DOI: 10.6092/2282-1619/2015.3.1062

Mediterranean Journal of Clinical Psychology MJCP

ISSN: 2282-1619

VOL. III, N. 1 (2015)

Clinical Aspects of Personality Disorder Diagnosis in the DSM-5

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Abstract: Personality disorders represent psychopathological conditions hard to be diagnosed. The Author highlights the clinical aspects of personality disorder diagnosis according to the criteria of the DSM-5. In this study, some of the numerous definitions of personality are mentioned; afterwards, some of the theories on the development of personality shall be. Later on, concepts of temperament, character and personality get analysed. Then, the current approach to personality disorders according to the two models of DSM-5 is reported. The first model is included in the Section II of DSM-5; while in the Section III there exists a proposal for a so-called *alternate model*. The first one suggests a qualitative or categorical kind of approach to personality disorders, whereas the alternate model proposes a dimensional or quantitative kind of approach and aims to formulate, as well as a diagnosis for general alterations of the personological functioning, even a trait-based personality disorder diagnosis, which can be formulated when a personality disorder is there but doesn't fit criteria for a specific disorder. Ultimately, it can be so claimed: 1) diagnostic criteria of the first model are similar to those of DSM-IV with its respective strenghts and weaknesses, and namely high probability in diagnosis, where there, of personality disorder, yet insufficient sensitivity in the specification of the disorder; 2) the alternate model, despite criticism, thanks to the possibility of delivering

a trait-based personality disorder diagnosis, seems to be more equipped both in the identification of the personality disorder and further specifications.

Keywords: Clinical aspects, Personality disorders, Alternate Model, DSM-5.

The term "personality" stems from the latin word *persona*. In theathers of ancient Rome, actors used to wear, alternatively, a certain amount of masks, called "*personae*" (e.d. persons) indeed, which would make it apparent to the public which attitudes and behaviours to expect from actors. Overtime, the term *persona* ended up identifying not just with masks, but the with roles which they envolved as well and, ultimately, it would relate to the very actors. Due to a continuous relationship with such tradition, nowadays this term still does include a variety of expectations on the adoption, in brand new contexts, of specific behavioral patterns (Caprara, Gennaro, 1994). The term *personality*, with its original meaning "mask for actors", became a metaphor for the psychological type represented in theathers and, by extension, the psychological type of single individuals. "The concept of *personality* involves one of the hardest issues that science and philosophy have ever raised; by saying "personality" we refer to the synthesis of all faculties and attributes of the human subjectivity; the whole of characters and of attributes which belong to a specific somebody and "by saying person, we shall say *individual*, that is, the thinking man"; personality, in such synthesis, is meant to identify a subject among a million like him: it's the unification of an endless number of characthers, factors and attributes in the individual, which creates a self-standing world, utterly autonomous, provided with an inner causality, which is the spiritual completeness of the subject." (Florian, Niceforo, Pende, 1943) Afore the variety of the problems which emerge from its definition, it is no wonder that some have spotted, in **personality**, the *place where the problems of psychology (Sève, 1969) and the ultimate and most complex of its aims* (Meili, 1963) *are gathered.*

Presently, it now would seem worthwhile to *scan solely some of* ***the very numerous definitions*** *of the concept of personality* under a psychological, sociological, psychiatric, criminological, forensic-psychiatric light, and so on. On the other hand, as of **theories on the development of the personality,** *only some will be briefly mentioned, given the vastity of topics in this sense*. It's important to point out that no definition of personality can describe it exhaustively, be it because all scholars have always begun their researches stemming from diverse groundworks, ideologies and experiences, and even when an agreement among the different doctrinal positions was found, a conciliation was limited to specific points, whereas, on many others, meaningful gaps lingered. Therefore, rather than focusing on this one matter, in order to spot the most suitable definition, it might seem more convenient for us to recall the most notorious Scholars' opinions. According to the most common dictionaries, *personality* is the complex of the specific attributes of a person. (Palazzi 1939, Garzanti 1970), namely the wholeness of the psychic features of an individual. (Dardano 1990), plus the personal, typical and specific being of an individual (Treccani 1991).

The international dictionary Webster defines *personality* as the "wholeness, in one individual, of the emerging tendencies in the acts and in behavior" and "the organization of the traits, of the specific attitudes /habits which mark an individual". According to Jaspers (1964), personality is "the whole complex of the comprehensible relationships of the psychic life which are individually different and specific".

In Freud's studies (1980*) we shall not find any definition of personality but we may stem it* from his assay on the psycho-sexual development and on the organization of the psychic system. On the one hand, personality is a way to establish a relationship with the outer world, which mirrors the events of an inner evolutional process. On the other, personality is a firm organization of attachments, awareness and behaviors which mirror the relationship between mental structures which own and rule all of the exertions of psychic energy (Caprara, Gennaro, 1994). As Bergeret points out (1974), the concepts of Freud (1980) on character have led to a further development of his theories in post-freudian works*: Abraham* (1924), *Alexander* (1930), *Glover* (1932, 1958),

Menninger (1958, 1963), *Scott* (1962), *Winnicot* (1969).

Theories on personality have raised issues about the appropriate method to adopt for surveys about it. The development of projective tests has contributed, above all, in giving a place in pshychology to the formal study of personality, by allowing it to become a legit investigation, relatively independent from issues in diagnosing and treatment. For biologists and psychologists, personality is given by the complex of organic functions which show in the physical build; by dispositions, that is tendencies, by istincts and by the highest feelings (Campailla, 1960). Personality has hence its roots in the deepest world of feelings, istincts and tendencies, it imposes and reveals itself through actions and thoughts and through the act of the Self.

The personality of an individual is "what which he is", namely what his genetic patrimony and the events in his life have enabled him to become. (Garzotto, Lattanzi, 1989). For Pichot (1965), it (e.d. *personality*) is the result of the habits acquired throughout growth (Lemperière, Féline, Gutmann, Ades, Pilate, 1989).

For Rossini (1969), it is a customized psychic life, that is specific and characteristic for a certain individual; it incorporates both the conscious and the unconscious sides, the latter seen under a more properly biological light as well. For Janet (1929), it is "the ultimate expression of a labor towards wholeness and distinctiveness: that is the whole of operations needed for an individual for building, maintaining and improving his wholeness and his distinctiveness before the rest of the world". Rotter defines personality "the characteristic way of reacting in an identifiable situation" (1972). According to Canepa (1952, 1974) "Personality is the whole of the emerging data from the thorough exam of a certain individual, who is examined with the aid of all the most recent and credited methods which science is able to provide, so as to differentiate him from the others". According to the above-mentioned scholar, this is the methodological concept of personality, the one which can be uttered in an empirical sense without any direct experience of it. Allport (1955) reports 18 thousand appropriate English terms for the description of specific features in the behavior of the individual, and in facing this issue, this scholar reports 50

definitions which discloses the complexity of this topic.

Of the above-mentioned definitions, the more strictly psychological ones can be divided into 7 groups:

a) **biosocial.** In this one, personality is regarded the way in which it is regarded in the common parlance, with the implication of a value-dependent judgement;

b) **biophysical**. Personality is here shaped in function of its traits which, although with different connotations, are related to and express either explicitely or not, psychological tendencies sticking to neurological functions and structures.

c) **omnibus**. Here, it is regarded as all what which relates to an individual;

d) definitions pointing out **its integrative and organizational function**.

e) definitions focusing on the **adaptive function** of personality to reality;

f) definitions which spot in personality **unique, individual** and **differential aspects** of each subject;

g) personality seen as the **essence**, the most representative part of the human being, "that which someone really is"(Cesa-Bianchi 1965).

According to Ponti (1990) "personality doesn't express but the wholeness of the terms employed for describing an individual" and "can hence be defined as the complex of features of each individual, the ones which show in the modes of his social living, in the kind of his interrelations with others and with the surrounding envinronment, in the relations with the community".

According to Franchini and Introna (1961) "as regards to forensic-medical and criminological aims, personality can be defined as the set of physical and psychic attributes which distinguish an individual, the synthesis of his manners of being". According to Bandini and Gatti (1987) "*personality* is the individual patrimony consisting of the integration of cognitive, motivational, emotional, morphological and physiological aspects of an

indivual". For others, personality is "the singular structure of its own attributes" (Guilford 1959), "the control unit of the body, an institution which continuously produces modifications from birth to death. (Murray 1936, 1938, 1943, 1962) (De Cataldo-Neuburger 1987).

Angyal (1941) extends the concept of integrating oneself, in the environment in which one lives, by introducing the concept of biosphere, including individuals and environment as aspects of one reality, which could only be separated from one another theoretically. In the biosphere, three dimensions are acknowledged: the vertical one, expressed by the existing connection between external behavior and deep tendencies; the progressive one, given by the inclusion of each action into a sequence of aimed actions; the transversal one, in which each action is inserted within an integrated behavior.

Lecky (1945) identifies the basic trait of personality, in the ability of maintaining a unified and self-consistent arrangement in an unstable environment from which it assimilates its own coherent values, rejecting others.

Maslow (1954) considers personality as an integration of basic needs, divided into physiological needs such as hunger and thirst, confidence needs, belonging needs and loving needs. Eventually, cognitive and aesthetic needs.

Lewin (1935) conceives psychological data as an organization of an energy field similar to an electromagnetic one, with a tendency towards inner-system balance. In such field, one occupies the central position and is surrounded by the psychological environment with which he interacts through a system of tensions, that can arise either from the mutation of the psychological environment or within person in the form of a need. This tension status activates processes such as thinking, acting, remembering, which continue to operate until the system balance is reached (Galimberti, 1992).

For Murray (1936, 1938, 1943, 1962), personality is like a system in which needs related to dissatisfaction, pressures related to objects of which they represent their real attributes (alpha) or perceptions (beta), are spotted, in order to fulfill one's needs; *theme*, which is the coherent need and pressure

unit making meaning out of certain behaviors and, finally, positive or negative *cathexis*, with which objects either attract or reject the individual, having his subjective corresponding in feeling. These traits making up personality can be demonstrated through the Thematic Apperception Test (T.A.T.), devised by Murray.

Murphy (1947) assumes as basic personality constituents physiological dispositions, canalizations through which energy is released with behavior, conditioned responses and cognitive/perceptive habits, which are the product of both canalization and conditionings. Within the development of personality, this Author distinguishes three stages: the global, the diversified and the integrated stage.

For Kelly (1955) each individual is guided by prediction about events that he will experience. This anticipatory activity leads him to issue personal constructs, dichotomous categorizations that he adopts against each element present in the environment. The organization of these constructs, their extension, hierarchy and modification give a picture of the individual's personality.

"The wholeness of thoughts, feelings and actions that a person is accustomed to use in his daily adjustments to life" (Freedman, Kaplan, Sadock, 1984).

"The specific manner of thinking and acting which identifies each person as a unique individuality" (Stagner 1961).

"The peculiar and unrepeatable essence of each person, which is expressed in the behavior and in the subjective experience of the Self lived as unitary, continuous, persisting overtime; that is, man perceives and is aware of himself, of being different and distinct from others, of maintaining his own individuality in his personal story, although with the gradual and continuous evolution of his own features; what he perceives is being perceived by others through his verbal and non-verbal behavior". (Balestrieri, 1986)

For Hall and Lindzey (1978), "personality is what orders and provides congruency to all different manners of behavior in which the individual express

himself".

The concept of personality is not really the outcome of experimental findings or clinical investigation, rather the expression of the theoretical basis on which researches and surveys are based, it is synonymous with the idea of the organismic functioning of the whole individual, or what allows the prediction of what a person will do in a given circumstance. About the different personality features, Jung (1921) spots four psychological functions: **thinking, feeling, sensation** and **intuition**; he also identifies two basic attitudes: **introversion** and **extroversion**. Different personalities are the results of the different possible combinations of functions and attitudes. Hence, Jung (1921) has identified eight psychological types:

1) the extrovert or introvert kind of thinking;

2) the extrovert or introvert kind of feeling;

3) the extrovert or introverto kind of sensation;

4) the extrovert or introvert kind of intuition.

Multifactorial analysis was applied to the studying of personality by Cattel (1950, 1965, 1985, 1990) and by Eysenck (1947, 1952, 1970). For Cattel personality is what allows the prediction on how an individual will behave in a given situation and traits are those particular mental structures which describe personality and that render this prediction reasonable. For Cattel there exist **surface traits**, which are unstable and present in each individual. Because of their charateristics, these traits don't prove needful in behavioral prediction. Then there are the so-called **origin traits** that proved more needful in predictions because of their major stability (Cattel, 1950, 1965, 1985, 1990), (Galimberti, 1992). Moreover, there are the so-called **unique traits**, such as pathological ones. Cattel spots traits stemming from three different data sources: evaluation of real life, self-evaluation and objective tests. (see Cattel-test 16 PF). He also conducted a deeper investigation on the motivational and dynamic aspects of personality through the Motivation Analysis Test (M.A.T.). Eventually, Cattel aims to provide structural and

dynamic models of personality, capable to give account of bescriptive and motivational aspects governing human behavior. (Caprara, Gennaro, 1994).

Eysenck (1947, 1952, 1970) defines personality "the number of the behavioral patterns of the organism, both actual and potential, inborn or acquired. Personality originates and develops through the functional interaction of the four main areas in which behavioral patterns are arranged: **cognitive (intelligence), conative (character), affective (temperament), somatic (physical build) areas".**

Antonelli e Salvini (1987) take personality into consideration in a dual perspective:

1) ***dynamic-motivational;***

2) ***characterological- structural.***

According to the first perspective "the concept of personality becomes an abstraction... a methodological device for helping us grasp the aspects... of the manner of being in the world." (Antonelli, Salvini, 1987). It is a dynamic system in which an interaction among multiple factors occurs: **istinctive ones, phylogenetic ones** (meaning by phylogeny the heritage of the human species which, in 3 million years, has stored patterns of adjustment and behavior inherent in its neuro-psychological structure); **ontogenetic** ones (meaning by ontogeny the set of the interactions between biological predispositions and the human environment, experienced in the developmental age: the amount of the affective, cognitive experiences and influences which determine personality structure, both by individualising it and by directing it, on the basis of the subjectively most significant motives) (Antonelli, Salvini, 1987); **hereditary ones** (meaning by heredity the genetic inheritance transmitted by parents, not seen as a "fate", but as a probabilistic constituent). Eventually, we shall mention **motivational, situational** and **cultural ones**. The latter are mostly unconscious, they interact with one another and they are hierarchically structured. Therefore, this condition leads to synergistic or conflicting phenomena, which are perceived on a intrapsychic, interpersonal level by personality. According to the

characterological-structural perspective, personality is 1) the set of all psychic and morpho-physiological features of an individual; 2) the concept of personality not only includes the complex of the different psychic functions, but their mutual cooperation or interference as well, their hierarchical structure, relationships between psychism and its shape (typology), age-related changes (development age, maturity, involution), the malleability shown while facing frustrations and conflict with the capability of the Self for defensive reactions, the tools to assess balance and dotation; 3) personality includes individuality too, that is the way each person represents him/herself, the consciousness of the individual psychic unity. (Antonelli, Salvini, 1987)

For Caprara and Gennaro (1994), *normal* personality is set up as a hierarchical organization of functions, seen as a stable constellation of manners of knowing, desiring and acting, as a system constantly interacting with other systems, provided with the faculty of enlarging, in the developmental age, one's levels of freedom in relation to the restrictions given by the biological nature and the physical and social environments; eventually, as an emerging entity provided with self-reflective and self-generating attributes.

In the different psycho-dynamic addresses, personality is set up as an affective-cognitive organization, resulting from the cooperation of drives coming from within and constantly competing with pressures and constraints from the outer world. (Caprara, Gennaro 1994)

As part of **the dispositional perspective**, personality is set up as an inborn trait-based constellation.

As part of the **behaviorist perspective**, personality is set up as an arrangement of "scripts", learned through the selective action of the surrounding environment. (Caprara, Gennaro, 1994)

As part of the **socio-cognitivist** and **interactionist perspectives**, personality is set up as an open system processing information, generating meanings, reacting and acting in the environment in terms of mutuality.

Some suggest that, as regards both to the pathological and the normal personality, a psycho-analytic model may be employed, meaning by this a coexistence of specific functioning areas of the mind at different times in the psychic life of the very same individual. That is, more specifically, the concept of psychotic nucleus of personality (Bion 1967). Each individual has mental functionings and potentially more regressive responses resulting from the psychotic aspect of personality. This state of the mind always does coexist with another one, known as *non-psychotic personality (neurotic part of personality).* (Gabrielli, Moscato, 2007)

Arieti states (1969) that, *even though no definition about personality is considered unanimously effective, there exist many explanations about this phenomenon*; some think this is due to the not-yet-mature science of personality; some others think this is an actual and unchangeable truth, due to the very nature of personality or to inhexorable divergencies of philosophical viewpoints, or to the basic psychological structures given by theorists of personality: a definition may appear more convenient than others according to specific problems of personality. Hence, a definition of personality, rather than being a source of actual knowledge about personality itself, shows the point of view and the skills of its theorist.

When it comes to personality, concepts of **temperament** and **character** inevitably come to play a role in it.

In the common parlance, these three terms are often used interchangeably as synonyms for indicating the psychological features of an individual; whereas in scientific speech, most Authors agree in giving the concept of personality a very broad meaning, extended to the whole psyche of the subject, while the concepts of character and temperament are listed apart from personality, although they represent its outward appearance, the one which shows to other people.

Ponti (1990) and Mantovani (1984) state that *boundaries between the different concepts of personality, temperament and character are so ambiguous that these terms get often identified with one another or get*

replaced with one another, so differentiations are aimed, more than anything else, to providing bases, for accurate *distinctions cannot acquire an axiomatic value*.

Temperament (from the greek *temperà* = *mixture*, related to mood) is the inborn, organic base, sometimes genetically determined of an individual and his specific arrangement of the various ways of reacting specifically to the environment; we speak, indeed, of lively, torpid, calm and dramatic temperaments, etc. (Rossini 1969) (Freedman, Kaplan, Sadock, 1984) (Balestrieri 1986) (Ponti 1990)

According to a **phenomenological-descriptive criterion**, Gabrielli and Moscato (2007) spot four main temperaments:

1) depressive or dysthymic temperament;

2) hyperthymic temperament;

3) cyclothymic temperament;

4) irritable or dysphoric temperament.

In such perspective, temperament is, within certain limits, unmodifiable, moreover the endless existential circumstances modify temperament, providing an individual with modes of acting and reacting, even different from the inborn ones: this is what we mean by *character*.

Some AA. have assumed the possible action of brain neuro-transmitters on four character dimensions: cognition-perception (dopamine), impulsivity-aggression (serotonin), affective instability (noradrenaline or acetylcholine) and anxiety-inhibition (GABA or norepinephrine). Hence, character stands for the result between temperament and environment.

The changeability of the character is relative, though, since temperament's deep core, beyond the range of life's experiences, stays unchanged; therefore, in character lies an overtime inherent constituent becoming less and less changeable as age progresses. *Thus, both temperament and character are*

included in the concept of personality.

Personality develops and evolves from birth to adulthood (conventionally, fixed as from 18 years old), a time in which it is assumed that biological systems at the bottom of the temperament have matured enough and that basic educational and maturational experiences related to the character have been fullfilled.

Instead, the *appearance of a later alteration in personality requires a careful diagnostic assessment aimed to acknowledging the likely presence of an organic disease* (personality change due to a general Medical Condition, like, for instance, a head trauma or to the effects of Drugs or medications).

Turning now to discuss personality disorders, we will stick to the criteria proposed by the DSM-5 in Section II (2013) without, however, neglecting a brief history on the classification of these disorders related to the -by now- classical definition by Schneider which has represented for several decades the basis for pshychologists, clinical and forensic psychiatrists, etc.

In **1923**, Schneider, under the name of *psychopathies*, described a certain amount of pathological personalities in relation to a so-called deviation from the so-called *norm*, according to the sphere of istincts, feelings, will and reactivity which are all ultimately characterised by an abnormal behavior.

Schneider divided these ten individual into **10 personological types**: **hyperthimic, depressive, self-unconfident** or **disquiet** (the latter defined *sensitive* by Kretschmer, 1955**), fanatic, personalities in need of asserting themselves, unstable or individuals with labile moods, explosive personalities, apathetic** or **cold**, **aboulic, asthenic**. Agreeing with the Schneiderian definition ("subjects who suffer about their abnormality or cause suffering in society"), Catalano-Nobili and Cerquetelli (1974) divide psychopath personalities into **neurotic** and **sociopathic ones**. Subjects diagnosed with **psychopath-neurotic personalities** have a structure characterised by a neurotic self which can either be hysterical, obsessive, anxious, etc.; moreover, there exist a neurotic conflit followed by control and defensive measures which sometimes lead to distorsions in dynamic

interactions with the environment. (Sarteschi, Maggini, 1990) *These individuals live their disorder as **ego-dystonic*.** **Socio-psychopath personalities** exert a behavior which doesn't evoke any subjective pain (anguish and guilt feelings). Their typical "*I can't go back*" and "*I can't give in*" causes a unilateral existential process on which psychopath modes of the interhuman encounter are based. (Sarteschi, Maggini, 1990). *These subjects live their disorder as **ego-syntonic***. For Cazzullo (1993), when alterations in the sphere of the personal and social functionings occur, then it comes to personality disorders: behavior, relational manner, adjustment, emotional control, motives, inner coherence, planning ability, insight and compensation, which come together into "the capability of an individual of redeeming oneself for his frustrations and of fixing losses by promptly re-establishing the previously-threatened psychological balance."

This classification was basically used for legal-medical assessments (Giberti, Conforto, 1996). Later on, among the several proposed nosographies, the ones by the DSM (in its different editions) and the ones proposed by ICD took over and defined these psychopathies **personality Disorders**, in which both ***sufferers*** (whose pain mainly concern psychiatry, especially as regards to the difficult impact with environment) and those **who cause suffering in society** (which mainly concern sociology and criminology) are included; but that doesn't involve that all those who commit crimes suffer from a personality disorder unlike those others who commit crimes right because of their disorder. *The current approach to personality disorders is reported in the Section II of the DSM-5 (2013) whereas, in the Section III, an alternate model is presented. The inclusion of both models in the DSM-5 mirrors the decision of preserving the continuity with current clinical practice, aside than introducing a new model aimed to facing several faults in the current approach to personality disorders.* For example, a patient who meets criteria for a specific personality disorder often fulfills those for other personality disorders. Likewise, a personality disorder diagnosis, with or without further specification, is often accurate (but most times, not any informative), meaning that there is a tendency for patients to occur with patterns of symptoms which do not uniquely match one personality disorder. *In the DSM-5 alternate*

model, personality disorders are characterised by impairments in the personality functioning and pathologic personality traits. Specific diagnoses for personality disorders resulting from this model cover six personological disorders: antisocial, avoidant, borderline, narcissistic, obsessive-compulsive and schizotypal disorders. *This approach includes, as well, a trait-based personality disorder diagnosis* (TB-PD) which can be issued when a personality disorder is thought to be there but criteria for a specific disorder are not fulfilled.

The DSM-5

In the DSM-5 alternate model, self-functioning and interpersonal functioning disorders form personality's psychopathology deep core and are assessed across a continuum. Self-functioning includes identity and self-directionality; interpersonal functioning includes empathy and intimacy; the **Level of Personality Functioning Scale** (*L.P.F.S.)* uses each of these elements for **distinguishing 5 impairment levels,** ranging from little or no impairment (that is, sane, adaptive functioning, level 0) to a slight (level 1), moderate (level 2), severe (level 3) and extreme (level 4) impairment. Personality trait-based system in the Section III includes **five major trait-variant domains-** negative affectivity (as opposed to emotional stability), detachment (as opposed to extraversion), antagonism (as opposed to disposability), disinhibition (as opposed to conscientiousness) and psychoticism (as opposed to mental Lucidity)-each consisting of **25 specific trait facets**. These five are maladaptive variants for the personality model's five domains, largely validated and replicated, known as "Big Five" or personality "Five Factor Model" (F.F.M.); trait facets also resemble Personality Psychopathology Five (PSY-5). **The 25 specific facets represent a personality facet-list selected according to their clinical relevance.** Ultimately, the L.P.F.S. provides brief descriptions on the typical functioning of each domain according, as aforesaid, to the severity level and the clinician is in due of selecting the level which he considers the most descriptive about the functioning of the individual. If the subject shows up with either a grave or moderate impairment level (score +2 or above) in two or more of the four areas (identity, self-directionality, empathy and intimacy), then it comes to criterion

B and pathological traits' presence is assessed. Traits, both of higher (trait domains) and lower (the 25 specific trait facets) order are meant in a dimensional sense, along a spectrum which covers the manifestations of the examined feature: for example, Psychoticism versus mental Lucidity. If the patient's profile matches the one described by the set of criteria for one out of the six personality disorders taken into consideration, then the clinician will issue a specific personality disorder diagnosis. If, however, the subject might show up with an impairment in the level of personality functioning in association with some pathological traits (wich, though, do not fit profiles of any out of the six disorders), then the clinician will have to formulate a trait-based personality disorder diagnosis. Trait-based personality disorder's diagnosis includes all subjects with a mixed or atypical personality disorder manifestation (Lingiardi, Gazzillo, 2014). Among the devises proposed by the DSM-5 for the evaluation of traits, we will find Personality Inventory for DSM-5 (PID-5) in the self-administered version and in the one for the informant; we will also find a brief version (PID-5-BF), both for adults and for kids ranging from 11 to 17 years old.

They were written down on the basis of meta-analytic revisions and empirical data, according to the existent relationships between traits and personality disorder diagnosis in the DSM-IV. The **clinical utility** *of the multidimensional model of trait-based personality, reported in the Section III,* lies in its inherent capacity of focusing attention on the multiple significant areas of personality's variation in each individual patient. Rather than focusing on the identification of a *sole optimal diagnostic label, trait-based personality's clinical application in the Section III* requires taking into account each of the five major personality domains. The alternate model of DSM-5 has received much criticism because its use has been considered unwieldy by clinicians even if it seems to be more equipped in comparison with the model of the Section II both in the identification of the personological disorder and in its specification. *The general criteria for a personality disorder diagnosis, according to the Section II of the DSM-5, will follow here:*

A) a habitual pattern of inner experience and behavior which

remarkably deviates from the expectations on the indivual's culture. This pattern manifestates in two (or more) of the following areas:

1) Cognition (ie, ways of perceiving and self-interpreting, interpreting others and events).

2) Affectivity (that is, variety, intensity, lability and appropriateness of the emotional response).

3) Interpersonal functioning.

4) Impulse control.

B) The usual pattern proves inflexible and pervasive in a vastity of personal and social situations.

C) The usual pattern causes clinically significant discomfort or functioning impairment in social, occupational and other important areas.

D) Pattern is stable and long lasting and its onset might date back at least to adolescence or early adulthood.

E) The usual pattern is not any better accounted than as a manifestation/consequence of any other mental disorder.

F) The usual pattern is not due to physiological effects of a substance (for example, a Drug or a medication) or to any other medical condition (for example, a head trauma).

The DSM-5 in the Section II lists the following 10 specific personality disorders: *paranoid, schizoid, schizotypal, antisocial, borderline, histrionic, narcissistic, avoidant, dependent and obsessive-compulsive disorders.*

3 more personality disorders are also mentioned asunder:

1) **personality's modification due to another medical condition;**

2) **personality disorder with other specification;**

3) **personality disorder without specification.**

Personality disorders are gathered into three groups according to descriptive similarities.

Group **A** includes paranoid, schizoid and schizotypal personality disorders. Individuals with these disorders often appear odd or kinky. Group **B** includes antisocial, borderline, histrionic, narcissistic personality disorders. Individuals with these disorders always appear showy, emotional or unpredictable. Group **C** includes avoidant, dependent, obsessive-compulsive personality disorders. Individual with these disorders often

appear anxious or fearful. Individuals frequently have a combination of personality disorders from different groups. Most ratings of all groups suggest 5,7% for disorders of group A, 1,5% for disorders of group B, 6% for disorders of group C and 9,1% for each personality disorder, which provides evidence to a frequent combination of the disorders of the different groups.

Many of the features present in the specific criteria of the Section II of the DSM-5 (2013) for delivering personality disorders diagnoses occur in other psychiatric disorders previously classified in the Axis I of DSM-IV-TR (2000) without, though, necessarily sticking to the greater affinity criterion (for example, avoidant personality disorder is more frequently associated with Obsessive-Compulsive disorder than it is for obsessive-compulsive personality disorder). Prognosis for a patient presenting a psychiatric disorder classified in the Axis I of DSM-IV-TR (2000) and diagnosed with an associating personality disorder is usually less favourable. *Some personality disorders types (especially antisocial and borderline personality disorders) tend to be less apparent* or to regress as age progresses, whereas this is less apparent for other types (for example, obsessive-compulsive and schizotypal personality disorders). Some personality disorders (for example, antisocial) are more frequently diagnosed in **males.** Others (for example, borderline, histrionic and dependent personality disorders) are diagnosed more frequently in **females**. Although these differences mainly reflect real gender differences, afore such patterns, clinicians ought to be heedful not to over/underdiagnose certain personality disorders either in male or in female individuals according to social stereotypes on typical gender roles and gender-related behaviors.

A personality disorder should be diagnosed solely when its defining features are typical **in the long-term functioning of the individual** and not exclusively related to another psychiatric pathology. At times, it may be difficult to discriminate a personality disorder from other early-manifestating and chronical course psychiatric diseases, like in Dysthymic Disorder. *Some personality disorders may also take part into* a **symptoms-syndromic continuum (spectrum)** *towards other psychopathological conditions* (for example, Schizotypal personality disorder and schizophrenia; Avoidant Personality Disorder and Social Phobia); (Gabrielli, Moscato, 2007)

When a personality disorder shows up before chronical /recurrent psychiatric diseases do (certain Schizophrenia forms or Depressiom with psychotic symptoms), it may be reported as **pre-morbid** and sometimes it

may have a predisposing role.

Alternatively to the **categorical approach** (proposed by the DSM-5 in the Section II) according to which personality disorders are self-standing clinical syndromes which are **qualitatively** distinguished, **dimensional** or **quantitative** diagnostic models were proposed (in the alternate model of the Section III of the DSM-5) which require the distribution, ranging from a minimum to a maximum, of the different psychopathological observed manifestations. The perks of such approach might lie in the possibility of evaluating the severity of each individual form (slight, moderate and severe) and, mostly, of diagnosing intermediate and mixed forms with a combination fo the different personality disorders. (Gabrielli, Moscato, 2007).

There have been many attempts of identifying basic dimensions underlying the whole personological functioning area, both the normal and the pathological one. One of these approaches consists of describing the most frequent personality dysfunctional areas, including several dimensions (for example, affective responsiveness, social apprehensiveness, cognitive distorsion, impulsivity, lack of honesty, egocentricity). Other dimensions proposals include: positive affectivity, negative affectivity and inhibition, pursuit of newness, addiction to gratification, avoidance of damage, persistence, auto-directionality and cooperativeness; power (dominance versus submissiveness) and affiliation (love versus hate); pursuit of pleasure versus avoidance of pain and passive adaptation versus active modification (Gabrielli, Moscato, 2007).

In literature there exist *numerous experimental studies regarding the clinical validity of personality disorder diagnosis* through the analysis of the two models proposed by the DSM-5 in the Section II and III. Of the latter, only a few shall be briefly mentioned even though, both the categorical (Section II) and the dimensional approach (Section III) ultimately have pros and cons, something which leads to the necessity of further and more intensive studies, aimed to provide one model with supremacy over the other. *The ultimate goal would be to render* ***diagnoses*** *and, accordingly,* ***treatment in clinical practice, more and more refined****.*

Schmeck et al. (2013) highlight the importance in the DSM-5 alternate model of identity in often delivering simultaneous diagnoses. This classifying alternate model allows, both clinicians and researchers, to be able to deliver far more detailed diagnoses than before. The importance of identity problems in evaluating and understanding personological pathology is spotted by Schmeck et al. (2013) exploiting the new approach in two

clinical cases of adolescents with a severe personality disorder.

Few et al. (2015) compared Section II and III of the DSM-5 with regard to antisocial personality disorder (ASPD) under a dimensional light (trait-based) and under a categorical light (based on externalizing behaviors). The Section III approach involves a psycopathy specifier (PS). This experimental study was conducted on a community sample (N=106) under mental health treatment. Both approaches have indicated high psychopathy scores, although Section III approach has shown almost twice the variance in comparison with Section II. A relatively small part of this predictability is more convergent with the concept of psychopathy. These results are mainly due to the trait-based model in Section III for ASPD rather than to psychopathy specifiers or to general personality dysfunction assessments.

Anderson et al. (2014) assessed continuity across the Section II and III models of personality disorders. The sample consisted of 397 undergraduate students, who were administered the Personality Invetory for the DSM-5 (Krueger et al., 2012) and the Structured Clinical Interview for the DSM-IV Axis II Disorders-Personality Questionnaire (First et al., 2013). It was examined whether facets of the Section III would match their counterparts in Section II, determining if those could augment the predictability of disorders of Section II. Results showed that, in general terms, disorders of the Section II were strongly associated with traits in the Section III. These findings provided support for the addition of not-yet-included facets in Section III, in order to augment diagnostic prediction.

Morey et al. (2013) attempted to determine whether a global evaluation on personality dysfunction through the use of LPFS proposed as a severity index for the DSM-5 would be associated with personality disorder diagnosis in the DSM-IV. Studies were conducted on a sample (N=337). Of those, 248 fulfilled criteria for one out of ten personality disorders of the DSM-IV; on the other hand, through the LPFS, 84,6% proved to be sensitive to the disorder and 72,7% proved evidence for specificity of the DSM-IV criteria. LPFS proposal in the DSM-5 has shown substantial validity correlations with existent treatment measures for personality disorders. The Scale proved itself to be the *best clinical prediction* and *assessment tool* of larger psychosocial mechanisms in personality functioning and can sometimes help determining risk, prognosis and needed treatment level for these diseases.

Zimmermann et al. (2014) have raised the preoccupation that *L.P.F.S.* would be relatively complex and conceptually burdensome, and would thus

overload clinical investigation. In order to overcome this issue, an assessment of the personality functioning was operated by 22 unexperienced, untrained students on 10 female patients under mental health treatment; for this purpose, a multi-element version of the LPFS was used. On the same sample, the assessment was replicated by experts. Results showed an acceptable inherent reliability of the Scale; in addition, the two assessments were compared in terms of severity of the disorders. This one comparison showed comforting results, as well. *These data suggest that, according to these AA., a successful application of the principles of the LPFS to clinical cases might not involve a massive clinical experience.*

In order to assess impairment in personality, some AA. propose to adopt the policy according to which personality deviates from the norm according to three different principles:

a) **statistical:** affective and behavioral relationships and cognitive functions statistically differ from those of the folk.

b) **functional:** social, occupational and relational functionings are inadequate.

c) **clinical:** as a consequence to abnormal reactions and behaviors the individual, his family and society experience pain.

As regards to **epidemiology**, aetiology and pathogenesis in personality disorders, several studies were conducted but none of these has come to definitive findings. The presence of personality disorders in people who have suffered traumatic or stressful experiences is very frequent. It's hard to figure out just how a certain personality disorder originates according to certain experiences. For some authors, personality disorders are a result of the interaction between:

1) genetically determined temperamental features;

2) growth in uncomfortable or frankly pathological familiar conditions and/or traumatic experiences;

3) level of social acceptability of one's own temperamental features.

Biological factors are possibly responsible of the specific way in which a personality disorder shall be shaped. **Social** and **psychological factors** possibly have a less specific effect in determining whether a particular vulnerability shall lead to a proclaimed disorder.

Aetiology and **pathogenesis,** as regards to personality disorders, as mentioned above, is pretty complex and probably multifactorial. It is not plausible, indeed, that a personality disorder might have only one environmental (for example, violence during childhood) or biological cause (for example, a gene). Available data about this matter indicate that these

disorders are perhaps the result of complex interactions between temperament (genetic and biologic factors) and psychological factors (growth/environment-related). Hales, Yudfosky, Talbott (2003) show that, even though the extent of the contribution of genetic and environmental factors in aetiopathogenesis might be variating in all personality disorders, these factors might play a role in all disorders. Subjects with such disorders have high rates in conjugal separation, vagrancy and child abuse; they have higher accident rates, more emergency room visits, more hospital admissions; also frequent violence episodes (including murders) and self-injurious behavior (suicide attempts suceeded or failed). The developmental history of the subject often shows individual difficulties and, as already mentioned, sometimes severe familiar problems (incest, abandone, diseases, death of parents, ecc.). A good relationship between parents and children is also important (Sadock, Sadock, 2003). *In the familiar anamnesis are often present, in relatives, psychiatric disorder-history cases.* Biological motives (genetic, perinatal injury, encephalitis, head injuries) were highlighted, along with high rate of convergence between monozygotic twins; particularly, a study conducted in the US on a 15 thousand pairs of both monozygotic and dizygotic twins showed that concordance in personality disorders was much higher in monozygotic twins rather than in dizygotic twins. Some biological studies revealed that which follows:

a) impulsive traits have been related to increased levels of testosterone, 17-estradiol and estron. Low levels of platelet monoamine oxidase may be associated with schizotypal personality disorder.

b) saccadic eye-movements are associated with introversion, low self-esteem, social withdrawal and schizotypal personality disorder.

c) high levels of endorphins can be associated with features of phlegmatic-passive personality. (Kaplan, Sadock, Grebb, 1996)

d) low levels of hydroxyindoleacetic acid (5-HIAA) are associated with suicide attempts, impulsivity and aggression. Pharmacological increase of serotonin may be associated with reduced sensitivity to rejection and to increasing assertiveness, self-esteem and stress tolerance.

e) in antisocial and borderline disorders, marked changes were shown in the electrical conductance of electroencephalogram with a slow-wave activity. Mild neurological signals were associated with the above mentioned disorders. Brain dysfunctions associated with personality disorders, especially antisocial personality disorder, are very small.

In the current state of knowledge, it is believed that the afore **reported biochemical and neurophysiological alterations** probably represent

psychobiological indexes rather than constantly assessed aetiological factors of personality disorders. Studies on the existence of relationships between biological indexes and psychological dimensions allow us to assume that the functioning level of single neurotransmitting systems don't play such a key role in human behavior but rather the mutual interaction between the different systems will, through feedback mechanisms usually in charge of keeping some precise balances. Neurochemical correlates of behavior could thus be grasped within both the harmonious and non-harmonious dispositions of biological substrates rather than in the specific alteration present in only one of them. (Castrogiovanni et al., 1991) (Giberti, Moscato, Rasore, 1996)

Personality disorders ultimately manifestate *psychopathological conditions* **often clinically hard to express** and represent a strongly critical aspect, for sufferers experience an unknown subjective emotional pain. These individuals also are particularly sensitive to certain **stimulating situations** in which they show decreased psychic control by achieving antisocial behaviors, far more frequent than a *sane* individual would (Barcellona, Faraone, 1980), and rebuilding, after the event, of the previous personological order: a sort of vulnerability area of personality mostly seen when the patient undergoes specific situational factors and "bursts in acting". (Bologna, Samory, 1994) Such pre-critical rearrangement of the personological order poses relevant issues, since it concerns, most times, pathologies characterised by temporary decompensations. Their common root seems to be, at times, a severe, for the most fleeting, reversible failure in sticking to the current values and, accordingly, to comply with the laws that underlie them. This continuity-discontinuity in personality disorders between sufferers who go through phases characterised by unstable balances and sufferers who do have a decompensated personality disorder (according to different possible degrees of severity) leads to relevant **interpretative and evaluational problems,** *taking into account the **extreme, clinical** and **behavioral polymorphism** of these diseases*. This problem can be overcome by only analysing structural and unchanging factors, which help clinicians put together psychopathological along with clinical and situational aspects. After pointing this out, it is better understood that diagnostic investigation becomes as more complex and difficult as more the disorder reaches the point of mild pathology (which is not homogeneous at all) and as easier as more the disorder reaches pathological scores.

The specific social concern on the problem arises from the fact that personality disorders affect a massive part of society and are much more

numerous than the so-called *proclaimed disorders*, therefore establishing themselves as a **real social pathology**; as a matter of fact, many statistical studies have allowed to establish that these diseases affect adult people in a percentage ranging between 10% and 15%, which makes these disorders even more frequent than schizophrenia or mood disorders themselves and more or less common as the so-called "neurotic disorders" (Cazzullo et Coll., 1993).

In the US about 15% of the adult population has a personality disorder. In addition, these individuals represent a big **criminological problem**, since statistical studies have revealed the considerable incidence of this problem on criminogenesis (40%), high frequency in criminals (70%) and the remarkable significance (80-90%) in routine-criminals. Nevertheless, **personality disorders** used to be, *in the clinical setting*, **frequently underestimated and underdiagnosed** as being considered almost not influencing the whole psyche of the individual; this has produced big consequences on the mental health of sufferers. Nowadays, thanks to substantial improvements in psychiatry and psychology, the afore-mentioned situation has mutated to such an extent that scholars stated that "**personality disorders represent the fundamental and basic expression of all psychopathology**" (Pallanti, Pazzagli, 1992).

It's hence due to this longstanding theoretical ambiguity (*proclaimed disorder or vague pathology?)* such strict division exerted by numerous clinicians and by the Italian case law, still anchoring onto a clear distinction between mental diseases in a classical sense (like psychotic and mood disorders to which a certain "dignity" of interfering with full possession of one's faculties was always acknowledged), and pathologies considered less serious, among which personality disorders, towards which a "sufficient dignity" used to be denied (Luzzago, Pietralunga, 1993).

Undoubtedly, both *under, a* **clinical***, mostly***,** and a forensic-psychiatric light, the evaluational matter on these pathologies requires further diagnostic investigation and interpretative caution in order not to underestimate these diseases because individuals with these disorders own the right of undergoing, when needed, pharmacological/psychological treatments in order to ease their suffering; whereas, in a criminological perspective, it is important to highlight the sake of society in being preserved from crimes that these individuals commit really frequently.

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Paper presented Apr 2015; published online: May, 2015
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