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Personality Disorders, Prevalence and Challenges -An overview

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ABSTRACT

Patients suffering from personality disorders exhibit common symptoms of impulsive behaviour, distorted perception, disturbed interpersonal relationships and dramatic or attention seeking behaviour. The present research has aimed to portray an overview on personality disorders, the prevalence rates and numerous challenges faced by those who are facing with personality disorders. The age factors of the occurrence of the disorder, prevalence rates, causes of the disorder and also the challenges faced by different types of patients with personality disorder condition are also addressed. Personality disorder condition in a family leads to elevated burden, anxiety and caregiver burden for the patient's family members too. In the present scenario the disorder is not addressed by the community, the present piece of research is an attempt to identify the struggle of the patients diagnosed with personality disorder.

Keywords*: Personality disorder, Prevalence, Self – Awareness, Childhood Trauma.*

Personality disorder is a condition where an individual have an unhealthy pattern of thinking, functioning and behaviour. Individuals with personality disorder have trouble in perceiving and relating to situation and people. Personality disorder usually starts from adolescence to young adulthood and leads to clinically noteworthy suffering or damage in social, occupational, or other important areas of functioning. There are many causes for personality disorder including genetics, childhood trauma, verbal abuse, high reactivity, Issue with self - esteem, problem maintaining close relationship, lack of empathy, problem in regulating emotions, low self - awareness are some signs of personality disorder. The aim of the present paper is to address the development of personality development in people, especially in children and adults. Along with the age factor, the paper also tries to look into the gender dynamics in the development of personality disorders and also the challenges and the relevance of intervention of personality disorders at an early stage. Now research and studies have begun to investigate the potential influences of various factors, from genetics and parenting to peer influences, and even the

randomness of life events.

DSM-1 published personality disturbances for the first time in 1952. Personality disorders are currently explained as pervasive, maladaptive, and chronic patterns of behaviour, thinking, and feeling, leading to distress and dysfunction. Patients with personality disorders suffer from distorted perceptions of reality and maladaptive coping mechanisms, along with subjective distress. They are most frequently associated with impaired interpersonal functioning. With no specific trigger, the average age of onset is childhood to adolescence. However, manifestation of symptoms usually occurs in early adulthood. There is no specific etiology of personality disorders, but they are believed to be a sum of genetic and environmental factors, along with early conditioning and formation of core beliefs. Personality disorders are also chronic in nature, with therapeutic interventions aimed at management rather than removal of symptoms.

The Diagnostic and Statistical Manual (DSM-III) in 1980 first published a separate axis of personality disorders (Axis II), there has been a hike in research around clinical features, assessment, management, course and outcome of personality disorders. The World Health Organization estimates the prevalence of a personality disorder to be 6.1%, with cluster A at 3.6%, B at 1.5%, and C at 2.7%. For individuals previously diagnosed with a psychiatric disorder, the prevalence increases to 30%. National Comorbidity Study Replication (NCS-R, 2007) reported a 9.1% prevalence of any personality disorder in US adults.

A recent global assessment (Winsper et al., 2020) revealed that the worldwide prevalence of any personality disorder was 7.8%, exceeding WHO's estimate of 6.1%. Global rates of Cluster A was 3.8%, Cluster B was 2.8%, and Cluster C was 5.0%. Empirical literature on personality disorders in India is scanty, and few reports on etiology, validity, service delivery and treatment is present (Sharan, 2010). In India, it is challenging to discover an accurate psychiatric epidemiology, as psychiatric symptoms differ considerably across cultures, and there is a lack of tools and measuring techniques that are specifically applicable on the Indian population. (Carstairs and Kapur, 1976)

A study done by Vidyasagaran et al., 2023, revealed a high prevalence of mental disorders in South Asian countries, however the research was limited to common mental disorders due to lack of evidence regarding personality (and other) disorders. There is an increasing need for research to better understand and gap the bridge between mental disorders, personality disorders, and personality traits.

Personality disorders may be understood as conditions that cause deviant patterns of experiences and behaviours in areas like cognition, affectivity, interpersonal relationships and impulse control. The prevalence and stability rate of personality disorders across the age groups are enumerated below. In adolescents, prevalence estimates for having minimum one PD have ranged from 6% to 17% correspondingly, the median prevalence is 11% (Johnson, Bromley, Bornstein, & Sneed, 2006). Proportional large-scale studies among adults suggest that prevalence rates are approximately 10% to 15% for minimum one PD, and 1% to 2% for each particular Personality Disorder diagnosis (Mattia & Zimmerman, 2001; Torgersen, 2005). Looking at these samples it appears that, Personality disorders are prevalent in adolescents as

in adults. The fact may be noted that the prevalence rate of PD may be higher in early adolescence to that to later adolescence, where it becomes comparable to youth and adulthood (Johnson, Bromley, et al., 2006). Even the stability of personality disorders are about the same in adolescence and adulthood, if the stability of the diagnosed symptoms in adolescence is low, then the gravity of the problem might be low.

To understand the stability of PD symptoms, it's important to have a to look into its rank-order stability, mean level change, and stability of PD diagnoses over time. Rank-order stability is the unchanging nature or the consistency in the relative order of an individual's ranking as compared to the others in the group, representing the degree to which individual differences persist over time. Rank-order stability of PD symptoms across time shows a moderate level that is, in a range of 0.40 to 0.60 in adolescents and young population (Cohen, Crawford, Johnson, & Kasen, 2005; Johnson, Bromley, et al., 2006). Similarly, moderate levels of rank-order stability were observed in adults (Grillo & McGlashan, 2005). The increase or decrease in the mean tarot level of a whole population is referred to as mean level change. As per this criterion, its observed that the peak in average level of PD symptoms occur in early adolescence and dips as it progresses to later adolescence and adulthood (Cohen et al., 2005; Johnson, Bromley, et al., 2006). Finally, the stability of PD diagnoses seems to be modest over time (Clark, 2007; Cohenet al., 2005; Grilo & McGlashan, 2005; Johnson, Bromley, et al., 2006; Skodol et al., 2005; Zanarini, Frankenburg, Hennen, Reich, & Silk, 2005, Shiner,2009). The reason for this can be attributed to the categorical PD diagnoses, which may lead to remission of some individuals by falling below threshold of diagnoses by only one symptom. In adults, acute symptoms such as strange behaviour, and self-harming can be resolved, but the underlying personality traits cannot be addressed. This means there are more and less stable aspects of PD symptoms in adults (Shiner, 2009, McGlashan et al., 2005).

McAdam and Pal (McAdams & Pals, 2006) divides personality into three domains-dispositional signatures, characteristic adaptations, and personal narratives (Shiner,2009). The personality traits that are exhibited in cognition, behavior and emotion with some consistency over time by an individual can be termed as dispositional signatures. Characteristic adaptations refer to those responses which are situational in nature, that is they depend on the circumstances. Personal narratives are the story built by an individual indexing their identity. Aspects of the three domains may influence the development of other domains. It is shown that children develop traits (dispositional signatures), and a range of characteristic adaptations, and youth develop personal narratives towards the end of adolescence (Shiner, 2009). Some researchers suggest that personality disorders in adults may represent maladaptive variations in the Big Five Traits- extraversion, neuroticism, conscientiousness, agreeableness, openness to experiences (Clark, 2007; Livesley, 2007; Markon, Krueger, & Watson, 2005; Trull & Durrett,2005; Widiger & Simonsen, 2005). Children manifest genetically influenced traits in their early developmental period, which also includes the Big Five traits. These normal ranges of traits can also have the contents for personality disorders, including variations from typical emotions, impulsivity, etc. Apart from this some pathological personality traits are also accountable for developing PD symptoms in children and adults and genetic factors seem to be the reason for these pathological dimensions (Shiner,2009). Hereditary factors may also be attributed to the development of PD symptoms (Perugula, M., Narang, P., & Lippmann, S.

(2017).

Two characteristic adaptations that can help in understanding personality disorders are mental representations and coping strategies (Shiner,2009). Mental representation is the many ways in which children and adults think and perceive about themselves, those around them and their circumstances based on previous experiences. The issue in PD symptoms is that mental representations appear as disturbances as in how people perceive themselves, others and their environment- disproportionately negative self-views, over inflated self-views, profound distrust and alienation from other, excessive tendency to idealizing or devaluing others (Skodol, 2005).

While addressing the role of personal narratives and narrative indentures in developing PD symptoms its seen that personal narratives develop around late adolescence and towards adulthood. Personal narratives help people to develop and articulate an explicit identity. Narrative identity is an important aspect of personality in adolescence. Researches show that the difficulty in integrating negative experiences into a positive functional story and the inability to construct a coherent story are some personal narrative processes that can explain the manifestation of PD symptoms. People need to find ways to positively integrate their negative experiences to the narrative, otherwise they will suffer. The contamination of a positive event by the following up of a negative sequence is associated with low self-esteem and greater depression (McAdams, 2009). Young people, throughout their transition in adolescence are overwhelmed with the task of constructing an identity. Some youths fail to build a coherent life story that brings together their sense of self and their experiences. This can cause problems for developing PD symptoms in adolescence and early adulthood (Shiner, 2009). Various dimensions of the identity construct, like subjective experiences and social-cognitive perspectives also helps to understand the aspects of self and interpersonal impairments associated with personality disorders (Benzi, Madeddu,2017)

Troubles with coping are crucial parts of both standard and pathological personality development. Difficulties with coping are part of the direct diagnostic criteria for some of the PDs. Taking the example of borderline PD, it includes behaviours suggesting poor coping with stressful emotions- through substance use or self-harming behaviour. Chanen &McCutcheon (2018), have stated that the early intervention of the personality can help reduction of long-term curve and could improve the outcome. The shortcomings and difficulties in prevention and intervention are discussed further. The late intervention of the issue is one of the failures in the treatment of personality disorders. The issue began in early childhood and continues into adulthood, although it is disregarded and handled in adulthood, which occasionally compromises the disorder's total elimination. Service accessibility is restricted, and many places lack the infrastructure necessary to put early intervention programs into place. Programs for prevention are lacking, and prevention techniques for personality disorder are not as advanced as those for other psychotic disorders. Other shortcomings noted include diagnostic stigmas and the expenses for treatment. Changing the belief that personality disorders in young people cannot be treated is one of the challenges in the community. This paper also highlights the necessity for change in the mindset of the community in order to actively treat personality disorders in children and adults. Effective intervention is required for preventing the disorder entering into adolescents. Psychotherapeutic techniques such as cognitive behaviour therapy and Dialectical behaviour therapy are effectively used for addressing the personality disorder.

Early intervention will address the issue by the helping the diagnosed individuals in developing coping skills that is necessary for the emotional regulation, in managing relationships and behaviour more effectively.

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