

Original Article

Demographic Profiles of Iranian Individuals with Personality Disorder

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Abstract

Background and Aim: Personality disorders (PDs) are widespread, rigid, and maladaptive with collections of traits that impair individuals and limit their capacity to function effectively. Recent studies indicate that PDs are consistently associated with several demographic characteristics. The present study was conducted to investigate the differences between the demographic characteristics of DSM-5 Sections II and III PDs in an Iranian clinical sample.

Materials and Methods: Data on the demographic distribution of DSM-5 Sections II and III PDs were derived from a total of 430 Iranian patients with PDs presenting to four clinical centers in Tehran using well-established measures. Different statistical analysis methods were used to compare demographic differences between DSM-5 Sections II and III PDs. These analyses were performed using SPSS software V. 22.

Results: Data analysis indicated that educational level, gender, age, marital status, average monthly household costs, and ethnicity had an impact on most PDs. In return, birth order accounted for the changes in only DSM-5 Section II histrionic PD.

Conclusion: Current research reveals that certain demographic subgroups have an impact on PDs. Accordingly, the need for psychiatric services for these individuals needs to be explored.

Keywords: Personality disorders, Demographic characteristics, DSM-5 Section II, DSM-5 Section III

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Introduction

Personality traits refers to ways of perceiving the world, relating to others, and thinking about oneself that are evident in a variety of social and personal contexts (1). Numerous studies

have been conducted to examine the relationship between personality traits, social and interpersonal well-being, and physical health (2,3,4). Personality disorders (PDs) are caused by rigid, maladaptive personality traits that lead to significant functional impairment or subjective distress (1). This group of

mental health disorders is increasingly recognized as important problems marked by significant and ongoing problems with self, others, and position in the world (5).

Two methods of conceptualizing and diagnosing PD are included in the DSM-5, the reprinted DSM-IV model and the model created by the DSM-5 PD committee (6). PD is still formally diagnosed using a categorical classification, but much recent research suggests that a dimensional view would provide a more comprehensive understanding of PD (7, 8). With this in mind, the Alternative Model of Personality Disorder (AMPD) was included in the Section III of the most current version of the Diagnostic and Statistical Manual of Mental Disorders. The AMPD is a trait-based, quasi-dimensional nosology of personality pathology in which elevations of certain traits are used as diagnostic markers along with indicators of personality dysfunction. The general criteria for PD in the AMPD are composed of 7 different criteria: A-G. Criterion B of this new model is intended to evaluate pathological personality traits through 25 more specific facets (such as Submissiveness, Withdrawal, Grandiosity, Irresponsibility, and Eccentricity) that load on one or more of the five higher-order pathological domains Negative Affectivity, Detachment, Antagonism, Disinhibition, and Psychoticism. The six traditional PD diagnoses-antisocial, avoidant, borderline, narcissistic, obsessive-compulsive, and schizotypal-can also be created with the AMPD (6).

Many variables can influence or correlate with PDs; one of these factors is demographic characteristics. In general, research has shown that PD is related to a variety of sociodemographic correlates (9, 10). In a large epidemiological study in New Zealand, young adults and participants from the two quintiles of the population with the lowest socioeconomic status accounted for the majority of patients with PD (11), and in a clinical sample, PD was more common in participants who were younger, unemployed, or economically inactive and less likely to have home ownership than in participants who did not have the disorder (12). All in all, there is evidence that greater incidence of PD is typically associated with younger age and poorer socioeconomic status (13, 14).

Data on sex differences in PD prevalence and PD clusters are relatively consistent. Trull and colleagues (15) reported that women are more likely to be diagnosed with paranoid, borderline, histrionic, avoidant, dependent, and obsessive-compulsive PD, whereas men are more likely to meet diagnostic criteria for PD overall and for schizoid, antisocial, and narcissistic PDs individually. In another large-scale survey, cluster A PDs was found to be slightly more prevalent in men. Similarly, the prevalence of cluster B PDs was higher in men (due to a higher rate of antisocial personality). In contrast, the prevalence of cluster C PDs was about the same in men and women (16). However, it is still not clear whether the asymmetric gender distribution in PD prevalence represents actual gender differences or fictitious differences caused by gender stereotypes and biased constructs (9).

Researchers have also found links between PD and challenging marital, educational, and other life circumstances. For example, according to a study by Torgersen, Kringlen, and Cramer, PD is associated with high school graduation or less and living alone (17). Other studies documented that the prevalence of PD in a community sample was higher among individuals who had previously been married and highest among individuals who had never been married, compared with ever-married individuals. They are also more common among high school dropouts than in graduates (16).

Although the relationship between PD and demographic characteristics such as socioeconomic status, age, and gender has generally been well studied (16, 18-20), the relationship between ethnicity and these disorders has been poorly explored (21). Given the numerous interconnections between culture and personality, the lack of such data is notable (22). Moreover, research has often been conducted in Western countries, particularly in English-speaking areas(22), which would limit the global application of such a diagnostic system across cultures. Indeed, cultures, with their unique laws and traditions, play a significant role in shaping people's beliefs and behaviors in society(23)and it is plausible that differences in behavioral norms between countries (e.g., individualisticversus collectivistic societies) may have some influence on PD incidence (24), suggesting

that more cross-cultural research is needed to examine how demographic characteristics influence PD, especially in non-Western cultures.

It should also be noted that the role of demographic variables in the emergence of the DSM-5 Section III PDs has been less studied. Accordingly, the present study was conducted to provide a comprehensive overview of how demographic characteristics vary across DSM-5 Sections II and III PDs in a clinical sample from Iran. The main objective was to investigate whether DSM-5 Sections II and III PDs would differ in terms of gender, age, average monthly household costs, marital status, educational level, birth order, and ethnicity. A secondary objective was to determine whether demographic characteristics differed in the underlying constructs of PD psychopathology.

Methods

Participants were drawn from four clinical centers in Tehran, Iran, who had received psychological therapy in the past month. Four clinical psychologists with PhDs were asked to refer the patients with a PD diagnosis according to DSM-5 Section II PDs. Exclusion criteria were severe cognitive impairment, severe psychiatric disorders requiring professional help, age under 18 years, and inability to read and write Persian. A diagnosed PD case relative to DSM-5 Section II PDs symptoms was also assessed based on SCID-5-SPQ (1). The included sample ($n = 516$) consisted of patients with a PD diagnosis according to the symptoms recorded in the SCID-5-SPQ, without a severe disorder such as schizophrenia or schizoaffective disorder. To assess underlying constructs of PD psychopathology, the three Higher Order (HO) scales from the MMPI-2-RF (i.e., Internalizing, Thought, and Externalizing Dysfunction) and the five broad domains from the PID-5 (i.e., Negative Affectivity, Detachment, Antagonism, Disinhibition, and Psychoticism) were used, both of which are the most commonly used assessment instruments to assess the general structures of PD psychopathology (25, 26). Participants' consent was recorded on a written form after they received a detailed description of the study. The study process was approved by the University of

Social Welfare and Rehabilitation Sciences Research Ethics Committees.

Those participants with more than 5% missing data were excluded from the study. In this regard, 37 participants were removed from the analysis. Of these patients, invalid profiles were also excluded from the analyses according to the interpretive guidelines outlined in the MMPI-2-RF manual resulting in the exclusion of 49 individuals. It must be emphasized that there were no significant differences in demographic characteristics between the remaining and excluded participants.

Materials

Structured Clinical Interview for DSM-5 Screening Personality Questionnaire(SCID-5-SPQ)

The SCID-5-SPQ published in 2016, is a 106-item self-report test used to assess 10 categories of the DSM-5 Section II PDs. A true/false response scale was used for the SCID-5-SPQ (1). For the present study, the Persian translation by GhamkharFard and Pourshahbaz was used (27). In the current study, the internal consistency (Cronbach's alpha) for the DSM-5 Section II PDs was as follows: paranoid PD = 0.54, schizoid PD = 0.48, schizotypal PD = 0.43, antisocial PD = 0.81, borderline PD = 0.71, histrionic PD = 0.55, narcissistic PD = 0.59, avoidant PD = 0.64, dependent PD = 0.68, and obsessive-compulsive PD = 0.44.

The Personality Inventory for DSM-5 (PID-5)

PID-5 is a 220-item measure that assesses five broad domains: Negative Affectivity, Detachment, Antagonism, Disinhibition, and Psychoticism. Each domain is described by a series of facets. Items are rated on a 4-point Likert scale ranging from "0 = very false or often false" to 3 = "very true or often true" (26). In the present study, GhamkharFard and Pourshahbaz's Persian translation was used to assess problematic personality traits, which has been shown to have good psychometric properties in a sample of Iranian adults (28). Six PDs from the DSM-5 Section III were extracted with respect to the pathological traits proposed in the alternative model for personality disorders (AMPD). The internal consistency of the PID-5 domains was generally acceptable (range = 0.66 (Negative Affectivity) - 0.84 (Psychoticism) for the Coefficient Alpha and 0.40 (Negative Affectivity) -

0.64 (Psychoticism) for the mean inter-item correlation). Similarly, Cronbach's alpha for the DSM-5 Section III PDs was as follows: antisocial PD = 0.77, avoidant PD = 0.72, borderline PD = 0.78, obsessive-compulsive PD = 0.56, narcissistic PD = 0.54, and schizotypal PD = 0.76.

The Minnesota Multiphasic Personality Inventory-2 Restructured Form (MMPI-2-RF)

The MMPI-2-RF is a 338-item self-report measure with true/false scale, based on the 567-item original MMPI-2, designed to measure nine validity scales, three Higher Order scales (HO), nine Restructured Clinical (RC) scales, 23 Specific Problems (SP) scales, two Interest scales, and five personality psychopathology (PSY-5) scales (25). In this study, to assess the three general structures of psychopathology (internalizing, thought, and externalizing problems), the MMPI-2-RF HO scales (EID = Internalizing Dysfunction; THD = Thought Dysfunction; BXD = Externalizing Dysfunction) were applied exclusively. Of note, a Persian version of the MMPI-2-R, prepared with the approval of the University of Minnesota Publishing, was used in this study. Construct and criterion validity, as well as reliability of the translated version, were well established in the study by GhamkharFard and Pourshahbaz. (27). The mean of Cronbach's alpha for the EID, THD, and BXD scales were 0.91, .84, and 0.73, respectively.

Results

In the present study, the final sample consisted of 430 participants, 208 (48.4%) women and 222 (51.6%) men, with a mean age of 31.06 years (SD = 8.14). The three most common PD diagnoses were borderline (22.6%), narcissistic (15.8%), and obsessive-compulsive (13.3%) PDs. The average education level of participants was 13.9 years (SD = 3.46), and 60.7% identified themselves as Persian. Married and unmarried participants accounted for 42.1% and 57.9% of the sample, respectively (Table 1). Several statistical analysis methods were used to compare demographic differences between DSM-5 Sections II and III PDs. These analyses were performed using SPSS software V. 22. Because PDs are described in the DSM-5 Section II based on a

Table 1: Demographic Characteristics of the Personality Disordered Patients (N=430).

	N	%
The main diagnosis of the valid data		
Paranoid PD	25	5.8
Schizoid PD	32	7.4
Schizotypal PD	35	8.1
Borderline PD	97	22.6
Antisocial PD	42	9.8
Narcissistic PD	68	15.8
Histrionic PD	24	5.6
Avoidant PD	32	7.4
Obsessive-Compulsive PD	57	13.3
Dependent PD	18	4.2
Age		
18-30	215	50.0
31-40	174	40.5
41 and older	41	9.5
Gender		
Female	208	48.4
Male	222	51.6
Marital Status		
Single	249	57.9
Married	181	42.1
Ethnicity		
Persian	261	60.7
Turkish	63	14.7
Kurdish	28	6.5
Lur	38	8.8
Other (Arab, Gilaki, or Armenian)	40	9.3
Educational Level		
Less than Diploma	62	14.4
Diploma	130	30.2
Bachelor	181	42.1
Master and above	57	13.3
Birth Order		
First child	151	35.1
Second child	88	20.5
Third child	62	14.4
Fourth child	43	10.0
Fifth child and above	75	18.1
Choose not to answer	8	1.9
Average Monthly Household Costs		
Two million and lower	103	24.0
2.1-3 million	113	26.3
3.1-5 million	122	28.4
5.1 million and above	86	20.0
Choose not to answer	6	1.4
Family History of Mental Health Problems		
Yes	133	30.9
No	296	68.8
NOS	1	0.2
Physical Problem		
Yes	20	20.0
No	343	79.8
Chose not to answer	1	0.2

count value, a series of nonparametric analyzes were performed for categorized PDs. For this purpose, the Kruskal-Wallis's test was used to determine whether PDs in the DSM-5 Section II differed according to the variables of ethnicity, age, average monthly household costs, birth order, and educational level. To determine gender differences in DSM-5 Section II PDs, the U-Mann-Whitney test was used.

Several parametric statistical procedures were used to analyze the dimensional variables (i.e., the PDs of the DSM-5 Section III and the broad personality

psychopathology domains); to assess how the dimensional PDs vary by ethnicity, age, average monthly household costs, birth order, and educational level, the one-way ANOVA was performed. Finally, an independent t-test was conducted to assess how the dimensional variables differ by marital status and gender. Bonferroni correction for pairwise comparisons was used in all analyses.

The demographic characteristics of DSM-5 Sections II and III PDs in an Iranian sample with PDs are presented in Tables 2 and 3. According to the results,

Table 2: Results of Tests for Each of DSM-5 Sections II and III Personality Disorders, the Big Three and the Big Five Higher-Order Domains by Gender, Age, Marital Status, and Ethnicity.

	Gender		Age		Marital Status		Ethnicity	
	test	Pairwise comparison	test	Pairwise comparison	test	Pairwise comparison	test	Pairwise comparison
DSM-5 Section II PDs								
PPD	2.07*	G1>G2	0.94		1.23		1.57	
SPD	0.98		1.44		2.17*	M1>M2	3.67	
STPD	1.28		3.20		0.24		9.29	
ASPD	6.10**	G1<G2	2.81		0.76		7.72	
BPD	1.37		6.99*	A1>A3	.04		13.12*	R1 and R2<R5
HPD	0.00		3.52		0.77		11.74*	R2 and R4<R5
NPD	0.83		17.12**	A1>A2 and A3	.35		9.02	
APD	0.54		0.82		1.03		1.70	
DPD	0.91		4.38		0.48		5.58	
OCPD	2.49*	G1<G2	4.50		0.92		0.39	
DSM-5 Section III PDs								
ASPD	2.74*	G1<G2	16.44**	A1>A2 and A3	1.47		3.47*	R1 and R2<R5
APD	0.49		0.78		2.08*		1.81	
BPD	0.89		9.96**	A1>A2 and A3	1.57		3.89*	R1,R2, and R3<R5
OCPD	2.29*	G1<G2	0.71		2.69*	M1>M2	0.98	
NPD	0.70		1.90		0.48		2.22	
STPD	3.20**	G1<G2	5.54*	A1>A2	2.23*		2.30	
PID-5 Domains								
Negative Affectivity	1.79	G1>G2	3.96*	A1>A3	0.58		2.53*	R3<R5
Detachment	0.27		.20		2.43*	M1>M2	1.62	
Antagonism	3.26*	G1<G2	9.58**	A1>A2 and A3	0.28		2.35	
Disinhibition	0.37		4.95*	A1>A2 and A3	0.63		2.32	
Psychoticism	2.53*	G1<G2	9.02**	A1>A2 and A3	2.21*	M1>M2	2.42	
MMPI-2-RF Higher Order Scales								
Internalizing Dysfunction	3.05*	G1>G2	1.04		0.65		2.83*	R3<R5
Thought Dysfunction	0.55		1.04		0.05		3.80*	R2<R5
Externalizing Dysfunction	5.00**	G1<G2	6.69**	A1>A2 and A3	0.32		0.90	

Note. * $p < .05$; ** $p < .001$; G1 = female; G2 = male; A1 = aged 18-30; A2 = aged 31-40; A3 = aged 41 and older; M1 = single; M2 = married; R1 = Persian; R2 = Turkish; R3 = Kurdish; R4 = Lur; R5 = others

Table 3: Results of Tests for each of the DSM-5 Sections II and III Personality Disorders, the Big Three and the Big Five Higher-Order domains by gender, Educational Level, Birth Order, and Average Monthly Household Costs.

	Education Level		Birth Order		Average Monthly Household Costs	
	Test	Pairwise comparison	Test	Pairwise comparison	Test	Pairwise comparison
DSM-5 Section II PDs						
PPD	17.70**	E1, E2, and E3>E4	0.47		4.63	
SPD	5.32		1.12		4.59	
STPD	15.31*	E1 and E2>E4	1.32		8.56*	C1>C3
ASPD	13.85*	E1>E3 and E4	8.55		3.17	
BPD	22.93**	E1and E2>E4; E1>E3	0.92		6.77	
HPD	9.88*	E1>E4	12.73*	B1 and B4>B2	4.89	
NPD	5.03		3.28		5.50	
APD	6.85		0.86		12.81*	C1>C3 and C4
DPD	2.76		2.89		5.68	
OCPD	0.97		0.07		2.09	
DSM-5 Section III PDs						
ASPD	8.16**	E1>E2, E3, and E4	1.24		0.83	
APD	3.70*	E2>E3	1.07		3.39*	C1>C3
BPD	7.80**	E1 and E2>E4; E1>E3	0.35		1.60	
OCPD	1.66		0.13		1.95	
NPD	1.48		0.89		1.67	
STPD	11.36**	E1 and E2>E3 and E4	1.57		1.45	
PID-5 Domains						
Negative Affectivity	3.18*	E1>E4	0.21		3.01*	C1>C4
Detachment	3.58*	E2>E3	1.03		2.28	
Antagonism	1.99		1.35		0.65	
Disinhibition	5.65**	E1>E3 and E4	0.10		0.92	
Psychoticism	14.64**	E1 and E2>E3 and E4	1.72		1.36	
MMPI-2-RF Higher Order Scales						
Internalizing Dysfunction	6.42*	E1 and E2>E4; E2>E3	0.59		3.05*	C1>C3
Thought Dysfunction	6.40*	E1>E3 and E4	0.81		2.16	
Externalizing Dysfunction	15.77**	E1>E2, E3, and E4; E2 and E3>E4	0.51		0.56	

Note. * $p < .05$; ** $p < .001$; E1 = less than diploma; E2 = diploma; E3 = bachelor's degree; E4 = master's degree or higher; B1 = first child; B2 = second child; B3 = third child; B4 = fourth child; B5 = fifth child and above; C1 = Less than 20 million Rial; C2 = Between 20 to 30 million Rial; C3 = Between 30 to 50 million Rial; C4 = Above 50million Rial.

gender, educational level, and age accounted for the changes in most DSM-5 Section II PDs. Conversely, birth order was only responsible for changes in DSM-5 Section II histrionic PD; the first and fourth children generally showed more dramatic behavior than the second child.

Specifically, the following findings were recorded from the DSM-5 Section II PDs: Pairwise comparisons using the Bonferroni correction revealed that antisocial PD was more common in

young and poorly educated men. Similarly, lower educational attainment and lower average monthly household costs were associated with higher levels of schizotypal PD. Narcissistic PD was found more frequently in younger patients. Regarding the relationships between demographic variables and cluster C PDs of the DSM-5 Section II, results showed that obsessive-compulsive PD was more common in men and avoidant PD in patients with lower average monthly household costs. Finally, no demographic

association was found with DSM-5 Section II dependent PD (Tables 2 and 3).

The findings of the PDs of the DSM-5 Section III strongly resembled those of the corresponding PDs of the DSM-5 Section II. With this regard, antisocial, obsessive-compulsive, and schizotypal disorders occurred more frequently in men. In addition, antisocial, borderline, and schizotypal disorders were generally associated with lower educational attainment and younger age (Tables 2 and 3).

Regarding maladaptive personality domains, except for Antagonism, lower educational level resulted in internalizing dysfunction (Negative Affectivity and Detachment), externalizing dysfunction (Disinhibition), and thought dysfunction (Psychoticism). Similarly, younger age generally resulted in higher scores in the other four main domains, except for detachment. Concerning gender, women tended to have higher scores on Negative Affectivity, whereas men tended to have higher scores on Antagonism and Psychoticism. Finally, single patients were more likely to have higher scores on Detachment and Psychoticism.

Discussion

This is, to the authors' knowledge, one of the first studies that has investigated the differences in the incidence of PDs in relation to demographic characteristics (i.e., gender, age, marital status, ethnicity, educational level, birth order, and average monthly household costs) in patients presenting to mental health services with clinical PD in Iran.

Because the fifth edition of the DSM provides for two independent diagnostic methods (categorical and dimensional), the variability of the two diagnostic methods in relation to demographic characteristics was examined. It is noteworthy that the results of the two DSM-5 Sections were very similar to each other. The relationship between demographic characteristics and higher-order personality psychopathology in the Big Three (i.e., Internalizing, Thinking, and Externalizing Dysfunctions) and Big Five (Negative Affectivity, Detachment, Antagonism, Disinhibition, and Psychoticism) models was also examined.

The overall results are consistent with previous data showing associations between sociodemographic

characteristics and psychiatric diagnoses, including PDs (10).

The results of the current study revealed that among individuals presenting to clinical settings with a diagnosis of PD, participants with younger age, lower education, and lower average monthly household costs were generally more likely to report symptoms of PD as well as a variety of higher-order problems. These findings are consistent with previous studies showing that the presence of PD is associated with several sociodemographic factors, including age, education, and socioeconomic status (9, 17). As in the present study, these researchers found that the prevalence of PD was increased, particularly in younger populations (12, 29). Similarly, many researchers found that people with lower socioeconomic status and education generally have lower levels of functioning and more PD symptoms (13).

The elevated PD symptoms among individuals with lower average monthly household costs likely indicate the importance of differences in socioeconomic status in the Iranian community. Individuals with low socioeconomic status have much poorer access to mental health care in developing countries and are therefore more likely to have high levels of personality pathology than individuals with higher socioeconomic status (30). This is because individuals with lower socioeconomic status are more susceptible to stress and have less access to social support (13). Hence, it is crucial to address the economic status of society because it has various effects on quality of life, mental illness, and access to treatment (31, 32).

In terms of gender differences in PDs, men were more likely to have antisocial, obsessive-compulsive, and schizotypal PDs along with higher scores for psychoticism and Externalizing Dysfunction (i.e., Antagonism), whereas women were more likely to have paranoid PD and Internalizing Dysfunction (i.e., Negative Affectivity). Although these findings are generally consistent with previous studies (33), the higher likelihood of paranoid PD in women was not expected. However, there are several plausible explanations for these findings. First, it should be emphasized that even though several lines of research indicate that men are generally more likely to report paranoid experiences (34), findings in this area are inconsistent. Most of these studies have focused on

nonclinical samples (20), and further studies should be conducted in clinical samples to further examine the association between gender and paranoid PD. Second, previous research has shown that paranoid psychopathology is expressed in women and men for different reasons; while in women this PD is generally based on the experience of interpersonal problems, in men, it appears to be rooted in the perception of physical or external danger (34). Therefore, in nonclinical populations, women are more likely to have high-quality relationships where they can get the support they need and potentially mitigate their threatening thoughts through conversation (35). In comparison, women in clinical populations are potentially more vulnerable to a paranoid PD diagnosis, likely due to greater social withdrawal (36). This might be a possible reason for more paranoid PD in women in the clinical sample of this study.

This study also investigated the associations between PDs and marital status. Findings revealed that single patients reported greater rates of detachment and psychoticism in higher-order personality psychopathology domains, as well as schizoid and obsessive-compulsive PDs, which is congruent with several previous studies (17). This is potentially because elevated levels of detachment and psychoticism interfere with engaging in long-term intimate relationships (33). Likewise, researchers stated that the cognitive and social challenges in those with cluster A PDs and the social anxiety in people with cluster C PDs may both contribute to marital problems (16).

Finally, results showed that patients with at least one of the ethnicities Arab, Gilaki, or Armenian were more likely to receive one of the diagnoses of antisocial, borderline, and histrionic PD compared to Persian, Turkish, Kurdish, and Lur. Before explaining this finding, it is important to emphasize that due to the low frequency of Arab, Gilaki, and Armenian ethnicities, these three ethnicities were grouped into one integrated item, namely "other." These three ethnicities are also part of a minority in the Iranian community. In this context, Chavira et al. (22) found that people who belong to an ethnic minority are more prone to experience emotional instability, rage, and difficult interpersonal

relationships. However, a more accurate statement requires the study of a larger sample of people from this ethnicity.

These demographic patterns help identify the community's subgroups who are most at risk for PDs, and therefore most likely to experience their negative effects and have the greatest need for support (37).

This study has several limitations. First, a structured clinical interview was not conducted, although patients PDs diagnosed by a clinical psychologist with a Ph.D. participated in our study. Second, there was no information on possible comorbidities that could affect the results. Accordingly, it would be beneficial to use objective measures (e.g., interviews) and examine comorbidities between PDs in further studies.

Conclusion

Despite these limitations, this study extends prior research by revealing the demographic distribution of DSM-5 Sections II and III PDs in an Iranian clinical sample. The pattern of results showed that PDs are related to various demographic characteristics such as age, gender, educational level, marital status, average monthly household costs, and ethnicity. These findings could help clinicians more accurately identify the populations they serve so they can provide more tailored mental health services to PD patients.

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None.

Conflict of Interest

The authors declare that they have no conflict of interest.

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