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Under recognition of personality disorders among psychiatric inpatients in a Romanian sample

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ABSTRACT

Personality disorders (PDs) are common in psychiatric populations but often remain underrecognized in routine practice, which can affect treatment and outcomes. This study examined the gap between screening results and documented diagnoses among psychiatric inpatients in Romania and explored their links with rehospitalization. Ninety-four patients completed the structured clinical interview for diagnostic and statistical manual of mental disorders, fifth edition screening personality questionnaire (SCID-5-SPQ), and existing diagnoses were extracted from hospital records. More than half of participants (59.6%) screened positive, yet only one patient (1.1%) had a recorded diagnosis, indicating very low concordance (1.8%). Patients screening positive seemed to have higher mean rehospitalization rates, although this difference was not statistically significant ($p = .160$). Dimensional scores showed modest but significant correlations with hospitalization frequency ($\rho = .25$-$.29$, $p < .05$) but were not significant predictors in regression analyses. These findings suggest a substantial gap in recognition of PDs in clinical settings and indicate the utility of brief screening tools in improving detection and guiding psychiatric care.

Keywords: personality disorders, Romania, psychiatric diagnoses, mental disorders, SCID-5-SPQ

INTRODUCTION

Personality and its disorders have long been recognized as integral to the understanding of human behavior, with origins traceable to ancient Greek thought and traditional Chinese medicine [1]. Over time, theories of personality have played a crucial role in shaping psychiatry and informing our current conceptualizations of mental illness.

The role of personality and personality disorders (PDs) in influencing the course and expression of mental disorders has become increasingly evident. PDs have been shown to complicate the trajectory of psychiatric illnesses and have been specifically associated with greater functional impairment, poorer prognosis for mood and anxiety disorders, and an increased risk of suicide, among other adverse outcomes [2]. Furthermore, because PDs are relatively stable over time, they can act as a substrate upon which other psychopathologies develop or as modifiers that shape their clinical course [3, 4].

Despite this well-established evidence, many psychiatrists and other mental health professionals still do not routinely screen for comorbid PDs in their patients [5, 6]. This occurs despite consistent findings showing that PDs are highly prevalent in psychiatric populations. For example, one review reported that when semi-structured diagnostic interviews were employed, nearly half of all patients screened positive for a PD [7]. Similarly, when structured interviews for DSM-IV PDs were used, almost half of psychiatric outpatients met criteria for at least one PD [8]. These figures contrast sharply with the general population, where the prevalence of PDs is estimated to be below 8% [9].

Unrecognized or unaddressed PDs also have an effect on prognosis. Patients whose PDs are not identified are more likely to experience recurrent hospitalizations and to utilize psychiatric resources more frequently and intensively [10-12]. These findings underscore the clinical and systemic benefits of screening for and addressing PDs in psychiatric settings. Interventions targeting underlying PDs have been shown to improve not only PD-specific symptoms but also global psychiatric outcomes, thereby reducing the overall burden on mental health services [13]. It follows logically that assessing PD comorbidity enhances the accuracy of clinical prognostication and facilitates a more individualized

Table 1. Sample characteristics, psychiatric diagnoses, and predominant SCID-5-SPQ personality dimensions (N = 94)

Socio-demographic/ clinical variables	Value	95% CI	Range	Psychiatric diagnoses	n (%)	Predominant PD dimension	n (%)
Age, M (SD)	50.53 (12.48)	[47.98, 53.09]	19-80	Depressive disorders	44 (46.8)	Obsessive-compulsive	27 (28.7)
Male sex	57 (60.6)	-	-	Schizophrenia spectrum disorders	21 (22.3)	Avoidant	24 (25.5)
Female sex	37 (39.4)	-	-	Substance use disorders	9 (9.6)	Schizoid	17 (18.1)
Urban residence	53 (56.4)	-	-	Anxiety/stress-related disorders	9 (9.6)	Dependent	6 (6.4)
Rural residence	41 (43.6)	-	-	Bipolar disorders	5 (5.3)	Paranoid	6 (6.4)
AverageDim PD score, M (SD)	5.45 (2.41)	[4.95, 5.94]	0-13	Organic/neurocognitive disorders	5 (5.3)	Schizotypal	5 (5.3)
MaxDim PD score, M (SD)	9.72 (2.55)	[9.20, 10.24]	0-13	Personality disorders	1 (1.1)	Borderline	3 (3.2)
Subsequent hospitalizations, M (SD)	2.26 (2.65)	[1.70, 2.82]	0-14	-	-	Histrionic	3 (3.2)
PD screen positive	56 (59.6)	-	-	-	-	Narcissistic	2 (2.1)
PD diagnosis present	1 (1.1)	-	-	-	-	Antisocial	1 (1.1)

Note. CI: Confidence interval; Predominant PD dimension refers to the SCID-5-SPQ domain with the highest dimensional score for each participant; & Subsequent hospitalization data were available for 89 participants

treatment planning, which in turn improves treatment outcomes. Indeed, untreated PDs have been associated with poorer therapeutic response [14].

Despite the extensive international literature on PDs, data on PDs in Romanian psychiatric inpatients remain limited. The extent to which findings regarding PDs in Western Europe and North America generalize to Romanian inpatient populations is unclear and remains sufficiently unexplored. Our study seeks to address this gap by examining the prevalence of PD profiles and their recognition in a sample of Romanian psychiatric patients. Just like in many systems, inpatient psychiatric treatment is primarily oriented toward the management of acute psychiatric symptoms [15].

This may limit the attention devoted to underlying personality pathology, as the diagnosis of PDs often requires detailed and longitudinal assessment of behavioral patterns, which may be difficult to accomplish during relatively brief inpatient admissions. This further highlights the need to examine the extent to which PDs are recognized and documented in Romanian psychiatric settings.

Although the underdiagnosis of PDs in clinical practice has been repeatedly highlighted in the literature, it remains unclear whether awareness of this issue has translated into meaningful changes in diagnostic behavior. One might expect that, given decades of discussion, psychiatrists would now more consistently screen for and document PDs.

This study seeks to test that assumption: to examine whether psychiatrists are increasingly identifying and addressing underlying PDs in their patients. In addition, we investigate whether inpatients who were correctly diagnosed with a PDs, alongside their primary psychiatric disorder, exhibited different hospital readmission rates compared to those whose PDs were missed.

A review of the literature makes it clear that PDs continue to be underdiagnosed in clinical settings [16-18]. Drawing from this, we hypothesise that PDs will be underdiagnosed in our sample of psychiatric inpatients. We further hypothesise that patients who are correctly diagnosed with a comorbid PD will demonstrate lower hospital readmission rates, based on the assumption that recognition of their PDs leads to targeted interventions and improved management.

METHODS

Study Design

This cross-sectional study was conducted at the “Elisabeta Doamna” Clinical Psychiatry Hospital in Galati, Romania, a provincial psychiatric hospital located in the Galati region. Participants were patients admitted to the psychiatric ward between December 2023 and February 2025. Participants were considered eligible if they were clinically stable, able to understand the study procedure and questionnaires, and provide informed consent. Ethical approval was obtained from the Ethics Committee of Elisabeta Doamna Psychiatry Hospital (Approval No. 4, 11/12/2023), and the procedures followed were in accordance with the Helsinki Declaration as revised in 2013.

Participants’ medical records were also reviewed to obtain relevant clinical information, including psychiatric diagnostic history and the number of hospital readmissions following the admission during which they participated in the study.

Participants

Of the 94 patients who agreed to participate in our study, 57 (60.6%) were male, and 37 (39.4%) were female. A slight majority resided in urban areas (n = 53, 56.4%), while 41 participants (43.6%) lived in rural settings. Participants’ mean (M) age was 50.53 years (standard deviation [SD] = 12.48, range = 19-80).

The M number of subsequent hospitalizations was 2.26 (SD = 2.65, range = 0-14). The distribution was positively skewed, with a small number of participants experiencing frequent readmissions. Hospitalization data were available for 89 participants (94.7%); follow-up data were unavailable for five participants, in some cases due to death during the study period. Detailed descriptive statistics and sample characteristics are presented in **Table 1**.

Measures

PDs were assessed using the structured clinical interview for diagnostic and statistical manual of mental disorders, fifth edition (DSM-5) screening personality questionnaire (SCID-5-SPQ) [19]. The SCID-5-SPQ is a self-report screening instrument designed to identify PD traits consistent with the DSM-5.

Table 2. Descriptive statistics and normality indices for continuous variables

Variable	M	SD	Skewness	Kurtosis	Shapiro-Wilk p	Interpretation
Age	50.36	12.34	-0.06	-0.14	.854	Normal
MaxDim PD score	9.66	2.56	-0.79	1.53	< .001	Non-normal
AverageDim PD score	5.45	2.45	0.29	0.44	.153	Normal
Subsequent hospitalizations	2.26	2.65	2.01	5.34	< .001	Non-normal

Note. N = 94; Shapiro-Wilk test was used to assess normality; Values of skewness and kurtosis within ±1.0 were considered approximately normal

It contains 106 dichotomous (yes/no) items corresponding to diagnostic criteria for the ten DSM-5 PDs and typically requires 20-25 minutes to complete. The American Psychiatric Association recommends the SCID-5-SPQ as a time-efficient and psychometrically sound screening tool for identifying individuals who may require further assessment with the full SCID-5-PD clinical interview.

Scores are calculated by summing “yes” responses within each PD section, with higher scores indicating a greater likelihood of meeting diagnostic criteria. However, cut-off scores are intended for screening purposes only and should be interpreted alongside clinical judgment.

Consistent with the SCID-5 users’ guide, which describes the SCID-5-SPQ as a preliminary screening instrument for identifying individuals who may require further evaluation with the full SCID-5-PD interview [19], the questionnaire was used for screening rather than diagnostic purposes. Because the PD domains differ in the number of items in each domain, raw domain scores were standardized into a common 0-13 scale by dividing the number of endorsed criteria by the total number of criteria for that disorder and multiplying by 13. Two summary indices were calculated: maximum dimension (MaxDim), defined as the highest dimensional score obtained in any one of the DSM-5 PD domains, and average dimension (AverageDim), defined as the M standardized score across all domains. Together, these indices characterized the participant’s most prominent PD trait profile (MaxDim) and their overall index of personality pathology severity across domains (AverageDim). For the purpose of this screening, we adopted cutoff scores of MaxDim ≥ 7 and AverageDim ≥ 5 to define positive screening for PD. These thresholds were selected to identify participants showing both elevated pathology within at least one PD domain and a broader pattern of personality pathology across domains and are not interpreted as diagnostic cutoffs.

The Romanian-language version of the SCID-5-SPQ was administered under license. To our knowledge, no peer-reviewed Romanian psychometric validation has been published, and no formal validation was conducted in this study. Accordingly, SCID-5-SPQ responses were used solely for screening purposes, not for diagnostic or psychometric inference. Existing evidence on the instrument’s psychometric properties includes a Persian validation study in a clinical sample reporting good face validity and high internal consistency (Cronbach’s alpha = 0.93) [20]. Historical psychiatric diagnoses were extracted from participants’ medical records, which followed ICD-10 diagnostic criteria routinely used in clinical practice.

Statistical Analyses

Normality of continuous variables was assessed using skewness and kurtosis indices and confirmed with the Shapiro-Wilk test (**Table 2**). Age and the AverageDim PD score showed approximately normal distributions, with skewness (-0.06 and 0.29) and kurtosis (-0.14 and 0.44) within the recommended ±1.0 thresholds [21], and non-significant Shapiro-Wilk results (p = .854 and p = .153, respectively).

In contrast, the MaxDim PD score and the number of subsequent hospitalizations deviated from normality, with elevated kurtosis and significant Shapiro-Wilk tests (p < .001). The maximum PD score was moderately left-skewed (skewness = -0.79, kurtosis = 1.53), whereas rehospitalization counts showed pronounced positive skew (skewness = 2.01, kurtosis = 5.34), consistent with a zero-inflated count distribution.

Given the sample size (N = 94) and evidence that parametric tests are robust to moderate deviations from normality [21-23], minor departures were not considered to threaten analytic validity. Accordingly, parametric procedures were applied to normally distributed variables (age and AverageDim), while nonparametric analyses were used for variables with significant deviations from normality.

RESULTS

To accommodate the modest sample size, we grouped the participants’ documented psychiatric diagnoses into broader ICD-10 categories. Depressive disorders (F32-F39) were the most common disorders (46.8%), followed by schizophrenia spectrum disorders (F21-F29). Substance use disorders (F10-F19) and anxiety/stress-related disorders (F40-F48) each accounted for 9% of the sample, bipolar disorders (F30, F31) and organic/neurocognitive (F00-F09) disorders each accounted for 5% (**Table 1**). Only 1.1% of the sample had a documented PD. Notably, this diagnosis was organic PD, which is classified within organic mental disorders rather than the primary PDs typically assessed by the SCID-5-SPQ.

The distribution of the predominant SCID-5-SPQ personality dimensions among the sample suggested a dominance of obsessive-compulsive and avoidant personality dimensions (28.7% and 25.5%, respectively), followed by a schizoid personality dimension (18.1%). Dependent and paranoid personality dimensions each accounted for 6.4% of the sample. Borderline and histrionic dimensions were the least common (3.2% each), followed by narcissistic (2.1%) and antisocial dimensions (1.1%).

An exploratory crosstabulation revealed that participants with schizophrenia spectrum disorders screened more frequently on the avoidant personality dimension (38.1%), followed by the obsessive-compulsive dimension (19.0%), and dependent and schizoid personality dimensions at 14.3% each. In depressive disorders, obsessive-compulsive dimensions were most common (36.4%), followed by avoidant (22.7%) and schizoid dimensions (13.6%). Patients with substance use disorders most frequently demonstrated schizoid dimensions (33.3%), while avoidant and obsessive-compulsive dimensions each accounted for 22.2% of cases. However, the association between psychiatric diagnoses and predominant personality dimensions was not statistically significant χ^2 (54, N = 94) = 49.93, p = .632. Therefore, any observed associations should be

Table 3. Cross-tabulation of SCID-5-SPQ screening results and ICD-10 PD diagnoses

Screening result	PD diagnosis present	No PD diagnosis	Total
Negative screen	0 (0.0%)	38 (100.0%)	38 (40.4%)
Positive screen	1 (1.8%)	55 (98.2%)	56 (59.6%)
Total	1 (1.1%)	93 (98.9%)	94 (100%)

Note. Screening classification based on MaxDim ≥ 7 and AverageDim ≥ 5 on the SCID-5-SPQ & Percentages are within each screening category

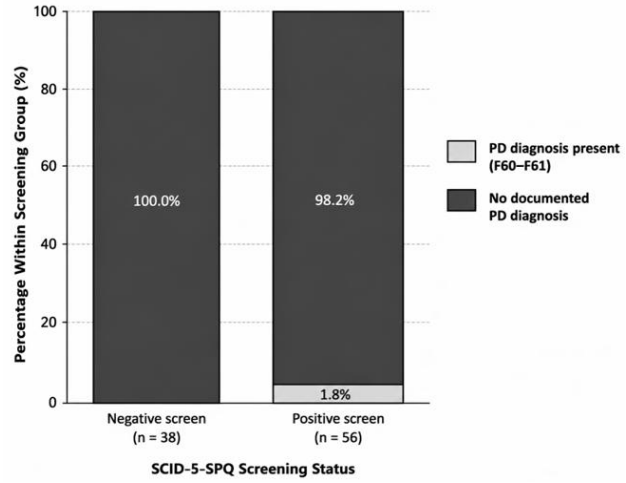

Figure 1. Distribution of ICD-10 PD diagnoses by SCID-5-SPQ screening status (the authors' own data)

taken cautiously and interpreted as exploratory, rather than definitive.

On the SCID-5-SPQ, participants had a mean dimensional PD score of 5.45 (SD = 2.41) and a mean MaxDim PD score of 9.72 (SD = 2.55) (theoretical range = 0-13). Screening across the full sample showed that 56 participants (59.6%) screened positive for a PD on the SCID-5-SPQ using the combined criterion of MaxDim ≥ 7 and AverageDim ≥ 5. Only one participant (1.1%) had a documented ICD-10 PD diagnosis (F60-F61) in their medical records. Among those who screened positive, one (1.8%) had a corresponding PD diagnosis recorded, while 55 (98.2%) had no documented PD. Conversely, the single participant with a documented PD diagnosis screened positive on the SCID-5-SPQ. Detailed frequencies are presented in **Table 3**, and the distribution is illustrated in **Figure 1**.

A Chi-square test of independence examined the association between SCID-5-SPQ screening results and documented ICD-10 PD diagnoses (F60-F61). The association was not statistically significant, χ^2 (1, N = 94) = 0.69, p = .41, indicating minimal concordance between screening classification and formal diagnostic documentation. Fisher's exact test confirmed this result (p = 1.00), reflecting the extremely low number of recorded PD diagnoses.

A one-way ANOVA examined differences in rehospitalization frequency across three groups:

(1) patients who screened negative for personality pathology,

(2) those who screened positive on the SCID-5-SPQ but had no documented PD diagnosis, and

(3) those with a documented PD diagnosis (**Table 4**).

Table 4. Rehospitalization frequency by PD screening and diagnosis status

Group	n	M	SD	95% CI for M	Min-max
No PD (screen negative)	36	1.61	2.87	0.64-2.58	0-14
Screen positive undiagnosed	52	2.71	2.44	2.03-3.39	0-12
Diagnosed PD	1	2.00	-	-	2-2
Total	89	2.26	2.65	1.70-2.82	0-14

Note. CI: Confidence interval; One-way ANOVA: F (2, 86) = 1.87; p = .160; Homogeneity of variances met; F (1, 86) = 0.20; p = .657; & Post hoc tests not performed due to single-case size (n = 1) in the diagnosed PD group

Table 5. Spearman correlations between PD severity and rehospitalization frequency

Variable	1	2	3	M	SD
1. Subsequent hospitalizations	-			2.26	2.65
2. MaxDim PD score	.25*	-		9.72	2.55
3. AverageDim PD score	.29**	.73**	-	5.45	2.41

Note. Values represent Spearman's rho correlations (two-tailed); p < .05; p < .01; & Higher scores indicate greater personality disorder severity and more frequent hospitalizations

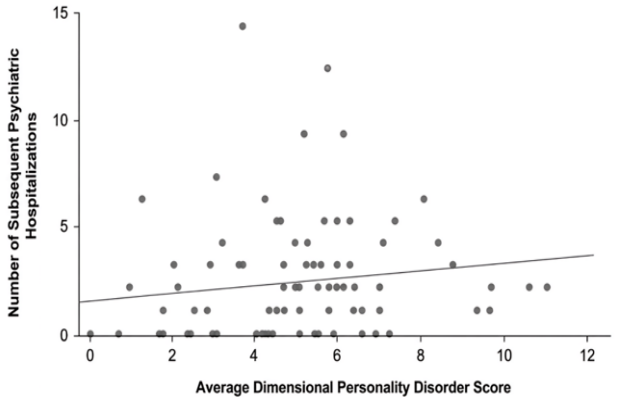

Figure 2. Positive association between SCID-5-SPQ AverageDim scores and frequency of rehospitalization (the authors' own data)

The assumption of homogeneity of variances was met, F (1, 86) = 0.20, p = .657. Mean rehospitalization counts did not differ significantly across groups, F (2, 86) = 1.87, p = .160. Patients who screened positive but remained undiagnosed (M = 2.71, SD = 2.44) showed somewhat higher rehospitalization counts than screen-negative participants (M = 1.61, SD = 2.87), although the difference was not statistically significant. Post hoc tests were not conducted due to the single-case size of the diagnosed PD group (n = 1).

Spearman's rank-order correlations were conducted to examine the association between dimensional PD severity and rehospitalization frequency. As shown in **Table 5**, both indices of PD severity were significantly and positively correlated with the number of subsequent hospitalizations. Higher MaxDim PD scores were associated with more frequent rehospitalizations, ρ = .25, p = .018, as were higher AverageDim PD scores, ρ = .29, p = .006.

Spearman's rank-order correlations showed significant positive associations between dimensional PD severity and the number of subsequent hospitalizations. Higher MaxDim PD scores were associated with more frequent hospitalizations (ρ = .25, p = .018), as were higher AverageDim PD scores (ρ = .29, p = .006; see **Table 5** and **Figure 2**).

Table 6. Negative binomial regression predicting rehospitalization frequency

Predictor	B	SE	Wald χ^2	p	95% CI for B
Intercept	0.29	0.57	0.25	.617	[-0.83, 1.41]
MaxDim PD score	0.02	0.08	0.05	.833	[-0.14, 0.18]
AverageDim PD score	0.06	0.08	0.59	.442	[-0.10, 0.23]

Note. Dependent variable: Subsequent hospitalizations; Model fit was adequate (deviance/df = 1.07; Pearson χ^2/df = 1.06; likelihood ratio χ^2 = 1.87, p = .393); Neither PD severity index significantly predicted rehospitalization frequency (p > .05)

Preliminary Poisson regression indicated overdispersion (deviance/df = 2.84), suggesting greater variability in hospitalization counts than expected under the Poisson distribution. A negative binomial regression was therefore applied, resolving the overdispersion (deviance/df = 1.07; Pearson χ^2/df = 1.06) and providing adequate model fit. The model examined whether PD dimensional severity predicted rehospitalization frequency, with average and MaxDim PD scores entered as predictors and subsequent hospitalizations as the dependent variable. The overall model was not statistically significant, Likelihood ratio χ^2 (2) = 1.87, p = .393. Neither MaxDim PD score (B = 0.02, SE = 0.08, Wald χ^2 = 0.05, p = .833) nor AverageDim PD score (B = 0.06, SE = 0.08, Wald χ^2 = 0.59, p = .442) significantly predicted rehospitalization (see **Table 6**). This attenuation likely reflects substantial overlap between the two severity indices (ρ = .73, p < .001), suggesting that although overall PD severity correlates with rehospitalization at the bivariate level, no single SCID-5-SPQ dimension uniquely predicts hospitalization risk when shared variance is accounted for.

DISCUSSION

The present study examined the recognition and documentation of PDs among psychiatric inpatients within our institution. While our findings are contextually situated, they reflect a broader pattern consistent with reports from other clinical settings. Consistent with prior literature, more than half of our sample (59.6%) screened positive for a PD on the SCID-5-SPQ, suggesting a high prevalence of personality pathology in acute psychiatric populations, even when not the primary cause of admission. Comparable rates have been reported across clinical settings, where structured or semi-structured interviews reveal that approximately half of all psychiatric patients meet criteria for at least one PD [7, 8, 24]. Despite this well-documented prevalence, diagnostic recognition of PDs remains exceptionally low. In our sample, only 1.1% carried a documented PD diagnosis, suggesting a 98% underdiagnosis rate—an extraordinary discrepancy that echoes the persistent diagnostic gap reported across decades of research [25, 26]. The fact that the PD diagnosis in our sample was for organic PD rather than a primary PD further highlights this discrepancy.

The reasons underlying the discrepancy between screening-positive PD cases and documented PD diagnoses are likely multifactorial. Acute affective, psychotic, or substance-related presentations often overshadow enduring personality traits [27], while clinical priorities in acute care typically emphasize crisis stabilization over longitudinal personality assessment. Institutional barriers may also contribute time constraints, limited physician training in personality assessment, and documentation systems not designed to facilitate PD coding [28-30]. Additionally, differences between the DSM-5 framework underlying the SCID-5-SPQ and the ICD-10 diagnostic system used in routine clinical practice during the study period may have contributed to discrepancies between screening-positive cases and documented PD diagnoses.

Against this backdrop, it is notable that decades of evidence linking unrecognized PDs to poorer outcomes have not translated into commensurate diagnostic traction. While clinicians appropriately prioritize acute stabilization, persistent system-level constraints and competing clinical priorities may limit the integration of personality assessment into routine care. These realities strengthen the case for implementing brief, low-burden screeners (e.g., SCID-5-SPQ) at intake to flag patients who warrant fuller evaluation, thereby aligning practice with evidence and supporting more individualized treatment planning, particularly given associations between unaddressed PDs and nonadherence, relapse, and disease chronicity [31]. In Romanian psychiatric settings, such screening could be incorporated into routine admission procedures as part of preliminary screening measures, such that patients who screen positive for PD pathology are referred for more comprehensive personality assessment when clinically indicated. This approach may improve the identification of clinically relevant personality pathology.

Our findings also hint at the possible clinical consequences of the underrecognition of PDs in psychiatric inpatients. Although the difference was not statistically significant, patients who screened positive for a PD appeared to have higher mean rehospitalization rates than those who screened negative. However, the presence of only clinically documented PD diagnosis in our sample precludes meaningful inferential comparisons between recognized and unrecognised groups regarding rehospitalization rates. The observed pattern of higher rehospitalization in unrecognized groups, while modest, aligns with prior research linking undetected PDs to treatment instability and increased relapse risk [32, 33]. The lack of statistical significance in our results likely reflects limited power due to the sample size, rather than the absence of a genuine effect. Even so, the observed trend should be interpreted cautiously and warrants further examination in future research.

Interestingly, while previous studies have found that PD severity predicts hospitalization frequency [32, 34, 35], our findings show a moderate correlation and suggest that PD severity alone may not directly account for rehospitalization risk. Instead, personality pathology may exert its influence indirectly, through mechanisms such as comorbidity, poor treatment adherence, interpersonal dysfunction, or social instability [36, 37]. However, given the exploratory nature of this study and the modest sample size, this finding should be interpreted cautiously. One possible interpretation for our observation is a multifactorial relapse model in which PDs act as vulnerability factors rather than direct causes of recurrence. This possibility is broadly consistent with contemporary dimensional and biopsychosocial frameworks, which conceptualize PDs as transdiagnostic risk factors that shape illness trajectories through interaction with environmental and interpersonal stressors [38, 39]. From a treatment perspective, this underscores the importance of addressing functional impairment and behavioral dysregulation, rather than focusing solely on symptomatic intensity.

Several limitations should be considered. Firstly, although the SCID-5-SPQ is officially translated and licensed in the Romanian language, we could not find evidence of its psychometric validation within Romanian populations. Therefore, conclusions regarding prevalence estimates are limited by this constraint, and findings should be interpreted with caution. Further research should prioritize psychometric validation of the Romanian version of the SCID-5-SPQ and replication of these findings in larger multicenter samples. In addition, PD assessment relied on the self-report SCID-5-SPQ without clinician confirmatory diagnostic interviews using the SCID-5-PD, thereby limiting our ability to draw conclusions about true prevalence or diagnostic accuracy. Our findings, therefore, reflect screening prevalence of PD profiles and should be regarded as orientative, rather than confirmed DSM-5 diagnoses. The inclusion of confirmatory diagnostic interviews, such as the SCID-5-PD, in future studies is needed. The absence of diagnostic confirmation may have resulted in both false-positive and false-negative classifications, potentially leading to either overestimation or underestimation of true prevalence of PDs in the study population. Consequently, the prevalence estimates reported in our study should be interpreted as approximate indicators of PD burden rather than precise estimates of DSM-5 PD prevalence. In addition, the use of the SCID-5-SPQ, which is a DSM-5-based screening instrument, alongside ICD-10 clinical diagnoses, may have contributed to discrepancies between screening results and documented diagnoses. Psychiatric diagnoses were extracted from existing medical records, which may underestimate true diagnostic awareness if personality pathology was clinically recognized but not formally documented. Additionally, the relatively small sample size (N = 94) of this study may have substantially limited statistical power to detect meaningful differences between subgroups. Only one participant in our sample had a documented personality diagnosis in their medical record, precluding meaningful inferential comparisons between patients with recognized and unrecognized PDs. Observations regarding hospitalization patterns should therefore be regarded as exploratory, rather than inferential. Larger studies are needed to examine the associations between PD recognition and subsequent hospitalization more rigorously.

Despite these limitations, the present study highlights a striking underrecognition of PDs within psychiatric inpatient care, or at the very least, their lack of documentation by physicians. These findings underscore the importance of routine personality screening in acute psychiatric settings. Early identification of personality pathology may support more individualized treatment planning, improve therapeutic alliance, and potentially reduce the risk of recurrent hospitalizations. Integrating brief screening tools into standard admission procedures may therefore represent a feasible strategy for narrowing the persistent gap between PD prevalence and diagnostic recognition.

Beyond its local context, these findings contribute to a broader international discussion on the recognition and clinical relevance of personality pathology. To our knowledge, this study is among the first systematic investigations of PD recognition in Romanian psychiatry using structured screening tools, providing context-specific evidence that is relevant to ongoing efforts to improve diagnostic accuracy and the integration of dimensional approaches into clinical practice.

Author contributions: C-IV: conceptualization, methodology, resources, supervision, writing – original draft, writing – review & editing; **ECO:** conceptualization, data curation, formal analysis, investigation, methodology, project administration, visualization, writing – original draft, writing – review & editing; **S-DM-C:** investigation, methodology, writing – review & editing; **M-CV:** investigation, validation, writing – review & editing; **AC:** data curation, investigation, writing – review & editing; **IM & AAC:** supervision, validation, writing – review & editing. All authors have agreed with the results and conclusions.

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Ethical statement: This study was approved by the Ethics Committee at the Elisabeta Doamna Clinical Psychiatry Hospital on 11 December 2023 with approval number 11/12/2023. All procedures followed were in accordance with the ethical standards of the Ethics Committee at the Elisabeta Doamna Clinical Psychiatry Hospital and with the Helsinki Declaration of 1964. Informed consent was obtained from all patients included in the study.

AI statement: Generative AI (ChatGPT -5.5 and OpenAI) was used solely to produce the graphical images based exclusively on the authors' original dataset and specifications. The AI-generated images were thoroughly reviewed and verified for accuracy to ensure they accurately represented the underlying data. The authors take full responsibility for the accuracy and integrity of the figures and all other content in this manuscript.

No generative AI or AI-assisted tools were used for the generation, analysis, interpretation of the study data, or the writing of the manuscript.

Declaration of interest: No conflict of interest is declared by the authors.

Data sharing statement: Data supporting the findings and conclusions are available upon request from the corresponding author.

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