BAHRIA JOURNAL OF PROFESSIONAL PSYCHOLOGY, JAN 2011, 9, 27-46

PREVALENCE OF PERSONALITY DISORDERS DURING THE YEARS 2003-2009 AT THE INSTITUTE OF CLINICAL PSYCHOLOGY, UNIVERSITY OF KARACHI

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ABSTRACT

The purpose of the present study was to investigate the prevalence rate of personality disorders reported at Institute of Clinical Psychology, University of Karachi-Pakistan during the years 2003-2009. Following archival method the totalsample was consisted of (3917) registered clients out of which (88) were diagnosed on Axis II (Personality Disorders) according to DSM-IV-TR (2000) text revisedcriteria. The whole sample went through complete psychological assessment by

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trained clinical psychologists. All registered cases of year 2003-2009 were selected and files of personality disorders were reviewed. Demographic variables and their diagnoses were observed. and analyzed. Frequency distribution and percentages of descriptive statistic were calculated. Findings showed that there are (2.22 %) ofcases, diagnosed on axis II (Personality disorders). Borderline personality disorder (18.18%), Histrionic Personality Disorder (14.94 %), and Narcissistic Personality Disorder (12.64%) have high prevalence rate as compared to other personality disorders. Furthermore, these personality disorders were mostly prevalent in single males belonging to middle class nuclear family systems. Present prevalence rate showed that people coming to psychological clinics are mostly diagnosed with Cluster B personality disorders. Awareness Programs should be developed for early identification of these disorders.

INTRODUCTION

Personality disorders are characterized by chronic patterns of inner experience and behavior that are inflexible and present across a broad range of situations. They have a marked impact on patients' interpersonal relationships, and social and occupational functioning, and can lead to problematic interactions in the medical setting (Ward, 2002). By definition, the symptoms of personality disorders cannot be caused by a major psychiatric disorder as diagnosed in the Diagnostic and Statistical Manual of Mental Disorders, 4th edition text revised (APA, 2000), Axis I, a medical disorder, or the effects of a substance. These disorders are coded on DSM-IV-TR (2000) text revised on axis II, which is used to

record personality disorders, personality traits (without code), mental retardation and defense mechanisms. This separate axis exists to ensure that appropriate attention is paid to these clinically significant disorders when a comprehensive psychological assessment is performed.

Personality disorders are heterogeneous in their clinical features and etiology. Their symptom complexes are caused by combinations of hereditary temperamental traits, and environmental and developmental events. The relative percentages of genetic and environmental factors vary with each specific disorder (Oldham, 1994).

It is suggested that their rigidity prevents people from adjustment to external demands thus they ultimately become self-defeating. The disordered personality traits become evident by adolescence or early adulthood and continue through much of adult life, becoming so deeply ingrained that they are highly resistant to change. The warning signs of personality disorders may be detected during childhood, even in the troubled behavior of preschoolers. Children with childhood behavior problems such as conduct disorder, depression, anxiety, and immaturity are at greater than average risk of developing personality disorders during adolescents (Bernstein Cohan, Skodol, Beziraganian & Brook, 1996).

Despite the self-defeating consequences of behavior, people with personality disorders do not generally perceive a need to change. Using psychodynamic terms, the DSM-IV-TR (2000) text revised notes that people with personality disorder tend to perceive their traits as ego-syntonic as natural parts of themselves. As a result, the people with personality disorder

are much more likely to be brought to the attention of mental –health professional by others than to seek services themselves. In contrast the people with anxiety disorder or mood disorders tend to view their disturbed behavior as ego dystonic. They don't see their behavior as parts of their self-identities and are more likely to seek help to relieve the distress caused by them (Nevid, Rathus & Greene, 2000).

Some experts believe that events occurring in early childhood exert a powerful influence upon behavior later in life. Others indicate that people are genetically predisposed to personality disorders. In some cases, however, environmental factors may cause a person who is already genetically vulnerable to develop a personality disorder (Carson, Butcher & Mineka, 2000). As with most mental disorders, no single factor explains its development. There are multiple factors like biological, psychological and social that play a role. The biological factors in personality disorders consist of temperamental (inborn or heritable) characteristics that are present in adulthood as stable personality traits: patterns of thought, affect and behavior that characterize individuals and are stable over time (Rutter, 1987). The biological studies suggested that infants' constitutional reaction tendencies may predispose them to the development of particular personality disorders. Most personality traits have been found to be moderately heritable (Carey & DiLalla, 1994) these heritable factors account for about half of the variability in virtually all traits that have been studied (Livesley, Jang & Vernon, 1998).

According to psychodynamic approach a person' s interpersonal and intrapsychic aspects have a major contribution in personality disorders (Kohut & Wolff, 1978). Psychosocial factors suggest that people with personality disorders

tend to have dysfunctional and inconsistent parenting (Leaff,1974). Families typically afforded them little support or security and did not encourage development of self esteem and an appropriate degree of independence (Kaplan & Sadock, 1985). Personality disorders tend to be proportionally overrepresented among lower socioeconomic and disadvantaged groups (Gunderson, 1988). However, whether those circumstances predispose people to develop personality disorders or whether the dysfunction of those with personality disorder has limited their socioeconomic advances is unclear.

According to DSM-IV-TR (2000) text revised, the prevalence of personality disorders are as follows; in cluster A the prevalence of paranoid personality disorder is 0.5%-2.5%, Schizotypal is 3% in general population and Schizoid personality disorder is uncommon in clinical setting. In cluster B the prevalence of antisocial is 3% in males and 1% in females, in Borderline personality disorder is 2% , in Histrionic personality disorder is 2% to 3% and the prevalence of Narcissistic personality disorder is less than 1% in general population. In cluster C the prevalence of Avoidant personality disorder is between 0.5% and 1%. Dependent personality disorder is among the most frequently reported personality disorder and prevalence of Obsessive-Compulsive Disorder is 1% in general population.

Lifetime prevalence of personality disorders in the general population is an estimated 10 to 13 percent (Weissman, 1993). Based on structured surveys, the prevalence rates of personality disorders in primary care outpatient settings may be as high as 20 to 30 percent (Moran, Rendu, Jenkins, Tylee & Mann., 2000; Hueston, Werth & Mainous, 1999;Casey & Tyrer,1990). The treatment of medical and psychiatric disorders is more complicated in patients with

comorbid personality disorders. Many patients with whom physicians experience problematic relationships, and who have been referred to in the literature as patients who are "difficult" have personality disorders (Steinmetz & Tabenkin, 2000; Schafer & Nowlis ,1998).

The diagnosis of a personality disorder is based on the patient's behavior over time in a variety of situations. In the primary care setting, many potential sources of diagnostic data are available (DSM IV, APA, 2000). Mostly clinical psychologists do a detailed Clinical interview, take Psychological tests that include intelligence testing, neuropsychological screening tests, and projective analysis, some also use objective personality tests.

The psychosocial functioning of patients with personality disorders can vary widely. These patients' history of interpersonal relationships, educational and work history, psychiatric and substance abuse history, and legal history are important areas to review. Usually, marked impairments exist in significant areas of the patients' life, such as intimate relationships or occupational functioning. Some patients are globally impaired and function marginally overall.

Patients may meet the criteria for more than one personality disorder. Comorbid mood, anxiety, and substance abuse disorders are common. When symptoms that may indicate a personality disorder, such as increased dependency, social isolation, obsessions, or poor impulse control, are identified, it is important to view them within the context of the patient's psychiatric and medical history (Ward, 2004).

The purpose of present study was to analyze the prevalence of personality disorders in Pakistan's culture as it has been observed that besides Clinical disorders which are diagnosed on Axis I, diagnosis of personality disorders (Axis II) are also common in Pakistan. Most of the clients, seeking treatment at different mental health clinics and hospital come with symptoms of emotional disturbances also have some maladaptive personality traits that hamper their performance in life. They may suffer from some personality disorder. There is no data available regarding this issue in Pakistan. Thus the present research would be very helpful in developing awareness regarding personality disorders and helping professionals in making accurate diagnosis and developing treatment strategies.

Institute of Clinical Psychology is providing services for different type of psychiatric problems. With the passage of time the awareness about psychiatric disorders has increased. There is a great need to rule out the prevalence rate of different psychological disorders and the pattern of these disorders in order to understand clients better. There are cultural differences that may be a cause of the differences in this phenomena in a cross cultural prospective. There are certain questions that need to be answered through the present study that is exploratory in nature.

1. Which personality disorder is more prevalent in Karachi?
2. Is there any difference in the prevalence rate according to different clusters?
3. Whether there is any difference in prevalence regarding demographic variables, like gender, socioeconomic status, and family system?

METHOD

Participants

Using the archival data, the sample consisted of seven years' (2003-2009) registered clients of Institute of Clinical Psychology, University of Karachi. There were 3910 registered clients out of which 88 were diagnosed on Axis II, according to the criteria of DSM-IV-TR (2000) text revised, by Clinical Psychologists on the basis of detailed history, clinical interview and psychological testing.

Procedure

Initially the researcher took permission from the In-charge/Director Institute of Clinical Psychology, University of Karachi for data collection, following this; the consent was taken from record room in-charge of Institute of Clinical Psychology, University of Karachi. Confidentiality and anonymity of identification was assured. Then the researcher collected data by reviewing all the files from the archives. Diagnosis and the demographic information about clients' age, gender, education, socio economic status, marital status and family systems were noted. Total number of registered clients during the year 2003-2009 was also taken from concerned record keeper.

Scoring and Statistical analysis

Scoring was done by taking number of different personality disorders during the period of 2003-2005. Demographic information was also tabulated then descriptive statistics and percentages were calculated.

Operational Definition of Types of Personality disorders

According to DSM-IV-TR (2000) text revised, there are 10 personality disorders and they are categorized into 3 clusters considering their nature of behavior.

Cluster A personality disorder consists of paranoid, schizoid, and schizotypal personality disorders individual with these disorders often seem odd or eccentric, with unusual behavior ranging from distrust and suspiciousness to social detachment.

Cluster B personality disorder consists of histrionic, narcissistic, antisocial, and borderline personality disorders individuals with these disorders have in common a tendency to be dramatic, emotional and erratic.

Cluster C personality disorder consists of avoidant, dependent, and obsessive-compulsive personality disorders. In contrast to other clusters, anxiety and fearfulness are often part of these disorders.

RESULTS

Table 1
Total no. of registered clients and no. of cases diagnosed on Axis II (personality disorder)

Variables	No. of cases	Percentages
Total No of Registered cases	3910	
		2.25%
Cases diagnosed on Axis II (2003-2009)	88	

Note: 2.25% means cases diagnosed with personality disorders

Table 2
Frequencies and percentages of personality disorder (Clusters) reported during the period of 2003-2009

Variables	No. of cases	Percentages
Cluster A	17	19.35%
Cluster B	42	47.72%*
Cluster C	28	31.8%

Note:*showed the highly prevalent personality disorder, cluster wise.

Table 3
Frequencies and percentages of different personality disorders reported during the period of 2003-2009

Variables	PersonalityDisorder	No.of cases	Percentages
Cluster A	Paranoid	10	11.36%*
	Schizoid	03	3.40%
	Schizotypal	04	4.54%
Cluster B	Borderline	15	17.04%
	Narcissistic	11	12.5%*
	Histrionic	13	14.7%*
	Antisocial	03	3.04%
Cluster C	Avoidant	10	11.36*
	Dependent	09	7.95%
	Obsessive Compulsive	09	7.95%

Note:* showed the highly prevalent personality disorders

Table 4

Demographic Information of clients with personality Disorders reported during the period of 2003-2009

Demographic Variables	Categories of Demographic Variable	f	%
1. Gender	Male	64	72.72%*
	Female	24	27%
2. Education	Matriculation	21	23.86%
	Above Matric	67	76.13%*
3. Family System	Joint	23	26.13%
	Nuclear	65	73.86*
4. Marital Status	Single	66	75%*
	Married	22	25%
	Widowed	1	02.96%
5. Socio Economic	Upper middle	17	19.95%
Status	Lower middle	7	7.955
	Middle	64	72.72%*
6 .Age	Early Adult (18-35 years old)	73	82.95%*
	Late adult (36-55 years old)	15	17.04%
Total		88	100%

Note:* showed the high prevalence regarding demographics of individual personality disorder

DISCUSSION

This study was conducted at the Institute of Clinical Psychology during the years 2003 to 2009 and out of the total number of cases registered (3910), 88 cases were diagnosed as having personality disorders (see Table). Overall the diagnosis of personality disorders is 2.25% of total cases reported. The prevalence of cluster B personality disorders are the highly diagnosed cases 48.86% (see Table II). In this category patients have a tendency to be dramatic, emotional and erratic. Whereas in the other two categories cluster C was prevalent at 31.8% and its symptoms are anxiety and fearfulness cluster A is the least diagnosed in overall category of personality disorders at 19.35% where the symptoms are unusual behavior ranging from distrust and suspiciousness to social detachment.

Further the findings show that in the subcategories of these disorders the prevalence of Borderline personality disorder is at 18.18% among the total reported cases and thus becomes the highest prevalent disorder (see Table III). Where as the histrionic personality disorder is prevalent in 14.7% of the reported cases and is the second highest prevalent disorder amongst the personality disorders. Narcissistic, Paranoid and Avoidant personality are third according to the prevalence rate as the percentages rate are 12.5%, 11.36% and 11.365% respectively. The rest of the subcategories in personality disorder are not diagnosed very highly as the obsessive compulsive personality disorder and the dependent personality disorder have the prevalence rate at 7.95%, while the prevalence rates of schizotypal, schizoid and antisocial cases are at 4.54%, 3.40%, 3.40% respectively. There are certain factors that predispose

individuals to develop personality disorders, some of the researches done in western countries indicated that prevalence of personality disorders are closely related to the genetic factors (Oldham, 1994) Where as the people with genetic factors are more vulnerable to the environmental risk factors (Carson et al., 2000).

Parenting is another major area of interest for clinicians to explore with reference to personality disorders as studies show that parenting styles can result into personality disorders in the offspring. As the development of the personality traits originate in the childhood hence the role of the parents becomes very significant during this early development, (Rutter,1997). It was further specified in the study that the aversive parenting behaviors may increase the risk for the schizotypal, borderline and paranoid personality disorders and on the other hand where parents show less affection towards their children it may increase the risk for the development of avoidant, borderline, schizoid, paranoid, or schizotypal personality disorder, (Johnson, Cohan, Chen, Kesen & Brook, 2006). Demographic variables associated with these disorders were also studied and it was found that people in their early adulthood are more often diagnosed with personality disorders. Furthermore, it was found that between the two genders, the prevalence is high in males as compared to females. It was more reported in people living in nuclear family systems, educationally above matriculation level, belonging to middle class families, with a marital status of single (see Table IV) They were mostly in their early adulthood, awareness may be contributed towards this findings, because in late adulthood most of the individuals develop their rigid pattern and they don't want to change them. Hence, they also don't seek treatment for these problems even if they

know that they are suffering from problematic behaviors.

These findings are attributed to certain factors that are related to marital discord, as well as interpersonal problems especially with the family. It was found from the case analysis that people diagnosed on Axis II belonged to conflicting families, some had an experience of abuse and some had poor relationships with siblings. Previously Epstein (1978) offered a model of the functioning of family system. He proposed some factors that suggested how family environment and stresses in family affects a person's behavior. Common stressful family situations are those in which one or more members find themselves playing roles which are difficult for them, and thus anxiety provoking; and those situations which arise when family runs into difficulties.

Limitations and Future Directions

This research was conducted on a very small data as there was limited data available at the Institute. Mostly people seeking help for their Psychiatric problems at ICP are from middle to upper middle class families as the institution is a government organization and treatment is provided at a very low cost. People from upper socioeconomic class seek treatment in highly facilitated hospitals. Results cannot be generalized to whole population hence it is proposed that this research can be conducted on a larger sample. Data can be collected from other hospitals of Karachi particular and Pakistan in genral. In the present study the researchers selected only registered clients diagnosed with personality disorders as it has been noted earlier that there are people who may not seek treatment themselves until they have more accompanying psychiatric problems. Therefore, the research survey can be conducted to rate the prevalence of personality disorders in the general population.

This research can be further extended to find out the causative factors related to the personality disorders as the demographic information reveal that there could be some specific psychosocial and psychodynamic aspects that cause personality disorders. The results of this research give us some knowledge about the highly prevalent personality disorders and these findings can be utilized to prevent people from these specific psychiatric disorders by giving awareness about the early development of children, parenting styles specifically knowledge about what behaviors should be avoided to give the children a healthy environment so that can grow as healthy human beings. It can also help professionals to make people understand the specific family interactions and systems which can lead towards such problems.

Conclusion

It is concluded from the present research findings that people coming to psychological clinics are mostly diagnosed with Cluster B personality disorder such as Borderline personality disorder (18.18%), Histrionic Personality Disorder (14.94 %), and Narcissistic Personality Disorder (12.64%). Further these personality disorders are mostly prevalent in single males belonging to middle class nuclear family systems. Further research should be conducted with larger sample to investigate the risk factors that lead to the development of these patterns in Pakistan's culture. Moreover mental health professionals should develop awareness programs for early identification of these disorders, so that early interventions can be provided to teach adaptive patterns of personality.

Notes

Note 1. At the Institute of Clinical Psychology University, of Karachi all of these clients had under gone psychological testing that included neuropsychological screening tests, intelligence tests and projective tests. Diagnoses of the clients were mostly based on projective tests i.e. Human Figure Drawings (HFD Koppitz,1968) ; Thematic Apperception Tests (TAT, Murray, 1943); and the Rorschach Inkblot Test (Klopfer, Ainsworth, & Holt,1954), detailed clinical interview, and consultation with senior clinical psychologists.

Note 2. Dr. Shazia Hasan, Assistant Professor was a faculty member at the Institute of Clinical Psychology, University of Karachi during this research period.

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