

Adaptation and the Psychometric Properties of Turkish version of the Structured Clinical Interview for the DSM-5-Personality Disorders - Clinician Version (SCID-5-PD/CV)



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SUMMARY

Objective: The aim of this study is to demonstrate the validity and reliability of the Categorical and Dimensional Psychometric Properties of the Structured Clinical Interview for DSM-5 Personality Disorders (SCID-5-PD) after its translation to the Turkish.

Method: The study was carried out with 102 volunteers from two university hospitals. The SCID interview was conducted by two experienced psychiatrists who interchanged positions as interviewer and observer; and completed the research forms without discussing the patient. The diagnostic agreement between the interviewers and the Kappa coefficient were calculated. Divergent and convergent validity analyses were carried out for diagnostic validity and the scores obtained from the self-report form as well as the dimensional evaluation scores were used in the statistical analyses.

Results: The group mean age for volunteers was 39.6±11.6 years and 66.7% consisted of females. The Kappa values for personality categories were 0.79 for avoidant personality structure, 0.64 for dependent personality structure, 0.81 for obsessive-compulsive personality structure, 0.76 for paranoid personality structure, 0.49 for schizotypal personality structure, 0.90 for histrionic personality structure, 0.66 for narcissistic personality structure, 0.89 for borderline personality structure and 0.71 for antisocial personality structure. Dimensional evaluation showed significant correlation with the diagnostic agreement between the interviewers and also with the scores of the self-report forms completed by the participants.

Conclusion: The results demonstrated that the Turkish version of the Structured Clinical Interview for DSM-5 Personality Disorders (SCID-5-PD-CV-TR) is valid and reliable.

Keywords: DSM-5, SCID-5-PD-CV-TR, reliability, validity

INTRODUCTION

The concept of personality includes adaptation features that are unique to the individual and distinguish the individual from others. These features are the patterns of emotion, thought and behaviour developed by the individual on a basis of cognitive evaluations in order to adapt to the inner and outer world and have the ability to give specific emotional reactions in certain situations, coping styles and defense mechanisms in the face of frustration and conflicts. It is very difficult to define personality disorder, one of the

most important reasons for the diagnostic difficulty being the uncertainty in classification and diagnostic methods (Öztürk and Uluşahin 2016).

While DSM evaluates personality from a categorical perspective, the dimensional perspective evaluates the harmony of the general personality structure (Taymur and Türkçapar 2012). While the categorical approach in personality disorders acts as if the diagnosis exists or not, the dimensional approach evaluates the personality traits. The dimensional model helps to understand the boundary

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between categorical diagnoses and heterogeneous symptoms by providing more satisfactory information about the threshold values of features and symptoms (Taymur and Türkçapar 2012). The necessity of the dimensional system on account of the shortcomings of the categorical system has been discussed in previous studies (Oldham and Skodol 2000, Widiger and Simonsen 2005, Widiger and Trull 2007). SCID-5 Personality Disorder Alternative Model Version has been developed with DSM-5 as well as SCID-5 Personality Disorders version that allows dimensional evaluation (APA 2013). The structured interview form SCID-II for Personality Disorders, used with DSM-III-R and DSM-IV, has thus been updated as the SCID-5 Personality Disorder Edition (First 2016). The reliability of the SCID-II used in the Turkish language in our country had been demonstrated by Coşkunol et al. (1994).

In this present study, Turkish adaptation and psychometric properties of Structured Clinical Interview-Personality Disorders (SCID-5-PD) prepared for DSM-5, which are widely used in our country, were investigated.

METHOD

Translation to the Turkish Language and Adaptation to the Turkish Population of the SCID-5-PD-CV

The final text of the SCID-5-PD-TR was created after the translation of the SCID-5-PD in the English language to the Turkish language and back translation to English of the SCID-5-PD-TR by the Boylam Psychiatric Institute, and its controls and equivalence were mutually accepted with the American Psychiatric Association.

Study Participants

The Local Scientific Research Ethics Committee of Manisa Celal Bayar University Faculty of Medicine granted the approval dated 02/01/2019 and numbered 20.478.486 for this study. The inpatients receiving psychiatric care and outpatients with or without a diagnosis, consulting the psychiatry clinics of Samsun Ondokuz Mayıs University and Manisa Celal Bayar University Medical Faculties between January and July of 2019 were invited to participate in the study. A total of 102 individuals volunteering to collaborate, aged ≥ 18 years, without severe psychotic symptoms and agitation and with the cognitive competence to comply with the interview, were included in the study.

Study Design and Implementation

This study was conducted by 4 psychiatrists from each center with at least three years of experience after attending 2 face-to-face training meetings, together with the researchers, on the

features and the use of the SCID-5-PD-TR before initiation of the research. The training meetings were completed with video interview samples that allow learning with simulated patients and also with real interview practices with volunteers.

A self-report form, used as a screening device comprising 106 questions to be answered as “yes/no”, is used as a road map for the interviewer before the implementing the SCID-5-PD interview. SCID-5-PD scans the diagnostic categories of ten personality disorders in DSM-5, and offers a categorical and dimensional approach, unlike SCID-II. Completion of the 106-item self-report questionnaire before the interview, not only provides data but also shortens the interview time. At the end of the interview, the forms were rated without discussions and without exchanging opinions. In practice, the interviewer checks whether the diagnostic threshold is met for each PD category; and, if not, the clinically significant subthreshold-threshold features are evaluated by the dimensional approach. In other words, if the categorical diagnostic criteria are only partly met, they can be evaluated by the dimensional approach which detects the sub-threshold and threshold diagnoses for each criterion and allows the total diagnostic score to be calculated from each approach (Somma et al. 2017). The dimensional scoring is based on “0 = none, 1= below threshold, 2= threshold”. Introduction of the dimensional approach in addition to the categorical approach allows for a more comprehensive evaluation of personality disorders further than ‘present’ and ‘none’ (Krueger et al. 2007). An average of 40-60 minutes is taken for implementing the SCID-5-PD, making it applicable to any volunteer older than 18 years and able to follow the earch instructions. The entire SCID-5-PD or only the PD that is of interest to the clinician can be administered.

For the purposes of this study, the interviews were organized in both centers, with the two psychiatrists exchanging positions as the interviewer and the observer with each successive interviewee, without a selection pattern of the order of interviewing. Preference was made for the actual interview instead of video calling as it shows the agreement between the interviewers in the best way by allowing coding the same conversation in the same session. If the interviewers separately evaluate the same interviewee, the performances of the interviewers are measured rather than the SCID-5-PD interview. Also, it is much more difficult to record a large number of sample interviews for different diagnostic categories in video recordings.

Statistical Evaluations

The interview data collected from both centers were evaluated by calculating the agreement between the interviewers and the Kappa coefficient for the same two interviewers for each interviewed participant. The Kappa coefficient values

of >0.75, 0.75-0.41 and <0.40 are rated as, respectively, perfect agreement, fair agreement and poor agreement in reliability (Fleiss 1981) and the same approach was followed in our study. For diagnostic validity, divergent and convergent validity analyses were performed using the self-report form scores and the dimensional evaluation scores; the expectation being to detect that the analyzed dimension of the scale shows a higher correlation with the related dimensions than with the unrelated dimensions. In this context, a wide correlation matrix was prepared and evaluated. Also, the correlation for each dimensional evaluation between the interviewers was examined. Correlation coefficients were calculated using the Pearson correlation analysis since the data were normally distributed.

RESULTS

The sociodemographic characteristics of the volunteers participating in the study are given in Table 1. The group mean age was 39.6 ($\pm$ 11.6;18-60) years; with 37.3% (n=38) having primary school education, 55.9% (n=57) being married, 66.7% (n=68) being females, of whom 30.4% (n=31) indicated being housewives. Beside the personality disorders, psychiatric disorders were diagnosed and evaluated in total without discriminating as the past or present comorbidities. Major depressive disorder was the most prevalent psychiatric disorder among the participants 46.1% (n=47), followed by anxiety disorders 19.7% (n=20), obsessive compulsive disorder 5.9% (n=6), bipolar disorder 5.9% (n=6), adjustment disorder 5% (n=5), dysthymic disorder 1% (n=1) and attention deficit and hyperactivity disorder 1% (n=1).

The agreement levels between the diagnoses and the Kappa coefficients made by the SCI-5-PD-TR interview are given in Table 2. Also, in order to both facilitate comparative reading of the results and prepare the ground for discussion, the results of Coşkunol et al. (1994) on the SCID-II for DSM-III-R personality disorders and of Somma et al. (2017) on the structured clinical interview for DSM-5 are given in Table 2 for comparison.

Comparing the numbers of the categorical diagnoses made by the interviewers on the SCID-5-PD-TR showed that interviewer 1 and interviewer 2, reported, respectively, 19 and 17 diagnoses of avoidant personality disorder, 5 and 7 diagnoses of dependent personality disorder, 23 and 28 diagnoses of obsessive-compulsive personality disorder, 20 and 22 diagnoses of paranoid personality disorder, 3 and 1 diagnoses of schizotypal personality disorder, 6 and 5 diagnoses of histrionic personality disorder, 9 and 11 diagnoses of narcissistic personality disorder, 18 and 17 diagnoses of borderline personality disorder and 5 and 6 diagnoses of antisocial personality disorder. Both

Table 1. Sociodemographic Features

N=102		
Age (Mean)	39.6 $\pm$ 11.6(SD)	
	Frequency (n)	Percentage (%)
Gender		
Male	34	33.3
Female	68	66.7
Education		
Illiterate	2	2
Literate	1	1
Elementary School	38	37.3
High School	30	29.4
University	31	30.4
Marital Status		
Single	36	35.3
Married	57	55.9
Divorced	7	6.9
Widow	2	2
Vocation		
Unemployed	5	4.9
Housewife	31	30.4
Officer	15	14.7
Employee	9	8.8
Self-employment	9	8.8
Retired	9	8.8
Student	21	20.6
Other	2	2
Past and Present Mental Disorder	102	100
Present		

interviewers did not report any diagnosis for schizoid personality disorder.

Considering the agreement level of all diagnoses on the SCID-5-PD-TR, the Kappa coefficients ranged between 0.49-1.00 and all were statistically significant ($p<0.05$). The respective Kappa coefficient for each category was 0.79 for avoidant personality disorder, 0.64 for dependent personality disorder, 0.81 for obsessive-compulsive personality disorder, 0.76 for paranoid personality disorder, 0.49 for schizotypal personality disorder, 1.00 for schizoid personality disorder, 0.90 for histrionic personality disorder, 0.66 for narcissistic personality disorder, 0.89 for borderline personality disorder and 0.71 for antisocial personality disorder. As can be seen in Table 2, Kappa coefficients were above 0.75, representing the perfect agreement for avoidant, obsessive-compulsive, paranoid, schizoid, histrionic and borderline personality disorder; and a fair agreement between the dependent, schizotypal, narcissistic and antisocial personality disorders.

The agreement between the interviewers for the dimensional evaluation of the SCID-5-PD-TR at each category was highly significant. The correlation coefficients were in the 0.73-0.96 range (Table 3). The very high correlation coefficient of 0.90 was determined for avoidant, obsessive-compulsive,

Table 2. Reliability Analyses

Categorical Evaluation (Interviewers)	SCID II (Coşkunol et al. 1994)		Italian SCID Validity and Reliability study (Somma et al. 2017)	SCID-5-PD Categorical Approach (DSM-5)		Interviewer 1	Interviewer 2	SCID-5-PD-TR (DSM-5)
	Kappa Coefficient	Percentage of Compliance (%)		Kappa Coefficient	Percentage of Compliance (%)	Frequency (n)	Frequency (n)	
Avoidant Personality Disorder	0.71		0.66	0.79	94	19	17	p<0.001
Dependent Personality Disorder	0.84	96	0.58	0.64	96	5	7	p<0.001
Obsessive Compulsive Personality Disorder	0.56	88	0.90	0.81	93	23	28	p<0.001
Paranoid Personality Disorder	0.82	86	0.85	0.76	92	20	22	p<0.001
Schizotypal Personality Disorder	0.92	98	1.0	0.49	98	3	1	p<0.001
Schizoid Personality Disorder	0.91	98	-	1	100	-	-	p<0.001
Histrionic Personality Disorder	0.80	92	1.0	0.90	99	6	5	p<0.001
Narcissistic Personality Disorder	0.57	90	0.88	0.66	94	9	11	p<0.001
Borderline Personality Disorder	0.94	98	0.89	0.89	97	18	17	p<0.001
Antisocial Personality Disorder	1	100	1.0	0.71	97	5	6	p<0.001

paranoid, schizotypal, histrionic, narcissistic, borderline and antisocial personality disorders. Values of 0.78 for dependent personality disorder and 0.73 for schizoid personality disorder also indicated high correlations.

Correlation between the dimensional evaluation and the self-report form examined for each category, after divergent and convergent validity analyses, indicated moderate correlations for avoidant, obsessive-compulsive, paranoid, schizotypal, narcissistic, borderline personality disorders, and low correlations for dependent, schizoid, histrionic, antisocial personality disorders (Table 4). Also, these correlations were higher between the coefficients of the related dimensions compared to the coefficients of unrelated dimensions. For example, as shown in Table 4, the correlation coefficient between the total scores of the dimensional evaluation and the self-report form for avoidant personality disorder was 0.61, whereas these were 0.44 and 0.21 for, respectively, the scores on dependent personality disorder and obsessive-compulsive personality disorder. Only in the case of narcissistic personality disorder, the correlation coefficient between the associated dimension and the self-report form score was 0.50, whereas the correlation coefficient between the narcissistic personality disorder and the borderline personality disorder was 0.52, the result being significant ($r=0.52$, $p<0.001$).

Table 3. Percentage of Agreement Between the Two Interviewers in Dimensional Evaluation

Dimensional Evaluation (Interviewers)	SCID-5-PD-TR (Dimensional Approach)	Italian SCID-5-PD Validity Reliability Study (Somma et al. 2017)
	Correlation Coefficient	ICC
Avoidant Personality Disorder	0.94	0.94
Dependent Personality Disorder	0.78	0.88
Obsessive Compulsive Personality Disorder	0.92	0.93
Paranoid Personality Disorder	0.93	0.94
Schizotypal Personality Disorder	0.83	0.96
Schizoid Personality Disorder	0.73	0.96
Histrionic Personality Disorder	0.91	0.88
Narcissistic Personality Disorder	0.87	0.92
Borderline Personality Disorder	0.96	0.89
Antisocial Personality Disorder	0.96	0.73

Table 4. Divergent and Convergent Validity Analyses for Dimensional Evaluation and Self-Report Form Relevance

Self-Report Dimensional	Avoidant PD	Dependent PD	Obsessive Compulsive PD	Paranoid PD	Schizotypal PD	Schizoid PD	Histrionic PD	Narcissistic PD	Borderline PD	Antisocial PD
Avoidant PD	0.61	0.44	0.21	0.60	0.48	0.27	0.20	0.31	0.27	0.20
Dependent PD	0.35	0.44	0.18	0.35	0.21	0.06	0.25	0.28	0.32	0.09
Obsessive Compulsive PD	0.39	0.34	0.51	0.50	0.41	0.31	0.22	0.35	0.35	0.25
Paranoid PD	0.38	0.23	0.23	0.58	0.26	0.08	0.33	0.44	0.42	0.13
Schizotypal PD	0.48	0.29	0.22	0.45	0.58	0.29	0.33	0.46	0.55	0.25
Schizoid PD	0.32	0.09	0.20	0.40	0.25	0.49	0.06	0.16	0.10	0.16
Histrionic PD	0.14	0.24	0.18	0.30	0.26	0.09	0.40	0.35	0.29	0.17
Narcissistic PD	0.25	0.38	0.26	0.46	0.28	0.05	0.47	0.50	0.52	0.07
Borderline PD	0.33	0.33	0.00	0.39	0.32	0.24	0.36	0.44	0.55	0.30
Antisocial PD	0.00	0.05	0.01	0.07	0.15	0.13	0.12	0.15	0.23	0.29

PD: Personality Disorder

DISCUSSION

In this study, the psychometric features of the SCID-5-PD-TR for DSM-5-PD are presented. In terms of the categorical approach, the Kappa coefficient was 0.79, and the diagnostic agreement between the interviewers was 94% for the avoidant personality disorder, indicating perfect agreement. The Kappa coefficient for avoidant personality disorder was reported as 0.71 by Coşkunol et al. (1994), reflecting a fair agreement. By comparison the corresponding result was 0.66 in the validity and reliability study on the Italian language version of the SCID-5-PD (Somma et al. 2017) approached our result and was indicative of fair agreement. In the dimensional approach for the diagnosis of avoidant personality disorder, an intraclass correlation coefficient (ICC) of 0.94 was found by Somma et al. (2017) which reflects a very high correlation.

In this study, the categorical approach on dependent personality disorder yielded a Kappa coefficient of 0.64, reflecting a fair agreement. The corresponding agreement between the interviewers was 96%. The corresponding results for dependent personality disorder in the SCID-II based study by Coşkunol et al. (1994) were, respectively 0.84 and 96%. Also, in the study by Somma et al. (2017), the Kappa coefficient was calculated as 0.58 and shows fair agreement. The results reported by other studies also have coefficients similar to ours. In our study, the dimensional evaluation determined a high correlation coefficient of 0.78. In the study by Somma et al. (2017), the ICC was found to be 0.88.

When assessed by the categorical approach, the Kappa coefficient of 0.81 determined in our study for obsessive-compulsive personality disorder reflects an excellent agreement, the agreement between the interviewers being 93%. The corresponding values for obsessive-compulsive personality disorder in the study by Coşkunol et al. (1994) were, respectively 0.56 and 88%, showing a fair agreement.

The Kappa coefficient was found to be 0.90 for obsessive-compulsive personality disorder by Somma et al. (2017), indicating perfect agreement. The results in all studies were evaluated to be very similar to each other. In the dimensional evaluation a coefficient of 0.92 obtained in our study, reflecting a very high correlation. In the study by Somma et al. (2017), the ICC was found to be 0.93.

Evaluation in our study of paranoid personality disorder by the categorical approach yielded a Kappa coefficient of 0.76, reflecting a perfect fit with an inter-reviewer diagnostic agreement of 92%, also reflecting a very good agreement. The corresponding results of the study by Coşkunol et al. (1994), were, respectively, 0.82 and 86%; and together with the Kappa coefficient of 0.85 reported by Somma et al. (2017), these results indicate perfect agreement, and bear similarity with our results. In the present study the correlation coefficient in the dimensional approach for paranoid personality disorder was 0.93, indicating very high correlation. In the study by Somma et al. (2017) the ICC found for paranoid personality disorder was 0.94.

The categorical evaluation of schizotypal personality disorder in our study, a Kappa coefficient of 0.49 and a 98% agreement between the interviewers reflected a fair agreement. A Kappa coefficient of 0.92 was reported for schizotypal personality disorder by Coşkunol et al. (1994), with the percentage of diagnostic agreement between the interviewers being equal to ours. Somma et al. (2017), determined a Kappa coefficient of 1.00 for the same disorder, showing perfect agreement. Our result with the dimensional approach for the correlation coefficient was a very high, 0.83. In the study by Somma et al. (2017), the ICC was found to be 0.96.

In studies evaluating the diagnosis of schizotypal personality disorder, repeated disagreements were reported between the interviewers on some items of the the diagnostic criteria both

in the structured interview and the self-report form. Some items were seen to confuse the diagnostic criteria of borderline, schizoid and paranoid personality disorders. The diagnostic criteria for these personality disorders were used in the DSM-5 while developing schizotypal diagnostic criteria. In the studies by others, diagnosis of schizotypal personality disorder was found to be low since the interviewers had not rated the diagnostic items they evaluated in personality disorders other than schizotypal personality disorder as also being 'present' in schizotypal personality disorder (Kirchner et al. 2018, Rosell and et al. 2014, Torbet et al. 2015). Therefore, although the Kappa coefficient reflected the acceptable limit of agreement in our study, the lower level than those reported by others may be attributed to the cited discrepancies. However, the high level of other psychometric coefficients related to schizotypal personality disorder shows that this dimension works well.

The Kappa coefficient was found to be 1.00 in our study for the categorical evaluation of the schizoid personality disorder, with 100% agreement between the interviewers. The corresponding results of Coşkunol et al. (1994) were, respectively, 0.91 and 98%. Since there were not any cases diagnosed with schizoid personality disorder in the study of Somma et al. (2017), a correlation coefficient was not calculated. In our study, the dimensional evaluation yielded a correlation coefficient of 0.73, reflecting a high correlation. The ICC was 0.96 in the study by Somma et al. (2017).

The Kappa coefficient of 0.90 obtained by the categorical approach on the histrionic personality disorder reflected perfect agreement, with 99% agreement between the interviewers. The corresponding values reported by Coşkunol et al. (1994) were, respectively, 0.80 and 92%; and a Kappa coefficient of 1.00 was reported by Somma et al. (2017), these results of both studies showing perfect agreement. Our results were found to be comparable to the results of other studies. In the dimensional evaluation, the correlation coefficient of 0.91 shows very high correlation and compares well with the ICC value of 0.88 reported by Somma et al. (2017).

The Kappa coefficient of 0.66 obtained by the categorical approach for narcissistic personality disorder diagnoses and 94% agreement between the interviewers reflect fair agreement. The corresponding values reported by Coşkunol et al. (1994) were, respectively, 0.57 and 90% also reflecting a fair agreement. In the study by Somma et al. (2017) perfect agreement was demonstrated by a very high Kappa coefficient of 0.87, while the ICC was found to be 0.92.

When borderline personality disorder was evaluated by the categorical approach, the Kappa coefficient of 0.89 with 97% agreement between the interviewers showed perfect agreement. The corresponding values reported by Coşkunol et al. (1994) were, respectively, 0.94 and 98%, also reflecting perfect agreement. Somma et al. (2017) reported a Kappa

coefficient of 0.89, identical to our results. In our study the dimensional evaluation yielded a very high correlation coefficient of 0.96; while the ICC was found to be 0.89 in the study by Somma et al. (2017).

A Kappa coefficient of 0.71, showing fair agreement, was obtained by the categorical evaluation of antisocial personality disorder diagnoses. There was 97% agreement between the interviewers. The corresponding results reported by Coşkunol et al. (1994) were, respectively, 1.00 and 100%, indicating perfect agreement. Similarly, Somma et al. (2017) reported a Kappa coefficient of 1.0. In our study, the dimensional evaluation resulted in a very high correlation coefficient of 0.96. The ICC reported by Somma et al. (2017) was 0.73.

In our study, a correlation coefficient of 0.29 was calculated for the correlation between the dimensional assessment and the self-report form scores for antisocial personality disorder, which seems to be the closest category to this low result. Consultation for psychiatric care by individuals with antisocial personality disorder are low, constituting only 3.6% of the total psychiatric help-seeking (Öztunç et al. 2015). This may explain the low number of participants with antisocial personality disorder in our study. Individuals with antisocial personality disorder having a normal mental capacity show good social functionality and can conceal their personality traits using defense mechanisms such as rationalization and reflection, and a high rate of lying (Doksat 2008). It was thought that the relatively weak correlation between the self-report form and the dimensional assessment found in our study may be due to the above-mentioned conditions.

In the simplest terms, divergent and convergent validity analysis is the subtype of construct validity analysis used as a method for assessing the extent of the overlap between the analyzed dimension with related dimensions and the discrimination from the unrelated dimensions. These analyses yield a wide correlation matrix where in the overlap and the difference are indicated by, respectively, the height and the depth of the correlations. While the correlation coefficients are high for related dimensions they are lower for unrelated dimensions (Raykov 2011, Calson and Herdman 2012).

In our study, a high correlation was demonstrated between the self-report form and the dimensional rating of the avoidant, obsessive-compulsive, paranoid, schizoid, histrionic, borderline, dependent, schizotypal and antisocial personality disorders, with low correlations being found for unrelated dimensions.

We obtained a correlation coefficient of 0.50 for narcissistic personality disorder, showing a strong correlation with borderline personality disorder while the correlations with the other personality disorders were weaker. This result is consistent with those reported in the literature, and the subject has been debated since the inclusion of the narcissistic

personality disorder in the diagnostic category of personality disorders in the DSM-III. Narcissistic personality disorder affects the diagnostic processes of borderline and antisocial personality disorders due to individual problems of self and the grandiose and narcissistic reflections of these problems on the diagnostic process, such that there are patients who cannot be fully differentiated with the existing operational criteria. One of the issues addressed in the DSM-5 alternative model is the expression of these narcissistic self-reflections (Morey and Stagner 2012, Euler et al. 2018, Fossati et al. 2016). It is thought that the result of our study reflect the above mentioned reasons.

The correlation between the dimensional component of the structured clinical interview and the self-report form, taken into account in our study in the divergent and convergent validity analyses, was statistically significant although both methods have their advantages and disadvantages. Samuel et al. (2013) found that both the structured clinical interview and the self-report form predicted personality disorder, and suggested that the validity of the diagnosis of naturalistic personality disorder should be "questioned" and the structured clinical interview should be "used".

Although the structured clinical interview approach has the advantages of providing standardization, increasing diagnostic validity and reliability by using diagnostic criteria, providing common language in studies, providing epidemiological data such as frequency and prevalence of disorders and improving psychiatric interview skills of healthcare professionals, it also has shortcomings relative to the self-report form resulting from short interview obligations and also the problems of data collection on long-term personal characteristics (Segal et al. 2006, Morey et al. 1988). The clinician's holistic approach to the diagnosis and being central to the interview on grounds of the clinical experience makes the structured interview advantageous (Westen 1997). On the other hand, the self-report form has the advantages of providing substantial amount of information by enabling participants to be more motivated to express themselves, being practical and more suitable for dimensional evaluation. Its disadvantages include the inability of some patients to evaluate their own personality correctly, the variability of their mood, lack of insight or limited self-expression bias (Paulhus and Vazire 2007, Ganellen 2007, Huprich et al. 2011). In this context, it seems more useful to use both methods of evaluation together.

Among the limitations of our study is not having received a specific certified training for SCID-5-PD by the researchers. Also, although warnings have been made to the interviewers on not to be affected by each other after the interview, it is a limitation that the recommended methods of using video or different sessions were not implemented to prevent the interviewers from being affected by each other during the scoring. The limited number of participants included in the

study and the low number of the individuals especially with antisocial personality disorder diagnosis have affected the results. In our study, presence of mental illness other than personality disorder presents a limitation as mental disorders can affect the appearance of the personality structure (Ekselius 2018). The SCID-5-PD has been developed for clinical studies rather than epidemiological field studies. Given that those with only personality disorder consult the psychiatry clinics, diagnosis of a mental disorder in all participants of our study may create limitations. Although personality disorders are usually diagnosed as comorbidities of mental illness, there may be further studies in the general population for personality assessments using the SCID-5-PD.

The value of our study is in its being one of the limited number of face-to-face interviews with the participants in a clinical setting to assess the reliability of the SCID-5-PD-TR.

CONCLUSION

This study has shown that both the structured clinical interview and self-report form of the SCID-5-PD-TR can be used to provide reliable and valid categorical and dimensional data for assessment of personality disorders.

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