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Types Of Personality Disorders And Its Therapeutic Measures: An Overview

MallikarjunVasam[*1], Chandrashekar Thalluri[*2], Ramya Krishna Nakkala[3], Shanmugarathinam Alagarsamy[4], Satyaraj D Ombase[1], Ananth Lakshmi G[5]

[*1]Department of Pharmaceutics, Annasaheb Dange College of B Pharmacy, Ashta, Shivaji University, Maharashtra.

[*2]Department of Pharmacy, Downtown University, Assam.

[3]Chebrolu Hanumaiah Institute of Pharmaceutical Sciences, Chowdavaram, Guntur, Andhra Pradesh-522019, India

[4]Department of Pharmaceutical Technology, Anna University, Tamil Nadu.

[5]Professor and Head of Pharm D Program, Sri Venkateshwara College of Pharmacy, Hyderabad, India

***Corresponding Author[*]**

Dr. Mallikarjun. Vasam

Professor, Annasaheb Dange College of B Pharmacy, Ashta.

Email ID: mallikarjunvasam@gmail.com

Dr. Chandrashekar Thalluri

Associate Professor, Downtown University, Assam.

Email ID: chandu6716@gmail.com

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ABSTRACT

Personality disorders (PDs) represent a significant global public health concern, with an estimated 10% of the population affected. In the UK, prevalence studies indicate PD diagnoses in 38% of females and 30% of males (2009-2010). According to the Indian Psychiatric Society, 75% of the population exhibits severe personality deviations, a defining feature of PDs. Characterized by maladaptive personality traits that severely impair daily functioning, PDs are associated with poor life quality, mental health comorbidities, and an elevated risk of premature death. PDs typically manifest in childhood or early adulthood and are influenced by genetic, environmental, and psychological factors. Clinical manifestations include social communication difficulties, emotional instability, depression, anxiety, and phobias. The DSM-5 categorizes PDs into three clusters: Cluster A (suspicious), Cluster B (emotional and impulsive), and Cluster C (anxious). This review aims to provide an overview of PDs and offer guidance on their identification, diagnosis, and treatment by healthcare professionals.

Keywords: *Personality disorders, cluster, social communication, lifestyle, Cluster A.*

1. INTRODUCTION

Personality refers to the discernment, feeling, and behavior that distinguishes one individual from another. Personality disorders (PDs) are defined as severe and persistent deficits in a disposition that influence various discrete qualities, interpersonal settings (lifestyle situations, hereditary features), and the surrounding environment [1–4]. In the early 1990s, the predominance of PD in nonclinical communal populations was unknown primarily [4–6]. Around 10% of the world's population reported PD conditions, having a prevalence rate of up to 24% in primary care [7–9] and over 30% in psychiatric patients [10–13]. As a collection of distinct psychological irregularities, PD is one of the most often encountered illnesses treated by psychiatrists and psychotherapists [14–16]. One of the reasons for the repeated practice of well-being institutions is to maintain the strictness and chronicity of minimizing such incredible levels of misery for arrogant patients and their families. An alternate explanation is related to the patient's prolonged grade of concurrent perceptual problems and physical ailments caused by PD. In the recent decade, epidemiology research on Parkinson's disease (PD) has indicated that low- and middle-income countries experience significantly more suffering (PD) than high-income countries.

Personality disorders are complex mental health problems worldwide [17,18] due in part to the recurrence of perceptual and therapeutic well-being difficulties [19–21]. PD is associated with different medical problems, cardiovascular disorders [22–24], sleep problems, chronic pain, arthritis, and obesity [25–27]. Previous research has indicated that PD and other health

issues, such as borderline personality disorder (BPD), are associated with sleep disturbance. Other psychological research has also discovered a significant co-occurrence rate between PD and various diseases, such as depression, ingesting disorders, substance use behaviors, and anxiety [28–30]. Although the cause of PD is unknown, it is believed to be triggered by genetic inheritance, environmental circumstances, and, most commonly, childhood trauma. Personality problems are most prevalent throughout the adolescent or early adult years.

This review provided more detailed information on the fundamental issues affecting personality disorders and critical knowledge about the many types of personality disorders and their treatment.

TYPES OF PERSONALITY DISORDERS

The PD is frequently over-classified, focusing on personality types that diverge from current societal prospects and remain defined by consistent arrays of maladaptive traits and behaviors. Individuals diagnosed with PD continue to be classified based on their habitual actions, which anchor them to sensation and cause them to engage in dysfunctional social traditions. Such behaviors tend to be considerable deviations from approaching a regular individual in a different lifestyle, containing deliberate feelings, and reporting others. In pursuant to the American Psychiatric Association (APA), those likely long-lasting patterns of behavior, intellectual stability, and overall perspectives are frequently analogous to inward proficiencies and individual intuitively as relevant. The diagnostic and statistical handbook, fourth edition, and text revision identify the eleven personality disarrays. Numerous personality disorders (Table 1); are classified into three groups depending on the indications and symptoms of various situations.

Table 1: Description of Personality Disorders; signs and symptoms.

NAME	DESCRIPTION	SIGNS & SYMPTOMS
Cluster A: Suspicious		
Paranoid personality disorder (PPD)	Those accompanying schizophrenia are due to the phenomenological correspondence of suspiciousness to paranoid delusion. The frequency rate of PPD at almost 2-4% in ordinary residents.	Knee – Jerk overreacts to perceived anger, compassion, overthinking, extreme paranoia, doubting people's loyalty seems close, and hard to relax. [31]
Schizoid personality disorder (SPD)	Categorized by a lack of desire to speak and weak interpersonal relationships, they have similar symptoms of schizophrenia. A prevalence study estimated that 1% of the population suffering SPD.	Lacking motivation and no interest in sexual activity, expressing emotional feelings, and avoiding developing new relationships and behavior different from others is challenging. [32]
Schizotypal personality disorder (STPD)	The heterogeneous syndrome is expressed across multiple disorganized symptomologies of the second stage of schizophrenia, positive, negative, and confusing. Prevalence studies report that 3.6% of the population.	Magical thinking, inappropriate emotional responses, uncomfortable feeling in close relationships, overthinking, odd perceptual experiences, and lack of social anxiety. [33]
Cluster B: Emotional and Impulsive		
Antisocial personality disorder (APD)	50% of men are suffering from APD conditions, a present like comorbid anxiety disorder. Historically, it was through that anxiety limited the criminal mind and violent behavior. The prevalence of APD is 4-5% of the population.	Disregard others' needs or feelings, impulsive behavior, recklessness, aggressiveness, and recurring problems with the law. [34]
Borderline personality disorder (BPD)	Enduring patterns of instability in emotion regulation described it. A high level of psychosocial impairment and a high rate of suicide (10%) were reported.	Moods are up and down, self-injury, suicidal behavior, stress-related paranoia, fragile self-imagination, and binge eating. [35]
Histrionic personality disorders (HPD)	Also identified as a histrionic personality disorder, a psychiatric ailment is notable by outlining exaggerated emotionality and	They constantly seek attention, are sexually provocative to gain attention, are excessively emotional, rapidly changing emotions, and are easily influenced by

	attention-seeking behavior.	others. [36]
Narcissistic personality disorders (NPD)	They are inclined to embellish their accomplishments and may brag about their allure or attainment	Fantasies about power, arrogance, the envy of others (or) certainty such different jealousy, unreasonable prospects of errands from others, compelling advantages of others personal life. [37]
Cluster C: Anxious		
Avoidant personality disorder (AVPD)	chronic ailment through age at onset and feeling influence and significantly allied through distress, injury, and disability in social interactions	Social inhibition, inadequacy, sensitivity to criticism or rejection, reluctance to take risks, inferiority, and unappealing. [38]
Dependent personality disorder (DPD)	Extreme reliance on other individuals for survival and nurture. The patient is highly dependent on close interpersonal relationships.	Vulnerable to manipulation by others, deep fear, abandonment, overly dependent on others, submissive and clingy behavior. [39]
Obsessive-compulsive personality disorder (OCPD)	Extreme concern with appearance and orderliness, extreme perfectionism, and the requisite to control one's environment are maladaptive designs.	Rigid and stubborn, inflexible around ethics, inability to discard broken, disregard of friends and amusing deeds, undue assurance to the effort, extreme perfectionism behavior. [40]

2. ETIOLOGY

Personality disorders primarily caused by aberrations may be perceived in the brain's frontal, temporal, or parietal lobes. Encephalitis, trauma, or hereditary disorders may trigger this anomaly during pregnancy. The PDs persist in the same way whether aberrant monoamine oxidase, serotonin, or oxytocin hormone production occurs.

Genetics factor (5%): Researchers are beginning to identify probable hereditary markers associated with long-standing personality disorders. Some researchers have identified a faulty gene, which may continue to be a causal factor in obsessive-compulsive personality disorders. Others, on the other hand, believe that genetic mutations, anxiety, and a severe fear factor play a part in PDs. The severity of anxiety and depression symptoms among elite athletes is significantly correlated with personality, the existence of the 5-HTTLPR genotype, and personality [22,41,42].

Psychological factors (30- 40%): Susceptible to light, noise, consistency, and additional stimuli may all have a role in the expansion of PD. For example, highly subtle children who require what scientists refer to as "high reactivity" are more likely to develop shy, timid, or anxious behaviors. On the other hand, 20% of infants have antisocial personality disorders. Studies of psychological mechanisms have yielded therapeutically applicable insights into the origins of personality disorder trait-described patterns of behaviour. Exploration of the concept of empathy demonstrates that there are numerous underlying systems that may be affected differently under different circumstances. It is believed that narcissistic personality disorders are related with reduced emotional empathy but relative preservation of cognitive empathy [43,44].

Social relative factors (60-70%): On average, patients with PD struggle with various social interactions and mood directive issues. These careful contours of insight are assumed, and the response is uncompromising and stable behavior. After the initial revisions of PDs, the combined longitudinal temperament disorders investigation identified additional social-psychological elements (Figure 1) that influence the PD cluster. Typically, the aetiology of PD is viewed as a reciprocal relationship between individual variations and a less supportive social environment. The type of social environment that promotes the development of PD has been described as less supportive, more invalidating, and marked by more chaotic caregiving [45][46].

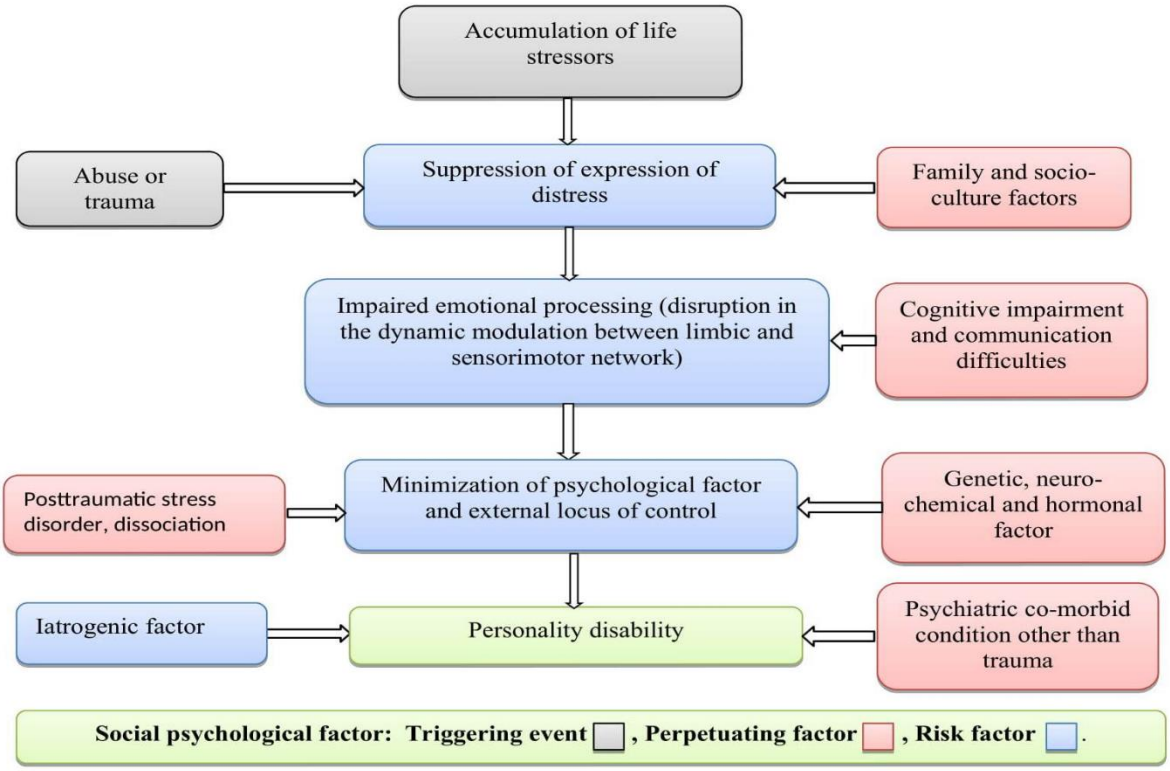

Figure 1: Social Psychological Factors

3. DIAGNOSIS

Personality disorder diagnosis remains predominantly based on the patient's signs and psychological behavior over time in various scenarios. Three distinct sorts of diagnoses exist.

Physical examination: In 2-3 observation sessions, the physician may do a physical examination and conduct an in-depth inquiry about the patient's health. Patients exhibit various indications that may accompany problematic and gauged alcohol and drug abuse testing.

Psychiatric evaluation: This encompasses an argument that is virtually entirely patient regarding psychological thoughts, feelings, and behavior. Specific questions are included in the patient's personal history and occupational position to inform family members. Examining these patients' interpersonal relationship history, educational and employment history, mental and substance abuse history, and legal history are crucial [47].

Diagnostic cater: It frequently transforms spectacularly given that the patient presents through gauges for various psychological problems, both within and outside the PD range. This is referred to as concomitant comorbidity [48][49]. It is still believed that the complete range of PDs and other mental illnesses encompasses a thorough outline of symptoms and a further austere complaint. As shown in the reflection, the overall number of contented measures for specific PD continues to relate to perceived dysfunction and stated quality of life [50]. Comorbidity of PDs and other mental illnesses predisposes alarmingly to efficient deterioration and accumulates the menace of prompt mortality [51].

Due to their distinctiveness, it is not uncommon for the individual who validates the diagnosis of PD to seek another mental condition, a factor that valor confuses throughout the diagnostic phase. Additionally, sporadic episodes of rapid onset depression and anxiety, such as the care episode, in which the coexisting hitches associated with a comorbid PD remain prominent. Another compelling argument is the comorbidity of an additional permanent character.

For example, pre-existing ADHD can obfuscate the medical signs of an ambiguous personality condition. Similarly, a simple and prolonged eating disorder may be responsible for concluding vital character disorders. When the diagnostic picture of Parkinson's disease remains complex and reasonably consistent across disparate detections, it is infrequently possible to disentangle disparate primary diseases. As a result, the discrepancy in diagnostic procedure will continue to grow, practically equating the virtual effect of the multiple noticeable stated indications on the sternness of operating. Self-assessment tools, semi-structured talks, and personality inventories can all be used to improve diagnostic precision. SCID-II remains the de facto standard for personality diagnosis following the DSM-I (Diagnosis and Statistical Manual of Mental Disorders), DSM-IV, and DSM-5[52].

4. TREATMENT

A personality disorder is a collection of circumstances that necessitate specific executive methods in the primary care conduct psychological sitting uttermost exertions on sustain and auxiliary the doctor-patient relationship [50]. The critical care programme's primary goal remains to verify that the patient can accept competent medical treatment regardless of the effort required to communicate with the doctor and health care practice. In some cases, physicians advise two distinct approaches to PD treatment: psychological counseling or psychotherapy and pharmaceutical treatment. The aging psychological treatment spectrum is based on patient behavior (over tricky resolving and psychological education) [47]. According to the National Institute for Health and Care Excellence (NICE), a combination or group of specialized treatments and other social service users may be optimum for beneficial outcomes. Physicians argue for a lengthier duration of pharmacological treatment based on the severity of the illness PD to the occurrence of sessions stated [53].

The goal of personality disorder treatment is much more illiberal than is frequently recommended. Only explicit components of drug therapy are emphasized, such as effective instability disorders and pathological consequences, such as influencing variability and intuitive mental conflicts. Physiological treatment primarily refers to borderline PD; the goal is to reduce acute life-threading symptoms [54].

Psychotherapy: One can examine the disease and converse with a cognitive health specialist during psychotherapy about the aura, state of mind, opinions, and performances. One can check whether it can control anxiety and complete patient-centered disease. Psychotherapy may continue to be offered in a traditional session setting; the group also supports family members. Similarly, social skills drills can be obtained there [55]. Through this exercise, one can put intuition and familiarity into work by researching healthy methods for achieving indications and minimizing activities such as restricting patient-operative behavior and social relations. Family remedy aids and education to families that allocate funds through a family member with a PD.

Medications: There are currently no FDA-approved therapies for indulgent PDs. On the other hand, numerous psychiatric treatments may require support from an infinite number of personality disorder symptoms [56].

- **Antidepressants:** Antidepressants may continue to be helpful if they require a depressed mood, fury, impulsiveness, impatience, or ineptness that may persist due to PDs.
- **Mood stabilizers:** For example, as their name implies, mood stabilizers can assist in resolving mood fluctuations or reducing impatience, immaturity, and aggression.
- **Antipsychotic medications:** Like neuroleptics, they may stay beneficial if symptoms include a loss of contact by reality (psychosis) or, in some instances, suffering from anxiety or anger complications.
- **Anti-anxiety medications:** These might provide consolation if experiencing anxiety, distress, or insomnia. Nonetheless, they have the potential to boost impulsive performance in specific cases, which is why they are avoided in certain types of PDs.

Cluster A personality disorders: Paranoid, schizoid, and schizotypal patients in this cluster A remain scratchy in individual states, ardently reserved, challenging to utilize, and isolative. The paranoid PD patient exhibits understandable mistrust and suspicion, but the schizotypal patient parades quirky or borderline delusory dogmas. This band was collectively labeled "schizophrenic spectrum cluster" because it matches people with schizophrenia regarding clinical presentation, supervisory approaches, and medication response (Table 2). Patients do not respond appropriately to distressing signals from the doctor and continue to be incapable of developing rudimentary response associations [57]. Once allocated via these patients, numerous plans for implementing a healing pact typically prove fruitless or detrimental. In the clinical setting, these patients may continue to be averse to maintenance because of the unusual interaction; they may interact in a reclusive and strange manner and may have puzzling views about their underlying disease. Attempts by the doctor to create a heated relationship with them or to delve into their specific worries are interpreted as indiscreet and tend to marginalize them. Physicians should value their interpersonal restraint while interacting with these patients and advocate for a reverent, slightly distanced proficiency perspective. Medical evidence should continue to be presented in a vivid, straightforward manner. Additionally, for paranoid and schizotypal individuals who exhibit mistrust or strange thoughts, it is critical not to argue or develop unwaveringly around these concepts.

Table 2: Cluster A Personality disorder: Diagnosis and Treatment management

Personality disorder	Diagnosis		Treatment management	
	Psychical	Psychiatric	Psychosocial therapy	Pharmacotherapy
Paranoid	Intensified sense of	Fear physicians might	Cognitive therapy.	Atypical antipsychotic

	fear and liability	harm, argue, fight		drugs.
Schizoid	Social detachment, emotional constraint	Anxiety, delay seeking care.	Psychiatric council about personal and social issues.	Anti-anxiety therapy
Schizotypal	Socially isolative, odd versions of ailment.	Delay seeking care, odd behavior, and anxiety	Group therapy and talk therapy	Antipsychotic drugs mainly use haloperidol.

Cluster B personality disorder: Patients accessed via cluster B Patients with PD are perplexed when encountered in clinical settings. Patients are excessively strenuous, serpentine, emotionally unstable, and socially inept. They may attempt to engineer contacts such as cross-competent precincts and resident physicians in high-stakes or conciliatory scenarios. Doctors frequently respond to these patients with overly sensitive emotional retorts. Once such patients have been allocated, physicians must remain intensely aware of the issues about scheming performance, professional restrictions, boundary situations, and intensive care for their distinctive emotional states [58].

The antisocial patient may exist in clinical worries such as incapacity valuation, pursuing precise wealth, or in situations involving bad or intense manners via an insistent outline of betrayal, impulsiveness, and disrespect for others' moralities. Clinical outcomes involving possible malingering or disagreements over constituent exploitation may serve as "red flags" for these procedures. There may also be disparities in the patient's performance, age, and physical examination. While the scientific portrayal indicates possible antisocial behavior, a comprehensive periodical of the patient's history, fair scrutiny and analysis, and potential conversation is necessary. Verdicts, imposts, endorsements, and restrictions must all stay visibly and conclusively connected to the patient. It may still be appropriate to seek psychiatric or legal consultation therapy (Table 3).

Table 3: Cluster B personality disorder: Diagnosis and Treatment management

Personality disorder	**Diagnosis**		**Treatment management**	
	Physical	Psychiatric	Psychosocial therapy	Pharmacotherapy
Antisocial	Masking fear, disregarding the right of other	Anger, impulsive behavior, deceit, manipulative behavior	Psychoanalytical therapy (life-threatening behavior).	Selective serotonin reuptake inhibitors (SSRIs) E.g., fluoxetine, sertraline
Borderline	Self-image, idealization	Terrifying fantasies, nontechnical explanations, consulting a psychiatrist.	Dialectical actions remedy, schema-intensive remedy, and metallization-based remedies.	Anticonvulsants drugs, Monoamine Oxidase Inhibitors (MAOIs). Commonly two drugs are prescribed for this condition that is phenelzine and haloperidol.
Histrionic	They are pursuing actions, emotionality, and a susceptible sense of desirability, desperately intense.	Somatization emphasizes objective issues.	Positive social behavior therapy.	Anti-depression therapy.
Narcissistic	Lack of empathy, need for admiration, attitude of entitlement.	Anxiety, grandiosity.	Counseling psychology, family therapy, group psychotherapy.	Antidepressants, anti-anxiety drugs.

Cluster C personality disorder: All Cluster C PD patient's exhibit anxiety, dread of assessment by others, desertion, or a loss of order; these patients elicit restrictive designs and feelings, such as a barrier to communication between physician and patient. The required physician employs appropriate strategies to ease this fear and establish a functional relationship with these patients. Through avoidant behavior, the tolerant individual stays primarily shy and subdued, with sparse strategies and low self-esteem [59]. The dependent patient suffers from the self-perception that they always are incapable of reason and hopelessly dependent on others for assistance. These signals of rising complexity in verdicts include eagerness, the formulation of a challenge, and reservations about being unrestrained by significant people. Patients who rely on them go to great lengths to maintain their relationships and sense of well-being within the context of the medical situation and pharmacological treatment based on the patient's symptoms (Table 4).

Table 4: Cluster C personality disorder: Diagnosis and Treatment management

Personality disorder	**Diagnosis**		**Treatment management**	
	Physical	Psychiatric	Psychological therapy	Pharmacotherapy
Avoidant	Social inhibition, fear of rejection or humiliation.	Withhold information and avoid questioning.	Cognitive actions remedy, group remedy.	Selective Serotonin Reuptake Inhibitors and sedative drugs. Eg: fluoxetine, diazepam and lorazepam.
Dependent	Excessive need to take care, fear of abandonment, helplessness.	Clinging behavior, submissive behavior, and anxiety	Behavioral health therapy.	Anti-anxiety drugs and sedative drugs.
Obsessive-compulsive	Fear, self-control loss.	Perfection, control, and preoccupation with orderliness.	Talking therapy, cognitive therapy.	Selective Serotonin Reuptake Inhibitors and monoamine oxidase inhibitors.

Prevalence and psychological patient counseling: Personality disorders are a significant public health concern worldwide, affecting all age groups. The acquaintance exploration provides information about the prevalence of PD, characterized by a significant decrease in self-psychological behavior disorders, pathological personality features, and relatively unstable situations. They are associated with an excellent death rate; 85 percent of patients are diagnosed through borderline personality disorder, have at least one other DSM-IV Axis-I illness, and 75% are diagnosed with other personality disorders. The PD is primarily related to patients with a low education level, who use drugs, and who consume alcohol, and the DSM-IV identified an increase in the risk of life-threatening suicidality [55][60]. In personality disorder, there is an increase in violent social behavior and a 60 percent increase in suicides. These severe detrimental impacts of Parkinson's disease on individual patients, their strong link with family members, and society's burden [61].

Psychological physicians argue that disposition is the early indicator of personality development in children. The six temperament features, which include activity level, urgency, petulance, horrible pain, soothability, and contemplation span, are invented to influence an individual's behavior during infancy and childhood. The Five-Factor Model (FFM) of behavior slant continues to be a collection of five major traits: amicability, thoroughness, extraversion, forthrightness in practice, and neuroticism, which has been used to characterize the average adult's personality. Recent research findings corroborate this perspective, suggesting a strong link between these super characteristics and personality development [62]. However, establishing a temperament-personality relationship at a single point is difficult, as the personality development process takes time. A meta-analysis of the persistence of behavioral variables across the lifespan revealed somewhat moderate, test-retest relationships between personality traits at two points in time and alongside persistence as an individual's age increases. Additionally, when the frequency of examination between two personality evaluations increases, the stability of these qualities' decreases [63]. However, as revealed an exciting finding with evidence suggesting that the temperament traits variability did the lifespan, endurance of behavior functioning in childhood remains reasonable and upsurges through adolescence and young adulthood.

5. CONCLUSION

The severity of personality disorders is often reflected in the increased psychiatric morbidity, social dysfunction, and higher rates of suicide or aggressive social behaviors. Early temperament traits, including activity level, urgency, irritability, distress

tolerance, soothability, and responsiveness, play a crucial role in shaping personality development during infancy and childhood. The Five-Factor Model (FFM) of personality, which evaluates traits such as socialization, conscientiousness, extraversion, openness, and neuroticism, provides a valuable framework for understanding adult personality. While personality disorders are often categorized in the DSM-IV-TR, they may also manifest in children and adolescents, though they are less stable in younger populations. This variability emphasizes the importance of continued research into the onset, stability, and progression of PDs in youth. Furthermore, early intervention and preventive strategies targeting developmental pathways related to PDs in adolescents are critical. With growing interest and advancements in research, future treatment approaches, including more targeted psychotherapies and medications, hold promise for improving outcomes for individuals with personality disorders.

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