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New criteria for personality disorders in DSM-V

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Diagnosing disorders in the current edition of the DSM-IV involves two aspects. The first is the concept of a personality disorder, which currently is defined as a pervasive, stable and presents at least from adolescence pattern of "inner experience and behavior" that is deviant from a person's cultural norms. The second aspect involves defining what type of personality disorder is present among a list of ten, with a catch-all "not otherwise specified category". There are many problems with the existing system: the different personality types are poorly defined and the diagnostic criteria overlap heavily. The proposed revision on the DSM-V website appears quite complicated and has three major facets: a new definition for personality disorder, focused on "adaptive failure" involving "impaired sense of self-identity" or "failure to develop effective interpersonal functioning"; five personality types (Antisocial/ Psychopathic, Avoidant, Borderline, Obsessive-Compulsive, and Schizotypal); and a series of six personality "trait domains", each of them with a subset of facets. This new proposed system for personality disorder diagnosis may be controversial. Finally challenges for the next future are discussed.

Key words:
Personality disorders. Definition. Diagnosis. DSM-V.

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La reformulación de los trastornos de la personalidad en el DSM-V

El diagnóstico de los trastornos de personalidad en la actual edición del DSM-IV implica dos aspectos centrales. El primero es el referido al concepto mismo de trastorno de la personalidad, que es definido como un patrón de conductas y de experiencias internas que está

generalizado, es estable y se mantiene al menos desde la adolescencia. El segundo aspecto se refiere a la identificación de un trastorno de personalidad en una lista de diez, con una categoría adicional de "no específico". Hay muchos problemas con el sistema actualmente vigente: los diferentes tipos de personalidad aparecen definidos de una forma muy pobre y hay un gran solapamiento de los criterios diagnósticos. La revisión propuesta en el borrador del DSM-V resulta más bien compleja y tiene tres características principales: una nueva definición de lo que es un trastorno de personalidad, centrada en los fallos de adaptación, que implican alteraciones de la identidad o en las relaciones interpersonales efectivas; cinco categorías diagnósticas (antisocial/psicópata, evitativo, límite, obsesivo-compulsivo y esquizotípico); y una serie de seis dominios de personalidad, cada uno de los cuales con un subconjunto de facetas o rasgos. Este nuevo sistema propuesto para el diagnóstico de los trastornos de la personalidad puede resultar controvertido. Por último, se comentan los desafíos para el próximo futuro.

Palabras-clave:
Trastornos de la personalidad. Definición. Diagnóstico. DSM-V

INTRODUCTION

The current classification of personality disorders (PD) in the DSM-IV-TR¹ is unsatisfactory in many ways. Among others, there are serious problems regarding the operative definition, classification, category or dimensional adscription, evaluation of severity or prototypicity, permanence in Axis I or Axis II, heterogeneity in the same diagnoses, relationship with the personality traits, comorbidity, cutoff between normality and abnormality and validation of the disorders being studied (depressive, passive-aggressive, etc.) that still need to be solved. All these points require a new approach to these abnormalities.

Personality traits are persistent patterns of ways of perceiving, relating and thinking about the setting and oneself that are observed in a wide range of social and

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personal contexts. Personality constitutes the personal identity before oneself and others. *Personality traits* only become *personality disorders* when they are inflexible and maladaptive, omnipresent, of early onset, resistant to change and when they cause significant functional deterioration or subjective malaise.

There are abnormal configurations of the egosyntonic personality and egodystonic personalities. Egosyntonics make others suffer. They do not know or accept they have a disorder. They have problems in interpersonal relationships and think that the others are those guilty of these problems. They are incapable of maintaining stable work or a prolonged affective relationship over time. They may have depressive symptoms or anxiety. However, they do not respond to conventional treatments. Ego-dystonics, on the contrary, suffer, feel unfortunate and would like to be different from what they are.

Although this is being intensely debated, all the current classifications of PD require: 1) that the onset of the disorder occurs in childhood or adolescence (early-onset); 2) that there is persistence of the behavior over time and in almost all situations (stability and consistency); and 3) that it causes personal suffering, problems at work or problems with family or social relationships.

However, some PDs are not as inflexible nor do they have as bad a prognosis as thought. In this sense, the differentiation of the Tyrer² group between *type R* patients (unaware of disorder and no motivation for change) and *type S* (with awareness of disorder and motivation for therapy) is interesting. This may be useful from the nosological point of view and introduces a predictive variable of treatment compliance. In addition, there are disorders that change over time. Thus, for example, the prevalence of antisocial disorder and others of group B and the impulse of personalities decrease with age while, on the contrary, the diagnoses of the group A and C disorders have a significant increase, probably as a consequence of social detachment.

Controversies on the personality disorders since the publication of the DSM-III/DSM-IV

The PD types of the DSM-IV and ICD-10³ classifications score low on psychometric properties. They perpetuate by consensus and tradition. According to Livesley,⁴ the validity of most of the diagnoses has not been empirically established. Validity has also not been demonstrated in the differential groups of the DSM (A, B and C clusters). These seem to be supported more by tradition and consensus than on empirical data.

In regards to the internal validity of the psychiatric

diagnosis, the clinicians have problems to relate the criteria suggested with the PD characteristics and, inversely, the combination of criteria do not always include those traits that the clinicians consider typical of this type of diagnosis. Furthermore, there are failures in the internal consistency up to the point that the overlapping of clinical pictures is excessively wide. On the other hand, when the factorial structure of the **Millon Clinical Multiaxial Inventory (MCMI)** and Psychophysiological and neuropsychological factors are evaluated, the construct validity in the categories in force of the PDs is rather low.⁵

The problems with the external validation are still very serious. Regarding the discriminant validity, the studies show that there is no possibility of discrimination since multiple diagnoses normally appear. In relationship with the external validity per se, there is no proof that the diagnoses predict significant external variables related with the etiology.

In spite of all these problems, the categorical model is perpetuated because of the close relations between psychiatry and medical models and because the cognitive functioning of humans tends to operate with categories when organizing the information coming from the exterior. Simply, it is a question of comfort and utility.

Categorical or dimensional evaluation of the PDs?

The classification of personality disorders made by the DSM-IV-TR and ICD-10 originates from a traditional categorical perspective, whose background is found in the classical model of Kurt Schneider,⁶ that considers PDs as individual pathological entities that are delimited. That is, each disorder makes up a diagnostic category and is supported by specific alterations. The categorical opinion consists in "*having or not having*" the disorder and has the advantage of being more parsimonious to form the concept of a syndrome and to transmit the information to other clinicians.

With the polythetic approach of the DSM-IV-TR, once the minimum criteria are met (half plus one, regardless of what they are specifically) for the diagnosis of a PD, each diagnosis can be made. The consequence of this polythetic approach is that there are very different ways of being able to comply with, for example, the diagnoses of antisocial disorder or borderline personality disorder, which leads to the proliferation of numerous subtypes.⁷

However, the categorical diagnosis in the PDs has severe associated problems. The criticisms regarding the categorical models have been summarized as follows: 1) scarce adjustment between patients and prototypes: 2) overlapping of the criteria

proposed between different categories and disorders on Axis I; 3) low temporal and inter-rater reliability; 4) poor diagnostic validity, and 5) there is little utility for the treatment.

A dimensional approach, on the contrary, offers diverse advantages: 1) it is solid with the observation of diffuse limits between the disorders and normality; 2) it is more in agreement with the complexity of the syndromes observed in the clinical practice; 3) the dimensional measurement can be transformed into categorical, but not to the contrary; 4) categorization beginning with dimensionalization makes it possible to vary the cutoffs, considering the contextual, cultural and individual specificities; 5) it is possible to make finer analyses of the characteristics of the patients; 6) it provides the therapists with specific intervention areas; 7) it improves the reliability of the evaluation; and 8) comorbidity is no longer a problem since an individual can be defined based on his/her combined characteristics of traits and not of categories.

There is little doubt regarding the fact that the adoption of a dimensional model could resolve several of the problems generated by the categories of the DSM-IV-TR and the ICD-10, especially the heterogeneity of the categories, the overlapping between criteria that generate important comorbidity on Axis II (excessive diagnoses) and the considerations of the categories as arbitrary. In fact, the DSM-IV-TR itself considers possible, at least, that the categorical approach is connected with another dimension (highbred model), as occurs, for example, in the case of mental retardation.*

This hybrid approach may facilitate the evaluation of the severity of the PDs. Thus, there are qualitatively more severe personality disorders, such as schizotypal, borderline or paranoid, but they can also be dimensionally quantified, for example, the risk of causing physical or psychological harm.⁸ More specifically, Tyrer and Johnson⁹ establish the following grading from greater to lesser severity: 1) accentuation of the normal personality traits, without reaching the diagnosis of a PD; 2) simple personality disorder, that consists in one or more diagnoses of PD of the same group or cluster; 3) complex personality disorder, that refers to two or more PDs of different groups; and 4) severe personality disorder, that is applied when a serious social dysfunction is also generated.

* DSM-IV: the diagnostic approach used in this manual represents the categorical perspective that the PDs represent qualitatively distinct clinical syndromes. An alternative to the categorical approach is the dimensional perspective that the PDs suppose maladaptive variants of the personality traits that imperceptibly overlap with normality and between themselves. There has been many different attempts to identify the fundamental dimensions of underlying the totality of the field of normal and pathological functioning of the personality. The groups of the PD of the DSM (e.g., odd-eccentric, dramatic-emotional and anxious-fearful) may also be considered dimensions that represent the spectrum of dysfunctions on a continuum with the mental disorders on Axis I. The alternative dimensional models have much in common and as a whole seem to cover the most important aspects of the personality disorders. Their integration, clinical utility and relationships with the diagnostic categories of the PD and with diverse aspects of the personality dysfunction continue to be actively investigated.

Does it make sense to maintain the distinction between Axis I and Axis II?

According to the DSM-III,¹⁰ there are powerful reasons to include personality disorders on an independent axis. The PDs, at least some of them, are generally egosyntonic. They may make up a predisposition for the initiation of many mental disorders; they condition their phenomenology, course and prognoses. They are abnormalities having early-onset and finally they have a permanent character.

However, the limits between disorders on Axis I and Axis II are frequently diffuse. This co-occurrence (comorbidity) especially is found between Schizotypal Personality Disorders and Schizophrenia, between Paranoid Personality Disorder and Delusional Disorder, between Mood State Disorders and Instability Disorder (borderline), between Obsessive-Compulsive Disorder and Obsessive-Compulsive Personality Disorder, between Social Phobia and Anxious Avoidant Disorder. Furthermore, there are anxiety disorders or mood disorders of early onset that are totally indistinguishable from any PD, this posing the possibility of considering PDs as variants of early onset of disorders on the Axis I.

The greater stability of disorders on Axis II compared to the more fluctuating syndromes on Axis I has also not been empirically proven. Thus, at present there is sufficient empirical support on the instability of some personality traits. Inversely, both those occurring in the acute form with crises as well as those that are chronic are included among the severe mental disorder. Even more, some PDs may not be extreme deviations of the personality structures but rather biological-pathological phenomena that have been assembled on a normal personality and that, therefore, may behave as do most of the mental disorders. Thus, the possibility that some PDs (schizotypal, borderline, among others, may be transferred to Axis I is being studied.¹¹

In summary, since there is no fundamental distinction, the proposal of many authors is to consider the PDs as one more among the different types of acknowledged mental disorders in the international classifications.⁴

Future proposals (DSM-V)

Specific proposals presented during recent years

There is a current search for consensus for the evaluation of the PDs in the future. The most interesting proposals may be summarized into four groups: A: Proposals on the dimensional profile of the current or future categories. B: Dimensional reorganization of the symptoms of PDs. C: Clinical spectrum models. D: Integration of the PDs with the general functioning of the personality.

The psychobiological proposals of Eysenck¹² with its three factors (extraversion, neuroticism and psychoticism), to which Gray¹³ has added two more (anxiety or susceptibility to punishment and impulsiveness or susceptibility to reinforcement) are well known. In turn, Zuckerman-Kuhlman proposes a model of five alternative factors: neuroticism-anxiety, aggression-hostility, activity, sociability and non-impulsive socialized sensation seeking.

Millon,¹⁴ who initially proposed his polarities and evolutionary theory model, has recently formulated a dimensional spectrum between 15 personality styles and 15 personality disorders. Each dimension includes, in the first place, the normal *style* of the prototype or of the personality (for example, retiring) and in the second place, the abnormal prototype or personality *disorder* (for example, schizoid). This is how the *circulargram* was constructed (see the official website of T. Millon). It represents the normal and abnormal prototypes of the theory and includes: the pain-pleasure, passive-to and self-other polarities; the personality styles, personality disorders, and finally, the MCMI-III scales.

Watson and Tellegen¹⁵ ascribe the affective disorders to two orthogonal factors: a positive affect/ negative affect bipolarity. The positive affect is defined as the tendency to experience emotions of positive valence and elevated activation (enthusiasm, excitement); in the negative affect, the negative valence emotions and those of limited activation are present (tiredness, sadness). Watson, Clark and Tellegen¹⁶ developed a measurement of these two dimensions with the Positive Affect Negative Affect Schedule (PANAS), validated in Spain. After, using the factorial analysis, Tellegen, Watson and Clark¹⁷ re-organized their theory, designing a model having three important factors (positive emotionality, negative emotionality and inhibition), supported on a hereditary basis.

The Costa and McCrae group,¹¹ who designed the model of five superfactors of personality (neuroticism, extraversion, openness to experience, agreeableness and responsibility) that could be evaluated using the NEO-PI-R instrument, has suggested a 4-step procedure: 1) description of the personality structure according to the 5-factor model of NEO-PI-R; 2) identification of the associated problems; 3) clinical significance of these problems; and 4) adaptation of the profile to prototypal cases to see if a diagnostic label is adequate.

Livesley and Jackson¹⁸ have proposed the "dimensional evaluation of the personality pathology." After multiple studies, the traits were grouped into four factors 1:) emotional dysregulation (neuroticism); 2) dissocial behavior; 3) introversion-inhibition; and 4) compulsiveness.

Cloninger,¹⁹ based on his 7-factor model, suggests that a PD be diagnosed according to the dimensions of *character*

(low cooperativeness, low self-transcendence and low self-control) and that *temperament* (sensation seeking, harm avoidance, reward dependence and persistence) should define the type.

Shedler and Westen²⁰ proposed a clinical evaluation and extracted 12 factors, which have shown good correlations with the NEO, using the SWAP-200 test. The SWAP-200 (*the Shedler-Westen Assessment Procedure*) is not a self-report, but rather a method to systematically record the observations of the clinicians. This instrument makes it possible to conceptualize the PDs as continuous, not as categories and also to incorporate intrapsychic and dynamic factors, such as motives, fantasies, object representations, conflicts and defenses, while the DSM only emphasizes the manifest symptoms.

Oldham and Skodol,²¹ in relationship with the polythetic evaluations, differentiate several levels: 1) prototypal (it fulfills all the type criteria); 2) moderate (it shows one or more criteria on the cutoff); 3) threshold (it exactly fulfills the criteria required); 4) sub-umbra (it has one criterion below the cutoff); 5) traits (it only shows 1-3 criteria); and 6) absent (it does not fulfill the criteria).

Regarding the diagnostic axes, Siever and Davis²² propose a continuum between Axes I and II, especially in regards to impulsiveness, anxiety and cognitive distortion. Specifically, they distinguish three personality dimensions: cognitive/perceptive organization, instability/aggressiveness; and anxiety/inhibition. The abnormalities of these dimensions occur on a continuum in which the extremes give rise to Axis I disorders of the DSM, while the milder deviations would make up, on becoming persistent, the pathologies on Axis II, but always on the same pathological basis (alteration of certain neurotransmitters).

In summary, there is currently some consensus on the following aspects: 1) penta-factorial models of the personality tend to predominate, supported on genetic, neuropsychological and factorial analysis studies. Those having the most consensus (see Table 1) refer to the dimensions: a) affective (anxiety, neuroticism, negative affect or dysregulation); b) cognitive (schizotypy, openness); c) exploratory (extraversion *versus* inhibition or introversion); d) impulsive (*versus* compulsive or responsibility); and e) dissocial (aggressiveness or antagonism *versus* kindness); 2) the PDs are considered as exaggerations of the normal personality traits and are genetically conditioned (genotypes), but always in interaction with the psychosocial and contextual factors; 3) the dimensional evaluation of the personality is more reliability than the categorical, but a mixed model that combines medical-psychiatric and psychological tradition is not ruled out; 4) the grade of prototypicity of the diagnostic categories and the severity of the PDs must be evaluated; 5) an evaluation is needed by the

Table 1 CORRELATIONS BETWEEN PERSONALITY FACTORS ACCORDING TO THE DIFFERENT MODELS AND PROPOSALS

TEST	AUTHOR					
DAPP-BQ	Livesley	Inhibition	Dissocial	Compulsivity	Dysregulation	
NEO-PI-R	Costa Et McCrae	Extraversion	Antagonism	Responsibility	Neuroticism	Openness
SNAP	Clark	Positive affect	Negative affect	Restriction	Negative affect	
PSY-5	Harkness Et Mc Nulty	Negative Emotionality	Aggressivity	Restriction	Negative Emotionality	Psychoticism
MCFI-III	Millon	Withdrawal	Aggressivity	Restriction	Neuroticism	
EPO	Eysenck	Extraversion	Psychoticism		Neuroticism	
ZKPQ	Zuckerman	Sociability	Hostility	Impulsiveness	Neuroticism	
	Siever Et Davis	Inhibition	Aggressiveness / impulsiveness		Affective Instability	Perceptive Cognition

clinician on the personality structure, adaptive capacity, static and dynamic aspects and problems in interpersonal relationships based on a description of the dispositions and behaviors; and 6) the conceptual fundamentals of the distinction between Axis I and Axis II are weak and the borders between both are frequently diffuse.

Bases of the current draft of the DSM-V (September 2010)

The APA, after a study and revision procedure, created a web site (www.dsm5.org) to make known the draft of the DSM-V and invite criticisms and proposals from the scientific community. Specifically, the Work Group recommends a significant reconceptualization of the psychopathology of personality as basic deficiencies in personality functioning, as pathological personality traits and as prominent types of pathological personality.

PDs are diagnosed following four criteria: 1) identification of five levels of severity in personality functioning; 2) establishment of five PD categories (proposal pending empiric validation); 3) creation of six general domains of personality and 37 more specific personality trait-facets and 4) redefinition of the PDs, based on pathological traits and severe deficiencies in the basic components of the functioning of personality.

The new concept of personality disorder

The revision proposed suggests modifying the "dominant pattern of thinking, feeling and behaving" (DSM-IV) for that of "adaptive failure" from two points of view: defect or

impairment in self-identity and/or failure in interpersonal relationships. In this way, the PDs represent incapacity to develop a sense of own identity (with deficits in the self-concept and self-control) and of establishing adaptive interpersonal relationships in the context of cultural norms of the individual and the expectations created, with specific alterations in the area of empathy, intimacy and interpersonal cooperation. This incapacity is stable in time and has an early origin.

Axis II

As previously commented, the suppositions on which the distinction between the Axes were forged have been collapsing. Therefore, in the 163rd Annual Meeting of the *American Psychiatric Association*, held in May 2010 in New Orleans, it was proposed to eliminate the current Axes II and III and join all the mental and personality disorders and medical diseases on a single axis.

It has been suggested to abandon the current multiaxial system and even to eliminate the PDs and substitute them for early onset variants of axis I disorders (for example, schizotypal disorder as a variant of schizophrenia). This, however, would be difficult for some PDs, such as narcissist (not included in the ICD-10), histrionic or dependent ones. Another solution considered is that of adding a chapter in the DSM-V of Disorders of Interpersonal Relationships, that would include maladaptive traits, given that these are generally expressed clinically when the patient interacts with others. This posture seems to be excessively radical.

Although this question is not clearly defined in the draft of the DSM-V, everything points to the disappearance of

Axis II or if it is maintained, it would do so in order to mention and evaluate the domains and traits of the person.

Level of Personality functioning

The psychopathology of the personality is fundamentally derived from disturbances in thoughts on ones self and others. Because there may be a greater or lesser degree of disturbance, each patient should be evaluated on the continuum made up of the following levels of functioning: interpersonal (Empathy, Intimacy and Cooperativeness and integration of representations of others) and personal (Identity, Self-concept and Self-directedness).

As with the general criteria of the PDs, when these dimensions of interpersonal and personal functioning are applied, they should have the following elements: 1) they should be several years in duration; 2) they should not only be a manifestation or consequence of another mental disorder, 3) they should not be solely due to the physiological effects of a drug or a medical condition. The conditions of personal and interpersonal functioning, as with the Functioning, Disability and Health (FDH), show the following levels of severity: *0 = No Impairment, 1 = Mild Impairment, 2 = Moderate Impairment, 3 = Serious Impairment, 4 = Extreme Impairment.*

Personality domains and traits or facets

The Work Group recommends that the patients be evaluated based on six higher order domains and 37 more specific trait-facets ones. These dimensions should be graded

dimensionally on a scale of 0 to 3 points, 0 being very little or not at all, 1 being mildly descriptive; 2 moderately descriptive and 3 very descriptive of the person.

The wide range domains and the traits-facets corresponding to each one of them are shown in Table 2.

Future diagnostic categories of the personality disorders

The categories will be redesigned to make them more homogenous, mutually excluding an exhaustive, so that all the cases can be classified and the comorbidity that is often no more than diagnostic confusion can be avoided. Many investigations have demonstrated excessive co-occurrence between the personality disorders diagnosed with the DSM category system. In fact, most of the patients diagnosed of personality disorders fulfill the criteria for more than one of them. In addition, all the criteria of the PD have arbitrary thresholds of compliance, that is, the number of criteria necessary for the diagnosis.

Thus, reducing the number of types is aimed at reducing the comorbid diagnoses of PDs. The use of dimensions and certain personality domains is aimed at offering greater temporal and inter-rater reliability. The current clusters or groupings (A, B and C) tend to disappear.

The Work Group recommends five specific categories defined dimensionally by their corresponding traits: *antisocial/psychopathic; borderline, avoidant; obsessive-compulsive; and psychotypal.* These are the categories that have the greatest empirical support and that correlate the

Table 2		
DOMAINS	TRAITS-FACETS OF PERSONALITY	NUMBER OF TRAITS (total: 37)
Negative Emotionality	Emotional lability, anxiousness, submissiveness, separation insecurity, pessimism, low self-esteem, guilt/ shame, self-harm, depressivity, suspiciousness	10
Introversion	Social withdrawal, social detachment, restricted affectivity, anhedonia, intimacy avoidance	5
Antagonism	Callousness, manipulativenes, narcissism, histrionism, hostility, aggression, oppositionality, deceitfulness	8
Disinhibition	Impulsivity, distractibility, recklessness, irresponsibility.	4
Compulsiveness	Perfectionism, perseveration, rigidity, orderliness, risk aversion.	5
Schizotypy	Unusual perceptions, unusual beliefs, eccentricity, cognitive dysregulation, dissociation proneness.	5

most with the personality dimensions proposed (antisocial-psychopathic, with antagonism and disinhibition; borderline, with negative emotionality and disinhibition; avoidant, with negative emotionality and introversion; obsessive-compulsive, with compulsiveness; and schizotypal, with schizotypy).

The other specific PDs that are currently contemplated in the DSM-IV-TR (schizoid, paranoid, histrionic, narcissistic and dependent), the other PDs under study (dependent, passive-aggressive) and the residual category of not otherwise specified PD, as they lack sufficient empirical support, would disappear and should be evaluated, as in the case of the PDs, with a detailed and dimensional description of the personality traits and domains (Table 3).

All the types should be evaluated on a dimensional scale of prototypicity, following the proposals of Oldham, Schedler and Westen. In this way, a clinician compares one patient with the prototypic description of each disorder and grades it on a 5-point scale:

- 5 = Very good. The patient *exemplifies* this type
- 4 = Good: The patient *significantly resembles* this type
- 3 = Moderate: The patient has *prominent features* of this type
- 2 = Low: The patient has *minor features* of this type
- 1 = Null. This description does not apply to the patient

Description of the diagnostic categories of the PDs in the DSM-V draft

a) Antisocial/psychopathic disorder

This category not only includes the disinhibition and irresponsibility component but also that of meanness, that is, the traits related with lack of sensitivity or lack of remorse, *manipulativeness* and predatory aggression. All of this is very similar to the current factors II and I of psychopathy. There is abundant evidence that these two factors differentiate in terms of their neurobiological correlates, which offers a solid base in relationship to these subtypes.

The antisocial type coincides greatly with the current criteria. In turn, persons who coincide with the psychopathic type are arrogant and egocentric, seek power over others and manipulate them or take advantage of them in order to inflict harm and to achieve their objectives. They are insensitive and show a little empathy unless these coincide with their interests. They show disdain for the rights, property or safety of others, and do not feel guilt or remorse about the harm they cause. They act aggressively or sadistically towards others in pursuit of their personal interest and seem to obtain pleasure or satisfaction when dominating,

humiliating or degrading others. They also have a superficial charm and capacity to please when it is convenient to their purposes. They show little conventional moral principles and tend to deny responsibility for their acts and to blame others for their own failures and defects.

The domains and descriptive traits of this disorder are the following: 1. Antagonism: Insensitivity; 2. Antagonism: Aggression; 3. Antagonism: *Manipulativeness*; 4. Antagonism: Hostility; 5. Antagonism: *Deceitfulness*; 6. Antagonism: Narcissism; 7. Disinhibition: Irresponsibility; 8. Disinhibition: Imprudence; 9. Disinhibition: Impulsiveness.

b) Avoidant disorder

The patients suffering this disorder have a negative sense of themselves, associated with a profound sense of inadequacy and inhibition in the establishment of intimate interpersonal relationships. More specifically, they feel anxious, inferior, socially inept and unattractive, so that they easily feel ashamed. They are timid and reserved both in professional and social situations and avoid them, even when desiring them, due to fear of making a fool of themselves or humiliation, so that they seek contexts that do not include other persons.

They are preoccupied with and very sensitive to criticisms or rejection of others, being reluctant to reveal personal information due to fear of disapproval or rejection. They seem to lack interpersonal skills, resulting in their having few close friends. Intimate relationships are avoided due to a general fear of intimacy, including sexual intimacy.

The individuals who resemble this type tend to blame themselves. They feel responsible for the bad things that occur and do not find enjoyment in activity of daily life. They also tend to be emotionally inhibited and have problems to express their desires or emotions, both positive and negative.

The traits related with this type are the following: 1. Negative emotionality: Anxiousness; 2. Negative emotionality: Fear of abandonment; 3. Negative emotionality: Pessimism; 4. Negative emotionality: Low self-esteem; 5. Negative emotionality: Guilt/Shame; 6. Introversion: Intimacy Avoidance; 7. Introversion: Social withdrawal; 8. Introversion: Restricted affectivity; 9. Introversion: Anhedonia; 10. Introversion: Social detachment; 11. Compulsivity: Risk aversion

c) Borderline disorder

Patients with this disorder have a very fragile self-concept, which is easily altered and fragmented under stress situations. This results in a poor identity level and chronic feelings of emptiness. As a result, they have emotional instability and have problems to maintain long-lasting close relationships.

These patients undergo rapid mood changes, in an intense and unpredictable way, and can be extremely anxious or depressed. They also may get angry or be hostile if they feel misunderstood or maltreated. They may become involved in verbal or physical aggression when they are angry. They generally give emotional reactions in response to negative interpersonal events that involve loss or deception. Their relationships are based on fantasy, on the need of others for survival and on excessive dependence, and on a fear of rejection or abandonment.

Dependency implies both insecure attachment, expressed as difficulty tolerating aloneness and urgent need for contact with significant others when stressed, sometimes accompanied by submissive behavior. At the same time, the intense and intimate dependence on another person often leads to fear of loss of own identity as an individual. Therefore, the interpersonal relationships are very unstable and alternate between excessive dependency and flight.

The principal interpersonal behaviors and traits may be associated with an alteration of cognitive regulation. That is, the cognitive functions may be impaired at times of interpersonal stress, which leads to split or dichotomic information, in a black or white manner. Furthermore, they may experience quasi-psychotic reactions, including paranoia and dissociation, which may progress to transient psychosis pictures.

Individuals with this type are characterized by being impulsive, acting with the emotions of the moment, and by becoming involved in potentially negative activities. The deliberate acts of self harm (for example, cutting themselves or burning themselves), suicide ideation, and suicide attempts typically occur accompanied by intense anxiety and dysphoria, especially within the context of feelings of abandonment, when an important relationship is broken. Intense anxiety may also lead to other risk behaviors, including drug abuse, reckless driving, food binging or sexual promiscuity.

The associated domains and traits are the following: 1. Negative emotionality: Emotional lability; 2. Negative emotionality: Self-harm; 3. Negative emotionality: Separation insecurity; 4. Negative emotionality: Anxiousness; 5. Negative emotionality: Low self-esteem; 6. Negative emotionality: Depressivity; 7. Antagonism: Hostility; 8. Antagonism: Aggression; 9. Disinhibition: Impulsivity; 10. Schizotypy: *Dissociation proneness*.

d) Obsessive-compulsive personality disorder

Those who have this type of PD are governed by their need for order, precision and perfection. They carry out their activities in an excessively methodically way. Thus, they have intense concerns with the time used, punctuality, schedules and rules. In this sense, they are extremely rigid and lack spontaneity.

The affected persons have an excessive development of sense of duty, as well as the need to try to complete all the tasks meticulously. This tendency may give rise to paralyzes of the behavior due to indecision and the need to weigh the alternatives, the pros and cons, so that important tasks frequently cannot be completed.

Mostly, the strong emotions, both positive (for example, love) and negative (for example, anger), are not consciously experienced or expressed. The individual may sometimes show great insecurity, lack of self-confidence and emotional malaise in form of guilt or shame because of the real or perceived deficiencies or faults in their behavior. They have a very strict sense of what is good and what is bad.

The traits and domains associated to this type are the following: 1. Compulsiveness: Perfectionism; 2. Compulsiveness: Rigidity; 3. Compulsiveness: Orderliness; 4. Compulsiveness: *Perseveration*; 5. Negative emotionality: Anxiousness; 6. Negative emotionality: Pessimism; 7. Negative emotionality: Guilt/ Shame; 8. Introversion: Restricted affectivity; 9. Antagonism: Oppositionality.

e) Schizotypal disorder

Persons with this type of PD are characterized by having social deficits and by feeling uncomfortable and with reduced capacity for interpersonal relationships. At the same time, they are eccentric in their appearance (for example, in their way of dressing or hygiene) and in their behavior (for example, in their posture or eye-contact), with cognitive and perceptive distortions regarding odd beliefs (superstition, clairvoyance, telepathy, etc.) or to arbitrary interferences, such as hidden messages or granting special meaning to common events. Quasi-psychotics symptoms may sometimes appear, such as pseudo-hallucinations, sensory illusions, overvalued ideas, mild paranoid ideation or even transient psychotic episodes.

In social situations, they feel marginalized. It is hard for them to feel connected with others and they mistrust the motivations of others, including their spouse, colleagues and friends. Their speech may be vague, circumstantial, metaphorical, excessively overelaborate, poor or stereotyped. The emotions shown are very limited and frequently inhibited. All this makes them seem to be distant and indifferent to the reactions of others.

The domains and traits associated to this type are the following: 1. Schizotypy: Eccentricity; 2. Schizotypy: Cognitive dysregulation; 3. Schizotypy: Unusual perceptions; 4. Schizotypy: unusual beliefs; 5. Introversion: Social condemning ; 6. Introversion: *Restricted affectivity*; 7. Introversion: Intimacy avoidance; 8. Negative emotionality: Suspiciousness; 9. Negative emotionality: Anxiousness.

CONCLUSIONS

As we mentioned in the beginning, the PDs are currently at a crossroad that is incumbent to the theory, investigation and conceptualization.²³⁻²⁶ Since the Conference for the planning of the DSM-V held in 1999, there has been abundant debate on the subject. The Work Group of the *American Psychiatric Association* is made up of 11 experts, five of whom have the Phd in medicine (Andrew Skodol; Renato Alarcón; Carl Bell; John Oldham; and Larry J. Siever), five in psychology (Donna Bender; Anna Clark; Robert Krueger; Leslie Morey; and Roel Verheul) and one in both disciplines (John Livesley).

An attempt has been made to reach a consensus on the most important proposals regarding the number of personality dimensions and the general criteria on globality, integration, organization, consistency and distinctiveness of the principal theories on personality. Furthermore, an attempt has been made to integrate the neurobiological and genetic fundamentals of the personality traits. The clinical evaluation includes static, psychodynamic and interactive features and the dimensional evaluation of prototypicality. Finally, the relationships are established with the International Statistical Classification of Diseases and Health related Problems (ICD-10) and with the International Classification of Functioning, Disability and Health (ICF). ** *Idem pero quitando el 2 y poniendo.***

According to the draft published on 19 February 2010 in the APA web, a provisional consensus has been reached on different features that have been very controversial over recent years and that have been explained in the present article. This draft was subjected to a *feedback* by the scientific community up to April 2010.

In the first place, a redefinition of the PD concept has been proposed, stressing the adaptive failure (nonadaptive personality) on the dominant pattern of thinking, feeling and behaving, present in the DSM at present. The new concept gives much importance to the difficulty to develop adaptive interpersonal relationships, stressing problems such as lack of empathy, lies and *manipulativeness*, and to cooperative behavior deficits. It also significantly includes the deterioration of the own identity, in line with the contributions of Cloninger.

In the second place, it establishes an evaluation of six domains of personality and 37 traits or facets. This systematization greatly approaches that of the five superfactors of Costa and McCrae, the five dimensions of Gray, the five alternatives of Zuckerman or the four of Livesley. It

also includes the three dimensions of the Eysenck model and the cognitive factor proposed by Siever and Davis.

The diagnostic categories are reduced to five, those that correlate with the six domains proposed. This means eliminating five specific categories, some having deeply rooted custom, and the non-specific PD residual, as they lack empirical backing that support them and do not show the mentioned correlations. This reduction in categories aims to improve the reliability and validity of the diagnoses and especially to avoid the overlapping of items, that is causing overdiagnosis of several PDs in the same patients.

Including the psychopathic personality disorder as a variety of antisocial/psychopathic is very important. This novelty means recognition of the diagnostic entity that was proposed by Cleckley and that has been developed by, among others, Hare, with his two factors and four facets, and whose construct validity has wide empirical support. Within this antisocial/psychopathic disorder, the antisocial variant seems to refer more to factor 2 of psychopathy while the psychopathic subtype is related with factor 1.

A categorial model is combined with another dimensional one, which makes up a hybrid model that is able to achieve a consensus between the traditional medical model and psychosocial one. The categorial diagnoses should be accompanied by a prototypicality evaluation, similar to that proposed in 1992 by Costa and McCrae and in 2000 by Oldham and Skodol. Each one of the five categories are explained by a narrative description. In this way, the clinician, following the formula proposed by Shedle and Westen, should define how much the patient resembles this description on a scale of 1 to 5. This system will substitute the current polythetic evaluation.

Furthermore, the persons should be described by domains and facets that also include a dimensional evaluation on a scale of 0 to 3. The definition of the maladaptive traits of the patient and their severity will be very useful for the therapist, who will thus have a much clearer view of the problems to treat, and the susceptibility of the patients to treatments (types S and R of Tyrer). This configuration of the provisions will open the door to development of new psychodiagnostic instruments.

The novel formulation of traits and domains synchronizes with the model of 5 superfactors of personality (Costa and McCrae), with the psychobiological models of Dollard and Miller, Eysenck, Gray, Atkinson, Tellegen, Depue and Iacono, Siever and Davis, Zuckerman, Livesley and Cloninger, among others, and with the studies on the genetics of behavior, especially analyzed by Livesley²⁷ and Livesley and Jang.²⁸

Regarding the multi-axial evaluation, everything points to the disappearance of Axes II and III, as was proposed in

** La fifty-fourth World Health Assembly approved the new classification with the title of International Classification of Functioning, Disability and Health, in resolution WHW 54.21 of 22 May 2001.

Table 3		
EQUIVALENCES BETWEEN THE SUM-IV-TR AND THE DSM-V DRAFT		
PD IN DSM-IV	PD IN DSM-V	OUTSTANDING PERSONALITY TRAITS
Paranoid	None	Distrust and suspiciousness Intimacy avoidance Hostility Unusual beliefs
Schizoid	None	Social withdrawal Intimacy avoidance Restricted affectivity Anhedonia
Schizotypal	Schizotypal	Eccentricity Altered cognitive regulation Unusual perceptions Unusual beliefs Social withdrawal Restricted affectivity Intimacy avoidance Distrust and suspiciousness Anxiety
Antisocial	Psychopathic antisocial /	Lack of sensitivity Aggression Manipulativeness Hostility Deceitfulness Narcissism Irresponsibility Imprudence Impulsiveness
Borderline	Borderline	Emotional lability Self-harms Fear of loss Anxiety Low self-esteem Depressivity Hostility Aggression Impulsiveness Dissociation proneness
Histrionic	None	Emotional lability Histrionism
Narcissistic	None	Narcissism Manipulativeness Histrionism Callousness
Avoidant	Avoidant	Anxiety Fear of loss Pessimism Low self-esteem Guilt or shame Intimacy avoidance Social withdrawal Restricted affectivity Anhedonia Social detachment Risk aversion
dependent	None	Submissiveness Anxiety Fear of loss

Obsessive-compulsive	Obsessive-compulsive	Perfectionism Rigidity Orderliness Perseveration Anxiety Pessimism Guilt or shame Restricted affectivity Oppositionality
depressive	None	Pessimism Anxiety Depressivity Low self-esteem Guilt or shame Anhedonia
passive-aggressive	None	Oppositionality Hostility Guilt or shame

the 163 annual meeting of the American Psychiatric Association, held in May 2010 in New Orleans. Thus, seemingly, the PDs will be included together with the other mental disorders and medical diagnoses, as occurs in the WHO classifications. This attempts to unifying the new DSM with the *WHO International Family of Classifications* (ICD, ICF, etc.), that lack this type of compartments. In this way, it is foreseen that there will only be 3 diagnostic axes instead of 5 in the DSM-V.

However, the new definition, the evaluation system and systematization of the PDs in the DSM-V, in addition to the disappearance of the five PDs as specific diagnoses, may be complicated, confusing and unfamiliar for the clinicians, as indicates Allen Frances, chief of the DSM-V work group (in *Psychiatric Times*, February 2010).

However, it should be mentioned that all these novelties are only proposals at the time of writing this article and that they are undergoing a validation process as well as possible modifications before the final writing of the DSM-V, whose publication is foreseen for the month of May 2013.

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