

## **Investigating The Prevalence Of At Risk Personality Disorders Among College Students In Rural Southern India.**

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**Abstract:** The assessment of personality disorders in young adults have received an increased research attention in the last 10-15 years. Although it has been reflected in the legitimization of personality disorder diagnosis in psychiatric nomenclature, and in national treatment guidelines around the world, it is yet to penetrate routine clinical care. It is therefore imperative to create a section on Developmental Aspects of Personality Disorder in youth to promote research into detection and diagnosis of personality disorder in young people. Research has supported the notion that emotional dysregulation and problems with impulse control are the core features of PD. Young adults experience more frequent and intense emotions than older individuals that cannot be regulated easily. Against this background, the overall aim of this study was to diagnose the level of prevalence of PD's in university students in Perambalur district, with special reference to their cognitive and behavioral symptoms. A questionnaire was developed to diagnose the level of PDs in students. It was administered with a sample of 516 students and data reveal that around 68% of the students who are not in treatment qualify for DSM 5 personality disorder diagnoses.

**Keywords:** personality disorders, youth, prevalence, university students, mental health ,India

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### **I. INTRODUCTION**

Personality disorder is now being accepted as an important condition in mainstream psychiatry across the world [1]. PD is now widely recognized as a major mental disorder that is associated with severe psychosocial dysfunction and poor quality of life. Moreover, PD has come to be considered treatable and, in some cases, even to remit [2][3] as against, considering this disorder as a special and intractable form of adult mental disorder separately from other mental disorders [4][5]. Ever since the official recognition by the American psychiatrists in 1950s, particularly since the introduction of DSM-III in 1980, there has been an increasing level of understanding, inclusion and, indeed, respectability that now allows Personality disorder to be considered as an equal partner with other mental disorders. This heightened recognition of PD is also reflected in the international proliferation of official treatment guidelines [6][7] [8][9]. Recently, this disorder has become more prominent in the international research literature as well [10].

However there have been few studies in personality disorder; in India. A study of PDs is justified for several reasons in India. They are common across countries and their presence influences the outcome of comorbid psychiatric disorders [11]. Today every fifth person in India is an adolescent (10-19) and every third – a young person (10-24) [12]. Investing in this segment is the best way to leverage the nation's competitive advantage – its demographic dividend. Considering the fact that 68.84 percent of population lives in rural areas [13] with only about 25 percent of the health infrastructure, medical manpower and other health resources, it may be surmised that the number of people affected with any mental and behavioral disorder would be higher in rural areas. The present research was prompted by the fact that data from India on prevalence and demography of PDs is sparse. Present study is undertaken to identify young adults who are not in treatment but qualify for DSM-V personality disorder diagnoses and that these diagnoses are associated with increased risk of psychological distress and functional impairment.

#### **1.1.Purpose and rationale of the Research**

This study surveys the existing state of prevalence of PDs in the first two decades of life. Although there is far less research on PDs in childhood and adolescence than on other early-emerging disorders, the research that does exist has made it clear that personality pathology does occur in childhood and adolescence and poses significant risks for mental health problems and impairment both concurrently and later in life [14][15] [16][17] [18][19] [20][21] [22][23] [24]. Researchers are finally turning their attention to the early

manifestations of personality pathology and to the antecedents of adult PDs[25][26] [27][28]. Borderline PD (BPD) in youth and the childhood antecedents of antisocial PD (ASPD—e.g., conduct disorder and psychopathy) have received considerable attention, but researchers have to explore many of the other PDs and broader personality pathology domains in youth as well.

Furthermore Almost one in five young American adults has a personality disorder that interferes with everyday life states Dr.Mark Olfson of Columbia University, 2008 based on a research study with 5,092 young adults between the ages 19 to 25. Studies suggest that 41% to 64% of adolescents in clinical settings meet diagnostic criteria for PDs, indicating they are highly prevalent[29].The study authors noted that tragedies such as fatal shootings at Northern Illinois University and Virginia Tech have raised awareness about the prevalence of mental illness on college campuses.

The available data on Personality Disorders in adolescence makes a compelling case for the development and implementation of empirically based prevention and early intervention programs[30].PD can have severe repercussions, and its developmental disruptions have cascading effects[31] that potentially alter or divert the entire course of development[32].Prevention and early intervention programs hold the promise of not only alleviating present difficulties but also potentially averting future negative outcomes through targeting PD pathology before it become more ingrained and chronic[33].

Early intervention programs aim for the early detection and treatment of the full-syndrome disorder. Consistent with knowledge on the course and development of PD, indicated prevention and early intervention programs should not just target the diagnostic features of PDs, which might naturally attenuate over time; rather, they should aim to improve adaptive functioning and alter the developmental trajectory of PD. For decades, there has been general agreement, as reflected in the official diagnostic manuals, that PD has its onset at least by adolescence or early adulthood[7]. Most young people are presumed to be healthy but, as per WHO, an estimated 2.6 million young people aged 10 to 24 yrs. die each year and a much greater number of young people suffer from illnesses ‘behaviors’ which hinder their ability to grow and develop to their full potential. Personality development disorder is considered to be a childhood risk factor or early stage of a later personality disorder in adulthood[34].The use of maladaptive behaviors during this life stage has implications that extend for a lifetime [35].Hence the present study is committed for an exclusive investigation in this regard to enable students at risk of Personality disorder to get rid of their symptoms so as to help them do well in their personal and academic life. Research studies shows that although there is considerable variation in the degree of distress, dysfunction caused and severity, Personality disorders are common clinical syndromes that often go unrecognized in medical practice.

The rural mental health services are neglected area which needs immediate attention considering the burden of disease and treatment gap [36].With an approximation of 68.84 % of the population being residents of rural and agricultural settings in India[37] there is a skewed scenario of the mental health condition there in contrast to that of urban India. Along With More than literacy which is 73% in rural TamilNadu[37]the rapid movement of awareness makes a huge difference in understanding and intervention for mental health conditions like personality disorder. The discrepancy lies in understanding these constructs and taking relevant measures to incorporate them as a part of living by de-stigmatizing them. From a cultural perspective, mental disorders are associated with a considerable amount of stigma in Indian society, leading to neglect and marginalization. Such individuals and their families face numerous challenges in daily life, both for managing the condition, as well as for making them productive due to prevailing attitudes, media portrayals, societal discrimination, and deprived opportunities. With less than 1 % (0.06 %) of the budget being allocated for mental health, treatment gap is a growing problem. Shortage of mental health professionals, lack of infrastructure, and limited training further compound the crisis in rural India.

Nevertheless, there are quite a few factors of the rural set-up that promote health as well. Community living is one of the biggest resources in rural India. Here, a strong family and an equally strong community are present in order to care for and support vulnerable individuals. Appropriate treatments can starkly reduce the burden of personality disorders and also by harnessing the preventive aspects of community living. It is in this assumption; the present study makes its attempt to investigate the college students who are at risk of Personality disorders.

## **II. METHODOLOGY**

The study was carried out in 6 colleges providing education in Arts and Science to a major area in the most backward district in South India, TamilNadu, Perambalur - Government Arts and science college, Veppinhattai ;Bharathidasan university constituent college, kurumbalur ; Than Thai Hans Roever Arts and science college, perambalur Dhanalakshmi Srinivasan Arts and Science college ,perambalur; Dhanalakshmi Srinivasan Arts and Science college for women, perambalur and in Bharathidasan university constituent model college,Veppur with students who come under the age group of 18-24 years. The students have a population base of approximately

40 million people with a broadly similar South Indian culture and a full range of socioeconomic variation. They come from the states of Tamil Nadu, Kerala, Karnataka, Andhra Pradesh and Telangana. These colleges serve as the first and direct contact for almost all courses in central Tamil Nadu.

Using a survey design with self report questionnaires of 70 questions with 516 random samples from 6 colleges in perambalur has been conducted thereby understandings of personality disordered were explored. A brief structured informant based questionnaire similar to Standardized Assessment of Personality Disorder(SAP) was conducted for all personality disorders. An interpretive, collaborative approach to research was adopted in which university-, clinical- and service user (consumer) researchers were jointly involved in carrying out interviews and analyzing interview data. Out of the total 655 student samples collected, who did not want to participate in the study were excluded. The subjects were informed of the objectives of questionnaires before completing the questionnaires and they had a thorough knowledge and freedom in the presence or absence in the research process. The statistic community included all students of who were students of the universities at the time of questionnaire completion and in the second semester 2015. The sample was selected from the community and via multi-stage cluster sampling method. The method of sample selection was randomly within each cluster of it, so that it covers 4 colleges in central town of perambalur one in east and the other west of perambalur district. Then two business days were selected randomly for each academic unit. Next, 10 classrooms were selected randomly from the entire same classrooms' academic unit during 2 days that totally three University units of BA, BSc and B com were selected with a sample size of 516 subjects under study sample. Of course, this is a sufficient number of samples for the study community according to Morgan table.

This test is composed of including all 22 clinical scales of personality models (scales of schizoid, avoidant, dependent, histrionic, narcissism, antisocial, aggressive, obsessive - incontinence, passive - sadism, critical patterns of personality (including schizophrenic, borderline and paranoid) and clinical symptoms (anxiety scales, bipolar confusion, bad tempered, dependence, drug dependence, thought disorder, major depression and delusional disorder. The test was first introduced in Veppinthattai and a pilot study was conducted for normalization of it in kurumbalur. Reliability coefficient of test has been reported through internal consistency of data .This questionnaire has the cutoff point and scores 15 or more in each factor is the indicator of at the risk personality disorder in that factor.

A dimensional trait score for each of the 10 DSM-5 PDs in three clusters was created by summing the score for all of the traits included in each of the personality scores. And later it was required that the examiner ask a series of direct questions about particular characteristics. Diagnosis of specific PDS made by a dimensional score for each PD was calculated for each of the 10 DSM -5 PDs by summing each constituent item of the specific disorder. The inter rater agreement among 2 psychiatrists in terms of the total number of DSM-5 PD symptoms was assigned. The relevant socio-demographic details of the sample were also collected using structured proforma. One concern over the appropriateness of the diagnosis of personality disorder in young people is its stability, particularly at a time of major developmental change during which some of the features that constitute the disorder are present, albeit at lower levels of intensity. The issue of stability of the diagnosis is important because it has an impact on the identification, diagnosis and treatment of personality disorder in young people. The most appropriate research design to establish whether the personality disorder diagnosis is stable in young people is the prospective cohort study. The evidence base reviewed, therefore, comprised all available prospective studies undertaken in young people in whom a diagnosis of personality disorder had been made either at baseline or at follow-up. Review studies focusing on personality disorder in young people were also sought to ascertain the state of the available literature and to check that the relevant references had been identified by the search strings use

### III. RESULTS

A total of 516 participants were included in the study. Majority of the participants were between 19 to 21 years of age at the time of study. The proportion of females was 76.5 % in the study population. Assessment of Educational qualification showed the participants were almost uniformly distributed across education categories where humanities constituted 64 %.( Table 1).

| Age         |                    | Education | Frequencies | Percent | Gender |      |
|-------------|--------------------|-----------|-------------|---------|--------|------|
| Mean        | Standard deviation |           |             |         | FEMALE | MALE |
| 19.37692308 | 0.78               | BASIC     | 185         | .36     | 395    | 124  |
|             |                    | SCIENCE   | 331         | .64     |        |      |
|             |                    | TOTAL     | 516         |         |        |      |

**Table 1.** Demographic characteristics of the sample in terms of age, education and Gender.

Descriptive statistics of the sample, including maximum, minimum, average, standard deviation and standard error of scores are provided in variables in Table 2.

| Variables            | MAXIMUM | AVERAGE  | STANDARD DEVIATION | MINIMUM | STANDARD ERROR |
|----------------------|---------|----------|--------------------|---------|----------------|
| Paranoid             | 30      | 9.337    | 6.59               | 0       | 0.28           |
| schizoid             | 25      | 3.157    | 3.89               | 0       | 0.17           |
| Antisocial           | 35      | 9.712    | 6.04               | 0       | 0.26           |
| Narcissistic         | 40      | 18.445   | 7.95               | 0       | 0.34           |
| Histrionic           | 15      | 2.658    | 3.57               | 0       | 0.15           |
| Avoidant             | 45      | 16.583   | 8.94               | 0       | 0.39           |
| Dependent            | 30      | 8.742    | 6.70               | 0       | 0.29           |
| Obsessive compulsion | 40      | 13.838   | 7.38               | 0       | 0.32           |
| Schizotypal          | 25      | 7.571977 | 5.14               | 0       | 0.22           |
| Borderline line      | 40      | 16.38196 | 8.86               | 0       |                |

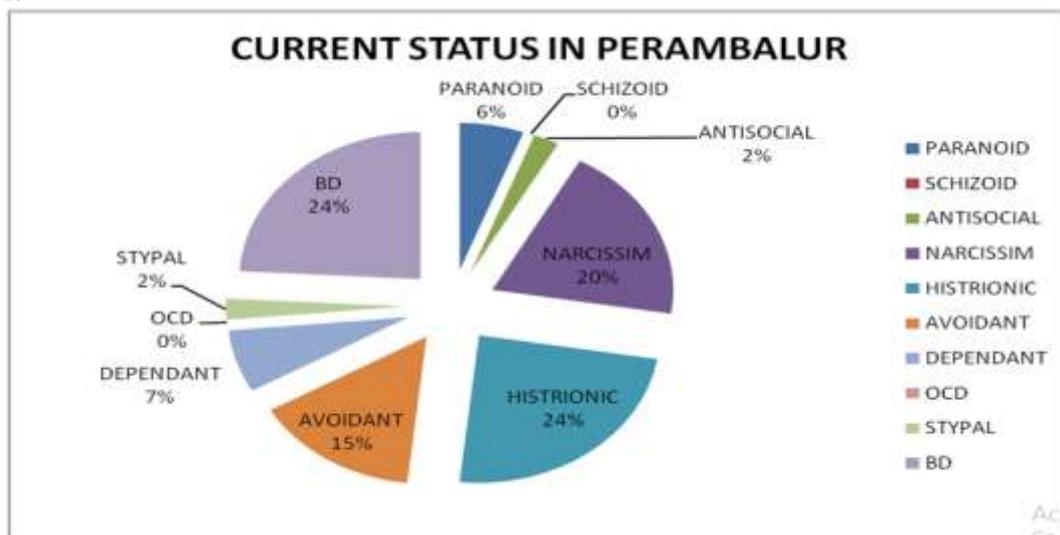
**Table 2.** Descriptive statistics of the sample in studied variables.

In accordance with what has been proposed in the present study, one of the main objectives of the present study was to determine the prevalence of personality disorders among university students. The frequency and prevalence of personality disorders have been listed in Table 3.

| PERSONALITY DISORDERS | SAMPLE | NUMBER OBSERVED |
|-----------------------|--------|-----------------|
| Paranoid              | 516    | 150             |
| Schizoid              | 516    | 71              |
| Antisocial            | 516    | 48              |
| Narcissistic          | 516    | 307             |
| Histrionic            | 516    | 50              |
| Avoidant              | 516    | 232             |
| Dependent             | 516    | 155             |
| Obsessive compulsion  | 516    | 144             |
| Schizotypal           | 516    | 81              |
| Borderline            | 516    | 230             |

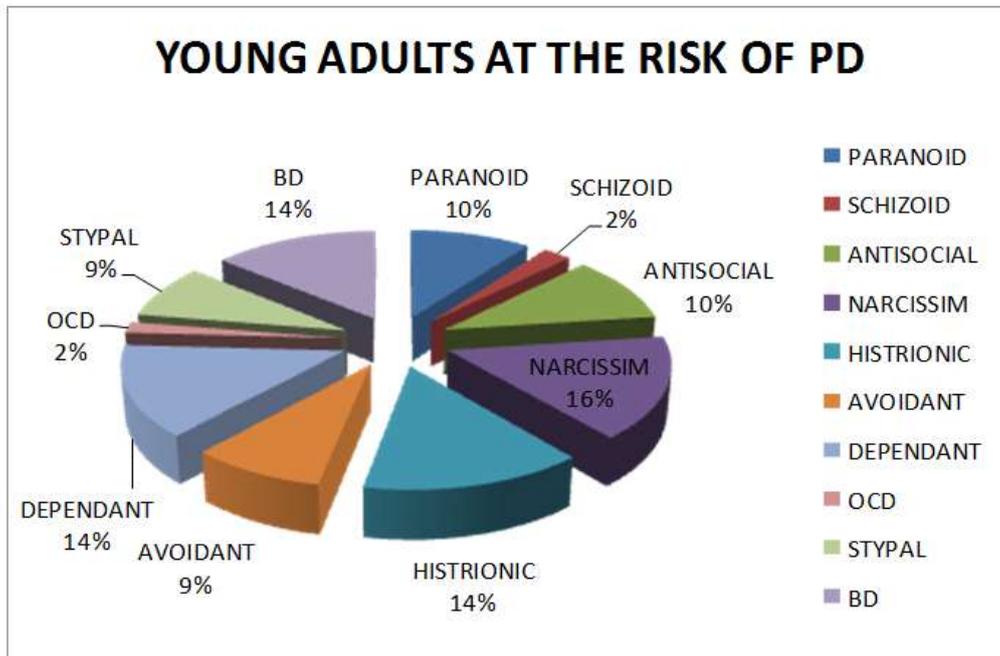
**Table: 3** personality disorders observed

Samples' showing Current status in perambalur district with very high symptoms of specific disorder is shown in Fig 1.



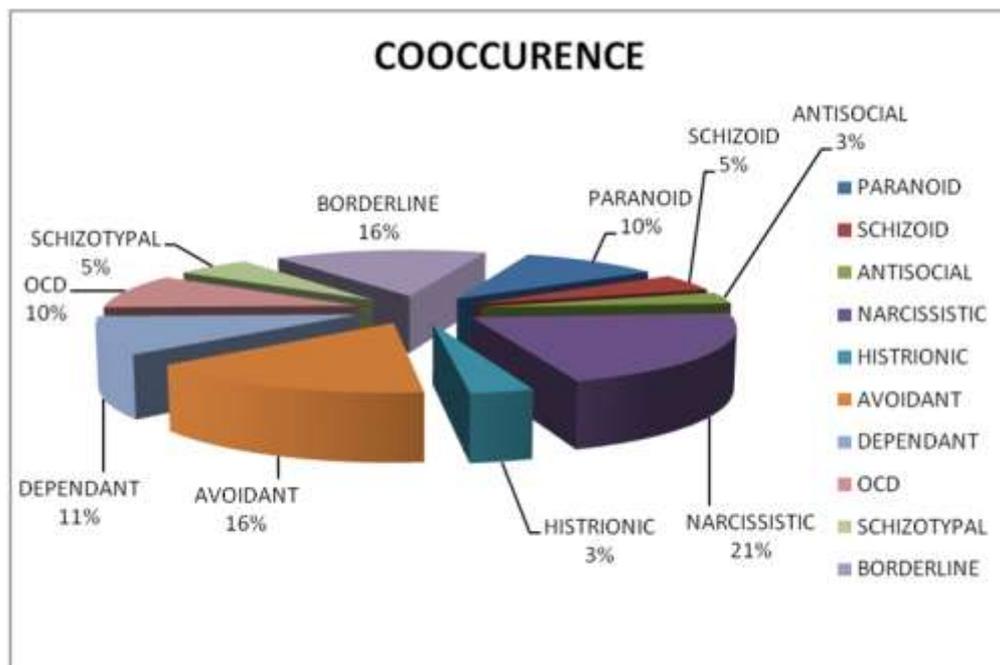
**Figure :1** Current status in perambalur district with very high symptoms

Fig: 2 illustrates the prevalence of personality disorder symptoms with moderate /at the risk levels, who are qualified for diagnosis of specific PDS in perambalur district, TamilNadu.



**Figure: 2** prevalence of personality disorder symptoms with moderate /at the risk levels.

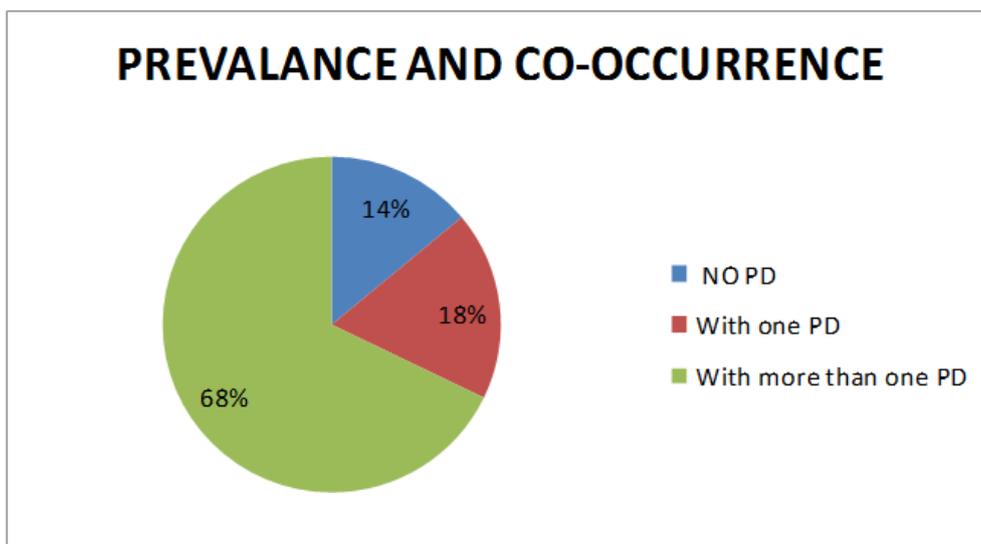
Numbers also lists out the co-occurrence of disorders in higher figures. See Fig:3



**Figure :3** co-occurrence of personality disorders

**Table 4** illustrates the presence of disorders in three modes (see Fig 4).

| Personality disorder  | SAMPLES | Number observed |
|-----------------------|---------|-----------------|
| NO PD                 | 72      | 516             |
| With one PD           | 94      | 516             |
| With more than one PD | 350     | 516             |



**Figure : 4** shows the prevalence and co-occurrence of personality disorders.

#### IV. DISCUSSION

Considering the wide range of adverse health outcomes resulting from Personality disorders (PDs) [38][39] and reported co-occurrence with other psychiatric disorders [40][41][42][43][44][45], the current study has attempted to document the at risk population to identify the prevalence of PDS among young adults. It is important to estimate the prevalence of PDs across the lifespan, in order to obtain a clearer developmental perspective on the emergence and course of PDs. At this point, far more prevalence studies have been conducted in adult samples than in samples of youth. Chanen and McCutcheon (2013) [46] have convincingly shown that this condition is diagnosable in adolescence, and suggest that its prevalence at that stage may be particularly high. Both quantitative and qualitative reviews find that around 75% to 80% of those individuals treated with psychotherapy benefit from it [47][48].

The prevalence of PD in adolescent community samples and primary care settings generally ranges from 6% to 17% across studies [49]. An exception to these estimates was a study by Lewinsohn and colleagues [50] which found a low prevalence of PD in the community (1.7% among participants without and 3.8% among participants with a history of other mental disorders). Prevalence estimates in clinical samples range from 41% to 64% [29][51], and from 36% to 88% in juvenile justice samples [52][53] [54].

The main finding of the present study was that more than one fifth of the adolescents who were considered had chances of having one or more personality disorders. The prevalence of personality disorders in the present study was similar to previously reported from community samples [53]. Clinical samples of adults display high current rates of PDs, with an estimate range of 46–81%, and with estimates as high as 51–88% when PD-NOS is included [55] which corresponds to the present study. The prevalence of personality disorder was 86% among the study population was comparatively low, when compared with the reported prevalence of PDs among psychiatric patients from various other countries by Beckwith H., et al., who has reported estimates ranging from 40% and 92% in Europe, and high, between 45% and 51% in the USA [56]. But the prevalence was very high, as compared to the reported prevalence of 1.07% from India [40]. The fact that the above study was carried out to identify young adults who are at the risk, may have been responsible for the difference. The prevalence is also very higher as compared to the prevalence of Personality Disorders reported in the general population, which are ranged from 6.1% to 10% [57]. This emphasizes that the likelihood of co-existing personality disorder is very high in young adults, compared to general population and psychiatric outpatients and warrants regular screening in this high risk population.

Over the years, NPI (Narcissistic personality Index) questionnaires have been administered to many samples of college students, and analyses that bring all of the data together reveal that the average narcissism score has been steadily increasing and the average empathy score has been steadily decreasing ever since the questionnaires were developed [58]. The changes are highly significant statistically and sufficiently large that approximately 70 percent of students today score higher on narcissism and lower on empathy than did the average student thirty years ago.

In terms of the DSM-5, Section II, grouping of PDs into three clusters on the basis of descriptive similarities, Cluster B PDs appear to be the most prevalent during adolescence [29][59], a finding that again converges with data for adult populations [60]. The most common type of personality disorder while identifying who are qualified for diagnosis in this study is narcissism (16%) followed by borderline (14%) both comes

under cluster B and dependent (14%) which is under cluster C personality disorders. In addition to these statistics, it's important to know that many have traits of a PD, but not the full disorder. The most common personality disorders in study by Gupta S, et al. (2010) was avoidance (7.7%), followed by anti-social (5.17%) and borderline (3.45%) personality disorders [40].

According to the largest study ever conducted on personality disorders (PDs) by the U.S. National Institutes of Health (NIH), of the people meeting the criteria for a BPD diagnosis, 53 percent were women and 47 percent were men [61]. This is contrary to the old DSM-IV statistic of 75% women. Of the people meeting the criteria for NPD, 62 percent were men and 38 percent were women [62]. But college students' scores on the Narcissistic Personality Inventory indicate that young women are increasingly narcissistic and closing the gap with men [63], so these gender percentages are not statistically significant enough to make any assumptions about men or women predominantly having one or the other disorder.

In the present study girls had more than twice the personality disorder prevalence of boys, but the difference was not statistically significant. However, a trend was discernible toward significantly higher prevalence for girls having at least one personality disorder, and even stronger for girls with more than one personality disorder. However the representation of boys in the study was low. The limited available information on community samples of PDs and PD traits in youth suggests that gender differences in prevalence rates or levels of symptoms are likewise small or nonexistent [64] [65], other than the consistent finding that conduct problems are more prevalent in samples of males [66].

Almost 40 percent of people with one of these disorders also have the other, according to an NIH study [61] [62]. Comorbidity appears to be the rule rather than the exception among PDs in both adolescents and adults. There tends to be a high level of comorbidity among PDs in epidemiological samples of adults [67] [68]; in fact, it is relatively uncommon for an adult to have only one PD, and this is even rarer in clinical samples [68]. In contrast to the substantial literature on comorbidity among PDs in adults, there are surprisingly few studies of such comorbidity in youth. The current study shows nearly 68% of the samples show the presence of more than one PD. The Children in the Community study has not reported specific rates of PD comorbidity, but Cohen, Crawford, and colleagues (2005) noted that in this sample, "There is relatively high comorbidity and correlation among the criteria counts for the PDs" (p. 470) [14]. Becker, Grilo, Edell, and McGlashan (2000) reported that a sample of hospitalized adolescents with BPD showed unusually high rates of comorbidity with Cluster A and Cluster C PDs, compared to a comparison sample of adults [69]. Similarly, and De Clercq colleagues (2004) found unusually high rates of overlap among PD symptoms in their adolescent sample [70]. Future work should address the question of whether comorbidity among PDs is especially high in youth.

## **V. RECOMMENDATIONS AND SUGGESTIONS**

The findings of the study suggest important considerations, and recommendations for future research. There is a clear need for research focusing on PD in college students to be conducted in countries other than the US and Europe. The systematic searches in the existing studies failed to uncover reported prevalence in the India and in fact a greater proportion of Asia. While US-based studies are unquestionably useful, factors that are associated with variance such as race cannot be generalized to countries where college students tend to be more homogenous. Relatedly, a range of demographic characteristics associated with PD is not measured in most of the existing studies review. This information was not available for a large proportion of the studies, and is worth including in current research.

At a research level, there is a clear imbalance among specific Personality Disorders with the highest focus on Antisocial and Borderline Personality Disorder. So far, little has been published about Race, Ethnicity, Culture and Personality Disorders in youth as well as with adults. The wider topic of the interface between culture, race, ethnicity and Personality Disorders still remains relatively unexplored, as compared to other aspects of Personality Disorders. People from rural communities access PD services at a lower rate than the general population. This has been attributed to general patterns of misdiagnosis and lower access to talking therapies, leading to poorer outcomes. Youth in rural are diagnosed with Personality Disorders much less frequently than with other mental disorders, although no specific reasons have so far been identified for a lower prevalence of these disorders among these groups. More research is needed in this field.

While people approach doctors for major psychiatric disorders, in which the symptoms are easily recognizable, very few with mild to moderate PD reach out for help, poor awareness and the stigma associated with personality disorders are the main cause. An elaborate awareness program and its importance have to be taken up immediately in order to build a productive generation. Treatment in India is more affordable than in most western countries as treatments, therapies' and medicines are cheaper. In the United States, though psychiatric disorders are covered by insurance, the number of times one can visit a doctor is limited. The hindrance is only the identification/early identification of this disorder. Although the 2015-2016 survey by NIMHANS was very comprehensive and covered all zones it didn't give much importance to personality disorders. One of the major recommendations of the report was that the treatment gap needs to be bridged which should include personality disorders as well.

The most significant advantage of early diagnosis seems to be the likelihood of early treatment while decreasing prevalence as well as severity of impairment in functionality. Despite a marked increase in research supporting the assessment, diagnosis and treatment of personality disorder (PD) in young adults, clinicians continue to be reluctant to apply treatment guidelines and psychiatric nomenclature in routine clinical care. This gap arises from several beliefs: (1) psychiatric nomenclature does not allow the diagnosis of PD in adolescence; (2) certain features of PD are normative and not particularly symptomatic of personality disturbance; (3) the symptoms of PD are better explained by other psychiatric syndromes; (4) their personalities are still developing and therefore too unstable to warrant a PD diagnosis; and (5) because PD is long-lasting, treatment-resistant and unpopular to treat, it would be stigmatizing to label a young adult with personality disorder (PD). Before now, because of the widespread misconception that PD cannot be treated, many people have been denied access to services. This has led many people with PD to be wary and distrusting of mental health professionals. 'In order to engage these people in services', it will be necessary to foster an attitude of respect for their suffering and an approach that recognizes their dignity as fellow human beings. In this paper, the empirical evidence challenging the importance to identify and giving early treatment is attempted and thereby preventing the disorder. Although a comprehensive diagnostic system for mental disorders organized by personality variation remains well in the future, the current research suggests that the potential of such a system deserves careful consideration and research attention.

More training across teams both within and reaching out to other services , More support – case consultations and carer support ,Better treatments – less hospital management, and more integrated multi-disciplinary approaches , Better guidelines and protocols – across services from acute to outpatient and Reduce stigma as a barrier to help – change staff attitudes to treatment of personality disorders are very much required in the present scenario and the present study hopes to contribute for the same in a wide manner along with identifying and giving early treatments for personality disorders. Services need more expert consultations with evidence-based practices: as Evidence evenly supports Behavioral (e.g. DBT) and Dynamic (e.g. MBT, TFP) treatments, but Dynamic awareness, training and practice is low , Clinicians report that their work practices are dominated by crisis work through hospitals and unstructured case management ,Guidelines-lead brief and extended evidence-based therapies and studies on personality disorder on practical side helps them to work for the need group from the base level.

Finally, the review suggests resource allocation considerations for colleges. At a pooled prevalence rate in the present study the findings suggest that PD is apparent in college student populations. Given symptoms of the disorder include high-risk behaviors such as self-harm, suicidal expression and aggression; the study findings have particular relevance for college-based mental health services. College-based treatment programs such as modified Dialectical Behavior Therapy, have demonstrated promising results in treating students with BPD symptoms cost-effectively[71]. Multiculturalism is another factor that plays a role in determining Personality disorders. Not all cultures have the same underlying belief about the causes or nature of mental illnesses. Personality Disorder Studies using a different methodology should be conducted to understand what is considered, in different cultures, as deviating from the expectations of the individual's culture, and as a significant impairment in self and interpersonal functioning, as defined by the DSM-5 (Personality and Personality Disorders in Urban and Rural Africa: Results from a Field Trial in Burkina Faso ,Jérôme Rossier, Abdoulaye Ouedraogo, Donatien Dahourou, Sabrina Verardi, Franz Meyer de Stadelhofen). What may be considered as an illness or malpractice in one culture may be normative to the other and the scope of the current study is relevant very much in this aspect also.

## **VI. CONCLUSION**

An examination of current research trends needs to consider the research directions needed to arrive at a more systematic understanding of the etiology, development, course, and treatment of personality disorder. Specific research themes with promise are systematic studies of gene-environment interplay, investigations of biological substrates, and longitudinal studies capable of generating information on how the different domains of personality pathology change over time. It could also be improved phenotypes and more sophisticated research designs to explicate mechanisms specific to the various patterns of personality disorder. There also needs a treatment research that is less concerned with comparing the outcome of treatments that often seem modest in effects and limited in scope and more concerned with identifying the most effective treatment methods for each domain of psychopathology. Along with these developments it is also important that research pays more attention to how the integrative processes within personality become dysfunctional in personality disorder. Studies with more frequent assessments could better identify transactions between youth and their environments over time. Well-designed studies could also address fundamental epidemiological questions about PD in youth, including changing prevalence rates over time; gender differences; differences across socioeconomic groups, ethnicities, races, and cultures; and rates of comorbidity among PDs. In future work, it will be especially important to examine the environmental contributions to the development of personality pathology. Vulnerable youth may encounter life experiences that lead to abrupt changes in their personality

functioning. In future work, it will be important to recognize the possibilities of the diverse (linear and continuous or nonlinear and abrupt) processes leading to PDs. The progress made in understanding PD in youth has begun to accelerate in recent years; our hope is that the upsurge in new knowledge about PD in children and adolescents will have an increasingly positive impact on clinical practice.

## REFERENCES

- [1] P.Tyrer, R. Mulder, M.Crawford, G.Newton-Howes, E.Simonsen, D. Ndeti, B.Barrett, Personality disorder: a new global perspective. *World Psychiatry*, 9(1), 2010, 56-60.
- [2] E.Ronningstam, E. Simonsen, J. M.Oldham, C. Maffei, J.Gunderson, A.M Chanen, & T.Millon, Studies of Personality Disorders: Past, Present, and Future in Recognition of ISSPD's 25th Anniversary. *Journal of Personality Disorders*, 28(5), 2014, 611-628.
- [3] A. E. Skodol, J. G. Gunderson, T. H.McGlashan, I. R.Dyck, R.L.Stout, D.S.Bender, J.M Oldham, Functional Impairment in Patients with Schizotypal, Borderline, Avoidant, or Obsessive-Compulsive Personality Disorder. *American Journal of Psychiatry*, 159(2), 2002, 276-283.
- [4] J.M.Oldham, Borderline Personality Disorder Comes of Age. *American Journal of Psychiatry*, 166(5), 2009, 509-511.
- [5] K.R.Silk, Augmenting Psychotherapy for Borderline Personality Disorder: The STEPPS Program. *American Journal of Psychiatry*, 165(4), 2008, 413-415.
- [6] *Borderline personality disorder: Treatment and management. [NICE guideline number 78]*, National Collaborating Centre for Mental Health, London, UK, 2009.
- [7] *Clinical Practice Guideline for the Management of Borderline Personality Disorder*. National Health and Medical Research Council, Melbourne, 2012.
- [8] *Antisocial personality disorder: Treatment, management and prevention. [NICE clinical guideline 77]*, National Institute for Health and Clinical Excellence (NHS), London, 2009.
- [9] *Personality disorder: No longer a diagnosis of exclusion. Policy implementation guidance for the development of services for people with personality disorder*, National Institute for Mental Health England, Leeds, UK; 2003.
- [10] P.Tyrer, N. Coombs, F. Ibrahim, A.Mathilakath, P. Bajaj, M.Ranger, R. Din, Critical developments in the assessment of personality disorder, *The British Journal of Psychiatry*, 190(49), 2007, s51-s59.
- [11] J.H.Reich & A.I.Green, Effect of Personality Disorders on Outcome of Treatment. *The Journal of Nervous and Mental Disease*, 179(2), 1991, 74-82.
- [12] Y.Kim & P.Tyrer, Controversies Surrounding Classification of Personality Disorder, *Psychiatry Investigation*, 7(1), 2010. Census of India, 2011.
- [13] P.Cohen, T.N .Crawford, J.G. Johnson & S. Kasen, The Children in the Community Study of Developmental Course of Personality Disorder. *Journal of Personality Disorders*, 19(5), 2005, 466-486.
- [14] F.De Fruyt & B. De Clercq, *Childhood Antecedents of Personality Disorders*, Oxford Handbooks Online, 2012.
- [15] A.Freeman, & M.A.Reinecke, *Personality disorders in childhood and adolescence* (Hoboken, NJ: John Wiley & Sons, 2007)
- [16] Hill, J. Disorders of personality, in D. Rutter, D. Bishop, D. Pine, S. Scott, J. Stevenson, E. Taylor, et al. (Eds.), *Rutter's child and adolescent psychiatry* (London: Blackwell, 2008) 841-851.
- [17] J.G.Johnson, J.L.Tackett, C.S. Baugh, C.McCullough, J.S. Sneed, H. Lawson, et al. Emergent personality disorders among adolescents with anxiety disorders, in D. McKay & E. A. Storch (Eds.), *Handbook of anxiety disorders in children and adolescents* (New York: Springer, 2012) 187-207.
- [18] I.Mervielde, B. De Clercq, F. De Fruyt, & K.Van Leeuwen, Temperament, Personality, and Developmental Psychopathology as Childhood Antecedents of Personality Disorders. *Journal of Personality Disorders*, 19(2), 2005, 171-201.
- [19] R. L. Shiner, Personality disorders in E. J. Mash & R. A. Barkley (Eds.), *Assessment of childhood disorders* (4th ed) (New York: Guilford Press, 2007) 781-816.
- [20] R. L. Shiner, The development of personality disorders: Perspectives from normal personality development in childhood and adolescence. *Development and Psychopathology*, 21, 2009, 715-734.
- [21] J.L.Tackett, Measurement and assessment of child and adolescent personality pathology: An introduction to the special issue. *Journal of Psychopathology and Behavioral Assessment*, 32, 2010, 463-466.
- [22] J.L.Tackett, S. Balsis, T.F.Oltmanns, & R.F.Krueger, A unifying perspective on personality pathology across the life span: Developmental considerations for the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders. *Development and Psychopathology*, 21, 2009, 687-713.
- [23] D.Westen & C. Chang. Personality pathology in adolescence: A review in A. H. Esman, L. T. Flaherty, & H. A. Horowitz (Eds.), *Adolescent psychiatry: Developmental and clinical studies* 25 (Mahwah, NJ: Analytic Press, 2000) 61-100.
- [24] J.A.DeFife & L.A. Ritschel (Eds.), Special series on personality disorders in adolescence, (Special issue) *Clinical Psychology: Science and Practice*, 20(4), 2013.
- [25] D.Cicchetti & N.R. Crick, Precursors and diverse pathways to personality disorder in children and adolescents. *Development and Psychopathology*, 21, 2009, 683-685.
- [26] R.S.Biskin, & J. Paris, (Eds.), Personality disorders in adolescence. [Special issue]. *Journal of the Canadian Academy of Child and Adolescent Psychiatry*, 22(3), 2013.
- [27] J.L.Tackett, & C. Sharp, (Eds.), A developmental psychopathology perspective on personality disorder: Introduction to the special issue. *Journal of Personality Disorders*, 28(1), 2014, 1-4.

- [28] C.M Grilo, T.H.McGlashan, D.M.Quinlan, M.L. Walker, D. Greenfeld, & W.S.Edell, Frequency of Personality Disorders in Two Age Cohorts of Psychiatric Inpatients. *American Journal of Psychiatry*, 155(1), 1998, 140-142.
- [29] A.M Chanen & Thompson, Preventive Strategies for Borderline Personality Disorder in Adolescents. *Current Treatment Options in Psychiatry*, 1(4), 2014, 358-368.
- [30] J.Garber, Classification of Childhood Psychopathology: A Developmental Perspective. *Child Development*, 55(1), 1984, 30.
- [31] A.S.Masten & D. Cicchetti, Developmental cascades. *Development and Psychopathology*, 22(03), 2010, 491-495.
- [32] P.McGorry, Issues for DSM-V: Clinical Staging: A Heuristic Pathway to Valid Nosology and Safer, More Effective Treatment in Psychiatry. *American Journal of Psychiatry*, 164(6), 2007, 859.
- [33] R.Krueger, Carlson, Scott Personality disorders in children and adolescents. *Current Psychiatry Reports* 3 (1), 2001, 46-51.
- [34] Mental health commission of Canada, A report on mental illnesses in Canada, *health*, 2002.
- [35] A.Kumar, Mental health services in rural India: challenges and prospects. *Health*, 03(12),2011, 757-761
- [36] C.Chandramouli,*Census of India, 2011: Series 1*. Office of the Registrar General & Census Commissioner, India, Ministry of Home Affairs, Govt. of India, 2011.
- [37] K.L.Dixon-Gordon, D.J. Whalen, B.K.Layden, &A.L. Chapman, A systematic review of personality disorders and health outcomes. *Canadian Psychology/Psychologie canadienne*, 56(2), 2015, 168-190
- [38] H.Chabrol, A.Montovany, S. Callahan, K.Chouicha, & E.Ducongé, Factor Analyses of The DIB-R in Adolescents. *Journal of Personality Disorders*, 16(4), 2002, 374-384
- [39] S.Gupta & S.K.Mattoo, Personality disorders: Prevalence and demography at a psychiatric outpatient in North India, *International Journal of Social Psychiatry*, 58(2), 2010,e-pub-2012,146-152.
- [40] G.Newton-Howes, P.Tyrer, K.Anagnostakis, S.Cooper, O.Bowden-Jones & T.Weaver, ,The prevalence of personality disorder, its comorbidity with mental state disorders, and its clinical significance in community mental health teams. *Social Psychiatry and Psychiatric Epidemiology*, 45(4), 2009, 453-460
- [41] T.F.Oltmanns,M.M. Rodrigues, Y.Weinstei &M.E. Gleason, Prevalence of Personality Disorders at Midlife in a Community Sample: Disorders and Symptoms Reflected in Interview, Self, and Informant Reports. *Journal of Psychopathology and Behavioral Assessment*, 36(2), 2013, 177-188.
- [42] P.Tyrer J.Gunderson, M.Lyons,M. Tohen,Special Feature: Extent of Comorbidity between Mental State and Personality Disorders. *Journal of Personality Disorders*, 11(3), 1997, 242-259.
- [43] N.Wongpakaran, V.Boonyanaruthee, M. Pinyopornpanish, S. Intaprasert & T.Wongpakaran, Comorbid personality disorders among patients with depression. *Neuropsychiatric Disease and Treatment*, 2015, 1091.
- [44] M.Zimmerman, L. Rothschild&I. Chelminski, The Prevalence of DSM-IV Personality Disorders in Psychiatric Outpatients. *American Journal of Psychiatry*, 162(10), 2005, 1911-1918.
- [45] A.M.Chanen, &L. McCutcheon, Prevention and early intervention for borderline personality disorder: current status and recent evidence. *The British Journal of Psychiatry*, 202(s54), 2013, s24-s29.
- [46] J.J Lambert, & B.M.Ogles , The efficacy and effectiveness of psychotherapy in M. J. Lambert (Ed.), Bergin and Garfield's handbook of psychotherapy and behavior change 5 (New York: Wiley,2004)139-193.
- [47] B.E.Wampold, *The great psychotherapy debate: Model, methods, and findings*( Mahwah, NJ: Lawrence Erlbaum Associates,2001)
- [48] J.G.Johnson, E. Bromley,R.F., Bornstein &J.R Sneed, Adolescent personality disorders in D.A. Wolfe & E.J. Mash (Eds.), Behavioral and emotional disorders in children and adolescents: Nature, assessment, and treatment (New York: Guilford Press,2006)463-484.
- [49] P.M.Lewinsohn, P.Rohde, J.R.Seeley, &D.N. Klein, Axis II Psychopathology as a Function of Axis I Disorders in Childhood and Adolescence. *Journal of the American Academy of Child & Adolescent Psychiatry*, 36(12), 1997, 1752-1759.
- [50] D.J.Feenstra, J.J Busschbach, R.Verheul &J. Hutsebaut, Prevalence and Comorbidity of Axis I and Axis II Disorders among Treatment Refractory Adolescents Admitted for Specialized Psychotherapy. *Journal of Personality Disorders*, 25(6), 2011,842-850.
- [51] N.P.Gosden, P. Kramp, G.Gabrielsen & D.Sestoft, Prevalence of mental disorders among 15-17-year-old male adolescent remand prisoners in Denmark. *Acta Psychiatrica Scandinavica*, 107(2), 2003, 102-110.
- [52] M.Kongerslev,P.Moran, S.Bo, & Simonsen, E,Screening for personality disorder in incarcerated adolescent boys: preliminary validation of an adolescent version of the standardized assessment of personality – abbreviated scale (SAPAS-AV). *BMC Psychiatry*, 12(1), 2012.
- [53] D.Lader, N.Singleton& H.Meltzer, Psychiatric morbidity among young offenders in England and Wales. *International Review of Psychiatry*, 15(1-2), 2003 144-147.
- [54] S.Torgersen, Epidemiology, in T. A. Widiger (Ed.), The Oxford handbook of personality disorders (New York: Oxford University, 2012) Press 186-205.
- [55] H.Beckwith, P.F Moran, & J.Reilly, Personality disorder prevalence in psychiatric outpatients: A systematic literature review. *Personality and Mental Health*, 8(2), 2014, 91-101.
- [56] Y.Huang,R. Kotov,G. De Girolamo, A.Preti, Angermeyer, M., Benjet, C., Kessler, R. C,DSM-IV personality disorders in the WHO World Mental Health Surveys. *The British Journal of Psychiatry*, 195(1), 2009, 46-53.
- [57] J.M.Twenge, &J.D. Foster ,Birth cohort increases in narcissistic personality traits among American college students, 1982-2009," *Social Psychological and Personality Science* 1,2010, 99-106. // Konrath, S. H., O'Brien, E. H., & Hsing, C,Changes in dispositional empathy in American college students over time: A meta-analysis. *Personality and Social Psychology Review*, 15,2011, 180-198.

- [58] J.G.Johnson, P.Cohen, S. Kasen,A.E.Skodol, F. Hamagami, &J.S Brook, Age-related change in personality disorder trait levels between early adolescence and adulthood: a community-based longitudinal investigation, *Acta Psychiatrica Scandinavica*, 2000, 102(4), 265-275.
- [59] M.F.Lenzenweger, Epidemiology of Personality Disorders,*Psychiatric Clinics of North America*, 31(3),2008, 395-403.
- [60] B.F.Grant, S.P. Chou, R.B.Goldstein, B.Huang, F.S.Stinson, T.D.Saha, W.J. Ruan, Prevalence, Correlates, Disability, and Comorbidity of DSM-IV Borderline Personality Disorder: Results from the Wave 2 National Epidemiologic Survey on Alcohol and Related Conditions. *The Journal of Clinical Psychiatry*, 69(4), 2008, 533–545.
- [61] F. S. Stinson, D. A. Dawson, R.B. Goldstein, S.P. Chou, B.Huang, S.M. Smith, B.F. Grant, Prevalence, Correlates, Disability, and Comorbidity of DSM-IV Narcissistic Personality Disorder: Results from the Wave 2 National Epidemiologic Survey on Alcohol and Related Conditions. *The Journal of Clinical Psychiatry*, 69(7), 2008, 1033–1045
- [62] J.M.Twenge, &W.K. Campbell The narcissism epidemic: Living in the age of entitlement(New York, Free Press,2009).
- [63] D.P.Berstein, P. Cohen, C.N.Velez, M. Schwab-Stone, L. Siever, L. Shinsato , Prevalence and stability of the DSM-III-R personality disorders in a community-based survey of adolescents. *American Journal of Psychiatry*,150, 1993, 1237–1243
- [64] D.W.Belsky, A. Caspi, L. Arseneault, W.Bleidorn, P.Fonagy,M. Goodman, T.E Moffitt, Etiological features of borderline personality related characteristics in a birth cohort of 12-year-old children. *Development and Psychopathology*, 24(01), 2012, 251-265.
- [65] Moffitt, T. E., Caspi, A., Rutter, M., & Silva, P. A, Sex differences in antisocial behaviour: Conduct disorder, delinquency, and violence in the Dunedin longitudinal study(New York: Cambridge University Press,2001).
- [66] Skodol, A. E. Manifestations, clinical diagnosis, and comorbidity in J. M. Oldham, A. E. Skodol, & D. S. Bender (Eds.), *The American Psychiatric Publishing textbook of personality disorders* (Washington, DC: American Psychiatric Publishing,2005)57-87.
- [67] T.J.Trull, E.M. Scheiderer & R.L. Tomko, Axis II comorbidity, in T. A. Widiger (Ed.), *Oxford handbook of personality disorders*( New York: Oxford University Press,2012)
- [68] D.F Becker, C.M. Grilo, W.S Edell, & T.H McGlashan, Comorbidity of borderline personality disorder with other personality disorders in hospitalized adolescents and adults. *American Journal of Psychiatry*, 157, 2000 ,2011–2016.
- [69] B.De Clercq, F. De Fruyt, & K.Van Leeuwen, A “Little Five” lexically based perspective on personality disorder symptoms in adolescence. *Journal of Personality Disorders*, 18,2004, 479–499
- [70] R.Meaney-Tavares,& P.Hasking, Coping and Regulating Emotions: A Pilot Study of a Modified Dialectical Behavior Therapy Group Delivered in a College Counseling Service. *Journal of American College Health*, 61(5), 2013, 303-309.

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