RATES OF PERSONALITY PATHOLOGY AMONG CLINICAL AND NON-CLINICAL SAMPLES

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# ABSTRACT



**OBJECTIVE**

Tocompare the rates of personality disorders among clinical and non-clinicalsamples.

# STUDY DESIGN

Cross sectional study

# PLACE AND DURATION OF STUDY

The study was carried out at National Institute of Psychology, Quaid+Azom Universitylslomabad from August 17, 2015to June 10,2017.

# SUBJECTS AND METHODS

Employing the technique of convenience samplfng, 408 individuals seeking treatment in psychiatric wards and OPDs of Rawalpindi, Islamabad and Lahore were approached. Formal permission was taken from hospital authorities. Informed consent wastaken fromparticipants.Similarly data wascollected from 360 non-clinical individuals who were not on any psychiatric medicine. The age of the sample ranged from 18-59 years. For the sake of achieving equivalence, both groups were matched on age, gender, marital status, and socio-economic status. The current study utilizes the assessment of DSM-IV PersonalityDisorder Questionnaire (ADP-IV) to identify particular personality dirnrder.

# RESULTS

Rate of Personality disorders in Clinical sample was 68.1%, whereas for non-Clinical sample it was 16.3 %. Over all rate of Personalitydisorderswas43.8%.

# CONCLUSION

The present research conclude that special consideration needs to be given to personality pathology in designing treatment plansfor patientsseeking treatment formentalillness.

# KEYWORDS

Personality Co-Morbidity,Personality disorders

# INTRODUCTION

Personality Disorders are referred to as relativelyenduring patterns of behaviors that Interferes markedly with individuals normal and adaptive functioning.' There lies an underlying similarity in general criteria for diagnosing personality disorders in both International Classification of Disease (ICD) and Diagnostic and Statistical Manual (DSM).' Broadly personality disordershavebeenclassified into distinct clusters basedon descriptive similarities.' Cluster A(oddandeccentric disorders) include paranoid, schizoid, and schizotypal personality disorders.Cluster B(dramatic, emotional and erratic disorders)further include anti-social, borderline, histrionic and narcissistic personality disorder. Cluster C (anxious and fearful) include avoidant,dependent and obsessive compulsive personality disorders. Two other unspecified disorders include depressive and passive aggressive personalitydisorders,'Personalitydisordershavebeenstrongly linked with other mental illness, poor treatment adherence, attempts of suicide and mortality.'

Studies conducted in different parts of the world indicated that prevalence of Personality disorders varies in different societies. Researches in Britain recorded an overall prevalence of 4.4% in community sample with obsessive compulsive, avoidant, schizoid and borderlinebeingmostprevalent and dependent and schizotypal as least prevalent.' Studies in United States indicated that overall prevalence of personality disorders varied between S to 10 % in community samples.' The overall prevalence of Personality disorders for psychiatric out patientsvaried between 1.07 % forIndia to 60%for Pakistan.'

Comorbidity within personality has been well documented by researchers.' Individuals who meet the criteria for one Personality disorder arelikely to be morevulnerable to otherpersonality disorders as well.It might be from the similar cluster or from different as well.' Comorbidityis referred to asconditionsthatincludepresence of more than one disorder at either single point of time or across life span.' Researchers aimed at studying comorbidity indicated that 54% individuals had only one personality disorder, 22 % had two personality disorders, **11** % had three personality disorders and 14% had four to eight personality disorders.'

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Taking into account the comorbidity, researchers have devised a five point system of Classifying personality disorders (PD) based on severity and comorbidity ranging from O to 5. In this system 0 represent absence of Personality Disorder, 1representing Personality Difficulty which includes not meeting the full criteria of any PD but havingsymptomsof Personality disorder, 2 represents either simply one personality disorder or comorbidity within similar cluster, 3 represents complex personality disorders with presence of two or more disorders fromdifferent clustersand 4 represents two or more personalitydisordersresultingin massive societaldisturbance.'

Personality disorders also show comorbidity with other mental illness which were previously reported on Axis I.' Comparative studies indicate that both in patients and out-patients seeking treatment for other mental illnesses are likely to have an underlying comorbidpersonality disorder as well.'' Furthermore the prevalence of Personality disorders is much higher in clinical samples as compared with thenon-clinicalsamples.'

Local literature is scarce on the topic *so* current research aimed at comparing the rate of Personality disorders in both clinical and non­ clinicalgroups.

# SUBJECTS AND METHODS

### Participants

Employing the technique of Convenience sampling, data was collected from 408clinical and 306 non-clinical individuals. Theage of the sample ranged from 18-59 years. For the sake of equivalence groups were matched on age, education, marital status and Socio­ economic status.Clinical data wasobtained from Psychiatric unitsof Pakistan Institute of Medical Sciences Islamabad, Military Hospital Islamabad, Capital Development Authority Hospital Islamabad and Punjab institute of Mental Health Lahore. It was ensured that only those individuals were included from the clinical sample who were identified asstableby psychiatrist and had an orientation oftimeand place. Employing the technique of non-probability convenience sampling non-clinical sample was also obtained from Rawalpindi, Islamabad and Lahore. It was ensured that participants from non­ clinicalsample arenot on any psychiatric medicine fromthepasttwo year.An effort was made to have same age range, gender ratio and education level for both clinical and non-clinical groups to make the comparisonvalid.

### Instruments

The present research uses the assessment of DSM-IV Personality Disorder Questionnaire (ADP-IV). ADP IV employs diagnostic algorithm, which identify the presence of particular symptom for a disorder. It assess each item on trait and distress associated with it. Traitis rated on asevenpointLikert typescale and distressin ratedon three point scale. In present study Trait score greater than 5 and distress score greater than 1 hasbeen used to identify the diagnostic criteria according to DSM-IV-TRin light of threshold of symptomsfor eachPD. 9 It comprises of 94 items.Thescale categorizes individuals with Cluster A disorders including Paranoid (7 items), Schizoid (7 items) and Schizotypal personality disorders (9 items), Cluster B including Borderline (10 items), Histrionic (8 items), narcissistic (9 items) and anti-social personality disorder (8 items) and Cluster C

including dependent (8 items). Obsessive compulsive (8 items) and avoidant personality disorder (7 items). It also has not otherwise specified Passive aggressive NOS-PA (7 items) and depressive personality disorders NOS DP (7 items).The scale provides scores of eachsub-domain and overall cluster levelas well.The scalehas been translated and validatedfor Pakistani sample.'

### Procedure

After seeking formal permission from hospital administration data was collected from wards and OPDs of hospitals of Islamabad, Rawalpindiand Lahore. Participants wereformally briefed aboutthe purpose of the study and informed consent was sought from them. Individuals wereassured aboutthe confidentiality of theirresponses. Afterwards for the clinical sample items were read to the individuals and their responses were marked. For the sake of comparison demographically similar data was collected for non-clinical sample. Both of them were matched on age, education, marital status and Socio-economic status. In cases where individuals were educated questionnaireswere givento the respondents.They wereinstructed to mark any itemthat they thinkis either difficult to comprehend or culturally inappropriate. But in cases where individuals were not educateditems werereadto them andresponse weremarked as for the clinical sample. At the end participants were thanked for their cooperation.

# RESULTS

57.59%of clinicalsamplecomprised of males and 42A0%comprised of females. In contrast, for Non-Clinical sample 40.83 % comprised of males and 59.16 % comprised of females. SO% of the clinical sample wasbetween the ageof 18to 35where as50 % wasbetweenthe age of 36 to 59. Whereas 48.33% from non-clinical sample were between the ageof 18-35 and 51.66% were between the ages of 36 to 59.For clinical sample 23.52% of the sample comprised of individuals who did matric whereas for Non-Clinical 22.25 % comprised of sample who had completed matric. 38%of individuals comprised of clinical sample who were single whereas for non-clinical 34% individuals weresingle.

Table I indicated that the rate of Personality disorders in clinical sample was68.1%, whereasin non-clinical sample it was 16.3%. The

combined rate of PDs for both clinical and non-clinical sample was 43.8%.Borderline personality disorder was most prevalent in clinical

sample (f =184) followed by paranoid (f =123), Schizoid (f= 118) and

Obsessive compulsive personality disorder (f = 111). T<1ble 2 indicated significant differences on chi square for all PD's across gender wherefrequency of all PDs for males was higherascompared

with females except for Borderline, Depressive and Passive aggressive PDs for clinical sample.The gender wisecomparison was not possible in non clinical group because certain cellsin cross table hadcountless than 5.

Table**1**

**Rate of Personality P.:1Lhology amongClinical and Non- Clinical Sample**

|  |  |  |  |
| --- | --- | --- | --- |
| **Sample** | **N** | **Diagnosed** *f (%)* | **Un-Diagnosed** *ft%)* |
| **Clinical** | 408 | 278 (68.1%) | 130 (31.8%) |
| **Non-Clinical** | 360 | 59 (16.3%) | JOI (83.6%) |
| Total | 768 | 337 (43.8%) | 431 (56.1%) |



Table 2

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**Table 3**

Chi Square Anal~~,~~v~~·~~si!.of Personality Disorders as per Geoder.among Clinical Sample

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Clinic l(N~*408)* | | | | | |
| **PD** | | **\talc Female** | | | ***7.1,df*** |
| */("/4) /(:,(,)* | | |
| I. | Par | *Dia* | 84(20.59) | 39 ((9.55) | 8.24\*, I |
|  |  | *Undiag* | 151(37.01) | 134 (32.84) |
| 2 | Sch | *Dia* | 83(20.34) | 35 (8.57) | I1.03\*\*,I |
|  |  | *Umliag* | 152 (37.25) | 138 (33.82) |
| 3. | St | *Dia* | 63 (15.44) | *24* (5.88) | 9.93',I |
|  |  | *Umliag* | 172 (42.15) | 149 (36.SI) |
| 4. | AS | *Dla* | 53 (12.99) | 7 (1.72) | 29.20°-•,1 |
|  |  | *u,uliag* | 182 (44.6I) | 166 (40.68) |
| 5. | l.lPD | *Dit1* | 119 (29.16) | 65 (15.93) | 6.87,1 |
|  |  | *Undiag* | 116 (28.43) | 108(26.47) |
| 6. | llis | *Dia* | 30 (7.35) | .I (1.22) | 12.3911•·•.1 |
|  |  | *Undiag* | 205 (50.24) | 168 (41.17) |
| 7. | Nar | *f)fa* | 48\11.76) | 7(1.71) | 22.92u",I |
|  |  | *Umliag* | 187 (45.83) | 168(40.68) |
| 8. | Avo | *Dia* | 59 (14.46) | 20 \4.90) | 11.I 7••,1 |
|  |  | *U,idiag* | 176 (43.13) | 153 (37.5) |
| 9. | DE | *Dia* | 51 (12.5) | 18(4.41) | 9.05',I |
|  |  | *u,uiiag* | 184 (45.09) | 155 (37.99) |
| 10. | oc | *Dia* | 77 (18.87) | 34 (8.33) | 8.65\*,I |
|  |  | *Umliag* | 158 (38.72) | 139(34.06) |
| IJ. | DEP | *Diu* | 48 (11.76) | 29 (7.10) | .87,1 |
|  |  | *Umliag* | 187 (45.831 | 144 (35.29) |
| 12. | PA | *Oio* | 70(17.15) | 38(9.31) | 3.13,1 |
|  |  | *U11diog* | 165 (40.44) | IJ5 (33.08) |

*Note: PD* = *Personality Di.wm-/er, Pa,•= Paranoid. Sdr* = *Schi:wid, St* = *Sclli:m ipol. AS= Ana social, BPD* = *Borderline. His= Histrionic.*,Var= *NarcissisJic. Avo* =

*A vidam, Df.* =- *Dependenr, OC Obsessive Compulsive. DEP* - *Depressive, PA*

*Passive Aggre.ufre, Di{I* = *Dhrg,wsed. l./luliag Uniliagnoscd*

Results indicated that rate of personality pathology among clinical sample was muchhigher ascompared withnon-clinical sample. For clinical sample 67 individuals had considerable score on one personality disorder, 69 on two personality disorders, 49 on three personality disorders respectively (see table 3 for details). This co­ occurrence of the personality characteristic can be from the same cluster as well as from different clusters. For non-clinical sample 35 individualshad considerable score on one personality disorder, 8 on two personality disorders and 7 on simultaneous four personality disorders(see table3for details),

# DISCUSSION

Findings indicated thatpersonality pathology was higher in clinical sample as compared with non-clinical sample. The most frequently occurring personality disorder in clinical sample was borderline

Personallty Disordo"r.s for Clinical nnd Non Clinical .S,ample

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| I **Clinic.al INoo-dioical (,Y..408) (N-360)** | | | | | | |
| **ror onalily Di orderClusters** | | | *I* | *¾* | *I* | % |
| I. | Cluster A | Undiagnosed | 217 | 53.2 | 260 | 72.2 |
|  |  | Diagnosed on I PD | 92 | 22.5 | 77 | 21.4 |
|  |  | Diagnosed on 2 PO | 6) | 15.0 | 16 | 4.4 |
|  |  | Diagnosed on 3 PD | 38 | 9.3 | 7 | 1.9 |
| 2. | Cluster B | Undiagnosed | 204 | 500 | 336 | 93.3 |
|  |  | Diagnosed on I PD | 132 | 32.4 | 19 | 5.3 |
|  |  | Diagnosed on 2 PD | 32 | 78 | 5 | 1.4 |
|  |  | Diagnosed on 3 PD | 22 | *5.4* | 0 | 0 |
|  |  | Diagnosed on 4 J'D | 18 | 4.4 | 0 | 0 |
| 3. | ClustcrC | Undiagnosc.'<l | 256 | 62.74 | 314 | 87.2 |
|  |  | Diagnosed on 1 PD | 76 | 18.63 | 32 | .9 |
|  |  | Diagnosed on 2 | *45* | II.OJ | **8** | **2.2** |
|  |  | Diagnosed on 3 | 31 | 7.6 | 6 | 1.7 |
| 4. | Tutal Clusters | Undiagnose<I | 130 | 31.86 | 301 | 83.6 |
|  |  | Diagnose'<!on I PD | 67 | 16.4 | 35 | 9.7 |
|  |  | Diagno ed on 2 PD | 69 | 16.9 | 8 | 2.2 |
|  |  | Diagnosed on 3 PD | 49 | 12.0 | 3 | 0.8 |
|  |  | Diagnosed on 4 PD | 30 | 7.35 | 7 | 1.9 |
|  |  | Diagnosed on *5* PD | 17 | 4.17 | 3 | 0.8 |
|  |  | Diagnosed on *6* I'D | II | 2.7 | **2** | 0.6 |
|  |  | Diagnosed on 7 PD | 7 | 1.7 | I | 0.3 |
|  |  | O.iagnosed on R PO | 9 | 2.2 | 0 | 0 |
|  |  | Diagnosed on 9 PD | 13 | 3.2 | 0 | 0 |
|  |  | Diagnosed on IOPD | 6 | 1.5 | 0 | () |

personality disorder (f *=*184) which can be attributed to the fact that among all personality disorders people with Borderline Personality tend to seek more treatment.'·" Previous researches indicated that individuals withBorderline line personalitydisorder in particular and cluster B overall tend to seek moretreatment as these conditionsare

associated with marked degree of functional impairment as well as increased need to seek attention from significant others in society'"". They also tend to have greater comorbidity with other disordersaswell'·".

Though low as compared with clinical sample but a substantial number of individuals showed scores on personality pathology in non-clinical sample as well. Past researchers conducted on community sample confirm this finding that prevalence of personality disorderisapparentin non-clinicalsamples'.

Personality Pathology wasmorefrequent in malesascompared with females across clinical sample except for Borderline Personality Disorder, Depressive and Passive Aggressive Personality Disorder.



Previous literature also supports these findings where cluster A specifically i.e. Paranoid, Schizoid and Schizotypal disorders are found to be more prevalent among males'·'. For Cluster B mixed findingsareapparent.BPDhasbeen foundto bemostprevalent of all PDs and recent literature is suggesting that no gender differences exist in prevalence of BPD though differences might be in symptom severity. Similar trend was apparent for Cluster C where more males had dependent, obsessive compulsive and Avoidant personality disorder.



The presence of co-occurrence in personality pathology has been well documented by previous researchers.' "-".Thiscomorbidity has been attributed to shared etiological factors which might include genetics, biological, environmental, psychological and temperamental factors'. Researchers also argued that presence of one personality disorder makes an individual vulnerable for developing another personality disorder.' Similarly researches also attributed co-morbidity to complication models which argued that though two disorders represent distinct entities but they arerelated to one another as one disorder remains in a remitted form andhasa scar or complicated effect." Co-occurrence was apparent in both clinical and non-clinical groups with varying degree of complexity and severity. Researches indicated that presence of more than one personality disorder is likely to result in poor treatment **outcomes..1 1 1(1**

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The high rate of personality disorders clearly indicated that these needto be assessed properly at the timeof diagnosis and designing of intervention plans. It has been evident that personality disorders are often overlooked and ignored by professionals as they are considered to be manifestation of orher mental illness to be rated previously on Axis**I''.**Researchers further arguethat asthe symptoms of Axis I disorder improve, the level of associated personality pathology decreases". It is critical to assess personality disorders at the initial stage because it has been strongly linked up with shortened life expectancy as wellaspoor adherence to treatment""'. Awareness about prevalence and comorbidity apparent in personality pathologycan be helpfulin modification, adaptation and designing ofthetreatment plans."'

## CONCLUSION

It can be concluded that the rate of personality pathology is much higher in clinical sample as compared with non-clinical sample. Further co-occurrence of two *or* more personality disorder characteristics was also evident. Special consideration needs to be

given to the element of co-morbidity of personality pathology in planning treatment forbettertreatment outcomes.

## LIMITATION AND SUGGESTIONS

For assessment of personality pathology, present study used a self­ reportmeasure.Further evidencecan be gained by addinginformant rated measures. It has been suggested that collateral information shouldbeincluded when making diagnosesfor personality disorders ADP IV is based upon categorical approach which ignores the presence of symptoms that do not fully meet the criteria for a particular disorder. Future studies could take in to account the empirical system of taxonomies for assessment of personality pathology.

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