THE EFFECT OF TYPE D- PERSONALITY ON PERSONALITY DISORDERS: CLUSTER C PERSONALITY

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Abstract

Type D personality leads the individuals to show resistance towards rehabilitation and wallow in depression and doubt. The main objective of this study is to investigate the effect of Type D–Personality in increasing the level of personality disorder. In order to achieve the main objective, 165 undergraduate students from a public university in Baghdad, Iraq have been selected to respond to two sets of questionnaires namely Type D–Personality (TDP) by Denollet & Colleagues (2011), as well as the International Personality Disorder Examination (IPDE) by Loranger (1994). The results showed that TDP has a significant effect on AVPD & DPD, whereas it has no significant effect on OCPD. Implications and limitations of the study were discussed, and suggestions for future research are offered. The danger of the TDP should be introduced as early as possible before young couples started to become students and get into university society.

Keywords: Type D–Personality (TDP), Avoidant Personality Disorder (AVPD), Dependent Personality Disorder (DPD), Obsessive compulsive personality disorders (OCPD).

تأثير نمط الشخصية (دي) على اضطرابات الشخصية: الفئة سي لاضطرابات الشخصية

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نبذة مختصرة

نمط الشخصية (دي) يقود الأفراد إلى إظهار مقاومة تجاه إعادة التأهيل والاكتئاب والشك. كان الهدف الرئيس من هذه الدراسة هو دراسة تأثير نمط الشخصية (دي) في زيادة مستوى اضطراب الشخصية. وباستخدام مجموعة أساليب لتحقيق الهدف الرئيس. تم اختيار١٦٨ طالبًا جامعيًا من مختلف جامعات بغداد، العراق من اجل الاجابة على مجموعتين من الاستبيانات هما: نمط الشخصية (دي) (TDP) الذي تم بناؤه من قبل العالم دينولت وزملائه (٢٠١١)، وكذلك الاختبار الدولي لاضطرابات الشخصية (IPDE) الذي تم بناؤه من قبل العالم لورانجر (٢٠١١). وقد أشارت النتائج أن نمط الشخصية (دي) له تأثير كبير اضطراب الشخصية المتجنبة واضطراب الشخصية المعتمدة، ولكن ليس هنالك تأثير على نمط الشخصية الوسواسية القهرية. تم مناقشة الآثار والقيود للدراسة، وتم تقديم مقترحات للبحوث في المستقبل. خطر نمط الشخصية (دي) يجب الاهتمام به في أقرب وقت ممكن قبل أن يبدأ الأزواج الشباب في أن يصبحوا طلابًا ويدخلوا في المجتمع الجامعي.

الكلمات المفتاحية: نمط الشخصية (دي) (TDP)، اضطراب الشخصية المتجنبة (AVPD)، اضطراب الشخصية المعتمدة (DPD)، اضطرابات الشخصية الوسواسية (OCPD).

Introduction

Numerous studies have been conducted on personality types to focusing on the traits of personality and its influences on personality disorders. However, Type D personality or distressed personality, which leads the individuals to resistance towards wallow and rehabilitation in doubt and depression. Subsequently, leading to a tendency to experience increased emotions (negative) across situations and time (negative affectivity), and the difficulty to share the emotions with others because the fear of rejection or disapproval (social inhibition) as well as a loss of power (Denollet, 2005; 2013; Kadhim 2017). General attributes for TDP is considered as the main source to form the behaviour of an individual and attitude, as well as to diagnose individuals who have personality disorders which fall into three clusters (A, B, &C)
(Derksen, 1995; APA, 2000; Ali &Chaudhry, 2014; Pedneault, 2016).

The prevalence in the general population of all personality disorders is 6–10% (RCPS 2018). The latter consisted of avoidant, dependent and obsessive–compulsive that characterized by the most prevalent personality disorders in the general population, with a range of 3–11% (Samuels et al., 2002; Crawford et al., 2005; Lenzenweger et al., 2007; Laajasalo et al., 2013; Snir et al., 2015). For example, the prevalence of avoidant PD was 1.7%, prevalence of dependent PD was 0.7%, & prevalence of obsessive–compulsive PD was in the general population, 2.1%, it is also among the most common PDs in clinical populations 13.1% (Stuart et al., 1998; Zimmerman et al., 2005; David, 2006; Torgersen, 2009 Grohol, 2019).

In the context of personality disorders, AVPD is defined as involving a pervasive pattern of avoidance of occupational activities, which involve significant interpersonal context because of fears of disapproval, criticism, and rejection. Inhibition in new interpersonal situations because of feelings of inadequacy, unusual reluctance to take personal engage, risks, or in any new

activities because they may prove embarrassing, including an unwillingness to get involved with people unless certain of being liked. Perceptions of the self as personally unappealing, socially inept, inferior to others, and preoccupation with social rejection and criticism (APA, 2000).

Moreover, it is considered the most prevalent Personality Disorders in the community (Torgersen, 2009). It has also been found to be strongly associated with reduced quality of life in the community, as measured by subjective well-being, neighbourhood quality, relation to friends, self-realization, social support, and negative life events, related to the family of origin, as well as, associated with a high frequency of problems with wealth and status, psychosexual dysfunction, hypersensitivity to social inhibition and negative evaluation, and with lack of resilience and successful intimate relationships

(Cramer et al., 2006; Ulrich et al., 2007; Eggum et al., 2009; Mousa 2017).

AVPD would have a higher prevalence rate more than individualistic societies that are confirmed by Ono et al (1996), and Okonogi (1996). Though highly prevalent (Mendlowicz et al., 2006; Herbert, 2007; APA, 2013), has received scant research attention. Despite their centrality to the phenomenology of the disorder, little data exist regarding the interpersonal difficulties of individuals with APD (Millon et al., (2004); Skodol et al., 2005).

Dependent personality disorder (DPD) has evolved from an abstract idea rooted in a historic and psychoanalytic context to a codified diagnosis in the DSM-IV-TR. It is known that humans are Social by naturally so depends on others for survival across various stages of the lifespan. However, dependency in its more extreme forms is classified as a mental illness within the context of our current diagnostic system

(Disney, 2013; Laos et al., 2015).

Individuals with this personality disorder typically characterized by an excessive need to be taken care of, obsessional fears of being separated from

loved ones or caregivers, require a loved one or caregiver to take responsibility for their decisions in major areas of their lives, wary of expressing disagreement with others for fear of losing their support or approval and great difficulty making everyday decisions for themselves, such as what to wear or what to order in a restaurant (Harvard Medical School, 2007; Bornstein, 2011).

Therefore, can be described as a pervasive and excessive need to be taken care of that leads to submissive and clinging behaviour, fears of separation, they may think of themselves, or present themselves, as unable to cope with everyday life on their own. At the same time, they may fear that a show of confidence or competence will lead to rejection and abandonment, demand advice and reassurance when making even minor decisions, have difficulty initiating or completing projects on their own, making everyday decisions without substantial advice, and expressing disagreements (APA, 2000, 2013; Disney, 2013; Loas et al., 2015).

From the above, the Majority of traits is dangerous to the individual and lead to an inability to adapt to the surrounding environment, inability to complete his/her job, poor self-esteem. From this we can say that (DPD) is a problem in the current research and there will be a chance to see if (TDP) that occurs in early childhood have any impact on the development of this disorder.

By the end of the context of cluster C, there is the (OCPD) Obsessive-Compulsive Personality Disorder characterized by tend to possess features such as perfectionism that interferes with finishing the tasks, excessive devotion to work that impairs family and social activities, excessive fixation with lists, rigid following of ethical and moral codes, minor and rules details, unwillingness to assign tasks unless others perform exactly as asked, lack of generosity; hoarding behaviours, extreme frugality without reason (Noppen, 2010; Hagen, 2016). Even though these particular features might be taken as positive in some cultures

(Hairul & Prihadi, 2015), it was also proven that individuals with OCPD would likely to find difficulties in coping with their peers and other members of the society (Cicchetti & Crick, 2000; Michael et al., 2016).

Based on the studies noted that most of the qualities Cluster C shares with a TDP Gained by an individual during the first stage (oral stage) in the psychological development stage. On this basis, it is likely to be TDP essential variable in the development of qualities an avoidant, dependent, obsessive–compulsive personality disorders. Therefore, in this current study, Type D–Personality (TDP) is used as the independent variable and AVPD, DPD, & OCPD is used as the dependent variables.

This study aims to investigate the influence of TDP on AVPD, DPD, and OCPD among university students.

Related Literatures

Type D– personality (TDP)

Denollet in (1996) suggested the TDP was originally identified after observations of patients with aggressive and competitive. Moreover, it added that negative affectivity (NA) and social inhibition (SI) are the two traits distinct to Type D personality (Condén, 2014).

Negative affectivity is the tendency to negative emotions, anxiety, experience depression, feelings of irritability, apprehension, and dysphoria. By contrast, social inhibition is the tendency to pair with failure to adapt, interpersonal stress, and inhibit the expression of emotions (Gest, 1997).

The synergistic effect of SI and NA involves a considerable risk of social difficulties and several emotional, such as anxiety, lack of social support, low quality of life, depression, and low level of subjective well–being (Mols & Denollet, 2010). The main source of stress is the threat of negative reactions from others
(Smith et al., 2012).

The SI and NA have received initial attention because the TDP was determined based on the knowledge that psychosocial factors are linked with cardiovascular outcomes. In addition, it has been associated with a variety of social and emotions difficulties, as well as increased morbidity and mortality among patients with confirmed cardiovascular disease (CVD) (Kop, 1999; Rozanski et al., 1999; Pedersen & Denollet, 2003; Schiffer et al., 2007; Compare et al., 2014). Furthermore, TDP plays a clinically relevant role in psychological health outcomes because of persons with this personality report significantly higher levels of diminished psycho-physical well-being and quality of life, anxiety, social anxiety, perceived psychophysical stress, depressive mood, and interpersonal difficulties (Sogaro et al., 2010).

However, several studies have demonstrated that Type D-Personality predicts adverse clinical outcomes even after controlling for measures of negative effects, such as anxiety and depression. It was as well argued that depression reflects psychopathology, whereas, Type D-Personality represents a normal personality construct (Denollet & Brutsaert, 1998; Denollet, Vaes & Brutsaert, 2000; Williams, 2007).

Because TDP individuals tend to develop NA, they tend to experience negative emotions, sentiment, including anxiety, depressed mood, anger, and attention to negative stimuli than positive stimuli

(Denollet, 2000; Denollet & Van Heck, 2001); guilt, poor self-concept, contempt, fear, nervousness and disgust

(Watson & Clark, 1984; Koch et al., 2013).

Therefore, a TDP individual who scores high on negative affectivity is at risk for impending trouble. Conversely, a low negative affectivity score is characterized by a state of confidence, as well as, frequent states of serenity, activeness, considerable enthusiasm and calmness. Additionally, individuals with TDP is considered as almost always having a constant bad mood, excessively focusing on unimportant things; always holding bleak views,

dissatisfaction, worrying about the situation around them; and frequently expressing misery (Tellegen, 1985; Denollet, 2000; Denollet, 2005).

Furthermore, individuals with TDP are also known to develop SI, they frequently feel uncomfortable, inhibited, tense, and perceived that everything in the circumstances does not support them and insecure during an encounter with other people (Pedersen & Denollet, 2003; Habra et al., 2003). Their SI characteristic leads them to refuse to talk to strangers, often refraining from social interactions, wanting to be distant from people, unable to meet people, suffering from the difficulty of starting a conversation with others, and generally being unable to find the appropriate topics to discuss when interacting with others (Denollet, 2005). Through the above-mentioned qualities, about NA and SI found that most of them are similar to the qualities AVPD, DPD, and OCPD, Such as, a negative perception of things, difficulties in coping with their peers and other members of the society and unstable relationships with other people.

Avoidant Personality Disorder

Ibrahim & Askar (2005) defined AVPD as a Characterized by a fear of being ridiculed others, avoiding actions that need to share with others, a sense of inferiority and lack of demand for new activities that require adventure, and preoccupation with the fear of being subjected to rejection or criticism in social situations. American Psychiatric Association defined AVPD as a pervasive pattern of social inhibition, hypersensitivity to negative evaluation, feelings of inadequacy, and beginning by early adulthood and present in a variety of contexts (APA, 2013). In line with Sanislow et al., (2012) elaborated that such individuals are being clinically significant deficits in both the interpersonal relationships and self. Therefore, the APD self-definition encompasses intense fears of interpersonal rejection stemming from a heightened sensitivity to criticism from others is another key feature, leading to social detachment and a desire for affiliation hobbled by a sense of

personal inadequacy. In broader terms, the feelings of the person suffering APD have been described as behaviours as shyness and anxiety (Sanislow et al., 2012). Also, the evident type has a negative sense of self-associated with a profound sense of inadequacy and inferiority (Skodol et al., 2011).

Consequently, evident indulge themselves excessively in fantasy and imagination, both as a means of replacing anxiety-arousing cognitions of inadequacy and low self-worth and as a means of gratifying needs that cannot be met due to social withdrawal. Avoidance may be seen as having a highly developed ego ideal, including a high level of aspiration and desires for self-actualization, paired with an intense condemning superego that constantly finds fault with and disapproves of their every behavior. In effect, they have internalized parental standards of high achievement and social success, combined with blame and shunning for the smallest mistakes, also exposure to the rejection by the parents and severe criticism in the tiny resulting composition of negative self and interact with another cognitive formula.

(Millon et al., 2004; Ralevski et al., 2005; Ibrahim, 2006).

Furthermore, research has shown that AVPD and social phobia may represent different points on a severity continuum rather than easily defined discreet categories, suggesting that AVPD and social phobia may represent a spectrum of anxiety symptoms related to social anxiety and social inhibition (Tillfors et al., 2003). Overall, 14.79% of adult Americans (95% CI = 14.08 to 15.50), or 30.8 million, had at least 1 personality disorder. Avoidant personality disorder, 2.36% (95% CI = 2.14 to 2.58). The risk of avoidant personality disorders was significantly greater among women than men ($p < .05$) (Grant et al., 2004). The median prevalence of AVPD in 12 epidemiological studies was 1.7%, making it one of the most prevalent PDs in the community (Torgersen, 2009).

Avoidant personality disorder has also been found to be the PD most strongly associated with reduced quality of life in the community, as measured by self-realization, subjective well-being, neighbourhood quality, social support, relation to friends, relation to the family of origin, and negative life events (Cramer et al., 2006). Much of the literature on AVPD focuses on its discrimination from social phobia (SP), and specifically if it can simply be considered a severe form of generalized social phobia (GSP).

Although the conclusions drawn from many studies and reviews suggest that AVPD and GSP differ only quantitatively, but not qualitatively, a closer look at these studies indicates a more complex picture. Alden and colleagues (2002) noted that studies of social phobia/AVPD comorbidity typically examined a sample of patients, all of whom were included because they had one of these diagnoses, for overlap with the other. Such studies reliably find that many, though far from all patients with AVPD also have social phobia (Alden et al., 2002).

An adulthood disorder, is defined as involving a pervasive pattern of feelings of inadequacy, social inhibition, related to effective regulation/coping with negative emotion in social interactions, as well as low levels of maladjustment, and hypersensitivity to negative evaluation, beginning by early adulthood and present in a variety of contexts (Eisenberg et al.,1995; Lengua et al., 1998), it seems likely that people with AVPD, who tend to have problems with modulating their evaluative concerns and negative emotionality, are low in attentional regulation.

The majority of these qualities shared with TDP It is known to be associated with cardiovascular diseases and psychological, such as the tendency to the negative perception of everything and unwillingness to social interaction with others (Denollet & Brutsaert, 1998; Denollet et al., 2000; Sogaro et al., 2010; Williams, 2007). On this basis, the statement might have repressed by the negative effect for TDP on AVPD through enhanced the qualities that

motivate on social inhibition contact and negative emotion in life, this is what happens in the first stage of the stages of psychological development of the individual.

Dependent Personality Disorder

Little empirical research has been completed on the construct of DPD in comparison to other Axis II disorders (Loas et al., 2011; Disney, 2013). The core element of this disorder appears to be a view of the self as inept and helpless, along with a view of others who are seen as competent and strong (Bornstein, 1997; Skodol et al., 2011).

It has been found to be associated generally with moderate – to low impairment in functioning

(Crawford et al., 2005; Cramer et al., 2006; Ulrich, Farrington, & Coid, 2007). In the study by Stuart et al. (1998), DPD was the third most common PD, with a prevalence of 18.0%; in the study by Zimmerman and colleagues (2005), DPD was one of the least common, with a prevalence of 1.4%. In other, smaller clinical samples evaluated with semi-structured interviews, the prevalence also fluctuates from a high of 22.9% to a low of 5% (Zimmerman et al., 2005).

On the other hand, other studies of DPD have found extensive overlap with other DSM PDs (e.g., Skodol et al., 2012), suggesting a pattern of maladaptive traits and behaviours that cut across a range of personality psychopathology. More recently, Nestadt et al. (2006) examined all the DSM-IV PD criteria using both exploratory and confirmatory factor analyses and found that DPD was best represented by a single, latent trait dimension in both types of analyses. According to the classical psychoanalytic theory, the dependent personality is characterized by fixation during the oral stage, the first stage of psychosexual development. Because character types were named after their respective stage of psychosexual fixation, the dependent

personality is usually called the oral character in classic psychoanalytic theory (Abraham, 1927c).

In contrast, frustration during the oral stage was believed to result in an enduring ambivalence between hunger and hostility. Such children are unsure whether to nurse or bite. As adults, they seem to always require something more, but remain hostile, even when their needs are met. The psychoanalytic idea of oral fixation thus leads to a connection between the dependent and negativistic (passive–aggressive) personalities (Millon et al., 2004). On this basis, can see the fixation during the oral stage lead to acquisition TDP and DPD, Accordingly the negativity in TDP and DPD might be referring to influence of TDP on DPD.

Obsessive Compulsive Personality Disorder

The most famous scientists in the field OCPD is Freud (1908) defined it as a preoccupation with obstinacy (rigidity and stubbornness), orderliness, and parsimony (frugality). On the other, found that APA addressed OCPD in all its versions, but many developments have occurred in the qualities of the first version to the very latest version out that ended up defining as a preoccupation with efficiency, orderliness, mental and interpersonal control, perfectionism, and openness (APA, 2000).

In line with Freud, Jones (1918) elaborated that such individuals are likely to focus on tedious chores, have a "special sense of duty," and are "pathologically intolerant" of other views on morality issues. Moreover, they insist on organization, orderliness, and cleanliness; and dislike throwing anything away. Jones noted the negative social aspects of this trait type, which include a high level of negative effect, low level of positive effect, and antagonism (Jones, 1918).

Traits of individuals with OCPD were consistently reported. McGlashan et al. (2005) the least unstable criteria and most prevalent obtained over a period of 24 months were miserly behaviours, perfectionism, rigidity,

problems in delegating, and strict moral behaviour associated with OCPD. Further, it was also determined that Obsessive Compulsive Personality Disorder may be examined effectively within an undergraduate population; in their study, they further reported that Obsessive Compulsive Personality Disorder is the single most prevalent personality disorder in the college population (8%)
(Blanco et al., 2008; Samuel & Widiger, 2011; Kadhim 2017).

In line with the aforementioned paragraph, a study on of 536 showed that OCPD is a maladaptive version of the normal personality attribute of conscientiousness (Samuel & Widiger, 2011). Samuel et al. (2012) examined a newly developed measure of traits relevant to OCPD using Five Factors Model of Personality. twelve scales were constructed as maladaptive variants of specific Five Factors Model facets
(e.g., Perfectionism, as a maladaptive variant of FFM competence). Based on data from more than 400 undergraduate students sampled for Obsessive–Compulsive Personality Disorder symptoms, the twelve scales demonstrated convergent correlations with established Five Factors Model measures and Obsessive–Compulsive Personality Disorder. Hence, these findings support the validity of Five Factors Model as a tool to measure OCPD traits
(Samuel et al., 2012).

According to previous studies, there is a possibility to be influence of Type D– Personality on Obsessive–Compulsive Personality Disorder, where possible, that the individual who has a Type D– Personality that owns Obsessive Compulsive Personality Disorder and different levels, this is referred to several studies such as Shanmugasegrm and colleagues (2013) which investigated associations among TDP and attitude perfectionism in one hundred cardiac rehabilitation patients. The result indicates too Perfectionism was associated with both NA and SI of the Type D construct and the patients

have maladaptive coping with potentially negative implcations for their cardiac rehabilitation outcomes.

Stoeber and colleagues (2014) examined the relationship between the negative affectivity and perfectionism. The result was perfectionism have shown increased negative affect after failure. Therefore, perfectionism is vulnerability factors predisposing students to react with increased NA after repeated failure.

The Influence of TDP on AVPD, DPD, & OCPD

It may be unreasonable that all these disorders are associated with TDP but unfortunately there are many things that are similar as the existence of anxiety most of their actions in AVPD may represent a spectrum of anxiety symptoms related to social anxiety and social inhibition (Tillfors et al., 2003; Sanislow et al., 2012) which is the main factor for TDP. Also, the negative in many aspects of personality, as noted above negative exists in everyone.

On the other hand, AVPD defined as a pervasive pattern of social inhibition, has a negative sense of self, strongly associated with negative life events, and coping with negative emotion in social interactions (Eisenberg et al.,1994; Lengua et al., 1998; Cramer et al., 2006; Skodol et al., 2011; APA, 2013). Also, exposure to the rejection by the parents and severe criticism in the tiny resulting composition of negative self and interact with another cognitive formula (Millon et al., 2004; Ralevski et al., 2005; Ibrahim, 2006). Furthermore, characterized by avoiding actions that need to share with others, fear of being ridiculed others, preoccupation with the fear of being subjected to criticism or rejection in social situations (Ibrahim & Askar, 2005).

On this basis, there are common traits between TDP and AVPD such as Denollet in (1996) suggested the Type D personality was being hurried, aggressive and competitive.

Moreover, (NA) and (SI) are the two traits distinct to TDP. In addition, fear of being placed under rejection and criticism (social inhibition) (Denollet, 2005; Condén, 2014). In same the side, the psychoanalytic idea of oral fixation thus leads to a connection between the dependent personality disorder and negativistic (passive–aggressive) personalities (Millon et al., 2004; Gore et al., 2012).

In the same field, find that the psychological theory has a great role in the interpretation of most personality disorders, including AVPD, DPD, and OCPD that dealt in some detail by emphasizing the first stage of psychological development that are caused in many personality disorders and TDP (Freud, 1908, 1956; Cherry, 2018).

Moreover, the classical psychoanalytic theory indicated, the dependent personality is characterized by fixation during the oral stage, the first stage of psychosexual development. Because character types were named after their respective stage of psychosexual fixation, the dependent personality is usually called the oral character in classic psychoanalytic theory (Abraham, 1927; Loas et al., 2015).

Jones noted the negative social aspects of OCPD, which include a high level of negative effect (Jones, 1918; Michael et al., 2016). Also, Stoeber and colleagues (2014) examined the relationship between the negative affectivity and perfectionism (the main characteristic for Type D–Personality). The result was perfectionism have shown increased negative affect. On this evidence, there are negative social inhibition and fear of criticism and rejection shared among TDP, AVPD, DPD, and OCPD. So, the current research will try to find the influence of TDP on AVPD, DPD, and OCPD.

Prevalence

Classification of TDP related to Cardiovascular disease and personality disorders AVPD, DPD, and OCPD in cluster C the anxious It is a representation of the size of the problem of current research

(APA, 2013; Condén, 2014). So, it shall show the prevalence of TDP is 21% in the general population and ranges between 18% to 53% of cardiac patients (Denollet, 2005; Pedersen & Denollet, 2006).

Overall, 14.79% of adult Americans (95%)(CI = 14.08 to 15.50), or 30.8 million, had at least 1 personality disorder. Avoidant personality disorder, 2.36% (95%) (CI = 2.14 to 2.58) and the median prevalence of AVPD in 12 epidemiological studies was 1.7%, making it one of the most prevalent Personality Disorders in the community (Torgersen, 2009). Also, the risk of APD was significantly greater among women than men
(Grant et al., 2004). Dependent personality disorder was 0.7% (Stuart et al., 1998; Zimmerman et al., 2005; David, 2006; Torgersen, 2009), and diagnosed more frequently in females, and is one of the most hotly debated PDs in terms of gender (Disney, 2013). Critics argue that clinicians are biased and view this array of symptoms as more maladaptive when presenting in females than in males (Kaplan, 1983; Anderson et al., 2001).
Many studies are congruent with the DSM-IV and report a higher prevalence rate of DPD in females (Loranger, 1996; Barzega et al., 2001; Lowe et al., 2009), while others have reported no difference (King, 2000). The last disorder OCPD was in the general population, 2.1%, It is also among the most common PDs in clinical populations 13.1% (Stuart et al., 1998; Zimmerman et al., 2005; David, 2006; Torgersen, 2009). Blanco et al. (2008) reported that OCPD is the single most prevalent PD in the faculty population (8%)
(Blanco et al., 2008). Also reported a higher prevalence of OCPD among males than among females
(Coid et al., 2006; Light et al., 2006). All these prevalence percentages might indicate to the dangerous situation among students if has anyone from TDP, AVPD, DPD, and OCPD.

Null Hypotheses

The reviewed literature had indicated that the influence of TDP on the variables involved in this study suggested that TDP might alter the level of AVPD, DPD, & OCPD Through the early stages of psychological development of individuals because TDP is reported to acquire during the first stage after the birth of a child. Therefore, the following null hypotheses were to be tested:

1. There is no significant influence of TDP on AVPD.

2. There is no significant influence of TDP on DPD.

3. There is no significant influence of TDP on OCPD.

Methods

Sample and Data Collection Procedures

Data were gathered on 165 undergraduate students from a public university in Baghdad, Iraq. All of them are aged between 19-39 years old. They were randomly selected in several university cafeterias during classes' breaks. Three research assistants were recruited in order to collect the data, and they were briefed to select every third random person entered the cafeterias; if the person was not willing to participate, the next random third person should be chosen.

Instruments

In order to determine that the sample possesses Type D-Personality (TDP) An instrument called DS14 by Denollet & Colleagues (2011) was utilized to collect the data of TPD. This questionnaire contains fourteen items. Each item is scored on a scale of 0 to 4 (0 = the statement is false; 1 = the statement is less false; 2 = the statement is neutral; 3 = the statement is less true; and 4 = the statement true). The negative items (3,1), Negative Affectivity items (2, 4, 5, 7, 9, 12 and 13), Social Inhibition items (1, 3, 6, 8, 10, 11 and 14). Denollet et al (2011) had utilized the instrument to collect

data from 6222 patients in twenty-two countries to ensure the ability to predict TDP. In their findings, TDP has been found to be more prevalent in Eastern (35%) and Southern (37%) European countries compared with Northern (24%) (Denollet et al., 2013).

The International Personality Disorder Examination (IPDE)

In order to determine that the sample possesses AVPD, DPD, and OCPD an instrument called IPDE by Loranger (1994) was utilized to collect the data of AVPD, DPD, and OCPD. This questionnaire contains 59 items, each item is scored on a scale of 1 and 2 (1= True, 2= False). The International Personality Disorder Examination (IPDE) is a semi-structured clinical interview compatible with the DMS-5 classification systems and the international classification of diseases, eleventh Revision. The IPDE was administered by 58 clinical psychologists and psychiatrists to 716 patients enrolled in clinical facilities at 14 participating centres in 11 countries in Asia, Europe, North America, and Africa. To determine temporal stability, 243 patients (34%) were re-examined after an average interval of 6 months. To determine interrater reliability, 141 of the IPDEs (20%) were independently rated by a silent observer.

Results

Influence of TDP on AVPD

Table 1-3 depict the result of the regression analyses of the TDP on AVPD among the participants.

Table 1

Model Summary of TDP on their AVPD

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.383[a]	.147	.142	1.607

Table 2

Analysis of Variance, the TDP on their AVPD

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	72.932	1	72.932	28.249	.000[b]
	Residual	423.405	164	2.582		
	Total	496.337	165			

Table 3

Coefficients of TDP on their AVPD

Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	12.825	.412		31.092	.000
	TDP	-.081	.015	-.383	-5.315	.000

Table 1 – 3 indicated a significant regression was found F =28.249, p<.001) with an R^2 of .147. Participants' predicted AVPD is equal to 12.825 + -.081 TDP. In other words, TDP significantly predicted AVPD.

Influence of TDP on DPD

Table 4-6 depict the result of the regression analyses of the TDP on DPD among the participants.

Table 4

Model Summary of TDP on their DPD

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.212[a]	.045	.039	1.119

Table 5

Analysis of Variance, the TDP on their DPD

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	9.682	1	9.682	7.736	.006[b]
	Residual	205.258	164	1.252		
	Total	214.940	165			

Table 6

Coefficients of TDP on their DPD

Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	10.063	.287		35.038	.000
	TDP	-.029	.011	-.212	-2.781	.006

Table 4 – 6 indicated a significant regression was found F =7.736, p<.000) with an R^2 of .045. Participants' predicted DPD is equal to 10.063 + -.029 TDP. In other words, TDP significantly predicted DPD.

Influence of TDP on OCPD

Table 7-9 depict the result of the regression analyses of the TDP on OCPD among the participants.

Table 7

Model Summary of TDP on their OCPD

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.130[a]	.017	.011	1.331

Table 8

Analysis of Variance, the TDP on their OCPD

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	5.008	1	5.008	2.825	.095[b]
	Residual	290.751	164	1.773		
	Total	295.759	165			

Table 9

Coefficients of TDP on their OCPD

Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	10.945	.342		32.021	.000
	TDP	-.021	.013	-.130	-1.681	.095

Table 7 – 9 indicated a no significant regression was found F =2.825, p>.05) with an R^2 of .017. Participants' predicted OCPD is equal to 10.945 + -.021 TDP. In other words, TDP no significantly predicted OCPD.

Discussion and conclusions

The results of the statistical analyses were able to reject 1 &2 null hypotheses and accept hypothesis 3. Thus, the main finding of this study is that Influence of TDP on AVPD & DPD is significant among the graduate students but not significant on OCPD. Furthermore, the findings of this study reconfirmed the finding of Tillfors et al (2003); Sanislow et al (2012) who reported that AVPD related with social anxiety and social inhibition which is the main factor for TDP. Referring to the same result, where Eisenberg et al (1994); Lengua et al (1998); Cramer et al (2006); & Skodol et al (2011) found the AVPD has a negative sense of self, strongly associated with negative life events, and coping with negative emotion in social interactions. In addition to the above, there is the influence of the collective society to make the iraqi university students acquire (AVPD) and this was confirmed in a study Ono and his colleagues (1996) & Okonogi (1996), which noted that in individualistic societies, the avoidant personality fears negative evaluation, criticism from others, and rejection, but in a collectivist society, is more likely to be manifest as a fear of offending others with one's behaviour with the discomfort that one's own characteristics may be causing to others.

It is also very important to highlight that significantly predicted the development of DPD, this finding reconfirmed by Millon et al (2004) who reported that TDP has a connection with dependent personality disorder. In the same the line but with the last disorder in cluster C its OCPD, the result was disagreement result of a study Stoeber and colleagues (2014) who reported there are relationship between the perfectionism and TDP. The perfectionism also was have shown increased negative affect

(the main trait of TDP).

Overall, it can be concluded that the current study had achieved its aim to establish the influence of TDP on AVPD, DPD, & OCPD. It leads to the implication that any actions to reduce the influence of TDP among individuals, especially in south Asia –where the socio-cultural values encourage the practice of TDP– is significant in order to reduce the negative impact of TDP in the society. It is critical and imperative for the authority to develop programs to improve the positive, optimistic, sociality personality through educational institutions and social groups. It is also significant for the authority to educate parents to support their children's personality. In other words, the danger of the TDP should be introduced as early as possible before young couples started to become students and get into the university society.

Suggestions for Future Research

Future research in this subject matter should consider getting a greater sample size in order to get findings that are more accurate. Other than that, qualitative or mixed method research is highly suggested in order to obtain the deeper insight of the AVPD, DPD and OCPD phenomenon, especially in the collectivist society. Another variable that can be included into the equation is the authoritarian parenting style; this variable can be taken as another predictor for the effect on AVPD, DPD, & OCPD. Further studies on the effect of OCPD among children are also suggested due to its significance for the society. Most importantly, any research to develop educational programs for parents to eliminate TDP and culture because it xhas effect to increased symptoms AVPD & DPD highly suggested in order to facilitate the younger generation to develop better future.

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