Prevalence of Personality Disorders

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Abstract:- Globally the concept of personality disorder was not clearly defined in the mental health until the 1980s,Later, the DSM fully defined personality disorders, and a new challenge to the world was born in the field of mental health.There has not been much researches on the subject of personality disorder, especially on the occurrence of personality disorder. However, there are many types of personality disorder and each type has its own symptoms and signs, that is why researchers are not interested in this topic.On the other hand, the occurrence of this disorder is increasing day by day, and this disorder is often found in a person as comorbid with other mental illnesses (depression, Anxiety, Mood disorder).But in any case, an effort has been made in this study to be able to understand the definition and types of personality disorder by review of other studies in globally pattern. And also, through this research, we can fully understand the causes of personality differences, of course, these causes are related to geographical locations in the world.Through this study, we have obtained complete information about the prevalence of personality disorders in the world, USA and India.

Keywords:- *Personality disorders, prevalence, clusters.*

I. INTRODUCTION

A person with a "personality disorder" is said to have a personality that is not quite right. But the term "personality disorder" only designates a diagnostic group of mental illnesses that are marked by a persistent, rigid, and maladaptive way of interacting with the outside world. How someone thinks, feels, and acts is clearly indicative of this maladaptive habit. Negative effects on interpersonal interactions are the most prominent and noteworthy characteristic of these diseases. connections with others are seldom long-lasting, fulfilling, and meaningful for an individual with an untreated personality disorder, and the connections they do have are frequently troubled by issues and challenges.

A "personality disorder" diagnosis does not imply that a person is a freak of nature or that their personality is gravely defective. These diseases are really rather prevalent, and people who are diagnosed with them experience intense pain and distress. It is estimated that 10% of individuals may have a personality disorder, according to studies on the incidence of personality disorders conducted in various nations and among various groups (Torgersen, 2005). A full and entire departure from normal and healthy functioning is indicative of many different types of diseases (e.g., epilepsy).

It is impossible to comprehend personality problems apart from healthy personalities, nevertheless. Personality disorders are a variation of a normal, healthy personality as everyone has a personality (even if not everyone experiences epileptic seizures). In the same way that a square is a specific example of the more general construct of a rectangle, so too does a personality disorder exist as a special case of a normal, healthy personality. For this reason, it is helpful if we start talking about personality disorders by talking about the more generic, larger concept of personality.

The permanent characteristics of a person that manifest in their behavior under a range of conditions are referred to as their personality (Oxford Textbook of Psychiatry, 2018). A personality disorder is defined as a persistent pattern of inner experience and behavior that significantly deviates from the expectations of the person's culture. It begins in adolescence or early adulthood, is pervasive and unyielding, remains stable over time, and causes distress or functional impairment. (DSM-5, 18 May 2013, Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition).

II. BACKGROUND

Based on the research that has been done, mental illnesses are among the most significant and crucial aspects of the total burden of diseases. According to the 2015 global burden of diseases report, one of the primary causes of the global burden of illnesses is mental disorders.(Oxford Textbook of Psychiatry, 2018).

It is estimated that approximately 900 million people in the world suffer from mental illnesses, accounting for 19% of the world's total population. The personality disorders are the most important and significant components of psychiatric disorders. (Oxford Textbook of Psychiatry, 2018).

Since the fourth century BC, philosophers have been trying to understand what it is that makes ‘us’ what we are.

The term ‘personality’ has been used since the eighteenth century to label distinguishing qualities of a person. (Quality of physical health care among patients with personality disorder)

Over the past half-century, personality disorders have gained enough recognition and knowledge to be treated on an equal footing with other mental illnesses. (Oxford Textbook of Psychiatry, 2018).

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Before the 1960s, personality disorder was seen as an inaccurate diagnostic with little to no clinical utility, with the probable exception of the antisocial group. after then, nevertheless, there has been a growing awareness that personality disorder may be accurately defined and graded, even in spite of several flaws in its categorization, especially after the release of DSM-III in 1980. When present as a comorbid disease, personality disorder has been demonstrated to have a significant impact on the course of other mental disorders and may benefit from specialized therapy. (The Cost of Mental Health Care for Personality Disorders, 2008).

III. LITERATURE REVIEW

A study of the literature on the prevalence and results of personality disorders was conducted. We conducted a literature search using the following terms, both alone and in combination, on CINAHL, Medline, PsycINFO, and Google Scholar: personality disorder, prevalence pharmacological, psychotherapy, therapeutic connection, and alliance. Our search for literature was restricted to research on pharmaceutical and psychological interventions. Throughout the 1990s, the incidence of personality disorders in general populations remained mostly unknown and impossible to adequately measure (Lenzenweger, 2008). Numerous studies are constrained by their dependence on self-reporting, clinician interviews, telephone interviews, unrepresentative sample, and control groups from other research, and have lacked rigorous epidemiological rigor (Coid et al., 2006). Nonetheless, a number of foreign research have contributed to the body of knowledge about prevalence rates. Using ICD-10 diagnostic criteria, Jackson and Burgess (2000) carried out a national epidemiological assessment of personality disorder in Australia (n=10,641). Using weighted replicate weights to represent population demographics, it was estimated that 6.5% of Australians suffered from at least one personality disorder, of which 704 respondents had at least one. Male, younger, and single individuals were more likely to suffer from personality disorders.

Using DSM-IV diagnostic criteria, Coid et al. (2006) reported on a nationwide assessment of personality disorder prevalence and correlates (n=626) in Great Britain. Men had a greater weighted prevalence (5.4%) than women (3.4%), with a weighted prevalence of 4.4%. There were no reports of narcissistic or histrionic personality disorders, and the weighted total prevalence of individual illnesses ranged from 0.06% to 1.9%. Obsessive compulsive personality disorder was the most common (1.9%). The most common cluster of personality disorders was cluster C (2.6%), followed by cluster A (1.6%) and cluster B (1.2%). People with a cluster B diagnosis were more likely to have served time in prison, have a criminal record, or have been in institutional or local authority care; people with a cluster C diagnosis were more likely to have received psychotropic medication and counseling. Individuals with a cluster A diagnosis were three times more likely to have been in local authority care as a minor. According to Coid et al. (2006), impacted people were primarily male, older, single or divorced, jobless or economically inactive, from a lower socioeconomic level, renting, and residing in an urban location.

Using DSM-IV diagnostic criteria, Grant et al. (2004) reported on a national epidemiological study (n=43,093) of prevalence and correlates in the US. They state that 14.79% of people suffered from a personality disorder. The most common personality disorder was obsessive compulsive disorder (7.8%); women were substantially more likely than males to have avoidant, dependent, and paranoid personality disorders ($p<.05$), whereas men were significantly more likely to have antisocial personality disorder ($p<.05$). Generally speaking, risk factors included being Black or Native American, being a young adult, having a poor socioeconomic level, having been widowed, divorced, separated, or never married. Using DSM-IV diagnostic criteria, Lenzenweger et al. (2007) reported on a National Comorbidity Survey Replication (NCS-R) of prevalence and correlates (n=5692) in the US.

9.1% of people had at least one personality disorder, with the following clusters having the highest incidence rates: A (5.7%), B (1.5%), and C (6%). Antisocial personality disorder was generally less common in women; unemployment was positively correlated with borderline personality disorder (39%) while age and education were inversely correlated with cluster B disorders. Each cluster's members (A =25%, B =49.1%, and C =29%) reported having had treatment for either drug abuse or mental health concerns in the 12 months before.Prevalence studies vary in their findings; in the United States, one research found that around 1 in 10 persons, in Australia, 1 in 15 people, and in Great Britain, 1 in 20 people met the criteria for personality disorder.

Rather than being related to population demographics, these discrepancies are most likely the result of various sample techniques, various diagnostic tools, and the quantity of disordered categories covered (Coid et al., 2006). These studies provide insight into the significant frequency of personality disorders in society, with 5–10% of people possibly suffering from the condition.

In clinical settings for mental health, prevalence and comorbidity Due to the paucity of published research in this field, it is challenging to determine the precise frequency of personality disorder in mental health clinical settings; nonetheless, estimates range from 36% to 67% (National Institute for Mental Health in England, 2003).

Personality disorder is highly comorbid with a variety of axis I disorders, according to the literature (Jackson & Burgess, 2000; Leichsenring & Leibing, 2003; Lenzenweger, 2008). As a result, people with personality disorder frequently use a wide range of primary care and mental health services. In the NCS-R, Lenzenweger et al. (2007) discovered that 39% of participants had received treatment for a mental health or substance addiction issue in the year prior, and that this correlation was highest with cluster B illnesses. In an American research (n=664), Bender et al. (2001) discovered that 81% of the participants in the four representative personality disorder groups

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(schizotypal, borderline, avoidant, and obsessive-compulsive personality disorder) had taken psychotropic medication, and 96% had undergone psychotherapy. In therapeutic settings, personality disorder is underdiagnosed despite its high comorbid frequency, and its detrimental effects on treatment results are not well understood (Bender et al., 2001).

IV. METHODOLOGY

A review of the literature on personality disorders' prevalence, risk factors, and outcomes is being done as library research. The following keywords, both alone and in combination, were used to search for this work using CINAHL, Medline, PsycINFO, Google Scholar, and Oxford Textbook of Psychiatry: personality disorder, prevalence, etiology, pharmacology, psychotherapy, therapeutic connection, and alliance. Our search for literature was restricted to research on pharmaceutical and psychological interventions.

A. *Objectives*

- To identify behaviors associated with personality disorders.
- To know the prevalence of personality disorders.
- To identify the risk factors of personality disorders globally.
- To distinguish the symptoms of different personality disorders.
- To describe the available options of treatment for personality disorders.

B. *Finding*

This research has a library basis. After studying the journals and books under the title of personality disorder, we have achieved such a finding. Based on these findings, we are able to explain the definition of personality disorder and its types in detail. And also, with the help of these findings, we can now correctly clarify the etiology, epidemiology, and prevention methods and treatment types of personality disorders in the world, which will be fully understood in the next pages.

C. *Key features in personality disorders*

The individual approaches relationships and the environment in a rigid and dysfunctional way. The person's demands, views, and behaviors frequently create vicious loops that support unhealthy practices and elicit unfavorable responses from others. When put in difficult conditions, the individual lacks resilience and has erratic and fragile coping mechanisms.

V. THREE CLUSTERS OF PERSONALITY DISORDERS

- **Cluster A:** Odd, eccentric behaviorsParanoid, Schizoid & Schizotypal .

- **Cluster B:** Dramatic, erratic, emotional behaviorsAntisocial, Borderline, Histrionic, Narcissistic Disorders

- **Cluster C:** Anxious, fearful, controlling behaviorsAvoidant, Dependent, Obsessive-Compulsive Disorders

Other Personality Disorders

- **Personality changes due to a medical condition-** Disturbance due to the direct physiological effects of a medical condition (e.g., frontal lobe lesion).
- **Other Specified or unspecified personality disorders-** The personality pattern meets the criteria for a personality disorder, or there are qualities present that might be associated with many personality disorders but do not fit the criteria for a particular personality disorder. Or the person is thought to suffer from a personality disorder that isn't covered by the DSM 5 (such as depressed or passive-aggressive personality disorders, which were classified differently in the DSM IV).

A. *Cluster A - Paranoid, Schizoid, Schizotypal Disorders*

- Gender: more common in males
- Be mindful of how other cultures view certain behaviors.
- Onset – This type of conduct typically manifests in childhood and adolescence, and it is marked by isolation, strained peer relationships, academic underachievement, and being teased. People view individuals as strange or eccentric.
- Etiology - Neurophysiology, genetics
- Familial pattern: increased prevalence of schizophrenia and delusional disorders in family system.

➢ *Schizotypal Disorder patients*

- “Ideas of reference”- believes others are talking about them, even the TV and songs on the radio are about them, and often feels others stare at them.
- Believe they receive special messages, have experiences with the supernatural and can make things happen by wishing (magical thinking).
- Their behavior or appearance is odd, eccentric or peculiar.
- Affect is constricted or inappropriate.
- No close friends or confidants.
- Excessive social anxiety.

➢ *Paranoid Personality Disorder*

- Suspicious,Feelings unfounded suspicion that others are taking advantage of, hurting, or misleading them; distrustful of others.
- tenacious in holding grudges and slow to forgive those who may have offended them.
- Unable to form intimate relationships, and when they do, often suspect partner has been unfaithful
- Usually distant or irrationally furious and violent, especially when they feel insulted.

➢ *Schizoid Personality Disorder*

- Neither wants nor appreciates being in close ties, such as a family.
- almost usually opts for alone pursuits.
- has little desire to engage in sexual activity with another individual.

- Unaffected by compliments or disapproval.
- Flattened affect: the belief that few things truly bring them joy and that nothing truly makes them happy or unhappy.

B. Cluster B - Antisocial, Borderline, Histrionic, Narcissistic

- Gender
- ✓ Male - Antisocial PD
- ✓ Female - Borderline PD, Histrionic PD
- Age – All diagnosed after age 18 and may see some decrease in symptoms at midlife.
- Etiology - Neurophysiology, genetics
- High rates of depression, substance abuse

➢ *Borderline Personality Disorder*

- Frantic efforts to avoid real or imagined abandonment.
- Extreme ups and downs in relationships.
- Identity disturbance, frequently changing beliefs and goals.
- Impulsivity can include unsafe sex, substance abuse, spending, eating or driving reckless.
- Suicidal gestures and/or self-mutilation common.
- Sudden mood changes, temper outbursts and feeling empty inside.

➢ *Developmental Factors: Borderline Personality Disorder*

- Developmental theory suggests that the borderline person fails to achieve object constancy during the separation-individuation stage of psychosocial development (the period between 18 months &3 years of age). Fail to complete separation from primary caretaker & fail to achieve autonomy in childhood.
- Often emotionally, physically or sexually abused. 25% also have diagnosis of PTSD (Stuart, 2013).

➢ *Histrionic Personality Disorder*

- Likes to be the center of attention and feels uncomfortable when not.
- Sexually provocative, inappropriately seductive.
- Tries to draw attention to self by the way they dress or look and displays dramatic emotions.
- Suggestible, often changing their mind about things based on things they've read or seen on TV.
- Considers relationships to be more intimate than they really are (lots of very close friends?)

➢ *Narcissistic Personality Disorder*

- Grandiose sense of self-importance, exaggerates achievements and talents.
- Preoccupation with fantasies of success, power, fame, brilliance, beauty or ideal love.
- Feels special, entitled and deserves privilege and that there are few people worth their attention.
- Exploitive- takes advantage of others to achieve own desires "steps on toes".
- Not interested in other people's feelings or problems, lacking empathy.
- Often envious of others or believes others are envious of them.

➢ *Antisocial Personality Disorder*

- Must be at least age 18, but there is evidence of Conduct Disorder with onset before age 15, includes:
- Fighting, bullying, weapons use including a bat, sticks, broken bottle, bricks, rocks, knife or gun.
- Deliberately cause suffering, pain or torture to other people or animals.
- Stole while confronting victim such as mugging, purse snatching, extortion or armed robbery.
- Forced someone into sexual activity.
- Set fires or vandalized or broke into property.
- Stole items of nontrivial value while shoplifting, theft, forgery.
- Ran away from home at least twice while living in parental or parental surrogate home.
- Staying out very late at night despite parental prohibitions or often skipping school before the age of 13.

C. Cluster C- Avoidant, Dependent, Obsessive-Compulsive

- Gender
- ✓ Male - OCPD 2:1
- ✓ Female - Dependent
- Etiology - Genetic, environment

➢ *Avoidant Personality Disorder*

- Avoids jobs or tasks that involve interpersonal contact because of fear of criticism, disapproval or rejection.
- Unwilling to take initiative or become involved with someone unless certain that they will be liked.
- Find it very difficult to be honest about thoughts and feelings with anyone out of fear of being ridiculed.
- Fear about being criticized in social situations.
- Believes that they are not as good, smart, attractive as most other people.
- Reluctant to try new activities or meet new people.

➢ *Dependent Personality Disorder*

- Needs advice or reassurance before making everyday decisions like what to wear or what to order at a restaurant.
- Depends on others to handle responsibilities such as finances, childcare, living arrangements.
- Finds it difficult to disagree with others even when you think they are wrong, wanting their approval.
- Finds it difficult to start or work on tasks if no one is there to help, due to lack of self-confidence.
- Will volunteer to do unpleasant tasks solely to gain approval from others.
- Preoccupied fears of being left alone or being unable to take care of one's self if relationship ends.

➢ *Obsessive-Compulsive Personality Disorder*

- Preoccupied with details, lists, order, rules, organization or schedules, to the extent that the major point of the activity is lost.
- Shows perfectionism to the point of having trouble finishing tasks because the spend so much time trying to get things exactly right.
- So devoted to school or work, never taking time to just have fun or spend money on self or others.

- Inflexible on matters of morality, ethics, or values.
- Unable to discard items, even if space is cluttered.
- Stubborn and rigid with others and reluctant to delegate tasks out of fear they won't do it right.

VI. ETIOLOGY

There are no conclusively established causes for personality disorders, according to Whiteford HA, Ferrari AJ, Degenhardt L, Feigin V, Vos T. The global burden of mental, World Health Organization, Health WHODoM, Abuse S, Health WHODoM, Health SAM, Organization WH, Evidence WHOMH, et al. Mental Health Atlas 2005. But there are a lot of established risk factors and potential causes. Overall, research indicates that factors such as genetic predisposition and traumatic or abusive childhood events are important in the development of personality disorders, for example.Neglect and maltreatment of children are persistent risk factors for the emergence of personality disorders in adults. (Hakkaart-van Roijen, Soeteman DI) Another possible contributing factor to personality disorders has been considered to be socioeconomic position. Personality disorder symptoms are strongly correlated with poor parental/neighborhood socioeconomic level. (Oxford Textbook of Psychiatry, 2018).

Research indicates that parental personality problems may be the genesis of personality disorders. Because of this, the kid faces challenges of their own as an adult, including obstacles to completing their further education, finding employment, and establishing trustworthy relationships. There is currently a dearth of genetic studies to help understand how personality problems emerge. Nonetheless, certain potential risk factors are still being investigated. (Quality of physical health care among patients with personality disorder)

Attachment theory: "The basic tenet of attachment research on human infants is that an infant with secure attachment is one in which the parent responds to the infant's needs in a sensitive manner, while an infant with insecure attachment lacks such sensitive responding."

Throughout infancy and youth, insecure attachment can cause issues with trust and emotional control. Establishing and preserving wholesome connections over the course of a lifetime may be quite difficult.

VII. FACTORS IN THE DEVELOPMENT OF PERSONALITY IN INDIA

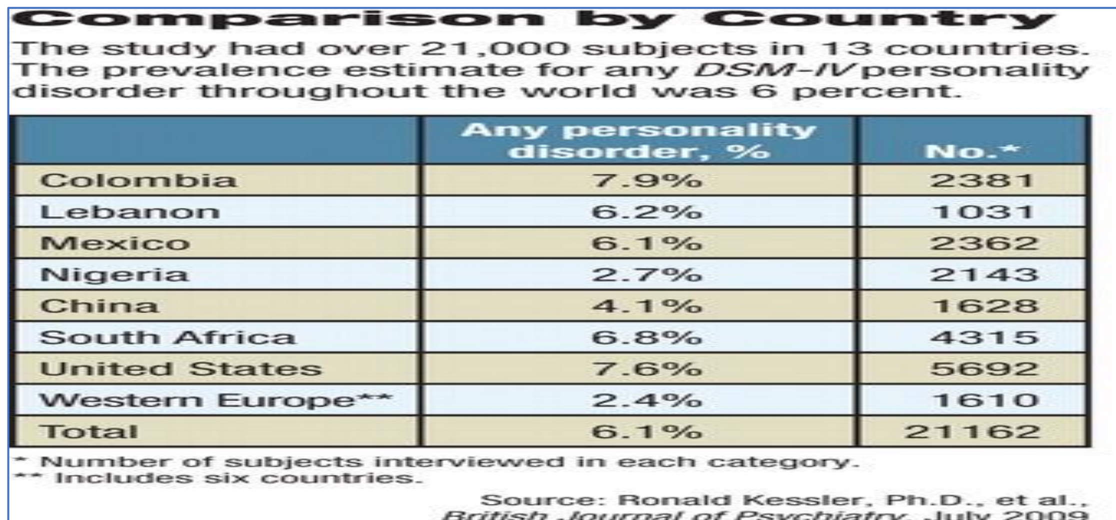
The majority of social scientists believe that a combination of social contextual factors and genetics determines an individual's personality and social conduct. They think that environmental influences have the most impact. According to social scientists, the main elements determining personality and behavior are birth order, parents, cultural environment, and heredity. The personality of children is shaped by their parents. The growth of children can be influenced by the parent's age. The educational attainment, religious affiliation, occupation, economic standing, and cultural background of parents are additional factors that might impact a child's social conduct and personality. (Indian j psychiatry , 2010)Culture has a strong influence on personality development. Culture has a big impact on how people form their personalities. The fundamental personality types that exist in a civilization are determined by its cultural surroundings. Every culture produces a set of model personalities, or personality qualities that are common to everyone in that community.(Indian j psychiatry , 2010).

VIII. EPIDEMIOLOGY

Personality disorder is a relatively new notion, and not much study has been done on it globally or in Afghanistan up to this point. Although the study in India takes a clinical form, I will discuss both global and Indian epidemiology in this session.

Before surveys began to be conducted in the 1990s, it was mainly unclear how common personality disorders were in the general population. A median incidence of 10.6% was calculated in 2008 for diagnosable Parkinson's disease (PD) based on six large studies conducted in three countries. Mark F. Lenzenweger (2008).

According to a 2009 World Health Organization screening study conducted in 13 countries using DSM-IV criteria, personality disorders were estimated to affect 6.1% of the population. The rate was occasionally influenced by socioeconomic and demographic characteristics, and co-occurring mental problems contributed to the explanation of functional impairment.The prevalence of around one in ten cases, particularly when linked to heavy cocaine use, is deemed a serious public health issue that has to be addressed by scientists and medical professionals.



Comparison by Country

The study had over 21,000 subjects in 13 countries. The prevalence estimate for any *DSM-IV* personality disorder throughout the world was 6 percent.

	Any personality disorder, %	No.*
Colombia	7.9%	2381
Lebanon	6.2%	1031
Mexico	6.1%	2362
Nigeria	2.7%	2143
China	4.1%	1628
South Africa	6.8%	4315
United States	7.6%	5692
Western Europe**	2.4%	1610
Total	6.1%	21162

* Number of subjects interviewed in each category.
** Includes six countries.

Source: Ronald Kessler, Ph.D., et al., *British Journal of Psychiatry*, July 2009

Fig. 1: Comparison by Country

In the US, the overall population prevalence of personality disorders was estimated to be about 7.9% based on screening data from the National Comorbidity Survey Replication conducted between 2010 and 2013 and interviews with a subgroup of respondents. Co-occurring mental illnesses (Axis I in the DSM) proved to be primarily responsible for the functional handicap associated with the diagnosis.

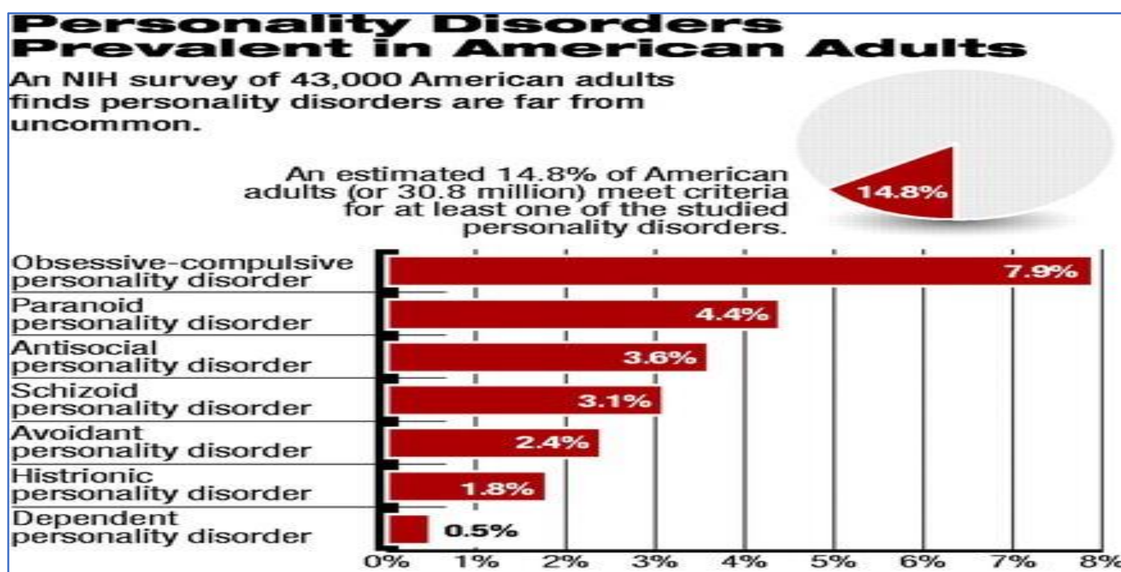


Fig. 2: Personality Disorders Prevalent in American Adults

Indian Journal of Psychiatry (2010) reports that Chandrashekar, Reddy, and Chandrasekaran et al. performed a meta-analysis of thirteen epidemiological studies from various regions of India. Seven studies evaluated the prevalence of personality disorders; the weighted prevalence rate was 0.6%, and the rate ranged from 0 to 2.8%. In community research, there was a substantial correlation found between the diagnosis of personality disorder and male gender.

Prevalence rates ranging from 0.3 to 1.6% were found in early research on clinical samples from India (which did not use operationalized criteria or diagnostic equipment). Special demographics, such as college students (19.1%), criminals (7.3–33.3%), patients with substance use problems (20–55%), and patients who tried suicide (47.8–62.2%), had greater rates, however.

IX. PROBLEM STATEMENT

Personality disorder is a new concept in Afghanistan and even the people are still not familiar with this disorder, so this topic is very important in Afghanistan to conduct studies and research related to these disorders in order to find a well-designed way to prevent these disorders. Also, standard guidelines should be established for treatment personality disorder. On the other hand, not a single study has been undertaken to date on personality disorder in Afghanistan, especially in Kandahar, so it is a problem in itself and creates a constraint for the current study.

X. TREATMENT MODALITIES

- Psychotherapy
- Milieu therapy
- Group therapy

- Cognitive/Behavioral Therapy Psychopharmacology

XI. DISCUSSION

The primary aim the study was to identify behaviors associated with personality disordersThrough the findings of this research, we were able to fully identify any behavioral changes associated with personality disorderfor example cluster A (solitariness, poor peer relationships, underachievement in school and subject of teasing. Individual is seen as odd or eccentric) cluster B (High rates of depression, substance abuse Sudden mood changes, temper outbursts and feeling empty inside Extreme ups and downs in relationships) cluster C (fear of criticism, disapproval or rejection, depends on others to handle responsibilities such as finances, preoccupied with details, lists, order, rules, organization or schedules, to the extent that the major point of the activity is lost). A secondary aim was to know the prevalence of personality disorders.We were able to determine the prevalence of personality disorder worldwide thanks to the research's findings. Actually, the goal was to determine the prevalence of personality disorders in Afghanistan and its surrounding countries (Iran, Pakistan), but sadly, no single study has been done about this topic. state the date Nevertheless, a World Health Organization screening study conducted in 13 countries using DSM-IV criteria revealed in 2009 that the prevalence of personality disorders was estimated to be about 6.1%. In the US, the overall population prevalence of personality disorders was estimated to be about 7.9% based on screening data from the National Comorbidity Survey Replication conducted between 2010 and 2013 and interviews with a subgroup of respondents. The third aim was to identify the risk factors of personality disorders globally.Through the findings of this research, we were able to identify the risk factors of personality disorder in the world (genetic disposition and life experiences, such as trauma and abuse, Socioeconomic status, Insecure attachment in infancy, culture). The fourth aim was to distinguish the symptoms of different personality disorders. Through the findings of this research, we were able to distinguish between the symptoms of all types of personality disorders. Through the findings of this research, we were able to distinguish between the symptoms of all types of personality disorders. The mention of the symptoms has been explained in the above pages, so examples and mentions are not necessary.

XII. CONCLUSION

In Asia, particularly in Afghanistan, personality disorders are still in their infancy as a field. There is currently a stream of publications in India that are especially about personality disorder, compared to nearly none in the 1980s. Still, it makes sense that the focus has been solely on clinical epidemiology thus far. Despite the paucity of methodologically sound studies, the growing body of knowledge in the discipline and its many methodological intricacies bodes well for the future. Genetic predisposition, trauma and abuse, and socioeconomic level are risk factors for personality disorders.

The World Health Organization reported in 2009 a prevalence estimates of around 6.1% for personality disorders in the world.The National Comorbidity Survey, indicated a population prevalence of around 7.9% for personality disorders in the U.S.A.

XIII. RECOMMENDATIONS

In Afghanistan obviously a need for better and more studies in relation to personality disorders on methodology and epidemiology (particularly community studies), and also on cultural and classificatory issues.

Further research is required to fill in the wide gaps in the field regarding the etiology, clinical features, assessment, management, course, and outcome. It is also necessary to address the various debates that characterize personality disorders, such as the validity of personality disorders as currently defined, the distinctions between personality disorders and mental state disorders, and the categorization or dimension of personality disorders.

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