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BORDERLINE PERSONALITY DISORDER CO-MORBIDITY AMONG PATIENTS ON REHABILITATION FOR ALCOHOL ABUSE IN NYAMAGABE CENTRE, RWANDA

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Abstract: **Alcohol abuse poses a significant public health challenge globally, leading to various social, economic, and health issues. There is a growing trend of individuals seeking rehabilitation services, highlighting the urgent need to address alcohol dependence. Research indicates that alcohol dependence often coexists with mental illnesses, including borderline personality disorder (BPD). However, there is limited information on the prevalence of BPD among patients undergoing alcohol rehabilitation in Rwanda. This study aims to assess the prevalence and impact of BPD among patients in rehabilitation at Nyamagabe Rehabilitation Center in Rwanda. It seeks to provide insights for policymakers, clinicians, and researchers to better understand the connection between BPD and alcohol abuse. Utilizing a mixed-methods design, the study incorporates both quantitative and qualitative approaches. The target population consists of 310 patients, with a sample size of 175 selected through systematic random sampling. To determine the prevalence of BPD among patients with alcohol abuse, descriptive statistics were employed to analyze frequencies and percentages. The relationship between BPD symptoms and alcohol consumption was assessed using the Pearson correlation coefficient through the Statistical Package for the Social Sciences (SPSS V. 28). Additionally, thematic analysis was conducted on semi-structured interviews to explore the challenges faced by health providers in treating BPD and alcohol abuse and to gather recommendations for improving treatment outcomes. The results revealed a significant prevalence of BPD symptoms among the respondents. Notably, 76.0% reported unstable relationships characterized by frequent arguments or breakups, and 74.3% admitted to self-harming behaviors or suicide attempts, indicating severe emotional distress. Impulsivity, a hallmark of BPD, was observed in 76.0% of participants, contributing to dysfunctional coping strategies such as binge eating and excessive drinking. Emotional instability affected 79.4% of patients, with 82.9% reporting frequent anger, complicating their interpersonal relationships. High percentages of distrust (90.3%), derealization (85.1%), and chronic feelings of emptiness (88.8%) were also noted. Furthermore, 86.9% of respondents lacked a clear sense of identity, and 91.4% expressed a desperate fear of abandonment. Bivariate analysis showed a significant positive correlation between BPD symptoms and alcohol consumption frequency (r=.214, p=.004), as well as the average daily intake (r=.189, p=.017). The analysis also indicated links between impulsive behaviors, such as excessive drinking (r=.190, p=.012), drinking six or more drinks during periods of extreme moodiness (r=.153, p=.043), and an inability to stop drinking once started (r=.155, p=.045). Thematic analysis of interviews revealed that therapeutic resistance in BPD patients, driven by trust issues and emotional instability, complicates treatment and increases relapse rates. The study recommends specialized interventions to address these challenges and reduce relapse rates among patients with dual diagnoses of BPD and alcohol abuse.**

Keywords: **Borderline personality disorder, Patients, Rehabilitation, co-morbidity, alcohol abuse.**

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1. BACKGROUND OF THE STUDY

Alcohol abuse is a pervasive public health issue worldwide, contributing to numerous social, economic, and health problems. Trends indicate rising rates of alcohol consumption and an increase in individuals seeking rehabilitation services. Research consistently shows that alcohol and drug dependency are often associated with mental health disorders, with common co-morbid conditions including antisocial personality disorder (APD), mood disorders, anxiety disorders, and nicotine addiction (Maeng et al., 2002). Among personality disorders, borderline personality disorder (BPD) is frequently observed in patients with Alcohol Use Disorder (AUD), significantly impacting their treatment outcomes and overall well-being. Studies conducted globally highlight the prevalence and impact of BPD in individuals with alcohol abuse issues. For instance, research in the United States shows that the occurrence of APD and BPD among individuals with AUD ranges between 9% and 21% in general populations but can rise to 31% in outpatient mental health settings (Cohen, 2020). Similarly, clinical practices in India reveal that BPD often coexists with AUD and is linked to impulsivity, leading to behaviors like excessive drinking and binge eating (Parmar & Kaloiya, 2018). The prevalence of alcohol abuse among the general population is estimated between 10% and 14.8%, but this rate can increase to as much as 73% among those receiving treatment for addiction. Furthermore, individuals with substance use disorders experience higher rates of personality disorders than those with AUD alone.

In African contexts, studies have explored the relationship between substance use and mental health. Research in South Africa revealed common co-morbidities in substance users, including anxiety, panic disorder, agoraphobia, post-traumatic stress disorder (PTSD), and depression (Amina, 2020). Similarly, a study in Kenya found that patients admitted to rehabilitation facilities frequently experienced depression, anxiety, social phobia, and various personality disorders (Kathono, 2022).

Rwanda's mental health landscape is uniquely shaped by the trauma following the 1994 genocide against the Tutsi, with many Rwandans experiencing long-term psychological consequences. Reports indicate that 37% of men and 35% of women were exposed to at least one traumatic event, such as witnessing violent deaths or being forcibly displaced. Subsequent studies revealed high rates of depression (12%), panic disorder (8.1%), and other mental health conditions among Rwandans, with alcohol use disorder and personality disorders being notable issues (Kayiteshonga & Sezibera, 2022). Given this context, the co-morbidity of AUD and BPD poses a significant challenge to Rwanda's healthcare system, particularly regarding effective treatment and rehabilitation.

The American Psychiatric Association (APA) highlights that BPD is often linked to trauma, violence, neglect, and family mental health issues. Individuals with BPD frequently turn to alcohol and other substances for self-medication, especially those with histories of childhood abuse or emotional neglect. Studies show that individuals with BPD are at a higher risk of developing substance use disorders, with approximately 10% of outpatient mental health clinic patients and 10% of psychiatric inpatients diagnosed with BPD (APA, 2022).

2. PROBLEM STATEMENT

Alcohol abuse in Rwanda represents a critical public health issue, with 28.5% of adolescents consuming alcohol and over 46,259 individuals receiving rehabilitation for substance abuse since 2010. However, relapse rates remain high, at 22.4% (NRS, 2024). A primary concern is the prevalence of mental health co-morbidities, particularly BPD, which complicates treatment, delays diagnosis, and contributes to high relapse rates of 30% to 60% (Torrens, 2024). Despite these challenges, there is limited research on BPD among patients undergoing alcohol rehabilitation in Rwanda, hindering effective treatment strategies for individuals with dual diagnoses. This study aims to fill this gap by examining the prevalence of BPD among patients with alcohol abuse at Nyamagabe Rehabilitation Center and assessing its impact on treatment outcomes.

Objectives of the Study

General Objective:

To assess the prevalence and impact of BPD co-morbidity among patients undergoing rehabilitation for alcohol abuse at Nyamagabe Rehabilitation Center in Rwanda.

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Specific Objectives:

(i) To assess the prevalence of BPD among patients in rehabilitation for alcohol abuse at Nyamagabe Center.

(ii) To examine the challenges and impact of BPD co-morbidity on treatment outcomes for patients with alcohol abuse.

(iii) To investigate the relationship between alcohol abuse and BPD in terms of severity and progression of both conditions.

(iv) To suggest strategies for improving the management and treatment of patients with BPD co-morbidity and alcohol abuse at Nyamagabe Center.

3. RESEARCH METHODOLOGY

3.1 Research Design

This study employs a mixed-methods design, integrating both quantitative and qualitative approaches to comprehensively investigate the prevalence and impact of borderline personality disorder (BPD) among patients undergoing rehabilitation for alcohol abuse at Nyamagabe Rehabilitation Center in Rwanda. The quantitative component utilizes a cross-sectional survey to determine the incidence of BPD and alcohol abuse, as well as the relationship between their severity and progression. Concurrently, the qualitative component involves in-depth interviews to explore the challenges and impacts of BPD co-morbidity on treatment outcomes, and to gather recommendations for enhancing rehabilitation strategies for individuals with dual diagnoses. The cross-sectional survey captures data at a single point in time, providing a snapshot of the current state of BPD and alcohol abuse among the target population (Babbie, 2021), while the qualitative interviews offer deeper insights into the personal experiences and treatment complexities faced by patients and healthcare providers.

3.2 Target Population

The target population for this study comprises 310 patients undergoing rehabilitation for alcohol abuse at Nyamagabe Rehabilitation Center. This population is selected to provide a representative sample for assessing the prevalence of BPD and understanding its impact on treatment outcomes within this specific context.

3.3 Sample Design

3.3.1 Sample Size Determination

The computation of the sample size for this study was conducted using Yamane's formula as cited by Adam (Adam, 2020), which is expressed as follows:

$$n = \frac{N}{1 + (N * e^2)}$$

$$n = \frac{310}{1 + (310 * 0.05^2)} = 175$$

In this case, substituting the values yield: n=310/ (1+(310∗ 0.05^2)) =175 here, **n** signifies the sample size, **N** means the total population, and **e** signifies the margin of error, set at 0.05. Consequently, the sample size will consist of 175 patients suffering from alcohol abuse who are admitted to the Nyamagabe rehabilitation center during the research period. Additionally, 15 health care providers and 30 patients from respondents will be interviewed to gain insights into their experiences in managing co-morbid cased and to formulate recommendations for effective management of the diagnosed conditions.

3.3.2 Sampling Technique

A systematic random sampling technique is employed to ensure an equal chance of selection for all participants. The participant list is sorted alphabetically, and every second individual (K=2) is selected after a randomly chosen starting point. This method guarantees a fair distribution of respondents throughout the sample list, enhancing the representativeness of the sample (Kenneth, 2024).

3.4 Data Collection Methods

Data collection involves systematic gathering of information using both quantitative and qualitative instruments to address the research questions effectively.

3.4.1 Data Collection Instruments

The McLean Screening Instrument for BPD (MSI-BPD) is a 10-item self-report questionnaire designed to screen for borderline personality disorder in individuals aged 15 and older, derived from the DSM-IV Diagnostic Interview for Personality Disorders and validated for assessing BPD symptoms. The Alcohol Use Disorders Identification Test (AUDIT), a 10-item screening tool developed by the World Health Organization (WHO), evaluates alcohol consumption, drinking behaviors, and related issues. Additionally, qualitative data was gathered through semi-structured interviews with healthcare providers and selected patients, aimed at exploring the challenges and effects of BPD co-morbidity on treatment outcomes and collecting recommendations for enhancing rehabilitation strategies.

3.4.2 Procedures of Data Collection

The data collection process begins with selecting appropriate participants and instruments aligned with the research objectives. Relevant variables are assessed, and a test-retest procedure is conducted with a small sample to ensure clarity and reliability. Instruments are translated into Kinyarwanda and back-translated to maintain accuracy. Ethical approval is obtained from the Ethics Committee of Mount Kenya University and written permission from the National Rehabilitation Services. Data collectors are trained to ensure consistent application of instruments. Informed consent is obtained from all participants, and confidentiality is strictly maintained. Data is verified for accuracy before analysis, ensuring a valid, reliable, and ethical data collection process.

3.4.3 Reliability and Validity of the Instruments

Reliability: Assessed using the test-retest method, where the same instruments are administered to a pre-test group twice, with a three-day interval. A correlation coefficient above 0.5 and a Cronbach's alpha of at least 0.7 indicate high reliability (Babbie, 2021). **Validity:** Ensured through expert review by supervisors and mental health professionals at Mount Kenya University, confirming that the instruments effectively measure the intended constructs and adequately address the research objectives.

3.5 Data Analysis

Data analysis involves both quantitative and qualitative methods to ensure comprehensive interpretation of the collected data. **Quantitative Analysis:** Data is edited, coded, and analyzed using the Statistical Package for Social Sciences (SPSS V.28), Descriptive Statistics used to calculate frequencies and percentages related to BPD prevalence among participants. Inferential statistics, specifically Pearson's correlation coefficient, were used to examine the relationship between the severity and progression of BPD symptoms and alcohol misuse. Qualitative data was analyzed using thematic analysis, applied to semi-structured interview responses to uncover patterns and themes regarding the challenges and impacts of BPD co-morbidity on treatment outcomes. This approach also helped generate recommendations for enhancing rehabilitation strategies

3.6 Ethical Considerations

Ethical standards were rigorously maintained throughout the study to ensure participant protection and respect. Ethical clearance was obtained from Mount Kenya University's Ethics Committee, and permission was granted by the National Rehabilitation Services. Informed consent was secured from all participants, ensuring they fully understood the study's purpose, procedures, and their rights. Participant identities were kept anonymous, with data securely stored and used solely for research purposes. The researcher ensured that participants understood their involvement was voluntary and that they could withdraw at any time without repercussions.

By adhering to these ethical guidelines, the study ensures the integrity and ethical responsibility of the research process, fostering trust and cooperation among participants and stakeholders.

4. RESARCH FINDINGS AND DISCUSSIONS

4.1 Demographic Characteristics of Respondents

The study surveyed a total of 175 respondents. The distribution shows that the majority (46.9%) of the participants were young adults between 18-25 years old (n=82). Respondents aged 31-40 constituted 29. 7% of the sample (n=52), while 18.9% of participants fell within the 26-30 age group(n=33). Only a small portion of the respondents (4.6%) were over the age 41(n=8). This demographic composition reflects a predominantly young adult population in the study.

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Table 1: Socio-demographic characteristics

Variables		Count	Column N%
Sex of the respondents	Male	175	100.0%
	Female	0	0.0%
What is your current marital status	Single	170	97.1%
	Married	0	0.0%
	Divorced	0	0.0%
	Separate	3	1.7%
	Widowed	0	0.0%
	Cohabite	2	1.1%
	Other specify	0	0.0%
Do you have children	None	168	96.0%
	One	5	2.9%
	Two	1	0.6%
	Three	0	0.0%
	Four	1	0.6%
With whom do you live? Parents	Parents	159	90.9%
	Partner	4	2.3%
	Relative	11	6.3%
	Other specify	1	0.6%
What was your previous occupation	Student	128	73.1%
	Famer	40	22.9%
	Driver	5	2.9%
	other non-specify	2	1.1%

Source: Primary data

The demographic characteristics presented in the study provide key insights into the population at the Nyamagabe center, focusing on BPD co-morbidity among patients in rehabilitation for alcohol abuse. The respondents were exclusively male, account for 100% (n=175) of the sample because the center currently accommodate only males.

An overwhelming majority of respondents (97.1%, n=170) reported being single, with only small percentages either separated (1.7%, n=3) or cohabiting (1.1%, n=2). This high rate of singleness may be linked to the challenges individuals with BPD and substance use disorders face in maintaining stable relationships. Borderline Personality Disorder is often characterized by difficulties in interpersonal relationships, which may contribute to the high percentage of single individuals in the sample.

A significant majority of respondents (96%, n=168) reported not having children , which may suggest a limited engagement in traditional family roles. BPD is associated with impulsivity and unstable emotions, factors that may hinder individuals' ability to take on parental responsibilities or form long-term partnerships. Additionally, the high percentage of childless participants could reflect the early stage of life for many of the respondents, as the majority are young adults. Most of the respondents (90.9%, n=159) lived with their parents. This could indicate that many of the participants are dependent on their families, potentially due to disabling effects of both alcohol abuse and BPD, which can make independent living challenging. Living with parents may also provide crucial support, though the dynamics of these relationships can be complicated by the emotional instability associated with BPD.

The majority of respondents were students (73.1%, n=128), with farmers making up a smaller but notable portion (22.9%, n=40). The large student's population aligns with the fact that most participants are young adults. However, BPD and alcohol abuse can severely disrupt educational and career trajectories. The predominance of students might reflect early intervention aimed at younger populations to address alcohol abuse before it further impairs their academic or career paths. Demographic characteristics highlight a population of young, single males, many of whom are students and living with their parents. This profile is important in understanding the co-morbidity of BPD with alcohol abuse. The instability in relationships, educational disruption, and reliance on family support systems may all be exacerbated by the emotional volatility and impulsive behaviors typical of BPD.

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4.2 Presentation of Findings

This section present the key findings of the study on Borderline personality disorder (BPD) co-morbidity among patients undergoing rehabilitation for alcohol abuse at Nyamagabe Centre, Rwanda. The primary focus of this study was to assess the prevalence of borderline Personality Disorder (BPD) among patients undergoing rehabilitation for alcohol abuse at Nyamagabe Centre, Rwanda. Using a cut-off score of 7 or above, individuals endorsing seven or more of the diagnostic criteria of BPD were considered likely to meet the diagnosis. The findings demonstrate that a significant portion of the respondents exhibit symptoms characteristics of BPD, with high percentages reported across various diagnostics criteria. Below is a summary of key responses to the BPD-related questions.

Table 2: The prevalence of borderline personality disorder among patients undergoing rehabilitation for alcohol abuse

Variables		Count	Column N %
Have any of your closest relationships been trouble by a lot of arguments or repeated breakups?	No	42	24.0%
	Yes	133	76.0%
Have you deliberately hurt yourself physically (e. g. punched yourself, cut yourself, cut yourself, burned yourself) How about made a suicide attempt?	No	45	25.7%
	Yes	130	74.3%
Have you had a least two other problems with impulsivity (e.g. eating binges and spending sprees, drinking too much and verbal outbursts)?	No	42	24.0%
	Yes	133	76.0%
Have you been extremely moody?	No	36	20.6%
	Yes	139	79.4%
Have you felt angry a lot of the time? How about acted in an angry or sarcastic manner?	No	30	17.1%
	Yes	145	82.9%
Have you often been distrustful of other people?	No	17	9.7%
	Yes	158	90.3%
Have you frequently felt unreal or as if things around you were unreal?	No	26	14.9%
	Yes	149	85.1%
Have you chronically felt empty?	No	21	12.0%
	Yes	154	88.0%
Have you often felt that you had no idea of who you are or that you have no identity?	No	23	13.1%
	Yes	152	86.9%
Have you made desperate efforts to avoid feeling abandoned or being abandoned (e. g., repeatedly called so yourself that he or she still cared, begged them not to leave you, clung to them physically)?	No	15	8.6%
	Yes	160	91.4%

Source: Primary data

The table 2 shows that 76.0% (n=133) of respondents reported experiencing close relationships troubled by frequent arguments or repeated breakups. This is a central feature of BPD, indicating a widespread difficulty in maintaining stable, harmonious relationships among the patients. In general, 74.3% (n=130) admitted to engaging in deliberate self-harm or having made suicide attempts in their lives; self-harm and suicidal behavior are among the most serious symptoms of BPD, suggesting a high level of emotional distress and vulnerability within the sample while 76.0% (133) of the respondents reported impulsive behavior in areas such as binge eating, spending sprees, or excessive drinking. Impulsivity is a defining characteristic of BPD and is particularly relevant to the study population, as it exacerbates alcohol abuse and contributes to dysfunctional coping mechanisms.

The study investigates the prevalence and interplay between borderline personality disorder (BPD) symptoms and alcohol abuse among patients at Nyamagabe Centre. A significant 79.4% of participants reported experiencing extreme mood swings, a common symptom of BPD that leads to challenges in emotional regulation and impulsive behaviors, including alcohol consumption. Moreover, 82.9% indicated feelings of anger, often resulting in interpersonal conflicts that

exacerbate feelings of isolation and distrust. An alarming 90.3% of respondents expressed distrust towards others, highlighting the pervasive paranoia characteristic of BPD that complicates relationship-building. Additionally, 85.1% experienced derealization, a dissociative symptom triggered by emotional distress, while 88.0% reported chronic feelings of emptiness. This emptiness is a driving factor behind impulsive behaviors, including substance abuse.

Identity disturbance was noted in 86.9% of participants, indicating a fragmented sense of self that complicates rehabilitation efforts. The fear of abandonment was also prevalent, with 91.4% making desperate efforts to avoid being left alone, illustrating a central emotional instability associated with BPD. Overall, the findings suggest that a substantial portion of respondents met or exceeded the cutoff score for a BPD diagnosis, revealing a high prevalence of co-morbidity between BPD and alcohol abuse. Emotional dysregulation, impulsivity, and interpersonal difficulties significantly challenge rehabilitation, as individuals often use alcohol as a coping mechanism for emotional pain.

The study further explores the correlation between BPD symptoms and alcohol abuse behaviors, as Key findings indicate that interpersonal conflicts linked to BPD significantly correlate with both the frequency of alcohol consumption ($r = 0.214$, $p = 0.004$) and typical daily intake ($r = 0.180$, $p = 0.017$). This suggests that the instability in relationships experienced by individuals with BPD not only perpetuates their emotional distress but also reinforces their dependence on alcohol as a maladaptive coping strategy. Overall, the high prevalence of BPD symptoms among patients undergoing rehabilitation emphasizes the necessity for integrated treatment approaches that simultaneously address alcohol dependence and the emotional challenges posed by BPD. This study underscores the critical need for targeted interventions aimed at enhancing emotional regulation and addressing the co-morbid conditions faced by this vulnerable population.

The co-morbidity of borderline personality disorder (BPD) and alcohol abuse presents a complex interplay of symptoms and behaviors that significantly impacts treatment outcomes. Research indicates a strong correlation between BPD and problematic alcohol use, particularly among individuals experiencing unstable relationships, impulsivity, and emotional dysregulation. In a study at Nyamagabe Rehabilitation Center, 76% of patients with alcohol abuse showed symptoms of BPD, with over 90% reporting difficulties in interpersonal relationships, impulsivity, mood instability, and fear of abandonment. Notably, 74.3% of respondents indicated a history of self-harm, which is closely linked to emotional turmoil and often serves as a coping mechanism for substance use. Impulsivity emerged as a crucial factor, with 76% of participants engaging in binge drinking and other impulsive behaviors, reflecting previous research that links impulsivity to increased relapse rates in this population.

Emotional dysregulation and mood instability were prevalent, affecting 79.4% and 82.9% of patients, respectively. These findings align with the literature that emphasizes the impact of mood disorders on interpersonal relationships and the risk of self-harm. Moreover, 88% of patients reported chronic emptiness and 86.9% experienced identity disturbances, which contribute to the cycle of substance abuse and complicate recovery. Statistical analyses highlighted significant correlations between BPD symptoms and alcohol consumption behaviors: troubled relationships were positively correlated with frequency and quantity of alcohol intake ($r=.214$, $p=.004$), and self-harm was linked to impulsive drinking ($r=.190$, $p=.012$).

The treatment of patients with co-morbid BPD and alcohol abuse poses unique challenges for therapists. Interviews with 15 psychotherapists revealed that the presence of BPD often complicates the rehabilitation process. Issues such as emotional dysregulation led to treatment resistance and higher relapse rates, as patients struggle to adhere to structured programs. The therapists emphasized the need for integrated dual-diagnosis treatment approaches, including Dialectical Behavior Therapy (DBT) for addressing emotional instability and substance use. Additionally, 13 therapists advocated for early screening for co-morbid conditions and a collaborative approach involving psychiatrists, psychotherapists, and substance abuse counselors.

To improve treatment outcomes, both patients and therapists identified several strategies. Integrated programs that address BPD and alcohol abuse concurrently were deemed essential, as treating one condition in isolation often leads to incomplete recovery. Trauma-informed care is crucial, given the histories of trauma in many BPD patients, alongside family therapy to manage interpersonal conflicts that trigger symptoms and relapses. Continuous aftercare support and crisis intervention services were highlighted as vital components of recovery, with a strong emphasis on psychoeducation around emotional regulation and relapse prevention.

In summary, the findings underscore the complexity of managing co-morbid BPD and alcohol abuse, revealing significant overlaps that necessitate a multifaceted treatment approach. The high prevalence of emotional instability, impulsivity, and interpersonal challenges among this population calls for integrated, trauma-informed, and patient-centered interventions to enhance recovery outcomes. By acknowledging the intertwined nature of these disorders, treatment strategies can be better tailored to address the unique needs of individuals at the Nyamagabe Rehabilitation Center and beyond.

5. CONCLUSION, RECOMMENDATIONS AND SUGGESTIONS FOR FURTHER STUDY

The study at Nyamagabe Centre revealed a high prevalence of borderline personality disorder (BPD) symptoms among patients in alcohol rehabilitation, with notable symptoms such as unstable relationships (76%), self-harm or suicide attempts (74.3%), impulsivity (76%), emotional instability, chronic emptiness, and significant distrust in others. These symptoms complicate treatment by increasing relapse rates and prolonging recovery. The findings emphasize that treating alcohol abuse alone without addressing underlying psychological disorders like BPD yields less effective recovery outcomes. An integrated treatment approach combining addiction recovery with targeted psychotherapy and psychoeducation for emotional regulation is essential for sustained recovery. Psychotherapists face challenges managing dual diagnoses, highlighting the need for specialized protocols and staff training. Recommendations include a dual-diagnosis approach in rehabilitation centers, professional training to recognize and treat BPD co-morbidity, and comprehensive aftercare programs to prevent relapse. Further research is advised to explore cultural impacts on BPD and alcohol abuse in Rwanda and to conduct longitudinal studies on recovery outcomes for dual-diagnosis patients.

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