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PERSONALITY DISORDERS (K BERTSCH, SECTION EDITOR)

Cultural Aspects in Symptomatology, Assessment, and Treatment of Personality Disorders

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Abstract

Purpose of Review This review discusses cultural trends, challenges, and approaches to assessment and treatment of personality traits and disorders. Specific focus include current developments in the Asian, Italian, Iranian, and Australian societies, as well as the process of acculturation, following moves between cultures with the impact on healthy and disordered personality function.

Recent Findings Each culture with its specific history, dimensions, values, and practices influences and gears the individual and family or group in unique ways that affect personality functioning. Similarly, each culture provides means of protection and assimilation as well as norms for acceptance and denunciations of specific behaviors and personality traits.

Summary The diagnosis of personality disorders and their treatment need to take into consideration the individual in the context of the culture and society in which they live. Core personality problems, especially emotion dysregulation and interpersonal functioning are specifically influenced by cultural norms and context.

Keywords Personality disorders · Acculturation · Stigma · Trauma · Adjustment · Emotional sensitivity

Introduction

The understanding of personality functioning and approaches to assessment and treatment of personality disorders present with considerable cultural differences. Social, religious, and family values with different traditions and practices tend to influence individual personality development and formation, both subjectively and interpersonally, as well as socially. Similarly, cultures and societies vary significantly regarding what is supported and accepted versus considered a deficit or unacceptable. Consequently, culturally determined expressions of self and interpersonal functioning tend to influence the international generalizability of diagnosis and empirical studies of personality disorders. In addition, moves and migrations between different cultures, with accompanying acculturation and adjustment, can impact personality functioning in various ways, some with significant consequences for personality disorders. International consistency in diagnosis of personality disorders across cultures require attention to how personality traits and functioning can be culturally influenced and determined, as well as how the individuals' personality functioning and interaction can be culturally perceived and evaluated [1–3].

Major psychiatric disorders have long been internationally acknowledged, while attention to personality-related functioning and disorders vary in different cultures. The DSM 5 diagnostic assessment has specifically attended to the cultural perspectives in diagnostic assessment [4]. The Cultural Formulation Interview (CFI) in DSM 5 focuses to how aspects of individuals' background, developmental experiences, and current social contexts can affect their perspective on psychiatric condition. For example, cultural definition of a problem

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can either compel or impede the patient to seek treatment. Cultural perception of cause, context, and support can influence treatment motivation, as well as contribute to factors that affect self-coping and help-seeking (DSM 5 pp. 750–754). The two dimensions for personality functioning, identity and self-direction (DSM 5, Section III, p 762), have specific relevance for evaluation of cultural-based sense of authorship, agency, autonomy, and acceptance [5, 6].

Each society contains structures that direct and control social behavior. In addition, approaches to behavioral abnormalities that threaten the accepted social norms and patterns can be very specific within each culture. Some societies have integrated social systems with clear norms that support controlled behavior, making impulsivity less likely. In societies with social roles that are more clearly and unambiguously prescribed by society, identity problems are less likely to emerge. Societal development and changes can impact personality functioning in different ways. Personality pathology could be a reflection of the breakdown of such cultural norms and varies with the rapidity of social change [7–9].

Traditional social and family-oriented versus modern individualistic and elitist societies and cultures tend to foster different personality development and functional patterns [8, 10]. Definitions of healthy development and mental wellbeing vary, and each culture present with a diverse range of challenges in personality development and daily functioning. Consequently, personality dysfunction and pathology are quite differently expressed and defined within each specific society. Similarly, cultures vary with regard to openness, flexibility, acceptance, and containment of personality differences and diversity. In some cultures, personality-related problems are paid less attention to or can be contained within the family or a subcultural group. In other cultures, differences in personality functioning are less accepted, readily leading to conflicts and rejection, or tend to affect mental health and be expressed in substance use disorder, depression, obsessive compulsive disorder, avoidance and social isolation, and personality disorders [11]. And while some cultures encourage and promote certain traits and patterns, others may suppress, devalue, or ignore those same character features [12].

Recent studies have stressed the importance of understanding patients in a sociocultural context with attention to the dynamic interactions between personality traits, developmental histories with challenges and adversities, and the current social situation [13••]. Major efforts to outline international guidelines for identifying and treating personality disorders, using empirically anchored diagnostic criteria and evidence-based treatment modalities, have led to increased public and clinical awareness in many countries around the world. Nevertheless, personality traits and functioning are culturally influenced and determined. Consistency in identifying and treating personality disorders across cultures also require attention to the specific cultural structures and traditions that can influence both the development and functioning of the personality, as well as how the personality is perceived.

The aim of this paper is to highlight different cultural trends, challenges, and approaches to assessment and treatment of personality disorders, specific for the Asian, Italian, Iranian, and Australian societies. These cultures vary significantly with regard to attitudes and approaches to personality functioning and mental illness. In particular, social and political differences tend to contribute to divergences in both occurrence and evaluation of behavioral and interpersonal problems. In the context of strong family values, like in Italy and parts of Asia, personality problems tend to be more contained, while in other cultures, like Iran, which are undergoing major social and political changes, extreme behaviors like aggression or other identity enhancing behavior, can suddenly dominate in the society. Similarly, enforced drastic cultural changes related to migration in Australia can contribute to trauma associated personality problems and identity diffusion. An additional aim is to discuss the process of acculturation, following moves from one culture to another and its impact on healthy and disordered personality function.

Borderline Personality Disorder from an Asian Perspective

In East Asia, the diagnosis of borderline personality disorder (BPD) has been met with skepticism by the Chinese psychiatric community. The community contended that some of BPD's diagnostic criteria, such as fear of abandonment, are not appropriate in the Chinese cultural context, which values collectivistic identities and enmeshed relationships [14, 15]. Consequently, BPD is not formally included as a diagnosis in the Chinese Classification of Mental Disorders-III [16]. Further, behavioral problems such as reckless driving and substance abuse, often included as examples of impulsivity in DSM 5 criteria for BPD, may not manifest as much in patients in certain parts of Asia, such as China and Singapore, where car ownership is less common, and use of drugs are strictly controlled [17••].

However, existing research suggests that BPD is a condition that exists in Asia. In China, studies find the prevalence of BPD to range from less than 1% in college students [18] to up to 8.4% in high school students [19]. In clinical settings, the prevalence rates of BPD range from 1.3 [20] to 7.1% [21]. In Southeast Asia, one study conducted in Thailand found that 13.0% of inpatients and outpatients met diagnostic criteria for BPD [22], whereas studies based in Singapore found that a prevalence rate of 16.3% in a prison setting [23] and 36% in a psychiatric setting [24•].

Meanwhile, there is emerging evidence that the factor structure of BPD may be unique in selected Asian contexts. Keng et al. [24•] examined the construct validity of a well-

established measure of BPD symptoms, the McLean Screening Instrument for BPD, in Singapore, and found a unique 3-factor solution consisting of (a) affect dysregulation, (b) self-disturbances, and (c) behavioral and interpersonal dysregulation. This is in contrast to several studies conducted in Western settings [25, 26], which found that the third factor could be reliably distinguished as two separate factors (of behavioral dysregulation and interpersonal dysregulation respectively). The finding suggests that within the Singaporean context (which consists of largely ethnic Chinese), the interpersonal difficulties facet of BPD may be particularly intertwined with the core feature of behavioral dysregulation. The findings may be attributable to the fact that Singapore is primarily a collectivistic society, which emphasizes traditional Asian values of social harmony, emotion control, and interdependence [27]. The fact that family members and individuals tend to live in close proximity and share close-knitted ties suggests that individuals may be particularly vulnerable to dysregulations arising in the context of interpersonal relationships [28, 29]. Such dysregulations may manifest in behavioral problems (e.g., self-harm behaviors), which in turn create further difficulties and invalidation in the social environment. The negative interpersonal effects of behavioral dysregulation might be particularly pronounced in a culture that values control of emotions [30]. The biosocial theory postulates that BPD is a disorder of emotion dysregulation that results from a transactional relationship between pre-existing emotional vulnerability and an invalidating environment [31]. Several Asian studies demonstrated a strong association between early experiences of invalidation (e.g., child abuse) and severity of BPD symptoms [32, 33]. While the findings are largely consistent with the biosocial model, recent research suggests that the association between invalidation and BPD symptoms may vary by specific dimensions of culture. For example, Soh and Keng [34] found that conformity (referring to the extent to which individuals endorse conformity to norms) and self-construal moderated the association between childhood invalidation and BPD symptoms, such that high levels of conformity predicted a stronger association between invalidation and BPD symptoms among individuals who endorsed interdependent self-construal, but not among individuals endorsing independent self-construal. The finding suggests that endorsing interdependent self-construal (i.e., the tendency to view the self as part of a larger group identity, as opposed to as an individualized identity) along with high levels of conformity may render an individual particularly vulnerable to the effects of invalidation, especially in a collectivistic Asian cultural context.

Overall, current research shows that BPD is a clinical presentation that exists in Asia, with preliminary evidence pointing towards differential clustering of symptoms in selected context(s). Notably though, little work has *directly* compared the symptomatology of BPD between Asia versus other parts of the world, in part due to challenges associated with establishing psychometrically valid cross-cultural BPD assessments. In two studies that compared Japanese versus US samples [35, 36], it was concluded that the clinical picture of Japanese BPD patients is largely similar to those in the USA. The lack of more empirical research examining cross-cultural differences in the presentation of BPD however should not be taken as evidence that no consistent cross-cultural differences exist, rather potential culture-specific variations in symptoms of BPD should be considered in light of research demonstrating cross-cultural differences in emotion regulation and expression. For example, East Asians have been found to engage in greater suppression of emotions [37] and attenuated behavioral reactivity to emotional stimuli [38] compared to European Americans, suggesting that expressions of emotion dysregulation may be less pronounced or heightened in East Asia. Future research should examine cross-cultural differences in emotion expression and dysregulation in the context of BPD, as well as compare the symptom presentation and etiology of BPD between Asia and other cultural contexts.

With regard to treatment, despite the fact that there are established, evidence-based treatments for BPD [39–41], there is an overall paucity of specialized treatment services or providers for patients with BPD in Asia. This is compounded by stigma against BPD, as well as a lack of awareness of BPD as a mental disorder, within the general population—and perhaps to varying extent—within the professional mental health community [42]. In general, patients with BPD, especially those with more severe, prominent behavioral problems such as self-harm and suicidal behaviors, tend to show up or get referred to emergency settings in hospitals. They are then seen by physicians or psychiatrists, many of whom take predominantly a medication-based approach in working with these patients and/or refer these patients to counselors or psychologists, who may or may not have specialized training in working with patients with BPD. Some who struggle with less severe symptoms may prefer to go to the general practitioners (GPs) as opposed to psychiatrists or psychologists for stigma-related concerns [43]. In Malaysia and Singapore (where co-author SLK is based), for example, there is no clinic or treatment service that specializes in treating patients with BPD. Many patients end up receiving services in the general hospital system, or from select few psychologists in private practice who have had training in treating BPD, if they can afford the private fees. Among the very small community of treatment providers who specialized in working with BPD, treatment approaches that are utilized consist of a mixture of approaches such as dialectical behavior therapy, transference-focused psychotherapy, and mentalization-based treatment. Overall, there is a pressing need to increase the availability of evidence-based treatments for BPD in Asia (e.g., through providing training to existing

mental health professionals), as well as to psychoeducate the public regarding BPD and dispel stigma against the condition.

The Impact of Italian Culture on the Features of Borderline Personality Disorder and its Treatment

Although influenced by socioeconomic changes over the past few decades, family remains an enduring force within Italian culture. Not only does it form the nucleus of Italian society, the entire culture is, in contrast to many western cultures, "collectivistic" in encouraging interdependent and cooperative behaviors. A review on empirical research of value-orientations found that Italian immigrants to the USA were characterized by more emotional expressiveness and collateral social relations when compared to other white ethnicities [44]. Associated with the dominant role of the family and collectivism is the evidence for high levels of affectivity in Italian families. When interacting with their infants, Italian mothers are found to display higher levels of social/affective and handling/holding behaviors than American mothers [45].

Clinical observation on BPD in Italy shows variations in symptoms rates, when compared to the existing US literature [46], some of which can be understood in light of the above stated cultural differences. Both Italian young and adult subjects show less impulsivity and fewer parasuicidal acts and suicidality. As Paris [47] suggests, in more traditional cultures, individuals with emotional sensitivity and reactivity may be shaped away from impulsive and suicidal behaviors. Actions taken against one's own body may be further more discouraged by prohibitions within the dominant Catholic religion against turning violence inward.

Italian borderlines at the same time seem to present with higher levels of interpersonal hypersensitivity and social anxiety. Expressions of assertiveness and individualistic pursuit of personal goals can go against the cultural grain and can lead to emotional pain, wherein he or she is fraught with shame and guilt. Developmental processes of separation and individuation can be inhibited in the Italian culture, where moving away from familial figures and exploring the world independently can strain the close familial bonds. For some, this means the maintenance of dependent relating, the constriction of independent exploration, and regression to more immature self-images and affects. In this context, comorbid somatic symptom disorders, as manifestations of such unexpressed stress, and "shy" narcissistic personality disorders are not infrequent. In addition to cultural factors interfering with the promotion of independence is the unfortunate fact that Italian youth unemployment levels are extremely high (37.5%) [48].

The same cultural influences shape the nature of clinical approaches to BPD in many ways. First, the fact that Italian patients are more likely to present with the internalizing symptoms of BPD—emotional sensitivity, emptiness, and painful interpersonal relationships—can lead clinicians to miss the diagnosis. They then apply approaches typical to the treatment of mood and anxiety disorders, which can easily result in treatment failures. Second, the social-emotional closeness among family members is a good match for providing psychoeducational interventions. In a country where family is central and health care is delivered mostly within a public sector system where specialized resources for BPD are so rare, the family should be seen as the central support system, where interventions take hold and where stressful situations are managed [49,]. Attention, validation, and concerned responses from family indicate their care and can be linked to better clinical outcome for BPD patients, especially when adequate treatment within the public psychiatric services is limited [50, 51]. On the other hand, the inclination of Italian families to sustain the burden of support places a high risk of caregiver burnout, and especially short-term recovery of Italian BPD patients is lower compare to North America. [50] Third, mental illness tends to be viewed as a "family's business," not to be shared elsewhere. This can bias some people against seeking help outside the family unless the problem becomes quite severe and therefore even more difficult to treat. This reluctance can be amplified in a culture where in part it is expected that the first search for help, outside of family, goes through Church, and in rural areas, through traditional healers.

Finally, gradual changes occurring in the Italian social and familial structure (i.e., a shift from more enlarged families to nuclear ones, the increasing rates of divorce, the globalization process) negatively impact the protective nature of traditional life. All of these factors will, most likely, gradually have their impact on the expression of core BPD problems in emotion regulation and interpersonal functioning, and in structures and processes of treatment. The rising rates of self-harm behaviors and suicidality in adolescents in Italy may be manifestations of these new trends.

Individual Behaviors in the Iranian Cultural Context

Iran is a country with over 79 million people undergoing an intense developmental period. The Iranian population is gradually becoming older; 49% of the population are women and more than 79% live in cities. In the past two decades, with the development of universities and higher education, a large number of young academic graduates have entered the community [52]. Noticeable is also that in recent years, middle age people tend to adhere to the old traditions while the younger generation tends to embrace a modern culture. Reflecting upon and evaluating people's behavior requires taking into account current social factors of the country. Given these

changes and conditions, a comprehensive approach to assessing personality disorder seems more appropriate rather than a more individual-focused approach [53].

In recent years, specific subtle behaviors have increased in the Iranian society, which can be signs of personality traits. For example, over 130,000 rhinoplasty surgeries are reported annually in Iran, which is one of the highest rates of such procedures in the world [54]. The question is whether this kind of procedure can be an indication of behavioral disorders or special personality characteristics, such as obsessive compulsive, narcissistic, or avoidant personality traits [55]. Qualitative studies of people who wanted to do rhinoplasty have identified reasons and personal motives, such as gaining a more attractive appearance in society, especially vis-a-vis the opposite sex in single people. Other reasons include feeling a need for change in appearance and mental state. Quotes from successful people who have done cosmetic surgery and reports in media, as well as the low cost of surgery, also influence people's tendency to seek out rhinoplasty. This study did not show an increase of personality disorders or psychiatric disorders in the applicants undergoing rhinoplasty [56]. However, this trend can be equivalent and compared to the by now quite frequent procedure of tattoos in Western societies [57]. Both include the effect of the mind on the body, which is perceived differently in different cultures.

The second trend is the occurrence of aggressive behaviors in the community. Based on reports from forensic medicine in Iran, an aggressive conflict is recorded every minute. The question is whether this can be a sign of people getting more aggressive, and if so, are more people affected by psychiatric disorders, or is there an increase in impulsive personality traits in the population? Evidence of epidemiologic studies shows that 23.6% of Iranians suffer from psychiatric disorders [58•]. The prevalence rate of personality disorders in the general population has yet not been determined. Personality disorders in Iran are diagnosed in clinical settings based on clinical interviews and DSM criteria. In surveys and clinical studies validated Persian standard tools, such as a SCID II (Structured Clinical Interview for DSM IV Axis II Personality Disorders), MMPI (Minnesota Multiphasic Personality Inventory), and MCMI (Millon Clinical Multiaxial Inventory), are used. The usual treatments for personality disorders are cognitive-behavioral therapy, dialectic behavioral therapy, and psychodynamic psychotherapy. In addition to psychotherapy medication is a usual treatment in personality disorder, and in severe cases, admission in a psychiatry inpatient unit is an option. Although reviews of studies over the past 20 years show a slight increase in psychiatric disorders, this increase cannot explain social phenomena such as increase in rhinoplasty or increased aggressiveness and violence in society. Consequently, the question remains how to explain the increase in outbreaks or epidemics of behavioral problems that cannot be considered psychiatric disorders, and here a social-cultural approach is called for. Among psychiatric disorders in Iran, anxiety disorders are most frequently reported [58•], and one of the symptoms can be angered and sudden reactivity.

In recent years, due to the sanctions and economic constraints, tensions in society have increased, as well as aggression and interpersonal conflicts. On the other hand, economic constraints have also led to the isolation of Iranian society, with less communication with the international community. Consequently, the Iranian society has become more closed, which reduces the possibility of social exchange with the outside world. These isolated conditions may increase the meaning and necessity of specific behaviors, such as social conformity, and certain behaviors within particular groups of people can be disseminated as a behavioral epidemic throughout the society [59].

Accordingly, one reason for the increase of cosmetic surgeries and aggressive behaviors could be the impact and contagion onto other people in the Iranian society with their limited contact with the outside world. Ultimately, in the evaluation of each person with any subtle behavior, it is necessary, regardless of individual appearance, to pay attention to both the difference between the subtle behaviors of other people, as well as to other social and cultural backgrounds of that period of time, until a more realistic understanding of the problems of that individual and the surrounding community can be achieved. The diagnosis of personality disorders and their treatment need to take into consideration the individual in the context of the culture and society in which they live. Study of the specific time will add significantly to the clinical process and reduce prejudices or inappropriate interventions [53].

Personality Disorders from Australian Perspective

In the Australian context, there are a number of cultural challenges in the assessment and treatment of personality disorders. Australia like many other countries experiences significant stigma and discrimination against mental illness, but especially personality disorders [60•]. Clinical experience and data from health services shows that there are real challenges in providing appropriate compassionate care to those with long-standing disordered personalities. Health practitioners have traditionally been reluctant to diagnose and therefore treat the disorder. This can take many forms, such as not offering evidence-based psychological treatments, or providing medications for other psychiatric conditions such as bipolar disorder or schizophrenia that have little efficacy in treating personality disorder [61]. Experts point to the lack of awareness and training in personality disorders, often due to outdated notions of "therapeutic nihilism" or "untreatability" [62].

Therefore, there is widespread poor identification, recognition, and treatment available for personality disorder [63]. This is despite Australia taking the significant step of issuing clinical practice guidelines to encourage changes in practice [61]. The two major modes of treatment for personality disorders in Australia are psychodynamic (including the conversational model of Russell Meares and colleagues in Sydney) and cognitive-behavioral (particularly DBT) [64].

One significant challenge in the identification and treatment of personality disorders in Australia is access to services from people from minority groups including the misrecognition of personality disorder when a person has a trauma background [65]. People with trauma are often harder to engage in mental health care due to high stigma and shame, but there are specific challenges. There have been waves of cultural dispossession experienced by peoples over the past 200 years that have challenged identity and stability. First have been the effects of colonization on the Australian indigenous population, and the ongoing trauma from the dispossession of land, culture, language, and identity. Mental illness are often seen within an indigenous context as characteristics of "personality" that can't be changed, rather than as treatable [66]. Today, an aboriginal person has a life expectancy 10 years less than the general population [67]. Second, significant waves of migration from people with disadvantage including Britain (from 1788) escaping poverty or famine, people from internment camps in Europe (from 1945), Indochinese following the Vietnam War (from 1975), and significant groups more recently from India and China and refugees from Middle Eastern and African nations. Each of these groups has brought people with trauma that have become long-standing and have created disordered ways of relating to the world and the self [68]. Each of these groups requires culturally sensitive approaches; however, the mainstream health service has been designed within a western biomedical model that is not a good fit with treating personality disorder and complex traumas from a cultural perspective.

A second pressing issue in Australia is problems in engaging men with personality disorder. It is difficult to separate discrimination by health practitioners against males with personality disorder symptoms, or ingrained self-stigmatization by males creating a reluctance to seek or accept help. In Australia rates of suicide in males is highest in older age, yet systematic reviews on depression identification and bolstering psychosocial connections have proven to be more effective with women than men [69]. Like many other estimates from various countries, the population prevalence of personality disorder is estimated to be 6.5%, with slightly higher estimates in men (6.83%) compared to women (6.13) [70]. Despite having similar presentations of men and women to hospital with personality disorder, data from a representative health service demonstrates that from 1058 persons presenting with diagnosed personality disorder, of the 362 referred to a personality disorder service only 30% were male, and when a further 148 were offered specialist long-term psychological therapy, the proportion of men fell to 15%, meaning 85% of specialist services for personality disorder went to women [71]. These data suggest additional attitudinal barriers to care for males with personality disorder and also that males resist seeking help perhaps because of the cultural stereotype of the "Australian Male" [72]. This stereotype is of the hardy warrior battling and overcoming the harsh environment through sheer physical strength, whether that environment is the outback dessert, the sporting field, or in the workplace. Behind the stereotype however can be high rates of domestic violence, misogyny, racism, homophobia, and suicide. National data demonstrates that one in six men with a mental health condition lasting at least 12 months sought help from their physician, in contrast to one in three women [70].

On a more optimistic note, there are now a number of national priority groups such as the Project Air Strategy for Personality Disorders (www.projectairstrategy.org) and Orygen Youth Health (oyh.org.au) that have begun to implement new more hopeful and culturally inclusive interventions [61]. Personality disorders have recently been recognized as an area needing mental health priority in Australia, in part because the ongoing stigma and cultural discrimination have meant people with these conditions are often not represented in data collection and overlooked when it comes to national strategies [60•].

Acculturation and Personality Disorders

Moving from one cultural context to another and adapting cultural traditions and practices that differ from those of one's origin tend to create significant mental challenges. Acculturation is defined as a process of cultural and psychological change in the meeting between countries and cultures. Individual acculturation is influenced by culture of origin and the new culture, as well as by the individuals' personality functioning [73, 74]. It is considered a bi-dimensional process with a dual task, to adjust and orient towards the new culture as well as to incorporate and leave behind the culture of origin [75, 76]. Ideally, acculturation can result in an integration and personal growth with balanced attitudes towards both the new culture as well as the culture of origin. However, the adjustment to a new culture can also involve difficulties separating from the culture of origin as well as incorporating a new culture, and simultaneously maintaining meaningful bonds with the culture of origin. This puts specific stress on personality functioning.

Studies have pointed to specific acculturation challenges that occur in the gap between expectations and the real encounter with the new culture, between hopes and envisions of the future that turn into worries, disappointments, regrets, and

even trauma [74, 77]. Such stress can be related to language, or to educational, professional, or financial changes and circumstance, or to social, interpersonal, or family-related experiences and conflicts. Aspects of the self and identity can become disavowed, and the stress accompanying the negotiation of social identity can contribute to a sense of failure or isolation. Mental health problems and escalating personality-related pathology can consequently result in substance abuse, family conflicts, emotion dysregulation, and sense of alienation. Suicidal ideations and behavior can in this context be caused primarily by subjective or social interpersonal experiences related to acculturation, rather than to mood and depression. One study of young adult Mexican immigrants in the USA found that acculturation stress related to substance dependency and anxiety disorder [78]. Another study of adolescents with immigrant parents in France found acculturation issues, in particular individualism with detachment from both culture of origin and the new culture, to increase suicide risk. Marginalization and assimilation, i.e., abandoning values and practices in culture of origin, increased suicide risk, especially in girls who also had traits of borderline personality disorder [79].

Cultural shifts and conditions can influence personality disorders in different ways. A culture of origin can provide social or interpersonal protective functions that overrule psychobiological vulnerability and prevent exposure and development of some typical features for personality disorders, i.e., emotion dysregulation. With migration and acculturation such protective cultural function can be lost, and consequently clinical manifestations of personality disorders can unfold in the new culture [80]. One study of psychological adjustment in South Korean foreign students identified a number of challenges and vulnerabilities including isolation and loneliness. Major causes related to disconnection from culture and family of origin, reactions to parental expectations and demands, and barriers in interpersonal connections due to differences in language and social or interpersonal style [81].

Personality functioning in the context of acculturation can also be misinterpreted or ignored. For instance, unresolved inner conflicts related to migration and moves can lead to changes in mood, impulsivity, ambivalence, unpredictability, and intense anger that resemble borderline personality disorder [7]. Similarly, flamboyance or exaggerated self-evaluation typical in some cultures may be misinterpreted as an indication of pathological narcissism or narcissistic personality disorder. For example, self-enhancement in the USA contrasts to the Japanese self-critical standards where deemphasizing positive aspects of the self is affirming social belongingness. On the other hand, self-enhancement can also be an essential tool in the acculturation adjustment process [12, 82, 83]. With regard to avoidance, some cultures encourage shyness, withdrawal, and protectiveness, which erroneously can be misinterpreted as avoidant personality disorder [84].

Identifying experiences of cultural conflicts and their impact on personality functioning, especially on identity, self-esteem, and sense of agency, is very important in assessment and treatment of personality disorders. In particular, attending to the effects of migration and multicultural challenges for patients in psychotherapy is essential. What is shaming, guilt inducing, or culturally inappropriate or forbidden in the culture of origin can contrast with the new culture, causing internal conflicts and behavioral symptoms that mistakenly can be considered traits of personality disorders. Similarly, what is considered highly valued and necessary for cultural co-existence in one culture may be out of place or even perceived as antagonistic in another. In addition, understanding stress management and emotion regulation in cultural contexts is equally essential and may require technical adjustments and modifications in psychotherapy [85].

Conclusions

Our time of migration, multicultural co-existence, and extensive international exchange through media and internet can readily generate the assumption that cross-cultural difference automatically can be bypassed. This paper has aimed at highlighting some aspects of the cultural impact on personality, and of the challenges in establishing unified perspectives and criteria for what can influence personality functioning and encompass a personality disorder from a cross-cultural perspective. Awareness of cultural values, traditions, interactional patterns, and social norms are increasingly necessary in evaluation and treatment of mental conditions, in particular personality disorders. This review has indeed pointed to the societal, political, and cultural influence on treatment of psychiatric illness in general and of personality disorders in particular, both with regard to its accessibility and its utilization. Attitudes and values, including personal, family, and culturally based, do indeed influence individuals' incentive and motivation to seek treatment. These can relate to manliness, like in Australia, strong family containment, like in Italy, changes in societal trends and dominant behaviors like in Iran, or intolerance and unacceptance of disordered behavior rather than considering the need for treatment like in certain parts of Asia. Specific challenges that are universal relate to accessibility to treatment especially in rural and remote areas, but others are cultural specific, e.g., the differences in identifying and accepting disordered personality functioning, tolerance of emotional expressions, and understanding the influence of migration-related trauma and sense of identity. Efforts to establish international norms and guidelines for assessment and treatment of personality disorders have to continue to consider our growing knowledge and awareness of the salient obvious as well as the more subtle subjective cultural standards and differences.

Compliance with Ethical Standards

Conflict of Interest Elsa F. Ronningstam, Shian-Ling Keng, Maria Elena Ridolfi, Mohammad Arbabi, and Brin F.S. Grenyer declare no conflict of interest.

Human and Animal Rights and Informed Consent This article does not contain any studies with human or animal subjects performed by any of the authors.

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- • Of importance
- •• Of major importance

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