Review Psikiyatride Güncel Yaklaşımlar-Current Approaches in Psychiatry 2025; 17(2):358-381
doi: 10.18863/pgy.1502717

Personality Disorders: A Theoretical and Psychometric Assessment

Kişilik Bozuklukları: Kuramsal ve Psikometrik Bir Değerlendirme

Aybala Albay[1], Hasan Atak[1]

[1]Kırıkkale University, Kırıkkale

ABSTRACT

The concepts of personality and personality disorder have been defined and classified in many different ways from different perspectives from past to present. Over time, international classification systems such as DSM and ICD have been developed and a common framework for the classification of personality disorders has been tried to be established. Personality disorders can significantly affect an individual's functionality, relationships and quality of life. Therefore, studies on better understanding of personality disorders and diagnostic processes are gaining importance. In this context, the main purpose of this article is to make a review on personality disorders. In this article, definitions of personality, personality theories, personality traits and personality disorders are examined and diagnostic changes in the current versions of classification systems are discussed through ICD-11, DSM-5 and alternative DSM-5 Model for Personality Disorders. The main features and diagnostic criteria of these personality disorders are examined in detail. In addition, existing theories and studies on personality disorders are also discussed. Finally, the characteristics of the measurement tools used in the assessment of personality disorders are emphasized. This article aims to contribute to the body of knowledge in the field of personality disorders by providing both a theoretical and practical perspective. As a result of the study, it was observed that the dimensional approach was emphasized in international diagnostic systems related to personality disorders instead of the commonly used categorical approach. In parallel with this, it is also among the results of the study that various measurement tools have been developed to be used in the diagnosis of personality disorders according to the dimensional approach.

Keywords: Personality, personality theories, personality traits, personality disorder, psychometrics

ÖZ

Kişilik ve kişilik bozukluğu kavramları, geçmişten günümüze değişik açılardan ele alınarak pek çok farklı şekilde tanımlanmış ve sınıflandırılmıştır. Zaman içinde DSM ve ICD gibi uluslararası sınıflama sistemleri geliştirilmiş ve kişilik bozukluklarının sınıflandırılmasına yönelik ortak bir çerçeve oluşturulmaya çalışılmıştır. Kişilik bozuklukları, bireyin işlevselliğini, ilişkilerini ve yaşam kalitesini önemli ölçüde etkileyebilmektedir. Bu nedenle kişilik bozukluklarının daha iyi anlaşılması ve tanı koyma süreçleri ile ilgili yapılacak çalışmalar da önem kazanmaktadır. Bu bağlamda, bu makalenin temel amacı kişilik bozukluklarıyla ilgili bir derleme yapmaktır. Makalede kişilik, kişilik kuramları, kişilik özellikleri ve kişilik bozukluğu tanımları incelenerek sınıflandırma sistemlerinin güncel versiyonlarında yer alan tanısal değişiklikler ICD-11, DSM-5 ve DSM-5 Kişilik Bozuklukları alternatif model üzerinden tartışılmıştır. Bu kişilik bozukluklarının temel özellikleri ve tanı kriterleri detaylı bir şekilde incelenmiştir. Ayrıca, kişilik bozukluklarıyla ilgili mevcut kuramlar ve yapılan çalışmalar da ele alınmıştır. Son olarak, kişilik bozukluklarının değerlendirilmesinde kullanılan ölçme araçlarının özellikleri üzerinde durulmuştur. Bu makale, kişilik bozuklukları alanında hem teorik hem de pratik bir bakış açısı sunarak alandaki bilgi birikimine katkıda bulunmayı amaçlamaktadır. Çalışma sonucunda, kişilik bozuklukları ile ilgili uluslararası tanı sistemlerinde, yaygın olarak kullanılan kategorik yaklaşımın yerine boyutsal yaklaşımın öne çıkarıldığı görülmüştür. Buna paralel olarak boyutsal yaklaşıma göre kişilik bozukluklarının tanısında kullanılmak üzere çeşitli ölçme araçlarının geliştirildiği de çalışmanın sonuçları arasında yer almaktadır.

Anahtar sözcükler: Kişilik, kişilik kuramları, kişilik özellikleri, kişilik bozukluğu, psikometri

Introduction

Many definitions have been made about the concept of personality from the past to the present. Personality is derived from the Latin word "Persona", which can be defined as a mask used in ancient theater performances. The mask worn by an actor exhibited the characteristics of the character portrayed, different from the actor's own identity. Over time, the term persona has shifted from this usage to refer to the real and distinct characteristics of a person that can be observed by others in daily life (Konduz 2015). While people respond similarly to basic events at a fundamental level, a more detailed examination reveals many differences.

Address for Correspondence: Aybala Albay, Kırıkkale University Institute of Social Sciences, Kırıkkale, Türkiye **E-mail:** aybala.albay@gmail.com
Received: 20.06.2024 | **Accepted:** 25.09.2024

Therefore, Atak (2022) defines personality as "an organized whole of various characteristics such as feelings, thoughts, and behaviors that distinguish a person from others. Similarly, Burger (2006) defines personality as consistent behavior patterns rooted in the individual and internal processes that shape a person's behaviors and emotions.

While defining personality, efforts have been made to be as objective as possible and to create functional definitions. However, when examining the literature on personality, it is evident that theorists' own philosophical approaches, cultural structures, and personality structures have influenced the theories they have developed. Therefore, each theorist emphasizes different elements in the formation of personality (Bilge 2014). For example, traces of Sullivan's relationship with his mother can be seen in his theory (Burger 2006). According to Sullivan, personality is the long-term form of social relationships, which varies from person to person and constitutes the distinguishing feature of a person's life. This is because social interactions are objectively observable. Sullivan states that the self-system is formed as a result of constantly differentiating social experiences, especially the emotional needs met through the bond established with the mother (Mohl 2007). The aim of this article is to provide an overview of the theories, diagnostic criteria, classification systems, measurement tools, and prevalence of personality disorders, while offering both a theoretical and practical perspective in light of recent developments. By comparatively examining past and present approaches to personality disorders, this study will contribute to the literature by identifying gaps and presenting the current state of the field.

Personality Theories and Personality Traits

Personality has been addressed and elaborated upon by different theorists from various perspectives, and regardless of how objective these studies are, each theory carries traces of the theorist's viewpoint due to the subjective evaluations in the process of interpreting and making sense of the collected data. Below is information about these theories.

Freud first explained personality using the topographical model and later the structural model. The topographical model explains personality through the concepts of the unconscious, the conscious, and the preconscious, while the structural model does so with the id, ego, and superego. Despite receiving much criticism for its scientific shortcomings, Freud's personality theory remains the most comprehensive theory proposed to date (Millon et al. 2004, Magnavita 2016). In Freud's classical psychoanalysis, which initially addressed personality through hysteria, early life experiences and psychosexual development stages emerge as determinants and dynamics of personality development (Geçtan 1997, Millon and Lerner 2003, Gençtanırım Kurt and Çetinkaya Yıldız 2017). According to psychoanalysis, the ego utilizes defense mechanisms to cope with threats from the id, the superego, and external sources, minimizing the anxiety accompanying these threats (Burger 2006).

The literature shows various theorists who followed Freud with modifications and are known as "Neo-Freudians." Names such as Alfred Adler, Carl Gustav Jung, and Karen Horney are included in this group (Karabaş 2021). Adler, a prominent figure in the Individual Psychology approach, also emphasized that the foundations of personality are laid in the first five years of life, similar to Freud. According to Adler, the beginning of every person's life is characterized by strong feelings of inadequacy (Magnavita 2016). Jung, another director of analytical theory, stated that personality consists of systems functioning in three different levels of consciousness: the conscious, the personal unconscious, and the collective unconscious, which constantly interact with each other. The psychic structure (psyche) is formed by the complementarity of the structures called the conscious and the unconscious. Additionally, the structure Jung called "persona" is the fundamental system that allows an individual to adapt in their relationships with their environment or cope with life events (Millon et al. 2004). Although Anna Freud and Erik Erikson are considered pioneers of ego psychology, names like Heinz Hartmann, Edith Jacobson, Rene Spitz, and David Rapaport are also included. Ego psychology extended the interest of psychoanalytic theory from psychopathology to include normal development processes, emphasizing the importance of the environment and interpersonal relationships in personality development and focusing more on social and psychological factors than biological ones (Schultz and Schultz 2007, Sharf 2017, McWilliams 2017).

According to Melanie Klein, recognized as the founder of object relations theory, the relationships a person forms with other objects in early life are crucial for personality development, and these relationships manifest in the individual's later life relationships and personality (Geçtan 1997). The contemporary representative of object relations and the founder of transference-oriented psychotherapy Otto Kernberg (2019), explains personality through the internalized representations formed by the attachment relationship with the caregiving

object. Kohut, who used the terms self-representation and self-object to explain personality development, defines self-representation as the way a person perceives themselves and the whole of their images of themselves, and self-object as the parents and other significant people with whom the child interacts (Kohut 2017, Kohut 2022).

When the literature on behavioral and cognitive approaches is examined, it is seen that they explain personality in relation to learning. Behaviorists have argued that psychopathological conditions can be corrected using principles of learning. The cognitive approach states that each individual's way of making sense of external world events is related to the schemas in their mind, and these schemas have a significant impact on the development of personality and psychopathology (Bilge 2014). Bandura differs from the classic behavioral approach by also addressing the cognitive dimension of human personality. According to him, external stimuli such as rewards and punishments, internal stimuli such as thoughts and expectations, and relationships with people in the environment all influence personality (Burger 2006).

The humanistic approach, which considers personality as an active concept, is represented by Carl Rogers, Abraham Maslow, and Erich Fromm (Yıldırım 2020). In this approach, for personality to develop healthily, the individual must be raised with unconditional love, and personality develops through the individual's relationships with others and their appropriation of what they gain from the external world (Fromm 1982). Abraham Maslow prepared the hierarchy of basic needs, with physiological needs at the bottom, followed by the need for safety, love and belonging, esteem needs, and self-actualization at the top. He stated that moving to the higher levels can only happen after satisfying the needs at the lower levels and that personality development is related to the manner of transition between levels (Maslow 1970). According to Carl Rogers, the fundamental concept of personality is the self. The ideal self represents the qualities an individual wishes to achieve, while the real self represents the realistic perceptions an individual has of themselves, and the congruence between the ideal self and the real self significantly shapes personality development and personality psychopathology (Rogers 2018). Sullivan defines personality as "relatively enduring patterns of recurrent interpersonal situations that characterize a human life." According to him, personality development occurs through relationships with others in a social environment. These relationships can be real or imagined (Yazgan İnanç and Yerlikaya 2012).

A personality trait can be defined as an individual's unique, consistent, and enduring patterns of behavior that develop over time (Çiçek and Aslan 2020). In the trait approach, which attempts to describe personality development, Allport emphasizes the "individual distinguishing traits" that make a person unique and set them apart from others. Cattell, using factor analysis on identified personality traits, defines 16 distinctive characteristics as the universal dimensions of personality: "perfectionism, tension, openness to change, anxiety, self-sufficiency, sincerity, absent-mindedness, rule-consciousness, warmth, liveliness, social boldness, problem-solving, sensitivity, caution, emotional stability, dominance" (Yazgan İnanç and Yerlikaya 2012, Dal and Eroğlu 2009). Hans Eysenck, who developed the three-factor theory, Initially, Eysenck divided personality into two major dimensions: introversion-extraversion and neuroticism, later adding psychoticism as a third dimension (Lewis et al. 2002). Eysenck preferred the dimensional approach over the classification-based approach in personality theory, arguing that individual differences in brain functions cause distinguishing traits (Eysenck 2006).

McCrae and Costa, leading figures in the five-factor theory, identified five basic personality traits through factor analysis: extraversion, neuroticism, openness to experience, agreeableness, and conscientiousness. According to them, the three core components of personality are basic tendencies, characteristic adaptations, and self-concept, and the environmental components of personality are heredity, objective biography, and external influences (Yazgan İnanç and Yerlikaya 2012, McCrae and Costa 2003).

Personality Disorder

Personality is a pattern formed by an individual's unique behavioral responses and attitudes in daily life (Köroğlu and Bayraktar 2010). The APA describes personality disorder as "a persistent pattern of emotion, thinking, and behavior that significantly deviates from the expectations of the culture in which the individual lives, is pervasive and inflexible, has an onset in adolescence or early adulthood, becomes stable over time without intervention, and causes stress or impairments in functionality" (Sezer Katar et al. 2022). In the diagnosis of personality disorder, the main criteria include deviations from the frequently encountered range of variability in the pattern forming the personality, excessive rigidity in personality traits, deterioration in the individual's social harmony and functionality, and causing distress in the individual's inner world (Köroğlu and Bayraktar 2010). Personality

disorders can also be described as the exaggerated expression of normal personality traits in a way that causes discomfort to the individual and those around them (Öztunç et al. 2015).

Diagnosing personality disorders is quite challenging, and one of the main reasons for this difficulty is the uncertainties in the methods used for the classification and diagnosis of personality disorders (Öztürk and Uluşahin 2011).

When the related literature is examined, two main sources are seen to have been influential in conceptualizing personality disorders in modern times. One of these sources is Freud and other psychoanalysts, and the other is Ribot and Kraepelin. DSM-5 (Diagnostic and Statistical Manual of Mental Disorders 5. Edition) is a product of this approach. Ribot and Kraepelin emphasized detailing and especially diagnosing the superficial behavioral characteristics of various dysfunctional personality types and the interrelationships of different personality-based disorders (Bingöl 2022).

In a study conducted by the World Health Organization (WHO), the prevalence rate for any personality disorder was determined to be 6.1%, with Cluster A personality disorders at 3.6%, Cluster B personality disorders at 1.5%, and Cluster C personality disorders at 2.7% (APA 2013).

A meta-analysis study conducted in the United States concluded that the prevalence of personality disorders among patients receiving outpatient psychiatric services was between 45% and 51% (Beckwith et al. 2014). The high prevalence of personality disorders and their co-occurrence with other mental disorders highlight the importance of studies related to mental health.

A study conducted in 2016, which covered countries such as England, Wales, Scotland, Western Europe, Norway, Australia, and the United States, found that the prevalence of any personality disorder ranged from 4.4% to 21.5%. Preliminary evidence from this study also supports the relationship between Cluster A and B personality disorders with cardiovascular diseases and arthritis (Quirk et al. 2016). The association of personality disorders with other diseases underscores the need for multidisciplinary research.

In a meta-analysis of studies including 113,998 individuals from Western countries, the prevalence of any personality disorder was found to be 12.16%, while the prevalence for Cluster A, B, and C personality disorders ranged from 5.53% to 7.23%. The study also found that obsessive-compulsive personality disorder had the highest prevalence (4.32%) and dependent personality disorder had the lowest prevalence (0.78%) (Volkert et al. 2018). In a meta-analysis study conducted in 2019, which involved 21 countries from six continents, the global prevalence of any personality disorder was determined to be 7.8%. The prevalence was higher in high-income countries (9.6%) compared to low-income countries (4.3%), with global rates for Cluster A, B, and C personality disorders found to be 3.8%, 2.8%, and 5.0%, respectively (Winsper et al. 2019). The higher prevalence of personality disorders in high-income countries is notable. The high global prevalence of Cluster C disorders aligns with Volkert et al.'s (2018) findings that obsessive-compulsive personality disorder, a Cluster C disorder, had the highest prevalence.

In a study conducted in the province of Aydın using the DIP-Q (DSM-IV and ICD-10 Personality Questionnaire) self-report survey, the prevalence of any personality disorder was found to be 4.8% (Şenyuva 2007). In a meta-analysis study conducted in Turkey, the prevalence of personality disorders was reported to be 52% in samples consisting of individuals diagnosed with various psychiatric disorders over the last 30 years using SCID-II (Dereboy et al. 2022). The limited number of studies on the prevalence of personality disorders in the national literature is particularly striking.

Factors causing the occurrence of personality disorders can be listed as genetic susceptibility, attachment experiences in childhood, traumatic events, family environment, societal, cultural, and political elements (Magnavita 2016). These factors are shaped by the interaction of chemical and neurological processes in physiological structure with psychological, societal, and cultural factors (Konduz 2015).

Theoretical Perspective on Personality Disorders

When the relevant literature is examined, it is seen that the first approaches to address personality disorders were biological and psychodynamic theories, and the prominent models in explaining personality are psychodynamic, biological, interpersonal, and cognitive approaches. The biological effects on personality can be examined under two headings: proximal and distal effects. Distant effects occur through the transmission of species-specific hereditary traits, while proximate effects emerge due to the influence of individuals' complex biological systems. It is suggested that biologically driven behavioral tendencies arise before the formation of personality (Millon et al. 2004).

In his early works, Freud claimed that neurotic conflicts were caused by forgotten childhood traumas. Later, he developed the structural model by stating that the mind consists of three structures: the "id," "ego," and "superego," and suggested that the conflicts among these three structures underlie personality disorders (Burger 2006, Freud 2019). Carl Rogers stated that personality disorders arise from the significant difference between the ideal self and the real self (Rogers 2018). Sullivan noted that mental disorders occur as a result of incompatibilities in the nature of a person's relationships and communication with others (Millon et al. 2004). The traditional behavioral approach suggests that learning behaviors not accepted by society or maladaptive behaviors leads to personality disorders (Şenyuva 2007). In Beck's cognitive approach, the primary assumptions regarding the emergence of personality disorders are that the individual forms maladaptive cognitive schemas about themselves and the world, and these schemas activate selective information processing that leads to biases (Beck 2008). In the Five-Factor Model, Widiger and Costa (1994) describe personality disorders as maladaptive and/or extreme versions of personality domains and traits. According to the evolutionary-neurodevelopmental approach, mental disorders emerge when there is a disruption in the harmony between an individual's unique characteristics and potential and their social environment (Konduz 2015).

Classification of Personality Disorders in ICD-10 and ICD-11

In ICD-10 (International Classification of Diseases 10. Edition), personality disorder is defined as an extreme disturbance in an individual's personality development and behavior patterns, encompassing various dimensions of personality and leading to personal and social impairment. Personality disorder consistently manifests itself through clearly maladaptive attitudes and behaviors in emotional, mental, and reactive processes and human relationships (Türkçapar et al. 2008). In ICD-10, personality disorders are listed under the main heading "Personality and Behavioral Disorders in Adults" and consist of the following specific titles (World Health Organization 2010):

F60 Specific Personality Disorders

F60.0 Paranoid Personality Disorder

F60.1 Schizoid Personality Disorder

F60.2 Dissocial (Antisocial) Personality Disorder

F60.3 Emotionally Unstable Personality Disorder

.30 Impulsive type

.31 Borderline type

F60.4 Histrionic Personality Disorder

F60.5 Anankastic Personality Disorder

F60.6 Anxious (Avoidant) Personality Disorder

F60.7 Dependent Personality Disorder

F60.8 Other Specific Personality Disorders

F60.9 Personality Disorder, Unspecified

F61 Mixed and Other Personality Disorders

F61.0 Mixed Personality Disorders

F61.1 Troublesome Personality Change

F62 Enduring Personality Changes, Not Attributable to Brain Damage or Disease

F62.0 Enduring Personality Change after Catastrophic Experience

F62.1 Enduring Personality Change after Psychiatric Illness

F62.8 Other Enduring Personality Changes

F62.9 Enduring Personality Change, Unspecified

Most research on the scope, causes, and consequences of diseases worldwide is based on the data usage of the ICD classification system. The ICD classification serves as the foundation for the planning and implementation processes of healthcare services (Harrison et al. 2021). However, similar to the DSM-5 classification for personality disorders, the ICD-10 classification has been criticized for its categorical approach. Studies have shown significant issues with the ICD-10 and DSM-5 categorical approaches to diagnosing personality disorders, including arbitrary diagnostic thresholds, substantial overlap between diagnostic categories, lack of evidence for diagnostic categories, and limited clinical utility. With scientific advancements and the process of digitalization, the need to revise classification systems has become increasingly apparent (Bach and First 2018). The current version of the ICD classification, ICD-11, came into effect in 2022 and introduced notable changes to the section on personality disorders (WHO 2024). Instead of the frequently criticized categorical classification of personality disorders, ICD-11 has adopted an evaluation method based on the severity of personality disorders, with a five-level scale established for this purpose (Aydın Seyrek 2022). The levels of this scale in ICD-11 are expressed as follows:

1. Personality Difficulty (not classified as a mental disorders)
2. Mild personality disorder
3. Moderate personality disorder
4. Severe personality disorder
5. -Personality disorder, severity unspecified (WHO 2021).

The severity of personality disorder in ICD-11 is based on the following factors:

a. The degree and extent of distress in interpersonal relationships and self-perception,
b. The intensity and breadth of emotional, cognitive, and behavioral processes,
c. The extent to which these patterns and problems cause distress or psychosocial impairment,
d. The level of risk of harm to oneself or others.

As the severity of personality disorder increases, the difficulties affect more areas, and evidence of harm to oneself and/or others becomes more widespread (Swales 2022).

According to ICD-11, personality disorder is characterized by long-term (2 years or more) impairments in self-functioning and/or interpersonal functioning, such as the ability to develop and maintain mutually close relationships, which cannot be explained by social or cultural factors, and manifest as significant distress or impairment in personal, family, social, educational, occupational, or other important areas of functioning (WHO 2021). This definition largely resembles the previous one. Instead of the classical classification of personality disorders, ICD-11 focuses on the general definition of personality disorder, along with the definitions of five trait domains, including "Negative Affectivity, Detachment, Disinhibition, Dissociality, and Anankastia." Additionally, under these trait domains, it includes another personality condition called the "Borderline Pattern" (Töre 2023).

“Negative Affectivity refers to a tendency to experience various negative emotions (such as anxiety, anger); Detachment refers to significant avoidance of social interaction; Disinhibition involves impulsive actions in response to immediate internal or environmental stimuli without considering long-term consequences; Dissociality refers to disregard for the feelings and rights of others; Anankastia is expressed as a rigid desire for perfectionism and control beyond social norms.” Additionally, for individuals with unstable/inconsistent affect and self-perception, the personality condition called “Borderline Pattern” has been defined (Swales 2022).

In the new system, when diagnosing personality disorders, it is first checked whether the general diagnostic criteria for personality disorder are met, which largely resembles the previous criteria. The next step is to determine the severity of the personality disorder. Since there are no separate definitions of personality disorders in the new system, the problem of comorbid diagnoses is eliminated. In the final step, personality disorder is characterized by personality traits and dimensions (Aydın Seyrek 2022). The general diagnosis and severity assessment of personality disorders facilitate effective intervention by mental health services and allow for tracking changes in the disorder, thus serving as a determinant of the recovery process (Bach et al. 2021). A study by Brown and Sellbom (2023) examined the validity and reliability of ICD-11’s classification system and reported promising results in addressing issues arising from categorical classification in the new system.

Alternative DSM-5 Model for Personality Disorders

The Alternative DSM-5 Model for Personality Disorders (DSM-5 AMPD), included in Section III of DSM-5, is described as a hybrid model for the assessment and diagnosis of personality disorders. This model reflects the decision to continue using current clinical practice while also addressing the limitations of the categorical approach to diagnosing personality disorders. For example, while diagnoses in the categorical classification system are generally accurate, they often lack informative value (APA 2013). Another criticism of the categorical system is the issue of comorbidity. Often, individuals meet the diagnostic criteria for more than one personality disorder, leading to multiple diagnoses. This comorbidity issue negatively affects the intervention process. Additionally, the lack of empirical basis is another critique of the categorical system (Swales 2022).

The alternative model was developed through various research studies and is based on: 1) The degree of impairment in personality (self and interpersonal) functioning, and 2) The dimensional ratings of 25 pathological personality traits organized into five broad trait domains. When combined with other inclusion and exclusion criteria, these assessments redefine the structure of personality disorders in terms of personality functioning and traits and allow for the diagnosis of six specific personality disorder categories through a more graded approach (APA 2013, Skodol et al. 2015). Self-functioning encompasses "identity and self-direction," while interpersonal functioning includes "empathy and intimacy" (Konduz 2015).

The general diagnostic criteria for personality disorders in the DSM-5 alternative model are expressed as: "Onset at least by adolescence or early adulthood, not better explained by another mental disorder, not attributable to the physiological effects of a substance or another medical condition, manifested in a broad range of personal and social situations, impairment in personality (self/interpersonal) functioning at a moderate or greater level, the presence of one or more pathological personality traits, impairments in personality functioning, and relatively rigid presentation of the individual's personality traits" (APA 2013).

The degree of impairment in personality functioning (Criterion A) is measured using the "Level of Personality Functioning Scale (LPFS)," which includes five levels of impairment (Hummelen et al. 2021). The five personality domains and 25 facet traits (Criterion B) in DSM-5 AMPD can be expressed as follows: "Negative Affectivity: emotional lability, seperation insecurity, anxiousness, perseveration, submissiveness, hostility; Detachment: intimacy avoidance, withdrawal, anhedonia, depressivity, restricted affectivity, suspiciousness; Antagonism: manipulativeness, deceitfulness, grandiosity, attention seeking, callousness, hostility; Disinhibition: irresponsibility, impulsivity, rigid perfectionism, risk taking, distractibility; Psychoticism: unusual beliefs and experiences, eccentricity, cognitive and perceptual dysregulation." (Töre 2023). In the DSM-5 Alternative Model for Personality Disorders (DSM-5 AMPD), diagnoses include "antisocial, avoidant, borderline, narcissistic, obsessive-compulsive, and schizotypal personality disorders." This approach features a diagnostic category called "personality disorder with specified traits" for individuals who meet the general criteria for personality disorder but do not fully meet the criteria for a specific personality disorder. However, in the alternative model, diagnostic criteria are expressed in terms of identity, interpersonal functioning, and facet traits, rather than traditional criteria (Konduz 2015).

To diagnose a personality disorder in the DSM-5 AMPD, an individual must exhibit moderate or greater impairment in personality functioning and possess at least one pathological personality trait (Hummelen et al. 2021). The hybrid nature of DSM-5 AMPD creates an original, flexible, and practical framework by combining fundamental paradigms of personality assessment, enriching theory and practice. It also integrates assessment and research traditions, making it easier to elucidate the case-specific situation (Waugh et al. 2017). Additionally, traditional classification details are discussed below.

DSM-5 Personality Disorders Classification

In the DSM-5 classification, personality disorders are categorized into three clusters named "A, B, and C." Cluster A (Odd and Eccentric Cluster) includes paranoid, schizoid, and schizotypal personality disorders. Cluster B (Dramatic, Emotional, and Erratic Cluster) includes antisocial, borderline, histrionic, and narcissistic personality disorders. Cluster C (Anxious and Fearful Cluster) includes avoidant, dependent, and obsessive-compulsive personality disorders (APA 2013).

The DSM-IV was criticized for using a categorical approach in diagnosing personality disorders. In response, DSM-5 introduced a dimensional approach in addition to the categorical approach, which is said to be more useful for diagnostic processes (Bilge 2014). The general diagnostic criteria for personality disorders in DSM-5's categorical evaluation are expressed as follows: "The person must exhibit a persistent pattern of inner experience

and behavior that deviates markedly from the expectations of their culture, affecting at least two of the following areas: cognition, affectivity, interpersonal functioning, or impulse control. This pattern must lead to clinically significant distress or impairment in social, occupational, or other important areas of functioning. The onset of the pattern must be in adolescence or early adulthood, it must not be better explained by another mental disorder, and it must not be attributable to the physiological effects of a substance or another medical condition" (APA 2013). The following sections will discuss personality disorder clusters and specific personality disorders.

Cluster A Personality Disorders (Odd and Eccentric Personality Disorders)

Personality disorders within Cluster A are typically described as odd or eccentric. Paranoid, schizoid, and schizotypal personality disorders fall within this cluster. Individuals with these disorders often exhibit characteristics such as social isolation, odd beliefs, and paranoid thoughts. Below is a detailed examination of Cluster A personality disorders.

1. Paranoid Personality Disorder

Individuals with paranoid personality disorder exhibit a reference idea, a belief that events around them are related to them even when they are not. These individuals look for hidden meanings in the treatment they receive. Consequently, they are often tense and distant. Paranoids avoid revealing secrets, fearing they might be used against them (Köroğlu and Bayraktar 2010).

People with paranoid personality disorder place great importance on power and disdain weak or inadequate individuals. They constantly test others. They focus so much on what they imagine that the line between reality and fiction begins to blur. They do not blame themselves; the real culprit is always others. Unable to cope with feelings of inadequacy and worthlessness, they create a fantasy of superior self-worth (Geçtan 1997). Situations or events such as close social relationships and personal inquiries often trigger maladaptive responses specific to paranoid personality disorder. Their predominant emotions are anger and jealousy. Their primary defense mechanisms are projection, denial, and rationalization (Köroğlu and Bayraktar 2010).

In DSM-5, the diagnostic criteria for Paranoid Personality Disorder are expressed as: 'Suspicion, without sufficient basis, that others are exploiting, harming, or deceiving them; unjustified doubts about the loyalty or trustworthiness of friends or associates; reluctance to confide in others due to a fear that what they say will be used maliciously against them; reading demeaning or threatening meanings into ordinary remarks or events; persistently bearing grudges; perceiving, without sufficient reason, that others' actions are a threat to their character or reputation, and responding with anger or counterattack; and recurrent, unjustified suspicions regarding the fidelity of their spouse or sexual partner.' These attitudes and behaviors must be present in four (or more) of these areas, resulting in a general mistrust and suspicion towards others" (APA 2013).

The prevalence of paranoid personality disorder is approximately 0.5-2% of the population, with a higher incidence in males. It is more common in families with a history of schizophrenia. Although it is thought to have a genetic component, there may be a history of childhood exploitation (Köroğlu and Bayraktar 2010). According to Benjamin (1996), paranoids may have been subject to harsh punishments in childhood and might have been scapegoated by their parents (Konduz 2015).

In the paranoid personality type, the individual trusts their decision-making process. They are good listeners and observers and can discern the underlying meaning of others' words. They value criticism and are committed to strong and sincere relationships, knowing that achieving such relationships is challenging. They can protect themselves by behaving rationally in their relationships. They express themselves without losing control or displaying aggressive behavior (Köroğlu and Bayraktar 2010). The diagnosis of paranoid personality disorder highlights traits such as distrust in interpersonal relationships, suspicion, and hypersensitivity to criticism, hyper vigilance, aggression, and anger (Öztürk and Uluşahin 2011). Paranoids often feel that others have malevolent intentions or have hurt them, even without objective evidence. They do not want to get close to other people, harbor feelings of hostility, and are vindictive. They doubt the loyalty of those close to them. Due to their distrust, they place high importance on independence (Köroğlu and Bayraktar 2010).

2. Schizoid Personality Disorder

Kretschmer defined schizoid personality disorder as a mild form of schizophrenia and described its main features within the schizophrenia spectrum as peculiar behavior and emotional restriction (Karamustafalıoğlu and Kahraman 2012). Individuals with schizoid personality disorder feel uncomfortable with others and avoid eye contact. Their reactions, whether positive or negative, are superficial and limited, resulting in poor social

relationships. Schizoids do not feel a need for others but may exhibit dependency on animals (Köroğlu and Bayraktar 2010).

People with schizoid personality disorder appear indifferent to romantic relationships and sexual matters, yet often display voyeuristic and pornographic interests (Akhtar 2009). Their sexuality is confined to their imagination. Men with this disorder typically remain unmarried, while women may reluctantly tolerate marriage in a passive manner. They struggle to express anger or joy, and apathy with emotional unresponsiveness are key symptoms (Köroğlu and Bayraktar 2010). They never experience being part of a family or enjoying romantic relationships (Konduz 2015).

Schizoid individuals describe themselves as thoughtful, introspective, and gentle, showing little interest in others and aware that others are similarly disinterested in them. Due to their insensitivity in social relationships and high thresholds for reaction and action, they do not need to employ defense mechanisms (Köroğlu and Bayraktar 2010). However, according to Masterson's approach, individuals with schizoid personality disorder use primitive defense mechanisms such as splitting, acting out, clinging, avoidance, denial, projection, projective identification, and fantasy rather than engaging in genuine relationships. In this approach, those with schizoid disorder strongly exhibit avoidance behavior (Tuncer et al. 2018). Due to their underdeveloped coping strategies, individuals with schizoid personality disorder live avoiding social relationships and may develop pathology if pressured in this direction (Geçtan 1997).

While it is more commonly found among individuals with relatives diagnosed with schizophrenia, the prevalence of schizoid personality disorder in the general population is claimed to be 7.5%, with a higher incidence in males than females. Genetic predisposition and negative childhood family relationships are among the contributing factors (Köroğlu and Bayraktar 2010). Avoidance of human relationships and lack of need for them, indifferent behaviors, internal sensitivity, absent-mindedness, and attentiveness are opposite poles of similar conditions. The tension between these poles forms the basis of schizoid disorder (Akhtar 2009).

In the schizoid personality style, they have very little need for friendship and are content with being alone. They appear calm, composed, and rarely show emotions. Their behavior is unaffected by sexual needs, and they are indifferent when deprived of them. Compliments or criticisms have little effect on them (Köroğlu and Bayraktar 2010).

In DSM-5, the diagnostic criteria for Schizoid Personality Disorder are expressed as: "A lack of desire for close relationships, including being a part of a family; disinterest in close relationships; a preference for solitary activities; very limited interest in sexual experiences; very little pleasure in most activities; having no close friends or confidants other than first-degree relatives; indifference to praise or criticism from others; emotional coldness, detachment, or flat affect. Four (or more) of these criteria must be present, resulting in social withdrawal and limited emotional expression in interpersonal settings" (APA 2013).

The key characteristic in diagnosing schizoid personality disorder is a pattern of detachment from social relationships and limited expression of emotions in interpersonal settings. Schizoids prefer activities that do not require social interaction (e.g., computer games, mathematics). Apart from immediate family members, they have no confidants or close friends. They present with a cold, aloof exterior and may experience brief psychotic episodes in response to intense stress (Köroğlu and Bayraktar 2010).

3. Schizotypal Personality Disorder

Schizotypal personality disorder was first described by Sandor Rado as a "schizophrenia-like phenotype" encompassing characteristics such as bizarre behaviors and thoughts, quick anger, social isolation, suspiciousness, and magical thinking (Mısır Alptekin 2020). It was included in the psychiatric diagnostic system with DSM-III (Akhtar 2009). Individuals with schizotypal personality disorder, found within the schizophrenia spectrum, exhibit many peculiarities and abnormalities in their mental, emotional, behavioral, and reactive processes, speech, and appearance. They often have idiosyncratic, unusual, strange ideas, feelings of persecution, delusions, and feelings of unreality (Köroğlu and Bayraktar 2010). They tend to have an inclination towards supernatural events, magical explanations, and may display skeptical and sensitive attitudes (Şener et al. 2006). They may join spiritual-oriented groups (sects, etc.).

Although schizotypal personality disorder is more prevalent among individuals with relatives diagnosed with schizophrenia, its prevalence in the community is claimed to be 3%. It is more prevalent in males, and it can emerge due to reasons similar to schizophrenia (Köroğlu and Bayraktar 2010).

In DSM-5, the diagnostic criteria for Schizotypal Personality Disorder are expressed as: 'Ideas of reference, odd beliefs or magical thinking that are inconsistent with subcultural norms and influence behavior, unusual perceptual experiences, odd or eccentric thinking and speech, suspiciousness or paranoid ideation, inappropriate or restricted affect, odd, eccentric, or peculiar behavior or appearance, lack of close friends or confidants other than first-degree relatives, excessive social anxiety that does not diminish with familiarity, accompanied by suspicious fears rather than negative self-assessment.' These attitudes and behaviors must be present in five (or more) of these criteria, resulting in a significant discomfort in close relationships and a reduced capacity for close relationships, alongside cognitive and perceptual distortions and eccentric behavior" (APA 2013).

Some schizotypal are cold, distant, socially isolated, numb, and apathetic, while others suppress their emotions and thoughts due to fear of exclusion. They feel alienated and may feel as if they are an imaginary entity. Schizotypal experience feelings of alienation and depersonalization on a daily basis. When societal expectations increase, they may cope by transitioning to a different realm or may experience paranoid or aggressive outbursts. Schizotypal, individuals filled with suppressed anxiety and hostility, exhibit frantic discharge after such outbursts. They cannot organize their thoughts logically or express their thoughts in a coherent manner when communicating (Köroğlu and Bayraktar 2010).

Individuals with schizotypal personality disorder fail to achieve consistent progress in areas such as marriage, school, and work. Intense interpersonal relationships often trigger this disorder. They cannot organize their thoughts and may repeatedly think about a single topic. They believe they have telepathic abilities. Their prominent basic thoughts include skepticism, others-focused thoughts, magical thinking, and delusions (Köroğlu and Bayraktar 2010). Individuals with schizotypal personality disorder believe they have a healing effect due to their distorted superstitions and religious beliefs. Their attire may be considered "eccentric" by society (Öztürk and Uluşahin 2011).

In their schizotypal personality form, individuals focus on their own emotions and beliefs. They show sensitivity to how they should behave towards others by observing them. They have a tendency for abstract and fictional thinking and are interested in supernatural subjects. They lead a highly unusual life, disregarding social values, and often live alone without needing other people (Köroğlu and Bayraktar 2010).

Individuals with schizotypal personality disorder lead an isolated life, which prevents them from receiving corrective feedback and catching clues (Konduz 2015). Schizotypals believe they can read others' thoughts and know events before they happen without their special powers. Their speech is scattered, and they use different, off-topic expressions. Due to their skeptical nature, their anxieties in a social environment tend to increase rather than decrease over time (Köroğlu and Bayraktar 2010).

Cluster B Personality Disorders (Dramatic/Emotional and Erratic Personality Disorders)

Cluster B personality disorders are characterized by dramatic, emotional, and attention-seeking traits. This cluster includes antisocial, borderline, histrionic, and narcissistic personality disorders. Individuals with these disorders typically exhibit features such as emotional instability, relationship problems, a need for attention, and manipulative behaviors. Below, Cluster B personality disorders are discussed in detail.

1. Antisocial Personality Disorder

Antisocial personality disorder has historically been referred to as "psychopathy," "sociopathy," or "character disorder." The term "antisocial personality disorder" replaced "antisocial personality" with the publication of DSM-III in 1980 by APA, which previously termed it as such in DSM-II (Geçtan 1997). Researchers indicate that antisocial behaviors typically begin before the age of 8, and approximately 80% of individuals with this disorder develop the initial signs by the age of 11 (Black 2015). In DSM-5, emphasis is placed on core features such as manipulation, deceitfulness, lack of remorse, impulsivity, exploitation of others, and tendency towards violence. They are inflexible. Individuals with this disorder are perceived by others as harsh, cold, and insensitive, and they often behave in a sarcastic, competitive, antagonistic, and malicious manner to support these beliefs (Köroğlu and Bayraktar 2010).

Individuals with antisocial personality disorder are hypersensitive to dissatisfaction and easily bored with routine (Akhtar 2009). Despite having cognitive abilities, they lack insight. They are insensitive and rude but generally aware of others' emotions (Köroğlu and Bayraktar 2010).

Individuals with antisocial personality disorder typically have a tendency to defy social norms and authority. They do not feel remorse after committing crimes. They do not learn from repeated mistakes (Alioğlu 2019). They have serious boundary issues in romantic relationships and tend to belittle and cannot love others. Even if

they do not openly express it, these individuals' self-perception is dominated by a feeling of worthlessness (Bilge and Mayda 2023).

Individuals with antisocial personality disorder skillfully use defense mechanisms to rationalize their behaviors and gain acceptance. The three main defense mechanisms they use are rationalization, elevation, and reflection. They think other people are bad, and sometimes they think they are good or bad themselves. They are relentless, competitive, self-confident, and powerful in their opinion (Köroğlu and Bayraktar 2010).

In antisocial personality, individuals are either 'soft-headed' or an exception to ordinary social rules. They fluctuate between childish helplessness and their inflated sense of strength. On one side, they are self-centered and exhibitionist, on the other side, they suffer from feelings of emptiness and worthlessness (Akhtar 2009).

Individuals with antisocial personality prefer to work independently and comfortably maintain it with their skills. They live according to their values rather than society's value judgments. They are not stingy in a material sense. They are successful in human relations. They do not worry about other people and have excessive sexual desires (Geçtan 1997).

In DSM-5, the diagnostic criteria for Antisocial Personality Disorder are expressed as: 'Evidence of conduct disorder before the age of 15, with specific manifestations since age 15 including failure to conform to legal obligations, engaging in repeated behaviors leading to arrest, frequent lying, using aliases, or conning others for personal gain or pleasure, specific deceitfulness, impulsivity or failure to plan ahead, frequent physical fights or assaults on others, specific irritability and aggressiveness, disregard for the safety of oneself or others, chronic irresponsibility with a lack of steady employment or failure to meet financial obligations, and specific lack of remorse for harming others, mistreating others, or stealing from others.' Three (or more) of these attitudes and behaviors must be present, with specific disregard for others' rights, and the individual must be at least 18 years old" (APA 2013).

The prevalence rate of antisocial personality disorder in men is between 3-7%, while in women, it is around 1%. The prevalence rate in close relatives of individuals with disorders such as antisocial personality and alcoholism is five times higher than the prevalence rate in society. Arbitrary punitive or exploitative attitudes of parents, genetic factors, and brain injuries may be effective in the occurrence (Köroğlu and Bayraktar 2010).

2. Borderline Personality Disorder

In the 1940s, individuals who were not ill enough to be diagnosed with schizophrenia but displayed significant disturbance according to psychoanalytic therapy began to be identified. The term "borderline" was first used in 1938 by Stern to describe a disorder stemming from narcissism (Geçtan 1997).

Over time, numerous descriptive definitions of borderline personality disorder have emerged. One prominent definition is Otto Kernberg's concept of "borderline personality organization," which integrates ego psychology and object relations theory approaches. Kernberg suggested that the diagnosis of borderline personality organization can be made through a sensitive structural analysis, as he believed various personality disorders overlap with each other (Geçtan 1997). Kernberg's borderline personality organization is not classified separately but is considered the psychic foundation for all personality disorders. Although overlapping in some aspects, borderline personality disorder and borderline personality organization exist at different levels of abstraction (Akhtar 2009).

In DSM-5, the diagnostic criteria for Borderline Personality Disorder are expressed as: 'Avoiding real or imagined abandonment through excessive efforts, a pattern of unstable and intense interpersonal relationships characterized by extremes of idealization and devaluation, identity disturbance: a markedly and persistently unstable self-image or sense of self, impulsivity in at least two areas that are potentially self-damaging, recurrent suicidal behavior, gestures, or threats, or self-mutilation, emotional instability due to a marked reactivity of mood, chronic feelings of emptiness, inappropriate, intense anger or difficulty controlling anger, transient, stress-related paranoid thoughts or severe dissociative symptoms.' Five (or more) of these attitudes and behaviors must be present, with a pervasive pattern of instability in interpersonal relationships, self-image, and affect, and marked impulsivity" (APA 2013).

A fundamental characteristic of individuals with borderline personality disorder is the fear of real or imagined abandonment, leading them to resort to any means to avoid it (Köroğlu and Bayraktar 2010). Their relationships are based on the satisfaction of their needs and are exploitative in nature. They present a dependent image. While they may display seductive behaviors initially in romantic relationships, they cannot sustain interest and may terminate them abruptly. They are prone to impulsive behaviors such as random and risky sexual acts, which

are maladaptive and irregular (Akhtar 2009). Individuals with borderline personality disorder can have impulsive behaviors around a variety of issues, including money, sexuality, binge eating, substance abuse and risky driving. Individuals with borderline personality disorder are easily angered (Köroğlu and Bayraktar 2010) and lack a cohesive sense of self (Akhtar 2009). Their self-perception is unstable, fluctuating between feelings of inferiority and feelings of superiority, which leads to identity confusion, chronic feelings of emptiness, boredom, and fear of abandonment. Consequently, individuals with this disorder have a compelling need for social interaction. The consistency of their self-perception and values is associated with the presence of others (Kernberg 2019). They are constantly anxious due to their inconsistent and often negative thoughts about themselves, leading to guilt after exhibitionistic attacks without receiving approval. Occasionally, anger directed at themselves can lead to self-harming behaviors (Köroğlu and Bayraktar 2010).

Individuals with borderline personality disorder often have irregularities in their educational and/or work lives and frequently change jobs (Akhtar 2009). They generally achieve lower occupational and academic success than their intelligence and skills would suggest (Köroğlu and Bayraktar 2010). In situations of disorder, they tend to resort to primary thinking processes and, if well managed and with an innate talent, this can lead to significant artistic and poetic creativity (Akhtar 2009). Individuals with borderline personality disorder complain of chronic insomnia and lead irregular lifestyles. They express their inner tension through depression and also use it as a means against other upsetting individuals (Köroğlu and Bayraktar 2010).

The main defense mechanism used by individuals with borderline personality disorder is splitting. The splitting process is used to protect the self from conflicts. Contradictory self-states are alternately revived, and as long as these contradictory self-states can be kept separate, anxiety is prevented. Another mechanism is primitive idealization. In borderline personality disorder, individuals tend to see external objects in an unrealistic completely good manner. These individuals also have tendencies for projection, with the primary purpose of explaining self and object images that are bad and aggressive with external factors. Additionally, these individuals use the denial mechanism while moving from one end of thought and emotion to another (Kernberg 2019). According to DSM-5, individuals with borderline personality disorder exhibit variability in self-perception, oscillating between idealization and devaluation of others, and inconsistency in mood. They may experience transient disturbances in evaluating reality (APA 2013).

In the borderline personality form, the individual displays seriousness and commitment in relationships. They are emotionally active and tend to act as they feel. They may have strong creative aspects, high life energies, active, attractive, and charming. They are curious about other cultures and have a high imagination (Köroğlu and Bayraktar 2010).

Various evaluations exist regarding the emergence of borderline personality disorder, although the role of genetic-structural defects in the central nervous system is often emphasized. For example, Grotstein suggests that a neurocognitive defect causes disorders in self-regulation (Geçtan 1997). Brain damage occurring during birth, encephalitis, head trauma, and other brain diseases are also indicated to have an impact (Köroğlu and Bayraktar 2010). Kernberg, referring more to Margaret Mahler's developmental theory, explains borderline personality disorder as being stuck in the separation-individuation phase of the child between the sixteenth and thirtieth months, attributing this to the mother's inability to provide the emotional support needed by the child during this period or to cope structurally with excessive aggression (Geçtan 1997). Benjamin (1996), in the Structural Analysis of Social Behavior (SASB) model, emphasizes four factors contributing to the development of borderline personality disorder: chaos in the family environment; traumatic abandonment experienced; family values that support a dependent, unhappy personality structure that hinders the child's independent action, expression of feelings, and success; and a family that shows interest only in situations of suffering (Konduz 2015).

The prevalence of borderline personality disorder is around 2% more common in women. It is reported that 90% of individuals with this disorder have an additional psychiatric diagnosis, and 40% have more than two diagnoses. It is more frequently observed in family members, especially mothers, with mood disorders and substance addiction (Köroğlu and Bayraktar 2010).

3. Histrionic Personality Disorder

The relationship between hysterical personality diagnosis and histrionic personality disorder has been a highly debated topic in the past. Current psychiatric findings suggest that there is no clinical or psychodynamic relationship between these two conditions (Geçtan 1997). Individuals with hysterical personality disorder have robust personalities and can develop consistent, empathetic relationships where they can distinguish between themselves and others. They predominantly utilize the defense mechanism of suppression. In contrast,

histrionic individuals exhibit identity fragmentation, splitting defense mechanisms, inability to integrate conflicting attributes of themselves and others, noticeable ego flaws, and limitations in autonomous self-functions (Akhtar 2009).

Blacker and Tupin suggest that women with histrionic personality disorder did not receive sufficient maternal love during the oral stage and did not successfully pass through the oedipal phase, resulting in underdeveloped sexual identities (Geçtan 1997). It is highly likely that interpersonal difficulties encountered in early childhood are resolved through role-playing. Past experiences might include an intolerant and distant father figure and a provocative, disruptive maternal history (Köroğlu and Bayraktar 2010).

In DSM-5, the diagnostic criteria for Histrionic Personality Disorder are expressed as: 'Discomfort when not the center of attention, displaying sexually seductive, provocative, or inappropriate behavior in interactions with others, showing rapidly shifting and shallow (superficial) emotions, consistently using physical appearance to draw attention, having a style of speech that is excessively impressionistic and lacking in detail, being theatrical, exaggerated in emotions, and attention-seeking, being easily influenced by others or circumstances, and thinking that relationships are more intimate than they actually are.' Five (or more) of these attitudes and behaviors must be present, with a pervasive pattern of excessive emotionality and attention-seeking" (APA 2013).

Characteristics that characterize histrionic personality disorder include excessive emotionalism and attention-seeking behaviors (Şimşek and Kaya 2020). They constantly strive to be colorful, flamboyant, eye-catching, and attractive, attempting to draw attention through seductive and enticing behaviors. Despite their seductive behaviors, they may fear sexuality. They exhibit addictive behaviors and lack emotional depth, being superficial in their interactions. They speak as if they are playing a role (Köroğlu and Bayraktar 2010). Chodoff and Lyons (1958) stated that histrionic individuals portray a caricature of femininity (Geçtan 1997).

Individuals with histrionic personality disorder appear initially gentle, warm-hearted, high in vitality, friendly, interested in social life, ethics, and morals, cognitively fast and decisive. Despite being dependent, they attempt to direct their surroundings narcissistically, engage in random sexual relationships, are impulsive, prone to addiction, have irregular professional lives, and do not pay attention to details cognitively (Akhtar 2009). While initially impressive due to their charms, histrionics withdraw when relationships require depth and continuity. They avoid increasing self-awareness and experiencing deep social relationships themselves, and similarly do not want others to delve deeply into their own depths. They lack insight or wish to be so (Köroğlu and Bayraktar 2010). Histrionic individuals experience intense anxiety when separated from their love objects (Geçtan 1997).

Histrionic individuals frequently use defense mechanisms such as suppression, regression, identification, somatization, conversion, dissociation, denial, and externalization (Köroğlu and Bayraktar 2010). They have a tendency to dramatize events and are not reluctant to lie in this direction. They show exaggerations in body movements and gestures (Öztürk and Uluşahin 2011). This can sometimes be evaluated as repulsive. Individuals with histrionic disorder are emotionally manipulative and cannot tolerate delaying satisfaction (Konduz 2015).

Histrionic individuals prefer to define themselves according to others' impressions rather than their own qualities. They do not want to look inward because they feel worthless and do not want to divide their interests in order to be constantly ready for external stimuli. In addition, they suppress their interiority because the impression they want to leave in others conflicts with their limited inner world (Köroğlu and Bayraktar 2010).

While individuals with histrionic personality disorder share similarities with borderline personality disorder (impulsiveness, susceptibility to corruption, random sexual intercourse, and substance abuse), histrionic individuals do not constantly display anger or harm themselves (Akhtar 2009).

Individuals with histrionic personality style prefer to be liked and exhibit seductive attitudes with their appearance and behavior. They take care of their appearances. They are lively. They enjoy displaying their emotions appropriately. They speak appropriately (Köroğlu and Bayraktar 2010). Research has shown that although histrionic personality disorder is more common in women, there is no significant difference between genders (Şimşek and Kaya 2020, Köroğlu and Bayraktar 2010).

4. Narcissistic Personality Disorder

Exaggerated self-esteem is the fundamental characteristic of narcissistic personality disorder. Individuals with this disorder have an insatiable desire for self-admiration, excessive ambition, and adulation from others. Due to their excessive self-focus, they are unaware of the needs and desires of others (Akhtar 2009). Narcissists feel empty because of weak bonds with others and a lost potential for love. To survive the threat of annihilation,

they maintain self-respect to the necessary extent and try to ward off this threat by gaining at least the admiration of others; in fact, narcissism symbolizes alienation from oneself (Geçtan 1997).

In DSM-5, the diagnostic criteria for Narcissistic Personality Disorder are expressed as "preoccupation with fantasies of unlimited success, power, brilliance, beauty, or ideal love, believing that they are special and unique and can only be understood by, or should associate with, other special or high-status people (or institutions), requiring excessive admiration, a sense of entitlement, being exploitative (taking advantage of others to achieve their own ends), lacking empathy (being unwilling to recognize or identify with the feelings and needs of others), often being envious of others or believing that others are envious of them, showing arrogant, haughty behaviors or attitudes" (APA 2013).

According to Kohut's theory, narcissistic individuals have suffered developmental setbacks because their parents failed to adapt to their periods. These children believe they exist to ensure the fulfillment of their narcissistic needs from others (Kohut 2017, Kohut 2022).

Kernberg (2019), states that individuals with narcissistic personality disorder are similar to those with borderline personality disorder. The distinction lies in the fact that narcissistic individuals do not develop dependencies due to the illusion of seeing themselves as sufficient, and their ways of self-expression are consistent, whereas borderline individuals' ways of self-expression are constantly changing.

Horney discusses three pathological consequences of narcissistic self-inflation, which she believes originate from disturbed relationships in childhood: (1) reduced productivity as they do not experience work as a source of gratification; (2) high expectations from the world without making any effort themselves; (3) disruptions in interpersonal relationships due to constant suffering and hostile attitudes (Horney 1936, Geçtan 1997). Narcissistic individuals often exhibit comfort and optimism. Their levels of social adaptation are quite high. However, when their expectations are not met, they fill with anger, sensitivity, and feelings of worthlessness. They also lack flexibility (Köroğlu and Bayraktar 2010). Narcissists harbor a chronic and intense sense of envy and try to conceal it by belittling others (Akhtar 2009, Geçtan 1997).

Individuals with narcissistic personality disorder turn inward and console themselves by creating a world in which they are esteemed when they fail or are humiliated. If their imaginary world proves insufficient, they resort to suppression. They activate the mechanism of rationalization by finding evidence of their own excellence. When this mechanism fails, they resort to projection by blaming others (Köroğlu and Bayraktar 2010). Narcissists appear initially seductive and open to all kinds of relationships in matters of love and sexuality. However, they cannot establish deep and lasting relationships (Akhtar 2009). Because they pursue superficial relationships with individuals dependent on their narcissistic egos (Şenyuva 2007). The prevalence of this disorder in society is around 1% (Köroğlu and Bayraktar 2010). Clinically, narcissistic personality disorder is observed with a prevalence rate of 2-16%; it is more common in males than females. Parents with narcissistic personality disorder are said to increase the risk of this disorder in their children by instilling a sense of grandiosity that does not align with reality (Konduz 2015).

Studies indicate that narcissistic traits affect job performance, motivation, and responses to feedback. Wallace and Baumeister suggest that narcissistic individuals are more successful in stressful and difficult jobs. According to them, these individuals prefer high-profile jobs. However, the possibility of not receiving the praise they deserve in teamwork reduces their performance (Atay 2009).

Individuals with narcissistic personality traits are sensitive to negative evaluations from others but can cope with them. They market their own ideas well and do not hesitate to use others' strengths. They are competitive, believe in their own qualities, and expect special treatment. They are partially aware of others' feelings and thoughts (Köroğlu and Bayraktar 2010).

Cluster C Personality Disorders (Anxious and Fearful Personality Disorders)

Cluster C personality disorders are known as fearful personality disorders. This cluster includes avoidant, dependent, and obsessive-compulsive personality disorders. Individuals with these disorders typically exhibit characteristics such as excessive anxiety, fear, perfectionism, dependency, and extreme orderliness. Below, C cluster personality disorders are discussed in detail.

1. Avoidant Personality Disorder

Avoidant personality disorder is distinct from other disorders due to feelings of extreme inadequacy, shame, fear of rejection, criticism, disapproval, and exclusion (Okay and Canel Çınarbaş 2021). Avoidant Personality

Disorder was first defined by Millon in 1969 and subsequently included in DSM-III (Sevinçok et al. 1998). This disorder has been criticized for its similarities to schizoid personality disorder. However, schizoid individuals do not enjoy social relationships and are indifferent to criticism. Individuals with avoidant personality disorder are overly sensitive to others' reactions and prefer to be in environments where unconditional acceptance is assured (Geçtan 1997). It is also likened to dependent personality disorder, but while dependent personality disorder involves a strong tendency for attachment and obedience, avoidant personality disorder exhibits a timid and withdrawn behavioral style (Köroğlu and Bayraktar 2010).

In DSM-5, the diagnostic criteria for Avoidant Personality Disorder are expressed as "avoidance of occupational activities involving significant interpersonal contact due to fears of criticism, disapproval, or rejection, unwillingness to get involved with people unless they are certain of being liked, restraint in intimate relationships due to fears of being shamed or ridiculed, preoccupation with fears of being criticized or rejected in social situations, inhibition in new interpersonal situations due to feelings of inadequacy, viewing oneself as socially inept, personally unappealing, or inferior to others, and being unusually unwilling to take personal risks or engage in new activities due to fears of embarrassment" (APA 2013).

Research has shown that four of the seven criteria for avoidant personality disorder overlap with criteria for social phobia. However, individuals with avoidant personality disorder experience more intense social anxiety, depression, and excessive fear of criticism. Additionally, they are less likely to have close friends and exhibit characteristics such as exaggerating risks in ordinary tasks, which are less common in social phobia (Okay and Canel Çınarbaş 2021).

The core feature of avoidant personality disorder is a persistent pattern characterized by inhibition in social relationships, feelings of inadequacy, and excessive sensitivity to criticism, occurring in changing situations during young adulthood. They perceive themselves as inadequate and the world as unjust, resulting in low self-esteem (Köroğlu and Bayraktar 2010). Individuals with avoidant personality disorder wish to remain invisible to avoid societal judgments. Winnicott stated, "To hide is a game but not to be found is a disaster," using a hide-and-seek metaphor to emphasize that the desire to be invisible does not imply a lack of desire to be present (Okay and Canel Çınarbaş 2021). Avoidant individuals seek only unconditional acceptance and to avoid being hurt because life, for them, is a negative experience stemming from both external and internal sources. They withdraw to avoid being hurt but face internal anguish due to feeling worthless, lacking trust in themselves or others. Individuals with avoidant personality disorder frequently employ defense mechanisms such as avoidance and inhibition (Köroğlu and Bayraktar 2010).

Individuals with avoidant personality disorder avoid professions or school activities requiring intense social contact due to fear of criticism, disapproval, or exclusion. They may refuse promotions in their jobs and avoid taking on new responsibilities (Geçtan 1997). These individuals turn to their imaginative and perceptual worlds because they cannot express their emotions openly, meeting their emotional needs through intellectual or artistic activities (Köroğlu and Bayraktar 2010).

In their daily routines, individuals with avoidant personality disorder are calm; deviations from their routines unsettle them. Besides their families, they have only a few close friends. They are highly sensitive to others' thoughts and exhibit a cautious and controlled behavior style. They may be curious and focus on specific interests (Köroğlu and Bayraktar 2010).

Millon et al. have suggested that underlying factors contributing to avoidant personality structure may include experiences such as intrusion and incest history, and physical abuse (Karabaş 2021). A contemptuous or overly protective parental attitude, and the presence of phobic traits in parents, can also be cited as reasons for the emergence of avoidant personality disorder. The prevalence rate of avoidant personality disorder ranges from 0.5% to 1%. Some publications suggest rates reaching up to 10% (Köroğlu and Bayraktar 2010).

2. Dependent Personality Disorder

The fundamental characteristic of dependent personality disorder is submission, where individuals are consistently and excessively reliant on others. This condition creates difficulties in social relationships and reduces functional capability in society. These individuals are characterized by a passive and dependent nature, avoiding making decisions on their own and evading responsibility. Their greatest fear is being neglected and unsupported (Öztürk and Uluşahin 2011).

In DSM-5, the diagnostic criteria for Dependent Personality Disorder are expressed as "difficulty making everyday decisions without excessive advice and reassurance from others, needing others to assume responsibility for most major areas of their life, difficulty expressing disagreement with others due to fears of

loss of support or approval, difficulty initiating or doing things on their own, going to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do unpleasant things, feeling uncomfortable or helpless when alone due to fears of being unable to care for oneself, urgently seeking another relationship as a source of care and support when a close relationship ends, and persistently preoccupying oneself with fears of being left to take care of oneself" (APA 2013).

Individuals with dependent personality disorder describe themselves, albeit superficially, as thoughtful, respectful, cooperative, and moderate in behavior. They unrealistically belittle themselves and feel guilty when receiving attention, denying their feelings and deceptive behaviors (Köroğlu and Bayraktar 2010). Those with dependent personality disorder are known in their social relationships for being submissive, sensitive, and exhibiting exaggerated behaviors of apologizing or showing excessive respect (Konduz 2015).

Individuals with dependent personality disorder will concede any concession and perform unwanted actions to avoid being alone or abandoned. When they think differently from other people, they cannot express it. Such behaviors often lead to distorted and unstable relationships (Köroğlu and Bayraktar 2010, Geçtan 1997).

In the dependent personality style, individuals do not mind seeking others' opinions when making decisions but ultimately can make their own decisions. They can take the first step on their own and fulfill responsibilities while respecting authority. Sometimes, they may endure difficulties for people they value and make compromises. They dislike being alone and may take corrective measures when criticized (Köroğlu and Bayraktar 2010).

Although more common in women, dependent personality disorder accounts for about 2.5% of personality disorders. Factors such as chronic physical illness, separation anxiety, or parental loss in childhood can contribute to this disorder (Köroğlu and Bayraktar 2010). The development of dependent personality is related to the parent's excessively protective attitude, over-involvement, and anxious nature. Autonomy has not developed (Konduz 2015). Because the message received in childhood is that autonomy is dangerous (Şenyuva 2007).

3. Obsessive-Compulsive Personality Disorder

Individuals with obsessive-compulsive personality disorder exhibit prominent characteristics such as an exaggerated need for orderliness, pursuit of perfection, and efforts to control thoughts and interpersonal interactions. They lack flexibility, adhere strictly to rules, and have a grim and stubborn demeanor (Öztürk and Uluşahin 2011). The pursuit of perfection in these individuals can sometimes be so overwhelming that it prevents them from achieving rigid standards and expectations, causing tasks to remain unfinished due to getting lost in details (Geçtan 1997). Those with obsessive-compulsive personality disorder frequently employ defense mechanisms such as emotional isolation, reaction formation, undoing, intellectualization, and rationalization (Köroğlu and Bayraktar 2010).

In DSM-5, the diagnostic criteria for Obsessive-Compulsive Personality Disorder are expressed as "preoccupation with details, rules, lists, order, organization, or schedules to the extent that the major purpose of the activity is lost, perfectionism that interferes with task completion, excessive devotion to work and productivity to the exclusion of leisure activities and friendships, rigidity and stubbornness regarding moral, ethical, or values-related matters, inability to discard worn-out or worthless objects, reluctance to delegate tasks or work with others unless they submit to exactly the way the individual would do it, excessive frugality; viewing money as something to be hoarded for catastrophic events, and a tendency to be rigid and stubborn" (APA 2013).

Individuals with obsessive-compulsive personality disorder demonstrate a rigid approach to moral issues and societal values. They are tight-fisted and tend to hoard. They lack joy in life and cannot truly engage in life's experiences. Beneath their strict adherence to rules lie suppressed feelings of rebellion and anger. They belittle others' flexibility and describe themselves as prudent and realistic (Geçtan 1997).

Individuals with this disorder tend to show excessive respect towards authority figures while displaying a condescending attitude towards those they consider inferior. They may channel their unconscious hostile feelings through socially acceptable roles such as judgment, military service, or surgery (Köroğlu and Bayraktar 2010). According to Gabbard, individuals with obsessive-compulsive disorder avoid intimacy with others because it could lead to the breakdown of their defense mechanisms and loss of control, potentially exposing their suppressed emotions (Geçtan 1997).

One view on the emergence of obsessive-compulsive personality disorder comes from Erikson. During Erikson's stage of shame and guilt over autonomy, a child expressing anger and dissatisfaction directly may face social isolation, shame, and criticism. In this state, the child attempts to avoid criticism through obsessive defenses.

The displacement mechanism may be employed by directing anger towards a neutral object (Karabaş 2021). It is often observed in individuals raised in families with strict discipline (Köroğlu and Bayraktar 2010). Individuals with obsessive-compulsive personality disorder may not have had their need for parental approval and love adequately met in childhood. This could be due to parents maintaining a distant attitude, lacking necessary warmth, or the child perceiving a greater need for love and acceptance compared to peers (Geçtan 1997). This disorder has an approximate prevalence rate of around 1% in the population, with a higher occurrence in males (Köroğlu and Bayraktar 2010).

In the obsessive-compulsive personality style, individuals meticulously consider their tasks and strive to complete them flawlessly and without error. They work hard and consider options and consequences when making decisions. They are often frugal but do not hesitate to share. They have a tendency to hoard and collect items and operate within strong principles (Köroğlu and Bayraktar 2010).

Comparison of DSM-5, DSM-5 Alternative Model, and ICD-11 Classification Systems

DSM-5 classifies personality disorders using the traditional clusters A, B, and C, with each personality disorder defined by specific criteria in addition to the general personality disorder definition. These disorders can be listed as "paranoid, schizoid, schizotypal, antisocial, borderline, histrionic, narcissistic, avoidant, dependent, and obsessive-compulsive personality disorders." This approach is categorical (APA 2013).

Both the ICD-11 classification and the DSM-5 Alternative Model (AMP) include domains related to personality functioning such as sense of identity, self-direction, understanding others, and relationships with others. In both models, the features of personality disorders are used as determinants that contribute to the individual expression of the personality disorder, in addition to the general classification of severity. Although these determinants are not sufficient for diagnosis, they can provide information about the intervention process for diagnosed individuals, how the therapeutic alliance is formed, and the determination of intervention goals (Bach 2020).

Both ICD-11 and DSM-5 AMP define personality disorder features as "negative affectivity, detachment, antagonism, and disinhibition." While ICD-11 includes a separate "anankastic" domain, DSM-5 alternative model personality disorders include "psychoticism" as a personality trait. Although ICD-11 describes "borderline personality pattern" similarly to personality traits, it is not defined as an additional feature in the DSM-5 Alternative Model. The criteria for assessing functionality and disorder do not completely align with each other. However, it can be expressed that both models emphasize personality traits and a dimensional approach over categorical classification in the assessment of personality disorders (Töre 2023). Despite the DSM-5 Alternative Model having diagnostic criteria distinct from traditional ones, there are still six personality disorder diagnoses: "antisocial, avoidant, borderline, narcissistic, obsessive-compulsive, and schizotypal personality disorders" (Konduz 2015). Table 1 presents a comparison of the DSM-5, DSM-5 AMP, and ICD-11 classifications of personality disorders.

Table 1. Classification of personality disorders according to DSM-5, DSM-5 PD alternative model and ICD-11 (APA 2013, WHO 2022).

DSM-5 PD	DSM-5 Alternative Model PD*	ICD-11 Model
Borderline PD	Borderline PD	Personality Difficulty**
Schizotypal PD	Schizotypal PD	Mild personality disorder
Narcissistic PD	Narcissistic PD	Moderate personality disorder
Antisocial PD	Antisocial PD	Severe personality disorder
Avoidant PD	Avoidant PD	Personality disorder (severity unspe-
Obsessive-compulsive PD	Obsessive-compulsive PD	cified)
Paranoid PD	Trait Specified PD (PD-TS)	
Schizoid PD		
Histrionic PD		
Dependent PD		

*The diagnosis of personality disorders in the DSM-5 Alternative Model is based on the assessment of the level of impairment in personality functioning and pathological personality traits.

**Personality difficulties refer to personality traits that may benefit from mental health services but do not reach the level of a personality disorder diagnosis.

As shown in Table 1, DSM-5 has a categorical approach to personality disorders, while DSM-5 AMP has a hybrid approach that combines categorical and dimensional approaches. ICD-11, on the other hand, displays an approach that defines personality disorders according to their levels rather than a categorical approach. Table 2 presents a comparison of personality disorders based on personality traits and domains.

Table 2. Comparison of personality disorders in DSM-5 according to DSM-5 alternative model and ICD-11 (APA 2013, WHO 2022).

DSM-5 PD	DSM-5 Alternative Model PD	ICD-11 Model
Paranoid PD	- Personality trait and trait domains: -Detachment -Negative Affectivity -Antagonism	- Trait domains: -Detachment -Negative Affectivity -Antagonism
Schizotypal PD	Schizotypal PD Personality trait and trait domains: -Psychoticism (Cognitive and perceptual dysregulation, unusual beliefs and experiences, eccentricity) -Detachment (Restricted affectivity, withdrawal, suspiciousness)	"Schizotypal Disorder" is included under the heading "Schizophrenia or other primary psychotic disorders". Trait domains: - Anankastic -Detachment
Schizoid PD	- Trait domains: -Detachment -Negative Affectivity	- Trait domains: -Detachment -Negative Affectivity
Borderline PD	Borderline PD Personality trait and trait domains: -Negative Affectivity (Emotional liability, anxiousness, depressivity, separation insecurity) -Disinhibition (Impulsivity, risk taking) -Antagonism (Hostility)	"The Borderline pattern" specifier has been included to enhance the clinical utility of the classification of PD. Trait domains: -Negative Affectivity -Disinhibition
Narcissistic PD	Narcissistic PD Personality trait and trait domains: -Antagonism (Grandiosity, attention seeking)	- Trait domains: -Antagonism
Histrionic PD	- Trait domains: -Disinhibition -Negative Affectivity -Antagonism -Detachment (low)	- Trait domains: -Disinhibition -Negative Affectivity -Antagonism -Detachment (low)
Antisocial PD	Antisocial PD Personality trait and trait domains: -Antagonism (Manipulativeness, callousness, deceitfulness, hostility, high levels of attention seeking) -Disinhibition (risk taking, impulsivity, irresponsibility) -Detachment (low levels of withdrawal) -Negative Affectivity (low levels of anxiousness)	- Trait domains: -Dissociality -Disinhibition -Detachment -Negative Affectivity (low)
Avoidant PD	Avoidant PD Personality trait and trait domains: -Negative Affectivity (Anxiousness) -Detachment (Withdrawal, anhedonia, intimacy avoidance)	- Trait domains: -Negative Affectivity -Detachment
Dependent PD	- Trait domains: -Negative Affectivity -Antagonism (low)	- Trait domains: -Negative Affectivity -Antagonism (low)

Table 2. Comparison of personality disorders in DSM-5 according to DSM-5 alternative model and ICD-11 (APA 2013, WHO 2022).

DSM-5 PD	DSM-5 Alternative Model PD	ICD-11 Model
Obsessive-compulsive PD	Obsessive-compulsive PD Personality trait and trait domains: -Negative Affectivity (Perseveration) -Detachment (Intimacy avoidance, restricted affectivity) - Conscientiousness (Rigid perfectionism) * It can be stated that Anankastic and Obsessive-Compulsive personality traits are similar.	*It is listed as "Obsessive-Compulsive Disorder" under the heading "Obsessive-Compulsive or related disorders". Trait domains: -Negative Affectivity -Detachment -Anankastic
-	Personality Disorder-Trait Specified (PD-TS) Personality trait and trait domains: -Negative Affectivity (anxiety, depression, guilt/ shame, worry, anger, dependency) -Detachment (Intimacy avoidance, restricted affectivity, avoidance of socioemotional experience) -Psychoticism (Exhibiting incongruent odd, eccentric, or unusual behaviors and cognitions) -Antagonism (maladaptive interpersonal relationships, callousness, manipulation) -Disinhibition (Orientation toward immediate gratification)	-

Assessment Tools Used in Personality Disorder Evaluation

There are fundamental measurement tools with psychometric properties used for the assessment and classification of personality disorders. The first of these is the Minnesota Multiphasic Personality Inventory (MMPI-2), developed by Graham et al. The MMPI-2 is a widely used psychological test for personality assessment, designed to objectively evaluate an individual's psychological state. Its subscales are designed to measure specific personality traits or psychopathological symptoms. These subscales focus on specific areas rather than general personality traits, providing a more in-depth assessment. Subscales of the MMPI-2 include Depression, Hypochondriasis, Paranoia, Psychasthenia, Social Isolation, and Hysteria. Each subscale is designed to assess specific psychopathological features. For example, the depression subscale measures depressive symptoms, while the paranoia subscale evaluates paranoid thoughts. The use of these subscales is important for understanding an individual's psychological structure in detail and can aid in directing therapeutic interventions. These subscales play a significant role in psychological assessment and treatment planning in clinical practice (Vatan and Dağ 2009, Taymur and Türkçapar 2012, Uluç et al. 2014).

Structured Clinical Interview for DSM-IV (SCID-II), developed by First et al., is a widely used clinical interview protocol for assessing personality disorders. SCID-II provides a comprehensive personality assessment using a structured interview format, guiding clinical professionals in better understanding an individual's personality structure and making diagnoses. Its subscales are designed to assess specific symptoms related to different personality disorders. For instance, various subscales such as Borderline Personality Disorder, Narcissistic Personality Disorder, and Obsessive-Compulsive Personality Disorder are used to identify relevant symptoms. These subscales help examine specific personality traits and psychopathological symptoms in greater detail (Taymur and Türkçapar 2012, Bilge 2018, Bilge and Mayda 2023).

The Structured Interview for Personality Disorders (SIDP-IV), developed by Pfohl et al., includes a series of questions covering symptoms specific to certain personality disorders outlined in DSM-IV. This protocol systematically investigates an individual's personality traits and symptoms, assessing the presence and severity of specific personality disorders. Conducted in a structured format, the interview standardizes the process of gathering information based on specific diagnostic criteria. Additionally, the use of SIDP-IV provides insights

into the epidemiology and etiology of personality disorders, making it a valuable tool for clinical assessment and research (Svela et al. 2022).

In addition to these, there are various other measurement tools used for assessing personality disorders, such as Shedler-Westen Assessment Procedure-200 (SWAP-200), Schedule for Nonadaptive and Adaptive Personality (SNAP), Dimensional Assessment of Personality Pathology-Basic Questionnaire (DAPP-BQ), Inventory of Personality Organization (IPO), Personality Assessment Schedule (PAS), among others. Furthermore, standardized personality assessment tools including Standardized Assessment of Personality (SAP), Millon Clinical Multiaxial Inventory (MCMI), Personality Diagnostic Questionnaire-Revised (PDQ-R), International Personality Disorder Examination (IPDE), Multimodal Assessment of Personality Pathology (MAPP), Iowa Personality Disorder Screen (IPDS), and Personality Belief Questionnaire (PBQ) are also used for measuring personality disorders (Bilge and Sertel Berk 2017, Ertan and Cankorur 2017).

Despite the development of numerous assessment tools for personality disorders, a literature review indicates that there are relatively few current measurement tools developed or translated into Turkish with studies on their psychometric properties. In Turkey, assessment tools used in research and diagnosis related to personality disorders include SCID-II based on DSM III-R, the initial version of MMPI-II, and the Personality Belief Questionnaire (PBQ) developed to assess underlying beliefs associated with personality disorders (KİÖ). Recently, adaptation of the Coolidge Axis II Inventory Plus (CATI+) based on DSM to Turkish has been completed, with only the KİÖ-KTF having undergone Turkish validation and reliability studies (Bilge, 2018). Subsequently, Bilge (2018) developed the Turkish short form of the Coolidge Axis II Inventory Plus (CATI+TR-KF) (Ertan and Cankorur 2017, Bilge 2018).

With the increasing preference for the DSM-5 Alternative Model (AMPD) and the implementation of ICD-11, various studies have been conducted to develop current assessment tools for measuring personality disorders. For example, the "DSM-5 Personality Functioning Clinical Assessment Form (Levels of Personality Functioning Scale – LPFS)," developed by the APA's DSM-V Personality Disorder Work Group, is a 12-item, Likert-type tool that illustrates these efforts (Konduz 2015). The LPFS is a self-report scale useful for initial assessment and monitoring clinical changes related to personality disorders, but it has limited use in clinical decision-making processes. Therefore, Bender et al. (2018), reviewed the LFDS and developed the "Structured Clinical Interview for DSM-5 Personality Disorders Alternative Model, Module I (SCID-5-AMPD-I)." Studies on the validity and reliability of this scale suggest that it can be used to determine the severity and presence of personality disorders according to the DSM-5 Alternative Model (Hummelen et al. 2021). Olajide et al. (2018) developed the Standardized Assessment of Personality Disorder Severity (SASPD) to assess the severity of personality disorders. Validity and reliability studies in clinical samples indicated that it provides a simple, brief, and reliable measure of personality disorder severity. Another tool, the PID-5BF+ short form, is a modified version of the Personality Inventory for DSM-5 developed by Bach et al. (2020). This 36-item tool underwent validity and reliability testing on a large international sample. The scale items were prepared in line with ICD-11 and DSM-5 Alternative Model diagnostic criteria. Similarly, Sellbom et al. (2024) developed the 14-item Personality Disorder Severity ICD-11 Clinician Rating Form (PDS-ICD-11) to assess the severity of personality disorders according to the ICD-11 model. This unidimensional tool, developed through the self-report PDS-ICD-11, was researched for its psychometric properties with participants from clinical samples in different countries, resulting in a valid and reliable measure.

Conclusion

Personality and personality disorders have been addressed with various theoretical frameworks and approaches from the past to the present. Freud's psychoanalytic theory explains personality through concepts of the unconscious, conscious, and preconscious, while Neo-Freudians like Adler, Jung, and Horney have offered different perspectives. Behavioral and cognitive approaches relate personality to the learning process, while prominent figures in humanistic psychology like Carl Rogers and Abraham Maslow have stressed the need for unconditional positive regard in nurturing personality development. The trait approach advocates the existence of stable characteristics in personality, while the five-factor theory defines basic personality traits as extraversion, neuroticism, openness to experience, agreeableness, and conscientiousness.

Personality disorder describes situations where the behavioral responses and attitudes that constitute personality excessively impair an individual's functionality and social adaptation (Köroğlu and Bayraktar 2010). Diagnosing personality disorders is often challenging, stemming from uncertainties in classification and diagnostic methods. Freud and psychoanalysts have had a significant influence on conceptualizing personality disorders. Carl Rogers emphasizes self-perception in the development of personality disorders, while Sullivan

focuses on the importance of interpersonal relationships in mental disorders. The traditional behavioral approach to personality disorders highlights negative social relationships, whereas Beck emphasizes maladaptive cognitive schemas. In the Five Factor Model, Widiger and Costa (1994) describe personality disorders as maladaptive and/or extreme versions of personality domains and traits.

Today, comprehensive diagnostic guides such as DSM-5 and ICD-10 are considered fundamental resources for diagnosing and classifying personality disorders. However, classification systems like the DSM-5 Alternative Model and the ICD-11, which came into effect in 2022, emphasize dimensional approaches over traditional diagnostic criteria, focusing on the severity of the disorder and personality traits. In these updated classification systems, the degrees of impairment in personality domains and functioning are crucial. While some mental health professionals advocate for the traditional categorical approach, others argue that a dimensional approach is more appropriate given the nature of personality and recent developments.

In the literature, various measurement tools developed according to categorical diagnostic systems, such as the Minnesota Multiphasic Personality Inventory (MMPI-2), the Personality Belief Questionnaire (PBQ), and the Structured Clinical Interview (SCID-II), are used. However, with innovations in classification systems, new tools like the DSM-5 Personality Functioning Clinical Assessment Form (LPFS), the Standardized Assessment of Personality Disorder Severity (SASPD), and the Personality Disorder Severity ICD-11 Clinician Rating Form (PDS-ICD-11) have been developed and are starting to be used. The limited number of measurement tools available for evaluating personality disorders in both the world and Turkey suggests a need for further research. An increase in studies in this area could aid in a better understanding of personality disorders. Finally, the scarcity of national studies on the prevalence of personality disorders is noteworthy. There is a need for such research to enhance policies related to mental health services and improve the quality of interventions in this field. This article provides a comparative overview of traditional definitions and classifications of personality disorders with current approaches, serving as a guide for researchers in their future work. Additionally, given the insufficient research on developments in diagnostic systems for personality disorders, it will encourage researchers to focus on this area.

References

Akhtar S (2009) Ağır Kişilik Bozukluklarının Tanı ve Sağaltımı için Başvuru Kitabı (Çeviri ed. M Alkan ve C Gürdal). İzmir, Odağ Psikanaliz ve Psikoterapi Eğitim Hizmetleri.

Alioğlu S (2019) Narsisistik, sınır ve şizoid kişilik bozukluklarına yatkınlıkta duygusal farkındalığın incelenmesi (Yüksek lisans tezi). İstanbul, Fatih Sultan Mehmet Vakıf Üniversitesi.

APA (2013) Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM 5). Washington, DC, American Psychiatric Association.

Atak H (2022) Kişilik Bozuklukları: Öyküsel Analizleri Çalışma Kitabı. Ankara, İksad Yayınevi.

Atay S (2009) Narsistik kişilik envanterinin Türkçeye standardizasyonu. Gazi Üniversitesi İktisadi ve İdari Bilimler Fakültesi Dergisi, 11:181-196.

Aydın Seyrek T (2022) ICD-11 kişilik bozukluğu tanı ölçütlerine yönelik klinisyen değerlendirmeleri ile özbildirim ölçeğinin geçerlik ve güvenirliği (Yüksek lisans tezi). Aydın, Aydın Adnan Menderes Üniversitesi.

Bach B, First MB (2018) Application of the ICD-11 classification of personality disorders. BMC Psychiatry, 18:351.

Bach B, Kerber A, Aluja A, Bastiaens T, Keeley JW, Claes L et al. (2020) International assessment of DSM-5 and ICD-11 personality disorder traits: toward a common nosology in DSM-5.1. Psychopathology, 53:179-188.

Bach B, Brown TA, Mulder RT, Newton-Howes G, Simonsen E, Sellbom M (2021) Development and initial evaluation of the ICD-11 personality disorder severity scale: PDS-ICD-11. Personal Ment Health, 15:223-236.

Beck AT (2008) Kişilik Bozukluklarının Bilişsel Terapisi (Çeviri ed. Ö Yalçın, EN Akçay). İstanbul, Litera Yayıncılık.

Beckwith H, Moran PF, Reilly J (2014) Personality disorder prevalence in psychiatric outpatients: A systematic literature review. Personal Ment Health, 8:91-101.

Bender DS, Skodol AE, First MB, Oldham JM (2018) Module I: Structured Clinical Interview For The Level of Personality Functioning Scale (SCID-5-AMPD). Washington DC, American Psychiatric Publishing.

Bilge Y (2014) Coolidge Eksen İki Envanteri Plus'ın Türkçe adaptasyonu ve DSM-5'te yer alan kişilik bozukluklarının davranışsal inhibisyon ve davranışsal aktivasyon sistemleriyle ilişkilerinin incelenmesi (Doktora tezi). İstanbul, İstanbul Üniversitesi.

Bilge Y (2018) Kişilik bozuklukları ve savunma mekanizmaları. Turkish Studies, 13:145-167.

Bilge Y, Mayda BS (2023) Antisosyal Kişilik Özellikleri Ölçeğinin geliştirilmesi: geçerlik ve güvenirlik çalışması. Yaşam Becerileri Psikoloji Dergisi, 7:75-91.

Bilge Y, Sertel Berk HÖ (2017) Coolidge Eksen II Envanteri Plus'ta (CATI+) yer alan DSM-III-R, DSM-IV-TR ve DSM-5 kişilik bozuklukları alt ölçeklerinin Türkçe güvenirlik ve geçerlik çalışması. Uluslararası Sosyal Araştırmalar Dergisi, 10:459–474.

Bingöl N (2022) Kişilik bozukluklarının kendilik nesnesi ihtiyaçları, savunma mekanizmaları ve kişilerarası ilişki açısından incelenmesi (Yüksek lisans tezi). İstanbul, Sağlık Bilimleri Üniversitesi.

Black DW (2015) The natural history of antisocial personality disorder. Can J Psychiatry, 60:309–314.

Brown TA, Sellbom M (2023) Examining the reliability and validity of the ICD-11 personality disorder severity diagnosis. Aust NZ J Psychiatry, 57:1043-1051.

Burger JM (2006) Kişilik (Çeviri ed. İD Erguvan Sarıoğlu). İstanbul, Kaknüs Yayınları.

Çiçek İ, Aslan AE (2020) Kişilik ve beş faktör kişilik özellikleri: kuramsal bir çerçeve. Batman Üniversitesi Yaşam Bilimleri Dergisi, 10:137-147.

Dal V, Eroğlu AH (2009) Farklı kişilik özelliklerine sahip bireylerin risk algılarının tüketici davranışı açısından incelenmesi: üniversite öğrencileri üzerine bir araştırma. Süleyman Demirel Üniversitesi İktisadi ve İdari Bilimler Fakültesi Dergisi, 20:361-385.

Dereboy F, Dereboy Ç, Kaçar Başaran S, Kırcı Dallıoğlu Ç, Aslan Kunt D (2022) Türkiye'de psikiyatri hastalarında SCID-II ile tanılanan kişilik bozukluğunun prevalansı: sistematik gözden geçirme ve meta-analiz. Turk Psikiyatri Derg, 33:118-137.

Ertan EA, Cankorur VŞ (2017) Kişilik bozukluklarının tanısı: yeni bulgular ile tanıda kullanılan anket ve ölçekler. Kriz Dergisi, 25:3.

Eysenck H (2006) The Biological Basis of Personality. New Brunswick NJ, Transaction Publishers.

Freud S (2019) Ego ve İd (Çeviri ed. SC Gülsay). İstanbul, Oda Yayınları.

Fromm E (1982) Sağlıklı Toplum (Çeviri ed. Y Salman, Z Tanrısever). İstanbul, Payel Yayınları.

Geçtan E (1997) Psikodinamik Psikiyatri ve Normaldışı Davranışlar, 13.Baskı. İstanbul, Remzi Kitabevi.

Gençtanırım Kurt D, Çetinkaya Yıldız E (2017) Kişilik Kuramları. Ankara, Pegem Akademi.

Harrison JE, Weber S, Jakob R, Chute CG (2021) ICD-11: an international classification of diseases for the twenty-first century. BMC Med Inform Decis Mak, 21(Suppl 6):206..

Horney K (1936) New Ways in Psychoanalysis. New York, Norton.

Hummelen B, Braeken J, Buer Christensen T, Nysaeter TE, Germans Selvik S, Walther K et al. (2021) A psychometric analysis of the structured clinical interview for the DSM-5 alternative model for personality disorders module I (SCID-5-AMPD-I): level of personality functioning scale. Assessment, 28:1320-1333.

Karabaş Z (2021) DSM-5'te yer alan kişilik bozukluklarının Erikson'un psikososyal gelişim dönemleri ve algılanan ebeveynlik biçimleri açısından incelenmesi (Yüksek lisans tezi). İstanbul, İstanbul Sabahattin Zaim Üniversitesi.

Karamustafalıoğlu KO, Kahraman N (2012) Şizofreni spektrumu kişilik bozuklukları. NP Akademi, 1:38-44.

Kernberg OF (2019) Sınır Durumlar ve Patolojik Narsisizm (Çeviri ed. M Atakay). İstanbul, Metis Yayınları.

Kohut H (2017) Kendiliğin Yeniden Yapılandırılması (Çeviri ed. O Cebeci). İstanbul, Metis Yayınları.

Kohut H (2022) Kendiliğin Çözümlenmesi (Çeviri ed. C Atbaşoğlu, MB Büyükkal). İstanbul, Metis Yayınları.

Konduz N (2015) DSM-5'e göre kişilik bozukluğu tanısı alan hastaların kişilerarası işlevsellikte yetersizlik düzeyleri (Yüksek lisans tezi). Aydın, Adnan Menderes Üniversitesi.

Köroğlu E, Bayraktar S (2010) Kişilik Bozuklukları, 2. Basım. Ankara, Hekimler Yayın Birliği.

Lewis CA, Francis LJ, Shevlin M, Forrest S (2002) Confirmatory factor analysis of the French translation of the abbreviated form of the Revised Eysenck Personality Questionnaire (EPQR-A). Europe J Psychol Assess, 18:79-85.

Magnavita JJ (2016) Kişilik Kuramları (Çeviri ed. T Özakkaş). Kocaeli, Psikoterapi Enstitüsü Eğitim Yayınları.

Maslow AH (1970) Motivation and Personality, 2nd ed. New York, Harper & Row.

McCrae RR, Costa PT (2003) Personality in Adulthood: A Five-Factor Theory Perspective, 2nd ed. New York, Guilford Press.

McWilliams N (2017) Psikanalitik Tanı: Klinik Süreç İçinde Kişilik Yapısını Anlamak (Çeviri ed. E Kalem). İstanbul, İstanbul Bilgi Üniversitesi Yayınları.

Mısır E, Alptekin K (2020) Şizotipi kavramı ve şizotipal kişilik bozukluğu. Klinik Psikiyatri Dergisi, 23:364-74.

Millon T, Grossman S, Millon C, Meagher S, Ramnath R (2004) Personality Disorders in Modern Life, 2nd Ed. New Jersey, Wiley.

Millon T, Lerner MJ (2003) Handbook of Psychology. Hoboken, New Jersey, John Wiley & Sons, Inc.

Mohl PC (2007) Diğer Psikodinamik Okullar. In: Sadock BJ, Sadock VA (Eds). Comprehensive Textbook of Psychiatry, 8. Baskı. (Çeviri Ed. H Aydın, A Bozkurt): 755-778. Ankara, Güneş Kitabevi.

Okay D, Canel Çınarbaş D (2021) Kendilik psikolojisi yaklaşımı üzerinden bir çekingen kişilik olgusunun incelenmesi. Nesne Psikoloji Dergisi, 9:204-220.

Olajide K, Munjiza J, Moran P, O'Connell L, Newton-Howes G, Bassett P et al. (2018) Development and psychometric properties of the Standardized Assessment of Severity of Personality Disorder (SASPD). J Pers Disord, 32:44-56.

Öztunç H, Bilge Y, Bilge Y (2015) Kişilik bozuklukları ile gelir ve cinsiyet değişkenlerinin ilişkisinin incelenmesi. Yakın Doğu Üniversitesi Sosyal Bilimler Dergisi, 8:63-82.

Öztürk MO, Uluşahin A (2011) Ruh Sağlığı ve Bozuklukları I-II, 11.Baskı. Ankara, Nobel Tıp Kitabevleri.

Quirk SE, Berk M, Chanen AM, Koivumaa-Honkanen H, Brennan-Olsen SL, Pasco JA et al. (2016) Population prevalence of personality disorder and associations with physical health comorbidities and health care service utilization: A review. Personal Disord, 7:46-136.

Rogers CR (2018) Kişi Olmaya Dair (Çeviri ed. A Babacan). İstanbul, Okuyan Us Yayınları.

Schultz DP, Schultz SE (2007) Modern Psikoloji Tarihi (Çeviri ed. Y Aslay). İstanbul, Kaknüs Yayınları.

Sellbom M, Brown TA, Bach B (2024) Development and psychometric evaluation of the Personality Disorder Severity ICD-11 (PDS-ICD-11) clinician-rating form. Personal Ment Health, 18:60–68.

Sevinçok L, Dereboy F, Dereboy Ç (1998) Çekingen kişilik bozukluğunun klinik özellikleri ve tedavisi. Klinik Psikiyatri Dergisi, 1:22-26.

Sezer Katar K, Gökçen Gündoğmuş A, Örsel S (2022) Kişilik inançları ve DSM-5'e göre boyutsal kişilik özellikleri arasındaki ilişkinin araştırılması. JCBPR, 11:136-146.

Sharf RS (2017) Psikoterapi ve Psikolojik Danışma Kuramları (Çeviri ed. N Voltan Acar). İstanbul, Nobel Akademik Yayıncılık.

Skodol AE, Morey LC, Bender DS, Oldham JM (2015) The alternative DSM-5 model for personality disorders: A clinical application. Am J Psychiatry, 172:606-613.

Svela EW, Korsgaard HO, Stänicke LI, Ulberg R (2022) Inter-rater reliability of the Structured Interview of DSM-IV Personality (SIDP-IV) in an adolescent outpatient population. Int J Environ Res Public Health, 19:12283.

Swales MA (2022) Personality disorder diagnoses in ICD-11: transforming conceptualisations and practice. Clin Psychol Eur, 4(Spec Issue):e9635.

Şener A, Bora E, Tekin I, Özaşkınlı S (2006) Şizotipal kişilik ölçeğinin üniversite öğrencilerindeki geçerlik ve güvenirliği. Klin Psikofarmakol Bulteni, 16:84-92.

Şenyuva HŞ (2007) Aydın ilinden alınan normal bir örneklemde kişilik bozukluklarının yaygınlık çalışması (Doktora tezi). Aydın, Adnan Menderes Üniversitesi.

Şimşek A, Kaya Y (2020) Histeriden histrionik kişilik bozukluğuna. Social Science Development Journal, 5(20):1-12.

Taymur İ, Türkçapar MH (2012) Kişilik: tanımı, sınıflaması ve değerlendirmesi. Psikiyatride Güncel Yaklaşımlar, 4:154-177.

Töre T (2023) Comparative examination of ICD-11 and DSM-5 alternative model in personality disorders. Psikiyatride Güncel Yaklaşımlar, 15:189-202.

Tuncer M, Kapısız Ö, Dönmez N. (2018) J. F. Masterson yaklaşımı çerçevesinde şizoid kendilik bozukluğu ve bu yaklaşım çerçevesinde tanımlanmış bir danışanın psikoterapisinin uygulanması. Türkiye Bütüncül Psikoterapi Dergisi, 1:79-99.

Türkçapar MH, Örsel S, Uğurlu M, Sargın E, Turhan M, Akkoyunlu S et al. (2008) Kişilik inanç ölçeği Türkçe formunun geçerlik ve güvenirliği. Klinik Psikiyatri Dergisi, 10:177-191.

Uluç PS, Vatan PS, Işıklı, PS (2014) MMPI lineer T puanları ve MMPI-2'nin tek tip T puanlarının Türk yetişkin örnekleminde karşılaştırılması. Turk Psikiyatri Derg, 25:190-200.

Vatan S, Dağ İ (2009) Problem çözme, umutsuzluk, çaresizlik ve talihsizlik MMPI-2 ile ölçülen psikopatolojinin yordayıcıları olabilir mi. Anadolu Psikiyatri Derg, 10:187-197.

Volkert J, Gablonski T, Rabung S (2018) Prevalence of personality disorders in the general adult population in western countries: systematic review and meta-analysis. Br J Psychiatry, 213:709-715.

Waugh MH, Hopwood CJ, Krueger RF, Morey LC, Pincus AL, Wright AG (2017) Psychological assessment with the DSM–5 alternative model for personality disorders: tradition and innovation. Prof Psychol Res Pr, 48:79-89.

WHO (2010) International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10). Geneva, World Health Organization.

WHO (2021) International Statistical Classification of Diseases and Related Health Problems 11th Revision (ICD-11). Geneva, World Health Organization.

WHO (2024) WHO Advances implementation and integration of ICD-11 and related medical classifications and terminologies. https://www.who.int/classifications/classification-of-diseases (Accessed: 05.07.2024).

Widiger TA, Costa PT (1994) Personality and personality disorders. J Abnorm Psychol, 103:78-91.

Winsper C, Bilgin A, Thompson A, Marwaha S, Chanen A, Singh S et al. (2019) The prevalence of personality disorders in the community: A global systematic review and meta-analysis. Br J Psychiatry, 216:69-78.

Yazgan İnanç B, Yerlikaya EE (2012) Kişilik Kuramları, 6.Baskı. Ankara, Pegem Akademi Yayıncılık.

Yıldırım GGC (2020) Kişilik organizasyonları envanterinin Türkçe uyarlaması: geçerlik ve güvenirlik çalışması (Doktora tezi). İstanbul, Doğuş Üniversitesi.

Authors Contributions: The author(s) have declared that they have made a significant scientific contribution to the study and have assisted in the preparation or revision of the manuscript
Peer-review: Externally peer-reviewed.
Conflict of Interest: No conflict of interest was declared.
Financial Disclosure: No financial support was declared for this study.