# Diagnosis of Borderline Personality Disorder in China: Current Status and Future Directions

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This paper reviews the current status and future directions of borderline personality disorder (BPD) research in China. Although the committee of the third version of the *Chinese Classification of Mental Disorders* (*CCMD-3*) rejected BPD as a valid diagnostic category and instead adopted the term *impulsive personality disorder* (IPD), our literature review on personality disorders from 1979 to 2008 in China indicated that BPD was the most popular research topic among researchers and clinicians. Available empiric evidence on BPD in China provided preliminary support for the construct validity and clinical utility of BPD in clinical and nonclinical Chinese samples. Future studies in the following areas are suggested: 1) developing reliable assessment instruments for measuring BPD pathology in China, 2) comparing the construct validity and phenomenology of *CCMD* IPD and *DSM* BPD among Chinese patients, 3) examining potential cultural differences in symptom expression of BPD pathology among the Chinese, and 4) exploring indigenous and imported methods for treating BPD patients in China.

## Introduction

Borderline personality disorder (BPD) is a serious character pathology [1,2] characterized by affective intensity and instability, impulsivity, chaotic interpersonal relations, and unstable sense of self [3,4]. The prevalence of BPD is estimated to be about 1% to 2% in the general population, about 10% in psychiatric outpatients, and about 20% among Western inpatients [5–7]. Most Western experts consider BPD to be a valid disorder [2]. Specifically, research evidence has indicated the following: 1) BPD has a characteristic clinical presentation that can be distinguished from that of other disorders [8], 2) at least some of its neurobiologic and environmental etiologic factors are known [9,10], 3) it runs in families [11], and 4) the course of the disorder has been mapped out to a certain extent [12,13]. However, BPD is not so well accepted or studied in China [14••]. In this paper, we review the history of the BPD diagnosis in China, recent development in Chinese BPD research, and possible future directions of BPD research in China.

## BPD in China: The Past

From the end of the Chinese cultural revolution in 1978 to 1990, few studies of personality disorders (PDs) were published in China. The term *borderline personality disorder* was first introduced to China in 1979 by Chinese psychiatrist Min-You Ling [15]. In his article, Ling described the psychoanalytic conceptualization of BPD pathology and the disorder's diagnostic features. He suggested that pharmacologic treatment for BPD patients should be individualized and that therapists must be well trained when treating BPD patients [15]. This article, however, did not draw much attention from the Chinese psychiatric community. Throughout the 1980s, only two short translated articles and one case report on pharmacologic treatment of BPD were published in China [16–18].

During the 1990s, more Chinese psychiatrists began to pay attention to BPD, and several clinical case reports emerged. Tang and Li [19] described two male BPD patients in forensic psychiatry using the *DSM-IV*. Zhu et al. [20] also reported two BPD cases seen in general psychiatric clinics. However, the BPD diagnosis was not well received then by mainstream psychiatry in China. Some Chinese psychiatrists argued that the BPD diagnosis was a vague construct lacking precise boundaries and that certain diagnostic features of BPD (eg, fear of abandonment, chronic feelings of emptiness) might not be culturally appropriate when used in China [21]. In 2000, the committee for the third version of the *Chinese Classification of Mental Disorders* (*CCMD-3*) [22] adopted the diagnostic category of

impulsive personality disorder (IPD) in its official nomenclature, which is modeled mostly after the IPD subtype of the emotionally unstable personality disorders in the 10th revision of the *International Classification of Diseases* (*ICD-10*) [23]. Luo [24] argued that although the *CCMD-3* does not include the BPD diagnosis, the diagnosis of IPD contains a significant number of diagnostic symptoms for BPD. According to the *CCMD-3*, IPD patients must display "affective outbursts" and "marked impulsive behavior" (two necessary diagnostic conditions) plus at least three of the following eight symptoms: 1) a marked tendency to quarrelsome behavior and to conflicts with others, especially when impulsive acts are thwarted or criticized; 2) liability to outbursts of anger or violence, with inability to control the resulting behavioral explosions; 3) inability to plan ahead; 4) difficulty in maintaining any course of action that offers no immediate reward; 5) unpredictable and capricious mood; 6) disturbances in and uncertainty about self-image, aims, and internal preferences (including sexual); 7) liability to become involved in intense and unstable relationships, often leading to emotional crises; and 8) recurrent threats or acts of self-harm [22]. Zhong and Leung [14••] compared the diagnostic criteria of *DSM-IV-TR* BPD and *CCMD* IPD and found that in addition to "affective outbursts" and "marked impulsive behavior," the two necessary diagnostic conditions for *CCMD* IPD, at least five other symptoms overlap for the two disorders: intense and unstable relationships (*DSM* criterion 2, *CCMD* criterion 7, *ICD* criterion 7), unstable self-image (*DSM* criterion 3, *CCMD* criterion 6, *ICD* criterion 6), recurrent threats of self-harm (*DSM* criterion 5, *CCMD* criterion 8, *ICD* criterion 9), affective instability (*DSM* criterion 6, *CCMD* criterion 5, *ICD* criterion 5), and impulsive aggression (*DSM* criterion 8, *CCMD* criterion 2, *ICD* criteria 2 and 3). Judging from its diagnostic criteria, *CCMD* IPD closely resembles *DSM* BPD but places greater emphasis on impulsivity. Moreover, three diagnostic items for *DSM* BPD are not included in *CCMD* IPD: fear of abandonment (*DSM* criterion 1, *ICD* criterion 8); chronic feeling of emptiness (*DSM* criterion 7, *ICD* criterion 10); and transient, stress-related paranoid ideation or severe dissociative symptoms (*DSM* criterion 9).

Because of these differences in diagnostic criteria, *CCMD* IPD patients in China and *DSM* BPD patients in the United States may differ in at least two ways. First, whereas all *CCMD* IPD patients must show strong traits of impulsivity, some *DSM* BPD patients, because of the polythetic diagnostic rule, may display no significant impulsive trait. Second, whereas some *DSM* BPD patients, probably the most disturbed subgroup, may display transient psychotic features, *CCMD* IPD patients are not supposed to display transient psychotic symptoms. Unfortunately, no systematic empiric study has compared the construct validity and clinical phenomenology of *CCMD* IPD and *DSM* BPD in China.

## BPD in China: The Present

We searched the Chinese academic database China National Knowledge Infrastructure and found 228 academic articles on PDs from 1979 to 2008 (Table 1). Although the *CCMD-3* does not include the BPD diagnosis, findings in Table 1 show that *DSM* BPD has been the most popular PD research topic in China, and most of the papers on PDs have been published after the year 2000 (Fig. 1).

The available studies that have appeared in recent years provide preliminary support for the construct validity of BPD among the Chinese population in China. For example, Yang et al. [25] reported good internal consistency of the *DSM-IV* BPD criteria as measured by the Personality Disorder Questionnaire-Revised among Chinese psychiatric patients. Leung et al. [26] also reported good internal consistency for the *DSM-IV* BPD criteria set among Chinese female psychiatric patients as assessed by the Chinese Personality Disorder Inventory. Findings from two recent studies examining BPD features in nonclinical Chinese samples, one among college students in Beijing [27•] and the other among adolescents in Hong Kong [28•], also demonstrated that the nine *DSM* BPD symptoms form a coherent construct. Other psychometric studies on different measures of PDs among Chinese psychiatric patients and college students reported similar findings [29,30]. Together, these findings indicate that the *DSM* BPD diagnosis represents a valid clinical construct among the Chinese population in China. Based on this evidence, Zhong and Leung [14••] argued that the BPD diagnosis should be included in the fourth edition of the *CCMD*. Including BPD in future editions of the *CCMD* is extremely important because the prevalence of BPD has been estimated to be 1% to 2% of the general population in the West. If this prevalence figure is generalizable to China, a country with 1.3 billion people, it means 13 to 26 million Chinese could be suffering from BPD but have never been properly diagnosed and treated under the current diagnostic system.

## BPD in China: The Future

Available research evidence thus far provides preliminary support for the construct validity of the *DSM* BPD diagnosis in the Chinese population [27•,28•,29,30]. However, because the *CCMD-3* does not include BPD as a formal diagnostic category, we lag far behind the West in empiric studies of the prevalence, symptom expression, etiologic processes, and treatment outcome of BPD in China. Considering the potential number of patients who may be suffering from this disorder in China, systematic research on BPD is urgently needed. The following future research directions on BPD may be helpful in filling this empiric knowledge gap in China.

**Table 1. Distribution of studies on personality disorders in China from the China National Knowledge Infrastructure database (1979–2008)**

| Personality disorder | Original studies, *n* | Reviews, *n* | Case reports, *n* | Total, *N* |
|---|---|---|---|---|
| Schizotypal | 1 | 2 | 0 | 3 |
| Schizoid | 0 | 0 | 1 | 1 |
| Paranoid | 0 | 0 | 3 | 3 |
| Borderline | 16 | 15 | 8 | 39 |
| Antisocial | 6 | 9 | 6 | 21 |
| Histrionic | 0 | 1 | 2 | 3 |
| Narcissistic | 0 | 6 | 3 | 9 |
| Avoidant | 0 | 0 | 1 | 1 |
| Dependent | 0 | 2 | 1 | 3 |
| Compulsive | 1 | 1 | 1 | 3 |
| *CCMD* IPD | 1 | 0 | 1 | 2 |
| Not otherwise specified | 2 | 5 | 2 | 9 |
| Cluster B | 6 | 0 | 0 | 6 |
| Cluster C | 1 | 0 | 0 | 1 |
| All personality disorders | 88 | 36 | 0 | 124 |
| **Total** | 122 | 77 | 29 | 228 |

*CCMD—Chinese Classification of Mental Disorders*; IPD—impulsive personality disorder.

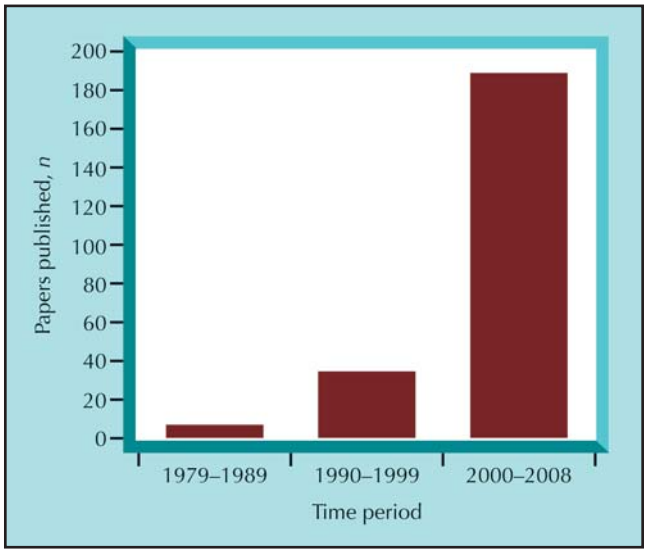


**Figure 1.** The number of published papers related to personality disorders in the China National Knowledge Infrastructure database, sorted by time period.

### Development of reliable assessment instruments for measuring BPD features

Valid and reliable assessment instruments for assessing the subject matter of study are essential for progress to be made in any research area. Chinese researchers recently have begun to adapt Western instruments to assess BPD pathology among the Chinese. For example, two recent studies have revised and examined the reliability of the McLean Screening Instrument for Borderline Personality Disorder (MSI-BPD) for use among college and adolescent Chinese samples [27•,28•]. The Revised Diagnostic Interview for Borderlines also has been translated into Chinese (Leung and Zhong, unpublished data), as have four diagnostic interview protocols for assessing PDs: 1) the International Personality Disorder Examination [31], 2) the Structured Clinical Interview for *DSM-III-R* Personality Disorders (SCID-II) [32], 3) the SCID-II Patient Questionnaire [33], and 4) the Personality Disorder Interview for *DSM-IV* [34,35]. Further clinical research to establish these assessment instruments' reliability and validity for BPD in China is needed [36].

### *CCMD* IPD and *DSM* BPD: are they the same disorder in China?

The *CCMD-3* has adopted the diagnostic category of IPD rather than the *DSM* BPD in its nomenclature. This decision, as Zhong and Leung [14••] pointed out, is based more on clinical impression than empiric evidence. The construct validity and clinical utility of IPD have never been empirically tested. Although *CCMD* IPD shares many important clinical features with *DSM* BPD (eg, both disorders are characterized by significant problems with mood and impulse dysregulation), little is known about the differences or similarities in clinical phenomenology, prevalence, etiologic factors, and developmental pathways of these two disorders. Is it possible that we just refer to the same personality pathology with two different names? Systematic studies documenting and comparing the similarities and differences between *CCMD* IPD and *DSM* BPD will advance our knowledge in this area.

### Are there any cultural differences in BPD symptom expression?

In recent years, clinicians have become increasingly aware that culture may affect symptom expression in psychopathology. For example, Chinese patients tend to report more somatic symptoms than Western patients [37], and chronic pain may be a manifestation of a self-regulatory disturbance among some patients with BPD [38]. Compared with BPD in the West, will Chinese BPD patients express their pathology differently, perhaps reporting more somatic symptoms, because of cultural differences? This is an interesting cross-cultural research topic to explore in the future.

### Exploring indigenous treatment modalities for BPD

A recent case report showed that traditional Chinese mindfulness therapy reduces BPD symptoms in China [39]. This treatment modality is consistent with the emphasis on training acceptance, distress tolerance, and emotion regulation skills in dialectical behavior therapy [40]. More treatment outcome studies exploring different indigenous and imported treatment modalities such as mentalization-based treatment [41] can be conducted in the future. Moreover, some Japanese researchers recently reported that one prescription of the Chinese traditional medicine *yi-gan san* improved certain BPD symptoms (eg, mood lability and impulsivity) [42•]. Further studies are worthwhile and can explore whether certain Chinese medicines may be helpful in improving specific BPD symptoms and can be used as auxiliary tools in a structured therapy program for BPD patients.

## Conclusions

BPD as a diagnostic category has not been accepted by the *CCMD* committee in China. However, available empiric evidence supports the *DSM* BPD criteria set as a coherent clinical construct among clinical and nonclinical Chinese samples in China. Although *CCMD* IPD shares many important diagnostic features with *DSM* BPD, it is unclear whether these two disorders are actually identical pathologies that carry different diagnostic labels in China. Systematic empiric research comparing the construct validity and clinical phenomenology between *CCMD* IPD and *DSM* BPD is urgently needed in China. Future research on BPD in China can focus on the following: 1) developing reliable assessment instruments for measuring BPD pathology in China, 2) comparing the construct validity and phenomenology of *CCMD* IPD and *DSM* BPD among Chinese patients, 3) examining potential cultural differences in symptom expression of the BPD pathology among the Chinese, and 4) exploring indigenous and imported methods for treating BPD patients in China.

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## Disclosures

No potential conflicts of interest relevant to this article were reported.

## References and Recommended Reading

Papers of particular interest, published recently, have been highlighted as:

- • Of importance
- •• Of major importance

1. Skodol AE, Gunderson JG, Pfohl B, et al.: **The borderline diagnosis I: psychopathology, comorbidity, and personality structure.** *Biol Psychiatry* 2002, **51:**936–950.
2. Zanarini MC, Frankenburg FR, Khera GS, Bleichmar J: **Treatment histories of borderline inpatients.** *Compr Psychiatry* 2001, **42:**144–150.
3. Lieb K, Zanarini MC, Schmahl C, et al.: **Borderline personality disorder.** *Lancet* 2004, **364:**453–461.
4. Zanarini MC, Gunderson J, Frankenburg FR: **Cognitive features of borderline personality disorder.** *Am J Psychiatry* 1990, **147:**57–63.
5. Swartz MS, Blazer D, Geroge L, Winfield I: **Estimating the prevalence of borderline personality disorder in the community.** *J Personal Disord* 1990, **4:**257–272.
6. Torgersen S, Kringlen E, Cramer V: **The prevalence of personality disorder in a community sample.** *Arch Gen Psychiatry* 2001, **58:**590–596.
7. Widiger T, Weissman M: **Epidemiology of borderline personality disorder.** *Hosp Community Psychiatry* 1991, **42:**1015–1021.
8. Paris J: *Personality Disorders Over Time: Precursors, Course and Outcome*. Washington, DC: American Psychiatric Publishing; 2003.
9. Torgersen S, Lygren S, Oien PA, et al.: **A twin study of personality disorders.** *Compr Psychiatry* 2000, **41:**416–425.
10. Zanarini M, Williams A, Lewis B: **Reported pathological childhood experiences associated with the development of borderline personality disorder.** *Am J Psychiatry* 1997, **154:**1101–1106.
11. Zanarini MC, Frankenburg FR, Yong L, et al.: **Borderline psychopathology in the first degree relatives of borderline and Axis II comparison probands.** *J Personal Disord* 2004, **18:**439–447.
12. Skodol AE, Gunderson JG, Shea MT, et al.: **The Collaborative Longitudinal Personality Disorders Study (CLPS): overview and implications.** *J Personal Disord* 2005, **19:**487–504.
13. Zanarini MC, Frankenburg FR, Hennen J, et al.: **The McLean Study of Adult Development (MSAD): overview and implications of the first six years of prospective follow-up.** *J Personal Disord* 2005, **19:**505–523.
14.•• Zhong J, Leung F: **Should borderline personality disorder be included in the fourth edition of the Chinese Classification of Mental Disorders?** *Chin Med J (Engl)* 2007, **120:**77–82.
In this recent review, we discuss the following two questions: do BPD patients exist in China, and should the BPD diagnosis be included in the fourth edition of the *CCMD*?
15. Ling MY: **The borderline state in psychiatric disorders: from the knowledge of Freudian.** *Foreign Med Sci Section Psychiatry* 1979, **5:**209–214.

16. Li SX: **Borderline personality disorder and suicide.** *Foreign Med Sci Section Psychiatry* 1987, **14:**119–120.
17. Wu CD: **Using a1 prazolam to treat borderline personality disorder: three cases.** *Foreign Med Sci Section Psychiatry* 1985, **12:**106.
18. Li SX: **The dexamathasone suppression test for the depression patients comorbid with borderline personality disorder.** *Foreign Med Sci Section Psychiatry* 1985, **12:**112.
19. Tang HY, Li CP: **Borderline personality disorder in forensic psychiatry.** *Chin J Clin Psychiatry* 1997, **7:**292–294.
20. Zhu H, Zhang Z, Yu Y: **Borderline personality disorder: two cases.** *Chin J Clin Psychiatry* 1999, **19:**336.
21. Jia Y: **Some opinions to the "borderline personality disorder."** *Chin J Clin Psychiatry* 1998, **8:**248–249.
22. Chinese Psychiatry Association: *Chinese Classification of Mental Disorders,* edn 3. Jinan, China: Shandong Science Press; 2000.
23. World Health Organization: **Mental health and behavior disorders. Diagnosis criteria for research.** In *Tenth Revision of the International Classification of Disease.* Geneva: World Health Organization; 1993:153–154.
24. Luo XN: **Borderline personality disorder is noteworthy in China.** *Chin J Clin Psychiatry* 2005, **15:**122.
25. Yang J, Bagby RM, Costa PT, et al.: **Assessing the DSM-IV structure of personality disorder with a sample of Chinese psychiatric patients.** *J Personal Disord* 2002, **16:**317–331.
26. Leung F, Cheung F, Cheung SF: **CPAI-2 profiles of Chinese female psychiatric patients displaying a significant level of borderline personality disorder features.** *Paper presented at the 28th International Congress of Psychology.* Beijing; August 8–13, 2004.
27.• Wang Y, Leung F, Zhong J: **The adaptation of McLean Screening Instrument for Borderline Personality Disorder among Chinese college students.** *Chin J Clin Psychol* 2008, **16:**258–260.

This study has revised and examined the reliability of the MSI-BPD among Chinese college samples in Beijing.

28.• Leung S, Leung F: **Construct validity and prevalence of borderline personality disorder among Chinese adolescents in Hong Kong.** *J Personal Disord* 2009 (in press).

This study has revised and examined the reliability of the MSI-BPD in a Hong Kong adolescent sample.

29. Lu N, Liu X, Zhu C, et al.: **Four existing instruments for assessing personality disorders: I.** *Chin Ment Health J* 2001, **15:**125–128.
30. Fu WQ, Yao S: **Personality disorders detected by PDQ-4+ in undergraduate students.** *Chin Ment Health J* 2004, **18:**621–623.
31. Sheng L: *The International Personality Disorder Examination (Chinese Version).* Beijing: Peking University Psychiatric Research Centre; 1995.
32. Lu N, Cai GQ: *The Chinese Version of Structured Clinical Interview for DSM-III-R Personality Disorders (SCID-II).* Chengdu, China: Mental Health Institute of West China Medical University; 1996.
33. Lu N, Cai GQ: *The Chinese Version of DSM-III-R Personality Disorders Questionnaire (SCID-II PQ).* Chengdu, China: Mental Health Institute of West China Medical University; 1996.
34. Yang J: *The Chinese Version of Personality Disorder Inventory.* Changsha, China: Clinical Psychology Institute of Hunan Medical University; 1996.
35. Yang J, Bagby R, Costa P, et al.: **Assessing the DSM-IV structure of personality disorder with a sample of Chinese psychiatric patients.** *J Personal Disord* 2002, **16:**317–331.
36. Wang LL, Xiao ZP: **The application status of BPD assessment instruments in China.** *Chin J Int Psychiatry* 2007, **34:**112–115.
37. Rydera AG, Yang J, Zhu X, et al.: **The cultural shaping of depression: somatic symptoms in China, psychological symptoms in North America?** *J Abnorm Psychol* 2008, **117:**300–313.
38. Sansone RA, Whitecar P, Meier BP, Murry A: **The prevalence of borderline personality among primary care patients with chronic pain.** *Gen Hosp Psychiatry* 2001, **23:**193–197.
39. Chen J, Xu HD, Fang YR, Wang ZC: **Using mindfulness therapy to treat borderline personality disorder: a case report.** *Shanghai Arch Psychiatry* 2006, **18:**294.
40. Verheul R, van-den-Bosch LMC, Koeter MWJ, et al.: **Dialectical behavior therapy for women with borderline personality disorder: 12 months, randomized clinical trial in the Netherlands.** *Br J Psychiatry* 2003, **182:**135–140.
41. Bateman A, Fonagy P: *Psychotherapy for Borderline Personality Disorder: Mentalization-Based Treatment.* New York: Oxford University Press; 2004.
42.• Miyaoka T, Furuya M, Yasuda H, et al.: **Yi-gan san for the treatment of borderline personality disorder: an open-label study.** *Prog Neuropsychopharmacol Biol Psychiatry* 2008, **32:**150–154.

This recent open-label study suggests that the Chinese traditional medicine *yi-gan san* may be effective for treating several BPD symptoms, including low mood, impulsivity, and aggression.