PSYCHOLOGICAL ASSESSMENT OF PERSONALITY DISORDERS ACCORDING TO ICD-11

Periš, Ivana

University of Split
Faculty of Humanities and Social Sciences
Undergraduate program Psychology

Psychological Assessment of Personality Disorders According to the ICD-11

Final thesis

Student:
Ivana Periš

Split, 2024

Department of Psychology

Psychological Assessment of Personality Disorders According to the ICD-11

Mentor:
Katija Kalebić Jakupčević

Student:
Ivana Periš

Split, September 2024

Table of Contents

1. Introduction

Personality disorders are characterized by disturbance in personality functioning, and are usually linked to significant disruptions in one's social and personal life (World Health Organization, 2024). They affect about one-sixth of the general population and over half of all psychiatric patients (Cloninger & Svrakic, 2008). The main symptoms of personality disorders include impairments in aspects of self-functioning such as identity, self-worth, ability for self-direction, and issues with interpersonal functioning which involves difficulties in establishing and maintaining close and mutually satisfying relationships, comprehending the viewpoints of others, and handling conflict in relationships (World Health Organization, 2024). Impairments in self or interpersonal functioning are manifested in maladaptive patterns of cognition, emotional experience and expression, as well as behavior (World Health Organization, 2024). Understanding these disorders is necessary, since they impact 7.8% of the world's population, with higher prevalence in high-income countries (9.6%) than in low and middle-income countries (4.3%), highlighting the significance of accurate diagnosis and treatment in enhancing patient's well-being (Winsper et al., 2020).

Previously, personality disorders were diagnosed categorically, as demonstrated by earlier versions of diagnostic manuals like the International Classification of Diseases, Tenth Revision (ICD-10). However, that approach of placing individuals into strict categories did not adequately represent the complex nature of personality pathology. With the release of the ICD-11, a shift in the classification and diagnosis of these disorders occurred, making it an important area of study.

The ICD manual has been the main standard for systematic recording, reporting, analysis, interpretation, and comparison of statistics on causes of mortality and morbidity (World Health Organization, 2024). The eleventh revision, ICD-11, was adopted by the 72nd World Health Assembly in 2019, and officially published in 2022 (World Health Organization, 2024). It is a universal system used for diagnosing and classifying diseases and health conditions, with over 70 countries being engaged in its implementation. For the first time, the ICD is completely electronic, providing access to 17 000 diagnostic categories and more than 100 000 medical diagnostic index terms, facilitating ease of use both online and offline (World Health Organization, 2024).

In the ICD-11, the ten specific personality disorders that were included in the ICD-10 were replaced with single dimensional classification personality disorder, which encompasses impairments in the functioning of aspects of the self (e.g., identity, accuracy of self-view), and/or problems in interpersonal functioning (e.g., desire and ability to develop and maintain close and mutually satisfying relationships, ability to understand others' perspectives, and ability to manage conflict in relationships) that persist over an extended period (World Health Organization, 2024).

ICD-11 allows for the diagnosis of personality disorders at three levels of severity: mild, moderate, and severe. Additionally, it includes a category relevant to this grouping called personality difficulty which represents characteristics that may affect individuals' overall functioning as well as their treatment, but do not meet the criteria for a full personality disorder. This aspect of the ICD-11 model acknowledges the spectrum of personality-related problems and ensures that all individuals get appropriate treatment and support. The classification system of the ICD-11 does not only assign a severity level, but also includes five trait domain specifiers; negative affectivity, detachment, dissociality, disinhibition, and anankastia that are measured along the continuum. The new model is also enhanced by the inclusion of an additional specifier, borderline pattern, that is applied to individuals whose personality disturbance is characterized by a persistent instability in their interpersonal relationships, self-image, and affects, as well as a noticeable impulsivity (World Health Organization, 2024).

Different viewpoints are crucial in diagnosing personality disorders since personality traits exist on a spectrum, and individual differences can be observed in their severity and manifestation. A dimensional approach, as opposed to a categorical one, provides a more flexible and nuanced view and understanding of these disorders. This enhances the relevance and precision of treatment by enabling a better alignment of diagnosis with real experiences of individuals.

The shift from the categorical to dimensional approach adopted in the ICD-11 is particularly significant because it addresses the limitations of previous systems which frequently forced individuals into rigid categories. These categorical classifications could overlook the complexity of their conditions. The ICD-11 model aims to improve diagnosis accuracy by identifying severity and specific trait domains on a spectrum. This does not only enhance the precision of diagnoses, but also allows for the modification of interventions in order to meet the needs of each individual. In the end, this approach offers a more detailed understanding of personality disorders and a better foundation for comprehending the entire range of personality-

related difficulties. Regardless of these advancements, thorough research is still required to assess the ICD-11's utility in clinical settings.

The present study aims to evaluate the ICD-11; more specifically, the purpose is to examine how effectively it functions in clinical practice and explore its efficacy in diagnosing and treating personality disorders in contrast to already established models. In particular, the changes in diagnosing personality disorders will be examined by exploring the changes made from the ICD-10 to the ICD-11. Additionally, the DSM-5, and some of the categorical inventories used for personality disorder diagnosis such as the Minnesota Multiphasic Personality Inventory (MMPI), Personality Assessment Inventory (PAI), and Millon Clinical Multiaxial Inventory-IV (MCMI-IV) will be compared with the ICD-11. Furthermore, recently established or modified tools aligned with the ICD-11 will also be taken into consideration including the Standardized Assessment of Severity of Personality Disorders (SASPD), Personality Disorder Severity (PDS-ICD-11), Personality Inventory for ICD-11 (PiCD), Five-Factor Personality Inventory for ICD-11 (FFiCD), Personality Inventory for DSM-5-Brief Form Plus (PID-5-BF). These instruments seek to provide reliable assessments of the severity and traits of personality disorders, contributing overall to more accurate diagnoses and better treatment outcomes (Widiger et al., 2024; Sleep et al., 2021).

Given the challenges in regard to the models' cultural sensitivity, the ICD-11's application to different cultures will also be explored. The cultural adaptation of the ICD-11 addresses potential biases in diagnosis and treatment and ensures its applicability and efficacy in a variety of cultural situations (Ayinde & Gureje, 2021).

Taking all that into consideration, this review aims to give insight on assessing personality disorders effectively. With the novel approach that the ICD-11 offers to the assessment of personality disorders, it is essential to evaluate its applicability as well as its validity and reliability in diverse populations and cultures. The purpose of this paper is to provide valuable understanding of the ICD-11 model by comparing it to previously established inventories used for the assessment of personality disorders. Utilizing this perspective, contributions to the ongoing improvement of personality disorder diagnosis and assessment are being made.

2. Body

2. 1. Historical Overview of Personality Disorders

Although borderline and narcissistic personality disorders are perceived as more recent and modern since the first model in which they were included was the DSM-III, the concept dates from the writings of classical times (Morey, 1997, as cited in Levy & Johnson, 2016). One of the examples of classical accounts for personality disorders is in the legend of Narcissus, the subject of the Greek myth from which the term narcissism derives. In fact, Narcissus fell in love with his own reflection in the river, showing his grandiose sense of self, as well as his lack of empathy and care for the close ones (Levy & Johnson, 2016).

Regarding modern conceptions of personality disorders, a number of psychiatry historians consider Philippe Pinel to be the first author to include personality disorders in psychiatric nosology (Crocq, 2013). Moreover, the concept of "madness without delirium" or confusion of the mind he defined contributed to the understanding of personality disorders. This term refers to behavioral and emotional disturbances without cognitive disruptions, such as delusions and hallucinations, and represents the core of personality disorders (Levy & Johnson, 2016).

However, the person who is important for the concept of personality types and dimensions that are used today is Emil Kraepelin. Kraepelin introduced the concept of "psychopathic personalities" in the early 20th century, highlighting that abnormal personalities are lifelong and a result of inborn defects rather than emerging suddenly. His work emphasized the innate and enduring nature of personality traits, which was important in later periods of diagnostic framework development. The 7th edition of Kraepelin's textbook included four types of pathological personalities: (1) the born criminal; (2) the irresolute or weak-willed, who lack capacity to work for a longer period of time; (3) the pathological liars and swindlers, characterized by hyperreactive imagination, unfaithful memory, and emotional instability; and (4) the pseudoquerulants, who correspond to today's paranoid personality (Crocq, 2013). Although most of Kraepelin's personality types that changed over time do not correspond with current measures, they influenced psychiatric diagnoses (Crocq, 2013). Nevertheless, Kraepelin's influence was preserved until the middle of the 20th century and the development of both the ICD and the DSM classification measures (Ebert & Bär, 2010).

Moreover, the beginning of the 20th century represents the earliest attempts to measure personality characteristics empirically (Pomerantz, 2023). That period is also marked by the

emergence of several elaborate systems of normal and abnormal personality (Crocq, 2013). Initially, the understanding and classification of personality disorders was merged with other mental disorders. It was only with the publication of the DSM-5 that the approach of viewing personality disorders along with other mental disorders was abandoned (Widiger, 2011). This change occurred because the earlier approach failed to capture the distinct, enduring patterns of personality disorders and the complex overlap of their symptoms that required the developments of novel diagnostic approaches (Monaghan & Bizumic, 2023).

The progression from Kraepelin's early classifications to the development of the DSM-5 and ICD-11 models shows historical advances that have been made for a better understanding and approach to the diagnosis and treatment of mental disorders, including personality disorders. Despite these improvements, there is still a need for further research and adaptation in the field of personality disorders that would ensure the effectiveness of diagnostic frameworks in clinical settings.

2. 2. The Evolution of Personality Disorder Assessment

The classification and assessment of personality disorders have undergone significant change in the last several decades, mainly due to advances in clinical and research practices. Initially, personality disorders were diagnosed using a categorical approach, dividing them into distinct and separate categories. The DSM and the ICD manuals both used this approach in their previous versions. While it offered a simple framework for diagnosis, it had significant limitations that were questioned and revised from time to time (First et al., 2004).

The first major efforts to systematically classify personality disorders began with the first edition of the DSM and the sixth revision of the ICD (American Psychiatric Association, 2024). Both measures were published after World War II, driven by the need to incorporate the outpatient presentations of veterans, including psychophysiological issues, personality disorders, and acute disorders (American Psychiatric Association, 2024). Both systems adopted a categorical approach, listing each personality disorder as a distinct entity. However, many studies have shown that the conceptualization of personality disorders into discrete categories results in failure to capture their complexity and variability, causing issues such as high comorbidity rates or the diagnosis of unspecified personality disorders since the expression of different symptoms continuously changes throughout one's lifespan (Ekselius, 2018). This rigid approach frequently led to oversimplified diagnoses that failed to measure the complexity of personality pathology.

In response to these limitations, contemporary nosology has largely shifted toward a dimensional perspective. The dimensional approach allows for a more sophisticated insight into personality pathology, meaning that clinicians evaluate patients along a continuum of traits and symptoms rather than classifying disorders into distinct groups. By application of this method, varying degrees of severity and stylistic differences are being captured. These models capture two criteria: severity and style (Monaghan & Bizumic, 2023).

Severity is related to the core distress that is present in all personality disorders, self-direction, intrapersonal functioning (i.e., identity), and interpersonal functioning issues (i.e., ability to form close relationships). According to the ICD-11, severity is the key requirement for making a diagnosis since it indicates the existence of dysfunction (Monaghan & Bizumic, 2023). Severity captures the core distress common to all personality disorders, reflected in the domains of self-direction, identity, and ability to form close connections (Monaghan & Bizumic, 2023). This is assessed by several factors: 1) the degree and pervasiveness of disturbances in relationships and sense of self, 2) the intensity and breadth of emotional, cognitive, and behavioral manifestations, 3) the extent of distress or psychosocial impairment, and 4) the level of risk to self and others (Swales, 2022). For a diagnosis, these disturbances must persist for at least two years, must not be attributable to cultural or social factors, and must cause significant distress or impairment in daily life (Swales, 2022). The intensity and pervasiveness of symptoms determine the severity, which in turn influences the treatment's intensity, frequency, setting, and level of care required (Bach & Simonsen, 2021, as cited in Swales, 2022).

The stylistic features that comprise the second criterion are derived from the Five-Factor Model (FFM). The FFM model comprises five broad trait dimensions, commonly known as the "Big Five": extraversion, agreeableness, conscientiousness, neuroticism, and openness to experience (Soto & Jackson, 2020). The FFM model was created to capture the wide range of individual personality differences using only a small set of trait dimensions. A number of psychologists agree that these five dimensions represent the most essential features and that many alternative trait models can be conceptualized in terms of the FFM structure (Soto & Jackson, 2020).

In the process of diagnosis the first step is to assess whether the person's difficulties meet the general requirements for a personality disorder. Afterwards, if these requirements are met, clinicians assess the severity of the difficulties (Swales, 2022). Lastly, there are two optional steps

that involve the description of the person's difficulties. Based on the Big 5 paradigm, ICD-11 has five trait domain specifiers that are relevant to typical personality traits (McCrae & Costa, 1987, as cited in Swales, 2022). Although the majority of research supports this five-factor framework, some propose four factors where one incorporates elements of anankastia and disinhibition (Bach et al., 2020; Oltmanns & Widiger, 2018, as cited in Swales, 2022). Severe examples of personality disorders can manifest with only one trait domain, but they frequently show numerous prominent qualities (Swales, 2022).

The 2013 release of the DSM-5 marked a significant change in the way personality disorders were classified, including a dimensional approach to diagnosis and classification with a categorical approach (American Psychiatric Association, 2013). The Alternative Model of Personality Disorders (AMPD), which incorporates a dimensional assessment of personality traits and severity, was introduced in the Section III of the DSM-5. This model provides a thorough assessment of personality pathology by utilizing the Level of Personality Functioning Scale (LPFS) along with 25 traits organized within five broad domains (negative affectivity, detachment, antagonism, disinhibition, and psychoticism) (Gore & Widiger, 2013). The AMPD enabled more nuanced assessment, resulting in a smaller gap between dimensional and standard categorical models.

The categorical approaches had several issues, one of them being low reliability, where individuals might show inconsistent results over a period of time. The reason for this inconsistency is that the categorical approach forces personality disorders into rigid, distinct categories which don’t always adequately represent the variability of an individual’s symptoms. Another problem with this classification is high comorbidity, where a person could show symptoms of multiple personality disorders, thus making it hard to determine the diagnosis and the best treatment options. Additionally, within-disorder heterogeneity marks another limitation of the categorical system where people with the same diagnosis might display different symptoms, leading to inadequate treatment outcomes. Furthermore, according to Hopwood et al. (2018), there is no evidence to support the hypothesis that personality disorders are categorical or that there is a specific number of discrete types of personality disorders.

The release of the ICD-11 in 2018 represents a step forward in the classification system for personality disorders since it completely incorporates a dimensional approach that is strongly supported by numerous empirical studies. By applying a dimensional approach, the DSM-5 AMPD

and the ICD-11 provide a more precise and accurate assessment of personality disorders. This allows for a more individualized and efficient treatment because a person's unique combination of traits and severity is evaluated. For instance, someone who was previously diagnosed with narcissistic personality disorder might now receive a more tailored treatment plan that addresses the specific traits and severity of their condition. This approach contrasts with the one-size-fit-all method that is adopted by categorical manuals like the earlier versions of the DSM, where the same diagnostic rules are applied across all individuals, without taking into account individual differences. A number of studies comparing the DSM-5 AMPD with the ICD-11 have shown that both frameworks demonstrate sufficient psychometric qualities and are effective in clinical settings (Pan & Wang, 2024). Studies like this demonstrate the clinical utility of the dimensional models by highlighting their consistency and reliability in measuring the severity and traits of personality disorders.

Despite all these advancements, there are still issues with guaranteeing the cultural sensitivity of these models. There is a need for more exploration of the clinical nature of personality disorders and how the constructs describing them function across cultures, especially given the fact that personality disorders have long been a group of highly controversial disorders (Ayinde & Gureje, 2021). Ensuring that assessment tools are culturally adapted and validated is crucial for their effectiveness in global mental health practice. Without cultural sensitivity, there is a risk of misdiagnosis or inappropriate treatment recommendations.

The assessment of personality disorders has changed throughout time, moving from rigid categorical classifications to more flexible and comprehensive dimensional models. By acknowledging the complexity of personality disorders, this shift in the DSM-5 and ICD-11 aims to enhance both the accuracy of diagnosis and treatment outcomes. It is expected that these models will become more useful in clinical practice as research on their validity in various contexts progresses, eventually leading to better patient care.

2. 3. Evolution and Classification of Personality Disorders in the ICD

The evolution of the ICD model and classification of personality disorders has evolved significantly over time. The first ICD model was released in 1900 under the name The International List of Causes of Death (ICD-1) (Hong & Zeng, 2022). However, the first ICD model that included personality disorders was the ICD-6, published in 1949, during the early development of the DSM (American Psychiatric Association, 2024). Still, the detailed classification of personality disorders

in the ICD model began with the publication of the ICD-10 in 1992 (World Health Organization, 1992). This progression emphasizes the growing recognition of personality disorders as distinct clinical entities and the need for specific diagnostic criteria.

The tenth revision of the ICD had personality disorders categorized under Chapter V by the name "Mental and Behavioral Disorders". The classification system included ten categories, each for a specific type of personality disorder. The categories were paranoid personality disorder, schizoid personality disorder, dissocial (antisocial) personality disorder, emotionally unstable personality disorder with two subtypes: impulsive type and borderline type, followed by histrionic personality disorder, anankastic personality disorder also called obsessive-compulsive personality disorder, anxious (avoidant) personality disorder, dependent personality disorder, other specific personality disorders, and personality disorder unspecified. Many instruments have been created to help in the accurate diagnosis of these disorders. One such tool is the International Personality Disorder Examination (IPDE), a semi-structured clinical interview that was designed to provide information from individuals who fulfill 10 or more criteria from the listed personality disorders but do not meet the requirements for the diagnosis of any specific disorder (Loranger et al., 1997). Loranger et al. (1997) noted that many behaviors characteristic of different personality disorders exist on a continuum with normality. This implies that the traits associated with personality disorders are not completely distinct from normal personality traits, but rather represent a more extreme or maladaptive form of typical behavior.

Many studies have noted a large percentage of dissatisfaction with the present classification and diagnostic system of personality disorders among clinicians and researchers (Bernstein, Iscan, Maser, & Boards of Directors of the Association for Research in Personality Disorders, 2007; Clark, 2007; as cited in Tyrer et al., 2014). This dissatisfaction is mainly the product of the ICD-10 categorical system, which has been criticized for its limited clinical utility and failure to capture the spectrum of personality pathology (Tyrer et al., 2011). For instance, when individuals exhibited characteristics of multiple personality disorders, clinicians had to diagnose them with a mixed personality disorder. Similarly, in cases where an individual's symptoms did not meet the full criteria for any specific personality disorder, but caused distress in everyday functioning, they would be diagnosed with a personality disorder not otherwise specified (PDNOS). Mixed personality disorder and PDNOS were extensively used because of the failure of the categorical system. A meta-analysis by Verheul & Widiger (2004) reported that the PDNOS accounted for

approximately 21 to 49% of the overall Axis II prevalence. Another study reported that the PDNOS was diagnosed in 21.6% of cases when considered on its own. Much higher percentage of the PDNOS diagnosis would be 70.8% if co-occurrence with the 10 officially recognized personality disorders is allowed (Verheul et al., 2007). These percentages indicate that the presence of PDNOS, especially in co-occurrence with a formal personality disorder, is associated with more severe problems and overall clinical presentations. Additionally, the study indicated a 12% prevalence of mixed personality disorder diagnosis (Verheul et al., 2007). Notably, it has been highlighted by Tyrer et al. (2014) that only borderline and antisocial personality disorders, two of the most frequently diagnosed personality disorders, have been the only ones reported in official statistics applicable to the categorical approach. This problem stems from the categorical nature of the previous manuals and has been reported by Verheul et al. (2007). This over-reliance on a few specific diagnoses can hide the true prevalence and diversity of personality disorders in the population, underscoring the necessity for a more comprehensive diagnostic framework.

Tyrer et al. (2011), reported another major deficiency of categorical measures due to the failure to acknowledge the dimensional nature of personality disturbance. Furthermore, dividing the population into those with and those without personality disorder does not reflect the whole range of personality pathology (Tyrer et al., 2011). Another reason for the reluctance to use the categorical approach for diagnosis in clinical practice, as stated by Tyrer et al. (2011), is the stigmatization of these disorders, even though they are common worldwide. The dimensional model not only improves diagnostic accuracy, but also reduces stigma because they are portrayed as extensions of normal personality traits rather than distinct abnormalities.

With the goal of creating a more complete framework and acknowledging these problems, the process of reclassification began with the ICD-11. In order to avoid possible mistakes that can occur using a categorical approach and because of the complexities regarding clinical utility, the ICD-11 Working Group avoided making a hybrid model and made a completely dimensional model (Tyrer et al., 2019). As Bagby & Widiger (2020) highlight in their study, the main change is that the ICD-11 replaced all of the ICD-10 classified personality disorder syndromes with a five-domain (negative affectivity, detachment, dissociality, disinhibition, and anankastia) trait model. In more severe types of personality disorders, these trait domains often co-occur, underscoring the complex nature of these conditions (Huprich, 2020). By applying this approach, improvements in

clinical practice as well as more tailored and effective interventions for individuals with personality disorders are expected.

The shift from the ICD-10 to the ICD-11 shift led to the restructuring of the disorder groupings, with an expansion from 11 to 21 groupings overall (Gaebel et al., 2020). This transition from the tenth to the eleventh revision of the ICD also reflected a more refined understanding of personality disorders and their diagnosis. According to Reed et al. (2019), the ICD-11 represents a major step forward in the categorization of mental and behavioral disorders, emphasizing a dimensional approach to improve diagnostic accuracy. The new approach offers greater simplicity and clinical utility for the diagnosis, with improved differentiation of patients who need complex treatments from those who require simpler ones, and a better mechanism for tracking changes that occur over time than the ICD-10 classification (Reed et al., 2019). This shift to a dimensional model shows a better reflection of personality pathology as it addresses many of the limitations of the categorical approach. It eliminates rigid boundaries between disorders that often result in high rates of comorbidity, and reduces the overuse of unspecified diagnosis (Reed et al., 2019). Previous categorical systems struggled with these issues forcing clinicians to fit patients into defined categories, frequently failing to capture the full spectrum of personality pathology (Reed et al., 2019).

2. 4. Overview of the DSM Development

Although literary writings describing personality disorders date back thousands of years, the official diagnosis of personality disorders as an independent entity did not arise until the first edition of the DSM, published in 1952 (American Psychiatric Association, 1952, as cited in Coolidge & Segal, 1998). It became the first official manual glossary of mental disorders, with an emphasis on clinical use (American Psychiatric Association, 2024). This represented a significant step towards a more structured approach to understanding and diagnosing mental health disorders. Three distinct categories within the DSM were cardinal personality types (inadequate personality, schizoid personality, cyclothymic personality, and paranoid personality), personality trait disturbances (emotionally unstable personality, passive-aggressive personality, and compulsive personality), and sociopathic personality disturbances (antisocial reaction, dissocial reaction, sexual deviation, and addictions) (Coolidge & Segal, 1998). Despite this significant advancement in the diagnosis of personality disorders, psychological tests for assessment of the disorders were still not developed at that time (Coolidge & Segal, 1998). The early absence of specific assessment

tools in the early stages of the DSM indicates the beginning of psychological diagnostic development.

The second edition of the DSM consisted of seven personality traits from the first edition and three additional (paranoid, cyclothymic, schizoid, explosive, obsessive-compulsive, hysterical, asthenic, antisocial, passive-aggressive, and inadequate personality). Also, another update that was present in the DSM-II were two additional categories of personality disorders: "other" type and "unspecified" type (Coolidge & Segal, 1998). These updates show the beginning of a growing recognition of the complex nature of personality disorders.

The publication of the DSM-III in 1980 represents a turning point in the history of personality disorders, including a multiaxial diagnostic approach and specific criteria for each disorder (American Psychiatric Association, 2024). The major alteration was the expansion of the manual's content, the shift from a psychoanalytic to a behavioral perspective, and the categorization of personality disorders into clusters. This shift represents a move towards more empirical methods in the process of diagnosis. An innovative multiaxial approach divided psychiatric diagnosis into five separate "axes", with personality disorders being classified on the Axis II along with some types of childhood problems (Coolidge & Segal, 1998). It was found that 40% to 50% of patients with a diagnosis of Axis I (major clinical syndromes such as depression, schizophrenia, etc.) also had an Axis II personality disorder (Coolidge & Segal, 1998). This shows the importance of the evaluation of personality disorders, as well as the improved validity and reliability of diagnoses from the previous models of the DSM. Another important aspect of the DSM-III is the number of criteria required for a personality disorder diagnosis. The set of criteria was "polythetic" meaning that there is no one criteria essential to get diagnosis (Coolidge & Segal, 1998). A more sophisticated view of personality disorders was made possible by this approach, acknowledging that individuals may have distinct symptoms while still meeting the criteria for the same condition.

Overall, the DSM-III included 11 personality disorders, four of them remaining from the previous two models of the DSM (paranoid, schizoid, antisocial, and passive-aggressive). The hysterical personality disorder from the DSM-II was changed into histrionic personality disorder, and obsessive-compulsive personality disorder changed back to its original name from the first edition of the DSM into compulsive personality disorder. Five new personality disorders were schizotypal, narcissistic, borderline, avoidant, and dependent (Coolidge & Segal, 1998).

Additional categories present in the DSM-III were “atypical”, “mixed”, and “other personality disorders” (Coolidge & Segal, 1998). A more methodical and evidence-based approach was adopted with the DSM-III, which established distinct criteria for each personality disorder and categorized them into three clusters: odd or eccentric clusters of personality disorder were in cluster A (paranoid, schizoid, and schizotypal); dramatic, emotional, or erratic personality disorders comprised cluster B (histrionic, narcissistic, antisocial, and borderline); and anxious or fearful personality disorders were in cluster C (avoidant, dependent, and obsessive-compulsive) (Coolidge & Segal, 1998). Each cluster comprises personality disorders that are characterized by specific shared qualities, as well as differences between each of them. The clustering system helped clinicians gain a better understanding of the similarity between personality disorders that share some common characteristics. This is also of special importance in cases of comorbidity.

Cluster A, or the eccentric personality type generally appears suspicious, isolated, and odd. If each personality disorder within the cluster is looked into, the conclusion that would arise is that individuals with paranoid personality disorders show distrust; those with schizoid personality disorders are detached and isolated, experience difficulty forming relationships, they have a decreased ability to express emotions (known as blunted affect), and are also indifferent to the criticism or praise. The last personality disorder within this cluster is schizotypal, whose traits overlap with odd behaviors and thoughts similar to schizophrenia, like inappropriate affect, magical thinking, and abnormal visual experiences (Fariba et al., 2023).

Histrionic, narcissistic, antisocial, and borderline personality disorders within Cluster B are known for their dramatic and incoherent nature. Histrionic individuals are attention seekers who display exaggerated emotions, while narcissistic individuals lack empathy and seek admiration for their grandiosity. Antisocial personality disorder is marked by a disregard for other people’s rights as well as legal and social norms, which frequently results in criminal activity. Intense relationships, self-harm, and emotional instability are the hallmarks of borderline personality disorder (Fariba et al., 2023).

Anxiety and fearfulness characterize Cluster C personality disorders, which include avoidant, dependent, and obsessive-compulsive personality disorders. People who are avoidant have low self-esteem and avoid social situations out of concern about being criticized. Those with dependent personality disorder depend unduly on other people for emotional support, while

individuals who are diagnosed with obsessive-compulsive personality disorder are perfectionists who are rigid and overly conscientious (Fariba et al., 2023).

Seven years later, the revision of the DSM-III was published, called the DSM-III-R. The only novelty in the revised model were two new personality disorders, sadistic and self-defeating, placed in Appendix A, meaning that more research was needed in order to be included in the categorical system (Coolidge & Segal, 1998).

The DSM-IV, published in 1994, refined the criteria for personality disorders by removing passive-aggressive personality disorder from Cluster C and placing it in Appendix B for further study under the alternate name "negativistic personality disorder". The DSM-IV also introduced depressive personality disorder in Appendix B while eliminating sadistic and self-defeating personality disorders (Coolidge & Segal, 1998).

The shift towards a hybrid dimensional-categorical classification of personality disorders is evident in the most recent publication of the DSM-5 model (Trull & Widiger, 2013). The DSM-5 model is closely aligned with the Five Factor Model (FFM) of personality traits. The Section III of the DSM-5 introduces a dimensional aspect by organizing 25 traits into five broad domains (negative affectivity, detachment, antagonism, disinhibition, and psychoticism) that are similar to the FFM (Gore & Widiger, 2013). This model simplifies the FFM which uses over 100 traits, to just 25 traits in order to ensure clinical practical application. Although the convergence between the two models is great, unlike the FFM's bipolar structure, the DSM-5 model is unidimensional, simplifying the trait model to make it more accessible in clinical practice (Trull & Widiger, 2013). The alignment with the FFM represents a significant step forward in the integration of personality theory with clinical practice. However, while the DSM-5 introduces a dimensional trait-based model, it also retains the traditional categorical structure of ten personality disorders classified within three clusters (Cluster A, Cluster B, and Cluster C) (Fariba et al., 2023). Moreover, these ten personality disorders remained unchanged and are being described as pervasive, maladaptive, and chronic patterns of behavior, thinking, and feeling that cause distress and dysfunction (Fariba et al., 2023). Retaining these clusters while incorporating a dimensional approach reflects an attempt to find a balance between tradition with innovation in personality diagnosis.

At time of the DSM-5 publication, the Personality Inventory (PID-5) for assessment of personality traits in self-report and informant formats was developed (Clark et al., 2021). The PID-5 is a 220-item self-report questionnaire that assesses the five domains of maladaptive personality

traits of the DSM-5 AMPD (negative affectivity, detachment, antagonism, disinhibition, and thought disorder or psychoticism) (Oltmanns & Widiger, 2019). Moreover, the briefer 36-item Personality Inventory for DSM-5 and ICD-11 Plus (PID5BF+) derived from the original PID-5 and covers both DSM-5 and ICD-11 trait domains, including 18 facets (Bach et al., 2020; Kerber et al., 2022, as cited in Sellbom et al., 2022).

2. 5. Comparison of the ICD-11 and DSM-5 Models

According to the current diagnostic system of personality disorders, the ICD-11 and the DSM-5 aim at a dimensional examination of the severity and stylistic features that accompany the disorder (Hualparuca-Olivera et al., 2023). This implies that both models evaluate the extent and characteristics of the disorders rather than only classifying them. What the DSM-5 and ICD-11 have in common is that both manuals include several measures that have been developed to assess personality disorder severity and traits (Hualparuca-Olivera et al., 2023). These measures give clinicians a more comprehensive picture of the severity of the disorder and specify the traits present in a patient, thus enabling them to get a better understanding of the disorder, as well as to offer patients better treatment outcomes.

Hualparuca-Olivera et al. (2023) evaluated whether there is a sufficient relationship between personality disorder measures of the ICD-11 and DSM-5 AMPD in the general population. Anankastia, psychoticism, and the borderline pattern were not compared since they are not comparable between the two models. Their study found moderate convergence between these models overall, although higher association would be more satisfactory given that they measure the same constructs. However, these results show empirical support for the interchangeable utility of these measures. This implies that clinicians can employ either system with confidence as they provide consistent and reliable information about the severity and traits associated with personality disorders. This can enhance the precision of diagnoses and ensure that patients receive the necessary treatment and care. This reliability across systems underscores the importance of standardized assessment tools.

Widiger et al. (2024) also highlighted the importance of a multimethod approach to enhance diagnostic accuracy. That type of approach involves using a variety of diagnostic frameworks and instruments, including both self-report inventories and semi-structured interviews. Such a comprehensive strategy enables the gathering of more thorough and reliable data on patients' personality disorders. Using multiple methods reduces the limitations of a single

diagnostic tool and increases the chances of a more accurate understanding of the patient's diagnosis.

For instance, there are five semi-structured interviews within the Diagnostic and Statistical Manual-5-Text Revision (DSM-5-TR) Section II personality disorders: Diagnostic Interview for Personality Disorders (DIPD), IPDE, Personality Disorder Interview-IV (PDI-IV), Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II), and Structured Interview for DSM-IV Personality Disorders (SIDP-IV) (Widiger et al., 2024). Among these, the PDI-IV is considered the most detailed in providing information about history, rationale, and major assessment issues for each of the personality disorder diagnostic criteria (Widiger et al., 2024). Semi-structured interviews are a source of qualitative data that supplement the quantitative information obtained from the self-report questionnaires.

These measures assess the DSM-5-TR Section II of personality disorders. However, Section III of the DSM-5-TR provides an AMPD consisting of a Level of Personality Functioning Scale (LPFS) and a five-domain dimensional trait model (negative affectivity, detachment, psychoticism, antagonism, and disinhibition) (Krueger & Hobbs, 2020). Compared to the traditional categorical approach, the dimensional approach, which encompasses these five domains within the ICD-11 model, offers a deeper understanding of personality disorders. Moreover, the DSM-5-TR also includes 25 underlying facets, all of which can be measured by the PID-5 (Widiger et al., 2024). These facets allow more detailed assessment and evaluation of personality traits, which can help tailor treatments more precisely to an individual's needs.

The specific scales within the model, such as the Level of Personality Scale-Brief Form (LPFS-BF), the DSM-5 Levels of Personality Functioning Questionnaire (DLOPFQ), the Self and Interpersonal Functioning Scale, and the specific Criterion A scales, all assess impairment tailored to each personality disorder (Sleep et al., 2021). However, despite high correlation, internal consistency, and convergence with other impairment measures, these measures lack discriminant validity, leading to different arguments among theorists (Sleep et al., 2021). While some debated that the lack of discriminant validity is problematic since it is important in differentiating between various diseases, others believed that the measures might be capturing a broader issue with personality functioning. Discriminant validity is crucial as it ensures that the tools accurately distinguish between different disorders, which is necessary for both effective diagnosis, and appropriate treatment planning.

Even though there are differences between the ICD-11 and the DSM-5, the two models share a five-domain trait model. However, the ICD-11 contains an additional borderline domain. This inclusion attempts to capture more specific aspects of personality disorders that are prevalent in clinical settings. The DSM-5 AMPD and ICD-11 trait models are very similar; indeed four domains are nearly identical: negative affectivity, detachment, antagonism/dissociality and disinhibition. They differ in the domain of psychoticism included in the DSM-5 AMPD, while the ICD-11 has an anankastia domain (Sellbom et al., 2022). Even though the assessment of the shared four domains is relatively comparable, a thorough assessment of the anankastia domain, which primarily focuses on the application of the rigid perfection facet of the disinhibition domain, is somewhat limited when attempting to use DSM-5 AMPD measures (Sellbom, 2022).

Although there are no specific interviews yet developed for the assessment of ICD-11, like for the DSM-5, there are independent measures of the ICD-11 trait models, such as the PiCD, the Preliminary Scales for ICD-11, and the Personality Assessment Questionnaire for ICD-11 (PAQ-11), as well as the Personality Assessment Form, from which the ICD-11 was derived (Widiger et al., 2024). The PiCD was developed to assess the five domains but does not include facet-level scales, which some researchers suggest could provide a more detailed assessment (Oltmanns & Widiger, 2020). By assessing a person's functioning on a facet model, clinicians can develop a more comprehensive understanding of their state and tailor their treatment accordingly. They represent a better approach to dimensional scales, moving from a narrower to a more unique approach to each individual.

Additionally, Bach et al. (2017) identified 16 out of 25 PID-5 instruments that align between the DSM-5 and ICD-11 models, supporting the use of these measures across both systems, as cited in Widiger et al. (2024). The model within the ICD-11 that was developed by Olajide et al. (2018), the SASPD, comprises nine items aligned with the ICD-11 impairment model, demonstrating good internal consistency and convergence with the DSM-5 impairment measures, and has been translated into several languages (i.e., Danish, German, and Spanish) (Sleep et al., 2021). The translation and validation of such tools guarantee their applicability in various cultural contexts, thereby enhancing their global use.

It is also important to recognize these models' clinical utility. Clinicians can better understand and treat personality disorders in a variety of populations by using the DSM-5 and the ICD-11 frameworks, which offer improved diagnostic as well as treatment outcomes (Bach et al.,

2021). Although this shows extensive knowledge about the general clinical utility of personality disorder severity and dimensional assessment, specific evidence supporting the ICD-11's diagnosis of personality disorders is still required (Bach et al, 2021). The ICD-11 model is expected to assist in clinical decision making, including relevant allocation of treatment resources such as its length, type, and intensity (Bach et al., 2021). There is growing evidence that, despite the familiarity of mental health professionals with the ICD-10 and the DSM-IV, the latest editions are perceived to have better clinical utility (Hansen et al., 2019, as cited in Ayinde & Gureje, 2020). Moreover, the DSM-5 was perceived to be equally or more useful than DSM-IV-TR on several measures while the AMPD trait model was perceived to be more useful than the DSM-IV-TR in five out of six aspects of clinical utility (Hansen et al., 2019, as cited in Ayinde & Gureje, 2020).

While the earlier version of the DSM-IV incorporated brief descriptions of cultural features characteristic for certain disorders, and listed "culture-bound syndromes" the ICD-10 broadly noted the presence of cultural variations (Gureje et al., 2019). In the process of the ICD-11 development, the Working Group made a guidance on cultural considerations within the model that would raise its global applicability (Gureje et al., 2019). The guidelines are designed to assist the clinician in making informed decisions that would promote patient-centered care that is sensitive to the cultural and social background (Gureje et al., 2019). However, the scientific data on cultural variation remains limited, as it often relies on Western research, so contributions from diverse global populations are essential (Gureje et al., 2019).

2. 6. The ICD-11 Personality Trait Domains

While it is possible to have a severe personality disorder and just exhibit one trait domain, people with more severe personality disturbances typically exhibit more dominant traits. So in order to obtain a full picture of the condition, it is necessary to examine all trait domains.

Experiencing frequent and strong unpleasant emotions such as grief, anger, and anxiety that are typically interpreted by others as disproportionate, but reasonable given the person's circumstances is known as negative affectivity (Swales, 2022). This trait highlights the subjectivity of emotional reactions and the significance of context in understanding an individual's emotional state. The presence of other personality traits such as disinhibition, detachment, and anankastia might influence the manifestation of this trait, which results in emotional instability, low self-

esteem, and dependency on others (Swales, 2022). Understanding these interactions is relevant for the development of more effective and individualized treatment plans.

Detachment, which can be social or emotional, is characterized by the avoidance of social situations and close relationships, as well as a restricted range of emotional expression and experience. As a result, a person may be lonely, distant, and have limited emotional reactions and enjoyment (Swales, 2022). This domain aligns with the schizoid personality disorder from the ICD-10 (Ekselius, 2018).

Disregard for the rights and feelings of others, self-gratification, and a lack of empathy are traits of dissocial or antisocial personality disorder. This type of person may be entitled, constantly seek praise, and completely focused on their own needs and wants, while frequently reacting angrily when others do not meet their expectations (Swales, 2022).

Disinhibition appears as impulsivity, distractibility, irresponsibility, recklessness, and poor planning. This trait frequently coexists with traits that were previously classified as borderline, narcissistic, or histrionic personality disorders. This overlap indicates the interconnectedness of personality traits, suggesting that a comprehensive diagnostic approach offered in models such as the ICD-11 is essential.

Individuals high in anankastia, a personality trait characterized by perfectionism, and strict adherence to personal standards and rules, often tend to rework others' tasks to meet these standards. They are preoccupied with order, control, and social rules, leading to rigidity, difficulty in decision-making, minimal emotional expression, and an aversion to spontaneity and risk (Swales, 2022).

Borderline personality disorder is characterized by a pattern of instability in interpersonal relationships, self-image, and emotions, along with impulsivity and self-harm (Brüne, 2016). The criteria set for this disorder are similar to those used for disinhibition. Symptoms of this condition include identity disruption, passionate and unstable relationships, excessive rage, persistent feelings of emptiness, and frantic attempts to prevent abandonment. Despite the high prevalence of BPD and its associated risk of suicide, it is frequently disregarded due to the misconception that its symptoms are indicators of manipulative behavior rather than signs of an illness, even though it has clear diagnostic characteristics (Ekselius, 2018). Because of this type of misunderstanding, stigmatization, followed by smaller chances for seeking help, leads to inadequate care. This proves

that despite all improvements in adequate measures, there is a need for better education and awareness among clinical professionals as well.

2. 7. Assessment Tools for Personality Disorders in the ICD-11

Since the initial draft proposal of the ICD-11 model, research has mainly focused on developing and adapting self-report measures for it (Sellbom et al., 2022). This type of measure has been created recently, mainly to address the severity aspect of personality disorders (Clark et al., 2021).

Two prominent measures developed within the ICD-11 framework are the SASPD and the PDS-ICD-11. The SASPD is a 9-item self-report instrument developed by Olajide et al. (2018) that evaluates the severity of personality disorder based on disability levels in nine areas of functioning. Four of them have an interpersonal focus (friendships, being with others, trusting others, and caring about others), and the other five have an intrapsychic/behavioral focus (two of them cover affect and emotional regulation, and the other three assess acting on impulse, being organized, and self-reliance) (Clark et al., 2021). On the other hand, Bach et al. (2021) developed the PDS-ICD-11, a 14-item measure that also assesses the severity aspect of personality dysfunction. Four of the items measure self-dysfunction; the other four measure interpersonal dysfunction, three items assess domains in which personality dysfunction is manifested; and the last three measure the extent of distress or disability caused by dysfunction (Clark et al., 2021).

Apart from these two measures focused on the severity aspect, there are additional measures that have been developed to assess the trait domain qualifiers (Clark et al., 2021). Oltmanns and Widiger (2018, 2020) created the 60-item PiCD and the 121-item FFiCD.

Other measures were developed based on the existing measures of personality traits, each differentiating in language and population that they assess (Clark et al., 2021). Bach et al. (2017) developed a 143-item measure available in Danish and English, sharing 16 PID-5 trait facets (Clark et al., 2021). The 158-item measure by Sellbom et al. (2020) is an updated version of the measure by Bach et al. (2017) and consists of two additional PID-5 facets (Clark et al., 2021). Furthermore, there is the 34-item PID-5-BF+ by Kerber et al. (2020) that assesses the personality disorder according to the ICD-11 criteria by using two items each from 17 facets of the PID-5, and the 36-item Modified Version of the Personality Inventory for DSM-5-Brief Form Plus (PID5BF + M) that assesses the ICD-11 model using 18 PID-5 facets along with the Psychoticism domain of the AMPD (Clark et al., 2021). The modified version is available in 12 different European languages,

as well as Brazilian Portuguese (Clark et al., 2021). The last instrument within the ICD-11 personality disorder model is a 40-item measure that was based on the Personality Assessment Schedule (PAS), and that was later used for the development of the 17-item self-report version of the Korean PAQ-11, developed by Kim et al. (2021) (Clark et al., 2021; Sellbom et al., 2022).

In conclusion, the ICD-11 framework for personality disorder assessment is supported by a number of adequate tools. These instruments provide a comprehensive evaluation that enables researchers and clinicians to assess the severity and complexity of personality disorders, facilitating precise diagnosis and, in the end, effective treatment planning.

2. 8. ICD-11 Personality Disorder Assessment Tools in Practice

Along with the ICD-11 publication, several assessment tools have been developed and validated to align with the dimensional approach to personality disorder diagnosis. The purpose of these tools is to offer more accurate and sophisticated techniques for diagnosis and evaluation of personality disorders.

Rek et al. (2019) investigated the psychometric properties of the German version of the SASPD in a mixed sample. Although SASPD captures some features of personality disorder severity, it does not fully adhere to a unidimensional structure, and its convergent and discriminant validity are modest. Despite the fact that this aspect limits its clinical utility for accurate assessment of severity, its total score could be a useful indicator for a broad spectrum of personality disorder features (Rek et al., 2019). Because of these conclusions, a revision of the SASPD by incorporating specific items on self and interpersonal impairments is required. Another option is to use alternative measures like the LPFS-BF 2.0 developed within DSM-5 that demonstrate a coherent factor structure, great internal consistency, high construct validity, and high sensitivity to change (Weekers et al., 2018).

Tarescavage et al.'s (2020) study focused on the PiCD, which demonstrated adequate internal consistency and generally showed adequate discriminant and convergent validity, particularly for the negative affectivity, disinhibition, and dissocial scales. However, detachment and anankastia had mixed validity results, suggesting potential content domain limitations, and factor analysis indicated that anankastic and disinhibition might be better conceptualized as opposite poles of a single construct (Tarescavage et al., 2020). To provide cross-cultural evidence for the reliability and validity of the PiCD, Somma et al. (2020) conducted research on the Italian adult community population. The research supported the unidimensionality hypothesis for the

PiCD negative affectivity, detachment, and dissocial scale items, whereas for the disinhibition and anankastic traits, a bifactor model, which accounts for both general and specific factors, provided an adequate fit. Somma et al. (2020) also found the 4-factor model to be an appropriate fit for the PiCD scale. Lastly, the PiCD scales demonstrated good internal consistency, test-retest reliability (Somma et al., 2020). The 4-factor structure for the PiCD was also found in a study done by Carnovale et al. (2020), with anankastia and disinhibition seen as distinct factors. They additionally found that the PiCD exhibited good internal consistency reliability (Carnovale et al., 2020).

Gutierrez et al. (2020) adapted the SASPD and PiCD to Spanish in order to assess the ICD-11 personality disorders' traits and severity. The PiCD demonstrated good reliability, while the SASPD had lower reliability. Furthermore, the PiCD's 4-factor structure was more replicable and consistent than the 5-factor model, which goes in line with previous research by Somma et al. (2020) and Carnovale et al. (2020). In terms of criterion validity, all PiCD domains correlated with the SASPD except for anankastia (Gutierrez et al., 2020). Finally, only negative affectivity, and to a lesser extent, detachment and dissociality, can predict SASPD scores (Gutierrez et al., 2020). This implies that negative affectivity was the most influential factor in predicting the severity of personality disorders as measured by the SASPD.

Bach et al. (2021) developed and evaluated the PDS-ICD-11, 14-item scale that demonstrated strong unidimensionality and reliability. It also showed good criterion and incremental validity and substantial convergence with other measures of personality disorder severity and psychosocial impairment, including LPFS-BF, SASPD, the Measure of Disordered Personality Functioning (MDPF), the Social Functioning Questionnaire-2 (SFQ-2), and the Personality Diagnostic Questionnaire-4 (PDQ-4) - 99-item self-report questionnaire designed to encompass the DSM-IV personality disorder criteria (Bach et al., 2021). Gutierrez et al. (2022) explored the psychometric properties of the PDS-ICD-11 in a Spanish mixed sample, confirming its internal consistency and unidimensionality. The study showed strong predictive power for borderline traits. They also employed the bipolar and unipolar scoring techniques, with bipolar technique giving more precise connections between personality traits and severity elements (Gutierrez et al., 2022). A more recent study examining PDS-ICD-11 was conducted by Bach et al. (2023) on a Danish general population, finding a high prevalence of personality dysfunction with 8.2% exhibiting mild dysfunction at a score of 9, while only 0.3% displaying severe

dysfunction at a level of 22, and only a minority of 13.8% having no personality dysfunction at all (Bach et al., 2023). Similar results were found in a general sample in one of the British studies (Yang et al., 2010, as cited in Bach et al., 2023). This high prevalence of problems in personality functioning is just another indicator of the need for a dimensional approach to assessment in order to get a more comprehensive understanding and provide better support. Statistical analysis showed that the PDS-ICD-11 score fits a single-factor model well, meaning that the items of the scale are measuring the same underlying trait which is, in this case, the severity of personality dysfunction. This finding was also present in studies done in the United States, Germany, and Spain (Bach et al., 2021; Gutiérrez et al., 2022; Zimmermann et al., 2022, as cited in Bach et al., 2023). The last finding of the study, suggested that the PDS-ICD-11 score shows slightly higher correlations with the LPFS-BF, the Work and Social Adjustment Scale (WSAS), a self-report measure assessing impairments in social and occupational functioning, and the EuroQol 5D (EQ-5D-5L), a self-report instrument for evaluation of health-related quality of life in health economic evaluations. The correlations were stronger for the PDS-ICD-11 score in comparison to the LPFS-BF score, suggesting that they measure overlapping, but still some distinct aspects of personality disorder severity (Bach et al., 2023). A study by Sellbom et al. (2022) validated the PDS-ICD-11 Clinician-Rating Form used for assessment of personality disorder severity according to the ICD-11 guidelines. All clinician-rated PDS-ICD-11 items fit a one-factor model. Another finding indicates that trained clinical research assistants could independently rate the PDS-ICD-11 in a highly reliable manner. The PDS-ICD-11 scores correlated highly with other established personality disorder severity measures.

Oltmanns & Widiger (2020) aimed to develop and validate the FFiCD by comparing it with the PiCD, the PID-5, and the FFM. Findings suggested that the highest convergence occurred between the FFiCD and PiCD and substantially with the PID-5. Factory analyses also recommended two possible structures for the facet-level structure of the FFiCD: a 4-factor solution with clear factors for detachment and dissociality, and a more detailed 7-factor solution that highlighted the five ICD-11 domains and two additional factors that captured additional characteristics of facets, one that was not clearly interpretable and another that captured anger or aggression. Lastly, there was an overlap between dissociality and disinhibition domains, while detachment nuances in the FFiCD showed strong correlation with PiCD and PID-5 detachment but only moderate correlation with low extraversion in the FFM (Oltmanns & Widiger, 2020). These

results indicate that although FFiCD nuances correlated well overall, some of the traits, like detachment, showed only moderate correlation, suggesting there are differences between FFiCD and FFM. Still, the FFiCD provides a facet-level approach to assessing personality disorder in line with the ICD-11 model. Sorrel et al. (2022) examined the factor structure and validity of the FFiCD. They found that the FFiCD factors aligned well with the corresponding domains of the PiCD and PID-5. Also, results partially support a 4-factor solution, with anankastia and disinhibition as opposite poles of the same factor, rather than the five-factor solution proposed in the ICD-11 classification.

PID-5-BF was translated by Bach and El Abiddine (2020) into Algerian in order to assess the structural validity of the ICD-11 and the DSM-5 AMPD. The first finding of the study is that all five factors of the ICD-11 model corresponded to the five trait domains within the DSM-5 AMPD, including a domain of psychoticism. Secondly, they found the 4-factor structure for the ICD-11 personality trait domains was also generally confirmed, with negative affectivity, detachment, and dissociality as distinct domains, and a combined factor of disinhibition versus low anankastia (Bach & El Abiddine, 2020). The combined factor that is present in the DSM-5 AMPD is considered a limitation of measures that are based on the PID-5 since they view anankastia as being the opposite end of disinhibition (Clark et al., 2021). However, these findings supported the structural validity of the ICD-11 and the DSM-5 personality disorder trait models.

A study by Pires et al. (2023) showed significant relations between PID5BF + M, LPFS, and the PID-5. Stronger correlations were found in the clinical sample. The findings sustain that the PID5BF + M has the potential to assess the severity and stylistic features of personality disorders as they are perceived by both the ICD-11 and the DSM-5 (Pires et al., 2023).

The goal of the study done by Sellbom et al. (2022) was to validate the PAQ-11 in a population-representative community sample. The confirmatory factor analysis indicated that the PAQ-11's 5-factor model showed poor fit since it did not fully adhere to the ICD-11 structure, with anankastia items splitting across two factors (Sellbom et al., 2022). These results do not conform to the same 5-factor model that was observed by Kim et al. (2021) (Sellbom et al., 2022). Moreover, exploratory factor analysis suggested a 4-factor solution grouping negative affectivity, detachment, disinhibition, and anankastia items, while dissociality items loaded onto detachment and disinhibition factors. Correlation analyses revealed that the PAQ-11 domain scales showed significant correlations with their counterparts on the PiCD and PID5BF + M measures, except for

the anankastia and dissociality domains. The PAQ-11 borderline specifier scale correlated primarily with negative affectivity, but did not show a large correlation with disinhibition and had meaningful correlations with most PID5BF + M and PiCD scales, except for PID5BF + M detachment, PiCD dissociality, and PiCD anankastia (Sellbom et al., 2022).

Lastly, Oltmanns and Widiger (2018) developed the Borderline Pattern Scale (BPS), a 12-item measure for the ICD-11 borderline pattern. The scale demonstrated strong internal consistency and convergent validity with some well-validated measures of borderline personality disorder, including the Schedule for Nonadaptive and Adaptive Personality (SNAP), the Wisconsin Personality Disorders Inventory (WISPI), the Coolidge Axis II Inventory (CATI), and the Five Factor Borderline Inventory (FFBI). Additionally, the BPS, along with the SASPD and LPFS, showed strong convergence with the PiCD and the FFM, particularly with traits like negative affectivity and disinhibition (Oltmanns & Widiger, 2018).

2. 9. The ICD-11 and Personality Disorder Inventories

There are many approaches to the assessment of personality disorders. The ICD-11 most recent dimensional approach represents a significant step in classification and diagnosis, aiming to provide a more nuanced approach compared to the previous assessment tools. The dimensional approach adopted in the ICD-11 involves assessing the severity and identifying traits of personality dysfunction, allowing greater flexibility and leading to more personalized treatment plans.

In comparison to the ICD-11, personality assessment tools such as the MMPI, PAI, and MCMI-IV serve different purposes and are used in various contexts.

The MMPI's popularity grew significantly between the 1940s and 1980s, after which its revised versions, the MMPI-2 (1989) and the MMPI-2RF (2008) were developed (Pomerantz, 2023). The most recent version, the MMPI-3, released in 2020, has updated norms and features dozens of new and revised items (Pomerantz, 2023). It is a self-report psychometric test used for assessment of personality structure and the existence of components of psychopathology (Floyd & Gupta, 2023). It consists of true-false questions that are scored on a scale; the test gives a score that falls between 0 and 120 for each category, the mean is 50, while a score greater than 70 indicates an issue in that category (Floyd & Gupta, 2023). A study done by Brown and Sellbom (2023) aimed to examine the associations between the MMPI-3 scales and the dimensional personality traits considered within the ICD-11 and DSM-5 AMPD models. Findings of their study revealed that the MMPI-3 is well suited for assessing a range of personality disorders through

dimensional approach as it was designed to assess and conceptualize the complexity of personality pathology with a hierarchical organization (Brown & Sellbom, 2023). The MMPI also released a version for adolescents (MMPI-A), applied to individuals aged 14-18 (Butcher et al., 1992). The MMPI-A version was developed out of concern that the MMPI-2 lacked adequate content relevant for adolescents (i.e., peer relations, school issues) and appropriate norms for the assessment of their behavior (Butcher et al., 1992). Based on numerous studies, the MMPI has been found to be a reliable and valid test of psychopathology, including personality disorders (Ben-Porath & Tellegen, 2020). It is considered a comprehensive test of personality characteristics and psychopathology and can therefore be helpful in forming DSM diagnoses (Pomerantz, 2023). However, there is no measure without limitation, and for MMPI versions, the main critics are the length of the inventory, which requires reading ability and prolonged attention, as well as susceptibility to "faking" by sophisticated clients (Pomerantz, 2023).

Similarly, the PAI provides a thorough assessment across multiple domains of psychopathology, including personality diagnosis. The PAI contains 344 items, which comprise 22 non-overlapping scales: 4 validity, 11 clinical, 5 treatment consideration, and 2 interpersonal (Morey & Hopwood, 2008). It is a self-administered, objective test of personality and psychopathology appropriate for individuals aged 18-89, but there is also an adolescent version of PAI-A for those aged 12 onwards (Pomerantz, 2023). The PAI does not measure personality traits like the Big Five, instead the focus is on constructs similar to mental disorders (Arizona Forensics, 2024). However, there is correlation between the PAI scales and the NEO Personality Inventory, and the relationships seem consistent, such as PAI anxiety correlating strongly with neuroticism, PAI paranoia correlating with agreeableness, while PAI Borderline Features show correlations with conscientiousness (Arizona Forensics, 2024).

The MCMI-IV is another widely used instrument similar to the MMPI and the PAI. It is an objective self-report tool administered using either pencil-and-paper or computer and consisting of true/false format, with the main focus being personality disorders (Pomerantz, 2023). It was developed to improve upon the MMPI by using fewer items, consisting of 195 items in the latest version (Pomerantz, 2023). The MCMI-IV is also closely aligned with the scales related to the personality disorders in the DSM-5 and ICD-10 (Millon et al., 2016). It conceptualizes personality patterns within three levels of personality functioning: normal style (adaptive personality patterns), abnormal traits (moderately maladaptive personality attributes), and clinical disorder (likelihood

of greater personality dysfunction) (Millon et al., 2016). It also has an adolescent version, the Millon Adolescent Clinical Inventory (MCAI), which contains 160 items in total and is available for clients aged 13-19 (Pomerantz, 2023). All MCMI instruments show strong reliability and validity, indicating they are a good choice for the assessment of personality disorders (Craig, 2008; Meagher et al., 2004; Pincus & Krueger, 2015, as cited in Pomerantz, 2023).

Based on this overview, the ICD-11's dimensional model offers a wider understanding of personality disorders, highlighting the importance of traits and severity that the dimensional model allows over a rigid categorical approach. This aligns with contemporary research and clinical practice, while also providing a better individualized framework for diagnosing and treating personality disorders. However, as mentioned, all these tools offer great validity and reliability, so their inclusion in the assessment could provide interesting insights.

2. 10. Limitations and Future Directions

The ICD-11 personality disorder assessment tools and dimensional approach this model utilizes can be considered as the beginning of a greater knowledge regarding personality functioning. However, there are several issues concerning it that should be addressed in regard to future research.

One of the limitations of the new model is lack of a standardized diagnostic interview that is necessary for valuable clinical practice (Bach & Mulder, 2022). Such an interview would enable clinicians to apply consistent criteria, thereby improving the accuracy of diagnoses. In line with this, personality disorders usually have onset in later childhood or early adulthood, typically decreasing over time (Cooper et al., 2014, as cited in Widiger et al., 2024). However, self-report inventories fail to capture whether the symptoms have been present since late childhood (Widiger et al., 2024). For this reason semi-structured interviews would be more appropriate as they make more effort for assessment of the temporal stability of symptoms (Widiger et al., 2024).

Longitudinal and intervention studies are essential for gaining more knowledge in the field of new classification approach. These types of studies could give an answer to the assumption that researchers, clinicians, and patients could benefit from focusing on a global personality disorder dimension where the disorder can improve gradually over time instead of simply being "cured" (Bach & Mulder, 2022). Moreover, given the link between the childhood maltreatment and internalizing psychopathology (e.g., anxiety and depression) with the possible explanation in personality traits, neurobiological studies could give more insight about diagnosis and eventually

lead to better treatment strategies (Bach et al., 2022; Bach & Mulder, 2022). These types of studies could even resolve a problem that was found in a study by Felding et al. (2021) where it was reported that the new ICD-11 personality disorder diagnosis overlaps with the new ICD-11 Complex Post-Traumatic Stress Disorder (C-PTSD) diagnosis (Bach & Mulder, 2022).

Despite the ICD-11's early validation across several countries, it is still up to additional research to examine its usefulness across more diverse cultures (Bach & Mulder, 2022). Apart from cultural diversity, there are a number of other factors such as gender differences, age-related variations, socioeconomic status, and education levels that require more attention. All these factors may significantly influence how personality disorders are manifested, diagnosed, and treated. Ensuring that the ICD-11 model accounts for these variables is necessary for it to be applicable across a variety of demographic groups.

Furthermore, a large amount of research indicates that the presence of mood, psychotic, and other disorders can affect the scores on personality disorder scales (Miller et al., 2012, as cited in Widiger et al., 2024). For instance, treatment for mood or anxiety disorders may lead to an increase in characteristics like assertiveness and self-confidence, and then could be mistaken for histrionic or narcissistic personality disorders (Widiger et al., 2024). To avoid this, it has been advised not to administer self-report inventory at the beginning of a treatment for mood or psychotic disorders, however it is usually at the beginning of treatment that most personality disorder measures are administered (Widiger, et al., 2024).

Also, it is still up to debate whether the borderline pattern qualifier should be left within the ICD-11 personality disorder model classification or it should be removed, as a number of research reports its close link to the overall severity of the personality pathology as well as its redundancy to the classification. It ultimately needs to be researched and confirmed through further studies (Mulder, 2021; Tyrer et al., 2019). Similarly, another questionable aspect within the ICD-11 personality disorder model is the relationship of disinhibition and anankastia domains (Mulder, 2021). While most of the studies support these two traits as distinct, others argue that they should be combined (Bach et al., 2020; Oltmanns & Widiger, 2018, as cited in Swales, 2022). It is still up to future studies, as well as clinical practice to reveal whether these two traits function as one or they differ enough to stay as distinct features.

Lastly, the utility of the ICD-11 personality disorder model still has to be researched. As reported by Hansen et al. (2019), the ICD-11 is only slightly more useful than the ICD-10 (Mulder,

2021). Although this is still something that has to be studied, the predicted relationships with other personality measures suggest that the ICD-11 might be useful in clinical practice (Mulder, 2021). However, it has been noticed that most of the studies have been conducted on community samples, making it a limitation. To gain more knowledge in its function, it would be relevant to conduct more studies on clinical samples, to get better insight into users' perspectives in order to refine diagnostic measures and treatment approaches.

3. Conclusion

The present study highlights the advancement in the evaluation of personality disorder through the transition from a categorical to a dimensional approach incorporated by the latest version of the ICD-11. By comparison with the previous version of the model, the ICD-10, then with the DSM-5, and also with other assessment tools evaluating personality disorders, it is evident that the dimensional model enhances the accuracy and efficacy of the diagnoses. The review of newly developed tools underlines their alignment with the ICD-11's framework and their utility in clinical practice. Overall, this review supports the adoption of the ICD-11, thus ensuring a better research approach in the future and improved clinical practice, contributing to more effective treatment outcomes for individuals with personality disorders.

4. Abstract

The eleventh revision of the International Classification of Diseases (ICD-11) represents a significant improvement in the assessment of personality disorders with the shift from a categorical to a dimensional approach. The development and efficacy of the ICD-11 will be provided in the present study in comparison with the previous version of the ICD-10 and the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), as well as other evidence-based assessment tools used for the evaluation of personality disorders. This review also looks into recently developed tools and instruments that are in line with the ICD-11, including the Personality Inventory for the ICD-11 (PiCD) and the Standardized Assessment of Severity of Personality Disorders (SASPD). Additionally, it discusses the cultural applicability of ICD-11, which is important for obtaining accurate results across diverse populations. Overall, this approach contributes to the ongoing process of personality disorder assessment, diagnosis, and better treatment outcomes by emphasizing the relevance of an accurate diagnosis.

Keywords: ICD-11, personality disorders, assessment tools, dimensional model, psychometric validity, diagnostic accuracy, cultural applicability

5. Sažetak

Jedanaesta revizija Međunarodne klasifikacije bolesti (MKB-11) predstavlja značajan napredak u procjeni poremećaja ličnosti uz pomak s kategoričkog na dimenzionalni pristup. U ovom istraživanju bit će prikazani razvoj i učinkovitost MKB-11 u usporedbi s prethodnom verzijom MKB-10 te Dijagnostičkim i statističkim priručnikom za mentalne poremećaje (DSM-5), kao i drugim procjenama utemeljenim na dokazima koji se koriste za evaluaciju poremećaja ličnosti. Ovaj pregledni rad također razmatra nedavno razvijene alate i instrumente koji su u skladu s MKB-11, uključujući Inventar osobnosti za MKB-11 i Standardiziranu procjenu težine poremećaja ličnosti. Štoviše, rad obuhvaća i kulturološku primjenjivost MKB-11, što je važno za dobivanje adekvatnih rezultata među različitim populacijama. Sveukupno, ovaj pristup pridonosi kontinuiranom procesu procjene poremećaja ličnosti, dijagnostici i boljim ishodima liječenja naglašavajući važnost točne dijagnoze.

Ključne riječi: MKB-11, poremećaji ličnosti, alati za procjenu, dimenzionalni model, psihometrijska valjanost, dijagnostička točnost, kulturološka primjenjivost

6. References

American Psychiatric Association. (2013). *DSM-5's integrated approach to diagnosis and classifications*.https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM-5-Integrated-Approach.pdf

American Psychiatric Association. (2024). *DSM history.* https://www.psychiatry.org/psychiatrists/practice/dsm/about-dsm/history-of-the-dsm

Arizona Forensics. (2024). *Personality Assessment Inventory (PAI)*. https://arizonaforensics.com/psychological-assessment-inventory-pai/

Ayinde, O. & Gureje, O. (2020). Cross-cultural applicability of ICD-11 and DSM-5 personality disorder. *Current Opinion in Psychiatry, 34*(1). 10.1097/YCO.0000000000000659

Bach, B., Bo, S., & Simonsen, E. (2022). Maladaptive personality traits may link childhood trauma history to current internalizing symptoms. *Scandinavian Journal of Psychology, 63*(5), 468-475. https://doi.org/10.1111/sjop.12830

Bach, B., Brown, T. A., Mulder, R. T., Newton-Howes, G., Simonsen, E., & Sellbom, M. (2021). Development and initial evaluation of the ICD-11 personality disorder severity scale: PDS-ICD-11. *Personality and Mental Health, 15*(3), 223-236. https://doi.org/10.1002/pmh.1510

Bach, B. & El Abiddine, F. Z. (2020). Empirical structure of DSM-5 and ICD-11 personality disorder traits in Arabic-speaking Algerian culture. *International Journal of Mental Health, 49*(2), 186-200. https://doi.org/10.1080/00207411.2020.1732624

Bach, B., & Mulder, R. (2022). Clinical implications of ICD-11 for diagnosing and treating personality disorders. *Current Psychiatry Reports, 24*, 553-563. https://doi.org/10.1007/s11920-022-01364-x

Bach, B., Simonsen, E., Kongerslev, M. T., Bo, S., Hastrup, L. H., Simonsen, S., & Sellbom, M. (2023). ICD-11 personality disorder features in the Danish general population: Cut-offs and prevalence rates for severity levels. *Psychiatry Research, 328*. 10.1016/j.psychres.2023.115484

Bagby, R. M., & Widiger, T. A. (2020). Assessment of the ICD-11 dimensional trait model: an introduction to the special section. *Psychological Assessment, 32*(1), 1-7. 10.1037/pas0000785

Ben-Porath, Y., & Tellegen, A. (2020). *MMPI-3.* Pearson. https://www.pearsonassessments.com/content/dam/school/global/clinical/us/assets/mmpi-3/mmpi-3-adminman-ch1.pdf

Brown, T. A., & Sellbom, M. (2023). Associations between MMPI-3 scales and the DSM-5 AMPD and ICD-11 dimensional personality traits. *SAGE, 30*(4), 943-958. 10.1177/10731911221075724

Brüne, M. (2016). Borderline personality disorder. *Evolution, Medicine, & Public Health, 2016*(1), 52-66. 10.1093/emph/eow002

Butcher, J. N., Williams, C. L., Graham, J. R., Archer, R. P., Tellegen, A., Ben-Porath, Y. S., & Kaemmer, B. (1992). Minnesota Multiphasic Personality Inventory--Adolescent (MMPI-A). https://doi.org/10.1037/t15122-000

Carnovale, M., Sellbom, M., & Bagby, R. M. (2020). The Personality Inventory for ICD-11: Investigating reliability, structural and concurrent validity, and method variance. *Psychological Assessment, 32*(1), 8-17. https://doi.org/10.1037/pas0000776

Clark, L. A., Corona-Espinosa, A., Khoo, S., Kotelnikova, Y., Levin-Aspenson, H. F. , Serapio-García, G., & Watson, D. (2021). Preliminary scales for ICD-11 personality disorder: Self and interpersonal dysfunction plus five personality disorder trait domains. *Frontiers in Psychology, 12*. https://doi.org/10.3389/fpsyg.2021.668724

Cloninger, C.R., & Svrakic, D.M. (2008). *The Medical Basis of Psychiatry. Personality disorders* (3rd ed.). Humana Press. https://doi.org/10.1007/978-1-59745-252-6_28

Coolidge, F. L., & Segal, D. L. (1998). Evolution of personality disorder diagnosis in the Diagnostic and Statistical Manual of Mental Disorders. *Clinical Psychology Review,* 18(5), 585-599. https://doi.org/10.1016/S0272-7358(98)00002-6

Crocq, M. A. (2013). Milestones in the history of personality disorders. *Dialogues in Clinical Neuroscience, 15*(2),147-53. 10.31887/DCNS.2013.15.2/macrocq

Ebert, A., & Bär, K. J. (2010). Emil Kraepelin: a pioneer of scientific understanding of psychiatry and psychopharmacology. *Indian Journal of Psychiatry. 52*(2), 191-2. 10.4103/0019-5545.64591

Ekselius, L. (2018). Personality disorder: a disease in disguise. *Upsala Journal of Medical Sciences, 123*(4), 194-204. 10.1080/03009734.2018.1526235

Fariba, K. A., Gupta, V., & Kass, E. (2023). *Personality disorder.* StatPearls. https://www.ncbi.nlm.nih.gov/books/NBK556058/

First, M. B., Pincus, H. A., Levine, J. B., Williams, J. B., Ustun, B., & Peele, R. (2004). Clinical utility as a criterion for revising psychiatric diagnoses. *American Journal of Psychiatry, 161*(6), 946-54. 10.1176/appi.ajp.161.6.946

Floyd, A. E., & Gupta, V. (2023). Minnesota Multiphasic Personality Inventory. *StatPearls.* https://www.ncbi.nlm.nih.gov/books/NBK557525/

Gaebel, W., Stricker, J., & Kerst, A. Changes from ICD-10 to ICD-11 and future directions in psychiatric classification. *Dialogues in Clinical Neuroscience, 22*(1), 7-15. 10.31887/DCNS.2020.22.1/wgaebel

Gore, W. L., & Widiger T. A. (2013). The DSM-5 dimensional trait model and five-factor models of general personality. *Journal of Abnormal Psychology, 122*(3), 816-821. 10.1037/a0032822

Gureje, O., Lewis-Fernandez, R., Hall, B. J., & Reed, G. M. (2019). Systematic inclusion of cluture-related information in ICD-11. *World Psychiatry, 18*(3), 357-358. 10.1002/wps.20676

Gutiérrez, F., Aluja, A., Ruiz, J., García, L. F., Gárriz, M., Gutiérrez-Zotes, A., Gallardo-Pujol, D., Navarro-Haro, M. V., Alabèrnia-Segura, M., Mestre-Pintó, J. I., Torrens, M., Peri, J. M., Sureda, B., Soler, J., Pascual, J. C., Vall, G., Calvo, N., Ferrer, M., Oltmanns, J. R., & Widiger, T. A. (2021). Personality Disorders in the ICD-11: Spanish validation of the PiCD and the SASPD in a mixed community and clinical sample. *Assessment*, *28*(3), 759-772. https://doi.org/10.1177/1073191120936357

Gutiérrez, F., Aluja, A., Rodríguez, C., Gárriz. M., Peri, J. M., Gallart, S., Calvo, N., Ferrer, M., Gutiérrez-Zotes, A., Soler, J., & Pascual, J. C. (2023). Severity in the ICD-11 personality disorder model: Evaluation in a Spanish mixed sample. *Frontiers in Psychiatry, 13*. 10.3389/fpsyt.2022.1015489

Hong, Y., & Zeng, M. L.. (2022). International Classification of Diseases (ICD). *Knowledge Organization, 49*(7), 496-528. https://www.isko.org/cyclo/icd

Hopwood, C. J., Kotov, R., Krueger, R. F., Watson, D., Widiger, T. A., Althoff, R. R., Ansell, E. B., Bach, B., Bagby, M. R., Blais, M. A., Bornovalova, M. A., Chmielewski, M., Cicero, D. C., Conway, C., De Clercq, B., De Fruyt, F., Docherty, A. R., Eaton, N. R., Edens, J. F., … Zimmermann, J. (2018). The time has come for dimensional personality disorder diagnosis. *Personality and Mental Health, 12*(1), 82-86. 10.1002/pmh.1408

Hualparuca-Olivera, L., Caycho-Rodríguez, T., Torales, J., & Ramos-Campos, D. (2023). Convergence between the dimensional PD models of ICD-11 and DSM-5: a meta-analytic approach. *Frontiers in Psychiatry, 14*. 10.3389/fpsyt.2023.1325583

Huprich, S. K. (2020). Personality disorders in the ICD-11: Opportunities and challenges for advancing the diagnosis of personality pathology. *Current Psychiatry Reports, 22*(8), 40. 10.1007/s11920-020-01161-4

Krueger, R. F., & Hobbs, K. A. (2020). An overview of the DSM-5 alternative model of personality disorders. *Psychopathology, 53*(3-4), 126-132. 10.1159/000508538

Loranger, A. W., Janca, A., & Sartorius, N. (1997). Assessment and diagnosis of personality disorders: the ICD-10 International Personality Disorder Examination (IPDE). *Cambridge University Press.* 9780521041669.pdf

Millon, T., Grossman, S., & Millon, C. (2016). *MCMI-IV*. Pearson.

Monaghan, C., & Bizumic, B. (2023). Dimensional models of personality disorders: Challenges and opportunities. *Frontiers in Psychiatry, 14.* 10.3389/fpsyt.2023.1098452

Morey, L. C., & Hopwood, C. J. (2008). The personality assessment inventory. *Personality Assessment,* 167-211. https://psycnet.apa.org/record/2008-08058-005

Mulder, R. T. (2021). ICD-11 personality dsiorder: Utility and implications of the new model, *Frontiers in Psychiatry.* 10.3389/fpsyt.2021.655548

Oltmanns, J. R., & Widiger, T. A. (2018). Evaluating the assessment of the ICD-11 personality disorder diagnostic system. *Research Gate.* 10.31234/osf.io/6guex

Oltmanns, J. R., & Widiger, T. A. (2020). The five-factor personality inventory for ICD-11: a facet-level assessment of the ICD-11 trait model. *Psychological Assessment, 32*(1), 60-71. 10.1037/pas0000763

Pan, B., & Wang, W. (2024). Practical implications of ICD-11 personality disorder classifications. *BMC Psychiatry, 24*(1), 191. 10.1186/s12888-024-05640-3

Pires, R. , Henriques-Calado, J., Sousa Ferreira, A., Gama Marques, J., Ribeiro Moreira, A., Barata, B. C., Paulino, M., & Gonçalves, B. (2023). Bridging the ICD11 and the DSM-5 personality disorders classification systems: the role of the PID5BF + M. *Frontiers in Psychiatry, 14*. https://doi.org/10.3389/fpsyt.2023.1004895

Pomerantz, A. M., (2023). *Clinical psychology.* (6th ed.). Sage Publications.

Reed, G. M., First, M. B., Kogan, C. S., Hyman, S. E., Gureje, O., Gaebel, W., Maj, M., Stein, D. J., Maercker, A., Tyrer, P., Claudino, A., Garralda, E., Salvador-Carulla, L., Ray, R., Saunders, J. B., Dua, T., Poznyak, V., Medina-Mora, M. E., Pike, K. M., … Saxena, S. (2019). Innovations and changes in the ICD-11 classification of mental, behavioural and neurodevelopmental disorders. *World Psychiatry*, 18(1), 3-19. 10.1002/wps.20611

Rek, K., Thielmann, I., Henkel, M., Crawford, M., Piccirilli, L., Graff, A., Mestel, R., & Zimmermann, J. (2020). A psychometric evaluation of the Standardized Assessment of Severity of Personality Disorder (SASPD) in nonclinical and clinical German samples. *Psychological Assessment, 32*(10), 984–990. https://doi.org/10.1037/pas0000926

Sellbom, M., Brown, T. A., & Bach, B. (2022). Development and psychometric evaluation of the Personality Disorder Severity ICD-11 (PDS-ICD-11) Clinician-Rating Form. *Personality and Mental Health, 18*(1), 60-68. https://doi.org/10.1002/pmh.1596

Sellbom, M., Chiasson, P. M., Brown, T. A., & Bach, B. (2022). Examining the construct validity of the Personality Assessment Questionnaire for ICD-11 (PAQ-11) personality trait domains in a community sample. *Personality and Mental Health, 17*(3), 197-207. https://doi.org/10.1002/pmh.1573

Sleep, C., Lynam, D. R., & Miller, J. D. (2021). Personality impairment in the DSM-5 and ICD-11: Current standing and limitations. *Current Opinion in Psychiatry, 34*(1), 39-43. 10.1097/YCO.0000000000000657

Somma, A., Gialdi, G., & Fossati, A. (2020). Reliability and construct validity of the Personality Inventory for ICD-11 (PiCD) in Italian adult participants. *Psychological Assessment, 32*(1), 29-39. https://doi.org/10.1037/pas0000766

Soto, C. J., & Jackson, J. J. (2020). Five-Factor Model of Personality. *Oxford Bibliographies.* 10.1093/OBO/9780199828340-0120

Sorrel, M. A., Aluja, A., García, L. F., & Gutiérrez, F. (2022). Psychometric properties of the Five-Factor Personality Inventory for ICD-11 (FFiCD) in Spanish community samples. *Psychological Assessment, 34*(3), 281-293. https://doi.org/10.1037/pas0001084

Surís, A., Holliday, R., & North, C. S. (2016). The evolution of the classification of psychiatric disorders. *Behavioral Sciences (Basel), 6*(1), 5. 10.3390/bs6010005

Swales, M. A. (2022). Personality Disorder Diagnoses in ICD-11: Transforming conceptualisations and practice. *Clinical Psychology in Europe, 4(Special Issue).* 10.32872/cpe.9635

Tarescavage, A. M., & Menton, W. H., (2020). Construct validity of the personality inventory for ICD-11 (PiCD): Evidence from the MMPI-2-RF and CAT-PD-SF. *Psychological Assessment, 32*(9), 889-895. https://doi.org/10.1037/pas0000914

Trull, T. J., & Widiger T. A. (2013). Dimensional models of personality: the five-factor model and the DSM-5. *Dialogues in Clinical Neuroscience, 15*(2). 135-46. 10.31887/DCNS.2013.15.2/ttrull

Tyrer, P., Crawford, M., & Mulder, R. (2011). ICD-11 working group for the revision of classification of personality disorders: Reclassifying personality disorders. *The Lancet, 377* (9780),1814-1815. 10.1016/S0140-6736(10)61926-5

Tyrer, P., Crawford, M., Sanatinia, R., Tyrer, H., Cooper, S., Muller-Pollard, C., Christodoulou, P., Zauter-Tutt, M., Miloseska-Reid, K., Loebenberg, G., Guo, B., Yang, M., Wang, D., & Weich, S. (2014). Preliminary studies of the ICD-11 classification of personality disorder in practice. *Personality and Mental Health, 8*(4), 254-263. 10.1002/pmh.1275

Tyrer, P., Mulder, R., Kim, Y. R., & Crawford, M. J. (2019). The development of the ICD-11 classification of personality disorders: an amalgam of science, pragmatism, and politics. *Annual Review of Clinical Psychology, 15*, 481-502. 10.1146/anANTOnurev-clinpsy-050718-095736

Verheul, R., & Widiger, T. (2004). A meta-analysis of the prevalence and usage of the personality disorder not otherwise specified (PDNOS) diagnosis. *Journal of Personality Diosrders, 18*(4), 309-319. 10.1521/pedi.18.4.309.40350

Verheul, R., Bartak, A., & Widiger, T. (2007). Prevalence and construct validity of personality disorder not otherwise specified. *Journal of Personality Disorders, 21*, 359–370. 10.1521/pedi.2007.21.4.359

Weekers, L. C., Hutsebaut, J., & Kamphuis, J. H. (2018). The Level of Personality Functioning Scale Brief Form 2.0: Update of a brief instrument for assessing level of personality functioning. *Personality and Mental Health, 13*(1), 3-14. 10.1002/pmh.1434

Widiger, T. A. (2011). The DSM-5 dimensional model of personality disorder: rationale and empirical support. *Journal of Personality Disorders, 25*(2), 222-34. 10.1521/pedi.2011.25.2.222

Widiger, T. A., Hines, A., & Crego, C. (2024). Evidence-based assessment of personality disorder. *Assessment, 31*(1), 191-198. 10.1177/10731911231176461

Winsper, C., Bilgin, A., Thompson, A., Marwaha, S., Chanen, A. M., Singh, S. P., Wang, A., & Furtado, V. (2020). The prevalence of personality disorders in the community: a global systematic review and meta-analysis. *The British Journal of Psychiatry, 216*(2), 69-78. 10.1192/bjp.2019.166

World Health Organization. (1992). *The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines.* https://cdn.who.int/media/docs/default-source/classification/other-classifications/9241544228_eng.pdf

World Health Organization. (2024). *Personality disorders. International Classification of Diseases, eleventh edition*. https://icd.who.int/browse/2024-01/mms/en#37291724

World Health Organization. (2024). *Clinical descriptions and diagnostic requirements for ICD-11 mental, behavioural and neurodevelopmental disorders: Specifiers for prominent trait domains in personality disorders.* https://iris.who.int/bitstream/handle/10665/375767/9789240077263-eng.pdf?sequence=1

Statement on the Storage and Publication of Assessment Paper

(final/graduate/specialist/doctoral thesis- underline as appropriate)

Student: Ivana Perišˇ

Work title: Psychological Assessment of Personality Disorders According to the ICD-11

Scientific area and field: psychology

Type of work: final thesis

Thesis Supervisor (first and last name, academic degree and title)

doc. dr. sc. Katija Kalebić Jakupčević

Thesis Co-supervisor (first and last name, academic degree and title)

Committee members (first and last name, academic degree and title):

doc.dr.sc. Ivan Buljan

Lana Pehar, mag. psych.

By this statement, I confirm that I am the author of the submitted assessment paper (final/graduate/specialist/doctoral thesis - circle as appropriate) and that the content of its electronic version fully corresponds to the content of the work defended and edited after defense. As the author, I declare that I agree to have my assessment paper published permanently and publicly in open access, free of charge, in the Digital Repository of the Faculty of Humanities at the University of Split and the repository of the National and University Library in Zagreb (in accordance with the provisions of the *Law on Higher Education and Scientific Activity* (Official Gazette no. 119/22).

Split, 18.9.2024.

Student signature: Ivana Perišˇ

Note: In the case of a need to restrict access to the assessment paper in accordance with the provisions of the Copyright and Related Rights Act (111/21), a substantiated request should be submitted to the Dean of the Faculty of Humanities in Split.

Form A.

UNIVERSITY OF SPLIT

FACULTY OF HUMANITIES AND SOCIAL SCIENCES

ACADEMIC INTEGRITY STATEMENT

by which I, as an applicant for obtaining a title university Bachelor's degree in psychology, I declare that this graduation thesis is the result of my own work only, that it is based on my research and draws on the published literature as indicated by the notes and bibliography used. I declare that not a single part of the thesis was written in an impermissible manner, that is, that it is not copied from an uncited work, and that it does not violate anyone's copyright. I also declare that no part of this thesis has been used for any other work at any other time higher education, scientific or work institution.

In Split, 18.9.2024.

Signature:

Ivana Perić