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The hybrid model for the classification of personality disorders in DSM-5: a critical analysis

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A personality disorder can be considered to be a generalized pattern of behaviors, cognitions, and emotions that is enduring, begins in adolescence or early adulthood, remains stable over time, and generates stress or psychological damage. The current focus on personality disorders (PDs) is found in Section II of DSM-5 and is unchanged compared to DSM-IV, except that the PDs were removed from the former Axis II of the DSM-IV and included in the central classification of disorders. However, an alternative model for further study is presented in Section III that aims to address the deficiencies in the current categorical model of PDs. The underlying idea is that PDs are an extreme version of the personality traits that everyone has. According to this approach, PDs are characterized by impaired personality functioning (areas of identity, self-direction, empathy, and intimacy) and pathological personality factors (negative affectivity, detachment, antagonism, disinhibition, and psychoticism). The diagnostic categories derived from this model include only antisocial, avoidant, borderline, narcissistic, obsessive-compulsive, and schizotypal PDs. This hybrid approach to the diagnosis of PDs is complex and requires more empirical evidence before it can be incorporated into clinical practice. The proposals of the draft ICD-11 for PDs, which are based primarily on severity and dominant personality traits, are also included.

Keywords: Personality disorders, Classification, Critical analysis, DSM-5

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El modelo híbrido de clasificación de los trastornos de la personalidad en el DSM-5: un análisis crítico

Un trastorno de personalidad puede considerarse como un patrón generalizado de conductas, cogniciones y afectos que es inflexible, comienza en la adolescencia o al inicio de la vida adulta, es estable en el tiempo y genera estrés o daño psicológico. El enfoque actual de los trastornos de personalidad (TP) figura en la Sección II del DSM-5 y no registra cambios respecto al DSM-IV, excepto que han sido removidos del antiguo Eje II del DSM-IV e incluidos en la clasificación central de los trastornos. Sin embargo, se presenta en la Sección III un modelo alternativo para estudios posteriores que tiene como objetivo hacer frente a las deficiencias planteadas por el modelo actual categorial de los TP. La idea subyacente es que los TP constituyen una versión extrema de los rasgos de personalidad existentes en todas las personas. En este enfoque los TP se caracterizan por daños en el funcionamiento de la personalidad (ámbitos de la identidad, autodirección, empatía e intimidad) y por factores de personalidad patológicos (afectividad negativa, desapego, antagonismo, desinhibición y psicoticismo). Las categorías diagnósticas derivadas de este modelo incluyen solo los TP antisocial, evitativo, límite, narcisista, obsesivo-compulsivo y esquizotípico. Este enfoque híbrido para el diagnóstico de los TP es complejo y requiere mayor evidencia empírica para ser incorporado a la práctica clínica. Se incluyen asimismo las propuestas del borrador de la CIE-11 para los TP, basadas fundamentalmente en los grados de gravedad y en los rasgos de personalidad dominantes.

Palabras clave: Trastornos de la personalidad, Clasificación, Análisis crítico, DSM-5

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INTRODUCTION

The classification of personality disorders (PDs) proposed in the final version of the DSM-5¹ represents a change from the previously known drafts² and a return to the DSM-IV categorical conceptualization of personality disorders in the official section of mental disorders (section II), although it leaves a door open to the dimensional approach in Section III (relative to "proposed disorders for future studies").

Once published, the DSM-5 received much criticism, including accusations of secretism, conflicts of interest, disappointment about a promised paradigm change, and concerns about the very definition of mental disorder. This manual has been accused of psychiatrizing normality and using deficient methodology.³ The validity of the categories has been criticized more based on consensus than evidence.⁴

The Personality and Personality Disorders Work Group of the American Psychiatric Association (APA) had to resolve serious problems regarding the operational definition of PD, classification, categorical or dimensional assignment, assessment of severity or prototypicality, permanence on Axis I or Axis II, heterogeneity of the same diagnoses, relation to personality traits, comorbidity, cutoff point for abnormality, and validation of the disorders under study (depressive, passive-aggressive, etc). All these points required a new approach to these anomalies.

The initial proposals for the PD section of DSM-5 involved a substantial departure, not only from DSM-IV, but also from the primary alternative frameworks proposed. For example, the first proposals consisted of representing specific PDs as narrative prototypes in which broad descriptions of a prototypical patient with a specific PD were proposed instead of the explicit diagnostic criteria for PDs that originated with the DSM III. In the DSM-5, the trait model was used according to the method used in the personality field and individual differences.⁵

The PD work group in 2010 proposed a dimensional assessment of the PDs using 37 personality traits and 6 global dimensions, as well as a reduction of the PDs to five, eliminating the schizoid, paranoid, narcissistic and dependent PDs, and including psychopathy as a variety of antisocial PD. A prototypical description of each disorder was also proposed for the system. In this way, a clinician can compare a patient to each of the prototypes and classify the patient on a five-point scale according to the degree of similarity with the prototype.²

In 2011, under the same system and with considerable controversy, the decision was made to include 25 trait facets and 5 domains, or factors, eliminating psychopathy and recovering narcissistic disorder. After intense debate and the criticism of certain professionals, no agreement was reached at the APA meeting of December 1, 2012. Thus, PDs were

finally described and classified in a way almost identical to DSM-IV Section II, which is the core of the official part. However, in Section III of the manual, a hybrid categorical-dimensional model was suggested as an alternative assessment for further studies.

At the structural level, the most notable change in DSM-5 is the elimination of the multiaxial system and the incorporation of the PDs into a single classification system, which implies the need to properly evaluate them. What justified the inclusion of the PDs in Axis II of DSM-III and DSM-IV was that the PDs were more structural, chronic, of early onset, and predisposed to the development of other disorders. However, the confusing nature of the axes for coding and their scant utilization has resulted in their suppression in DSM-5.

The aim of this article is to present the contributions of DSM-5 to the classification of personality disorders compared to previous versions of this manual, and to critically analyze and discuss future lines of research.

PERSONALITY DISORDERS IN DSM-5 SECTION II (OFFICIAL CLASSIFICATION)

According to DSM-5, and in similarity to DSM-IV, a PD is regarded as an *enduring pattern of inner experience and behavior that affects at least two of these areas: cognition, affect, interpersonal functioning; or impulse control. The enduring pattern is inflexible and pervasive. Its onset can be traced back to early adulthood or adolescence. The pattern is stable and of long duration, and it typically leads to significant distress or impairment.* Ultimately, a PD involves a *failure of adaptation* in terms of personal identity and interpersonal relationships.

The DSM-5 opts for a categorical approach to PDs and maintains the same classification scheme as for DSM-III and DSM-IV. The DSM-5 maintains the same 10 PDs that were formerly distributed over the same three *clusters*: A (rare and eccentric, which includes the schizoid, paranoid, and schizotypal PDs); B (dramatic, emotional or erratic, which includes borderline, antisocial, histrionic, and narcissistic PDs); and C (anxious and fearful, which includes anxious-avoidant, dependent, and obsessive-compulsive). In addition, other specified and unspecified personality disorders were added, which cover, for example, people with diagnostic criteria for different PDs ("mixed personality characteristics") or for PDs not included in the official classification (for example, depressive PD or psychotic/sadistic PD).

Inclusion in a category involves satisfying in each case one-half plus one of a group of diagnostic criteria (polythetic assessment). It is not necessary to specify which criteria are met or not, which perpetuates the problem of heterogeneity of the same diagnoses and clinicians not precisely knowing the specific areas of intervention.⁶

Table 1		General criteria and diagnostic categories of personality disorder according to the alternative assessment of DSM-5 (Section III)	
CRITERIA		DIAGNOSTIC CATEGORIES	
A. Moderate or severe impairment in personality functioning (personal/ interpersonal)		Antisocial personality disorder	
B. One or more pathological personality traits		Avoidant personality disorder	
C. Traits and relatively permanent and inflexible impairment of functioning in different social and personal situations		Borderline personality disorder	
D. Relative stability over time, beginning in adolescence or early adulthood		Narcissistic personality disorder	
E. Not better explained by another mental disorder		Obsessive-compulsive personality disorder	
F. Not attributable to addictive substances or medical conditions		Schizotypal personality disorder	
G. Not more attributable to age (development) or the sociocultural environment		Trait-specified personality disorder	

This system does not solve the problems that have been denounced by the scientific community. The classification of PDs in both DSM-IV and ICD-10, and now in DSM-5 Section II, parts from a traditional categorical perspective. That means that each disorder constitutes a diagnostic category sustained by specific disorders. The categorical judgment consists of "having or not having" the disorder and has the advantage of being more economical in conceptualizing a syndrome and transmitting information to other clinicians. With the polythetic approach of the DSM, once the minimum criteria for the diagnosis of a PD are met (one-half plus one, independently of the specific criteria), the diagnosis can be made.

The consequence of this polythetic approach is that there are very different ways of reaching, for example, the diagnoses of antisocial or borderline personality disorder, which leads to the proliferation of numerous subtypes. Furthermore, the categorical model of PDs entails other problems that can be summarized as follows: 1) poor fit between patients and prototypes; 2) overlap of the proposed criteria between diverse categories and other mental disorders; 3) low temporal and inter-rater reliability; 4) poor diagnostic validity; and 5) little utility for treatment.^{7,8}

Personality disorders in DSM-5 Section III: an alternative categorical-dimensional model

In section III of DSM-5 (devoted to the disorders that require further study), a new hybrid model of personality has been introduced. Some diagnostic categories are listed, but the assessment of disturbances in personality functionality (how an individual typically experiences his or herself and perceives others) are also included, in addition to 5 major personality factors or domains and 25 trait facets. This version has the advantages of the dimensional model over

the categorical model and the convenience of assessing traits on a continuum from normality to full pathology, as well as the need to assess the intensity of impairment in both the person and in interpersonal relationships. Only six specific disorders are taken into account, with broad empirical support (factorial, genetic, and neuropsychological)² (Table 1).

The dimensional approach offers several advantages^{2,5}: 1) it is consistent with the observation of fuzzy boundaries between disorders and normality; 2) it is more in accordance with the complexity of the syndromes observed in clinical practice; 3) the dimensional measure can be converted into categorical, but not the opposite; 4) categorization parting from dimensioning allows the cutoff points to be adjusted for specific contextual, cultural and individual factors; 5) finer analyses can be made of the patient characteristics; 6) the therapist is provided specific areas of intervention; 7) the inter-rater reliability of the assessment is improved; and 8) comorbidity ceases to be a problem because an individual can be defined based on their combined characteristics of traits rather than categories.⁵

This hybrid approach (categorical-dimensional) can facilitate assessment of the severity of the PD. There are PDs that are qualitatively more severe at the categorical level, but, for example, the level of functionality or severity of the maladaptive traits can also be quantified dimensionally. It seems that a similar type of grading will be used in the future ICD-11.⁹

Level of functionality of the personality

The psychopathology of the personality emanates mainly from durable disturbances in thought and feelings about

oneself and others. Since there may be a greater or lesser degree of disturbance, each patient should be evaluated on a continuum composed by the following levels of functionality: *personal* (identity and self-direction) and *interpersonal* (empathy and intimacy). At the personal level, identity involves the perception of oneself as unique and unrepeatable, with a stable self-concept, and self-direction represents the short-term pursuit of coherent and meaningful life goals, in addition to the capacity for self-control. In turn, at the interpersonal level empathy involves understanding and appreciating the experiences and motivations of others, with tolerance for different perspectives and the ability to perceive the effects of our actions on others, and intimacy is the ability to establish deep and lasting relationships with others.^{2,5}

The disorders of personal and interpersonal functioning, like the International Classification of Functioning, Disability and Health (ICF),¹⁰ show the following levels of severity: 0 = *No impairment*; 1 = *Mild impairment*; 2 = *Moderate impairment*; 3 = *Severe impairment*; and 4 = *Complete impairment*.

This model is consistent with multiple personality theories and is based on how people think about themselves and others and how they relate to others. For example, the identity disorder in PDs has been underlined by Schmeck et al.¹¹ or, earlier, Kernberg,¹² for whom the central pathology of patients with severe borderline personality disorders and others can be found in deterioration of the integration of identity. According to Skodol et al.,¹³ the projection of five items related to identity predicts the presence of a PD with 79% sensitivity and 54% specificity.

The role of self-direction, which is associated with the level of self-esteem, and of cooperation, which is associated with empathy, have also been highlighted in the psychobiological model of Cloninger et al.¹⁴ Moreover, as Sullivan¹⁵ has pointed out, the quality of interpersonal dimensions is a reflection of the personality structure.

Therefore, the failure to achieve security and self-esteem in interpersonal situations causes emotional dysregulation, which, when chronic and extreme, is a reflection of personality pathology and complicates both day-to-day interpersonal situations and long-term relationships.¹⁶ In turn, empathy involves cognitively and emotionally putting oneself in the place of another, parting from observation, verbal contents, or information accessed from the memory (taking on the perspective of others).¹⁷

In short, according to the DSM-5 personality functioning assessment scale, an adaptive personality has permanent awareness of a single ego and maintains appropriate roles (*identity*), aspires to reasonable goals based on a realistic assessment of personal skills (*self-direction*), can accurately

understand the experiences and motivations of others in most situations (*empathy*) and, lastly, maintains multiple satisfactory and lasting relationships in both personal and community life (*intimacy*).

Personality traits (domains and facets)

Personality traits, according to DSM-5, are *tendencies to feel, perceive, behave and think in a relatively consistent way across time and situations*. However, the trait levels of people can and do change over the course of life. Some changes are very general and accompany maturation (e.g., adolescents are generally more impulsive than adults), while other changes reflect specific individual life experiences.

Although traits are in no way immutable, they do show relative consistency compared with specific symptoms and behaviors. Thus, a person can behave impulsively at a given time for a specific reason, but it is only when the same behaviors are repeated over time and in changing circumstances that they can be characterized as traits. However, it is important to recognize that even people who are impulsive do not act impulsively all the time. A trait is a tendency or disposition toward specific behaviors; a specific behavior, in turn, may be the manifestation of a trait.

Similarly, traits differ from most symptoms in that symptoms tend to come and go, whereas traits are relatively stable. For example, individuals with higher levels of *depressivity* are more likely to experience discrete episodes of a depressive disorder and to exhibit symptoms of this disorder, such as anhedonia or difficulty concentrating. However, it is important to emphasize that both symptoms and traits are amenable to intervention. In fact, many interventions that target symptoms can affect more or less stable behavior patterns of personality functioning that are defined by personality traits.

According to the most relevant research,¹⁸⁻²⁵ personality is explained with a solution of 4 or 5 super factors, or dimensions, supported by genetic, neuropsychological, and factor analysis studies: 1) *Openness trait*: extraversion, sensation-seeking, sociability, positive affectivity (*versus* inhibition/introversion); 2) *Impulsivity trait*: impulsive sensation-seeking, disinhibition (*versus* compulsivity, control, restriction, responsibility); 3) *Affective trait* (anxiety-depression): negative affect, neuroticism, emotional dysregulation, instability, anxiousness (*versus* emotional stability); 4) *Dissozial trait*: antagonism, psychoticism, hostility, aggressiveness, antisocial behavior (*versus* agreeableness); and 5) *Cognitive trait*: psychoticism, schizotypy (*versus* lucidity) (Table 2).

Specifically regarding the DSM-5, the personality traits listed in section III encompass a spectrum of five general domains with two opposite poles: negative affectivity *versus* emotional stability; detachment *versus* extraversion; antagonism *versus* agreeableness; disinhibition *versus* con-

Table 2 Personality factors according to DSM-5 and some models and proposals					
DSM-5 (APA, 2013) PID-5	NEGATIVE AFFECTIVITY	DETACHMENT vs EXTRAVERSION	ANTAGONISM	DISINHIBITION	PSYCHOTICISM
NEO-PI-R (Costa & Mc Crae)	NEUROTICISM	INTROVERSION	AGREEABLENESS (low)	RESPONSIBILITY (low)	OPENNESS
PSY-5 MMPI (Harkness & McNulty)	NEUROTICISM	INTROVERSION	AGGRESSIVENESS	LACK OF CONTROL	PSYCHOTICISM
DAPP-BQ (Livesley)	EMOTIONAL DYSREGULATION	INTROVERSION- INHIBITION	ANTISOCIAL BEHAVIOR	COMPULSIVENESS (low)	
ZKPQ Zuckerman	NEUROTICISM- ANXIETY	SOCIABILITY (low)	AGGRESSION- HOSTILITY	IMPULSIVE SENSATION- SEEKING	
EPQ (Eysenck)	NEUROTICISM	EXTRAVERSION OR INTROVERSION	PSYCHOTICISM		

scientiousness; and psychoticism *versus* lucidity. In turn, these general domains have up to 25 more specific dimensions (facets). Thus, the opposite pole of *callousness* (within the domain of antagonism) is the tendency to be empathetic and kind-hearted. However, the opposite pole of the problematic trait may not always be adaptive (for instance, in the case of people who, due to their extreme kindness, become scapegoats for unscrupulous people).

In short, the five dimensions of the DSM-5 dimensional model are maladaptive variants of the general personality structure.

Consequently, negative affectivity is linked to neuroticism, detachment to introversion, antagonism to diminished agreeableness, disinhibition to diminished conscientiousness, and psychoticism to openness.^{3,26}

The domains (5) and facets of personality (25) in the DSM-5, some of which saturate more than one factor (depressivity, suspiciousness, restricted affect, hostility), are shown in Table 3. Facets must be assessed on a scale from 0 (not descriptive of the person) to 3 (very descriptive of the person).

Diagnostic categories

Personality disorders are usually regarded as exaggerations of normal personality traits and are genetically conditioned (genotypes), but always in interaction with psychosocial and contextual factors. Personality traits only constitute PDs when they are inflexible and maladaptive, ubiquitous, of early onset, resistant to change, and causing significant functional impairment.

The twenty-five facets that are grouped into the five higher-order personality domains (negative affectivity, de-

tachment, antagonism, disinhibition, and psychoticism) are used to categorically "compose" the PD (Figure 1). In Section III of the DSM-5, six categories of PD are proposed that are defined dimensionally by the corresponding traits: antisocial, borderline, narcissistic, avoidant, obsessive-compulsive, and schizotypal. These are the categories that have more empirical support and correlate more with the proposed personality dimensions. All the PDs except antisocial PD can be diagnosed before the age of 18 years.

The DSM-5 also includes an additional trait-specified PD (PD-TS), which may be used when a PD is considered to be present, but the criteria for a specific personality disorder are not fully satisfied.

For this diagnosis, as for any other PD, the clinician should take note of the severity of the disorder in personality functioning, with difficulties in two or more areas (identity, self-direction, empathy, or intimacy), as well as the presence of pathological domains and facets.

The other specific PDs that were contemplated in the DSM-IV and remain in section II of the DSM-5 (schizoid, paranoid, histrionic, and dependent), the other PDs under study (depressive, passive-aggressive), psychopathic/sadistic disorder, and residual unspecified PD disappear from this version. These PDs should therefore be assessed, as in the case of PDs, with a detailed description of the anomalies in personal and interpersonal functioning and a dimensional assessment of the personality domains and facets.

A polythetic assessment of maladaptive traits should also be made. Consequently, in order to satisfy criterion B, moderate or severe impairment of a certain number of personality facets is required: for antisocial PD, impairment of six or more out of a total of seven facets; for avoidant PD,

Table 3 Higher-order domains and facets of personality in DSM-5 (Section III)		
HIGHER-ORDER DOMAINS	PERSONALITY TRAIT FACETS	NUMBER OF TRAITS (total: 25).
Negative affectivity	Emotional lability, anxiousness, separation insecurity, submission, hostility, perseverance (common to other domains), depressivity (common to other domains), suspiciousness, restricted affectivity (common to other domains).	6
Detachment	Social withdrawal, avoidance of intimacy, anhedonia, depressivity, restricted affectivity, suspiciousness.	6
Antagonism	Manipulativeness, deceitfulness, grandiosity, attention seeking, callousness, hostility (common to other domains)	5
Disinhibition	Irresponsibility, impulsivity, distractibility, risk taking, lack of perfectionism.	5
Psychoticism	Odd beliefs and experiences, eccentricity, cognitive/perceptual dysregulation.	3

impairment of three or more out of a total of four facets; for borderline PD, four or more out of a total of seven facets (necessarily including one of the three core facets); for narcissistic PD, the two facets proposed; for obsessive-compulsive PD, three or more of the four facets that shape

the maladaptive disorder; and finally, for schizotypal PD, four or more of the six facets proposed.

As for the specific PDs, antisocial PD is characterized by a failure to conform to lawful or culturally normative ethical

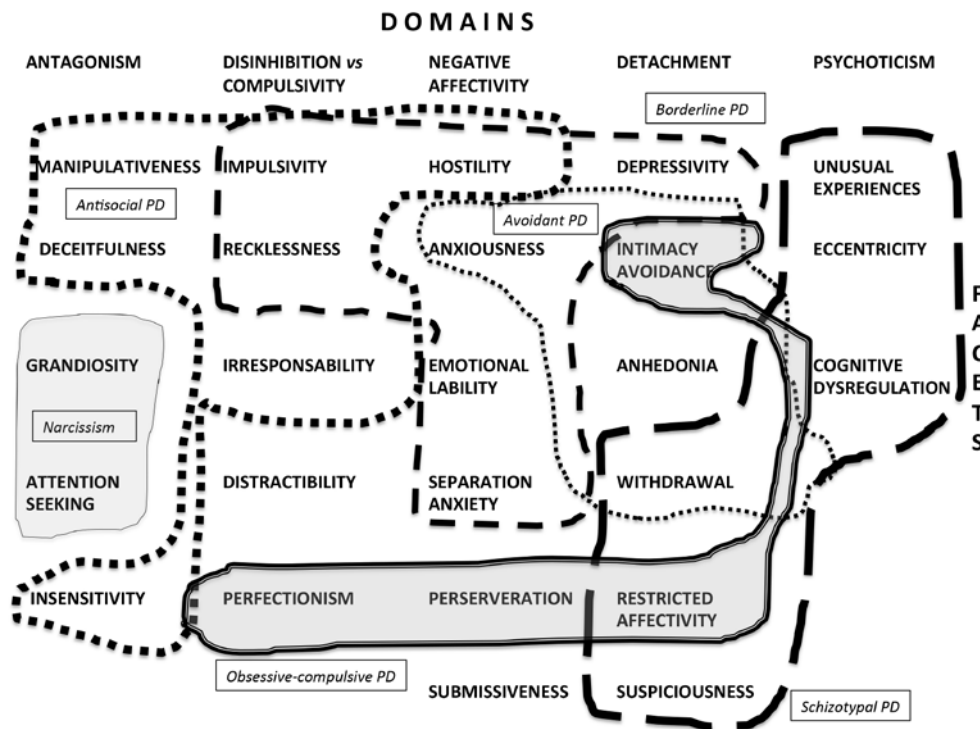


Figure 1 Composition of personality disorders from domains and facets

behavior, ego-centrism, lack of concern for others; and lack of remorse after hurting or mistreating another, accompanied by deceit, irresponsibility, manipulativeness and/or recklessness. Essential domains for assessment: antagonism and disinhibition.

The typical features of avoidant PD are withdrawal from social contacts and activity and avoidance of interpersonal attachments because of excessive feelings of shame or inadequacy, preoccupation with criticism or rejection, and fear of being shamed or ridiculed. Essential domains for assessment: negative affectivity and detachment.

Borderline PD is characterized by the instability of one's self-image, personal goals, relationships and emotions, as well as impulsivity, recklessness (risk-taking) and/or hostility. Essential domains for assessment: negative affectivity and disinhibition.

The typical characteristics of narcissistic personality disorder are variable and vulnerable self-esteem, with attempts at regulation by seeking attention and approval and overt or covert grandiosity. Essential domain: antagonism.

In obsessive-compulsive PD, difficulties in establishing and maintaining close relationships are present, associated with rigid perfectionism, inflexibility and limited emotional expression. Essential domains for assessment: negative affectivity and detachment.

Typical features of schizotypal personality disorder are impaired ability to establish social and close relationships and eccentricities in thought, perception and behavior, which are associated with a distorted self-concept and incoherent personal goals. Suspiciousness and constricted emotional expression are also present. Essential domains for assessment: psychoticism and detachment.

Finally, for the diagnosis of the specific personality trait disorder, the patient must have pathology in at least one of the five existing personality domains.

The interest of these requirements is that they could involve a decrease in the high rates of prevalence of PDs in current studies, as well as improved specificity and consistency in diagnosis.

Evaluation

The APA expects that inclusion of this new proposal in DSM-5 section III will encourage research that will provide support for this new form of diagnosis, contributing to a greater understanding of the causes of PDs and ultimately improving treatments for the condition.

For this reason, the assessment tools, as well as instructions and guidelines for interpretation, are freely available on the APA website. For example, the *Personality Inventory for DSM-5* (PID-5),²⁷ which is the measurement instrument

for the 25-trait dimensional model proposed by the DSM-5, is available online at DSM-5.org, where it is offered to psychiatrists, psychologists, and primary care physicians.

TOWARD THE ICD-11

According to the latest draft of ICD-11,²⁸ PDs are characterized by a generalized disturbance in the way people think about themselves, others, and the world, as reflected in the experience, emotional expression, and patterns of behavior. The disorder is associated with significant functioning problems, which are particularly evident in interpersonal relations and are manifested through a range of personal and social situations (i.e., not limited to specific relationships or situations). The disruption is long-lasting (two years or more).

Personality disorders usually exhibit their first symptoms during childhood and are fully evident in adolescence. However, in some cases PDs develop later in life, in which case the qualifier "delayed start" can be used.

The diagnostic criteria of the DSM-5 and future ICD-11 will necessarily have to be harmonized. The high prevalence of PDs is evident, but most are not serious. The WHO Work Group, under the direction of Peter Tyrer, has decided it is necessary to incorporate the assessment of severity in the ICD-11 classification of PDs. What is clear from empirical research studies is that the most serious PDs span many personality domains, in such a way that in the most severe disorders virtually no personality function is satisfactory.²⁹

Tyrer and Johnson,²⁹ in 1996, proposed an assessment of the severity of PDs for the DSM depending on whether the PD affects a single cluster or various clusters, and whether it resulted in severe and/or dangerous symptoms. What the patient often experiences is merely an accentuation of the basic personality traits in response to a stressful situation, without satisfying the requirements for early onset, ubiquity, and resistance to change that define a PD. On the other hand, a simple PD is not the same as a complex PD. A simple PD would consist of the appearance of one or more disorders in the same cluster (a, b or c). A diffuse or complex disorder includes various PDs from several different groups, or clusters.

In turn, the British government, which was determined to prevent very serious crimes, in 1999 introduced a new concept called "dangerous and severe personality disorder (DSPD)" for people who meet three requirements: 1) having a severe personality disorder; 2) presenting significant risk of causing serious physical or psychological harm to one or more victims; and 3) existing a functional link between dangerousness and the PD. Judgment about whether a person met the diagnostic criteria for DSPD should be

LEVEL OF SEVERITY	MAIN CHARACTERISTICS
No personality disorder	No significant alterations
Personality difficulties	Some personality problems in some situations, but not generalized
Simple personality disturbance	Persistent pattern of poor interpersonal functioning and self-control manifested at any age
Personality disorder	Well-defined personality problems manifested in a wide range of situations
Complex personality disorder	Defined personality problems, usually covering several areas of personality and occurring in all situations
Severe personality disorder	The same as the complex disorder, but with significant risk to oneself or others

objective and based on the assessment of psychopathy according to the Psychopathy Checklist-Revised (PCL-R).³⁰

The project of the latest draft of the ICD-11 organizes severity according to different criteria for intensity: 1) personality difficulty, 2) personality disorder, 3) simple personality disorder, 4) complex personality disorder, and 5) severe personality disorder (Table 4). Four personality domains are proposed in the draft, which are internalizing (labile, anxious), externalizing (hostile, dissocial), anankastic (perfectionist, rigid), and schizoid (susceptible and lacking in empathy). These domains, together with the assessment of severity, constitute the PD classification scheme³¹ (Table 5). The diagnostic overlap between several common forms of psychopathology is explained by two oblique factors of superior order: internalization and externalization. In this

model, internalization represents a substrate of depressive disorders and anxiety, while externalization essentially corresponds with the abuse of addictive substances and with antisocial personality characteristics. This model has consistent empirical support.

Moreover, the maturity of relationships with other people inversely correlates with the presence and severity of a diagnosis of PD. In addition, reflective function (i.e., the ability to understand and interpret one's own and others' mental states) is reduced in patients with borderline PD and is also inversely proportional to the number of PDs diagnosed in a particular patient.³²

In short, the variations in the PDs are limited to four or five factors that include dimensions such as impulsivity, co-

PERSONALITY DOMAINS	PERSONALITY TRAITS	SEVERITY
Schizoid	Detachment and emotional coldness, flattened affectivity, insensitivity, lack of empathy.	COMPLEX PERSONALITY DISORDER
Anankastic	Excessive conscientiousness, rigidity, perfectionism, inflexibility, excessive caution.	COMPLEX PERSONALITY DISORDER
Externalizing	Irresponsibility, antagonism, insensitivity to the needs of others, anger and aggressive behavior, deceitfulness, egocentricity	COMPLEX PERSONALITY DISORDER
Internalizing	Anxiousness, lack of self-esteem, shyness, dependence on others, indecision.	PERSONALITY DIFFICULTIES

vert aggression, isolation, rigidity and perfectionism, introversion and suspiciousness, or anxious-dependent traits, which are distributed dimensionally among all people. The most severe levels of PD represent a combination of the above traits.³³

CONCLUSIONS

There has been enough research to conclude that a personality disorder is a dimensional construct and that there are no essential differences in personality structure between subjects with PD and those without. The inadequacy of the PD classification in the DSM-IV, especially the assumption that these disorders do not form a continuum with normal personality, the overlap between diagnostic criteria for different PDs, the excessively frequent PD comorbidity, of the lack of discriminant validity of the classification anticipated the paradigm shift in the DSM-5 to a dimensional position.^{4,26,33-35}

However, the APA did not dare to make an abrupt change in the DSM-5 and wanted to ensure a smooth transition from the DSM-IV while awaiting the ICD-11, so it resorted to a hybrid model of two PD rating systems. As regards the above mentioned specific disorders, it is shocking that antisocial personality disorder was kept in DSM-5 when there is a solid investigation supporting the existence of a more specific and precise PD called *psychopathy*, which cover two factors: the antisocial components included in the DSM-5, and the affective components of this disorder (lack of empathy, cruelty, absence of remorse).^{2,36-38}

In our opinion, the proposed hybrid model is a complex and confusing juxtaposition of incompatible taxonomic models, lacking in solid empirical support and of little use for clinical purposes because the assessment is work-intensive.³⁵ The last point is important because most people with PDs resist being evaluated and treated in practice.³³ Clinically, the best predictor of therapeutic results with PD is severity rather than the particular type of PD.^{34,39} Therefore, this is the approach to be taken by the new ICD classification in its next edition planned for 2016-2017 (ICD-11).³¹

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