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REVIEW ARTICLE

Personality disorders in a non-Western context: A comprehensive meta-analysis of personality disorder prevalence in Turkiye

Dilara Nihal Carikci Ozgul[1,2], Ozden Yalcinkaya Alkar[2]

[1]Mehmet Akif Ersoy University, Rectorate, Burdur, Turkiye
[2]Ankara Yildirim Beyazit University, Faculty of Humanities and Social Sciences, Department of Psychology, Ankara, Turkiye

ABSTRACT

Personality disorders (PDs) are severe mental health conditions associated with significant distress and functional impairment. However, the epidemiology of personality disorders in non-Western populations is underrepresented. This meta-analysis aimed to estimate the prevalence of any personality disorder in both clinical and community samples in Turkiye. A systematic search was conducted in Web of Science, PubMed, Scopus, TRDizin, and the Turkish Psychiatry Index. The meta-analysis was performed in RStudio following the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines. A total of 49 articles, comprising 61 independent samples and 28,269 participants, were included. The pooled prevalence of any personality disorder across all samples was 26.06% (95% confidence interval (CI) [0.1870, 0.3507]). The pooled prevalence was 30.60% (95% CI [0.2049, 0.4301]) in clinical samples and 15.94% (95% CI [0.1063, 0.2322]) in community samples. The findings indicate that PDs are highly prevalent in both clinical and community settings. These results suggest that PDs represent a substantial public health concern and should not be considered solely within clinical populations.

Keywords: Personality disorders, prevalence, epidemiology, meta-analysis, Turkiye

INTRODUCTION

According to a comprehensive review, the prevalence of any personality disorder (PD) ranges from approximately 2% to 20% in the general population, whereas prevalence estimates in clinical samples are substantially higher, ranging from 40% to 90% in Europe and from 45% to 50% in the United States (1, 2). Gawda reported an overall prevalence of approximately 10% for any PD in community samples (1). In Turkiye, the average prevalence of any PD diagnosis among psychiatric patients has been reported to be 52% (3). Worldwide, the prevalence of PDs in the general population is estimated to be approximately 9–10% (4, 5). A notable disparity in prevalence estimates has been reported across Asian countries. For example, prevalence was estimated at 2% in India and 60% in Pakistan, (2) highlighting potential cultural differences in the diagnosis and classification of PDs. Despite growing interest in cross-cultural psychiatry, the epidemiology of PDs in non-Western populations remains underrepresented,

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Correspondence: Dilara Nihal Carikci Ozgul, Mehmet Akif Ersoy University, Rectorate, Burdur, Turkiye
E-mail: dncozgul@mehmetakif.edu.tr

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partly because of differences in cultural norms, stigma, and help-seeking behaviors. The presentation and prevalence of PDs vary across cultures, suggesting that cultural factors influence both symptom expression and diagnostic practices. For example, histrionic PD may be overdiagnosed in South American and Mediterranean cultures, where expressive emotional behavior is more culturally normative despite overlapping with diagnostic criteria (1). Conversely, obsessive-compulsive personality disorder (OCPD) has been reported to be more prevalent in Asian countries than in the United States (6). OCPD is the most commonly diagnosed PD in the United States and Australia, avoidant PD in Norway, and schizotypal PD in Iceland (7). One epidemiological study (8) reported that the prevalence of paranoid, schizoid, schizotypal, antisocial, and dependent PDs each ranged from approximately 0.5% to 1% in the general adult population. In a Turkish psychiatric sample, the prevalence of borderline PD (BPD) was 10.2%, followed by histrionic PD (5%), antisocial PD (ASPD; 3.8%), and narcissistic PD (0.95%) (9).

Studies examining psychiatric comorbidity consistently demonstrate a strong association between PDs and other mental disorders, with approximately 45% of psychiatric patients meeting criteria for at least one PD (8, 10, 11). The most common comorbid conditions include mood disorders among individuals with avoidant and dependent PDs, anxiety disorders among those with BPD, substance use disorders (SUDs) among individuals with schizotypal and borderline PDs, and eating disorders among those with histrionic and borderline PDs (12).

One study found that approximately 25% of individuals with SUD met criteria for BPD (11). PDs have been diagnosed in 44% of individuals with alcohol use disorders and in 79% of those with other substance use disorders (13). Similarly, Bowden-Jones et al. (14) reported prevalence rates of 53% among individuals with alcohol use disorders and 37% among those with substance use disorders. Although many individuals initially seek psychological treatment for substance-related problems, PDs are highly prevalent in this population (15).

Despite the growing body of research on PDs across diverse populations and cultural contexts, studies specifically estimating prevalence remain limited. Accurate prevalence estimates are important because PDs represent a significant public health concern due to their high rates of psychiatric comorbidity and their pervasive impact on multiple domains of functioning (15–17). Although research on PDs has primarily been conducted in clinical settings, community-based studies remain relatively scarce and are often limited by methodological weaknesses or insufficient sample representativeness (18). Furthermore, the considerable variability in prevalence estimates across studies underscores the importance of examining potential moderators, such as age, sample size, and year of publication.

The present meta-analysis aimed to estimate the prevalence of PDs in Turkiye. Specifically, we estimated the prevalence of any PD and individual PD categories separately in clinical and community samples. The following research questions were addressed:

1. What is the overall prevalence of any PD in Turkiye?
2. What is the prevalence of any PD in community-based samples in Turkiye?
3. What is the prevalence of any PD in clinical samples in Turkiye?
4. What are the prevalence estimates for individual PD categories in Turkiye?
5. Do prevalence estimates for any PD differ across psychiatric comorbidity subgroups?

METHODS

Search Strategy and Eligibility Criteria

This meta-analysis was conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Appendix 1) (19, 20). The literature search was performed between February 21 and March 19, 2024, using the Web of Science (WoS), PubMed, Scopus, TRDizin, and Turkish Psychiatry Index databases. The search strategy was designed to maximize sensitivity and capture all relevant studies. The core search term personality disorder was combined with a wildcard (personality disorder*) to identify plural forms and other lexical variations. In WoS, Scopus, and PubMed, the additional search terms Turkey, Turkish, or Türkiye were included. For the Turkish databases, the equivalent wildcard term kişilik bozuk* was used to capture variations in Turkish terminology. Searches in TRDizin and the Turkish Psychiatry Index were conducted using both English and Turkish search terms. Studies were eligible for inclusion if they (a) reported prevalence data for any PD, (b) employed a cross-sectional or longitudinal design, (c) included Turkish adolescents or adults residing in Turkiye (minimum age: 12 years), (d) were published in Turkish or English, and (e) appeared in peer-reviewed journals. Studies were excluded if they

(a) included fewer than 20 participants, (b) focused on highly specific populations (e.g., patients with neurological disorders), (c) were books, review articles, or conference abstracts, or (d) were unavailable in full text. No lower publication year limit was applied. All eligible studies published up to the final search date (March 19, 2024) were considered to ensure comprehensive coverage of the literature. Although the search period extended through 2024, the eligible studies were published between 1996 and 2022.

Study Selection Process

The initial database search identified 1,034 records (WoS: 305, PubMed: 36, Scopus: 436, Turkish Psychiatry Index: 19, and TRDizin: 238). After screening according to the eligibility criteria, 49 articles comprising 61 independent samples were included in the meta-analysis. The study selection process is illustrated in Figure 1, and the characteristics of the included studies are summarized in Appendix 2.

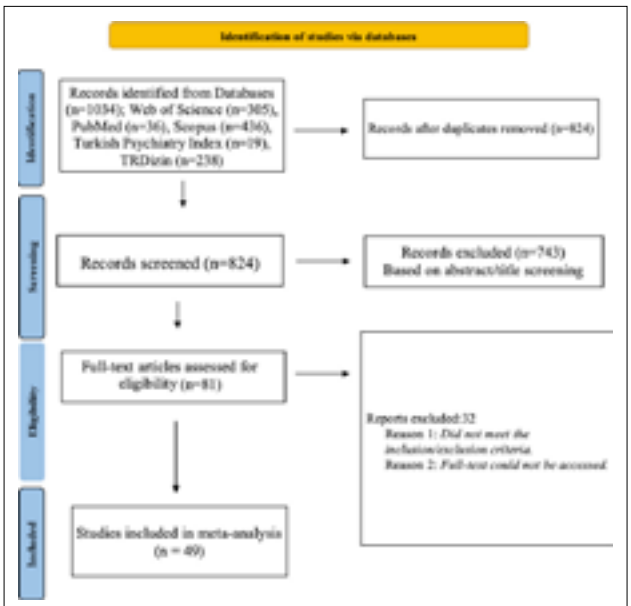

Figure 1. Flow diagram of the study selection process.

Quality Appraisal and Statistical Analysis

The methodological quality of the included studies was assessed using the Joanna Briggs Institute (JBI) Critical Appraisal Checklist for Studies Reporting Prevalence Data (21). Each item was scored as 1 ("yes") or 0 ("no" or "unclear"). All included studies achieved a quality score of 6 or higher. All statistical analyses were conducted in RStudio using the metafor and meta packages (22–24). Given the substantial variability across studies in terms of methodology, sampling procedures, diagnostic criteria, inclusion and exclusion criteria, and study populations, pooled prevalence estimates were calculated using a random-effects model with restricted maximum likelihood (REML) estimation (25). In proportional meta-analyses, when study proportions deviate substantially from 0.5 and approach either 0 or 1, statistical challenges arise because these extreme values can receive disproportionate weight in the analysis (26). For this reason, transformation of the effect size estimates is recommended. Although no consensus exists regarding the optimal transformation method, the generalized linear mixed model (GLMM) has been recommended because of its robust statistical performance (27). The GLMM, which assumes a binomial distribution, was implemented in R. Accordingly, the meta-analysis was conducted using a GLMM with a logit transformation.

The prevalence of any PD was estimated for the overall sample and separately for the clinical and community samples. Subgroup analyses were also conducted to estimate the prevalence of PDs among participants with specific psychiatric comorbidities, including bipolar disorder, substance use disorder, attention-deficit/hyperactivity disorder (ADHD), obsessive-compulsive disorder (OCD), and schizophrenia. In addition, pooled prevalence estimates were calculated for each specific PD diagnosis. In proportional meta-analyses, substantial heterogeneity is generally expected because of inherent differences in study populations, settings, and measurement methods (28). Heterogeneity was assessed using Cochran's Q test and the I^2 statistic, which quantify the extent of variability among studies beyond that expected by chance (29). To examine whether the observed heterogeneity was attributable to combining clinical and community samples in a single analysis, subgroup analyses and meta-regression analyses were conducted. Traditional methods for assessing publication bias are generally considered inappropriate for proportional meta-analyses and have been criticized in this context (30). Therefore, publication bias was not formally assessed in the present review.

RESULTS

Study Characteristics

A total of 61 samples from 49 studies comprising 28,269 participants, were included in the meta-analysis. Although passive-aggressive and self-defeating personality disorders (PDs) are not included

in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), these diagnoses were retained because most of the included studies used DSM-III-R criteria. Comorbid diagnostic categories represented by fewer than three samples were excluded from subgroup analyses. The included studies were published between 1996 and 2022. The Structured Clinical Interview for DSM Axis II Personality Disorders (SCID-II) was the most commonly used structured diagnostic interview, whereas one study used the DSM-IV and ICD-10 Personality Questionnaire (DIP-Q) (31, 32).

The included studies comprised both clinical (n=25,065) and community (n=2,894) samples. Participants ranged in age from 15 to 80 years, and mean ages across studies ranged from 21.4 to 46.3 years (Appendix 2). Clinical samples consisted of psychiatric outpatients and inpatients with a variety of diagnoses. Community samples predominantly included university students, adults from the general population, pregnant women or mothers of infants, and members of several occupational groups. The inclusion criteria varied substantially according to the primary aim of each study. For example, alcohol dependence was an inclusion criterion in studies focusing on substance use disorders. Accordingly, participants were recruited from clinical or community settings appropriate to the objectives of the individual studies. Retrospective studies based on hospital records were also included. Forensic cases derived from forensic hospital records were categorized as clinical samples. All included studies assessed PDs through interviews conducted by psychiatrists. Sex distributions and age-related eligibility criteria varied according to the aims of the individual studies. Detailed study characteristics are presented in Appendix 2.

Pooled Prevalence of Personality Disorders

A total of 61 samples were analyzed to estimate the pooled prevalence of any PD in Turkiye (Appendix 3). In clinical samples, the pooled prevalence of any PD was 30.60% (95% confidence interval (CI) [0.2049, 0.4301]; I^2=98.2%, Q=2393.16, p<0.001). In community samples, the pooled prevalence was 15.94% (95% CI [0.1063, 0.2322]; I^2=93%, Q=215.45, p<0.05). Across all samples, the pooled prevalence of any PD was 26.06% (95% CI [0.1870, 0.3507]; I^2=97.8%, Q=6247.72, p<0.001). The difference in prevalence between clinical and community samples was statistically significant (p<0.05).

Pooled prevalence and heterogeneity estimates for individual PD diagnoses were calculated across 36 samples. The pooled prevalence of paranoid PD was 3.58% (95% CI [0.0185, 0.0680]; I^2=79.9%, Q=173.82, p<0.01). The prevalence of schizoid PD was 0.23% (95% CI [0.0005, 0.0105]; I^2=75.9%, Q=132.70, p<0.01), and prevalence of schizotypal PD was 2% (95% CI [0.0106, 0.0303]; I^2=79%, Q=152.5403, p<0.01). The pooled prevalence of ASPD was 1.08% (95% CI [0.0032, 0.0353]; I^2=81%, Q=184.51, p<0.01). BPD had pooled prevalence of 5.65% (95% CI [0.0342, 0.0920]; I^2=83%, Q=206.27, p<0.01), whereas the prevalence of histrionic PD was 2.48% (95% CI [0.0130, 0.0466]; I^2=76.2%, Q=134.70, p<0.01). The pooled prevalence of narcissistic PD was 0.9% (95% CI [0.0017, 0.0215]; I^2=86.8%, Q=243.04, p<0.01). Avoidant personality disorder (AvPD) had a pooled prevalence of 7.51% (95% CI [0.0496, 0.1121]; I^2=88.6%, Q=332.30, p<0.01). The prevalence of dependent PD was 2.92% (95% CI [0.0187, 0.0452]; I^2=3.4%, Q=63.55, p<0.01). The pooled prevalence of OCPD was 8.66% (95% CI [0.0576, 0.1281]; I^2=85.2%, Q=250.80, p<0.01). The prevalence of passive-aggressive PD was 3.45% (95% CI [0.0212, 0.0556]; I^2=77.1%, Q=130.99, p<0.01), and the prevalence of self-defeating PD was 1.18% (95% CI [0.0029, 0.0465]; I^2=69.9%, Q=29.89, p<0.01).

Subgroup Analysis

A sufficient number of samples was available to conduct subgroup analyses by psychiatric comorbidity only for the prevalence of any PD (n=53). Across these samples, the pooled prevalence of any PD among participants with comorbid psychiatric disorders was 22.70% (95% CI [0.1556, 0.3187]; I^2=97.8%, Q=2327.84, p<0.001) (Appendix 4). When the subgroups were examined, heterogeneity was low for the OCD subgroup (I^2=20.6%, Q=5.04, p=0.28) and the schizophrenia subgroup (I^2=0%, Q=1.19, p=0.55). In contrast, heterogeneity was substantial in the bipolar disorder (I^2=97.5%, Q=121.76, p<0.01), SUD (I^2=94.5%, Q=201.68, p<0.01), suicide attempt (I^2=98.8%, Q=255.05, p<0.01), and ADHD (I^2=89%, Q=18.17, p<0.01). The pooled prevalence of any PD was 8.25% in the bipolar disorder subgroup (95% CI [0.0263, 0.2304]), 41.38% in the SUD subgroup (95% CI [0.2989, 0.5389]), 47.53% in the suicide attempt subgroup (95% CI [0.1347, 0.8405]), 46.75% in the OCD subgroup (95% CI [0.3967, 0.5396]), 27.74% in the ADHD subgroup (95% CI, [0.0804, 0.6276]), and 73.55% in the schizophrenia subgroup (95% CI [0.6605, 0.7989]). The differences in prevalence across psychiatric comorbidity subgroups were statistically significant (p<0.001).

Meta-Regression Analyses

Meta-regression analyses were conducted to investigate potential sources of overall heterogeneity. Mean age did not significantly explain the observed heterogeneity (Q=1.2900, df=1, p=0.2561). Publication year also did not have a statistically significant effect (Q=3.3032, df=1, p=0.0691). In contrast, sample size significantly explained variation across samples (Q=18.6159, df=1, p<0.001).

DISCUSSION

This meta-analysis synthesized data from 61 samples comprising 28,269 participants. The overall pooled prevalence of any PD was 26.06%. It is important to emphasize that the reported prevalence of 26.06% does not represent the prevalence of personality disorders in the general population of Turkiye. Rather, it reflects the pooled prevalence across both community and clinical samples included in this meta-analysis. Nevertheless, the estimate exceeds the DSM-5 general-population prevalence estimate of 9.1% (4). In contrast to Lenzenweger (16), the discrepancy between prevalence estimates may suggest that DSM-based figures underestimate the true burden of personality disorders. However, this interpretation cannot be confirmed without evidence that the included studies were methodologically rigorous and representative of the underlying population.

High heterogeneity observed across all included studies (I^2=98.2%) may reflect methodological differences among the studies. A qualitative synthesis showed that most studies used the SCID-II as the diagnostic instrument and DSM-III-R as the diagnostic criteria. Although the studies contributing to the high heterogeneity were not methodologically identical, the variation in prevalence estimates is unlikely to be explained solely by methodological differences related to sample representativeness. To explore potential sources of heterogeneity, three separate meta-regression analyses were conducted. Mean age was not significantly associated with heterogeneity in the overall meta-analysis. The publication year also did not reach statistical significance, although the result approached the conventional threshold (Q=3.3032, p=0.0691), suggesting that temporal changes over the approximately 25-year study period may warrant further investigation. Sample size, however, significantly explained variation across studies (Q=18.6159, p<0.001). In large prevalence meta-analyses, the I^2 statistic may be inflated because large total sample sizes reduce within-study sampling error (n=28,269). Accordingly, the high heterogeneity observed in this review should not be interpreted solely as evidence of methodological weakness. It may also reflect genuine clinical variability arising from the inclusion of general-population cohorts and participants with diverse psychiatric conditions. Despite this heterogeneity, the present review provides the first comprehensive synthesis of PD prevalence across clinical and community samples in Turkiye.

The observed variation in prevalence estimates across studies is consistent with Gawda's assertion that the prevalence of personality disorders differs across cultural contexts (1). The reported prevalence of personality disorders in the general population ranges from 2% to 20% across the United States, Africa, Europe, Asia, and Australia (1, 33, 34). The pooled prevalence of 26.06% observed in the present meta-analysis appears to be slightly higher than this reported range. This finding may suggest that personality disorders are more prevalent in Turkiye; however, such an interpretation should be made cautiously because of substantial methodological and cultural differences across studies. The relatively high prevalence observed in Turkiye may also be influenced by the diagnostic criteria used, particularly given the limited number of personality disorder studies conducted in the country. Clemente et al. (6) reported that DSM-III criteria yielded lower diagnostic rates than other diagnostic systems. The high pooled prevalence is particularly noteworthy, given that most included studies used DSM-III or DSM-III-R diagnostic criteria. This finding highlights the need to consider the potential for overdiagnosis when interpreting prevalence estimates.

A systematic review of general-population studies in Western countries reported an overall PD prevalence of approximately 9% (35). These lower prevalence estimates appear inconsistent with concerns that studies using DSM-III-R may overdiagnose personality disorders. According to a global meta-analysis (36), the worldwide prevalence of personality disorders typically ranges from 5% to 10%. The findings of the present meta-analysis suggest that the prevalence of personality disorders in Turkiye may be higher than the global estimate. Therefore, additional methodologically homogeneous studies are needed to determine whether the prevalence of personality disorders in Turkiye is truly higher than that reported in other populations.

Fewer community samples were available than clinical samples. Globally, prevalence studies are conducted less frequently in community populations than in clinical samples (18). The pooled prevalence of any personality disorder in community samples was 15.94%, which was lower than that observed in clinical samples. A meta-analysis of community-based studies reported a prevalence of 7.8% (36), whereas another review estimated the prevalence at 10% (1). These findings suggest that prevalence estimates from Turkish community samples may be slightly higher than those reported in the international literature. The results also indicate that the prevalence of any PD varies according to sample characteristics. The prevalence of any PD was significantly higher in clinical samples than in community samples. However, because relatively few meta-analyses have examined prevalence across both clinical and community populations, direct comparisons remain limited. This underscores the contribution of the present study to a more integrated understanding of PD prevalence. According to a previous meta-analysis of individuals with psychiatric diagnoses in Turkiye, the prevalence of any PD was 52% (3). In the present meta-analysis, the pooled prevalence of any PD among comorbid diagnostic groups was 22.70% across 53 samples. Several methodological differences may explain this discrepancy. Most notably, Dereboy et al. (3) included only studies that used the SCID-II, whereas the present review also included studies that used other validated assessment instruments. Additionally, the inclusion and exclusion criteria were broader in the present meta-analysis. Consequently, the greater methodological diversity likely contributed to the relatively high heterogeneity observed. The broader scope of this review also allowed the inclusion of a more diverse range of samples, which may have contributed to the differences in PD prevalence estimates compared with the previous meta-analysis. The divergence between the findings of these two meta-analyses, conducted within a relatively short period in the same country, underscores the need for further research.

According to the findings, the highest prevalence of any PD was observed in the schizophrenia subgroup (73.55%), whereas the lowest prevalence was found in the suicide attempt subgroup (7.53%). The comparatively low prevalence in the suicide attempt subgroup may reflect cultural factors related to mental health, such as accessibility to services and stigma. Heterogeneity was low in the schizophrenia subgroup, suggesting that the findings were relatively consistent across studies. Given the high prevalence of PDs in this subgroup, these findings underscore the importance of routinely screening individuals with schizophrenia for comorbid PDs. Furthermore, previous evidence suggests that not only individuals with schizophrenia but also their relatives are at increased risk of PDs (4). Overall, the prevalence of any PD differed significantly across comorbid diagnostic subgroups ($p<0.0001$), indicating that individuals with schizophrenia were more likely to have a comorbid PD than those with a history of suicide attempts or the other comorbid conditions examined in this review.

The prevalence of 12 personality disorder diagnostic categories was examined in the clinical, community, and total samples. In the total sample, schizoid PD had the lowest prevalence (0.23%), whereas OCPD had the highest prevalence (8.66%). For all PD diagnoses that could be compared across clinical and community samples, prevalence was consistently lower in community samples than in clinical samples. Because the prevalence of schizotypal PD could only be estimated for the total sample, it could not be included in this comparison. Overall, heterogeneity tended to be lower in community samples than in clinical samples. Within the clinical sample, schizoid PD had the lowest prevalence (0.49%), whereas ASPD had the lowest prevalence in the community sample (0.15%). The prevalence of schizoid personality disorder in the total sample was also comparable to that of ASPD (0.19%).

Among the personality disorders most frequently reported in the literature are AVPD and BPD (7, 16). In the present meta-analysis, OCPD had the highest prevalence, followed by AVPD (7.51%) and BPD (5.65%). In a previous study conducted in Turkiye, the prevalence of BPD in a psychiatric sample was reported to be 10.2% (9). In the present review, conducted 27 years later, the prevalence of BPD in clinical samples was 9.86%. The prevalence of BPD appears to have remained relatively stable over time in both clinical and general populations. The slight difference between the two estimates may reflect changes in diagnostic practices or shifts in population characteristics over time. The prevalence of BPD observed in the present review (9.86%) is also very close to, although slightly lower than, the DSM-5 estimate for clinical populations (10%) (5). Overall, the prevalence of individual PD diagnostic categories ranged from 0.19% to 11.9%. Because PDs are chronic conditions that adversely affect multiple domains of functioning, they represent not only an individual clinical concern but also an important public health issue.

High heterogeneity was observed in many analyses, which is expected in proportional meta-analyses because of the inherent variability among prevalence studies. Although this review adhered to the PRISMA guidelines, the study protocol was not prospectively registered in a public registry such as PROSPERO. The absence of prospective registration represents a limitation in terms of review transparency. However, to minimize the risk of post hoc analytical decisions and selective reporting, all eligibility criteria, quality appraisal procedures, and statistical analysis plans were established before data extraction and implemented without deviation. Despite an extensive database search, no specific efforts were made to identify unpublished studies. Publication bias was not assessed because conventional methods for evaluating publication bias are not considered appropriate for proportional meta-analyses, as described in the Methods section. This represents a limitation of the present review. However, to minimize the risk of bias, a standardized study quality appraisal tool was applied, and no substantial methodological concerns were identified. Another limitation is that the literature search was restricted to Web of Science, PubMed, Scopus, TRDizin, and the Turkish Psychiatry Index. Comprehensive repositories of academic dissertations, such as the Turkish Higher Education Council National Thesis Center and ProQuest, were not searched. The exclusion of these sources represents a methodological limitation, as it may have resulted in the omission of relevant local research, including unpublished master's and doctoral dissertations, thereby increasing the risk of publication bias. Consequently, the pooled prevalence estimates may be slightly inflated if studies reporting non-significant or null findings were less likely to be published in peer-reviewed journals. Although the primary objectives of the included studies varied, all were retained because they reported valid prevalence estimates for PDs. Another methodological limitation relates to the search strategy. The literature search relied primarily on the term personality disorder*, without explicitly incorporating the names of individual PD subtypes (e.g., borderline personality disorder, antisocial personality disorder, narcissistic personality disorder, or obsessive-compulsive personality disorder) or relevant diagnostic codes. Although subsequent sensitivity searches using subtype-specific keywords did not identify any additional eligible studies, this search strategy may nevertheless have introduced a theoretical risk of selection bias. In particular, this approach may have excluded regional publications that focused exclusively on a single personality disorder subtype without indexing or referencing the broader term personality disorder in the title, abstract, or keywords. Nevertheless, the primary objective of this review was to estimate the prevalence of any PD. Another important limitation concerns the demographic composition of the included samples. Because community samples were not fully representative of the broader Turkish population, the estimated community prevalence (16%) may not be generalizable to older adults, rural populations, or other underrepresented groups. Finally, difficulties were encountered when transforming the data for schizotypal personality disorder, preventing separate subgroup analyses for clinical and community samples. As specified in the predefined eligibility criteria, only studies reporting the prevalence of any PD were included. Future systematic reviews and meta-analyses focusing on individual PD diagnoses may provide more robust prevalence estimates for schizotypal personality disorder.

CONCLUSION

Determining the prevalence of personality disorders is important because of their chronic and pervasive nature. As PDs are typically diagnosed using diagnostic manuals and assessment instruments developed in Western cultural contexts, questions remain regarding their cross-cultural applicability. In addition, individual prevalence studies are often limited by issues of representativeness. Consequently, proportional meta-analyses provide an important means of synthesizing the available evidence. The findings of this meta-analysis suggest that the overall pooled prevalence of PDs in Türkiye (26.06%) is relatively high compared with estimates reported in the literature. When examined by sample type, the prevalence was higher in clinical samples (30.60%), as expected given patterns of help-seeking behavior. However, the prevalence observed in community samples (15.94%) also appears higher than that reported in previous studies of non-clinical populations. This finding suggests that PDs represent a significant public health concern and should not be considered solely within clinical settings. Furthermore, high rates of PD comorbidity were observed in specific diagnostic groups, particularly among individuals with schizophrenia, OCD, and SUD. Although the existing literature indicates that personality disorders are highly prevalent, further prevalence studies and meta-analyses are needed to strengthen the evidence base.

Online Appendices Files: https://dusunenadamdergisi.org/storage/upload/files/1787827400-appendix-en.pdf

Ethical Approval: Ethical approval was not required because this study is a meta-analysis using only data from previously published studies.

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Category 1	Concept/Design	D.N.C.O., O.Y.A.
	Data acquisition	D.N.C.O.
	Data analysis/Interpretation	D.N.C.O.
Category 2	Drafting manuscript	D.N.C.O.
	Critical revision of manuscript	O.Y.A.
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