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Original Research Paper

Psychiatry

ASSESSMENT OF PERSONALITY MORBIDITY IN MEDICAL STUDENTS OF A COLLEGE IN NEW DELHI

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ABSTRACT

BACKGROUND: The presence of unrecognized or untreated personality morbidity in medical students could compromise their future professional conduct. Studies on the prevalence of personality disorders in medical students in India are scarce. This study aims to contribute to this important but neglected topic.

AIMS AND OBJECTIVES: To identify potentially morbid personality features in individual medical undergraduates and to counsel the diagnosed individuals to seek professional counsel.

MATERIAL AND METHODS: Randomly selected medical students of both genders of a medical college in New Delhi were the subjects. Mini International Neuropsychiatric Interview – Version 6 (MINI-6.0) and Personality Assessment Schedule – Quick (PAS-Q) were the diagnostic tools used.

RESULTS: Presence of Personality Disorder was nil. Personality Difficulties were present with Anankastic (19.4%), Paranoid (11.7%) and Anxious (11.7%) types predominating. No subject was found to have any significant features of Dissocial Personality Disorder. Major Depression and Anxiety Spectrum Disorders were co-morbid with Anankastic Personality Difficulty. Paranoid Personality Difficulty had Bipolar Affective Disorder and Anxiety Spectrum Disorders as co-morbidities.

CONCLUSIONS: Personality morbidity in medical students is a reality not to be ignored. The current situation of a negligible number of studies on this matter requires to be corrected with larger multi-centric studies all over India.

KEYWORDS : Medical Students, Personality Disorders - Paranoid, Anankastic, Borderline

INTRODUCTION

Personality

In formal psychological parlance personality of an individual includes the archetypal and enduring pattern of perceiving, thinking, emoting and behaving in specific life circumstances repeatedly. The personality of an individual is considered to be evolving during childhood and adolescence, and finally getting concretized at around age 18 years, when one attains adulthood. The personality by its very definition is stable and broadly unchanging in its basic characteristics for the rest of one's life.

Personality Morbidity – Personality Disorders

A personality disorder may be defined as "an enduring pattern of inner experience and behaviour that deviates markedly from the general expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time and leads to distress and impairment"[1]. There are certain morbid personality features which are generally considered undesirable for the medical professional, as they can encumber and compromise the professional, inter-personal and personal functioning of the physician

OBJECTIVES OF THE STUDY

The main objective of this cross-sectional study was to detect the prevalence of personality morbidity in medical students of a college in New Delhi. The other objective was to counsel and advise appropriate referral to those identified with personality difficulties or disorders.

MATERIAL & METHODS

Study Subjects: The subjects of the study were the undergr aduate medical students pursuing the M.B.B.S. course in a medical college in New Delhi. Both genders were eligible for inclusion in the study. Randomly selected students, totaling about 150 were offered the chance to enroll in the study. In the event, 103 participated on their own. Every student had an equal opportunity to participate.

Ethical Clearance: The necessary clearance for the study was sought and obtained from the concerned University Ethical Committee

METHOD:

The randomly selected roll numbers were identified, and these students were informed about the general layout of the proposed project in their respective lectures or postings to the Community Medicine department. The protection of anonymity of the subjects was assured absolutely. The willing and consenting were enrolled by allotting a unique alphanumeric code to each. At the mutually agreed time and location each student was administered the clinical rating scale by the principal investigator (the author). When a diagnosis of a Personality Disorder (PD) or Personality Difficulty (PD_i) was manifest, the individual was informed and appropriate therapeutic referral suggested.

Tools:

The Personality Assessment Schedule – Quick or PAS – Q. This is a structured questionnaire which is designed to screen for individual Personality Disorder features as per the ICD-10 manual. This tool has been found to have professionally acceptable reliability and validity[2]. The screening is at two levels, the first screens for the significant presence of features of the particular Personality Disorder which then is qualified as Personality Difficulty. These individuals are then subjected to the second level of screening to establish a full-fledged PD. The Personality Disorders looked for were: Paranoid, Schizoid, Dissocial, Impulsive, Borderline, Histrionic, Anankastic, Anxious and Dependent.

Before the administration of PAS-Q, each subject was evaluated for current and/or past diagnosis of Psychiatric Disorders using the Mini International Neuropsychiatric Interview, version 6.0 (MINI 6.0), which is again a well-validated and reliable tool[3].

SAMPLING TECHNIQUE & SIZE

The sampling method was simple random. The sample size envisaged was around 110 and ultimately 103 subjects were enrolled.

DATA COLLECTION & ANALYSIS

Data collection was done from January 2016 to December 2018. Each individual who consented to for the study was administered the clinical rating scales MINI and PAS-Q, by the author in complete privacy and with assured anonymity. When

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any past or current psychiatric diagnosis or personality disorder traits were evident, they were informed about it and possible therapeutic interventions and relevant professional referrals were suggested.

REVIEW OF LITERATURE

Out of the very few studies on the prevalence of Personality Disorders in the general population, Torgersen *et al* published a paper in 2001 on the urban community of Oslo in Norway. They found the prevalence of PDs to be 13.4%, with Avoidant (5%), Paranoid (2.4%), Histrionic (2%), Anankastic (2%), Dependent (1.5%) and Schizoid (1.7%) predominating[4].

Coming to Indian studies, Reddy and Chandrasekhar in 1998 did a meta-analysis of 13 psychiatric epidemiological studies from India consisting of 33,572 persons. They concluded a weighted prevalence of Personality Disorders to be 0.4%[5]. Sharan in 2010 reviewed the research studies on Personality Disorders in India and concluded that "the field of personality disorders is at a nascent stage of development in India. From a situation of almost no articles specifically focused on personality pathology till the 1980s, there is now a trickle[6]." Gupta and Mattoo in 2012 investigated the prevalence of PDs in the outpatient setting in north India. They found a prevalence of 1.07% of whom 32.8% were students. The commonest PDs were Anxious and/or Borderline[7].

Lieven, *et al* conducted a study in 1997 on the personality characteristics and academic performance among 631 medical students in Belgium. The Five-Factor Model (FFM) of Personality was used to rate the subjects. The subjects scored highest on extraversion and agreeableness. The academic performance was found to be positively related to conscientiousness while being negatively related to gregariousness[8].

In 2011, Doherty and Nugent of Ireland reviewed papers on personality factors and medical training. They found that the main personality characteristic repeatedly identified in medical students was conscientiousness. This characteristic was also found to be positively correlated to academic performance in most studies[9]. Haight, *et al* in 2010 found that conscientiousness predicted all clinical skills, while extraversion predicted clinical skills reflecting interpersonal behavior, and empathy predicted motivation[10].

Tyssen *et al,* in 2001 studied suicidal ideation among Norwegian medical students, and found a positive correlation between Neuroticism and contemplated suicide[11]. Li Peng *et al,* in a 2012 study on Chinese Medical students found that psychiatric pathologies had a positive correlation with negative life events and Neuroticism[12].

Wongpakaran, N and Wongpakaran, T of the Chiang Mai University in Thailand studied personality disorders in 99 medical students. The prevalence of Personality Disorders (PDs) was 9%. The proportion of all PDs was as follows; 1%, 3%, 2%, 2%, and 1% for paranoid, impulsive, histrionic, anankastic, and dependent, respectively[13].

RESULTS

There were 55 males (53.4%) and 48 females 46.6%). The average age on the date of evaluation was about 20 years, with a range from 18 years to 23 years. Out of 103 subjects, only 3 (2.9%) said that they did not join the medical college willingly but were compelled by their parents to do so. Subjects were asked about the motivating reasons for joining the medical college. Their responses are shown in table no. 1.

Table no. 1 – Reasons for joining the Medical College

S.N.	Reason for Joining	Respondents	% [n=103]
1.	Medicine is a Noble Profession	56	54.4
2.	Parents are Doctors	16	15.5
3.	Humanitarian Cause	33	32.0
4.	Make Original Contribution to Medical Sciences	51	49.5
5.	To win the Awards in Medicine	22	21.4
6.	Earn Respect in the Society	10	9.7
7.	Earn a lot of Money	47	45.0
8.	Become Attractive to the Opposite Gender	33	32.0
9.	Become Famous and Powerful	5	4.9
10.	Gain the Respect of the Peers	27	26.2

Respondents joining the medical profession wanting to become attractive to the opposite gender were predominantly males (87.9%), and those joining to earn a lot of money were mostly females (77.3%).

When the subjects were administered the PAS-Q, none of them qualified for a full-fledged Personality Disorder of any type. However, 43 (41.8%) of them qualified for at least one type of Personality Difficulty. Notably, not a single case with features qualifying for Dissocial Personality Difficulty or Disorder was picked up. Table no. 2 shows the distribution of Personality Difficulties amongst the study group.

Table no. 2 – Prevalence of Personality Difficulties or Personality Disorders

S.N.	Personality Type	Personality Difficulty	Percentage (n=103)	Male / Female [%] / [%]	Personality Disorder
1	Paranoid Personality	12	11.65	5 / 7 4.85 / 6.79	Nil
2	Schizoid Personality	1	0.97	0 / 1 0.0 / 0.97	Nil
3	Dissocial Personality	Nil	0.00	0 / 0 0.0 / 0.0	Nil
4	Impulsive Personality	2	1.94	1 / 1 0.97 / 0.97	Nil
5	Borderline Personality	2	1.94	0 / 2 0.0 / 1.94	Nil
6	Histrionic Personality	5	4.85	2 / 3 1.94 / 2.91	Nil
7	Anankastic Personality	20	19.41	13 / 7 12.62 / 6.79	Nil
8	Anxious Personality	11	10.67	6 / 5 5.82 / 4.85	Nil
9	Dependent Personality	1	0.97	1 / 0 0.97 / 0.0	Nil

Many of the individuals displayed features of multiple Personality Difficulties. The details are depicted in Table no. 3.

Table no. 3 – Co-morbidity between Personality Difficulties

S.N.	Co-morbid Combinations	Nos.	% [n=43]
1	Anankastic + Anxious + Dependent	1	2.32
2	Anankastic + Anxious	6	13.95
3	Paranoid + Anankastic + Dependent	1	2.32
4	Paranoid + Anankastic	3	6.98
5	Paranoid + Schizoid + Impulsive + Borderline + Anankastic	1	2.32
6	Impulsive + Anankastic + Anxious + Dependent	1	2.32
7	Impulsive + Borderline + Anankastic	1	2.32
8	Histrionic + Paranoid	1	2.32

A total of 11 (25.6%) subjects with Personality Difficulties gave a history of Psychiatric Illness in their families. These are represented in Table no. 4.

Table no. 4 – Family History of Psychiatric Disorders in Subjects with Personality Difficulty

S.N.	Personality Difficulty Type	Family History Details
1	Histrionic	Paternal Uncle and Grandmother had Depression
2	Paranoid + Schizoid + Impulsive + Borderline + Anankastic Personality	Paternal Aunt has Psychotic Disorder
3	Paranoid Personality	Paternal Aunt has Depression
4	Paranoid Personality	Father has Major Depression
5	Anxious Personality	Paternal Uncle has Bipolar Affective Disorder
6	Anankastic + Anxious Personality	Maternal Grandfather had Bipolar Affective Disorder and Mother has Depression
7	Anankastic + Anxious Personality	Mother has Depression with Psychotic Features and Brother has Dysthymia
8	Anankastic Personality	Maternal Uncle has Paranoid Schizophrenia
9	Anankastic Personality	Maternal Aunt has Depression
10	Anankastic Personality	Brother has Bipolar Affective Disorder
11	Impulsive Personality	Father has Anxiety and Obsessive-Compulsive Disorder

Out of 43 subjects with Personality Difficulties, 20 (46.5%) had Co-morbid Psychiatric Disorders, either Current or Past. These can be seen in Table no. 5 below

Table no. 5 – Co-morbidity with other Psychiatric Disorders

S.N.	Personality Difficulty Type	Co-morbid Psychiatric Disorders [Current/Past]
1	Histrionic	Bipolar Affective Disorder + Panic Disorder
2	Impulsive Personality	Obsessive-Compulsive Disorder
3	Impulsive + Anankastic + Anxious + Dependent Personality	Bipolar Affective Disorder + Panic Disorder
4	Paranoid + Schizoid + Impulsive +Borderline + Anankastic Personality	Major Depressive Disorder
5	Paranoid Personality	Agoraphobia without Panic Disorder
6	Paranoid Personality	Bipolar Affective Disorder-II
7	Paranoid Personality	Bipolar Affective Disorder + Panic Disorder + Social Phobia + Obsessive Compulsive Disorder + Generalized Anxiety Disorder
8	Anankastic + Anxious Personality	Major Depression
9	Anankastic + Anxious Personality	Bipolar Affective Disorder + Obsessive Compulsive Disorder + Generalized Anxiety Disorder
10	Anankastic + Anxious Personality	Social Phobia
11	Anankastic + Anxious Personality	Panic Disorder
12	Anxious Personality	Generalized Anxiety Disorder
13	Anankastic Personality	Major Depression + Obsessive-Compulsive Disorder
14	Anankastic Personality	Major Depression
15	Anankastic Personality	Major Depression
16	Anankastic Personality	Bipolar Affective Disorder + Generalized Anxiety Disorder
17	Anankastic Personality	Social Phobia
18	Anankastic Personality	Major Depression + Panic Disorder + Generalized Anxiety Disorder
19	Anankastic Personality	Panic Disorder
20	Anankastic Personality	Agoraphobia without Panic Disorder

DISCUSSION

More than 50% of the respondents stated the nobility and humanitarian ideals of the medical profession as the chief motivation for joining the medical college. The absence of any Dissocial Personality features perhaps reflects the kind of personality types attracted to the medical profession. Significantly, not a single subject qualified for a full-fledged Personality Disorder. This is in marked contrast to the findings of the study from Thailand[13]. Anankastic Personality Difficulty was the most prevalent. Some Anankastic features like conscientiousness and regimentation, are perhaps useful attributes for a medical professional, albeit in moderation. The next common were Anxious and Paranoid Personality Difficulties, whose features in any valence compromise professional conduct. Among the Psychiatric co-morbidities, Major Depression and Anxiety Spectrum Disorders were most associated with Anankastic Personality Difficulty. Paranoid Personality Difficulty had Bipolar Affective Disorder and Anxiety Spectrum Disorders as co-morbidities. Obsessive-Compulsive Disorder was seen associated with Anankastic, Paranoid and Impulsive Personality Difficulties.

CONCLUSIONS & RECOMMENDATIONS

Personality disorder features in medical students is a reality with little focus of researchers and the concerned authorities. These personality features get progressively ingrained and ultimately adversely influence future professional behaviour. Personality disordered individuals have a lack of insight into their morbidity and are usually resistant to therapeutic interventions. The earlier the problem is identified and treatment initiated, the better is the prognosis. These kinds of studies should be done on a larger scale for a more comprehensive picture.

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REFERENCES

1. The ICD-10 Classification of Mental and Behavioural Disorders, World Health Organization, Geneva, 1991
2. Quick Personality Assessment Schedule (PAS-Q): validation of a brief screening test for personality disorders in a population of psychiatric outpatients, Germans S, Van Heck GL, Hodiamont PP, Australia New Zealand Journal of Psychiatry, 2011 Sep; 45(9):756-62
3. The Mini-International Neuropsychiatric Interview is useful and well accepted as part of the clinical assessment for depression and anxiety in primary care: a mixed-methods study, Agneta Pettersson, Sonja Modin, Rolf Wahlström, Sandra af Winklerfelt Hammarberg, Ingvar Krakau, BMC Family Practice, 2018; 19: 19
4. The Prevalence of Personality Disorders in a Community Sample, Svenn Torgersen, Einar Kringlen, Victoria Cramer, Arch Gen Psychiatry. 2001; 58(6):590-596
5. Prevalence of Mental and Behavioural Disorders in India: A Meta-Analysis, Venkataswamy M. Reddy and C.R. Chandrashekar, Indian J Psychiatry, 1998 Apr-Jun; 40(2): 149–157.
6. An overview of Indian research in personality disorders, Pratap Sharan, Indian J Psychiatry. 2010 Jan; 52(Suppl1): S250–S254
7. Personality disorders: prevalence and demography at a psychiatric outpatient in North India, Gupta S and Mattoo SK, International Journal of Social Psychiatry, 2012 Mar; 58(2): 146-52
8. Medical students' personality characteristics and academic performance: a

five-factor model perspective, Filip Lievens, Pol Coetsier, Filip De Fruyt & Jan De Maeseneer, Medical Education 2002;36:1050–1056
9. Personality factors and medical training: a review of the literature. Doherty EM & Nugent E, Royal College of Surgeons in Ireland, e-publications@RCSI, 1-2-2011
10. Associations of medical student personality and health/wellness characteristics with their medical school performance across the curriculum, Haight SJ, Chibnall JT, Schindler DL , Slavin SJ, Acad. Med., 2012 April; 87(4): 475-485
11. Suicidal ideation among medical students and young physicians: a nationwide and prospective study of prevalence and predictors, Reidar Tyssen, Per Vaglum, Nina T. Grønvold, Øivind Ekeberg, Journal of Affective Disorders, April 2001; 64(1): 69-79
12. Negative life events and mental health of Chinese medical students: The effect of resilience, personality and social support, Li Peng, Jiajia Zhang, Min Li, Peipei Li, Yu Zhang, Xin Zuo, Yi Miao, Ying Xu, Psychiatry Research, 30 March 2012; 196(1): 138-141
13. Personality disorders in medical students: measuring by IPDE-10, Wongpakaran N, Wongpakaran T, Journal of the Medical Association of Thailand, 2005 Sep; 88(9): 1278-81