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Original article

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The Inter-Rater Reliability and convergent validity of the Italian translation of the Structured Clinical Interview for the DSM-5 Alternative Model of Personality Disorders Module III in a psychotherapy outpatient sample

Summary

Objectives

The present study aimed at assessing the inter-rater reliability of the Italian translation of the Structured Clinical Interview for the DSM–5 Alternative Model of Personality Disorders Module III (SCID-5-AMPD-III), the convergent validity of the SCID-5-AMPD-III personality disorder (PD) diagnoses with respect to the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5) Section II PD diagnoses, and the frequency of multiple PD diagnoses in a clinical sample of adult participants who were voluntarily asking for psychotherapy.

Methods

We relied on a pairwise interview design to assess the inter-rater reliability of the SCID-5-AMPD-III PD diagnoses in a sample of 84 adult clinical participants (53.6% female; participants' mean age = 36.42 years, SD = 12.94 years) who voluntarily asked for psychotherapy treatment.

Results

Our findings showed that the SCID-5-AMPD-III PD diagnoses were provided with adequate inter-rater reliability (median Cohen's k = .83). Convergent validity data for the SCID-5-AMPD-III PD diagnoses were also encouraging (median Cohen's k = .54). Substantial agreement was observed between the SCID-5-AMPD-III and the SCID-5-PD on the frequency of multiple PD diagnoses (Cohen's k value = .62).

Conclusions

Our data support the hypothesis that the SCID-5-AMPD-III PD diagnoses are provided with adequate inter-rater reliability and convergent validity with SCID-5-PD diagnoses, at least among Italian clinical adult participants.

Key words

Structured Clinical Interview for the *DSM-5* Alternative Model of Personality Disorders Module III • SCID-5-AMPD Module III • Inter-Rater Reliability • Adult Clinical Participants

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Introduction

To overcome the difficulties (e.g., lack of empirically validated cut-offs, high co-occurrence rates among PDs, within-PD heterogeneity) with the categorical model of personality disorders (PDs; see [1], for a review), the Fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5* [2]) provided the Alternative Model of Personality Disorder (AMPD) in Section III, "Emerging Measures and Models" (pp. 761-781), while retaining the criteria for categorical personality disorder (PD) diagnoses listed in *DSM-IV* Axis II [3] in *DSM-5* Section II.

The *DSM-5* AMPD adopts a dimensional conceptualization of personality pathology, which is based on two main criteria: (A) personality-functioning impairment, and (B) personality-trait pathology. Personality-functioning impairment (i.e., Criterion A) considers two higher order domains: (a) self, including the two subdomains of identity and self-direction; and (b) interpersonal, including the two subdomains of empathy and intimacy [2]. Criterion B, personality-trait pathology, is based on a hierarchical trait model with five dysfunctional personality domains and 25 dysfunctional personality traits. A score of 2 (i.e., moderate impairment) or greater on the Level of Personality Functioning Scale (LPFS [2]) was considered suggestive of clinically-relevant personality-functioning impairment.

The LPFS assesses impairments of 12 subdomains of personality functioning organized within four main domains: identity, self-direction, empathy, and intimacy [2]. LPFS scores range from *0 (little or no impairment)* to *4 (extreme impairment)*; the threshold for PD diagnosis is set at LPFS Level 2 *(moderate impairment)*, as this was intended to maximize the sensitivity and specificity of PD identification 4. Rather, to assess *DSM-5* AMPD Criterion B, a dimensional model of pathological personality traits was constructed along with a corresponding instrument named the Personality Inventory for *DSM-5* (PID-5 [5]). The presence of a LPFS score ≥ 2 and one or more dysfunctional personality traits listed in the *DSM-5* AMPD Criterion B were deemed to be necessary for the PD Trait-Specified (PD-TS) diagnosis 2.

As Clark and colleagues [6] acutely pointed out, the *DSM-5* AMPD could have been conceptualized as purely dimensional, with a PD diagnosis specified by individuals' domains and severity of both their personality-functioning impairment and their pathological trait(s). According to this perspective, only PD-TS diagnosis would be necessary to fully capture individuals' unique characteristics [6]. Indeed, a substantial body of literature documented that PDs are likely to be dimensional in nature [7]; however, to ease the transition to the new conceptualization, the *DSM-5* Personality and PD Work Group derived a hybrid model by mapping six of the *DSM-5* Section II PD categorical diagnoses – namely, Antisocial, Avoidant, Borderline, Narcissistic, Obsessive-Compulsive, and Schizotypal PDs – using the *DSM-5* AMPD model of impairment in personality functioning and dysfunctional traits [6].

Four disorders were excluded from this hybrid model on the basis of the simplicity of their trait component (e.g., histrionic PD is essentially captured by emotional lability and attention seeking) and limited empirical validity [6 8]. Finally, a diagnosis of PD-TS was provided to denote personality trait-and-functioning pathology in the absence of one of the six specified PDs.

For each of the six PD diagnosis, the *DSM-5* AMPD [2] indicates the moderate or greater typical impairment in personality functioning, manifested by characteristic difficulties in two or more of the identity, self-direction, empathy and intimacy areas, as well as pathological personality traits that should be elevated in order to meet criteria for diagnosis. Individuals who have a pattern of impairment in personality functioning (i.e., Criterion A) and maladaptive traits (i.e., Criterion B) that matches one of the six defined personality disorders should be diagnosed with that PD [2]. For instance, typical features of Narcissistic PD are variable and vulnerable self-esteem, with attempts at regulation through attention and approval seeking, and either overt or covert grandiosity [2]. Difficulties characterizing Narcissistic PD are apparent in identity, self-direction, empathy, and/or intimacy (i.e., Criterion A), along with specific maladaptive traits (Attention Seeking and Grandiosity) in the domain of Antagonism [2].

A number of psychometrically-sound measures were developed to provide self-reports (e.g., [9-12]) and clinicians ratings [13 14] of the *DSM-5* AMPD Criterion A. The PID-5 was provided with strong empirical support (e.g., [15]) and cross-cultural validity [16] as a measure of the *DSM-5* AMPD Criterion B domains and traits.

Although the LPFS represented a synthesis of clinician-administered measures for assessing personality functioning into a composite model [4], different from the PID-5 for Criterion B, no method provided a comprehensive assessment of the proposed constructs (Morey, 2018).

Moreover, as Morey [12] nicely pointed out no instrument was designed to simultaneously assess both Criterion A and Criterion B of the *DSM-5* AMPD, while also evaluating the six categorical PD diagnoses that were retained in the *DSM-5* AMPD. With this purpose in mind, First and colleagues [17] developed the Structured Clinical Interview for the *DSM-5* Alternative Model for Personality Disorders (SCID-5-AMPD [17]).

The SCID-5-AMPD is a semi-structured diagnostic interview to guide the assessment of the severity of impairment in personality functioning according to the LPFS (assessed in SCID-5-AMPD Module I), the 25 pathological personality trait facets (assessed in SCID-5-AMPD Module II), as well as the six specific personality disorders and the PD-TS diagnosis (assessed in SCID-5-AMPD Module III). Therefore, a unique component of SCID-5-AMPD is its Module III (SCID-5-AMPD-III), which facilitates the evaluation of the specific diagnoses listed in *DSM-5* AMPD allowing to assess Criterion A (required impairments in personality functioning) and Criterion B (required pathological personality trait facets) for each of the six specific diagnoses of the AMPD [17]. If full criteria are not met for any of the specific PDs, PD-TS diag-

nosis is considered based on a determination of at least moderate impairment in personality functioning from the Criterion A assessments and the presence of at least one pathological personality trait based on the Criterion B trait evaluation [17].

The modular format of the SCID-5-AMPD allows the researcher or clinician to focus on those aspects of the AMPD of most interest [17]. For instance, Christensen and colleagues [18] focused on the SCID-5-AMPD Module I and examined the reliability of its Norwegian translation showing that it was provided with adequate interrater reliability with intraclass correlation coefficient (ICC) values ranging from .89 to .95 for LPFS domains (ICC = .96 for the LPFS total score), at least when it was assessed relying on the video-recording method. Moreover, ICC ranging from .59 to .90 were observed for LPFS domains (LPFS total score ICC value = .75) when the SCID-5-AMPD Module I test–retest reliability was assessed according to a short term (maximum interval between interviews = 2 weeks) design [18].

Notwithstanding Christensen and colleagues' [18] encouraging findings, to the best of our knowledge, no further study examined the psychometric properties of the SCID-5-AMPD. Moreover, although numerous previous studies have examined the convergence between the AMPD proposed trait facets (i.e., Criterion B) and the Section II PDs they are meant to capture [19] (see [20] for a meta-analysis), a lesser number of studies (e.g., [21]) examined the degree to which the proposed *DSM-5* AMPD diagnoses converge with *DSM-5* Section II PD diagnoses. Indeed, the relevance of this issue should not be neglected since the six categorial PD diagnoses were retained in the *DSM-5* AMPD with the aim of easing transition to the new conceptualization of practitioners who were used to rely on the *DSM-IV* axis II/ *DSM-5* Section II categorical PD diagnoses. Despite its immediate clinical pragmatic usefulness, this issue may be helpful in order to start evaluating the potential challenges (e.g., [22,23]) inherent to current categorical approaches to PD diagnosis, including AMPD (e.g., Clark et al., 2015). For instance, Clark and colleagues [6] provided convincing evidence that the proposed PD-TS diagnosis may offer a more straightforward method to PD diagnosis than relying on specific PDs with unique trait criterion sets, also removing the dependency on fallible PD constructs with questionable validity support (see also [20]).

Starting from these considerations, we designed the present study with three major purposes. First, we aimed at assessing the inter-rater reliability of AMPD diagnoses as they were assessed by the Italian translation of the SCID-5-AMPD Module III in a clinical sample of adult participants who were voluntarily asking for psychotherapy. We also assessed the convergent validity of the SCID-5-AMPD-III PD diagnoses with respect to the *DSM-5* Section II PD diagnoses that were based on the Italian translation [24] of the Structured Clinical Interview for *DSM-5* Personality Disorders (SCID-5-PD [25]). Finally, the base rate estimates of the six SCID-5-AMPD-III categorical PD consensus diagnoses and the corresponding SCID-5-PD-III categorical PD diagnoses was computed; moreover, the base rate estimate for any SCID-5-AMPD-III categorical PD diagnosis was compared to the base rate for any categorical SCID-5-PD.

In the present study, we relied on a pairwise interview design to assess the inter-rater reliability of the SCID-5-AMPD-III (as well as SCID-5-PD) diagnoses. Participants were administered the second interview roughly 48 hours after the first interview; the interview order was randomized and counterbalanced. For each participant, two raters were randomly extracted to administer the SCID-5-AMPD-III, and two different raters were randomly extracted to administer the SCID-5-PD. For both interviews, each rater acted as interviewer and observer roughly the same number of times. Each SCID-5-AMPD-III interview was rated independently by the corresponding interviewer and observer; an identical procedure was used for the SCID-5-PD ratings. For each participant, the SCID-5-AMPD-III was administered and scored by raters who were blind to the SCID-5-PD rating; similarly, the SCID-5-PD was administered and scored by raters who were blind to the participant's SCID-5-AMPD-III ratings.

Methods

Participants

The sample was composed of 84 adult participants who were consecutively admitted to the Clinical Psychology and Psychotherapy Unit of San Raffaele Turro Hospital from December 2018 to July 2019. Forty-five (53.6%) participants were female and 39 (46.4%) were male; participants' mean age was 36.42 years, *SD* = 12.94 years. Forty-two (50.0%) participants were single, 36 (42.8%) participants were married, 5 (6.0%) participants were divorced, and one (1.2%) participant was widow. Twelve (14.3%) participants had junior high school degree, 50 (59.5%) participants had high school degree, and 22 (26.2%) participants had university degree. Thirty-two (38.1%) participants received at least one *DSM-5* Section II non-PD psychiatric diagnosis; in this sample, depressive disorders (*n* = 16, 19.0%) and substance abuse disorders (*n* = 16, 19.0%) were the most frequently diagnosed *DSM-5* Section II non-PD psychiatric diagnosis. *DSM-5* Section II non-PD psychiatric diagnoses were assessed by trained clinical psychologists during their initial assessment interviews; since *DSM-5* Section II non-PD psychiatric diagnoses were not the

primary focus of this research, they were used mainly for descriptive purposes in the current study.
All participants were admitted to the Clinical Psychology and Psychotherapy Unit in order to receive psychotherapy treatment for interpersonal difficulties and/ or problems with behavior and emotional regulation on a strictly voluntary basis; inpatient participants were referred to the Unit by the clinicians who were following them in treatment. Potential participants were screened for the following exclusionary criteria: (1) age less than 18 years; (2) IQ less than 80; (3) diagnosis of schizophrenia, schizoaffective disorder, schizophreniform disorder, or delusional disorder according to *DSM-5* diagnostic criteria; (4) diagnosis of dementia or organic mental disorder according to DSM-IV diagnostic criteria; (5) education level lower than elementary school, and (6) the absence of acute symptom remission. All participants in the current research passed this screen. Participants with psychiatric disorder diagnoses were administered the SCID-5-AMPD-III and the SCID-5-PD after acute symptom remission according to the judgment of the clinicians who were following them in treatment to avoid confounding effects of non-PD psychiatric disorders on these measures [26].

Procedures

All participants volunteered to take part in the study after being presented with a detailed description and all were treated in accordance with the Ethical Principles of Psychologists and Code of Conduct; none of the participants received an incentive, either directly or indirectly for participating, and were administered all measures as part of their routine clinical assessment. Participants were administered the SCID-5-AMPD-III and the SCID-5-PD as part of routine clinical assessment and blind to the aim of the present study; interviewers (PsyD trainee) were also kept blind to the aim of the study (they were required to perform pairwise interviews with independent rating as part of their routine training). Since 10 graduate psychologists in their first year of training as clinical psychologists (PsyD) trained in administering the SCID-5-AMPD and SCID-5-PD participated in the present study, we used a pairwise interview design in order assess the inter-rater reliability of the SCID-5-AMPD diagnoses. Raters were paired randomly. Each rater served approximately equally as interview and observer. The participant attribution to interview-observer pairs was randomized by consecutive admission.

Measures

Structured Clinical Interview for the DSM-5 Alternative Model for Personality Disorders Module III (SCID-5-AMPD-III [17])

The SCID-5-AMPD-III is a semi-structured interview that allow to assess the six specific PDs and PD-TS that are included in the *DSM-5* AMPD. After the *General Overview* for the SCID-5-AMPD, Module III began with eight *Preliminary Questions About View of Self and Quality of Interpersonal Relationships*; then, the interviewer had to continue with the assessment of Criterion A and Criterion B for each of the six specific *DSM-5* AMPD PDs; afterward, the assessment of the two personality trait facets not associated with any specific personality disorder (Submissiveness and Distractibility) needs to be carried out. Finally, suggested interview questions are provided to assist the interviewer in determining whether the General Criteria for PDs are met. For those individuals who have a pattern of impairment in personality functioning and maladaptive traits that does not meet the diagnostic criteria for one or more of the six defined PDs, the interviewer considers whether the diagnosis of PD-TS applies. Finally, the interviewer uses the LPFS for rating the interviewee's level of functioning according to the interviewer's overall judgment regarding the level of functioning. In line with SCID-5-PD, the order of *DSM-5* AMPD PDs assessment in the SCID-5-AMPD is different from the order of presentation in *DSM-5* AMPD to avoid assessing the more challenging personality disorders first (e.g., Antisocial PD).

Structured Clinical Interview for DSM-5 Personality Disorders (SCID-5-PD 25)

The SCID-5-PD is a 119-item semi-structured interview designed to assess the 10 *DSM-5* PDs in Clusters A, B, and C. In the present study, the SCID-5- PD was preceded by the administration of its self-report screening questionnaire (SCID-5-SPQ). SCID-5-PD enables direct probing of negative SCID-5-SPQ answers when this is considered clinically relevant for assessing the 10 *DSM-5* PDs. Previous studies [24] showed that the Italian translation of the SCID-5-PD was provided with adequate psychometric properties.

Data analysis

Cohen's *k* coefficient was used to assess the interrater reliability of SCID-5-AMPD-III (and SCID-5-PD categorical diagnoses). Cohen's *k* coefficient was computed only for those PDs that were diagnosed at least five times by either interviewer or observer. Intraclass correlation coefficient was computed as an index of inter-rater reliability for the number of SCID-5-AMPD-III categorical PDs. In the present study, odds ratio (OR) was used as a measure of association for SCID-5-AMPD-III PD diagnoses. The inter-rater reliability of the individual criteria of the SCID-5-AMPD-III PD diagnoses was evaluated calculating Cohen's linearly weighted *k* coefficient (k_w). Cronbach's α coefficient was used to assess the internal consistency reliability of the SCID-5-AMPD-III and SCID-5-PD diagnoses. Finally, the McNemar test was computed to test the difference between paired proportions (i.e., the base

rate estimate for any PD diagnosis between SCID-5-AMPD-III and SCID-5-PD interviews).

Results

The frequencies, base rate estimates, agreement indices and inter-rater reliability coefficient (Cohen's *k*) values for the SCID-5-AMPD-III categorical diagnoses are summarized in Table I. As it can be observed in Table I, Cohen's *k* values indicate that all SCID-5-AMPD-III PD diagnoses could be safely reproduced across independent raters. Only two participants received a SCID-5-PD Schizotypal PD diagnosis by either Rater 1 or Rater 2; thus, Cohen's *k* coefficient could not be computed. Rather, the PD-TS diagnosis is included only in the SCID-5-AMPD-III. The intraclass *r* value for the number of SCID-5-AMPD-III categorical PDs that were diagnosed by Rater 1 (*M* = 1.15, *SD* = 1.07) and Rater 2 (*M* = 1.14, *SD* = 0.95), respectively was .84, 95% CI = .77, .90. The average administration time for the SCID-5-AMPD-III was 99.40 minute, *Mdn* = 90.00 minutes, *SD* = 15.45 minutes.

The inter-rater reliabilities (i.e., Cohen's linearly weighted *k* coefficient values) for the individual criteria of the SCID-5-AMPD-III PD diagnoses are summarized in Table II. As shown in Table II, good-to-excellent agreement [31 32] was observed for the large majority (i.e., 94.6%) of SCID-5-AMPD-III indicators. In the present study, the inter-rater reliability estimate (i.e., Cohen's k_{w} coefficient) of the Level of Personality Functioning Scale score between Rater 1 (*Mdn* = 2.00, *SD* = 0.90) and Rater 2 (*Mdn* = 2.00, *SD* = 0.86) was .87, $p < .001$.

Considering the SCID-5-AMPD-III PD consensus diagnoses, the average co-occurrence rate estimates (i.e., the average rate of co-occurrence of each SCID-5-AMPD-III PD with all the remaining five SCID-5-AMPD-III PD diagnoses) were 28.20, 31.10, 20.70, 27.60, 35.00, and 16.00% for Avoidant PD, Obsessive-Compulsive PD, Narcissistic PD, Borderline PD, Antisocial PD, and Schizotypal PD, respectively (median co-occurrence rate = 27.90%). Significant associations were observed between Avoidant and Borderline PDs, OR = 3.69, 95% CI = 1.19, 11.41, Narcissistic and Borderline PDs, OR = 3.33, 95% CI = 1.20, 9.17, and Borderline and Antisocial PDs, OR = 6.25, 95% CI = 1.35, 28.98 (Tab. III).

Discussion

To the best of our knowledge, the present study represents the first attempt at testing the psychometric properties of the SCID-5-AMPD-III. Confirming and extending previous findings on the SCID-5-AMPD Module I [18], our data seemed to show that the SCID-5-AMPD-III is provided with adequate inter-rater reliability, at least in a study group of Italian participants who voluntarily asked for psychotherapy treatment. Convergent validity data for the SCID-5-AMPD-III PD diagnoses were also encouraging, particularly when compared to

TABLE I. *The Structured Clinical Interview for DSM-5 Alternative Model of Personality Disorders – Module III: Personality Disorder Diagnosis Base Rate Estimates, Agreement Indices, Inter-Rater Reliability Coefficient (Cohen's k) Values, and Structured Clinical Interview for DSM-5 Personality Disorders Cohen's k Values (n = 84).*

	Rater 1		Rater 2		Agreement Indices and Inter-Rater Reliability coefficients								SCID-5-PD
SCID-5-AMPD-III PD Diagnoses	*N*	%	*N*	%	O-	E-	O+	E+	O	E	*k*	95% CI	*k*
Avoidant	17	20.2	16	19.0	98.5	67.2	94.1	10.9	98.8	68.4	.96	.89, 1.00	1.00
Obsessive-Compulsive	8	9.5	13	15.5	93.4	77.6	61.5	6.3	94.1	78.0	.73	.51, .95	.56
Narcissistic	29	34.5	28	33.3	91.4	49.3	84.0	20.4	94.1	55.2	.87	.76, .98	.78
Borderline	21	25.0	18	21.4	92.5	62.3	77.3	13.0	94.1	64.3	.83	.69, .97	.89
Antisocial	7	8.3	4	4.8	96.3	87.7	57.1	3.1	96.4	87.7	.71	.40, 1.00	.92
Schizotypal	5	6.0	6	7.1	98.7	87.7	83.3	3.4	98.8	87.8	.90	.71, 1.00	--
Trait-specified	17	20.2	17	20.2	91.4	66.3	70.0	11.3	92.9	67.7	.78	.61, .95	--
Mdn	--	--	--	--	93.4	67.2	77.3	10.9	94.1	68.4	.83	.69, .98	.89
Any PD diagnosis	63	75.0	67	79.8	81.0	12.6	94.0	63.0	95.2	64.9	.86	.74, .99	.82

Note. SCID-5-AMPD-III: Structured Clinical Interview for DSM-5 Alternative Model of Personality Disorders – Module III; SCID-5-PD: Structured Clinical Interview for DSM-5 Personality Disorders; PD: Personality Disorder; k: Cohen's k; O-: Percentage of Observed Negative Agreement; E-: Percentage of Expected Negative Agreement; E+: Percentage of Expected Positive Agreement; O+: Percentage of Observed Positive Agreement; O: Percentage of Observed Agreement; E: Percentage of Expected Agreement; 95% CI: 95% confidence interval for SCID-5-AMPD-III Cohen's k ; --: statistic not computed; Mdn: median value.

TABLE II. *Structured Clinical Interview for DSM-5 Alternative Model of Personality Disorders: Individual Criterion A and Criterion B Indicator Inter-Rater Reliability Index (i.e., Cohen's linearly weighted k Coefficient) Values (n = 84).*

Criterion A	k_w	Criterion B	k_w
Avoidant PD		**Avoidant PD**	
Identity	.81	Anxiousness	.69
Self-direction	.76	Withdrawal	.71
Empathy	.72	Anhedonia	.73
Intimacy	.63	Intimacy avoidance	.73
Obsessive-compulsive PD		**Obsessive-compulsive PD**	
Identity	.74	Rigid perfectionism	.64
Self-direction	.75	Perseveration	.70
Empathy	.66	Intimacy avoidance	.69
Intimacy	.67	Restricted affectivity	.67
Narcissistic PD		**Narcissistic PD**	
Identity	.68	Grandiosity	.72
Self-direction	.63	Attention Seeking	.69
Empathy	.56		
Intimacy	.61		
Borderline PD		**Borderline PD**	
Identity	.78	Emotional lability	.64
Self-direction	.72	Anxiousness	.52
Empathy	.69	Separation insecurity	.70
Intimacy	.64	Depressivity	.64
		Impulsivity	.76
		Risk taking	.73
		Hostility	.65
Antisocial PD		**Antisocial PD**	
Identity	.68	Manipulativeness	.73
Self-direction	.68	Callousness	.72
Empathy	.71	Deceitfulness	.82
Intimacy	.75	Hostility	.63
		Risk Taking	.61
		Impulsivity	.56
		Irresponsibility	.74
Schizotypal PD		**Schizotypal PD**	
Identity	.75	Cognitive dysregulation	.64
Self-direction	.66	Unusual beliefs	.72
Empathy	.70	Eccentricity	.67
Intimacy	.79	Restricted affectivity	.70
		Withdrawal	.65
		Suspiciousness	.75
		Other Criterion B Traits	
		Submissiveness	.63
		Distractibility	.68

Note. *PD: Personality Disorder; k_w: Cohen's linearly weighted k coefficient; all k_w ps <.001.*
The internal consistency reliability coefficient (i.e. Cronbach's a) values, base rate estimates, agreement indices, and convergent validity coefficient (i.e., Cohen's k) values of the SCID-5-AMPD-III and SCID-5-PD consensus diagnoses are summarized in Table III. On average, the convergent validity between SCID-5-AMPD-III PD diagnoses and SCID-5-PD diagnoses was moderate, with a median k value of .54. According to SCID-5-AMPD-III, 24 participants (28.6%) received two or more PD diagnoses, whereas 18 participants (21.4%); the corresponding Cohen's k value was .62, 95% CI = .43, .81. In our sample, the average number of SCID-5-AMPD-III PD diagnoses was 1.17 (SD = 1.06), whereas the mean number of SCID-5-PD diagnoses was 0.94 (SD = 0.90), with a convergent validity estimate (intraclass r coefficient) of .73, 95% CI = .61, .81. Interestingly, the base rate estimate for any PD diagnosis was not significantly different between SCID-5-AMPD-III and SCID-5-PD interviews, McNemar test 2-tailed p >.34. Thus, our data seemed to suggest that relying on the SCID-5-AMPD-III or on the SCID-5-PD does not result in an increased overall rate of PD diagnoses.

TABLE III. *Structured Clinical Interview for DSM-5 Alternative Model of Personality Disorders-Module III and Structured Clinical Interview for DSM-5 Personality Disorders Consensus Diagnoses: Internal Consistency Reliability Coefficient (i.e., Cronbach's a) Values, Base Rate Estimates, Agreement Indices, and Convergent Validity Coefficient (i.e., Cohen's k) Values (n = 84).*

	SCID-5-AMPD-III			SCID-5-PD			Agreement indices						Convergent validity	
PD diagnoses	α	*N*	%	α	*N*	%	O-	E-	O+	E+	O	E	*k*	95% CI
Avoidant	.87	17	20.2	.76	8	9.5	88.2	73.6	47.1	6.9	89.3	74.1	.59†	.35, .82
Obsessive-compulsive	.79	9	10.7	.42	8	9.5	86.4	81.6	21.4	5.3	86.9	81.8	.28*	.00, .59
Narcissistic	.85	30	35.7	.77	34	40.5	76.3	44.7	64.1	23.4	83.3	52.7	.65†	.48, .82
Borderline	.87	21	25.0	.87	19	22.6	88.2	61.5	66.7	13.5	90.5	63.7	.74†	.57, .91
Antisocial	.93	8	9.5	.85	7	8.3	91.3	83.6	36.4	4.7	91.7	83.7	.49†	.16, .81
Schizotypal	.86	5	6.0	.71	2	2.4	94.0	91.9	16.7	1.7	94.1	92.0	.26*	.00, .70
Mdn	.86	--	--	.77	--	--	88.2	77.6	41.8	6.1	89.9	78.0	.54†	.26, .81
Any PD diagnosis	--	64	76.2	--	60	71.4	63.0	14.9	85.1	58.4	88.1	68.2	.69†	.52, .86

Note. SCID-5-AMPD-III: Structured Clinical Interview for DSM-5 Alternative Model of Personality Disorders – Module III; SCID-5-PD: Structured Clinical Interview for DSM-5 Personality Disorders; PD: Personality Disorder; a: Cronbach's a; k: Cohen's k; O-: Percentage of Observed Negative Agreement; E-: Percentage of Expected Negative Agreement; E+: Percentage of Expected Positive Agreement; O+: Percentage of Observed Positive Agreement; O: Percentage of Observed Agreement; E: Percentage of Expected Agreement; 95% CI: 95% confidence interval for Cohen's k ; --: statistic not computed; Mdn: median value.
** p < .05; † p < .001.*

convergent validity coefficients that were usually reported for *DSM-IV* axis II PD diagnoses [27 28].

Of course, our findings should not be considered as evidence for the validity of the categorical PD diagnoses; we would like to stress that a number of taxometric studies consistently documented the dimensional nature of PDs [7] and the clinical usefulness of dimensional models of personality dysfunction has also been demonstrated [1 6 22 29]. Rather, our data seem to suggest that the SCID-5-AMPD-III may represent a reliable measure to help clinicians shifting from the typological model of PD assessment to the dimensional model included in the *DSM-5* AMPD, while providing a reliable alternative to the *DSM-5* Section II PD diagnoses in clinical decision making or in the forensic assessment.

Although the use of a joint-interview design might have spuriously increased our inter-rater reliability estimates [30], our data seemed to indicate that all SCID-5-AMPD-III PD diagnoses could be safely reproduced across independent raters. Moreover, the Cohen's *k* values indexing the inter-rater reliability of the SCID-5-AMPD-III PD diagnoses were roughly of the same size of those that were observed for the corresponding SCID-5-PD diagnoses. Interestingly, the chance-corrected reproducibility (i.e., Cohen's *k* value) of the Obsessive-Compulsive PD diagnosis was higher for the SCID-5-AMPD-III than for the SCID-5-PD. Even the SCID-5-AMPD-III Antisocial PD diagnosis was adequately reliable in terms of between-rater reproducibility, although its Cohen's *k* value was smaller than the value that was observed for the SCID-5-PD Antisocial PD diagnosis. In our opinion, this difference may simply reflect the reliance of the SCID-5-PD on deviant behavior for Antisocial PD diagnosis. Interestingly, the SCID-5-AMPD-III allowed clinicians to reliably evaluate both Criterion A (median Cohen's k = .70) and Criterion B (Cohen's k = .69) indicators of the individual *DSM-5* AMPD diagnoses. In our study, fair agreement (i.e., $.50 < k < .60$ [31 32]) was observed for two SCID-5-AMPD-III indicators, whereas good-to-excellent agreement (i.e., $.61 < k < 1.00$ [31 32]) was observed for 53 (94.6%) SCID-5-AMPD-III indicators. Consistent with Christiansen and colleagues' data, our findings suggested that the SCID-5-AMPD-III was likely to provide LPFS scores that were provided with substantial inter-rater reliability [31 32]; the importance of this finding should not be overlooked since the opportunity to obtain reliable PD severity measures is relevant for both treatment planning and forensic assessment.

Finally, it should be observed that in our study the SCID-5-AMPD average administration time seemed to be comparable to the average administration time (90 minutes) that was reported for the Italian version of the SCID-5-PD [24]. This finding seemed to stress that the SCID-5-AMPD-III may represent a viable alternative to the SCID-5-PD in routine clinical PD assessment.

When PD consensus diagnoses were taken into account, the SCID-5-AMPD-III seemed to provide internally consistent PD diagnoses; all Cronbach's α values for the SCID-5-AMPD-III PD diagnoses were > .70 and were not worse than those that were observed for the

corresponding SCID-5-PD diagnoses. Moreover, our data seemed to suggest that using the SCID-5-AMPD-III is unlikely to result in a significant increase of the overall rate of PD diagnoses when compared to using the SCID-5-PD in personality pathology assessment.

Based on our findings, the convergent validity between SCID-5-AMPD-III PD diagnoses and SCID-5-PD diagnoses was on average (median k = .54) moderate [31] with fair clinical significance [32]. Interestingly, Cohen's k values were > .20 and significant for all SCID-5-AMPD-III PD diagnoses.

Based on Landis and Koch's [31] and Cicchetti's [32] "benchmarks" for interpreting Cohen's k (and intraclass r) values, in our study substantial agreement [31] between SCID-5-AMPD-III and SCID-5-PD diagnoses with good clinical significance [32] was observed for Narcissistic PD, Borderline PD, any PD diagnosis, overall number of PD diagnoses, and presence of multiple PD diagnoses. Moreover, moderate agreement [31] between SCID-5-AMPD-III and SCID-5-PD diagnoses with fair clinical significance [32] was observed for Antisocial PD and Avoidant PD.

Finally, fair agreement [31] between the SCID-AMPD-III and SCID-5-PD diagnoses with poor clinical significance [32] was observed only for Obsessive-Compulsive and Schizotypal PDs. In the case of Schizotypal PD, the low frequency (n = 2) of the SCID-5-PD Schizotypal PD diagnosis may have negatively biased the corresponding convergent validity estimate. Similarly, the relatively small Cohen's k value that was observed for the Obsessive-Compulsive PD diagnosis may have been influenced by the limited internal consistency reliability (i.e., Cronbach's a value) of the corresponding SCID-5-PD scale.

Notwithstanding their psychometric appeal, our convergent validity data seemed to suggest that the SCID-5-AMPD-III PD diagnoses are not completely redundant with the SCID-5-PD diagnoses. This finding was not unexpected, but it may have relevant clinical implications. Indeed, different from the SCID-5-PD, the SCID-5-AMPD-III does not rely on the participant's self-description on the self-report screening questionnaire. Moreover, the SCID-5-AMPD-III ask participants to report their personality problems in terms of impairment in self- and interpersonal functioning, as well as in terms of dysfunctional domains and traits; rather, the SCID-5-PD assesses personality pathology in terms of symptom-like features, usually starting from the participant's self-report. These considerations may help clinicians to appreciate that SCID-5-AMPD-III PD diagnoses are not simply a translation of selected *DSM-5* Section II PD categories into a different language, as well as the *DSM-5* Section II PDs are unlikely to convey the same clinical information of their *DSM-5* AMPD counterparts. Indeed, both approaches have strengths and weaknesses. On the one hand, using the SCID-5-AMPD-III might hypothetically help keeping the PD assessment phase in continuity with the following PD psychotherapy treatment, since it helps subjects to describe themselves in terms of self-other dynamics, representations, and interactions (i.e., Criterion A areas), as well as in terms of basic tendencies, motivational/affective traits, and regulatory dimensions (i.e., Criterion B traits), while relying on operational criteria. On the other hand, the *DSM-5* AMPD approach to PD diagnosis may sound too "psychologically-oriented" to some interviewers. At the opposite, the SCID-5-PD has the advantage of representing a easy-to-administer instruments; however, it should be bear in mind that it relies on diagnostic criteria that are deemed to lack validity [1 6]. Interestingly, neither the SCID-5-AMPD-III nor the SCID-5-PD requires specific interviewer characteristics.

We feel that the substantial agreement that was observed in our study between the SCID-5-AMPD-III and the SCID-5-PD on the frequency of multiple PD diagnoses deserves a comment. Indeed, this finding seemed to indicate that using the SCID-5-AMPD-III and the SCID-5-PD is likely to result in a similar number of multiple PD diagnoses. In other terms, relying on the *DSM-5* AMPD PD categories is likely to result in roughly the same number of multiple PD diagnoses that would be obtained using the *DSM-5* Section II PD criteria. In our study, non-negligible co-occurrence rates were observed for all SCID-5-AMPD-III PD diagnoses, and large and significant odds ratios were observed for selected SCID-5-AMPD categorically-diagnosed PDs. Our findings are consistent with previous results [6 20] which suggested that relying on the *DSM-5* AMPD categorical PD diagnoses was likely to result in high rates of diagnostic overlap and diagnostic confusion.

Consistent with previous data [6], our findings seemed to suggest that the problem of the overlap among PD diagnoses does not stem from relying on the *DSM-5* Section II PD criteria; rather, it seems to stem from relying on imposing arbitrary boundaries on continuous personality dimensions. Of course, adopting a dimensional perspective on PD assessment based on a single PD-TS diagnosis is likely to represent the best answer to this problem [6]; it should be observed that a similar approach to PD assessment has been adopted in the 11th edition of the International Classification of Diseases [33]. In any case, relying on the SCID-5-AMPD might help clinicians shifting to a dimensional perspective on PD assessment by relying on its Module I, and possibly Module II.

Of course, we feel that our findings should be considered in the light of several limitations. In the present study, we relied on a sample of participants who voluntarily asked for psychotherapy treatment; samples

with different clinical and demographic characteristics may yield different results. Moreover, we relied on adult clinical participants; this limits the generalizability of our findings on the interrater reliability of the Italian translation of the SCID-5-AMPD to clinical adolescent populations, as well as to elderly and forensic populations. Pairwise interview designs are known to yield excessively optimistic estimates of the actual measurement reliability [30]; however, it should be observed that pairwise interview designs represent the most commonly used approach to inter-rater reliability assessment because of their simplicity and ecological validity (they are closely akin to the typical training to clinical diagnosis). In the light of these considerations, further studies on SCID-5-AMPD-III test-retest reliability are demanded. Although previous data on the psychometric properties of the SCID-5-AMPD Module I are already available [18], in our study we administered only the SCID-5-AMPD-III; future study on the psychometric properties of the SCID-5-AMPD Module I and Module II may provide useful information on their inter-rater reliability and validity. Even keeping these limitations in mind, we feel that our data support the hypothesis that the SCID-5-AMPD-III PD diagnoses are provided with adequate inter-rater reliability and convergent validity with SCID-5-PD diagnoses, at least among clinical adult participants who voluntarily asked for psychotherapy treatment.

Conflict of interest

The Authors declare to have no conflict of interest.

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