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Challenges in the Identification and treatment of Personality disorders among university students.

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Abstract: The persistent and pervasive effect of personality disorder is often overlooked in routine clinical practice, both as an important moderator of mental health and physical disorders, and as a disorder that should be recognised and managed in its own right. The article explores the problems faced by the professionals in identifying the personality disorders at an early stage. Contemporary research has shown that personality disorders are common, can be recognised early in life, evolves continuously across the lifespan, and is more vulnerable than previously believed. These new insights offer opportunities to intervene to support more adaptive development than before, and research shows that such intervention can be effective. Several studies revealed that there is a lack of awareness on personality disorders among the public. Appropriate interventions are less in India to identify the personality disorders and the number of cases reported are a very few. This paper highlights the major difficulties encountered by the experts in identifying the personality disorders and providing appropriate educational accommodations to these students. The researchers of the present study have adopted the interview and observation technique to find out the difficulties encountered by the mainstream clinicians and psychiatrists to identify personality disordered students in clinical as well as non clinical samples. Data suggests that overcoming these issues is more important than ever due to the increased prevalence of students who arrive at college campuses with more serious psychiatric problems.
Keywords: challenges, Identification, personality disorder, treatment, students

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I. INTRODUCTION

In recent years, personality disorders – psychiatric constructs understood as enduring dysfunctions of personality – have come into ever-greater focus for mental health professionals and service-users and British policymakers. Disputes have focussed largely on highly controversial attempts by the UK department of Health to introduce mental health law and policy. At the same time, clinical framings of personality disorder have dramatically shifted: once regarded as untreatable conditions, severe personality disorders are today thought of by many clinicians to be responsive to psychiatric and psychological intervention. Research investigation have shown that about 30 percent of people who require mental health services have at least one personality disorder (PD)-characterized by abnormal and maladaptive inner experience and behaviours.

Personality disorders, defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-V), is a persistent pattern of internal experience and behaviour which manifests in two or more of the areas of thinking, feeling, interpersonal relationships, and impulse control. This pattern greatly differs from the expectations of the individual's culture, is insidious and uncompromising, has an onset in adolescence or early adulthood, stabilizes over time, and can cause disturbance or affliction to the affected individual [1]. Personality disorders are associated with a significant burden on the individuals with the disorder, those around them and on society in general. Along with substantial social difficulties [2] individuals with personality disorder also experience poor general health [3] and reduced life expectancy [4]. Yet prospective, population-based research shows that even after accounting for the effects of concurrent mood and anxiety disorder, personality disorder is an independent risk factor for poor future mental health, as well as serious relational difficulties [5].

The probability of consulting and receiving effective treatment from psychiatric services varies according to demography, degree of disability and diagnosis [6][7].

Dysfunction has been viewed as arising from impairment of the organizational, integrative and self-regulatory processes required to achieve evolutionary tasks of:

a) stability of the self system;
b) satisfactory interpersonal functioning (for example, meeting needs for intimacy, affiliation and attachment); and
c) social integration in the form of prosocial and cooperative behavior [8][9].

Typical Challenges Among College Students mentioned by Kadison & DiGeronimo, 2004 include:
- Academic pressure to succeed
- Balancing extracurricular activities
- Parental expectations
- Racial and cultural problems
- Financial worries
- Social fears *(terrorism, campus safety, sexual assault)*
- Pressure to find work

People with personality disorders can possess very different personality disturbances, they have at least one thing in common: chances are their mental illness will not remit without professional intervention. However, exactly what that intervention should consist of remains a subject for debate. This, along with the disorders' notoriety for being problematic to treat, has posed challenges to their successful resolution, or at least management.

Both ICD and DSM, diagnostic systems provide a definition and six criteria for a general personality disorder. These criteria should be met by all personality disorder cases before a more specific diagnosis can be made.

The ICD-10 lists the following general guideline criteria: [10]

✓ Markedly disharmonious attitudes and behaviour, generally involving several areas of functioning; e.g. affectivity, arousal, impulse control, ways of perceiving and thinking, and style of relating to others;
✓ The abnormal behaviour pattern is enduring, of long standing, and not limited to episodes of mental illness;
✓ The abnormal behaviour pattern is pervasive and clearly maladaptive to a broad range of personal and social situations;
✓ The above manifestations always appear during childhood or adolescence and continue into adulthood;
✓ The disorder leads to considerable personal distress but this may only become apparent late in its course;
✓ The disorder is usually, but not invariably, associated with significant problems in occupational and social performance.

The ICD adds: "For different cultures it may be necessary to develop specific sets of criteria with regard to social norms, rules and obligations." [10]

In DSM-5, for a personality disorder diagnosis it must meet the following criteria: [1]

✓ An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture. This pattern is manifested in two (or more) of the following areas:

- Cognition (i.e., ways of perceiving and interpreting self, other people, and events).
- Affectivity (i.e., the range, intensity, lability, and appropriateness of emotional response).
- Interpersonal functioning.
- Impulse control.

✓ The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.
✓ The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.
✓ The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood.
✓ The enduring pattern is not better explained as a manifestation or consequence of another mental disorder. The enduring pattern is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., head trauma).

DSM suggests that personality disorders tend to fall into three groups, according to their emotional 'flavor': Cluster A: 'Odd or Eccentric; Cluster B: 'Dramatic, Emotional, or Erratic'; Cluster C: 'Anxious and Fearful'. Paranoid, schizoid, schizotypal as cluster A; antisocial, borderline and histrionic and narcissistic as cluster B; and obsessive-compulsive, avoidant and dependent personality disorders as cluster C. The criteria specified for each of the personality disorders in Section II of the DSM–5 [1] centrally describe problems with sense of identity or inter-personal problems.

Treatment modalities for Personality Disorders: People with personality disorders have received a wide range of treatments, including pharmacological, psychoanalytic, cognitive, cognitive analytic, dialectical behavior, community and other therapies. Although the evidence base is not large, there are indications in the literature that some psychotherapeutic interventions may be effective [11] [12] [13] [14] [15] but it remains to be determined whether any one therapeutic approach is more effective than any other or whether it is the non-specific aspects of a treatment (for example, structure, specification of targets for change and forming a therapeutic relationship) that produce the treatment effect. Fewer individuals with a personality disorder make contact with psychiatric services compared with those with other conditions such as schizophrenia and depression [7]and their probability of withdrawing from treatment is considerably higher [16].

There are many different forms (modalities) of treatment used for personality disorders: [17].

- Individual psychotherapy has been a mainstay of treatment. There are long-term and short-term (brief) forms.
- Family therapy, including couples' therapy.
- Group therapy for personality dysfunction is probably the second most used.
- Psychological-education may be used as an addition.
- Self-help groups may provide resources for personality disorders.
- Psychiatric medications for treating symptoms of personality dysfunction or co-occurring conditions.
- Milieu therapy, a kind of group-based residential approach, has a history of use in treating personality disorders, including therapeutic communities.

There is also often a focus on common therapeutic themes that seem to be beneficial regardless of techniques, including attributes of the therapist (e.g. trustworthiness, competence, caring), processes afforded to the client (e.g. ability to express and confide difficulties and emotions), and the match between the two (e.g. aiming for mutual respect, trust and boundaries). There are different specific theories or schools of therapy within many of these modalities. They may, for example, emphasize psychodynamic techniques, or cognitive or behavioural techniques. In clinical practice, many therapists use an integrated approach, taking elements of different schools as they seem to fit to an individual client.

Response of Patients with Personality Disorders to Biological and Psychosocial Treatments [18]			
Cluster	**Evidence for Brain Dysfunction**	**Response to Biological Treatments**	**Response to Psychosocial Treatments**
A	Evidence for relationship of schizotypal personality to schizophrenia; otherwise none known	Schizotypal patients may improve on antipsychotic medication; otherwise not indicated	Poor. Supportive psychotherapy may help
B	Evidence suggestive for antisocial and borderline personalities; otherwise none known	Antidepressants, antipsychotics, or mood stabilizers may help for borderline personality; otherwise not indicated	Poor in antisocial personality. Variable in borderline, narcissistic, and histrionic personalities
C	None known	No direct response. Medications may help with comorbid anxiety and depression	Most common treatment for these disorders. Response variable

Psychotherapy is at the core of care for personality disorders. Because personality disorders produce symptoms as a result of poor or limited coping skills, psychotherapy aims to improve perceptions of and responses to social and environmental stressors.

Challenges in identification of personality disorders

Research studies show that personality disorders are common in the clinical population in India and that rates vary across sub populations. In discussing the efficacy of treatments for personality disorder, it is essential to be aware of the special problems associated with identification and assessment of these conditions:

· the high level of comorbidity with other disorders of both personality and mental state [19];

· the fluctuating nature of personality status over time, mainly as a consequence of con- comitant mood changes [20];

· the need to have a long period of observation, preferably at least a year, before a treatment can be said to be properly evaluated;

· the recognition that personality disorder is a multifaceted condition that can be influenced in many different ways and fully justifies the use of what are now described as 'complex interventions' [21] to treat it. Complex interventions lead to complex evaluations and consequent greater difficulty in interpreting results.

Also it is identified that in many of the research studies that the main issues regarding the identification of personality disorders as:

1. The incidence of personality dysfunction is quite high in populations of concern. [22] [23].
2. Personality dysfunction is often a comorbid condition, making it difficult to determine direct causation [24] [25], Although comorbidity as a clinical concept can increase understanding, in the practical arena it can lead to confusion by making apportionment of responsibility or fault more difficult.
3. The diagnostic subcategories are not clearly or exclusively defined. [26].
4. There is significant overlap with what law individuals would perceive as accepted variation on normal

functioning (most individuals have experienced to some degree many of the symptom criteria identified) [27].
5. It is hard to determine where on a continuum personality trait should be defined as illness. [28].
6. The characteristic dysfunction of personality disorders often appears to be under volitional control.
7. Individuals suffering from personality dysfunction often do not self-define their symptoms and behaviors as illness.
8. There is no quick or obviously effective treatment interventions that are likely to result in change, with some personality disorders (ASPD) often viewed as untreatable. [29] [30].
9. The most widely understood personality disorder (ASPD) within the legal system too closely mirrors our general concept of criminality. This negative connotation colors the way all personality dysfunction is viewed within the legal system.
10. Personality disorders are rarely viewed as removing an individual's capacity to make a choice.

As clinicians, we can rarely say that in personality disorders the individual has lost the ability to not break the law or to make a reasoned choice. [31]. Afflicted individuals are frequently unaware of their symptoms, as certain personality disorders (i.e., narcissistic personality disorder) do not disrupt intellectual and perceptual functioning. Consequently, individuals' self-reported information about their symptoms is often incomplete or inaccurate. Also, individuals who are aware of their symptoms may be reluctant to report them, (e.g., in a job selection situation, because they fear rejection).Commonly used personality disorder assessment tools (e.g., Minnesota Multiphasic Personality Inventory Restructured Form [MMPI-2-RF]), Tellegen & Ben-Porath, 2008; Personality Assessment Inventory [PAI], Morey, 1991) rely on the subject's self-report, which is likely to be inaccurate in situations where the individual is not aware of his or her symptoms or is engaged in deception. In addition, although a well-trained clinician may be able to accurately diagnose severe personality disorders based on a clinical interview, such diagnoses often yield subjective descriptions that can vary across clinicians and lack standardized quantitative results. All of these poses serious challenges in early identification of the disorder.

Due to these issues, many general mental health services struggle to provide an adequate service for people with personality disorder. In many services people with personality disorder are treated at the margins – through A&E, through inappropriate admissions to inpatient wards, on caseloads of community team staff who are likely to prioritise the needs of other clients and may lack the skills to work with them. They have become the new revolving door patients, with multiple admissions, inadequate care planning and infrequent follow-up.

Challenges in identification and treatment of personality disorders in Indian context

It is a paramount need to identify students with personality disorder in the earlier stages to provide appropriate interventions and accommodations to overcome these disorders for normal functioning of life and to avoid the associated societal and economic costs.

Researchers in this study attempted to find out the certain difficulties encountered by the experts in identifying the personality disorders in India and providing appropriate accommodations to these students in Indian context: What are the problems faced by the experts in the field of clinicians in identifying the students with personality disorder? This key question led to important discussions: what are the early intervention tools available to identify the personality disorder students in India? and what are the problems to provide appropriate intervention and classroom accommodations to the personality disordered students? To seek the answer for these questions, the researchers adopted the focus group interview technique to find out the difficulties faced by clinicians attending psychiatric unit of a tertiary care teaching hospital in south India, which is one of the hospitals where the maximum number of mental health cases are admitted. The subjects for the focus group interview consist the experts providing general adult mental health services: four general clinicians, and three psychiatrists. The experts in the study were all asked to explain their understanding of personality disorders. This question was supplemented by a further question asking whether they thought there is a shortage in number of cases admitted in the hospital with personality disorder. One of the researchers gave a brief introduction about the discussion and then they were asked to discuss about the topic. It is noted that one of them provide a dedicated personality disorder service, 4 of them provide some level of service, and 2 provide no identified service for personality disorders. The discussion was recorded and the transcript was subjected to the qualitative analysis through subdividing into different codes and themes. The subjects' responses for the issue are listed below:

- Amongst those providing services for personality disorder, there was a disparity of therapeutic approach and mode of service delivery. The most common therapies used being psychodynamic psychotherapy, cognitive behaviour therapy (CBT), dialectical behaviour therapy (DBT), or cognitive analytic therapy (CAT). Services were being delivered both on an out patient and day patient basis by the full range of disciplines, with the lead being taken variously by psychology departments, psychotherapy departments, community mental health teams, and specialised PD teams. The only

dedicated in patient provision currently provided is in specialist therapeutic communities, although several respondents noted that people with a primary diagnosis of personality disorder are admitted to general in-patient psychiatric wards, often inappropriately, because of a lack of other service options.

- All dual diagnosis/drug & alcohol and eating disorder services are treating significant numbers of people with personality disorder. Similarly, clinicians and practitioners usually assess and provide some kind of intervention for people with personality disorder, if only to exclude them from active treatment. In many of the primary care centres in India it is seen that the treatment of personality disorder is not seen as the focus of intervention, and that they do not see the provision of services for personality disorder as being part of their core business.
- There are a limited number of gold standard services in India. No common patterns could be discerned as to costs, numbers in treatments, or numbers of referrals, although it was clear that several services were being delivered at a low cost, involving a handful of clinicians. Many of these services had grown up because of the enthusiasm and commitment of a single individual, who had successfully championed the cause of personality disorder services in the locality, attracting other clinicians over time to join, and persuading local commissioners to fund.
- It is also observed that no mental disorder carries a greater stigma than the diagnosis "Personality Disorder", and those diagnosed can feel labelled by professionals as well as by society. There was a strong feeling that many professionals did not understand the diagnosis, and often equated it with untreatability.
- Many researchers from India noted that those with personality disorder have been described as "*the patients' psychiatrists dislike*", and many reported being called time-wasters, difficult, manipulative, bed-wasters or attention-seeking. Some felt that a more appropriate description would be "attachment-seeking". They felt blamed for their condition and often sought basic acceptance and someone to listen to them. They sought to gain legitimacy rather than being told "you're not mentally ill". Some preferred terms such as "emotional distress".
- 'Antisocial personality disorder' was felt to be even more stigmatising, and there was concern that the "dangerous and severe personality disorder" label would be wrongly applied, and lead to an inappropriate use of compulsory detention.
- It was acknowledged that accurate diagnosis could be a useful and meaningful process, but needed to be backed up with the provision of reliable information. Unlike other conditions there is little easily available officially printed information for patients in India. More is available on the internet, but its quality is variable, and much is American with little relevance for British service provision.
- There was strong agreement that there are not enough services available for people with personality disorder in India especially in the rural areas. In the main, experiences of general adult mental health services were negative. Unhelpful attitudes from staff were encountered, who would see "just the label", and were often prejudiced about the condition, and belittling or patronising in manner.
- The different attitudes in adolescent services, compared with adult ones, towards intervention and treatability were striking. Early intervention was highlighted as crucial to the prevention of major deterioration in personality disorder.
- User needs to be acknowledgement by professionals that personality disorder is treatable: a negative experience on initial referral to a psychiatrist makes engagement less likely. There was also general agreement that endings of therapeutic relationships were often not addressed adequately. Also, once people show any improvement, services can be removed; this can discourage improvement.
- Regarding the staffing issues, it is noted that there is a need to be skilled to handle therapeutic relationships, particularly regarding attachment. They need to deal sensitively with issues of gender and sexual orientation in those who have a history of abuse. Staff with their own experiences of mental health difficulties were perceived as having much more insight into the difficulties of patients. It was recognised in the discussion however that in clinical settings problems arise when boundaries break down, and staff begin to share their own problems with patients. However, it was felt to be therapeutically important for there to be a shared experience between patient and professional, and for professionals to be in touch with the patient's distress but not overwhelmed by it.
- Clinicians thought that they should be engaged and paid to help train professionals in order to promote greater understanding, although it was recognised that this could be a challenging task.
- Clinicians with regard to psych education, suggested teaching about mental health in schools as part of the life skills and citizenship curriculum. This could have a preventative function, educate adolescents about vulnerability, how to seek appropriate help, and reduce stigma. The experts offered their opinion that TV shows, debates, discussions and documentaries could be effective ways of communicating information, whilst recognising that it is difficult to control how mental health is portrayed.

It is observed by the clinicians that many clinicians are reluctant to work with people with personality disorder because they believe that they have neither the skills, training, or resources to provide an adequate service.

Clinicians may find the nature of interactions with personality disordered patients so difficult that they are reluctant to get involved. There is significant disparity in the availability of services for people with personality disorder.

It is also observed by the researchers as a part of the study that some of factors that lead to the unsuccessful identification and treatment of personality disorders are:

- Lack of continuity of clinicians
- Clinicians without appropriate training
- Availability of clinicians are determined by a very few mental health hospitals in select locations only working during office hours only
- Rigid adherence to a therapeutic model in cases where it becomes unhelpful
- Passing on information without knowing a person
- Long-term admissions
- Use of physical restraint and obtrusive levels of observation
- Inappropriate, automatic or forcible use of medication
- Withdrawal of contact used as sanction
- Treatment decided only by funding/availability/diagnosis
- Inability to fulfil promises made
- Critical of expressed needs (e.g. crisis or respite)
- responding to behaviour
- not interested in causes of behaviour
- Dismissive or pessimistic attitudes

II. CONCLUSION

Personality disorder does not mean that someone cannot be treated or should be excluded from mental health services. Students, rather than feeling labelled and stigmatized, feeling recognised and helped would make them respond better for the disorder. The above challenges are only a few of those faced by mental health professionals as personality disorders represent one of the most challenging and mysterious problems in the field of mental health. Establishment of a stable, supportive physician-patient relationship lies at the core of the approach to managing personality-disordered patients in a primary care setting. The use of techniques specific to the prominent personality traits demonstrated by the individual patient can assist in forming and maintaining such a relationship. Early interventions, before crisis point is always the normal code of prevention. Good assessment, conducive environment, listening to feedback, supportive peer networks, shared understanding of boundaries, appropriate follow up and continuing care, participation of patients as experts ,attitude of acceptance and sympathy and Specialist services, not part of general Mental health, good clear communication ,accepting, reliable, consistent ,clear and negotiated treatment contracts ,a focus on education and personal development, atmosphere of “truth and trust” are some of the proven thoughts are the need of the hour for the successful management of the personality disorders.

REFERENCES

[1] Personality Disorders, Diagnostic and Statistical Manual of Mental Disorders (Fifth ed.), American Psychiatric Association , 2013,645–684.

[2] Coid J, Yang M, Bebbington P, et al. Borderline personality disorder: health service use and social functioning among a national household population. Psychological Medicine, 2009; 39(10): 1721–1731.

[3] Fok M, Hotopf M, Stewart R, Hatch S, Hayes R, Moran P. Personality disorder and self-rated health: a population-based cross-sectional survey. JPersDisord, 2014; 28(3): 319–33.

[4] Fok ML, Hayes RD, Chang CK, Stewart R, Callard FJ, Moran P. Life expectancy at birth and all-cause mortality among people with personality disorder. Journal of Psychosomatic Research, 2012; 73(2): 104–7.

[5] Moran P, Romaniuk H, Coffey C, et al. The influence of personality disorder on the future mental health and social adjustment of young adults: a population based cohort study. Lancet Psychiatry, 2016; 3(7): 636–645.

[6] Saarento, O., Rasanen, S., Nieminen, P., et al Sex differences in the contact rates and utilization of psychiatric services. A three-year follow-up study in northern Finland. European Psychiatry, 2000,**15**, 205– 212

[7] Andrews, G., Issakidis, C. & Carter, G., Shortfall in mental health service utilisation. British Journal of Psychiatry, 2001,179, 417-425.

[8] Livesley, W. J, Diagnostic dilemmas in the classification of personality disorder in K. Phillips, M. First & H. A. Pincus (eds),Advancing DSM: Dilemmas in Psychiatric Diagnosis in (American Psychiatric Association Press-2003) 153–189.
[9] Livesley, W. J, The relevance of an integrated approach to the treatment of personality disordered offenders. Psychology, Crime and Law,2007, **13**, 27–46.
[10] Disorders of adult personality and behaviour (F60-F69)". The ICD-10 Classification of Mental and Behavioural Disorders - Clinical descriptions and diagnostic guidelines ,WHO ,2010,157–158. .
[11] Bateman, A. & Fonagy, P. Effectiveness of partial hospitalization in the treatment of borderline personality disorder. A randomized controlled trial. American Journal of Psychiatry, 1999,156.
[12] Perry, J. C., Banon, E. & Ianni, F. Effectiveness of psychotherapy for personality disorders. American Journal of Psychiatry, 1999,15**6**, 1312–1321.
[13] Leichsenring, F. & Leibing, E, The effectiveness of psycho-dynamic therapy and cognitive behaviour therapy in the treatment of personality disorders. A meta-analysis. American Journal of Psychiatry, 2003,160, 1223–1232.
[14] Verheul, R., Van Den Bosch, L. M. C., Koeter, M. W. J., et al ,Dialectical behaviour therapy for women with borderline personality disorder. 12-month, randomised clinical trial in The Netherlands. British Journal of Psychiatry, 2003,182, 135–140.
[15] Bateman, A. W. & Tyrer, P, Psychological treatments for personality disorders. Advances in Psychiatric Treatment, 2004,10, 378–388.
[16] Percudani, M., Belloni, G., Contini, A., et al (2002) Monitoring community psychiatric services in Italy: differences between patients who leave care and those who stay in treatment. British Journal of Psychiatry, **1**80, 254– 259.
[17] Magnavita, Jeffrey J. "Personality-guided relational psychotherapy: A unified approach," 2005.
[18] Tasman, Allan. "Introduction from Allan Tasman." Asia-Pacific Psychiatry, 2012, 4(2), 93-94.
[19] Tyrer, P., Gunderson, J., Lyons, M., et al Extent of comorbidity between mental state and personality disorders. Journal of Personality Disorders, 1997,11, 242–259.
[20] Clark, L. A., Vittengl, J., Kraft, D., et al , Separating personality traits from states to predict depression. Journal of Personality Disorders,2003, 17, 152–172
[21] Campbell, M., Fitzpatrick, R., Haines, A., et al A framework for the design and evaluation of complex interventions to improve health. BMJ, 2000,321, 694–696.
[22] Robins LN., Tipp J., Przybeck T. Antisocial personality in Robins NL, Reiger D, (eds) Psychatric Disorders in America: The Epidemiologic Catchment Area Study. (New York, NY: Free Press,1991)258–290.
[23] Neighbors HW., Williams DH., Gunnings TS., et al The Prevalence of Mental Disorder in Michigan Prisons.Final report for Michigan Department of Corrections,1987.
[24] Widiger TA. Integrating normal and abnormal personality structure: a proposal for DSM-V. J Pers Disord. 2011,25,338–363.
[25] Decuyper M., De Fruyt F., Buschman J. A five-factor model perspective on psychopathy and comorbid Axis-ll disorders in a forensic-psychiatric sample. Int J Law Psychiatry. 2008,31,394–406.
[26] Widiger TA., Trull TJ. Plate tectonics in the classification of personality disorder: shifting to a dimensional model. Am Psychologist. 2007,62,71–83.
[27] Kendell RE. The distinction between personality disorder and mental illness. Br J Psychiatry. 2002,180,110–115.
[28] Hall DL., Miraglia RP., Lee LW. The increasingly blurred line between 'mad' and 'bad' treating personality disorders in the prison setting. Albany Law Rev. 2011,74,1277–1300.
[29] Bailey J., MacCulloch M. Patterns of reconviction in patients discharged directly to community from a special hospital: implications for after care. J Forens Psychiatry. 1992,3,445–461.
[30] Dolan B., Coid J. Psychopathic and Antisocial Personality Disorders: Treatment and Research issues. (London, UK: Gaskell/Royal College of Psychiatrists,1993.)
[31] Peay J. Personality disorder and the law: Some awkward questions. Philos Psychiatr Psychol. 2011,18,231–244.

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