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Comparative Examination of ICD-11 and DSM-5 Alternative Model in Personality Disorders

Kişilik Bozukluklarında ICD-11 ve DSM-5 Alternatif Modelin Karşılaştırmalı İncelenmesi

Türkmen Töre[1]

[1]University of Kyrenia, Kyrenia, TRNC

ABSTRACT

Personality disorders tried to be explained by changing diagnoses and approaches varying from school to school throughout history. With the updated approaches and scientific developments in today's diagnostic booklets, developing and more understandable diagnostic categories for personality disorders are created. New models can be an important resource for diagnosis, treatment and common language among clinicians. Both ICD-11 and DSM-5 main part section III. have highlighted new models beyond the previous personality disorders diagnostic approach. In both models, personality disorders are examined according to severity levels and prominent personality features model. Moreover, personality disorder includes structures that take into account the course of basic personality traits such as self, identity and bilateral relations. While DSM-5 part III. Alternative model on personality disorders section has a content of 5 prominent features, 25 sub-features and functionality which are all for evaluating the disorder, the ICD-11 model includes an approach that includes five features and borderline pattern and definitions, and a 4-dimensional structure in which functionality is evaluated. Although both models include models of features that stand out in personality but not completely overlap with each other. For example, while Psychoticism finds its place as a personality trait in alternative model in section III of DSM-5, as it is not accepted in personality feature in ICD-11. In contrast, the borderline pattern is not named as a feature in DSM-5 in section III, but the ICD-11 treats the borderline pattern as a kind of feature. This is one of the important differences between the two guidelines. Similarly, the criteria by which functionality and impairment are evaluated are not compatible with each other and do not progress in parallel. This means that two different guidelines accept different severity levels as thresholds. However, it can be said that both models accept the personality disorders approach, which includes longitudinal processes in which personality traits can be seen instead of categorical models. The differences between the new models can be interpreted as an obstacle to the development of a common language in terms of diagnosis and treatment.

Keywords: Personality disorders, personality, psychiatric diagnosis, mental disorder

ÖZ

Kişilik bozukları tarih boyunca değişen tanılamalarla ve ekolden ekole değişen yaklaşımlarla açıklanmaya çalışılmıştır. Günümüzün tanı kitapçıklarında güncellenen yaklaşımlar ve bilimsel gelişmeler ile kişilik bozuklukları için gelişen ve daha anlaşılır olabilen tanı kategorileri oluşturulmaktadır. Yeni modeller tanı, tedavi ve klinisyenler arası ortak dil için önemli bir kaynak olabilir. Hem ICD-11'de hem de DSM-5 III ana bölümünde daha önceki kişilik bozuklukları tanı yaklaşımının ötesinde yeni modelleri öne çıkarmıştır. Her iki modelde de kişilik işlevselliği değerlendirilerek kişilik bozukluğu incelenmektedir. Değerlendirmede önce işlevselliğin bozulmasının şiddet seviyesi, daha sonra, benlikte, kimlikte ve ikili ilişkilere yansıması gibi özellikler incelenmektedir. DSM-5'te yer alan alternatif model kişilik bozuklukları bölümünde, kişilik bozukluklarında öne çıkan 5 temel özellik 25 alt özellik ve işlevselliğin değerlendirildiği bir içeriğe sahipken, ICD-11 kişilik bozukluğu modeli beş özellik ve sınırda örüntüsünü ve tanımlamasını içeren bir yaklaşımı ve işlevselliğin değerlendirildiği 4 boyutlu bir yapıyı içermektedir. İki modelin kişilikte öne çıkan kişilik özellikleri birbiriyle tamamen örtüşmemektedir. Örneğin, Psikotizm DSM-5 alternatif model kişilik bozukluklarında bir kişilik özelliği olarak kendine yer bulurken, ICD-11'de kişilik bozukluklarında bu özellik yer bulmamıştır. Sınırda örüntüsü DSM-5 alternatif model kişilik bozukluklarında bir özellik gibi isimlendirilmemektedir ancak ICD-11 sınırda örüntüsünü bir tür özellik olarak ele almaktadır. Bu durum iki kılavuz arasındaki önemli farklılıklardandır. Benzer şekilde işlevselliğin ve bozukluğun değerlendirildiği ölçütler birbirleriyle uyumlu ve paralel ilerlememektedir. Bu da iki farklı kılavuzun farklı şiddet seviyelerini eşik olarak kabul ettiği anlamını taşımaktadır. Ancak her iki modelinde kategorisel modeller yerine kişilik özelliklerin görülebildiği ve daha boylamsal süreçlerin içerdiği kişilik bozuklukları yaklaşımını kabul ettiği söylenebilir. Yeni modellerin birbirleriyle farklılıklar göstermesi, tanı ve tedavi bakımından ortak dilin gelişmesine engel gibi yorumlanabilir.

Anahtar sözcükler: Kişilik bozuklukları, kişilik, psikiyatrik tanı, ruhsal hastalıklar

Address for Correspondence: Türkmen Töre, University of Kyrenia, Faculty of Arts and Sciences, Department of Psychology, Kyrenia, TRNC **E-mail:** turkmentore@gmail.com
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Introduction

Personality disorder (PD) is a diagnosis given to mental illness that is integrated with ones' thinking style, relationships, and lifestyles, which are interpreted as rigid and dysfunctional characteristics of individuals (Sperry 2016). Individuals with personality disorders experience typical reflections and filters while perceiving events, their environment, themselves and people. Besides, they may have difficulties in their bilateral relations, individuals' relationships with themselves and their environment (Carlson and Oltmanns 2015). These individuals with personality disorder having a typical thinking styles. Moreover, there is a tendency to function in a certain type also in other cognitive domains as well. They have distorted content when perceiving and interpreting the world in mechanisms such as affect, reaction, behavior and memory. In other words, the individual exhibits similar attitudes while perceiving, interpreting and living his environment, himself and the world (Millon 2011). Personality disorders often become apparent or appear in the teenage years or early adulthood. There are many defined personality disorders and these are among the diagnoses of mental illness (Smith et al. 2020). Along with scientific advances in explaining personality disorders, successful treatment methods have been developed. Due to the high prevalence of personality disorders in studies, the interest and studies of clinicians in this field have increased (Huprich 2015, Waugh et al. 2017). The prevalence of personality disorders may differ in studies. In the combined studies, prevalences were found to be around 12% (Volkert et al. 2018), 7.8% (Winsper et al. 2019), and 4.4% – 21.5% (Quirk et al. 2016). Although very different results are obtained in outpatient psychiatric patients, the primary diagnosis or co-diagnosis of personality disorder is encountered in approximately half of these cases (Beckwith et al. 2014).

Throughout history, different approaches have been proposed when diagnosing and explaining personality disorders. Various classification systems used to diagnose and describe personality disorders in different periods of history have been limited to the knowledge, social attitudes and scientific paradigms available in the historical period in which they were designed (Beck et al. 2007, Öztürk and Uluşahin 2016). Sigmund Freud and his colleagues were among the first to move beyond the descriptive categorization of mental disorders. With his psychoanalytic theory, Freud tried to understand how personality structure is formed. Although Freud's influence on psychology was great, the first version of the DSM (Diagnostic and Statistical Manual of Mental Disorders) published by the American Psychiatric Association was also interpreted as having a psychoanalytic tendency (Kotan et al. 2018). The personality disorders approach included in DSM-I and DSM-II has been interpreted as inadequate due to insufficient explanations and lack of criteria (APA 2022). Diagnostic criteria, which are accepted as an important change in personality disorders, were published in the DSM-III version for the first time in the DSM model. In the DSM-III version, personality disorders are discussed in the categorical model. In this model, diagnostic criteria were established for each personality disorder (Cierpiałkowska 2013). Diagnostic criteria have been interpreted as enabling clinicians and researchers to use a common language and providing a facilitating factor in diagnosis and treatment (Widiger 1993).

In DSM-III, personality disorders are defined in 11 different diagnostic categories under 3 clusters. As;

Cluster A: Paranoid, Schizoid, and Schizotypal Personality Disorders

Cluster B: Antisocial, Narcissistic, Histrionic, Borderline Personality Disorders

Cluster C: Avoidant, Dependent, Obsessive Compulsive, Passive Aggressive Personality Disorders.

In the later updated version, DSM-IV, 11 personality disorders were also included. Unlike DSM-IV, Passive Aggressive Personality Disorder was not included in the DSM-5, and all of the remaining 10 personality disorders were published in the personality disorders section of the first part of the DSM-5 (APA 2013). Due to current studies and recommendations, in addition to this diagnosis category, DSM-5's III. An alternative model of personality disorders has been proposed in the section (Tyrer et al. 2010, Kotan et al. 2018). With this alternative model, personality disorders are included in psychological clusters consisting of longitudinal distinctive features and sub-characteristics, spread over time, instead of categorical features and criteria including symptoms. The DSM-5 has two different personality disorder models in this regard (APA 2013). The first of these is a model that includes 10 personality disorder typings, diagnosis and criteria in the traditional sense, and the other is a new alternative personality disorder model in which severity and characteristics can be specified under the diagnosis of a basic personality disorder (Bastiaens et al. 2021). The new alternative personality disorder model of DSM-5 is similar to the personality disorder approach in the updated diagnostic guide in the 'International Classification of Diseases 11th Edition (ICD-11), the World Health Organization's (WHO) International Classification of Diseases Guidelines published in 2019. (Bach and First 2018, Krueger and Hobbs 2020). Before the publication of ICD-11, personality disorder models published in WHO's diagnostic guidelines included a categorization model like DSM-IV. However, there were 9 different personality disorder diagnoses and many

sub-diagnosis groups in the ICD-10 model. In this regard, the ICD-10 diagnostic model was also criticized for causing confusion (Tyrer et al. 2019, Mulder 2021). Similarly, the DSM-IV's categorical handling of personality pathologies and the treatment approaches of symptoms based on criteria were criticized by experts for not being dimensional. For these reasons, the ICD-11 Personality Disorder Model and the DSM-5 Personality Disorders Alternative Model (DSM-5 PD AM), which were tried to be reconstructed, included certain typical markers under the diagnosis of personality disorder in the new models in both diagnostic guidelines and discussed them in a dimensional structure beyond the category model. In two guides, personality organizations are evaluated from two perspectives in terms of functionality and characteristics. It can also be interpreted that these models are more comprehensive and dimensional diagnostic systems, by specifying features that can change, emerge or changes in severity over time (Hopwood et al. 2012, Gitlin and Miklowitz 2013). For this purpose, in this study, it is aimed to compare the DSM-5 alternative personality disorder model and the ICD-11 personality disorder model.

Method

In this study, the ICD-11 personality disorders model and the alternative personality disorder model in the III part of DSM-5 were examined. In this context, how the two guides deal with personality disorder, how they explain the trait model, and their severity levels are evaluated. DSM-5 PD AM descriptions, which are within the scope of this study, are included in accordance with the original without changing the values such as features and criteria. The ICD-11 model is a digital manual published in English. In this respect, the original Turkish translation of the criteria and features included there has not been made. If the terms used for ICD-11 are the same as those in the DSM-5 in the English original edition, the same words are preferred. If there is a special situation, it is explained in the form of a note in the relevant section. Values such as characteristics, criteria, and severity include approaches in both the ICD-11 model and the DSM-5 model. These models were not created by the author.

Analysis of Models

ICD-11 Personality Disorders Model (ICD-11 PD)

The ICD-11 PD model includes an assessment of severity (mild, moderate, or severe PD) and a separate description of five trait domains, including Negative affect, Detachment, Disinhibition, Dissociality, and Anankastic (WHO 2022). In addition to these, there is another personality condition called "borderline pattern" under the trait domains. Field descriptors with ICD-11 are specified as they can be used to describe the characteristic features of people diagnosed with personality disorder (in the mental and behavioral disorders section) or personality difficulty. However, it is emphasized that a trait field should be coded only if it stands out in the personality structure of the individual diagnosed with personality difficulty or disorder. Also if there is an evidence that the traits described by the trait field are associated with impairment in psychosocial functioning it should be coded. It has also been mentioned that more than one feature area can be specified in order to describe the characteristics of the personality disorder (WHO 2022). The ICD-11 classification highlights an area of modeling in which specialists can present in various combinations more unique diagnostic profiles and delineate the dynamics of personality functioning (Mulder 2021).

The following explanation n Table 1 is used to diagnose personality disorder in ICD-11 (WHO 2022).

Table 1. Definition and diagnostic criteria of personality disorder in ICD-11

Personality disorder

Personality disorder is characterised by problems in functioning of aspects of the self (e.g., identity, self-worth, accuracy of self-view, self-direction), and/or interpersonal dysfunction (e.g., ability to develop and maintain close and mutually satisfying relationships, ability to understand others' perspectives and to manage conflict in relationships) that have persisted over an extended period of time (e.g., 2 years or more). The disturbance is manifest in patterns of cognition, emotional experience, emotional expression, and behaviour that are maladaptive (e.g., inflexible or poorly regulated) and is manifest across a range of personal and social situations (i.e., is not limited to specific relationships or social roles). The patterns of behaviour characterizing the disturbance are not developmentally appropriate and cannot be explained primarily by social or cultural factors, including socio-political conflict. The disturbance is associated with substantial distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning (ICD-11 WHO 2022).

Essential (Required) Features:

- An enduring disturbance characterized by problems in functioning of aspects of the self (e.g., identity, self-worth, accuracy of self-view, self-direction), and/or interpersonal dysfunction (e.g., ability to develop and

maintain close and mutually satisfying relationships, ability to understand others' perspectives and to manage conflict in relationships).

- The disturbance has persisted over an extended period of time (e.g., lasting 2 years or more).
- The disturbance is manifest in patterns of cognition, emotional experience, emotional expression, and behaviour that are maladaptive (e.g., inflexible or poorly regulated).
- The disturbance is manifest across a range of personal and social situations (i.e., is not limited to specific relationships or social roles), though it may be consistently evoked by particular types of circumstances and not others.
- The symptoms are not due to the direct effects of a medication or substance, including withdrawal effects, and are not better accounted for by another mental disorder, a Disease of the Nervous System, or another medical condition.
- The disturbance is associated with substantial distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.
- Personality Disorder should not be diagnosed if the patterns of behaviour characterizing the personality disturbance are developmentally appropriate (e.g., problems related to establishing an independent self-identity during adolescence) or can be explained primarily by social or cultural factors, including socio-political conflict.

Degree and pervasiveness of disturbances in functioning of aspects of the self:

- Stability and coherence of one's sense of identity (e.g., extent to which identity or sense of self is variable and inconsistent or overly rigid and fixed).
- Ability to maintain an overall positive and stable sense of self-worth.
- Accuracy of one's view of one's characteristics, strengths, limitations.
- Capacity for self-direction (ability to plan, choose, and implement appropriate goals).

Degree and pervasiveness of interpersonal dysfunction across various contexts and relationships (e.g., romantic relationships, school/work, parent-child, family, friendships, peer contexts):

- Interest in engaging in relationships with others.
- Ability to understand and appreciate others' perspectives.
- Ability to develop and maintain close and mutually satisfying relationships.
- Ability to manage conflict in relationships.

Pervasiveness, severity, and chronicity of emotional, cognitive, and behavioural manifestations of the personality dysfunction:

Emotional manifestations:

- Range and appropriateness of emotional experience and expression.
- Tendency to be emotionally over- or underreactive.
- Ability to recognize and acknowledge emotions that are difficult or unwanted by the individual (e.g., anger, sadness).

Cognitive manifestations:

- Accuracy of situational and interpersonal appraisals, especially under stress.
- Ability to make appropriate decisions in situations of uncertainty.
- Appropriate stability and flexibility of belief systems.

Behavioural manifestations:

- Flexibility in controlling impulses and modulating behaviour based on the situation and consideration of the consequences.
- Appropriateness of behavioural responses to intense emotions and stressful circumstances (e.g., propensity to self-harm or violence).
- The extent to which the dysfunctions in the above areas are associated with distress or impairment in personal, family, social, educational, occupational or other important areas of functioning (ICD-11, WHO 2022)

According to this functionality model in ICD-11, an additional scale is used to determine the severity in order to define the individual who has difficulties in various areas and whose functionality is weakened. A four-point scale – which completes the diagnosis and shows the severity/intensity of the personality disorder – is used in this situation. In addition to the severity of personality disorder, personality compulsion is also included. This scale is defined in ICD-11 as follows.

-Personal difficulty(not classifed as a mental disorders)

-Mild personality disorder

-Moderate personality disorder

-Severe personality disorder

-Personality disorder, severity unspecified (WHO 2022)

The definition of Personality Disorder is defined by its severity or prominent personality traits, and if necessary

and appropriate, it is possible to add a single severity indicator with more than one feature. It is important in this respect that the severity of the Personality Disorder can be shown only once. Because it is not appropriate to diagnose both moderate and severe personality disorder at the same time. In addition, the following prominent models can be specified and more than one feature can be defined only if necessary.

ICD-11' Prominent Personality Traits or Patterns

Negative affectivity in personality disorder or personality difficulty

The core feature of the Negative Affectivity trait domain is the tendency to experience a broad range of negative emotions. Common manifestations of Negative Affectivity, not all of which may be present in a given individual at a given time, include: experiencing a broad range of negative emotions with a frequency and intensity out of proportion to the situation; emotional lability and poor emotion regulation; negativistic attitudes; low self-esteem and self-confidence; and mistrustfulness (WHO 2022).

Detachment in personality disorder or personality difficulty

The core feature of the Detachment trait domain is the tendency to maintain interpersonal distance (social detachment) and emotional distance (emotional detachment). Common manifestations of Detachment, not all of which may be present in a given individual at a given time, include: social detachment (avoidance of social interactions, lack of friendships, and avoidance of intimacy); and emotional detachment (reserve, aloofness, and limited emotional expression and experience) (WHO 2022).

Dissociality in personality disorder or personality difficulty

The core feature of the Dissociality trait domain is disregard for the rights and feelings of others, encompassing both self-centeredness and lack of empathy. Common manifestations of Dissociality, not all of which may be present in a given individual at a given time, include: self-centeredness (e.g., sense of entitlement, expectation of others' admiration, positive or negative attention-seeking behaviours, concern with one's own needs, desires and comfort and not those of others); and lack of empathy (i.e., indifference to whether one's actions inconvenience hurt others, which may include being deceptive, manipulative, and exploitative of others, being mean and physically aggressive, callousness in response to others' suffering, and ruthlessness in obtaining one's goals) (WHO 2022).

Disinhibition in personality disorder or personality difficulty

The core feature of the Disinhibition trait domain is the tendency to act rashly based on immediate external or internal stimuli (i.e., sensations, emotions, thoughts), without consideration of potential negative consequences. Common manifestations of Disinhibition, not all of which may be present in a given individual at a given time, include: impulsivity; distractibility; irresponsibility; recklessness; and lack of planning (WHO 2022).

Anankastia in personality disorder or personality difficulty

The core feature of the Anankastia trait domain is a narrow focus on one's rigid standard of perfection and of right and wrong, and on controlling one's own and others' behaviour and controlling situations to ensure conformity to these standards. Common manifestations of Anankastia, not all of which may be present in a given individual at a given time, include: perfectionism (e.g., concern with social rules, obligations, and norms of right and wrong, scrupulous attention to detail, rigid, systematic, day-to-day routines, hyper-scheduling and planfulness, emphasis on organisation, orderliness, and neatness); and emotional and behavioural constraint (e.g., rigid control over emotional expression, stubbornness and inflexibility, risk-avoidance, perseveration, and deliberativeness) (WHO 2022).

Borderline pattern

The Borderline pattern specifier may be applied to individuals whose pattern of personality disturbance is characterised by a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, as indicated by many of the following: Frantic efforts to avoid real or imagined abandonment; A pattern of unstable and intense interpersonal relationships; Identity disturbance, manifested in markedly and persistently unstable self-image or sense of self; A tendency to act rashly in states of high negative affect, leading to potentially self-damaging behaviours; Recurrent episodes of self-harm; Emotional instability due to marked reactivity of mood; Chronic feelings of emptiness; Inappropriate intense anger or difficulty controlling anger; Transient dissociative symptoms or psychotic-like features in situations of high affective arousal (WHO 2022).

As can be seen, ICD-11 has listed personality disorder under a basic name and according to five different types of characteristics, and borderline/borderline is additionally stated as a pattern in the definitions. According to ICD-11, in order for a person to be diagnosed with a personality disorder, the condition specified under the diagnosis of PD must be met, its severity must be specified, and if there are additional features specified, it must be added to the diagnosis. Similarly, any personality trait can be specified as a major and its severity can be added (Bach and Bernstein 2019, McCabe and Widiger 2020, Gutiérrez et al. 2021).

DSM-5 Personality Disorders Alternative Model (DSM-5 PD AM)

DSM-5 has been published personality disorders in two different models in the light of new studies and updates. The first of these is the continuation of a categorization model, which is seen as a continuation of DSM-IV-Tr, and the other one is the DSM-5 Personality Disorders Alternative Model. The new DSM-5 PD AM is in the main part III section of the DSM-5 manual. The new model is an alternative model of personality disorders in order to preserve and update current clinical practices and knowledge and to eliminate the deficiencies of approach (Krueger and Hobbs 2020). However, this model is not entirely dimensional or categorical. This model includes an approach that evaluates the severity and dominant characteristics of personality disorders (Esbec and Echeburúa 2015, Clark et al. 2017). Moreover, it facilitates diagnosis for clinicians and researchers due to its multiple key features and 25 sub-features that emerge accordingly (Huprich et al. 2019). In the DSM-5 alternative model, there is a general diagnosis of personality disorder plus 6 typical and traditional personality disorder diagnoses. These six typical diagnoses have a so-called hybrid content with the aim of facilitating clinicians, which is explained according to the approach of the new alternative model. The six personality disorders in question are antisocial, avoidant, narcissistic, obsessive-compulsive, borderline and schizotypal personality disorders. The main change and renewal made with the alternative model is related to the evaluation of personality disorders in 5 trait areas besides 2 basic conditions in all cases. While identity and interpersonal functionality are the primary criteria in this assessment, five sub-features constitute the secondary main criterion, which includes various emotional, behavioral and cognitive features that can be examined under 25 sub-titles (APA 2013). These criteria are explained in the new model with their explanations. All of the aforementioned and typically common six subjective personality disorders are explained by both identity and interpersonal functioning status. Negative affectivity, detachment, antagonism, disinhibition and psychoticism (Bach et al. 2017, Bach and First 2018, Gutiérrez et al. 2021).

DSM-5 General Criteria for Personality Disorders

The essential features of a personality disorder are:

A. Moderate or greater impairment in personality (self /interpersonal) functioning.

B. One or more pathological personality traits.

C. The impairments in personality functioning and the individual's personality trait expression are relatively inflexible and pervasive across a broad range of personal and social situations.

D. The impairments in personality functioning and the individual's personality trait expression are relatively stable across time, with onsets that can be traced back to at least adolescence or early adulthood.

E. The impairments in personality functioning and the individual's personality trait expression are not better explained by another mental disorder.

F. The impairments in personality functioning and the individual's personality trait expression are not solely attributable to the physiological effects of a substance or another medical condition (e.g., severe head trauma).

G. The impairments in personality functioning and the individual's personality trait expression are not better understood as normal for an individual's developmental stage or sociocultural environment (APA 2013).

In this model, two conditions are necessary for the diagnosis of personality disorder to be made. The first is to measure the severity specified in the A diagnostic criterion in the context of identity and interpersonal relationships. The second is the presence of unhealthy, dysfunctional personality traits in criterion B. The second criterion defines the way in which personality disorder is expressed, functionalized as any one or more of 25 specific traits or five broad areas in which they are organized. These five feature areas are; negative affect, distancing, opposition, limitlessness, and psychoticism. Criterion A includes assessment of personality functionality. While the evaluation of functionality here is evaluated under the title of self, under two sub-titles as self and self-direction; interpersonal functionality is evaluated under the sub-headings of empathy and intimacy.

Table 2. Distribution of 25 sub-characteristics of 5 prominent personality traits in DSM-5 PD AM.
Negative Affectivity (vs.Emotional Stability)
Emotional Lability Seperation insecurity Anxiousness Perseveration Submissiveness Hostility Restricted affectivity (lack of) (Common with Detachment personality trait) Depressivity (Common with Detachment personality trait) Suspiciousness (Common with Detachment personality trait)
Detachment (vs. Extraversion)
Intimacy avoidance Withdrawal Anhedonia Depressivity Restricted affectivity Suspiciousness
Antagonism (vs: Agreeableness)
Manipulativeness Deceitfulness Grandiosity Attention seeking Callousness Hostility (Common with negative afectivity personality trait)
Disinhibition (vs: Conscientiousness)
Irresponsibility Impulsivity Rigid perfectionism(lack of) Risk taking Distractibility
Psychoticism (vs: Lucidity)
Unusual beliefs and experiences Eccentricity Cognitive and perceptual dysregulation

The severity of the disorder is assessed through a rating scale. These are ; 0 little or no impairment, adaptive functioning; 1 some impairment; 2 moderate impairment; 3 severe impairment and 4 extreme impairment (APA 2013).

Table 3. Comparion of severity and trait manuals of ICD-11 PD and DSM-5 PD AM.	
ICD-11 PD	**DSM-5 PD AM**
Severity of the Personality Disorder	Personality functionality
-	Little or No Impairment -0-
Personality Difficulty	Some Impairment -1-
Mild Personality Disorder	Moderate Impairment -2-
Moderate Personality Disorder	Severe Impairment -3-
Severe Personality Disorder	Extreme Impairment -4-
Personality disorder, severity unspecified	-
ICD-11 Prominent personality traits or patterns	DSM-5 PD AM, B criteria, personality traits
Negative Affectivity	Negative Affectivity
Detachment	Detachment
Dissociality	Antagonism
Disinhibition	Disinhibition
Anankastia*	-
Borderline Pattern**	-
-	Psychoticism***

*Anankastia coincides with DSM-5 PD AM with low disinhibition and high negative affectivity. However, DSM-5 PD AM did not define a separate feature area for Anankastia domain (Gecaite-Stonciene, Lochner, Marincowitz, Fineberg, and Stein 2021).

**The Borderline Pattern feature specified in ICD-11 PD section also includes an area that may contain features that may overlap with Psychoticism in DSM-5 PD AM, however, an exact equivalent domain in DSM-5 PD AM has not been defined for Borderline Pattern. However, Borderline Personality Disorder in the DSM-5 PD AM section is also defined with its own sub-features.

*** Psychoticism was included as a feature in DSM-5 PD AM, but this feature was not included in ICD-11 PD.

Table 4. Comparison of 10 personality disorders in DSM-5 Personality Disorders according to the sub-features of other models.

DSM-5 PD	DSM-5 PD AM	ICD 11 Model
Paranoid	Detachment	Detachment
	Negative Affectivity	Negative Affectivity
	Antagonism	Dissociality
Schizotypal	Psychoticism	Schizotypal Disorder*
	Detachment	Detachment
		Anankastia
Schizoid	Detachment	Detachment
	Negative Affectivity	Negative Affectivity
Borderline	Negative Affectivity	Negative Affectivity
	Disinhibition	Disinhibition
	Psychoticism	Borderline Pattern
Narcissistic	Antagonism	Dissociality
Histrionic	Disinhibition	Disinhibition
	Negative Affectivity	Negative Affectivity
	Detachment(low)	Detachment(low)
	Antagonism	Dissociality
Antisocial	Antagonism	Dissociality
	Disinhibition	Disinhibition
	Detachment	Detachment
	Negative Affectivity(low)	Negative Affectivity(low)
Avoidant	Negative Affectivity	Negative Affectivity
	Detachment	Detachment
	Antagonism(low)	Dissociality(low)
Dependent	Negative Affectivity	Negative Affectivity
	Antagonism(low)	Dissociality(low)
Obsessive-compulsive	-	Anankastia
	Disinhibition(low) Detachment	Disinhibition(low) Detachment
	Negative Affectivity	Negative Affectivity

*Schizotypal Disorder is a diagnosis that is being evaluated in the Spectrum of Schizophrenia and Other Major Psychotic Disorders according to the ICD-11 diagnostic guide, but was previously classified as a personality disorder (Skodol et al. 2015, Bach et al. 2017, Bach and First 2018, Oliveira et al. 2020).

When evaluating diagnostic criterion A, four areas are considered under these two headings.

Self:

1. Identity: Experience of oneself as unique, with clear boundaries between self and others; stability of self-esteem and accuracy of self-appraisal; capacity for, and ability to regulate, a range of emotional experience.

2. Self-direction: Pursuit of coherent and meaningful short-term and life goals; utilization of constructive and prosocial internal standards of behavior; ability to self-reflect productively.

Interpersonal:

1. Empathy: Comprehension and appreciation of others' experiences and motivations; tolerance of differing perspectives; understanding the effects of own behavior on others.

2. Intimacy: Depth and duration of connection with others; desire and capacity for closeness; mutuality of regard reflected in interpersonal behavior.

Disruptions in personality functioning indicate a personality disorder, and the severity of the disability gives a clue about the presence of a typical personality disorder or more personality disorder. A diagnosis of personality disorder requires at least moderate impairment; This threshold is based on scientific evidence and aims to maximize the specialist's ability to accurately and effectively diagnose a personality disorder. Criterion B explains its pathological features in five structures. These five constructs are listed as negative affectivity, detachment, antagonism, disinhibition and psychoticism. These five features consist of 25 special subtypes. It has been reported that all features were evaluated in the new alternative model in the light of scientific data (Bach et al. 2017).

Table 2 shows the differentiation of five basic features in terms of sub-characteristics in the alternative model of DSM-5 personality disorders. The five personality traits are described in the DSM-5 PD AM as follows. Negative affectivity: Having a wide variety of negative emotions (eg, anxiety, depression, guilt/shame, worry, anger) and associated behavioral (eg, self-harm) and interpersonal (eg, addiction) states;

Detachment: Withdrawal from interpersonal interactions (ranging from casual, everyday interactions to friendships and close relationships) and limited emotional experience, limited amusement and expression, and avoidance of social emotional experiences;

Antagonism: Behaviors that place the individual in conflict with other people, including an exaggerated sense of self-worth and the accompanying expectation of special treatment, as well as inability to discern the needs and feelings of others, and to using others for their own self-interest and with feelings of opposition-hostility;

Disinhibition: Current thoughts and behaviors and external stimuli, impulsive behaviors and inability to delay gratification, without taking into account past experiences or calculating what may happen in the future;

Psychoticism: Exhibiting a huge range of culturally incongruent ordinary, eccentric, or uncommon behaviors and cognitions, along with both system (e.g., perception, dissociation) and content material (e.g., ideals) (APA 2013).

In Table 3, the severity assessment criteria and dominant personality traits of two different models that may correspond to each other are given.

In Table 4, 10 typical personality disorders are shown in the firs column. These diagnosis are included in the first part of the DSM-5 and were frequently the subject of research, are examined in terms of features in the new personality disorder models. In addition to this table, Antisocial, Avoidant, Narcissistic, Obsessive-compulsive, Borderline and Schizotypal personality disorders are included in DSM-5 PD AM. The six typical disorders included were not evaluated with the traditional DSM-5 categorical criteria, but in terms of identity, interpersonal functioning, and sub-characteristics. Histrionic, schizoid, dependent and paranoid personality disorders, which are in the categorical model of personality disorders in the first part of the DSM-5, are not included in the DSM-5 PD AM' model.

Discussion

Categorical diagnosis of personality disorders is a method used since DSM-III. According to this model, a personality disorder could be determined as present or absent. Categorical criteria and symptoms indicate that a diagnosis exists when it meets a certain condition and occurs (Tyrer et al. 2010, Kotan et al. 2018). The alternative model of personality disorders published in the III. chapter of DSM-5 and the ICD-11 Personality Disorder Model both can be interpreted as a new approach that includes the dimensional approach. The dimensional approach adopts an understanding that separate personality traits can emerge independently of each other and at different levels in individuals. In other words, while the categorical approach explains personality disorders with diagnosis, the dimensional approach can be interpreted as prominent personality traits and additional features. In the categorical approach, meeting a certain number of criteria is sought, while in the dimensional approach, it is possible to evaluate the behavior by considering it with different characteristics. In this respect, the dimensional model can explain personality disorders in a wider range in many respects (Öztürk and Uluşahin 2016, Gutiérrez et al. 2021). However, there are also scientists who support the categorical approach in the diagnosis of personality disorders. First of all, it has been reported that the categorical approach facilitates the selection of the clinical focus and the creation of the appropriate treatment plan, as well as the convenience for the common language among clinicians (Trull and Durrett 2005, Bach 2015). In addition, there are also opinions that do not support the categorical approach. According to these views, the dimensional approach brings a natural classification in the diagnosis of personality disorders, while the

categorical approach creates artificial distinctions (Gøtzsche-Astrup and Moskowitz 2015, Bach, et al. 2017, Flory 2020). The dimensional approach in personality disorders makes it possible to evaluate the specific situation for each patient and allows for specific treatments depending on this (Green 2015). When examined, it is seen that the new diagnostic models have some common points. The new approaches do not include categorizing the ten typical personality disorders. They includes an approach that evaluates personality disorder in terms of its characteristics and basically directs it to be evaluated with the level and severity of impairment. The ICD-11 approach includes the structure and process of diagnosing a personality disorder, drawing attention to the universal characteristics of personality dysfunction, including severity classification. Similarly in the DSM-5 PD alternative model, the ICD-11 includes evaluation according to four severity categories that cannot coexist, such as a patient cannot have both mild personality disorder and the severe personality disorder at the same time. However, these disorder level measures do not proceed in parallel. In the DSM-5 PD AM, personality disorder severity is evaluated in four dimensions. ICD-11, on the other hand, addresses this situation at three levels of severity. 'Severe impairment' in DSM-5 PD AM and 'moderate personality disorder' in ICD-11 can be interpreted as levels closer to each other. Because when severity assessments are examined, 'some impairment' in DSM-5 PD AM parallels to 'personality difficulty' in ICD-11. Moreover, 'moderate impairment' in DSM-5 PD AM corresponds to 'mild personality disorder' in ICD-11. Importantly, mild impairment in DSM-5 BP AM does not correspond to a diagnosis of a disorder. However, there is a slight deterioration in the classification in ICD-11. The important point is that in order to be diagnosed with a personality disorder according to DSM-5 PD AM, it must meet the definition of moderate, severe or extreme levels of impairments in functioning, that is, some or mild personality impairment is not sufficient for the diagnosis of the disorder according to DSM-5 PD AM. In contrast, mild personality disorder has been described according to the ICD-11 guidelines. Although there is no common language in understanding the level of impairment in the two guidelines, a classification system based on severity can be interpreted as having the advantage of simplifying the process of identifying a personality disorder. It can be said that this is a feature that can facilitate both the clinician's relationship with the client and the understanding of the individual's difficulties (Millon et al. 2010, Green 2015, Bach and First 2018).

In both models, sense of identity, self-direction, understanding others, and relationships with others are shown as the first areas to be examined in personality disorder. Typical symptoms and difficulties experienced or seen in these four areas can be interpreted as the first sign of a personality disorder. While the DSM-5, published by the American Psychiatric Association, starts the process of evaluating personality disorder under these four headings under the alternative model, these four areas are also covered with broader explanations in the ICD-11 guide published by the World Health Organization. In this respect, it can be said that the two guidelines display a common approach, focusing on identity and interpersonal functionality in understanding personality (Bach et al. 2017, Gamache et al. 2021). Both the ICD-11 PD section and DSM-5 PD AM allow researchers and clinicians to provide clearer diagnostic profiles in various combinations. In addition, defining an individual with a personality disorder according to the difficulty and descriptive feature has been interpreted as a more realistic approach due to the dynamic nature of personality (Bach and First 2018, Pires et al. 2021). However, it may be useful to draw attention to the points where the two models are not compatible with each other. For example, while Anankastia is defined as a feature in ICD-11, it is not included in DSM-5 PD AM section. In ICD-11, the borderline pattern is described in a similar way to personality traits but In DSM-5 PD AM the borderline pattern is not explained as an additional feature. But DSM-5 PD AM having a hybrit modelling as well, which includes Borderline Personality Disorder with an explantation with with the descriptions of characteristics of dominant personality feautures, with also includes identity and interpersonal functionality criterias. Borderline pattern and borderline personality disorder is still a hotly debated topic. Some talk about a position between neurosis and psychosis for this condition, while others talk about it as a categorical personality disorder (Zanarini 2005, McCabe and Widiger 2020, Krueger and Hobbs 2020). In DSM-5 PD AM, psychotic status is evaluated in personality disorders, but ICD-11 directly associates such conditions with psychotic disorders and does not include psychotic states among personality disorders (Bach and First 2018). In DSM-5 PD AM, psychotic feuatures are evaluated in personality disorders, but ICD-11 directly associates such conditions with psychotic disorders and does not include psychotic states among personality disorders (Bach and First 2018). If psychosis or a psychosis-like condition-symptom is observed when assessing personality using the ICD-11 guideline, the ICD-11 can benefit from the borderline pattern most closely. Because there is an information that includes psychosis-like conditions in the borderline pattern. It is known that if psychosis symptoms are more pronounced, it can be evaluated in the spectrum of psychotic disorders using the ICD-11 guideline (Bach 2018). Differently, psychotic features are included in both the categorical personality disorders model and the alternative personality disorders model of the DSM-5 (For example, Psychotic personality trait and Schizotypal Personality disorder). In this case, probable diagnosis in DSM-5 PD AM is allowed for an individual with psychotic features or psychosis-like features. In DSM-5 PD AM, it is advantageous that the psychotic state is

included as a prominent feature in personality disorders. While DSM-5 PD AM' explains the psychotic personality trait; displaying strange, eccentric, or unusual behavior and cognitions that are culturally incompatible, belief that the person has unusual abilities, such as mind-reading, telekinesis, thought-action fusion, unusual reality experiences, including hallucination-like experiences, strange, unusual, or bizarre behavior, appearance and/or speech; having strange and unpredictable thoughts; strange or unusual thought processes and experiences, including saying unusual or inappropriate things, depersonalization, derealization, and dissociative experiences; mixed sleep-wake state experiences; It includes a broad set of psychosis experiences and symptoms, including thought-control experiences. This situation is often discussed by scientists in terms of the presence of psychosis-like conditions or whether it is a precursor to psychosis. Some studies mention the advantages of evaluating schizotypal personality in the schizophrenia spectrum (Barrantes-Vidal et al. 2015, Cicero et al. 2019). However, there are other studies suggesting that it would be clinically appropriate to evaluate the display of strange or eccentric behaviors such as telekinesis, which are not completely detached from reality or culturally incompatible behaviors (Balaratnasingam and Janca 2015, Schultze-Lutter et al. 2019). For example, schizotypal personality disorder was similarly re-explained in the alternative model of DSM-5 in terms of identity and interpersonal functioning and 25 sub-characteristics, and proposed with a new and hybrid diagnostic approach. This new approach has been similarly done in the DSM-5 PD AM for the other five typical personality disorders. These six typical personality disorders have been proposed with a hybrid approach that can be evaluated both categorically and could be interpreted with typical features and diagnostic criteria in terms of studies. Categories like these have a structure that has been researched since the DSM-III published in 1980 and can be accepted as a common language by clinicians. While reinterpreting old diagnoses in the new model, the most common symptoms were considered. In other words, it is clear that there is no single type and criterion of any diagnosis. It is known that the need for new models is due to the fact that the diagnostic criteria are not suitable for many people and that more than one personality disorder can be diagnosed at the same time or the diagnosis may be insufficient (Bender et al. 2014, Oldham 2015, Bach and First 2018). Undoubtedly, many people can be identified with more than one feature in new models, but this will be a facilitating factor in establishing different features and additional subheadings in DSM-5 PD AM instead of two or more diagnoses. In this way, it has been suggested by some researchers that this situation may become even more complicated, since too many words and definitions may need to be mentioned when describing a person's personality disorder (Öztürk and Uluşahin 2016, Hopwood et al. 2019). It has been stated that adding the difficulties and affective processes one by one in the new models to a case that can be diagnosed with more than one personality disorder, perhaps clarifies the image of the individual's disorder, while it can tire attention with the excess of symptoms (Oldham 2015, Green 2015).

All 25 sub-features given in DSM-5 PD AM are explained in the manual in terms of content and meaning, but this is not available in ICD-11. Moreover, identity and interpersonal functioning patterns are similarly described in ICD-11 and DSM-5 PD AM. In addition, there is an assessment of personality functionality in terms of cognitive, emotional and behavioral aspects in ICD-11. When examined in terms of features, it can be said that it is easier to understand what DSM-5 PD AM means by the prominent features and patterns in question. However, it is seen that the features left open-ended in ICD-11 are left to the understanding and interpretation of the clinician. The fact that both DSM-5 PD AM and ICD-11 personality models are based on the severity of the disorder and have a common nomenclature for some basic personality traits can be interpreted as exhibiting an important commonality. It can be said that both the 5 basic features and 25 sub-headings specified in DSM-5 PD AM and 6 features and explanations specified in ICD-11 provide clinicians and researchers with a range of motion in defining personality type (Bach et al. 2017, Bach and First 2018, Huprich et al. 2019, Gamache et al. 2021).

The important differences between the two guidelines are that the ICD-11 has a different approach to the border pattern in the personality dimension, while in the DSM-5 PD AM this situation is handled in the hybrid system as a personality disorder and not interpreted as a stand-alone feature. The recognition of psychosis in the trait dimension in DSM-5 PD AM and the treatment of psychotic states within the scope of schizophrenia and other psychotic disorders in ICD-11 seem to be serious differences in understanding personality. In addition, the issue of whether psychosis can be seen in the personality dimension has been a subject that has been discussed for many years (Shmukler 2021). Another issue is the DSM-5 PD AM's inclusion of 6 typical personality disorders in its alternative model, helping researchers in understanding the traditional and long-standing diagnostic categories (Sevecke et al. 2014, Morey et al. 2015). In the alternative model, 6 typical personality disorders were examined in terms of prominent personality traits as well as situations such as sense of identity and interpersonal functionality. In this respect, it can be interpreted as the advantageous aspect of the hybrid system (Huprich et al. 2019, Gamache et al. 2021). When examined in general, it can be interpreted that the two guidelines have common aspects, and the development of new approaches to understanding personality can

facilitate diagnosis and treatment and strengthen communication between clinicians (Öztürk and Uluşahin 2016, Hopwood et al. 2019).

Conclusion

It was a necessity to develop a common language by examining changing approaches in defining personality disorders in the light of scientific studies. It is an important issue that DSM-5 PD AM and ICD-11 show similar approximate features. The structures that take the place of the criteria features with a wide variety of features that can change over time are important when examined in terms of the variability of human life (Öztürk and Uluşahin 2016, Hopwood et al. 2019). Because a person's personality may contain features belonging to the same cluster that may appear different in various areas. In this respect, the personality structure, which is examined according to the feuatures, shows a facilitating approach in understanding, diagnosing and while treating it (Bach and First 2018, Huprich et al. 2019, Gamache et al. 2021). IIn this study, a detailed analysis of 25 sub-characteristics and a comparison of the evaluation of personality severity in ICD-11 were not included, so further studies would be needed in this area. Moreover, examining and comparing individuals diagnosed according to these two new models in terms of characteristics and severity would be meaningful for the field. The fact that there are not enough studies on this subject in Turkish sources and the examination of ICD-11 (personality disorder approach), which has been fully used in 2022, through this research has the potential to make a meaningful contribution to the field. It can be said that much research is needed in this area.

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