Adolescents with Personality Disorders: A Systematic Review

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Abstract: **Personality Disorder is a mental health disorder recognized by the International Classification of Diseases (ICD) and the Mental Disorders Diagnostic and Statistical Manual (DSM). Personality Disorder refers to personality characteristics that, for a prolonged period, are maladaptive, inflexible, and pervasive in many contexts, causing severe discomfort and disability. The study was DSM-5 lists three clusters of personality disorders with ten specific disorders in those categories. An adolescent must meet the DSM-5 requirements to be diagnosed with a personality disorder. The primary aim of this article is to review research documenting the underlying mental health problems in personality disorders amongst adolescents and, to evaluate research on potential intervention for such disorders.**

Eligibility criteria: **This systematic review has exclusion and inclusion criteria that were applied to the search results of publication within the last 20 years and included personality and adolescence in the title.**

Results: **Nineteen studies were considered out of sixty (60) primary studies, of which 19 (31.66%) satisfied the inclusion criteria. The primary studies reviewed personality disorder in childhood/adolescence and the screening for personality disorder in adolescents and impaired functioning from adolescence to adulthood. Personality Disorder was predominately measured using the Structured Clinical Interview for DSM Axis II disorders (n = 9), the Diagnostic Interview for GHQ & SIPP (n = 2), and DSM criteria based psychiatric evaluation (n = 8). The primary studies utilized cross-sectional, case-control. Studies comprised a mix of clinical and non-clinical populations and ranged in duration from 10 to 24 years.**

Conclusions: **Adolescent personality has significant genetics and environmental impact. This systematic review shows that many adolescents display behaviour to a certain degree, making it challenging to differentiate mental health disorder and normal adolescent behaviour from a personality disorder. A significant clue is when adolescents have recurrent issues or defiance and when these behaviours are getting more severe. Adolescents at risk of PDs may also be having substance abuse disorder, including alcohol, which exacerbates depression or anxiety. The self-reported data provided very few cases that met diagnostic requirements for personality disorders in adolescence. Hence, more studiesare still needed.**

Keywords: **Adolescent, personality disorders, mental health, anxiety, depression.**

I. INTRODUCTION

The word personality originates from the Latin expression persona, initially reflecting the theatrical mask used by ancient dramatic players. Persona indicates a pretence of appearance: the possession of characteristics other than those that define the person behind the mask, as a mask assumed by an actor. (Millon et al., 2012)

Two similar words, character, and temperament are frequently mistaken for personality. While all three words in casual use have similar meanings, a character refers to attributes acquired during childhood and connotes a degree of compliance with ethical, social norms. On the other hand, temperament applies not to socializing factors but to a specific biological inclination towards such activities. One individual may be said to be of "good character," and another individual may have an "irritable temperament." The character, thus, reflects the crystallized influence of nurture, and the physically coded influence of nature is expressed by temperament.

Personality traits can be defined by genes, influenced by the environment, and motivated by Nature, Nurture and Structure (Akanni, 2020).

Nurture

The character represents the sum of all personality factors that originate from organizational levels in which the individual is embedded, including family, peers, and community. Personality is the dynamic interaction of both character and disposition factors, environment, and the patterning of characteristics across the person's entire existence.

Nature

Temperament reflects the amount of all personality factors from organizational levels below the individual, including neurotransmitter profiles and, more specifically, genes. Nonetheless, childhood verbal abuse is likely to hurt the development of interpersonal relationships during childhood and adolescence.

During childhood, maternal verbal abuse was more than three times as likely as those who did not experience verbal abuse to have borderline, narcissistic, obsessive-compulsive, and paranoid PDs during adolescence or early adulthood. (Johnson et al., 2001)

Personality Disorder is a mental health disorder recognized by the International Classification of Diseases (ICD) and the Mental Disorders Diagnostic and Statistical Manual (DSM). Personality Disorder refers to personality characteristics that, for a prolonged period, are maladaptive, inflexible, and pervasive in many contexts, causing severe discomfort and disability.

Childhood verbal abuse can also raise the risk of developing PDs by raising the probability that young people will encounter intensely maladaptive thoughts and emotions, such as distrust, shame, doubt, guilt, inferiority, and identity diffusion during their most crucial years of psychosocial devolution, even though several studies have explored connections between physical and sexual exploitation of adolescents and PDs. (Fonagy & Luyten, 2016).

Personality disorders are characterized in adolescents by four primary symptoms, according to research:

- Thinking and perception are skewed.
- Problematic emotional reactions
- Impulse regulation that is either over-or under-regulated
- Difficulty interacting with others and maintaining relationships.

These four characteristics interact in various ways to shape the ten personality disorders listed in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V).

It should be noted that various pathways can lead to disorders of personality. Narcissistic, obsessive-compulsive, paranoid, and antisocial disorder, for instance, may, through improving applicable policies by significant others or both, result in compensation or as fear, i.e., because of a sense of chaos, coercion, or victims. The value of identification with other members of the family cannot be ignored. Personality problems tend to develop in most people from the inheritance of a strong predisposition.

A personality disorder is a form of mental health disorder that usually begins in adolescence. As a result, an adolescent personality disorder can significantly disrupt the development of adolescent identity, relationship, and emotional control. Furthermore, untreated personality disorders can contribute to social isolation and drug abuse.

Personality disorders usually include unhealthful patterns of thought, functioning, and behaviour. Adolescents with personality disorders have trouble recognizing and communicating with others and their environment. Therefore, their family relations, social life and academic success may be affected. To be diagnosed with a personality disorder, the adolescent must meet the requirements set out in the DSM-5 for that disorder. The diagnosis of adolescent personality disorder also includes that symptoms trigger difficulties in everyday life. (Westen et al., 2006).

Each person has a collection of unique personality traits that make up his or her personality. Personality can be characterized as identifiable and permanent characteristics and attitudes expressed in thoughts, feelings, and actions (pulse control, establishing and managing interpersonal relationships). Personality has developed and evolved since infancy and during life.

Temperament is a biologically defined characteristic that has been evident since birth. Temperamental characteristics display a high degree of maturity and are developmentally correlated with personality traits during adulthood, including extraversion or high energetic level, congeniality, conscientiousness, neuroticism, and openness.

Parenting has a demanding job specification that allows it to be in good mental health. Parents must manage their own negative emotions, not react to stress or anxiety with anger, aggression, cruelty, or panic. Parents need a perfect test of reality. (McAdams & Olson, 2010) As in any other work, even in most resilient parents, daily life events can temporarily disrupt parenting skills. Relationship breakdown, work stress, physical illness or mild mental disorders can contribute to temporary parenting performance impairment. More psychiatric severe disorders can lead to more severe parental disability (Royal College of Psychiatrists, 2011).

Maternal personality disorder can have an indirect effect on children's growth by influencing how families are planned and constituted. Women with borderline personality disorder appear to have severe and dysfunctional intimate relationships with other people.

In infancy, children develop theory of minds: a collection of psychological capabilities that control their internal psychology and social psychological skills. Parental behaviour and mental state are environments that interact with a child's genetic vulnerability or resilience to influence the development of emotional and mental abilities. Ellis (2008) indicates that some conditions can affect even the most resilient adolescent. Parental harshness, chronic aggression and rejection are behaviours or actions that tend to be especially harmful or dangerous to the developing child. They are also a theory of mind or behaviour that may be more prevalent in parents with personality disorders and give rise to certain forms of 'maladaptive parental behaviour' correlated with high child and adolescent psychology (Johnson, 2001).

II. MATERIAL AND METHOS

Criteria of Inclusion and Exclusion

All systematic review standards are followed. According to Moher et al. and the PRISMA Group (2009), exclusion and inclusion criteria were applied to the search results. Necessary but not exclusive elements of this inclusion criterion included items that had to be published within the last 20 yearsand include personality and adolescence in the title. Something devoid of content has been published in a peer-reviewed

academic journal as a research article or as a follow-up to another research piece.

The studies were conducted in mainstream educational settings concerned students who were identified to have a personality disorder. They included indicators of interventions, supports, and services and education levels that ranged from primary school. The preliminary studies failed to reach a consensus on what PD means, showing a lack of agreement about the term's definition. Personality Disorder is a mental health disorder recognized by the International Classification of Diseases (ICD) and the Mental Disorders Diagnostic and Statistical Manual (DSM). Personality Disorder refers to personality characteristics that, for a prolonged period, are maladaptive, inflexible, and pervasive in many contexts, causing severe discomfort and disability.

In contrast, others conceptualized it as a form of neurodiversity, "to be accepted and tolerated just like other human differences". The flowchart in Figure 2 represents the screening process using PRISMA. The primary search strategy initially performed two stages of research. First, titles and abstracts were checked to find the most promising papers. Studies incorporated into the product, which was subjected to a second screening, were evaluated through a full-text search. Our overall screening process, which consisted of various stages, identified nineteen studies that met the criteria.

Table 1: Mapping of Nineteen (19) Studies (n=19) on Adolescents with Personality Disorder

Authors	Year	Country	Sample (n, age)	Study design	Control Group	Assessment (Cut-Point)	PD FACTORS
Chen et al	2008	USA	n=736; (<20 years) M= 13.7 years	Longitudinal study	Axis I disorder or PD Adolescents with Axis I disorder or PD or both.	Child Behavior Checklist, Teacher's Report Form and Youth Self Report	Higher odds of pain and physical illness and poorer physical health and a more rapid decline in physical health
Paul Moran etal	2016	UK	n=8 (24–25 years) n=10 (34–35 years)	Longitudinal cohort study	2-item General Health Questionnaire (GHQ-12)	the Standardised Assessment of Personality	Depressive disorder, anxiety disorder, smoking and alcohol consumption, illicit substance use,
Gwen et al.	2012	UK	(10–15 years) (16–21 years) M= 13.7 years	Cross sectional	Axis I and Axis II disorders	Psychopathy Checklist – Youth Version (PCL-YV) and the Structured Assessment of Violence Risk in Youth (SAVRY)	Avoidance and internalized emotional dysregulation, characterized by preoccupying anxieties.
Jean et al.	2018	Canada	n=8 (24–25 years) 10 (34–35 years) M=11 years	Clinical and epidemiological studies	Axis I and Axis II disorders	Diagnostic Interview for Borderlines-Revised and the Childhood Interview for DSM-V	Avoidant/Abandonment, unstable interpersonal relationships, identity disturbance, impulsivity, suicidal and self-mutilating behaviors
Ilariaet al	2018	Italy	n= 562(13-19 years) M=16.24	Cross sectional	SIPP-118 is a dimensional measure	Symptom Check List-90-Revised (SCR-90)	Internalizing behavior Externalizing behavior
Patricia et al.	2006	*USA*	n=54 (1–10 years)	Cross sectional	Axis I and Axis II disorders	Child Behavior Checklist, Teacher's Report Form and Youth Self Report	Internalizing behavior Externalizing behavior
Thomas et al	2001	USA	n=54 (9-12 years)	Clinical and epidemiological studies	Axis I and Axis II disorders ,	Symptom scales for histrionic, borderline, and narcissistic personality disorders, Antisocial behaviour	Co-occurring internalizing andexternalizing Symptoms, emotional distress
Barbara De et al	2003	Belgium.	n=419 (12-18 years) M=16 years	Cross sectional	Axis II of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)	Wisconsin Personality Disorders Inventory	Neuroticism, Internalizing behavior Externalizing behavior
Johnson et al	2000	USA	n=816 (17-28 years) M=22 years	Clinical and epidemiological studies	Axis I and Axis II disorders	Diagnostic Interview Schedule for Children (DISC-I), the Personality Diagnostic Questionnaire, the Disorganizing Poverty Interview	Internalizing behavior Externalizing behavior
Johnson et al.	2008	USA	n=816 (14-16 years)	Cross sectional	Axis I and Axis II disorders	the Personality Diagnostic Questionnaire, the Disorganizing Poverty Interview	Internalized emotional dysregulation, characterized by preoccupying anxieties.
Sohye et al.	2014	USA	n=N/R (14-16 years)	Clinical and epidemiological studies	Axis I and Axis II disorders	Cognitive Emotion Regulation Questionnaire (CERQ)	Internalizing behavior Externalizing behavior

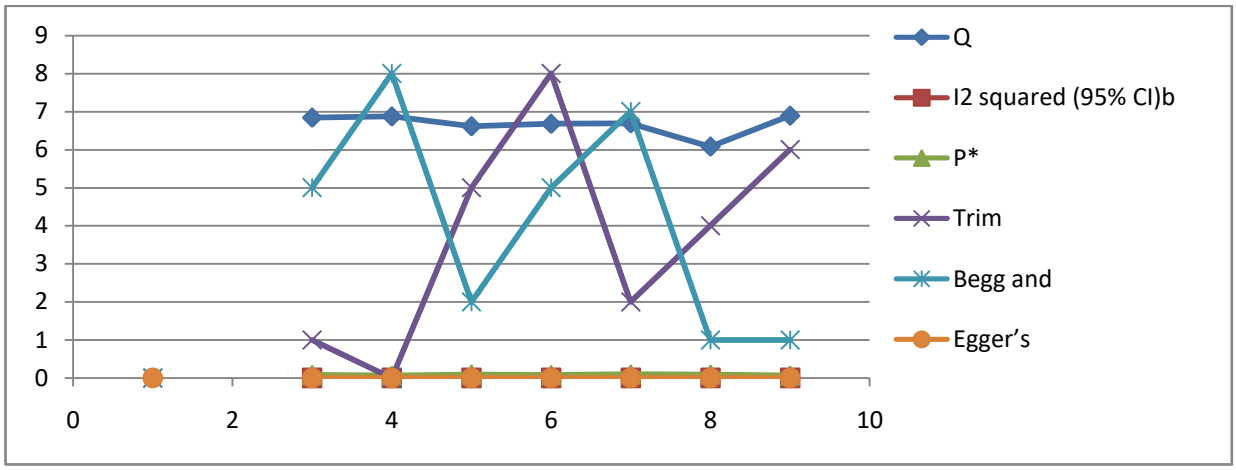
Kim et al.	2008	USA	n=411	Clinical and epidemiological studies	DSM-IV Axis-II personality disorders	Child Behavior Checklist, Teacher's Report Form and Youth Self Report	(a) Cluster B symptoms, (b) externalizing symptoms, (c) internalizing symptoms
Kirsten	2017	Netherl ands	n=62(16-23years) M=18.2	Cross sectional	Structured Clinical Interview for DSM personality disorders and the Symptom Check List 90	Structured Assessment of Violence Risk in Youth (SAVRY)	Paranoid; Schizoid; Schizotypal; Antisocial; Borderline; Histrionic; Narcissistic; Avoidant; Dependent; Obsessive compulsive; Depressive; Passive aggressive
Carla	2017	USA	n=110 (<18 years)	Cross sectional	DSM-5 section II BPD	Borderline Personality Questionnaire (BPQ)	Internalizing behavior Externalizing behavior
Carla	2018	USA	n=69(4-22 years)	Longitudinal cohort study	DSM-IV clusters with baseline assessment at age 9	McLean Study of Adult Development	Personality pathology and independent of internalizing and externalizing pathology
Eunice et al.	2017	UK	n=366(12 – 17 years)	Longitudinal cohort study	Structured Clinical Interview for DSM-IV Axis II (SCID-II)	Treatment in Suicidal Teenagers study, ASSIST	Depression; Suicidal ideation
Salome etal	2017	USA	n=301(12 – 17 years) M=15.22	Cross sectional	Childhood Interview for DSM-IV Borderline Personality Disorder	Youth Self-Report	Antisocial peers
Sylia et al	2019	USA	n=998(14 – 24 years) M=17.90	Longitudinal cohort study	Structured Clinical Interview for DSM-IV Axis II (SCID-II)	Multidimensional Personality Questionnaire	Oppositional defiant disorder, conduct disorders, Substance use disorder, major depressive, Anxiety disorders

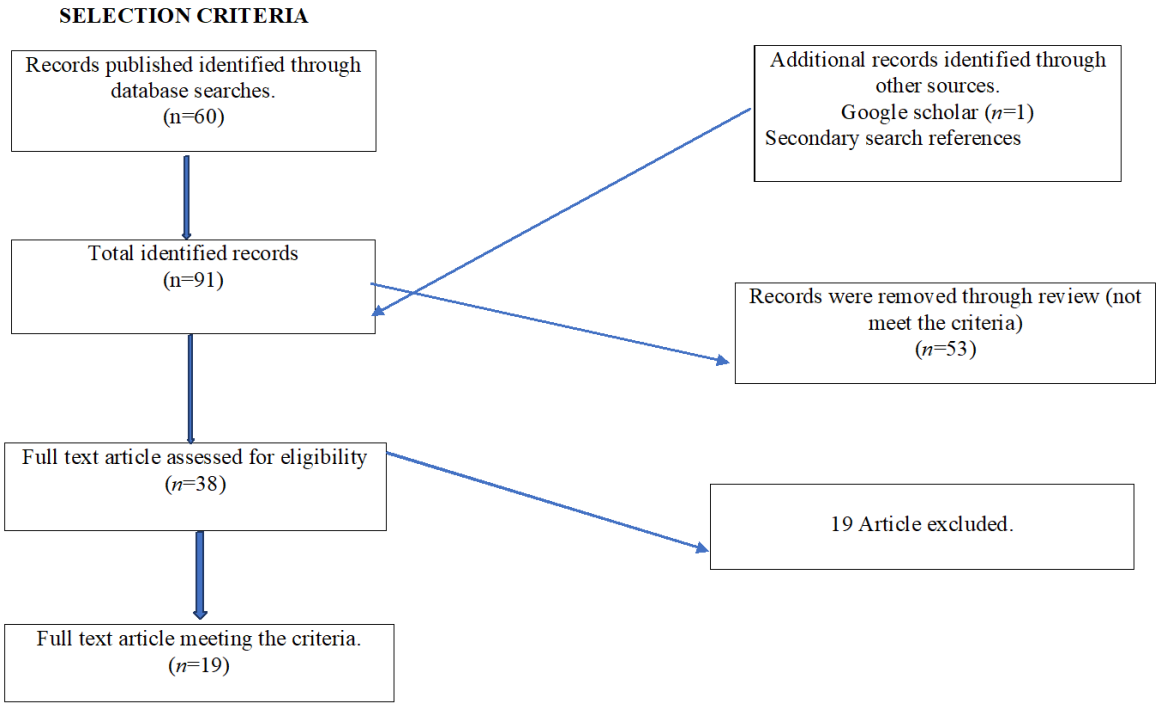
Summary of Hypothetical Meta-Analytic Results of PD in Adolescents

	Cohen's d (95% CI)	Q	I^2 squared (95% CI)[b]	P*	Trim and Fill	Begg and Mazumdar's Test	Egger's Test
Higher odds of pain and physical illness and a more rapid decline in physical health	5.71(3.2; 1.3)	6.8392	(0.00, 10.02)	.082	1	5	0
Depressive disorder, anxiety disorder, smoking and alcohol consumption, illicit substance use,	6.25(3.8; 1.1)	6.8710	(0.00, 11.03)	.067	0	8	0
Antisocial peers, oppositional defiant disorder, conduct disorders	4.46(4.0; 1.0)	6.6134	(0.00, 12.04)	.095	5	2	0
Avoidance and internalized emotional dysregulation, characterized by preoccupying anxieties.	4.35(3.7; 1.3)	6.6771	(0.00, 22.00)	.082	8	5	0
Avoidant/Abandonment, unstable interpersonal relationships, identity disturbance, impulsivity	4.76(3.3; 1.5)	6.6932	(0.00, 26.05)	.099	2	7	0
Internalizing behavior and Externalizing behavior	5.78(4.1; 1.1)	6.0790	(0.00, 16.00)	.095	4	1	0
Paranoid; Schizoid; Schizotypal; Antisocial; Obsessive compulsive; Depressive; Passive aggressive	6.11(2.7; 1.2)	6.8901	(0.00, 35.02)	.071	6	1	0

Note. k = number of studies; N = total number of participants; Cohen's d = standardized mean difference; CI = confidence interval, **p < .001

Fig 1: Hypothetical Meta-Analytic Results of Personality Disorders in Adolescents





III. DEMOGRAPHIC RESULTS

Nineteen (19) studies were reviewed with sample age below > 10years (Gwen et al., 2012; Patricia et al., 2006; Thomas et al., 2001; Kim et al., 2008; Carla, 2018). Eleven studies showed age samples ranged from > 10 years but not more than 22 years (Chen et al., 2008; Gwen et al., 2012; Ilaria etal., 2018; Thomas et al., 2001; Barbara De et al., 2003; Johnson et al., 2008; Sohye etal., 2014; Carla, 2017; Carla, 2018; Eunice et al., 2017; Salome et al., 2017). Seven (7) studies` age samples ranged from < 22 years were defined by (Paul Moran et al., 2016; Jean et al., 2018; Johnson et al., 2000; Kim et al., 2008; Kirsten, 2017; Carla, 2017; Sylia et al., 2019), while only two (2) studies` age samples were < 38years (Kim et al., 2008; Chenet al., 2008). This is evident that the studies considered studies involving Children and adolescents. However, most of the participants were adolescents as the ages were defined as 10 – 22 years in the study.

IV. OVERALL RESULTS

Studies on personality disorders on adolescents were considered from nineteen (19) articles from which factors such as higher odds of pain and physical illness and poorer physical health and a more rapid decline in physical health; depressive disorder, anxiety disorder, smoking and alcohol consumption, illicit substance use. Avoidance and internalized emotional dysregulation, characterized by preoccupying anxieties; Avoidance/abandonment, unstable interpersonal relationships, identity disturbance, impulsivity, suicidal and self-mutilating behaviours, etc., were said to show the effect of PD in adolescents. Scholars like (Ilaria et al., 2018; Patricia et al., 2016; Barbara De et al., 2003; Johnson et al., 2008; Sohye et al., 2014; Kim et al., 2008; Carla, 2017) identified Internalizing behaviour and Externalizing behaviour as the influential factors that might bring about Personality disorder in Adolescents. Meta-analyses indicated that internalizing behaviour and externalizing behaviour were both factors that determine personality disorder with approximately six times (i.e., 5.78) increased odds of a PD in Adolescents. Sub-analysis comparing studies with Male (n = 2) and Female (n = 7) samples indicated a significant effect. Moreover, this showed an increased risk of Internalizing behaviour and Externalizing behaviour in Adolescents samples. The pooled correlation of the studies indicated higher association (r = .095; 95% CI= 4.1; 1.1). However, Pro-social peers and antisocial peers were also considered (Thomas et al., 2001; Kirsten, 2017; Salome et al., 2017; Sylia et al., 2019). The majority of the studies were assessed through Child Behaviour Checklist, or Teacher's Report Form and Youth Self Report, except, Symptom scales for histrionic, borderline, and narcissistic personality disorders (Thomas et al., 2001) and Structured Assessment of Violence Risk in Youth (SAVRY) Kirsten (2017). Meta-analyses on antisocial peers indicated approximately five times (i.e., 4.46) increased odds of a PD in Adolescents. The pooled correlation of the studies indicated higher association (r = .095; 95% CI= 0.00, 12.04).

However, factors such as depression, suicidal ideation, anxiety disorder, smoking and alcohol consumption, illicit substance use were also acknowledged as signs of personality disorder (Paul Moran et al., 2016; Kirsten, 2017; Eunice et al., 2017). The studies were assessed through Diagnostic Interview for Borderlines-Revised and the Childhood

Interview for DSM-IV-TR BPD and control by Axis I and Axis II disorders. Meta-analyses on Depression and Suicidal ideation, anxiety disorder, smoking and alcohol consumption, illicit substance use indicated approximately six times (i.e., 6.25) increased odds of a PD in adolescents. The pooled correlation of the studies indicated higher association (r = .067; 95% CI= 3.8; 1.1). Consideration was also on Avoidant/Abandonment, unstable interpersonal relationships, identity disturbance and impulsivity as defined by (Jean et al., 2018) and assessed through Diagnostic Interview for Borderlines-Revised and the Childhood Interview for DSM-IV-TR BPD and on Axis I and Axis II disorders. Meta-analyses on Avoid abandonment, unstable interpersonal relationships, identity disturbance and impulsivity indicated approximately five times (i.e., 4.76) increased odds of a PD in adolescents. The pooled correlation of the studies indicated higher association (r =.099; 95% CI= 3.3; 1.5). Paranoid; Schizoid; Schizotypal; Antisocial; Obsessive-compulsive; Depressive; Passive-aggressive as defined by (Kirsten 2017) and assessed with Structured Assessment of Violence Risk in Youth (SAVRY), controlled by Structured Clinical Interview for DSM personality disorders and the Symptom Check List 90. Meta-analyses on Paranoid; Schizoid; Schizotypal; Antisocial; Obsessive-compulsive; Depressive; Passive-aggressive indicated approximately six times (i.e. 6.11) increased odds of a PD in Adolescents. The pooled correlation of the studies indicated higher association (r = .071; 95% CI= 2.7; 1.2). Finally, only one study was obtained on Avoidant PD and internalized emotional dysregulation, characterized by preoccupying anxieties as a factor mitigating personality disorder in Adolescents. This was defined by (Gwen et al., 2012) and assessed with Psychopathy Checklist – Youth Version (PCL-YV) and the Structured Assessment of Violence Risk in Youth (SAVRY). Meta-analyses on Avoidance and internalized emotional dysregulation, characterized by preoccupying anxieties, indicated approximately four times (i.e. 4.35) increased odds of a PD in Adolescents. The pooled correlation of the studies indicated higher association (r = .082; 95% CI= (3.7; 1.3). This strong and positive Correlation (r = .082; 95%) is evidence that Avoidance and internalized emotional dysregulation, characterized by preoccupying anxieties, significantly determine PD in Adolescents. Most of the factors were confirmed to be cogent determinants of personality disorders in Adolescents.

Psychotherapies those are often effective for adolescent's personality disorders.

1. *Behavioral therapy based on dialectical and cognitive principles.*

Cognitive Behavioural Therapy and Dialectical Behavioural Therapy have been widely developed for many groups, including adolescents. Cognitive Behavioural Therapy focuses on identifying and modifying negative thought patterns and improving disturbed behavioural self and social-regulation skills thought to underlie disorders.

An adolescent with a borderline personality disorder may be eligible for a modified form of the DBT known as Adolescent Emotional Control (AER) (Rathus, 2002). Adolescent DBT puts a little more emphasis on managing emotions and interpersonal relationships. This is because it was initially developed as a treatment for BPD, often marked by dramatic swings in mood and behaviour that can make having relationships with others difficult. Parents are more involved in the counselling program, emphasize the family, and teach fewer skills. (Rathus, 2002).

Improving the control of emotions can help create a System of training for emotional predictability and problem-solving (STEPPS; Blum 2009). This has proven to be successful with adolescents (Schuppert, 2009). Adolescents who had completed the STEPPS programme indicated having a greater sense of control over their mood swings. STEPPS uses programming for anyone close to adolescent, along with family, peers, and experts with common knowledge of skills, so that a community of people who are closer to a young person can strengthen and encourage newly learned skills.

This includes parent training, cognitive problem-solving training for young people, work-based parental and child programs, foster care, and family counselling. Many of these approaches are successful.

2. *Acceptance and Commitment Therapy*

ACT teaches skills to help individuals live and act in ways that are compatible with personal values while at the same time improving psychological resilience. ACT practitioners help individuals understand how their efforts to block, manipulate, and monitor emotional experiences generate difficulties. By identifying and solving these issues, individuals will become better able to make room for value-based behaviours that promote well-being.

The basis of Acceptance and Commitment Therapy involves six fundamental concepts. They work together towards the critical objectives of successfully managing traumatic thoughts and memories and building a prosperous, vital life (Hayes, 2009). The principles are as follows:

- Acceptance.
- Cognitive Difusion.
- Being Present; Contact and connect with present moment
- Self as Context; The observing self
- Values; Values clarification
- Committed Action.

3. *A multisystemic approach*

Multisystemic therapy is used in adolescents and children at risk of developing antisocial behaviour. The intervention was conducted in various test trials with young people and their families and appeared successful. Care focuses on communication and parenting skills and strengthening pro-

social interactions with peers and the school's success and the family and community (Henggeler et al., 2009).

Teenagers should be treated with therapies that deal with problems such as harassment and addiction. However, the fact that these treatments do not change the fundamental mechanisms of the personality remains uncertain. Since so many disordered personalities are related to a history of unsafe attachment, it seems essential to build a stable basis for treatment and help patients learn new ways of thinking and feeling about themselves and others. More recent studies have shown that attachment styles may exhibit different signs and behavioural problems in younger people.

4. Parenting Style

Moreover, parents teach empathy and respect character qualities such as integrity and compassion over being complex or dominant, modifying entitled attitudes, and avoiding entitled behaviour.

Construct healthy self-esteem (low self-esteem may also contribute to superiority and support one's ego using others). Parenting styles related to the development of narcissistic personality are often avoided, such as neglecting, indulgent (spoiling with privilege and belongings and fostering entitled attitudes) and cold, overcontrolled authoritarian approaches that focus on a child's perfection, winning, and toughness. Parents should also help their adolescents learn to identify narcissists to prevent or withstand their toxic damage. The capacity to think critically about what someone says or does, which begins to grow during puberty, is a necessary foundation for this. Critical thinking abilities allow one to distinguish lies from the facts and decide when someone manipulates or want to take advantage (Boucher, 1999).

Parents can give their children life-long defensive gifts of healthy levels of self-esteem and critical thinking abilities while squelching entitlement and narcissistic characteristics. Furthermore, parents and adolescents should not forget that there is no shame in getting help to get things done-it is a sign of courage, not weakness, in seeking information and assistance.

V. CONCLUSIONS

Many adolescents display this kind of behaviour to some degree, making it difficult to differentiate "normal" adolescent behaviour from a personality disorder. A significant clue is when the adolescent has recurrent issues or when these behaviours are getting more severe. Adolescents at risk of personality disorders may also be abusing substance, including alcohol, which also exacerbates depression or anxiety. Relationship issues, parental separation, familiarity with stressful events and other social or family stressors may also raise the likelihood of personality disorder.

Mental health practitioners are ideally qualified to carry out an assessment. Professional help may minimize the effects of personality disorders, although there is a range of more practical methods, such as school-based prevention services and community-based family intervention.

There is significant evidence that such psychological programs can reduce the symptoms of depression and anxiety in PD. Through mental health education, young people and their parents can recognize the signs that someone may have a problem. Such awareness may encourage parents to seek help from their children.

Educational programs often allow youth aware of the forms of assistance available to them that can be delivered online or by qualified educators. Prevention, early detection, and intervention of PD are essential to avoid long-term effects of PD on adolescents' overall functioning and interpersonal relationships. When diagnosing PD in adolescents, adequate and specialized personality disorders care must be provided.

The introduction of PD therapy in time and with a licensed therapist is highly successful, particularly during the adolescent phase, which has maximum remedial potential. On this basis, programs should be structured to respond early and to the adolescent community – home, school, and neighbourhood. Treatments for adolescents must improve their resilience, treat the condition, and create a prosocial identity. The focus needs to be changed to prevention in the form of programs for parents and caregivers. Environmental childhood trauma raises the risk of developing a wide variety of childhood and adolescence situations that may persist in adulthood. These disorders are expensive, not just for young people and their families but also for us.

Parental behaviours, such as bullying and harshness, are correlated with infant oppositional and violent behaviours (Stormshak et al., 2000), self-regulation deficits, and psychopathology (Egeland & Sroufe, 1981; Larsson, Viding, Rijsdijk, & Plomin, 2008; Rodriguez, Ayduk, et al., 2005; Sethi et al., 2000). Therefore, it is fair to assume that parental warmth and harshness can be positively and negatively correlated with personality development during adolescence.

Adolescent personality has significant genetics and environmental impact. "Nature, Nurture and Structure influence children personality traits" Olubukola Akanni. While the degree to which social factors affect personality, traits continue to be debated (Bleidorn, Kandler, Riemann, Angleitner, & Spinath, 2009), several behavioural genetic studies have shown that 50% or more of the variation in personality characteristics arises from environmental influences (Loehlin, 1992). Earlier research indicates a significant shift in personality during puberty, as demonstrated by test-retest correlations (Roberts & DE Vecchio, 2000). In the present inquiry, we suggest that parental characteristics and behaviour can be explained at least some of this shift.

In conclusion, it is also expected that parent personality can predict adolescent personality directly. There are two explanations for that assumption. First, behavioural genetic

studies have shown that a substantial variation in personality traits arises from genetic factors (Loehlin, 1992). This finding is consistent with a positive relationship between parent and child personality. Secondly, it is also conceivable that parents and children's characteristics can be related separately from the parenting variables considered in this study through social learning processes. There should be further studies on how parental personality disorders determine children's personality traits and disorders and the impact on learning (formal and informal).

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