Personality Disorders in the 10th and 11th Editions of the International Classification of Diseases

Personality Disorders in the 10th and 11th Editions of the International Classification of Diseases

By

Elias Abdalla-Filho

Cambridge
Scholars
Publishing

Personality Disorders in the 10th and 11th Editions of the International Classification of Diseases

By Elias Abdalla-Filho

This book first published 2022

Cambridge Scholars Publishing

Lady Stephenson Library, Newcastle upon Tyne, NE6 2PA, UK

British Library Cataloguing in Publication Data
A catalogue record for this book is available from the British Library

ISBN (10): 1-5275-7733-3
ISBN (13): 978-1-5275-7733-6

I dedicate this book to my family, my true friends
and my patients.

TABLE OF CONTENTS

FOREWORD

Elias Abdalla's book is important as a prompt for thinking about personality disorder. It sets out something of the clinical consensus on classification and raises due concerns about the extent to which we may need to change our clinical approaches. This is timely because on January 1st 2022 the *11th Edition of the International Classification of Diseases* (ICD-11) finally comes into effect, meaning that we must think harder about personality traits along a continuum rather than personalities with hard boundaries between functionality and disorder. For so-called personality disorders such boundaries are rarely truly distinct or without a measure of pejorative judgement. Some reference to this paradigm shift is in most chapters, but it also has its own chapter which emphasises that this change is not without controversy. Indeed, this may have been one of the key factors in the long gestation of ICD-11. Elias explores this. Finally, it is not clear how a dimensional approach will help clinically – such manuals are, after all, just about classification and not about diagnosis. They draw on clusters of presenting features with some reference to their history and consistency and they support reliability in labelling, but do not offer diagnoses. The latter requires inbuilt concepts of aetiology and natural life course of disorder if untreated.

Of particular interest to us, Elias is concerned that the adoption of a dimensional approach may make life especially difficult for the subgroup of people diagnosed with personality disorder who become offenders. He suggests that criminal courts will be even less inclined to accept personality disorder as a mitigating factor for criminal behaviour, not least because he considers that the cognitive deficits and impairments that contribute so strongly to the limitations suffered by so many people attracting a personality disorder diagnosis seem to be played down in this new manual. On this point, if pressed, ICD-11 should be treated in the same way in court as its USA based counterpart, the 5th Edition of the Diagnostic and Statistical Manual (DSM-5), the preamble of which includes a clear disclaimer that it was not designed for use in court and, if referenced there, should be so with great caution (p.25). In court, as in clinical practice, the expert's task is to draw out the components of any disorder that may help the court to understand the degree to which the

offender may be regarded as responsible for his or her criminal act – culpable in the court's terminology – and any related future risks to the public or offender together with any recommendations for a clinical role in promoting safety. In the UK, allowance for the role of any mental disorder in respect of a specific offender generally takes place in the sentencing phase of the criminal hearing. In England, the Sentencing Council (2020), having consulted widely with clinicians and others, has, for the first time, developed a guideline on *Sentencing offenders with mental disorders, developmental disorders, or neurological impairments* (see also Taylor et al, 2021). Incorporated is some practical introductory material on types of mental disorder, including personality disorder; this is to help sentencers to fulfil the call to consider mental disorder or impairment in every case. If it seems relevant, then the sentencer may call on specialist expertise and it is such expertise, not manuals, on which the sentencer should rely, treating each offender as an individual.

Elias Abdalla's book is also timely, because, in the UK, at least some clinicians and some people who have been given a diagnosis of personality disorder have reached consensus on a way forward (https://www.mind.org.uk/media-a/4353/consensus-statement-final.pdf). This built on an earlier English Department of Health supported document *Personality Disorder: No Longer a Diagnosis of Exclusion* paving the way to more clinical acceptance of need and evidence based interventions (National Institute for Mental Health in England, 2003). Three of the authors of the Consensus Statement: Norman Lamb, then a member of parliament, Sue Sibbald, with lived experience of having been given a diagnosis of personality disorder, and Alex Stirzaker, a clinical psychologist (Lamb et al, 2018), highlighted the substantial risks carried with the disorder – reducing life expectancy by about 19 years (Fok et al, 2012) – the grounds for optimism in the range of now well evidenced treatments (Duggan et al, 2007; 2008; 2014) but also the grounds for despair in poverty of access to them. The Royal College of Psychiatrists is building on its January 2020 guidance on treatment of personality disorder (https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/position-statements/ps01_20.pdf?sfvrsn=85af7fbc_2), engaging every specialist faculty in the process so that not only the psychotherapy and forensic psychiatric faculties, in the UK rather used to working together effectively in this area, but also the general adult faculty and all the smaller faculties such as eating disorder and older age faculties, will agree positive ways forward; with the potential for prevention, the Child and Adolescent Psychiatry Faculty is also involved. As with almost all College activities, people who

have had to live with the disorder and, here, the rarely welcoming and often ineffective services to date, are engaged with us in this process.

There is much to like about the structure of Elias's book, although perhaps he would now wish us to question the neat categorical approach to dealing with personality disorder as a collective of distinct disorders? Nevertheless, he does do, one disorder per chapter. Using a familiar format for each is a real strength, helpful for rapid learning. Every chapter follows through from the opening summary of highlights, into aetiological factors, clinical features, diagnosis, treatment, forensic aspects, main disagreements in the literature and one or more illustrative clinical cases. As this is an introductory work, each component is admirably brief. It would have been good, nevertheless, to add a whole chapter on models of understanding disorder development and how to support staff. While it is true that this may be more appropriate for a more treatment focussed book, such as our older volume on hospital treatment models for serious offenders with personality disorder (Newrith et al, 2006), it is generally helpful to present well established models of disorder development just to help clinicians in learn how to manage some of the inevitably difficult relationships that emerge when a patient presents with disorders of personality. It is useful to have some knowledge of attachment theory and its relevance, theory of mind, trauma history and neurochemical disruptions and how they all link. Above all, it would have been good too to see more about the interpersonal disruptions that may feed the disorder – to which therapists are themselves far from immune. Ron Blackburn's interpersonal circle was developed for work with offender patients in secure hospitals (Blackburn, 1998; Blackburn and Renwick, 1996). Of value in any setting is a key component of the operational psychodiagnostics (OPD) system (Cierpka et al, 2007). In theory, there is no need for analytic training for completing any part of this lengthy tool, but it is Axis II of the instrument that is so useful in routine clinical practice. It requires thinking about the four aspects of habitual experience in any set of relationships and rating them according to a set of given criteria, such as admiring or idealising, helping or caring, devaluing or blaming, attacking and threatening, abandoning …. there are 30 such items. Thus, the patient is asked to say how, *time and time again*, s/he experiences her-/him-self, then how s/he experiences others; the therapist or other clinicians are asked how, *time and time again*, they experience the patient and – the dimension we so often forget or deny – how, *time and time again*, we experience ourselves when relating to the patient. On this basis, the consonance and dissonance in relationships can be examined together, acknowledged in non-pejorative language and strategies for optimal communication and therapy developed from there.

Elias's use of case material grounds the work well – and yet this welcome element of the book seemed too brief. That gentle criticism, however, leads to the most positive and enthusiastic of recommendations. Elias should write a second book of case stories illustrating good clinical practice in the field. These would, for sure, highlight some of the immense barriers to engagement even for full assessment, let alone treatment, but also what has really worked – in some cases in making small steps, in some in really helping a person struggling with lifelong difficulties in relating to the world to turn around his or her life experience. Indeed, those who manage this may not only be exceptionally well placed to help – a long standing principle in therapeutic communities – but also in advising on service developments and even be recruits for that next book?

—Pamela J Taylor

References

Blackburn R (1998) Criminality and the Interpersonal Circle in Mentally Disordered Offenders. *Criminal Justice and Behavior* doi.org/10.1177/0093854898025002001

Blackburn, R., & Renwick, S. J. (1996). Rating scales for measuring the interpersonal circle in forensic psychiatric patients. *Psychological Assessment, 8*(1): 76–84. doi.org/10.1037/1040-3590.8.1.76

M. Cierpka T. Grande G. Rudolf M. von der Tann M. Stasch and the OPD Task Force (2007) The Operationalized Psychodynamic Diagnostics System: Clinical Relevance, Reliability and Validity. *Psychopathology*, 40:209–220. DOI: 10.1159/000101363

Duggan, C., Huband, N., Smailagic, N., Ferriter, M., Adams, C. (2007) The use of psychological treatments for people with personality disorder: A systematic review of randomized controlled trials. *Personality and Mental Health*, 1: 95-125.DOI: 10.1002/pmh.22

Duggan, C., Huband, N., Smailagic, N., Ferriter, M., Adams, C. (2008) The use of pharmacological treatments for people with personality disorder: A systematic review of randomized controlled trials. *Personality and Mental Health*, 2: 119-170.doi.org/10.1002/pmh.41

Duggan C and Taylor PJ with Andrew Hider, Tony Maden and Estelle Moore (2014) in Personality Disorders. Chapter 16 in Gunn J and Taylor PJ (Eds) *Forensic Psychiatry, Clinical, Legal and Ethical Issues.* CRC Press: Boca Raton, FL. pp 383-417.

Fok ML, Hayes RD, Chang CK, Stewart R, Callard FJ, Moran P. Life expectancy at birth and all-cause mortality among people with

personality disorder. *Journal of Psychosomatic Research* 2012; **73**(2): 104-7. doi: 10.1016/j.jpsychores.2012.05.001

Lamb N, Sibbald S, Stirzaker A. (2018) *Shining lights in dark corners of people's lives*: Reaching consensus for people with complex mental health difficulties who are given a diagnosis of personality disorder. *Criminal Behaviour and Mental Health* 28:1-4. doi.org/10.1002/cbm.2068

National Institute for Mental Health in England (2003) *Personality Disorder: No longer a diagnosis for exclusion. London: Department of Health.* http://personalitydisorder.org.uk/wp-content/uploads/2015/04/PD-No-longer-a-diagnosis-of-exclusion.pdf

Newrith C, Meux, C and Taylor PJ (Eds) (2006) *Personality disorder and serious offending: Hospital treatment models.* Hodder Arnold: Oxford, UK.

Sentencing Council (2020) *Sentencing offenders with mental disorders, developmental disorders, or neurological impairments*. https://www.sentencingcouncil.org.uk/overarching-guides/magistrates-court/item/sentencing-offenders-with-mental-disorders-developmental-disorders-or-neurological-impairments/

Taylor PJ, Eastman N, Latham R and Holloway J. (2021) Sentencing offenders with mental disorders, developmental disorders, or neurological impairments: what does the new Sentencing Council Guideline mean for psychiatrists? *British Journal of Psychiatry*, 218, 299–301. doi: 10.1192/bjp.2021.21

PREFACE

Personality Disorders in the 10th and 11th Editions of the International Classification of Diseases deals with personality disorders (PDs) for three main reasons:

A. Many professionals find working with patients with PD difficult because of patients' responses to medication or psychotherapy; their frequent involvement in legal issues; their non-recognition of the disorder (which can depend on predominant 'traits'); and the countertransference reactions provoked in professionals. Such factors can generate a vicious circle; psychiatrists' views become increasingly outdated, while patients become correspondingly more resistant.

B. Even though some psychiatrists are disinclined to work with patients with PD, knowledge of the subject is essential. Patients treated for one type of mental disorder may have a comorbid PD, which, if not detected, will compromise the effectiveness of treatment.

C. It is an opportune time to discuss PDs because we are currently transitioning from the 10th to the 11th edition of the International Classification of Diseases (ICD). Although there has been a substantial shift from categorical (ICD-10) to dimensional classification (ICD-11), both have been included and compared herein. Many scholars now prefer to take a hybrid approach to these classifications, so knowledge of both editions is required.

The book takes both a clinical and forensic approach to PDs. This is because, as was noted above, many patients with PDs become involved in legal matters. Also, clinical psychiatrists frequently have trouble dealing with forensic issues. Each chapter is illustrated with clinical or forensic cases, both real and fictional, which will allow for a greater understanding of the different categories and dimensions of disturbed mental functioning.

An entire chapter has been devoted to psychopathy, in particular because of its importance in forensic psychiatry. It pays close attention to the differences between psychopathy and the diagnosis of antisocial personality disorder.

We hope that *Personality Disorders in the 10th and 11th Editions of the International Classification of Diseases* will arouse a greater interest in PDs amongst psychiatrists, psychologists, psychiatric residents, and students.

—Elias Abdalla-Filho

CHAPTER 1

PERSONALITY DISORDER: GENERAL ASPECTS AND CLASSIFICATION

Highlights

Most mental health professionals, including psychiatrists, are not adequately trained to deal with personality disorder (PD) patients.

The aetiological factors of PD are the least investigated aspects of this subject.

The clinical classification of personality disorders (PD) is in the middle of a transition phase, with some preferring the categorical classification of the tenth revision of the International Classification of Diseases (ICD-10), the dimensional classification of the eleventh revision of ICD (ICD-11) or even a hybrid classification.

Compared to other psychiatric conditions, PD patients are among the fewest seeking specialized services for their disorder; at the same time, they are associated with a disproportionately high demand for other health treatments.

More attention and further study are needed regarding medical comorbidities in personality disorders.

Personality disorders are very present in forensic psychiatry, and there are frequent disagreements regarding the criminal responsibility of patients.

Introduction

Perhaps the most contentious subject in psychiatry, both in its clinical and forensic spheres, personality disorders (PD) encompass behaviours considered inappropriate and distant from those expected by society. The problem with the term arises when it is used without evidence-based support (Nathan & Wood, 2016).

The International Classification of Mental and Behavioural Disorders (ICD-10) (World Health Organisation 1990) defines a personality disorder as: "a severe disturbance in the characterological condition and behavioural tendencies of the individual, usually involving several areas of the personality, and nearly always associated with considerable personal and social disruption."

The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) (American Psychiatric Association 2013) defines a personality disorder as: "an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment."

Despite these clear theoretical definitions, psychiatric practice reveals another reality in which several obstacles or biases can make it difficult to diagnose PD. As will be seen later, comorbidities can obscure the identification of a PD. In addition, lifestyle, ethnic, racial, and cultural peculiarities need to be carefully considered so as not to misdiagnose a PD. Other aspects will be considered throughout this chapter.

There is a significant prevalence of PDs in general, especially in urban areas and in younger populations, and they are highly associated with disability (Grant et al., 2004). However, a divergence of results in the various research studies arises when considering specific aspects (such as specific types of PD), especially when relating PDs to certain variables such as gender. There is considered to be a prevalence of 10–13% of PD in society; when including unspecified types, that value increases to around

15% in epidemiological research (Coid et al., 2006; Zimmerman et al., 2005). Lenzenweger (2008) found a median prevalence rate of 10. 56% for “any PD” and a mean prevalence rate of 11. 39% in his study of an American community.

Ma et al. (2016) describe the epidemiological findings of a study conducted by the World Health Organization; the prevalence estimates are 6. 1% for any PD and 3. 6%, 1. 5%, and 2. 7% for Clusters A, B, and C, respectively (these clusters are explained in detail in the topic "Classification" of this chapter). This study also disclosed other important data; PD are significantly elevated among males, the previously married (Cluster C), the unemployed (Cluster C), the young (Cluster A and B), and the poorly-educated. These values are expected to be much higher in psychiatric services and prisons, where the prevalence of people with mental disorders is much higher than in the general population. In a survey of British psychiatric hospitals, an average of 36–67% prevalence of PDs was found (National Institute for Mental Health in England, NIMHE, 2003).

Coid et al. (2006) also found a higher prevalence in males and found cases of comorbidity that might alter the epidemiological study by confusing the diagnosis. In contrast, NIMHE (2003) reports an equivalent distribution between males and females and argues that the higher prevalence between both genders depends on the specific type of PD. This institution found the most prevalent antisocial type in males and the borderline type in females. This correlation between these two specific types of PD and gender was also found in a study by Gawda and Czubak (2017). However, these authors found a different result from that in the study of Torgersen et al. (2001), regarding the obsessive-compulsive (anankastic) type. While the former reported a higher prevalence of this type in females, the latter found a higher frequency of this type in males.

It is important to remember that the use of different diagnostic patterns is one variable that influences epidemiological studies. However, the studies of Gawda and Czubak (2017) and Paris (2004) found a higher prevalence of the following types of PD in females: avoidant, dependent, obsessive-compulsive, depressive, and borderline. In males, the most common types were antisocial, schizotypal, and schizoid.

McGilloway et al. (2010) make a severe criticism, claiming that there is a negligence in the study of the influence of culture, race, and ethnicity on PDs. In their systematic review, the authors found a significant difference in prevalence between black and white groups, but not between Asian or

Hispanic groups, compared with white groups. They reported that black groups had a lower prevalence of PD in British studies. However, it is worth noting the warning of these authors that there is a risk that PD is neglected and not treated in black people with PD. They therefore call for greater attention to these variables in epidemiological studies. Alarcon (1996) has also criticized the DSM-IV, as he considers that this classification system includes only a few suggestions on transcultural aspects of PD.

The following results for PD rates in general populations were obtained by Huang et al. (2006): Western Europe (2. 4%), Colombia (7. 9%), Lebanon (6. 2%), Mexico (6. 1%), Nigeria (2. 7%), Republic of China (4. 1%), South Africa (6. 8%), and USA (7. 6%). However, it is difficult to attribute the epidemiological differences only to ethnic, racial, or cultural variables, as several factors might influence the results such as different sampling methods and instruments used (Tyrer et al., 2010).

In addition, it is worth reproducing here certain peculiarities of different regions studied by various authors and described by Gawda and Czubak (2017). Such peculiarities directly affect the epidemiological study of PDs worldwide. Despite being a recent study, it has some results that might be outdated, but it has the merit of illustrating the diversity of cultural and racial aspects that influence the epidemiological study of PDs. By describing personality characteristics (influenced by local culture) of particular people, the authors warn of the danger of misdiagnosing PD. The main findings are: avoidant, dependent, and borderline PDs are not specified in the Chinese Classification of Mental Disorders (Tang & Huang, 1995); in India, no avoidant PD and no borderline PD in Kenya were diagnosed (Loranger et al., 1997); the prevalence of the borderline type is the highest worldwide except in Kenya (Loranger et al.,1994); in collectivistic cultures, crime rates and PD are lower than in individualistic cultures (Cooke & Michie, 1999); people from the Middle East and Eastern Europe appear more secretive or distrustful to outsiders (Calliess et al., 2008); typical patterns of histrionic PD such as hyper-emotionality, seductiveness, charm, somatization, and the tendency to dramatize can cause risk of misdiagnosis in individuals from the Mediterranean area as displaying histrionic PD (Castaneda & Franco, 1985); Spaniards tend to be unwilling to adjust to social standards, which can be interpreted as histrionic features (Calliess et al., 2008); Southern European or Latin American people might be misdiagnosed as narcissistic (Loranger et al., 1994); Asians, including Filipinos, more frequently than Europeans or North Americans express being shy, afraid, and passive, which might be

interpreted as avoidant or dependent PD traits, and immigrants from foreign countries might be perceived as hostile and cold, which reflects some schizoid patterns (Calliess et al., 2008); the main personality dimensions taken into consideration by cultural psychiatrists are individualism vs. collectivism, dependence vs. independence, and idiocentricism vs. allocentricism (Calliess et al., 2008).

There are several aspects that might explain the different results in the epidemiological studies of PDs such as different research methodologies, the presence or absence of comorbidities with Axis I disorders, and information sources (Beckwith et al., 2014). According to these authors, the prevalence estimate is much higher with the use of structured diagnostic instruments compared to unstructured and clinical diagnoses. Information sources can also greatly change the prevalence estimate and might even double it (Zimmerman et al., 2008).

PD differs from other mental illnesses in several ways, as described in the clinical features topic. However, it is important to remember that each patient's personality traits can affect the pattern of symptoms presented in other mental disorders as well as the results of treatment (Casey &Tyrer, 1990).

Despite these considerations, one cannot forget that comorbidity between PD and other mental disorders is frequent. Comorbidity with PD compromises a good evaluation of the treatment of other mental disorders, and it contributes to treatment abandonment (Tyrer et al., 2010).

Aetiological factors

The systematic review by McGilloway et al. (2010) showed that aetiology was the least researched topic in personality disorders. It is important to consider the procedural character of personality development to address the aetiological risks of different natures (Abdalla-Filho & Engelhardt, 2016). In general, it can be said that such risk factors might have biological bases (constitutional or not) and/or are acquired from the external environment, or they have a multifactorial aetiology in the same individual. Coid (1999) warned of a negligence in the aetiological investigation of PD and criticized the studies carried out until then due to the restriction of the considered variables. This author, who reinforced the idea that the study of the aetiological risk factors of PD could provide new therapeutic approaches, divides these factors into three categories: a) family history of mental disorder in first-degree relatives (such as

depression, schizophrenia, alcoholism, learning disability, or personality disorder); b) neurobiological risk factors (perinatal complications, motor or speech delays, developmental delays, epilepsy, cerebral trauma, and/or infection); and c) early environmental adversity before age 15 (adoption or foster care during childhood, cared for by relatives for five years or more, parental separation, parent lost to death, placement in local authority care, raised in material poverty, experience of repeated arguments and/or violence between parents, physical abuse resulting in injury, or cruelty resulting in severe emotional distress carried out repeatedly or over a prolonged [two years or more] period).

The investigation of the neurobiology of psychiatric disorders often begins with the observation that this disorder is at least partially heritable (New et al., 2008). These studies begin with genes, followed by the genetic influence on neurons through neurotransmitters and enzymes, and further with the structure and function of the central nervous system (Ma et al., 2016). Studies with monozygotic twins have shown very similar behaviours in their personal, social, and professional choices, even when raised in separate environments. The same similarity was also observed in the development of PD and was greater when compared to dizygotic twins. These results were later reinforced by research involving foster children (Kaplan & Sadock, 1981).

Genetically inherited predisposing factors convey a vulnerability that led to the development of the disorder if the individual encounters triggering environmental factors (New et al., 2008). According to these authors, the two personality disorders for which there is the best evidence of familial transmission and heritability are borderline (BPD) and schizotypal (SPD) . They found revealing data on the importance of genetics in the aetiology of PDs such as: a) family studies of BPD reveal that the first-degree relatives of probands with BPD are 10 times more likely to have been treated for BPD; and b) emotional instability and impulsivity were more common in first-degree relatives of BPD patients compared with other psychiatric probands.

Biomarkers for personality disorders can bring clinical classification closer to biology-based evidence, and potential biomarkers can be found in abnormalities of gene sequences, neurotransmitter systems, and the structure and function of the brain (Ma et al., 2016). Paris (2015) remembers that genetic influences can be measured by temperament, too. According to him, a vulnerable temperament tends to increase the likelihood of developing a personality disorder, and he exemplifies:

"highly introverted people will rarely develop narcissistic PD, and a highly extraverted person would not develop avoidant PD."

Birth complications in combination with early child rejection are associated with violent crime in early adulthood (Raine et al., 1994). According to these authors, for the understanding of violent behaviours present in some PDs, it is important to consider the interaction between biological and social predispositions, since the existence of only one risk factor does not have the same aetiological importance for these cases.

Another biological aspect can be observed in the association between high testosterone hormone levels and more aggressive behaviour. However, while the relationship between testosterone and aggressiveness is well established in animals, there appears to be only a weak positive correlation in humans (Book et al., 2001; Abdalla-Filho & Engelhardt, 2016).

Deregulation of serotonin levels has also been associated with impulsive aggressiveness, a symptom that can be observed in some PDs as antisocial and emotionally unstable (Checknita et al., 2015). These authors studied the role of epigenetic processes in the biology of aggressiveness and concluded that reduced monoamine oxidase A (MAOA) activity might contribute to this deregulation of the serotonergic system.

Other biological factors are also investigated in the aetiology of PD including: obstetric difficulties (low weight prematurity or traumatic delivery); brain abnormalities such as early poor development of limbic and septal structures; epilepsy; brain infection; traumatic brain injury; or delayed psychomotor development in childhood. Abnormal electroencephalogram results (such as slow waves in the temporal lobes) have been associated with violent behaviour in certain types of PD (Raine et al., 2010; Abdalla-Filho & Engelhardt, 2016).

Regarding external factors, the influence of a personal history of deprivation stands out. The interaction of the child with the environment in which he/she lives in his/her early years is extremely important as this is the period of formation of the core of his/her personality. The treatment he/she receives, especially from his/her parents, is of crucial value. It is observed, for example, that a consistent and good quality family bond favours the development of confidence that the child and future adult will have in him(her)self.

Particular types of adversity are linked to some specific types of PDs. For example, poor responses to the child's emotions and emotional abuse/neglect

were associated with borderline personality disorder. Also, severe and inconsistent discipline has been linked to antisocial behaviour (Nathan & Wood, 2016).

Sociocultural factors of the empathy development process, including the type of education received by the family, have been associated at least in part with the behaviour adopted by people in interpersonal relationships. People differ in their capacity for empathic accuracy; some of them are good, others are average, and others are poor at inferring the contents of other people's thoughts and feelings (Mast and Ickes, 2007). Empathy deficits, especially emotional empathy, are thought to account for part of the interpersonal style of patients with narcissistic personality disorder, although cognitive empathy is relatively preserved (Nathan and Wood, 2016).

Some studies have examined associations between PD and stressful cultural experiences linked to ethnicity and migration. Chavira et al. (2003) defend the idea that one aspect that has been overlooked that might reveal a better understanding of the aetiology (and treatment) of personality disorder is the impact of culture, race, and ethnicity on PD. They studied the distribution of four types of PD (borderline, schizotypal, avoidant, and obsessive-compulsive) in Caucasian, African American, and Hispanic groups and then made a comparative analysis. The authors found the following results: Hispanics showed a higher borderline rate than Caucasians, and African Americans had higher rates of schizotypal compared to Caucasians. They conclude that the ethnic groups studied present different patterns of personality disorders. Other hypotheses were raised in the review by McGilloway et al. (2010) such as difficulty of adaptation in migrant ethnicities and lower incidence of PD in higher social classes. Aetiological studies on both hereditary and environmental factors have been centralized according to Ma et al. (2016) on paranoid, schizoid, emotionally unstable, and dissocial personality disorders.

Clinical features

Personality disorders are complex psychic conditions that cover a range of extremely varied mental states, with patient suffering at levels ranging from very mild to very high depending on the symptoms presented, as well as the level of their functional capacity. Interpersonal dysfunction and self-dysfunction are commonly seen as general factors in PD (Beeney et al., 2019). In addition, it is difficult to imagine any PD that does not arouse

suffering in people linked to the patient, even those who lack a meaningful bond with them.

According to Kendell (2002), it is impossible to confidently define personality disorders as mental illnesses because the term “mental illness” has no agreed upon meaning. However, a personality disorder can be considered a type of mental abnormality, which differs from clinical disorders in several ways; perhaps the biggest one is that the patient himself/herself is his/her own disorder, although he/she might perceive mistakenly, as in the case of antisocial disorder, where the patient sees his/her entire problem externally. Unlike a mental illness that occurs at a certain point in a patient’s life that can change it permanently or temporarily, PD runs through the patient’s entire existence or great part of it, although it is usually only perceived after a certain period (often in adolescence) and diagnosed only after adulthood, when the personality is expected to have had time to reach maturity.

Depending on the symptoms and their intensity, the clinical features of PDs can be perceived early in the patient’s life, even in childhood or adolescence, even if this diagnosis cannot be given in this age group. In other cases, manifestations appear later and yet might still be mistaken as if they were merely patient “crazes” without a pathological character. Only when the suffering of the patient or the family becomes significant is attention directed to seeking diagnostic clarification.

As mentioned earlier, in the observation of clinical features, it is essential to consider the cultural, racial, and ethnic aspects in which the person is inserted, given the strong influence they have on people’s behaviour. However, it is very difficult to individualize these variables in a comparative analysis of the various studies on the subject. This is because simultaneously there are several others that can affect the final result of the research performed. The very competitive lifestyle present in more developed urban areas can also have a major influence on the aggravation of certain types of PD such as obsessive-compulsive. This is because the person is under pressure to perform with an increasing degree of excellence (Gawda & Czubak, 2017; Paris, 2004).

Each PD has its own behavioural impairment characteristics, which in turn drive its classification. Genetic factors determine the susceptibility to environmental hazards. For example, very resilient people might not be affected by major setbacks in life, while very sensitive people will be affected more easily and proportionately more intensely (Paris, 2015).

Such impairments can manifest in various areas, both cognition and volition, interfering with affectivity, interpersonal functioning, and impulse control. Impairment of psychological, social, and professional functioning is a condition present in PD. Some conditions can make it difficult to recognize a particular behaviour as a PD since a necessary requirement is the persistence of characteristics over a long period of time and its manifestation in different situations and contexts (Camilleri, 2018). This author also draws attention to the difficulty of differentiating one type of PD from another, on one hand for the subtlety of certain differences and, on the other, the sharing of some characteristics between different PDs.

Little attention is paid to the medical comorbidity of PD (Frankenburg and Zanarini, 2006). However, some studies point to a frequent association between PDs and various health problems (Taylor, 1999): chronic pain syndromes, sleep disorder, and borderline personality (Sansone & Sansone, 2012; Dixon-Gordon et al., 2015); higher body weight and paranoid, antisocial, and avoidant PDs for women, overweight men, and lower rates of paranoid PD and underweight women with higher odds of schizoid PD (Mather et al., 2008). Some personality disorders (cluster C) are highly prevalent in patients who suffer from chronic insomnia and become addicted to hypnotic substances (Ruiter et al., 2012; Tan et al., 1984).

PDs are associated with a disproportionately high demand for other health treatments. In this way, the likelihood of an interaction between physical and mental health problems among people with PDs seems to be high. That's because there are high rates of co-occurrence between PDs and other clinical disorders such as depression, eating disorders, anxiety, and substance use disorders (Dixon-Gordon et al, 2015). Despite the fact that little is known about the factors involved in this association, biological, psychological, and environmental factors are considered (Dixon-Gordon et al., 2018). From a biological point of view, there is a tendency of patients with PD to suffer from metabolic or inflammatory dysfunctions. From a psychological point of view, it is clear that personality traits can aggravate their biological vulnerability. And from an environmental point of view, the poor health care provided to these patients is considered as well as their low social and professional functioning. However, according to the latter authors, these studies of PDs and health-related issues are still few compared to those performed with patients with other disorders such as depression, bipolar, or panic disorders. These comorbidity studies are very important and should be deepened for several reasons including the high

cost suffered by society due to this association between chronic clinical conditions and personality disorders (Frankenburg and Zanarini, 2004).

In other situations, the clinical features might be obscured by some comorbid condition such as drug addiction. This comorbidity can attract the full attention and concern of the psychiatrist or of people who live with the patient toward drug-related harm so the PD goes unnoticed. This is a very complicating factor, as some personality traits can make it very difficult to conduct psychiatric or other medical treatments.

Diagnosis

There is a worldwide debate about the real value of diagnosing PD, which takes into account several aspects. Among its proponents, some arguments lie in the importance of diagnostic criteria as they reflect aspects of diagnostic pathology, namely: long duration, independence from psychopathological states, and harmfulness (Peri et al., 2018). In addition, difficult patients probably have undiagnosed PD (Moukaddam et al., 2017). Difficulties are often reflected in the doctor-patient relationship with personality characteristics that hinder good fluency between the pair, causing countertransference reactions that are difficult to handle by the psychiatrist. If PD is not perceived, diagnosed, and treated, the outcome of the treatment could be impaired. In this sense, the patient might not follow up, look for several professionals without being able to perform treatment with one of them, and repeatedly seek emergency care, wanting a quick and almost magical therapeutic response to their symptoms. Another risk of not diagnosing PD when it is in comorbidity with other mental disorders is represented by an excess in medication prescription or unnecessary hospitalization (Crawford et al., 2011) in an attempt to achieve efficacy in treating the diagnosis.

On the other hand, those who condemn the diagnostic categories argue against the stigma of the term, even among medical professionals, considering that many clinicians associate this term with the idea of a patient with difficult management and therapeutic refractoriness, which might have bad repercussions for the patient's treatment outcome (Bechwith et al., 2014). However, this argument seems fragile as this aspect could be circumvented and even overcome by a good medical education.

PD diagnoses might not be accurate, as they are influenced not only by the actual characteristics of the target person but also by the view that the perceiver has of the target person (Leising et al, 2017). It is a very

complex subject with different points of view among the most diverse authors and scholars of the subject. This eventually led to a division between categorical diagnosis, existing in the ICD-10 and section II of the DSM-V, and dimensional diagnosis, present in section III of DSM-V and, as will be seen in a later chapter, in the ICD- 11.

Categorical diagnosis is based on interviews, whereas dimensional diagnosis is based essentially on self-reports. Despite the importance and recognized value of the questionnaires, which are considered by some authors to be as valid as the interviews (Kelley et al., 2016), they might not reliably identify the general criteria for a diagnosis of PD, as would be achieved in the interviews. Questionnaires can provide important insights into the personality traits of respondents, but they have limitations in differentiating non-harmful personality variants (Peri et al., 2018). Perhaps the best method is double assessment, combining questionnaires with interviews. The former would provide important data on personality traits while the latter would provide diagnostic accuracy and avoid false-positive results (Huprich et al., 2011). The concern expressed by Peri et al. (2018) that the general diagnostic criteria of PD might have no place in questionnaire-based assessments is legitimate, although they concluded in their study that the benefits of assessing the general criteria for PD with interviews barely outweigh their costs.

According to the ICD-10, the diagnostic criteria for PD are as follows (World Health Organization, 1990):

1. markedly disharmonious attitudes and behaviour, involving usually several areas of functioning, e. g. affectivity, arousal, impulse control, ways of perceiving and thinking, and style of relating to others;
2. the abnormal behaviour pattern is enduring, of long standing, and not limited to episodes of mental illness;
3. the abnormal behaviour pattern is pervasive and clearly maladaptive to a broad range of personal and social situations;
4. the above manifestations always appear during childhood or adolescence and continue into adulthood;
5. the disorder leads to considerable personal distress, but this might only become apparent late in its course;
6. the disorder is usually, but not invariably, associated with significant problems in occupational and social performance.

As can be seen, the following diagnostic criteria of the DSM-V section II are very similar to those of the ICD-10:

A. A persistent pattern of internal experience and behaviour that deviates sharply from the expectations of the individual's culture. This pattern manifests itself in two (or more) of the following areas:
   1. cognition (i. e., ways of perceiving and interpreting oneself, other people, and events).
   2. affectivity (i. e., variation, intensity, lability, and appropriateness of emotional response).
   3. interpersonal functioning.
   4. impulse control.

B. The persistent pattern is inflexible and covers a wide range of personal and social situations.

C. The persistent pattern causes clinically significant distress and impairment in social, professional, or other important areas of functioning.

D. The pattern is stable and long lasting, and its onset occurs at least from adolescence or early adulthood.

E. The persistent pattern is no longer best explained as a manifestation or consequence of another mental disorder.

F. The persistent pattern is not attributable to the physiological effects of a substance (e. g., drug of abuse, medicament) or to another medical condition (e. g., head trauma).

These are the current DSM-V criteria. However, the DSM-V Personality and Personality Disorders Working Group has provided an alternative model in its Section III with the mission, according to its authors, to approach and address the vulnerabilities of section II. While section II gives an update on the categorical classification of PDs, section III takes a dimensional approach to them. It focuses on impaired personality functioning and existing pathological traits and recognizes six types of PDs rather than the 10 included in section II. They are: schizotypal, antisocial, borderline, narcissistic, avoidant, and obsessive-compulsive.

Section III provides seven general criteria for personality disorders. The inclusion of social and cultural factors, which has been increasingly valued in recent research to avoid false diagnoses of PDs, can be observed as culture significantly influences human behaviour. It is also worth highlighting the fact that in the dimensional evaluation, a pathological personality trait might be sufficient to diagnose a PD.

The following are the general criteria of dimensional diagnosis:

1. moderate or severe impairment in personality functioning (self/interpersonal);
2. one or more pathological personality traits;
3. impairments in personality functioning and the expression of an individual's personality traits are relatively inflexible and diffuse within a wide range of personal and social situations;
4. impairments in personality functioning and expression of an individual's personality traits are relatively stable over time, and their onset can be traced back to at least adolescence or early adulthood;
5. impairments in personality functioning and the expression of an individual's personality traits are no better explained by another mental disorder;
6. impairments in personality functioning and the expression of an individual's personality traits are not solely attributable to the physiological effects of a substance or other medical condition;
7. impairments in personality functioning and the expression of an individual's personality traits are no longer best understood as norms for an individual's developmental stage or sociocultural environment (American Psychiatric Association, 2013).

There is a significant similarity between the criteria in section III and those presented in section II of the DSM-V. However, according to these criteria in section III, it is necessary to evaluate not only the existence of pathological features, but also the level of impairment of personality functioning, as this needs to be moderate or severe (A). In addition, criterion B opens a space for examination of the impairment of personality functioning or maladaptive traits in a broader, non-plastered manner. All criteria need to be met, emphasizing that criterion G attempts to avoid false diagnoses of PD based on consideration of cultural and social aspects of different people.

Recently, genetic and neuroimaging studies have been of great value in constructing the diagnosis of personality disorders. Genetic studies mainly investigate the genes encoding neurotransmitters and enzymes in the serotonergic and dopaminergic systems, and neuroimaging studies focus on the frontal and temporal lobes as well as the limbic-paralimbic system (Ma et al., 2016). It is important to separate the assessment of people's personality dispositions from the assessment of the consequences that