jealousy towards family towards her father and her siblings, which included her unconscious wish for absolute love, acceptance and recognition from father and most importantly in terms of her identity, she was lost to where she fitted in. She felt she did not fit in as a Malay.

AD had the following defence mechanism:

1. Splitting (e.g. my mother is 'good', father and sister are 'bad', ex-boyfriends are 'bad, my husband is 'good')
2. Acting out (e.g. being rebellious to get her father's attention and love. There was also the learned behaviour of cutting herself and harming herself when she stressed)
3. Sublimation (e.g. when stressed, she tends to exercise or do extreme sports).

Course of Therapy

'I am not a normal Malay girl', was how AD described herself at the beginning of the session. She wanted to learn about other religions, not just about Islam. In school, she felt uncomfortable wearing a hijab, *baju kurung* (traditional Malay lady clothing) as it was the mandatory uniform for Muslim secondary school girls. Her parents would expect her to be decently dressed and fully covered up by not exposing her *aurat* (private parts as stipulated in the Quran). She considered herself the black sheep of the family. *'I drink wine and celebrate all festivals'.* She identified more with her mother-in-law, a Muslim convert who did not actively practice her religion. *'Her religious status in the identification card is documented as Muslim. But she does not follow'.* Her father's conservative family has always looked down upon her; *'My father's family, they always put me down. Call me the rebellious girl. They cannot accept*

who I am. They want me to be more conservative'. Her cousins would complain to her father about her dressing and she would get scolded by her parents about how she dressed.

She found herself being judged all the time for being open. *'I cannot say that I'm fully Chinese. I cannot say that I'm fully Malay. So basically I'm nowhere.'* She felt Malays have so many rules and regulation which frustrated her. She once put a picture of a family tree of a Greek God on her Facebook. She intended to show that she had read a particular book on the Greek Gods. Her aunt had called her an apostate, which she vehemently denied. '*My aunty likes to make me look bad and make my dad fight with me'*. She took it down to avoid further issues. '*I didn't want any problem so I took it down. It's just knowledge. People don't understand'.*

As an animal lover, she loved dogs, however, her Malay friends chided her for patting a dog once, telling her that it was forbidden in Islam. Her response to that was '*dogs never harm me; why should I hate them'.*

Her relationship with her husband was better compared to her last two relationships. However, her husband voiced out his concerns about her view of culture and religion. '*He is summing up that I am a free spirit that I do not know what I am. As in no cultural identity'.* Her response was '*Religion does not define me. I told him I believe in every religion but I do not follow anything in particular. I'm not an atheist. I'm just trying to understand other religions'.*

Therapy Monitoring and use of Feedback Information

The earlier sessions were targeted on helping AD to shift her understanding on identity to be more flexible and hence accepting her uniqueness. Different analogies were used along the process. The idea of grey areas in culture and religion was inculcated, including the presence of different interpretation and comprehension on the values, which subsequently improve her ability to tolerate disagreement.

Her maladaptive defence mechanisms were being analysed and discussed in detail. She began to be more aware of her extreme idolisation and devaluation on identity, i.e. disagreement does not equate to be a bad character. Instead of responding aggressively to defend one's cause, skills on how to manage a difficult and uncomfortable conversation in the case of conflict was practiced so that she could communicate assertively. Furthermore, skills on how to manage her negative feelings were practiced also in order to manage her anger during a disagreement. AD is defiant, likes to test boundaries regularly and likes challenges. However, her husband helps to contain her disruptive behaviour, attributed to the trust and security toward her husband. This particular positive feature was reflected to her and reinforced during the therapy.

During the mid-session assessment, her CGI-S showed improvement on the 8th session was 3 (Mildly ill) and CGI for Improvements (CGI-I) was 3 (Minimally improved)- there is some symptoms reduction.

The last five sessions were dedicated to the termination of the therapy. The breakthrough came about when her communication has improved and her husband was able to accept her viewpoint. *'My husband told me - I will accept you for who you are. I love you… Don't get me wrong, he still believes in the Muslim God, but you know, he is asking questions and we debate about it. I am happy. He finally understands me. And he explains religion to me, helping me to see the other point of view. I was surprised. No one has ever done that before. It's not all black or white, there is a grey area*'. Her relationship with her family had improved too with her ability to express assertively. *'I think my father and sister realize my worth and realize that I am important to them. I feel lighter. They talk to me properly'.*

Assessment on her last (15th session) showed that her CGI-S was 1 (Normal) and her CGI-I was 1 (very much improved), for the last seven days the symptoms of the disorder were not present and she felt better. Her husband noticed that there were changes in her (i.e. not getting angry fast, more jovial and noticed her relationship with her father and sister had improved). He was happy with the changes and their relationship has improved. Therefore, full functional recovery was achieved at the termination of her psychodynamic sessions. Her oral medication was continued for another six months, completed with a discharge from service.

Discussion

Erikson defines identity as 'accrued confidence in the inner sameness and continuity of one's meaning for others'- dealing with role commitment and consistency in behaviour.[4] Adolescents across many cultures are known to endure a period of identity crisis or identity formation that would play a role in their development psychopathology.[5] The concept of identity disturbance has been the centre of current theoretical frameworks used to understand borderline personality disorder[6] although the nature of this disturbance has received little empirical attention.[7] A confirmed sense of identity leads to healthy relationships and a good role in society with optimum psychological functions, however, a negative identity is a role negatively viewed by the boarder culture.[5,7]

Malaysia is a melting pot of different ethnic, religion, and culture, which include the Malay, Chinese, Indian, and indigenous groups with a different characteristic social-cultural-religion background. Interracial marriages are common and there is some dissonance due to the different cultural and religious practices, given not all religious conversion are allowed constitutionally. Although Islam is the official religion of Malaysia, other religions such as Buddhism, Christianity, Hinduism are commonly practiced among the other ethnics. Religion and spirituality play an important role in Islam. As religion is a major part of a Malaysian's family, it forms a major component of identity development among the Malay.[8] Various studies found that people with good spirituality showed better mental health overall and reported less psychiatric symptomatology e.g. anxiety, depression, suicidality, self-harming behaviour or

substance abuse.[9,10] In a study done by Hafizi et al,[16] the authors postulated that lack of commitment to religious values and norms could lead to identity instability. People with borderline personality traits suffer from poor interpersonal relationships which causes them some difficulty in conforming to religious norms and values. They make group involvement difficult and often get excluded from religious groups.[10]

Conclusion

A culturally-informed therapeutic approach is important in helping borderline personality disorder patients with a complex ethnoreligious background. Although the generalizability of the finding in the case report may be limited, further qualitative and quantitative systematic exploration of the meaning of "identity disturbance" among borderline personality disorder patients from a different ethnoreligious background can be performed to elucidate the implication of cultural component on this psychopathology, which will potentially serve as a training guide for clinical assessment and psychosocial treatment.

With good intelligence, insight, motivation, and a supportive husband, she was able to self-reflect plus expressing her issues freely in the therapy. She appreciated that her husband accepted her as a free spirit, which had liberated her and helped her to repair her relationship with her father and sister. With the culturally-informed psychodynamic therapy sessions, she managed to embrace her complex ethnoreligious identity.

Conflict of Interest

None.

Acknowledgement

The authors would like to thank the Director-General of Health, Malaysia for his permission to publish this article.

References

1. Leichsenring F, Leibing E, Kruse J, New AS, Leweke F. Borderline personality disorder. *Lancet.* 2011;377(9759):74-84.
2. Dixon-Gordon KL, Peters JR, Fertuck EA, Yen S. Emotional processes in borderline personality disorder: An update for clinical practice. *J Psychother Integration.* 2017;27(4):425.
3. Lopez AB, Huynh VW, Fuligni AJ. A longitudinal study of religious identity and participation during adolescence. *Child Dev.* 2011;82(4):1297-309.
4. Erikson EH. Childhood and society, New York (WW Norton) 1950.
5. Chen KH, Lay KL, Wu YC, Yao G. Adolescent self-identity and mental health: The function of identity importance, identity firmness, and identity discrepancy. *Chinese J Psychol.* 2007;49(1):53-72.
6. Agnew G, Shannon C, Ryan T, Storey L, McDonnell C. Self and identity in women with symptoms of borderline personality: a qualitative study. *Int J Qual Studies Health Well-being.* 2016;11(1):30490.
7. Wilkinson-Ryan T, Westen D. Identity disturbance in borderline personality disorder: An empirical investigation. *Am J Psychiatry*. 2000;157(4):528-41.
8. Bin A. Sabri HA. Malaysia Malay religious dilemma in a multifaith atmosphere. *OIDA Int J Sustainable Dev.* 2012;4(8):79-92.
9. Hafizi S, Tabatabaei D, Koenig HG. Borderline Personality Disorder and Religion: A perspective from a Muslim country. *Iranian J Psychiatry.* 2014;9(3):137.
10. Sansone RA, Kelley AR, Forbis JS. Religion/spirituality status and borderline personality symptomatology among outpatients in an internal medicine clinic. *Int J Psychiatry Clin Pract.* 2012;16(1):48-52.

How to cite this article: Subhas N, Loo JL, Ho BKW. Ethnoreligious identity conflict in a Malaysian patient with borderline personality disorder, a psychodynamic psychotherapy case report. *Telangana J Psychiatry.* 2020;6(2):179-182.