Classification of personality disorders: categorical vs dimensional approach

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Classification of personality disorders: categorical vs dimensional approach

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Classification of personality disorders: categorical vs dimensional approach

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1. Introduction

„Personality refers to the enduring characteristics and behavior that comprise a person's unique adjustment to life, including major traits, interests, drives, values, self-concept, abilities, and emotional patterns“ (American Psychological Association, 2018). There is a great number of theories trying to explain the structures of personality and its characteristics, subsequently, they all have one thing in common - personality is one of the factors that determine behavior. The main characteristic of personality disorders is having severe personality traits that cause disturbance in and limit areas of functioning. Every personality trait that is amplified can turn into a pathological disorder and cause disturbed social adaptation. It can also impact various areas responsible for behavior and mental functioning (Ekselius, 2018). Personality disorders are classified in two manuals, DSM-5 and ICD-11. „Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR), is the most comprehensive, current, and critical resource for clinical practice available to today's mental health clinicians and researchers.“ DSM is a worldwide manual that is translated into more than twenty languages and used all over the world, not just by psychologists but also by researchers, lawmakers, criminal courts, and medical care practitioners (American Psychiatric Association, 2013). "The International Classification of Diseases (ICD) is the global health information standard for mortality and morbidity statistics. It is used by health care providers around the world to classify diseases and conditions, monitor the incidence and prevalence of diseases, and manage health care, among other purposes." (World Health Organization, n.d.). It was the first attempt at disease classification, and greatly helped healthcare facilities report morbidity and recognize conditions more easily. In the 1600s and 1700s, there were first attempts to classify diseases. However, efforts were taken seriously only in the 1800s. In 1893 the first classification of diseases manual was introduced. It was adopted by the International Statistical Institute the same year. It was invented by Jacques Bertillon in France. In the next couple of years, his classification system became known as the 'International List of Causes of Death' or for short 'ICD'. At first, it contained 169 causes of death, but as the years went on it got refined and more complete (World Health Organization, n.d.) As psychiatric nosology developed throughout the years, its inclusion in mental health branched out of the lines of mental institutions. An interest to concise psychopathological conditions in one place or system was on the rise. The American Medico-Psychological Association made the first attempt at creating a standard nomenclature of psychopathological conditions in 1918. They published it under the name of '*Statistical Manual for the Use of Institutions for the Insane*'. It is now thought to be

the predecessor of DSM (Grob, 1991). In 1952 the first edition of the '*Diagnostic and Statistical Manual of Mental Disorders' (DSM-I)* was published (Raines, 1953). It consisted of one hundred and two diagnostic categories which were divided into two categories of disorders. The first category was characterized by disorders that have been caused by brain dysfunction due to trauma, intoxication, or physical conditions. The second category was characterized by disorders that occur due to individuals' inability to withstand the pressure of socio-environmental stressors or one's biological constitution. This second category was later divided into a category with psychoses and a category with psychoneuroses (American Psychological Association, n.d.). In 1968, the second edition of DSM, DSM-II, with a few expansions and corrections had been published. In the new version, eight more diagnostic categories have been added, as well as a section for children and adolescents. It also removed the ban on diagnostic comorbidity. The nomenclature and classification stayed the same, except the term „reaction" was erased from it (Suris et al., 2016). For a while, DSM-II was a good enough classification and diagnostic tool, but the further development of personality disorders called for a newer version. In 1980, DSM-III has been published. It was seen as a revolutionary version. It even prompted an international conference in Denmark, to make changes to ICD-9 so it could be more similar and adhere to a new version of DSM-III (Sartorious, 2001). The creation of the third version represented the rejection of the psychoanalytic and the adoption of a new behavioral perspective (Coolidge & Segal, 1998). It brought a few changes to the classification. For instance, disorders were now classified according to their scientific evidence, as before, they were categorized by clinical consensus - subjective agreement among professionals. This means that the classification of mental disorders was influenced by the collective judgment and experiences of clinicians, rather than by empirical scientific evidence. They were categorized into three clusters (A, B, C). Firstly, cluster A consists of schizotypal, schizoid, and paranoid personality disorder. In cluster B there are histrionic, narcissistic, antisocial, and borderline personality disorders. Lastly, cluster C consists of avoidant, dependent, and obsessive-compulsive personality disorders (Kerns, 2020). Another major change was the introduction of a multiaxial classification. It allowed using many organizing principles at the same time without them overlapping. Axis I was a description of the patient's psycho-pathology syndrome, axis II of personality style, axis III of medical etiology, axis IV of environmental factors, and axis V of role disturbances. Moreover, there was a significant change in the DSM III volume. Since it included more mental disorders it increased in size from 92 to 482 pages (Spitzer & Fleiss, 1974). Although it has been an increased and more detailed version of the DSM, a few years later, it underwent a revision and was renamed DSM-III-R. In this version

a few categories were renamed, six were deleted and a couple of new ones were added, contributing to a complete 297 categories in the revised version. Just three years later, in 1994 ICD-9 was renewed to a version of ICD-10. In ICD-9 diseases were classified according to three-character codes that could have an optional character for better classification. In ICD-10 there was a major shift in the coding system since the renowed system contained letters and numbers and codes could have a maximum of seven characters. It added a great amount of codes into the new version and had a broader classification and new terminology to go with it. Publication of the DSM-IV in 1994 was not seen as such a milestone as DSM III was, because it was mainly done to refine the diagnosis and add and remove certain disorders. It helped to make the diagnostic process more detailed and defined (Suris et al., 2016). Soon after, DSM IV was upgraded to DSM IV-TR (text revision) with slight changes made in the text but no added or removed disorders. The most recent version is DSM V, which has been published in 2013. In this version, some of the disorders were reclassified and certain diagnostic criteria were revised. The DSM V slowly integrated a new approach to classification, called the dimensional approach. It allowed for a multifaceted approach to a spectrum of disorders and their criteria. Disorders are categorized based on twenty-five traits across five wide-range domains (Gore & Widiger, 2013). In 2018 the new version of ICD was also published. The new version, called ICD-11 brought many changes to the classification and diagnostic process. As well as the new version of the DSM this is a sign of modernization of categorization of the disorders. ICD-11 also uses a dimensional approach which accounts for many categorization drawbacks of the old approach (Reed et al., 2019).

The aim of this study is to describe the origin, development, and classification of personality disorders and their clinical diagnosis throughout the years. In more detail, it will follow the emergence of personality disorders from ancient Greece to the 21st century, as their definitions and characteristics evolved. It will showcase the etiology and prevalence rates of every disorder on a global scale, using the newest theoretical framework. The purpose of this paper is to give a detailed insight into the classification and diagnostic process of personality disorders, which can serve as an additional tool in furthering the improvements of these disorders and their clinical utility. Special emphasis will be put on evaluating and comparing the two approaches (categorical and dimensional approach) that are credible for the classification and diagnostic criteria in DSM V and ICD-11 that we have today.

2. Body

2.1. Early description of personality disorders

Ancient Greece

The emergence of personality disorders dates back to 400 BC. At that time, they were not fully defined and called like they are today. Still, their development changed and continues to change even today. One of the first people to ever try to classify personalities was Hippocrates. Hippocrates, also known as the „father of medicine“ was an ancient Greek physician. He lived in Greece’s Classical period and one of his most known life works was creating one of the oldest personality type systems in the world (Smith, 2024). His system consists of four personality types based on the proportion of bodily fluid in one's body called humor. According to him, four main humors are accountable for a specific blueprint of personality and it's disease susceptibility. The four classifications according to the excess of humor were blood, black bile, yellow bile, and phlegm. An excess of blood produced a „sanguine“ temperament, which is known for its cheerfulness and extraversion. An excess of black bile created a “melancholic” often known as a depressive temperament. The third temperament named „choleric“ was the product of the excess of yellow bile, and was known for anger and explosiveness. The last temperament was named „phlegmatic“ and was created by the excess of phlegm, recognized by its calmness and easygoingness. This theory was not only important for the classification of personalities but also for medical care and support which was done by observing the temperament's complexities. „Furthermore, the physicians that followed the Four Humours Theory observed the patient's physical properties that correlate with the associated nature elements and seasons of the humor. For example, people who were hot to the sense of touch were believed to have imbalanced yellow bile, the humor that was associated with the summer season. Evidently, the Four Humours Theory included the scientific premise of observation and was a major advancement compared to the preceding ideas that relied heavily on mere superstitions and mystical powers to explain the cause of diseases.“ (Hope, 2014). After Hippocrates, another system of personality types worth mentioning was created by the Greek philosopher Theophrastus. Theophrastus was a Peripatetic philosopher and studied under Aristotle in Athens. His biggest life's work is the book called „Characters“. Theophrastuses book was also used as the basis for a well-known literary piece of Jean de La Bruyère, Les Caractères. This book consists of thirty vigorous character sketches that represent various moral types. These types are drawn from many of Aristotle's studies about personalities and character. The characters represent malicious,

savage, and unpleasant human behavior that is depicted through humorous sketches or caricatures. Following every sketch, there is a definition of the personality type and a prologue that states the moral usage of that particular character (Lerodiakonou, 2020). Theophrastus begins his writing by stating how puzzled he feels by such various patterns of different characters in life. Additionally, he states that this book is a guide for his sons to recognize and choose which type they live by. „Often before now have I applied my thoughts to the puzzling question - one, probably, which will puzzle me forever - why it is that, while all Greece lies under the same sky and all the Greeks are educated alike, it has befallen us to have characters so variously constituted. For a long time, Polycles, I have been a student of human nature; I have lived ninety years and nine; I have associated, too, with many and diverse natures; and, having observed side by side, with great closeness, both the good and the worthless among men, I conceived that I ought to write a book about the practices in life of either sort. I will describe to you, class by class, the several kinds of conduct which characterize them and the mode in which they administer their affairs; for I conceive, Polycles, that our sons will be the better if such memorials are bequeathed to them, using which as examples they shall choose to live and consort with men of the fairest lives, in order that they may not fall short of them" (Theophrastus, 1870). We can draw parallels between some of the thirty descriptions of characters and the personality disorder classifications today. For example, character number seventeen, called the „Thankless Man" as described depicts the traits that are today known as anhedonia, apathy, and emotional numbness. Additionally, character number eighteen, called the „Suspicious Man" is comparable to today's paranoid personality. In the book, he is described as very skeptical, thinking everybody is fraudulent. He is further described by patterns such as "The suspicious man is the sort of person who sends a servant to market and then sends another to watch him and find out the price he pays" (Theophrastus, 1870). In the 17th and 18th centuries, this book gained a lot of influence in Western Europe. „Character refers to a permanent or long-standing mode of functioning that is inscribed in the fabric of the person, like a coin that has been stamped" (Theophrastus, 1870).

Eighteenth-century

Long before DSM-III, the permanence of traits has been part of the definition of a personality disorder, although certain personality disorders may be acquired to some degree, and are amenable to change as a result of treatment (Crocq, 2013)." There are a few more individuals who helped in the recognition, classification, and definition of what is today known as personality disorders besides the ancient Greco-Roman philosophers. In the eighteenth

century, there was a focus on psychiatric development in medicine. The centerpiece of attention was on patients who did not have a clearly defined mental pathology but demonstrated violent and unusual behaviors. One of the most influential individuals at that time was Philippe Pinel. He is also known as the father of modern clinical psychiatry. According to most historians of psychiatry, Philippe Pinel (1745-1826) was the first author to include a personality disorder in psychiatric nosology. In his 'Traite medico-philosophique stir l'alienation mentale ou la rnanie', Pinel introduced a category termed 'manie sans delire' (mania without delusion). At that time, ”mania“ referred to states of agitation. Pinel described a few male patients who appeared normal to the lay observer. Indeed, 'without delusion' meant, in Pinel's depiction, that the patients did not present with abnormalities of understanding, perception, judgment, imagination, memory, etc. However, they were prone to fits of impulsive violence, sometimes homicidal, in response to minor frustration (Crocq, 2013). In late 1883, there was a published article titled “Moral Insanity“ by the American Journal of Insanity (Ozarin, 2001). Moral insanity as a term had connotations with personality disorders throughout history. It alluded to a mental disorder that consisted of atypical emotions and behaviors that had not been accompanied by any delusions, hallucinations, or intellectual impairments.

Nineteenth-century

In the second half of the 19th century, moral insanity was a legitimate diagnosis in America and Europe. The first mention and use of moral insanity as a description of a mental disorder happened in 1835 by the physician James Cowles Prichard. He mentioned it in his thesis that had been written on insanity and other disorders that affect the mind (HandWiki, 2022). In 1835 he wrote: “There is a form of mental derangement in which the intellectual faculties [are uninjured], while the disorder is manifested principally or alone in the state of feelings, temper, or habits. . .The moral. . .principles of the mind. . .are depraved or perverted, the power of self-government is lost or greatly impaired, and the individual is. . .incapable. . .of conducting himself with decency and propriety in the business of life.“ (Ozarin, 2001). At the end of the nineteenth century, a new term emerged as a replacement for moral insanity, as a consequence of further development of personality disorders (Gutmann, 2008). The new term that emerged in 1888 was 'psychopathic inferiority' which was first used by Julius Ludwig Koch in Germany (Ozarin, 2001). „It was more or less a synonym for mental abnormity in general and comprised the psychoses, as well as his psychopathic inferiorities (Gutmann, 2008). “ The first group known as the independent elementary mental abnormalities consisted of isolated hallucinations and compulsive phenomena, which could occur in healthy as well as

ill individuals. When it occurred in ill individuals it would be a bit more problematic since it was difficult to distinguish schizophrenia from isolated hallucinations. The second group, known as the psychopathic inferiorities had been the main subject of Koch's three-volume thesis. The last, third group known as the psychoses encompassed states of idiocy or mental retardation (Gutman, 2008). In 1917, the National Committee for Mental Hygiene in collaboration with the American Medical Psychological Association founded the first psychiatric nomenclature in America. They introduced the rubric "psychosis with constitutional psychopathic inferiority." Later, in 1934 during the eighth revision the term "psychopathic personality" was used. It consisted of subtypes such as pathological sexuality and emotionality, with asocial or amoral trends. „APA assumed responsibility for the *Diagnostic and Statistical Manual* in 1952 and included the renamed 'sociopathic personality disturbance' with subtypes of antisocial reaction, dissocial reaction, and sexual deviation." (HandWiki, 2022).

Twentieth century

Between the late nineteenth and early twentieth century, the nosology of personality disorders was still developing. This period is marked by the presence of differentiation and systems for normal and abnormal personality which were connected to degree types and dimensions. There were a few European psychologists who contributed greatly to furthering the knowledge of personality disorders (Ribot, 1896). Théodule-Armand Ribot was a French psychologist best known for his destain and critiques of psychology which was philosophically oriented. He wanted to popularize the new psychology in France, which was oriented toward experimenting. He tried doing so by studying the works of the psychologists from England and Germany, who were active during that period. His works and efforts drove a lot of scientists to consider giving attention to a new way of doing research in psychology. It was mostly seen in the experimental research field in Germany (Nicolas et al., 2016). He published a few studies and books during his time, some of which are still relevant today. They included studies of diseases of will, personality, and attention. Later on, affective and emotional factors captured his study interest (Britannica, 2024). Ribot came up with a classification for personality disorders of his own. He stated that the character appears in childhood, lasts, and is stable throughout the whole life. His classification consisted of several 'primary types' that were accompanied by 'subtypes'. Although the terminology in his approach is slightly outdated his classification is still of great significance due to the dimensions that are described in it. He characterized normal personality by three primary types: sensitive, active, and apathetic. The

sensitive, also known as an emotional one is characterized by pleasant or unpleasant emotions and introverted feelings. The active is characterized by extroversion, courage, and easy-goingness. The apathetic which correlates with the lymphatic temperament in the humoral classification showed a limited amount of excitement and emotional reactions. These categories were created into subtypes based on various dimensions. For example, the first primary category known as the sensitive one was divided into three subtypes. The humble demonstrated limitations in intelligence and energy, the contemplative demonstrated sharp intellect and sensitivity, and the emotional was the last subtype (Ribot, 1896). „In short, beginning with the true character (i.e., the affirmation of a personality under a stable form consistent with itself), which is never completely realized, or free from transient eclipses, there are all possible shades of deviation from unity and stability, till we reach that stage of uncoordinated multiplicity at which character has either not come into being or has ceased to exist“ (Ribot, 2007). An individual who was also very important in creating a new direction for psychology and its approaches was Gerard Heymans. Heymans was a philosopher and psychologist from the Netherlands. From 1890 to 1928 he also lectured at the University of Groningen. He greatly supported the experimental approach to psychology, using empirical methodology as much as possible. Moreover, he opened the first psychology lab in Groningen in 1892, it was the first one in the Netherlands. He preferred doing experiments in the field of general psychology. He also liked researching optical illusions, psychic blocks, and telepathy. Gerard was the pioneer in applying empirical research methods when it comes to the study of personality. One of his most impressive creations is the 'Cube of Heymans', which served to describe the personality typology (Gauchet & Lambert, 1959). According to him, personality types are divided into three dimensions; activity level, emotionality, and primary versus secondary functioning. The last dimension corresponds to extroversion and introversion. Dimension marked as the activity level referred to a personal urge to work and strive as opposed to inner passivity. Emotionality refers to individuals who are easily affected by the environment versus individuals who demonstrate unbothered behavior. The last dimension was based on the primary and secondary effects of consciousness. Secondary effects lasted longer and occurred when the original contents were out of the center of consciousness (Van der Werff, 1985). On the Heymans cube, these dimensions are positioned on x-, y-, and z-axes. „All combinations of these three dimensions are what define the eight personality types. The eight personality types are amorphous, sanguine, nervous, choleric, apathetic, phlegmatic, sentimental, and passionate. The eight types are Heymans terminology, obviously inspired by Greek medicine, and constitutes a link between ancient schools and modern experimental psychology.“ (Crocq,

2013). To follow up, English scientist Sir Francis Galton made the first modern attempt to define the core of human personality. Lead by the assumption that personality characteristics that are going to be important to a group of people will eventually be represented in their language, he described the personality dimensions by using a lexical approach. Later on, other scientists followed his example and used the lexical hypothesis which enforces a belief that the traits that are obligatory to human interaction are encoded in the language (Galton, 1884). Toward the middle of the twentieth century, the terminology used for personality disorders changed a lot. Some terms faded and some got a new connotation, for example, the term 'psychopathic' which is now associated with an aggressive and anti-social personality. With the further development of psychiatry and new approaches in psychology, a more general concept of character disorders came into use (Millon et al., 2003).

2.2. Assessment

The diagnostic process of personality disorders is based on correctly and dubiously evaluating the long-term behavioral model. This long-term behavior model comprises permanent and pervaded patterns of emotional expression, perception of oneself and one's interpersonal relationships as well as social functioning alone and with other people. For significant results, this long-term model of behavior must meet the general diagnostic criteria in at least two areas mentioned above (Brekalo, 2023). When it comes to giving the right diagnosis, an indispensable thing to do is obtain information from the patient and his environment. It can be done so by looking into previous public or private records, such as school and medical records, as well as any troubles with law/prison records. Other crucial information can be extracted from statements and observations of the patient's loved ones, particularly friends and family but also acquaintances or work colleagues (Semple and Smyth, 2013). These third-party data are of valuable importance since these kinds of patients usually cannot have objective insight into their behavior. When diagnosing a personality disorder a psychologist should take three criteria into account to rule out other pathologies. The first criterion is that the defining characteristics had been exhibited by early adulthood. The second is that the characteristics are pervasive regarding the long-term functioning of the patient. The last one is that characteristics do not only occur during an episode of another mental illness disorder. The last criterion is of key importance for cluster A disorders. Also, worth mentioning is that if the diagnostic process regards children, their symptoms must last at least a year. The only exception to that rule is antisocial personality disorder because it cannot be diagnosed if the patient is under eighteen. This is because the disorder is characterized by a long-standing

pattern of disregard for the rights of others and for societal norms, which usually requires a significant period of time to develop and manifest consistently. When approaching the diagnostic process, the cultural, social, ethnic, and religious background should be taken into account since it is a major basis for creating beliefs and certain behaviors as a consequence (Marčinko et al., 2015).

2.3. Categorical approach

The categorical approach is applied in ICD-10, DSM-IV, and section II of DSM-5. Within this approach, disorders can be either present or absent. Their presence depends on whether they are close to matching a standard universal description of certain characteristics. The diagnostic process is in the end solely black and white as there should not be any in-between diagnoses. It can be explained by the premise that any disorder is just a deviation from the norm. In terms of any diagnostic case, the disorder is present only if the proven and categorical satisfying symptoms constitute it. With this approach, there is a greater amount of disorders whose presence depends on standard prototypes. For instance, there can be two separate disorders present that can coexist together, such a state is called a comorbidity. If the symptoms concerning the two disorders are present at the same time, disorders become comorbid (Avatashi et al., 2014). In the DSM-IV-TR version hierarchical taxonomic system was used to classify personality disorders. The ten personality disorders are stated as polythetic categories which means that they are bound by certain criteria but not all criteria have to be fulfilled to get the diagnosis. All of them are set forth by a range from seven to nine items. Every disorder has a subset that has to be matched for them to reach the threshold for diagnosis. Every disorder existence usually requires five present symptoms, and a cutting score defines every disorder. The categorical approach allows for a great amount of variations, for instance, diagnostic criteria for BPD can be met in one hundred twenty-six ways. In the DSM-IV-TR version personality disorders are categorized into three categories that are called clusters. Disorders are grouped into clusters by their similar features, for easier remembrance and association (Trull & Durrett 2005). There are a few advantages to using the categorical approach. According to (Frances, 1990; Gunderson et al., 1991; Millon, 1981) this approach is more convenient than others, due to the consideration of one to a few categories rather than considering certain disorders throughout the whole spectrum of degrees of existence. It offers simplicity, clear starting and cut-off lines for pathology, and the distinction between categorical membership (Cantor et al., 1980; Shedler et al., 2010). At first, the categorical approach was more favorable and it was enough to look at the classification of DSM-IV-TR to see the effect

it left on clinical assessment and its framework development. But very soon the flaws of such an all-or-nothing system became evident. „The categorical approach would be appropriate if there were a qualitative or at least a clear distinction between the presence and absence of a personality disorder." (Grove & Andreasen, 1989; Kendell, 1975). Four studies have tried tackling this premise and the conclusion of all four was that the results were more in line with the dimensional model (Frances, Clarkin, Gilmore. Hurt, & Brown, 1984; Kass et al., 1985; Nestadt et al., 1990; Zimmerman & Coryell, 1990). „If the threshold for the diagnosis of a personality disorder is largely arbitrary, it is readily understandable that clinical diagnoses would be unreliable." (e.g., Mellsop, Varghese, Joshua, & Hicks, 1982). There is a high probability that everyone has at least one maladaptive personality trait but the problem arises when there is no clear border at which maladaptive traits are considered clinically significant. Consequently, clinicians use their own discernment to decide at what point the patients should get their diagnosis. Although, DSM-III-R is the provider of the diagnostic thresholds nine out of the eleven diagnoses were not based according to it but rather on the agreed rules set by the Personality Disorder Advisory Committee. Moreover, the placement of cutoff points was not accompanied by data, hence why for avoidant personality disorder the threshold is set up to five out of seven needed criteria. This setup seemed to be too constraining but lowering it to three out of seven seemed too extensive. ICD-10 faced similar problems as both versions of DSM when it came to the categorical approach. There were ten prototypes of personality disorders followed by a great number of related symptoms, which would often overlap. Psychologists often used three diagnostic categories for disorders, making the remaining classification seem excessive and unnecessary. They divided into Emotionally Unstable Personality Disorder; Antisocial Personality Disorder; and Personality Disorder Not Otherwise Specified. Additionally, comorbidity was not only a problem for DSM but also for ICD classification. Comorbidities, due to patients meeting many more than one criteria, seemed more pervasive than they should have been, which raised suspicion around their validity. As a result, it contributed to the enlarged stigmatization of mentally ill individuals and personality disorders in general since it greatly increased the number of diagnoses. Following the accumulation of problems regarding the categorization approach, the newer, upgraded version of ICD-10 called ICD-11 brought a new approach to diagnosing and classification of personality disorders (Swales, 2022).

2.4. Dimensional Approach

Dimensional, in contrast to the categorical approach draws strong scientific support from research regarding the understanding of personality disorders and the usage of dimensionality on personality traits (Krueger & Eaton, 2010; Peter Tyrer, 2012; Widiger et al., 2009). The dimensional approach is particularly known for clarifying the variations when it comes to comorbid and individual traits. Additionally, the usage of more universal and constant trait dimensions ensured the minimization of multiplicity in classification systems (Widiger, Simonsen, Sirovatka, & Regier, 2006). Morey et al. (2012) study discovered that traits used in the dimensional approach had greater accuracy than DSM-IV structures of classification in the forecast of functioning, psychopathological descriptions, and usage of medication over 10 years. The new, upgraded version of DSM, called DSM-5 brought to light the merge of these two approaches when it comes to the diagnosis and classification of personality as well as other disorders. Past editions of the DSM required clinicians to conclude on presence of the disorder based on strict categorical models. The dimensional approach now permits clinicians more room for assessing the degree of the condition, without limiting it only to a rigorous threshold ranging from normal to disorder state. It can also help further research in this field by using models of assessment that focus on symptomatic severity and gather more data for furthering treatment plans. A characteristic of categorical approach was the narrowness in obtaining clinical data, thus slowing the search for solutions and betterment in regards to diagnosing, treating, or prognosis of mental disorders. The dimensional approach also has better and deeper insights into symptoms, consequently leading to destigmatizing the disorders since it decreases the number of patients who could have been falsely diagnosed under the overlapping criteria of DSM-IV. The approach in DSM-5 is more individual-centered, rather than categorically centered. “We have all been preoccupied with diagnostic categories and ignored the individual.“ (Livesley, 2013, Keynote). Usually, individuals don't fully belong to one or more categories, and since this approach highlighted the spectrum of dimensions that automatically allows for more freedom to express oneself in terms of diagnostic criteria. Research data that is obtained by spectrum assessment has shown to have higher reliability, stability, and validity. For testing and formulation of hypotheses, spectrum models are wanted more than categorical ones. „To ensure DSM-5 is not overly disruptive to clinical practice, its spectrum measures are compatible with categorical definitions. The new edition combines the best of both categorical and dimensional approaches to provide better guidance to clinicians and, as a consequence better treatment for patients.“ (American Psychiatric Association, 2013). The main goals of the

new approach were to simplify and make the most use of the classification system. When it comes to the development from ICD-10 to ICD-11 the process of classification has become more simple. The basis is that it consists of two diagnostic steps. First to see whether the patient meets the requirements for certain disorders (that in the new versions have more clearly defined and fewer symptoms) and then assess how severe the condition is. Giving attention to the severity of the disorder has been needed for a while. It is closely connected with the intensity of treatment, the amount of required support, and the frequency needed for dealing with the disorder (Bach & Simonsen, 2021). Of late, researchers delegated the methodological power of severity (Pincus et al., 2020; Sharp & Wall, 2021). Many of them wanted it to become a central requirement in the diagnostic process, and in their conducted research a solid bond can be found between the severity of symptoms and outcomes in clinical settings (Clark et al., 2018; Crawford et al., 2011; Yang et al., 2010). A few characteristics determine severity. „The degree and pervasiveness of disturbance in the person's relationships and their sense of self. The intensity and breadth of the emotional, cognitive, and behavioral manifestations of the person's disturbance. The extent to which these patterns and problems cause distress or psychosocial impairment. The level of risk of harm to self and others.“ (American Psychology Association, 2013). As the disorder furthers on in its severity it affects a greater amount of areas in the patient's life, areas become burdened with difficulties coming from the disorder, and tendencies to harm oneself or other people become evidently more pervasive. Severity is marked by three categories, mild, moderate, and severe. Mild Personality Disorder is the 'weakest' form of the disorder, only some domains of personality performance are affected. For instance, patients with this diagnosis might face difficulties when it comes to social relationships and roles, but some are still maintained and or carried out. The demonstrated difficulties are usually not connected to the idiations of harming oneself or other people. All this is not to say that the patient does not feel disturbance on a few levels of functioning, or in more levels but with less intensity. Moderate personality disorder has multiple areas of functioning that are affected. Such areas are usually a sense of self, having and maintaining close relationships, and the ability to control behavior. Even with these disturbances, some fields might be a little less impacted, but the connections with harming oneself or others are sometimes present. Patients who have severe personality disorder experience a greater amount of disturbances when it comes to their sense of self-functioning. Disturbances that happen most often are having no sense of who the person is, dramatic changes in their beliefs and feelings, and experiencing a strong sense of numbness. Certain patients might possess a very strict and inflexible outlook on life and their routines. Their sense of self can also be characterized by

grandiosity, eccentricity, and or feelings of self-contempt (Tyrer, 2015). Even though there are only two required steps in the making of a diagnosis, clinicians can take two additional steps to gain more insight into the patient's condition. In ICD-11 there is a description of five sets of dimensions called 'trait domain specifiers' that align with normal structures of personality characteristics. They are also correspondent with the 'Big Five' model (McCrae & Costa, 1987) Factor analytic studies broadly speaking support the ICD-11 five-factor structure (Bach et al., 2017; Mulder et al., 2016), although some studies have found four factors rather than five, where one factor captures the two opposites of disinhibition versus anankastia (Bach et al., 2020; Oltmanns & Widiger, 2018). Although a few trait domain specifiers can be utilized to depict personal characteristics, patients who have severe disturbances often have more visible traits. However, it is valid for them to demonstrate solely one trait domain (Tyrer, 2015). The trait domain specifiers in ICD-11 are negative affectivity, disinhibition, dissociality, anankastia, and borderline pattern. Negative affectivity is the inclination to feel a wide spectrum of unpleasant emotions, such as anxiety, anger irritability, depression, and others. They usually manifest as the result of real or imagined small stressors. Disinhibition is the inclination to act impulsively on the basis of external or internal stimuli. Individuals with that trait do not think about the consequences that could occur. The third trait is dissociality. It stands for neglect of other people's feelings and rights due to individuals being self-centered and lacking empathy. Anankastia is a state of wanting everything to be susceptible to one's own strict and narrow requirements of perfection and, a sense of right and wrong. To affirm conformity, these individuals want to be able to control one's own and others' behavior. The borderline pattern is applied to patients who have characteristics of unstable personal relationships, fluctuating self-image, and avoidance of any kind of abandonment (World Health Organization, 2019). „Whilst transitioning away from well-understood and familiar concepts presents a challenge, the simplified structure of the classification opens up potential benefits in terms of simplicity and clinical utility, increased awareness of risk and better matching of resource-intensive therapies to severe presentations. How far these benefits are realized will depend upon clinicians embracing the new classification, on researchers further developing measures to capture the new method of classifying, and on treatment developers evaluating their treatments using the new structure." (Swalles, 2022).

2.5. Personality Disorders

Cluster A Personality Disorders

Personality disorders in cluster A are followed by characteristics of being odd and eccentric (American Psychiatric Association, 2013). They perceive the world as being the 'problem' and 'out of line', rather than thinking they are (Derksen 1995). This perception can make them appear self-centered and selfish with no regard to other people, and make it harder for them to initiate or maintain any kind of relationship.

Schizotypal Personality Disorder (F 21)

„A pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships as well as by cognitive or perceptual distortions and eccentricities of behavior, beginning by early adulthood and present in a variety of contexts." (5th ed.; DSM–5; American Psychiatric Association, 2013).

Diagnostic criteria

There are nine diagnostic criteria in the DSM-V. The first criterion is having ideas of reference that come from incorrectly interpreting casual incidents as having deeper odd meanings behind them. They think somehow everything is directly because of them or connected to them. These should be distinguished from delusions of reference, in which the beliefs are held with delusional conviction. The second criterion is having odd beliefs or magical ideations that have a great impact on their behavior. These ideations are inconsistent with subcultural norms, such as; superstitions, telepathic abilities, sixth sense, and clairvoyance. Similar to that, the next criterion is about having unusual perceptual experiences which can include bodily illusions like sensing the presence of another person or hearing a voice murmuring their name. The fourth criterion, according to the DSM-V, is thinking and speaking oddly, in a vague, metaphorical, and overelaborate manner. It can also include idiosyncratic construction and phrasing. Individuals who suffer from this disorder can often be suspicious and have thoughts about other people wanting to harm them, which is the fifth criterion. Inappropriate or constricted affect would define the sixth criterion, because these individuals often seem to be inappropriate and stiff in their social interactions. They often appear to talk in a very blended and constricted fashion. It all goes alongside the seventh criterion, about demonstrating very odd, peculiar, or eccentric behavior. Their outward appearance can also seem peculiar including fashion, hygiene, and mannerisms. Since they

appear odd and have a restricted social range they lack people they can trust and they don't have many close friends other than first-degree relatives, which is the eighth criterion. The last criterion is having excessive social anxiety which doesn't get easier with familiarity because it is often associated with paranoid fears related to others rather than negative judgments about self.

Paranoid Personality Disorder (F 60.0)

„A pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent, beginning by early adulthood and present in a variety of contexts.“ (5th ed.; DSM–5; American Psychiatric Association, 2013).

Diagnostic criteria

The first criterion is suspicion about other people exploiting, harming, or deceiving them, without sufficient basis. The second criterion is constantly having unjustified doubts about the intentions and loyalty of other people, whether they be friends or associates. They have thoughts about other people plotting against and attacking them, and feel as if they have been betrayed or hurt by others even when there is no objective evidence for this. The third criterion is not wanting to confide in others because of irrational fear that somehow given information will be used maliciously against them. If there is any perceived deviation from trustworthiness it serves to support their underlying assumptions. The next criterion is assigning hidden threatening meanings to benign remarks or events. They can interpret innocent mistakes, humor, or assumptions as an attack or malicious intent. The fifth criterion is about constantly holding grudges, It entails being unforgiving of insults, injuries, slights, and mistakes in general that they think they have received. The sixth criterion is perceiving attacks on their character that are not apparent to others. The last criterion is characterized by having recurrent suspicions about the fidelity of their partner that is without justification. Gathering seeming evidence to support their claims, and wanting to maintain control over their love partner.

Schizoid Personality Disorder (F60.1)

„Schizoid personality disorder is a pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings, beginning by early adulthood and present in a variety of contexts.“ (5th ed.; DSM–5; American Psychiatric Association, 2013)

Diagnostic criteria

The first criterion for this disorder is about not enjoying or desiring to be a part of the family or having any close relationships for that matter. The essential feature of this disorder is detachment from social relationships and having a limited range of interpersonal emotions. The second criterion is primarily choosing solitary activities. The third criterion is a lack of interest in having sexual experiences or intimacy with another person. The fourth criterion is that they take little to no pleasure in activities. The next criterion is lacking friends or people they can rely on other than their first-degree relatives. The last two criteria are kind of similar, appearing indifferent to the praise or criticism of others and showing emotional coldness and detachment. They even may be oblivious to social cues and social interaction, thus, making them seem socially inept or superficial and self-absorbed. They do not display emotions or expressions of any kind, they rather appear as having a "bland" exterior.

Cluster B Personality Disorders

Being the most common in clinical practice, they are characterized by very high rate of suicide attempts. Individuals suffering from one of these disorders experience suicidal ideations, threats of harming themselves or others, and disturbances in function regarding their personal and social lives (Jemal et al., 2022).

Antisocial Personality Disorder (F60.2)

„A pervasive pattern of disregard for and violation of the rights of others, occurring since age 15 years, as indicated by three (or more) of the following criteria." (5th ed.; DSM–5; American Psychiatric Association, 2013).

Diagnostic criteria

The first criterion is the inability to conform to social norms. They have no respect for lawful behaviors, as indicated by repeatedly performing acts, such as destroying property, stealing, harassing others, or pursuing illegal occupations, which are all grounds for arrest. Connected to the first criterion, the second is being deceitful, which is demonstrated by constant lying, manipulating, and conning others for personal profit or pleasure. The third one is a failure of strategic planning and impulsivity. The fourth criterion is being highly and constantly irritable and displaying aggressiveness through physical fights or assaults. Similarly, they have no regard for the safety of self or others, which is the fifth criterion. It can be displayed with reckless driving, speeding, driving under the influence, engaging in reckless

sexual behavior, or substance use that has a high risk for harmful consequences. The sixth one is consistent irresponsibility, in work and personal obligations, lack of motivation and dedication across all fields of life. They show little to no remorse for the consequences of their actions because they are rationalizing them. They often appear indifferent and cruel because of that, which is the seventh and last criterion. Other diagnostic criteria according to the DSM5 is that the individual has to be at least 18 years old. Lastly, if conduct-disordered behavior happened before the age of fifteen and if the antisocial behavior is happening independently, apart from schizophrenia or bipolar disorder episodes.

Borderline Personality Disorder (F60.3)

„A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts.“ (5th ed.; DSM–5; American Psychiatric Association, 2013).

Diagnostic criteria

The first criterion and the most recognizable feature of this disorder is going to great lengths to avoid real or imagined abandonment. They do not tolerate being alone or distant even if it is for a couple of hours, which leads them to have inappropriate and dramatic outbursts, sometimes threatening to harm themselves or others. That sense of instability leads to a pattern of unstable and intense interpersonal relationships. Individuals are usually characterizing their relationships by alternating between extremes of idealization and devaluation, which is the second criterion. The third criterion is consistently having an unstable sense of self, which causes identity disturbance. These individuals often experience dramatic shifts in self-image, they are usually characterized by sudden and drastic changes in values or goals, concerning career plans, sexual identity, interpersonal relationships, etc. The fourth criterion is impulsivity but in at least two areas that are potentially self-damaging. The impulsivity can be manifested in reckless spending, risky sexual endeavors, substance abuse, binge eating, and or speeding. It is worth mentioning that these self-damaging areas do not include suicidal or self-mutilating behavior, which is covered in criterion five. To better define it, the fifth criterion would be recurrent suicidal behavior, gestures, threats, or self-mutilating behavior. Self-harm is very common, while completed suicides happen in 8%–10% of cases. Moreover, individuals with BPD can display affective instability which happens because of marked reactivity of mood. It can also be impacted due to the individual’s extreme reactivity to interpersonal stresses. They can, as stated in the seventh criterion, suffer from chronic

feelings of emptiness, they constantly seek something new to do. The eighth criterion states that these individuals often times demonstrate inappropriate and intense anger. They also face problems with controlling it, alongside their verbal outbursts, bitterness, and extreme sarcasm. After anger is demonstrated they often feel ashamed and guilty, which further reinforces their inner belief about being an evil person. The last, ninth criterion is having paranoid ideations or severe dissociative symptoms during times of extreme stress. Most often, they happen because of the real or imagined behavior they think they are experiencing. It can change and last from minutes to hours and can go into remission if the person who seemingly abandoned them comes back.

Histrionic Personality Disorder (F60.4)

„A pervasive pattern of excessive emotionality and attention seeking, beginning by early adulthood and present in a variety of contexts.“ (5th ed.; DSM–5; American Psychiatric Association, 2013).

Diagnostic criteria

The first criterion for diagnosing histrionic personality disorder is that these individuals are not comfortable with situations in which they are not at the center of attention. They feel unappreciated if not in the center, and thus, tend to draw attention to them by appearing lively and dramatic or open or flirtatious. The second criterion is that their interactions with others are filled with provocative and sexually seductive behavior. The next, third, criterion is that they display very rapid and shallow expressions of emotions. The fourth criterion is the excessive use of physical appearance to draw attention to the self. They take excessive amounts of care, energy, and money into bettering their physical appearance. The fifth criterion is speaking in a vague but impressionistic way. The sixth criterion is characterized by theatricality, having an exaggerated expression of emotion. Reacting, talking dramatically, and demanding the full attention while they are telling their stories. The seventh criterion is being very easily swayed, or influenced by others or by circumstances. They can be very suggestible, and adopt convictions quickly. The eighth criterion is that when it comes to relationships, they consider them to be more intimate than they actually are.

Narcissistic Personality Disorder (F60.81)

„A pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy, beginning by early adulthood and present in a variety of contexts." (5th ed.; DSM–5; American Psychiatric Association, 2013).

Diagnostic criteria

The first criterion is defined by the individuals having a grandiose sense of self-importance. They often appear boastful or pretentious. The second criterion is having excessive fantasies of grand and unlimited access to power, success, and beauty. Being preoccupied with them and thinking they deserve them without making an effort to get them, just because they are special. The feelings of being special and unique are characteristics of the third criterion. They believe they cannot be understood by just anyone, but only by other „special" or high-status people. Closely tied to that one, the fourth criterion is requiring excessive admiration from other people. The fifth criterion is having a sense of entitlement. They usually have very unreasonable expectations of others to give them favorable treatment or to automatically comply with whatever they want. They are often very exploitative in their interpersonal relationships, which is the sixth criterion. They take advantage of others to achieve their own goals, they believe that the end justifies the means. The seventh criterion is their lack of empathy. They cannot or they are unwilling to recognize and identify with the feelings and needs of others. The eighth criterion is that they are constantly envious. The last criterion is the arrogant behaviors or attitudes that these individuals demonstrate. They can appear very patronizing and coincided which can manifest in very cruel ways; toward their friends, colleagues, or other institutional workers.

Cluster C Personality Disorders

Characteristics of the Cluster C disorders are anxiousness and fearfulness. These individuals suffer from low self-esteem thus they often avoid any social occasions to not be criticized. They must depend on somebody and fear being alone and in charge. They are not flexible, do not like compromises, and plan every detail of their lives meticulously in their minds (Fariba et al., 2023).

Avoidant Personality Disorder (F60.6)

„A pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation, beginning by early adulthood and present in a variety of contexts.“ (5th ed.; DSM–5; American Psychiatric Association, 2013).

Diagnostic criteria

The first criterion according to the DSM-5 is avoidance of occupational activities in which there is significant interpersonal contact involved because these individuals fear criticism, disapproval, or rejection. The second criterion is the unwillingness to get involved with other people because they are not a hundred percent certain other people like them. They also demonstrate restraint when it comes to intimate relationships because they have fears of being shamed or ridiculed, which defines the third criterion. In their interpersonal relationships, they are restrained and often withhold intimate feelings. The fourth criterion is a preoccupation with rejection and criticism in social settings. The fifth criterion is inhibition when it comes to new interpersonal situations, it is done due to feelings of inadequacy. The sixth criterion is viewing oneself as personally unappealing, socially inept, or inferior to others. These beliefs become more prominent when there is a social interaction with strangers. The last criterion is an unusual reluctance to take any personal risks or to engage in any new activities because these may prove embarrassing. They are prone to exaggeration of the potential dangers in ordinary everyday situations and their restricted lifestyle stems from their needs for certainty and security.

Dependent Personality Disorder (F60.7)

„A pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation, beginning by early adulthood and present in a variety of contexts.“ (5th ed.; DSM–5; American Psychiatric Association, 2013).

Diagnostic criteria

The essential feature of dependent personality disorder is a pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation (5th ed.; DSM–5; American Psychiatric Association, 2013). The first criterion for the classification of dependent personality disorder, according to the DSM-5, is the inability to make everyday decisions if there is not an excessive amount of reassurance and advice from other people. The second criterion is needing others to be or take responsibility for major areas

of their life. They depend on others to decide where they are supposed to live, what job should they take, or which friends to have. This need goes beyond age and situation-appropriate requests. The third criterion is difficulty when it comes to expressing disagreement with others because of fear of loss of support. The fourth criterion is having difficulty initiating or doing things on their own because they lack self-confidence in their abilities, rather than a lack of motivation. These individuals are convinced that they cannot function independently and present themselves as inept and requiring constant assistance. The fifth criterion is being so afraid of losing nurturance and support from others that they go to excessive lengths to obtain it, even if it includes doing unpleasant things. The sixth criterion is experiencing feelings of helplessness when being alone due to their fears of being unable to care for themselves. The seventh criterion is urgently seeking a new relationship after the close relationship ends, due to needing a source of care and support- they are motivated by their fears of being alone. The eighth criterion is an unrealistic preoccupation with fears of being left alone to take care of themselves.

Obsessive-Compulsive Personality Disorder (F60.5)

„A pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency, beginning by early adulthood and present in a variety of contexts.“ (5th ed.; DSM–5; American Psychiatric Association, 2013).

Diagnostic criteria

The first criterion is a preoccupation with little things; such as details, lists, rules, or order to the extent that the major point of the activity is already lost. The second criterion is demonstrating perfection which then interferes with task completion. For example, failing to meet the deadline because their own overly strict standards are not met. The third criterion is excessive devotion to work and productivity which excludes social interactions and leisure activities. The fourth criterion is being overconscientious and inflexible when talking about matters of morality, ethics, or values that are not accounted for by cultural or religious identification. The fifth criterion is the inability to discard worthless objects even when they have no sentimental value. The sixth criterion is a reluctance to teamwork due to their fear of others not being able to submit to their way of doing things. They would rather work alone to perfection, in „controllable“ conditions, rather than having to compromise their way to it. The seventh criterion is an unhealthy relationship with money. Money is hoarded and stored for

future catastrophes, it is hardly spent on pleasures. The big characteristics of obsessive-compulsive personality disorder are rigidity and stubbornness, which define the eight criteria. They are often too deep into their perspective and way of doing things that they are not willing to change it for anybody. They hardly listen to other people's ideas or proposals, it disturbs their „perfect plans" that are already meticulously planned in their minds.

2.6. Etiology

The origin of personality disorder remains elusive which allows for the creation of a broad range of hypotheses. Personality disorders are seen as the product of the relationship between genetics and experienced traumatic events. According to the psychoanalytic theory, it is suggestable that these disturbances come as a consequence of failing to progress through proper psychosexual development. Followed by Freud's drive theory which explains how obsession at different stages of development can be demonstrated into separate disorders. For instance, a dependent personality disorder is a consequence of obsession at an oral stage, while obsessive-compulsive and histrionic are failed progressions at anal and phallic stages (Fariba et al., 2023). Individuals suffering from BPD and antisocial disorder have disturbances in intimate relationships and have a lack of trust. Both components can be closely related to the consequences of childhood abuse or trauma. There are a few researches which explored the consequence of exposure to unpleasant events in childhood and the risk for developing a disorder later on. A study by Bjorkenstam et al., (2017) showed that there is a close relationship between accumulated childhood adversity and diagnosis of personality disorder. „Furthermore, childhood or adolescent psychiatric disorders have been suggested to trigger a chain of behaviors and responses that foster the more persistent psychopathology of a personality disorder." (Kasen et al., 1999). It is believed that dysfunctional domains have a link to certain neural circuits in the brain. Hence, for the past decade, neuroimaging techniques have contributed to the exploration of the circuits's neural integrities in patients with personality disorders. Borderline is the most researched disorder. „In general, the studies have thus far demonstrated deviations in neuronal circuitry in areas previously found to be active in the symptomatology that characterizes the specific type of PD. Even if the results of such studies contribute to an understanding of underlying physiological processes, they are not yet ready to be used in clinical practice." (Fariba et al., 2023). Since the origins of the disorders are not fully known it makes it harder to find out their pathophysiology. Today, studies aim to explore abnormalities in the function and structure of the brains suffering from these disorders. Extensive studies found abnormal neurobiological workings in individuals suffering from

schizotypal, borderline, antisocial, and paranoid personality disorders. „Findings in paranoid personality disorder point to altered amygdala functioning; in schizotypal personality disorder, a volumetric decrease in the frontal lobe, along with dysfunctional temporal lobe cingulum; and in BPD, significantly decreased responsiveness of midline regions of the prefrontal cortex, resulting in a dysfunctional top-down control of the affective response. To determine the importance of genetic and environmental factors in early childhood in personality pathology the relationship between vulnerability to child abuse and antisocial personality patterns in adulthood was investigated." (Caspi et al., 2002). One of the findings was that individuals who possess a gene called polymorphism also have lower monoamine oxidase A (MAOA) activity and have a higher chance of developing an antisocial personality disorder in contrast to those with higher MAOA activity, but the additional factor is that the first group had experienced child abuse in the past (Byrd & Manuck, 2014). The purpose of the MAOA gene is to code for the monoamine oxidase A which is an enzyme. That enzyme is responsible for catabolizing dopamine, norepinephrine, and serotonin. In recent studies, it has been found that men with the MAOA-L gene have higher activity in the amygdala and lower activity in prefrontal areas during emotional arousal. Which has implications for cognitive and emotional channels that tie the MAOA-L gene and impulsive aggression. Polymorphism inside the MAOA gene can serve as a mediator to the consequences of traumatic events that happened early on, which can affect the inclinations of engagement in violence later on. It has also been found that children who lived through abuse and had lower MAOA activity have higher chances of developing antisocial disturbances as they grow up (McDermott et al., 2009). The relationship between genes and environment has been confirmed in other studies as well (Byrd & Manuck, 2014). Research on other genes has also been done and it showed the similar effects between antisocial tendencies and childhood abuse. All of this calls for more serious consideration of the role the relationships between genetics and environment have on the progress of functional and dysfunctional personality traits.

2.7. Prevalence

According to the estimation of the World Health Organization prevalence of personality disorders in the general population is 6.1% (Tyler et al., 2015). Out of that percentage 3.6% fall on cluster A disorders, 1.5% on cluster B disorders, and lastly, 2.7% on cluster C disorders (Ma et al., 2016). Some of the disorders are not equally prevalent in men and women, for example, women get diagnosed more with BPD, histrionic and dependent disorder, meanwhile, men get diagnosed with antisocial disorder more often. Histrionic, borderline, and dependent

disorders are more common in women, while antisocial personality disorders are more common in men (Marčinko et al., 2015). Personality disorder rates also vary across different countries. It is a result of different cultural and societal norms that play a huge part in the recognition and diagnosis of these disorders (Fariba et al., 2023).

Table 1. Prevalence rates among the general population according to the 5th ed.; DSM–5; American Psychiatric Association, 2013.

Personality disorder	**Prevalence rates**
Paranoid Personality Disorder	2.3% to 4.4%
Schizoid Personality Disorder	3.1% to 4.9%
Schizotypal Personality Disorder	3.9% to 4.6%
Antisocial Personality Disorder	0.2% to 3.3%
Borderline Personality Disorder	1.6% to 5.9%
Histrionic Personality Disorder	1.8%
Narcissistic Personality Disorder	0.5% to 1%
Avoidant Personality Disorder	2.4%
Dependent Personality Disorder	0.5%
Obsessive-Compulsive Personality Disorder	2.1% to 7.9%

3. Conclusion

This study aimed to encompass the origin and development of personality disorders and their clinical diagnosis throughout the years. It follows the emergence of personality disorders from ancient Greece to the 21st century, as their definitions and characteristics evolved. It showcases the etiology and prevalence rates including the definition and diagnostic criteria of every disorder. The diagnostic process has been particularly showcased. A jump from a categorical approach to a dimensional approach for the classification of personality disorders in both DSM and ICD has marked a substantial step in their further development. Adopting a dimensional approach meant leaving behind rigid all-or-nothing classification and adopting a new multifaceted approach. It allowed for the creation of the diagnostic spectrum which subsequently decreased stigmatization and prevalence of the disorders, which is in line with researched literature. The acceptance of the dimensional approach changed ICD and DSM permanently. This study reviewed those changes through a theoretical framework and evaluated both the categorical and dimensional approaches with their manifestations from older to a new version of ICD-11 and DSM-5.

Abstract

The evolution of personality disorders stems back from the Ancient Greco-Roman world and is still ongoing, even though extensive research has already been done on their classification and diagnostic process. They are classified into two manuals; the International Classification of Diseases (ICD-11), and the Diagnostic and Statistical Manual of Mental Disorders (DSM-V). Their development is followed by many changes in nomenclature, classifications, diagnostic criteria, and approaches. This study evaluates those changes. It also accentuates the comparison between the two main approaches, categorical and dimensional, that are credible for the classification and diagnostic criteria in DSM V and ICD-11 that we have today. Moreover, this study explores and demonstrates the origin, characteristics, etiology, and prevalence of personality disorders, from their emergence up to now, in alignment with the theoretical framework.

Keywords

Personality disorders, DSM-V, ICD-11, categorical approach, dimensional approach, diagnostic criteria

Sažetak

Evolucija poremećaja ličnosti potječe iz starog grčko-rimskog svijeta i još uvijek je u tijeku, iako su već provedena mnoga opsežna istraživanja o njihovoj klasifikaciji i dijagnostičkom procesu. Razvrstani su u dva priručnika; Međunarodna klasifikacija bolesti (ICD-11) i Dijagnostički i statistički priručnik za duševne poremećaje (DSM-V). Njihov razvoj prate mnoge promjene u nomenklaturi, klasifikacijama, dijagnostičkim kriterijima i pristupima. Ovaj pregledni rad razmatra te promjene. Također, naglašava usporedbu između dva glavna pristupa, kategoričkog i dimenzionalnog, koji su zaslužni za klasifikacijske i dijagnostičke kriterije u DSM V i ICD-11 koje danas imamo. Sveukupno, ovaj pregledni rad istražuje i prikazuje podrijetlo, karakteristike, etiologiju i prevalenciju poremećaja ličnosti, od njihove pojave do danas, u skladu s teorijskim okvirom.

Ključne riječi

Poremećaji ličnosti, DSM-V, ICD-11, kategorički pristup, dimenzionalni pristup, dijagnostički kriteriji

4. References

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). *American Psychiatric Publishing.*

American Psychological Association. (2018.). Personality. https://www.apa.org/topics/personality

Avasthi, A., Sarkar, S., & Grover, S. (2014). Approaches to psychiatric nosology: A viewpoint. *Indian journal of psychiatry, 56*(3), 301-304. https://doi.org/10.4103/0019-5545.120560

Bach, B., & Simonsen, S. (2021). How does level of personality functioning inform clinical management and treatment? Implications for ICD-11 classification of personality disorder severity. *Current opinion in psychiatry, 34*(1), 54–63. https://doi.org/10.1097/YCO.0000000000000658

Begić, D. (2014.) Psihopatologija. Drugo izdanje. Zagreb: *Medicinska naklada.*

Bjorkenstam. (2017). Childhood adversity and risk of suicide: a cohort study of 548 721 adolescents and young adults in Sweden. *British Medical Journal, 357,* j1334. https://doi.org/10.1136/bmj.j1334

Brekalo, F. (2023). The Evolutionary Significance and Survival of Personality Disorders [*Master's thesis, University of Zagreb, School of Medicine.]* https://urn.nsk.hr/urn:nbn:hr:105:534862

Britannica, T. Editors of Encyclopaedia (2024, April 11). Theophrastus. *Encyclopedia Britannica.*

Britannica, T. Editors of Encyclopaedia (2024, April 5). Théodule-Armand Ribot. *Encyclopedia Britannica.* https://www.britannica.com/biography/Theodule-Armand-Ribot

Byrd, A. L., & Manuck, S. B. (2014). MAOA, childhood maltreatment, and antisocial behavior: meta-analysis of gene-environment interaction. *Biological psychiatry, 75*(1), 9-17. https://doi.org/10.1016/j.biopsych.2013.05.004

Cantor N., Smith E., French R. D., & Mezzich J. (1980). Psychiatric diagnosis as prototype categorization. *Journal of Abnormal Psychology, 89,* 181-193.

Caspi, A., McClay, J., Moffitt, T. E., Mill, J., Martin, J., Craig, I. W., Taylor, A., & Poulton, R. (2002). Role of genotype in the cycle of violence in maltreated children. *Science, 297*(5582), 851-854. https://doi.org/10.1126/science.1072290

Charland, L. C. (2008a). Sir Alexander Crichton on the psychopathology of the passions. *History of Psychiatry, 19*(3), 275–296.

Classification of personality disorders: Reclassifying personality disorders. *Lancet, 377* (9780), 1814-1815. 10.1016/S0140-6736(10)61926-5

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), 147–153. https://doi.org/10.31887/DCNS.2013.15.2/macrocq

Derksen, J. (1995). Personality disorders: Clinical and social perspectives: Assessment and treatment based on DSM-IV and ICD-10. *John Wiley & Sons.*

Ekselius L. (2018). Personality disorder: a disease in disguise. *Upsala journal of medical sciences, 123*(4), 194–204. https://doi.org/10.1080/03009734.2018.1526235

Esterberg, M. L., Goulding, S. M., & Walker, E. F. (2010). Cluster A Personality Disorders: Schizotypal, Schizoid and Paranoid Personality Disorders in Childhood and Adolescence. *Journal of psychopathology and behavioral assessment, 32*(4), 515–528. https://doi.org/10.1007/s10862-010-9183-8

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

Galton F. (1884). Measurement of character. *Fortnightly Review., 36:179–85*

Gauchet F., Lambert R. (1959). La caracteroiogie d'Heymans et Wiersma. Paris, France: *Presses Universitaires de France.*

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

Grob, G. N. (1991). Origins of DSM-I: A study in appearance and reality. *The American Journal of Psychiatry, 148*(4), 421–431. https://doi.org/10.1176/ajp.148.4.421

Gutmann, P. (2008). Julius Ludwig August Koch (1841-1908): Christian, philosopher and psychiatrist. *History of Psychiatry, 19*(2), 202-214. https://doi.org/10.1177/0957154X07080661

HandWiki. (2022, October 28). Moral Insanity. *In Encyclopedia.* https://encyclopedia.pub/entry/31756

Ierodiakonou, K., Theophrastus", The Stanford Encyclopedia of Philosophy (Winter 2020 Edition), *Edward N. Zalta* (ed.), https://plato.stanford.edu/archives/win2020/entries/theophrastus/.

Javier, H. (2014). The Four Humours Theory, *ESSAI: Vol. 12, Article 21.* http://dc.cod.edu/essai/vol12/iss1/21

Jemal, M., Tessema, W., & Agenagnew, L. (2022). Cluster B personality disorders and its associated factors among psychiatric outpatients in Southwest Ethiopia: institutional-based cross-sectional study. *BMC psychiatry, 22*(1), 500. https://doi.org/10.1186/s12888-022-04143-3

Kasen S., Cohen P., Skodol A. E., Johnson J. G., Brook J. S. (1999). Influence of child and adolescent psychiatric disorders on young adult personality disorder. *Am J Psychiatry.* 156:1529–35. [PubMed] [Google Scholar]

Kerns, J. G. (2020). Cluster A Personality Disorders. *The Cambridge Handbook of Personality Disorders, 195–211*. doi:10.1017/9781108333931.037

Kosky, N. (2001). Personality disorder – The rules of engagement. *International Journal of Psychiatry in Clinical Practice, 5*(3), 169–172. https://doi.org/10.1080/136515001317021626

Ma, G., Fan, H., Shen, C., Wang, W. (2016). Genetic and Neuroimaging Features of Personality Disorders: State of the Art. *Neurosci Bull. 32*(3):286-306.

Marčinko D., Rudan V. (2013). Narcistični poremećaj ličnosti i njegova dijagnostička opravdanost Zagreb : *Medicinska naklada*.

McCrae, R. R., & Costa, P. T. (1987). Validation of the five-factor model of personality across instruments and observers. *Journal of Personality and Social Psychology, 52*(1), 81–90. https://doi.org/10.1037/0022-3514.52.1.81

McDermott, R., Tingley, D., Cowden, J., Frazzetto, G., & Johnson, D. D. (2009). Monoamine oxidase A gene (MAOA) predicts behavioral aggression following provocation. *Proceedings of the National Academy of Sciences of the United States of America, 106*(7), 2118–2123. https://doi.org/10.1073/pnas.0808376106

Millon, T. (1981) Disorders of Personality. *John Wiley and Sons, Hoboken.*

Millon, T.,; Simonsen, E.; Birket-Smith, M.; Davis, R. D. (2003). *Psychopathy: Antisocial, Criminal, and Violent Behavior. Guilford Press.* ISBN 978-1-57230-864-0. https://books.google.com/books?id=LSiBsdxcGigC. ;

Morey, L. C., Hopwood, C. J., Markowitz, J. C., Gunderson, J. G., Grilo, C. M., McGlashan, T. H., … Skodol, A. E. (2012). Comparison of alternative models for personality disorders, II: 6-, 8- and 10-year follow-up. *Psychological Medicine, 42*(8), 1705–1713. doi:10.1017/S0033291711002601

Nicolas, S., Sabourin, M. & Piolino, P. (2016). The seminal contributions of Théodule Ribot (1839-1916): The centenary of the passing of the founder of modern French psychology. *L'Année psychologique, 116, 519-546.* https://doi.org/10.3917/anpsy.164.0519

Ozarin, L. (2001). Moral Insanity: A Brief History. *Psychiatric News, 36*(10), 21–21. https://doi.org/10.1176/pn.36.10.0021

Raminani, S. R. (2024, February 3). International Classification of Diseases. *Encyclopedia Britannica.* https://www.britannica.com/topic/International-Classification-of-Diseases

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., Ayuso-Mateos, J. L., Kanba, S., Keeley, J. W., Khoury, B., Krasnov, V. N., Kulygina, M., Lovell, A. M., de Jesus Mari, J., Maruta, T., Matsumoto, C., Rebello, T. J., Roberts, M. C., Robles, R., Sharan, P., Zhao, M., Jablensky, A., Udomratn, P., Rahimi-Movaghar, A., Rydelius, P. A., Bährer-Kohler, S., Watts, A. D., 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

Ribot T. La psychologie des sentiments. Paris, France: *Felix Alcan*; 1896:371–413.

Sartorius N Principal Investigator. The WHO/Alcohol, Drug Abuse, and Mental Health Administration Joint Project on Diagnosis and Classification. *Cooperative agreement U01MH035883, from the National Institute of Mental Health to the World Health Organization,* 1983-2001.

Semple, David, and Roger Smyth (eds), *Oxford Handbook of Psychiatry, 3 edn, Oxford Medical Handbooks* (Oxford, 2013; online edn, Oxford Academic, 1 Mar. 2013), https://doi.org/10.1093/med/9780199693887.001.0001, accessed 21 Aug. 2024.

Smith, W. D. (2024, August 13). Hippocrates. *Encyclopedia Britannica.* https://www.britannica.com/biography/Hippocrates

Spitzer, R. L., & Fleiss, J. L. (1974). A re-analysis of the reliability of psychiatric diagnosis. *The British journal of psychiatry: the journal of mental science*, 125(0), 341–347. https://doi.org/10.1192/bjp.125.4.341

Surís, A., Holliday, R., & North, C. S. (2016). The Evolution of the Classification of Psychiatric Disorders. *Behavioral sciences* (Basel, Switzerland), 6(1), 5. https://doi.org/10.3390/bs6010005

Swales M. A. (2022). Personality Disorder Diagnoses in ICD-11: Transforming Conceptualisations and Practice. *Clinical psychology in Europe, 4*(Spec Issue), e9635. https://doi.org/10.32872/cpe.9635

Šimičić, D. (2018.) Usporedba shizotipnog poremećaja ličnosti i shizofrenije.

Theophrastus. (1870). The characters of Theophrastus: An English translation from a revised text (R. C. Jebb, Trans.). *Macmillan.* (Original work published ca. 4th century BCE)

Trull, T. J., & Durrett, C. A. (2005). Categorical and dimensional models of personality disorder. *Annual Review of Clinical Psychology,* 1, 355–380. https://doi.org/10.1146/annurev.clinpsy.1.102803.144120

Trull, T. J., Widiger T. A. (2013). Dimensional models of personality: the five-factor model and the DSM-5. *Dialogues Clin Neurosci, 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. *Lancet*, 377 (9780),1814-1815. 10.1016/S0140-6736(10)61926-5

Van der Werff, J. J. (1985). Heymans' temperamental dimensions in personality research. *Journal of Research in Personality, 19*(3), 279–287. doi:10.1016/0092-6566(85)90019-4

World Health Organization. (2019). *International classification of diseases for mortality and morbidity statistics (11th ed.).* https://www.who.int/standards/classifications/classification-of-diseases

Wright, A. G. C., Ringwald, W. R., Hopwood, C. J., & Pincus, A. L. (2022). It's time to replace the personality disorders with the interpersonal disorders. *American Psychologist, 77*(9), 1085–1099. https://doi.org/10.1037/amp0001087

Yale Divinity School. (n.d.). Robert Raines (1953 BD). https://divinity.yale.edu/alumni/alumni-awards/award-recipients/robert-raines-1953-bd

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