

UNIVERSIDADE DE LISBOA

Faculdade de Psicologia



Estudo Transcultural do Inventário de Personalidade para o DSM-5 (PID-5) na População
Emeritense dos Emirados Árabes Unidos e na Portuguesa

Olga dos Santos Martins Coelho

Orientadores: Prof. Doutor Bruno Ademar Paisana Gonçalves

Prof.^a Doutora Rute Isabel Estevão Oliveira Pires

Prof.^a Doutora Ana Maria Portela Nunes de Sousa Ferreira

Tese especialmente elaborada para a obtenção do grau de Doutor em Psicologia, na
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Resumo

A presente dissertação procurou alargar o conhecimento sobre o papel da cultura na avaliação de traços desadaptativos de personalidade definidos pelo DSM-5 e medidos pelo Inventário de Personalidade para o DSM-5 (PID-5), através do estudo transcultural comparativo do PID-5 em amostras comunitárias e clínicas dos Emirados Árabes Unidos (EAU) e de Portugal, utilizando a versão árabe (Al-Attayah et al., 2017) e portuguesa (Pires et al., 2017) do PID-5. Para alcançar este objetivo realizámos três estudos: No primeiro estudo procurámos avaliar as qualidades psicométricas da versão árabe do PID-5 numa amostra comunitária da população emirita, bem como examinar a sua estrutura fatorial e explorar a associação entre os domínios do PID-5 e o Modelo dos Cinco Fatores (MCF), medidos pela versão árabe do NEO-FFI (Alansari, 1997). Os resultados confirmaram adequadas qualidades psicométricas da medida e identificaram uma estrutura de cinco-fatores semelhante à dos domínios do PID-5. No segundo estudo, testámos a utilidade clínica do PID-5 para distinguir grupos clínicos e não clínicos, explorámos a validade convergente das suas escalas com as dimensões psicopatológicas da versão árabe da SCL-90-R (Al-Behairy, 1984), na amostra clínica e, analisámos a sua estrutura fatorial. Os resultados revelaram que o PID-5 é uma medida adequada para distinguir traços patológicos de personalidade em grupos clínicos e não-clínicos, porém a estrutura obtida na amostra clínica não replicou inteiramente a estrutura original, dado que apenas quatro dos cinco fatores foram identificados. Por último, no terceiro estudo, testámos a invariância do PID-5, em amostras emparelhadas da população comunitária e clínica dos EAU e de Portugal e, comparámos os resultados das pontuações médias de ambas as amostras e países. Os resultados confirmaram a invariância da medida nas amostras clínicas e, de um modo geral, a população emirita apresentou pontuações mais elevadas do que a portuguesa, apesar da baixa dimensão do efeito das escalas do PID-5.

Palavras-chave: Inventário de Personalidade do DSM-5; Modelo Alternativo das Perturbações da Personalidade, PID-5 português, PID-5 árabe, Traços Patológicos de Personalidade

Abstract

The present dissertation aimed to contribute to the knowledge on the role of culture in the assessment of maladaptive personality traits, as stated by the DSM-5, and measured by the Personality Inventory for the DSM-5 (PID-5). Our ultimate goal was the cross-cultural study of the United Arab Emirates and Portuguese, clinical and non-clinical population, using the Arabic (Al-Attiyah et al., 2017) and Portuguese (Pires et al., 2017) versions of the PID-5. To accomplish these objectives, we conducted three studies: the first, aimed to assess the psychometric properties of the Arabic version of the PID-5 in a community sample of the Emirati population and examine its factor structure, as well as to explore the relation between the PID-5 domains and the Five Factor Model (FFM) personality traits, measured by the Arabic version of the NEO-FFI (Alansari, 1997). The results confirmed acceptable psychometric properties of the measure and identified a five-factor structure similar to the PID-5 domains. In the second study, we tested the clinical utility of the PID-5 to distinguish clinical and non-clinical groups, explore the convergent validity of its scales with psychopathologic dimensions of the SCL-90-R Arabic version (Al-Behairy, 1984) in the clinical sample and analysed its factor structure. The results shown that the PID-5 is an appropriate measure to identify pathological personality traits in clinical and non-clinical groups, although the factor structure obtained did not entirely replicate the original structure, as only four of the five factors were retained. Finally, the third study tested the PID-5 invariance, in match community and clinical samples of the UAE and Portugal and compared the mean scores of both samples and countries. The results confirmed measurement invariance of the PID-5 in the clinical samples, and overall, the Emirati population presented higher scores, although with small effect sizes.

Keywords: Personality Inventory for DSM-5 (PID-5); Alternative Model for Personality Disorders, Portuguese PID-5, Arabic PID-5, Pathological Personality Traits

Índice Geral

Agradecimentos	II
Resumo	IV
Abstract	VI
Índice Geral	VII
Índice de Tabelas	IX
Capítulo I – Introdução Teórica e Desenho de Investigação	1
1. Introdução.....	2
1.1. A Cultura Árabe do Médio-Oriente e Dimensões Culturais da Personalidade	5
1.2. A Linguagem.....	9
1.3. Estudos Transculturais da Personalidade nos EAU.....	12
1.4. O Modelo Alternativo das Perturbações da Personalidade do DSM-5	14
1.5. O Inventário de Personalidade para o DSM-5.....	20
2. Desenho de Investigação	30
2.1. Participantes e Recolha da Amostra	33
2.2. Instrumentos	37
2.3. Procedimentos Estatísticos	39
2.4. Ética.....	41
Capítulo II – Estudos Empíricos	43
Estudo 1 – Arabic version of The Personality Inventory for the DSM-5 (PID-5) in a community sample of United Arab Emirates Nationals.....	44
Abstract.....	44
Introduction	46
Methods	49
Results	51
Discussion.....	58
Conclusion.....	62
Estudo 2 – The Arabic version of The Personality Inventory for the DSM-5 (PID-5) in a clinical sample of United Arab Emirates (UAE) Nationals	63
Abstract.....	63
Introduction	64
Methods	67
Results	71
Discussion.....	79

Estudo 3 – Cross-cultural study of the Personality Inventory for the DSM-5 (PID-5) across the Portuguese and the United Arab Emirates (UAE) community and clinical populations	84
Abstract.....	84
Introduction	86
Methods	89
Results	94
Discussion.....	112
Conclusion.....	117
Capítulo III – Discussão Integrada dos Estudos e Considerações Finais	118
3. Discussão Integrada dos Estudos	119
3.1. Limitações dos Estudos	133
3.2. Propostas para Estudos Futuros.....	134
3.3. Considerações Finais	136
Referências Bibliográficas	137
Apêndices	182
Apêndice A – General Population Informed Consent Form	
Apêndice B – General Population Sociodemographic Questionnaire	
Apêndice C – Diagnostic Report Sheet A and B	
Apêndice D – Clinical Population Participant Consent Form	
Apêndice E – Patient Information Sheet	
Apêndice F – Clinical Population Sociodemographic Questionnaire	
Apêndice G – PID-5	
Apêndice H – NEO-FFI	
Apêndice I – SCL-90-R	
Apêndice J – Research Protocol (Fundamentação do Projeto)	

Índice de Tabelas

Tabelas do Estudo 1 (Capítulo II)

Table 1 - Internal consistencies (α), means (M), standard deviations (SD) and Cohen's d between the three studies for the 25 facets and five domains	52
Table 2 - Stability coefficients of the Arabic version of the PID-5 facets and domains	54
Table 3 – Correlations r of the Arabic version of the PID-5 with the NEO-FFI	56
Table 4 – Exploratory factor analysis with Equamax rotation solution in an Emirati community	56

Tabelas do Estudo 2 (Capítulo II)

Table 1 – PID-5 scales' descriptive statistic and Wilcoxon Signed Ranks test	72
Table 2 – Spearman correlations of the Arabic PID-5 with the SCL-90-R in a UAE clinical sample	76
Table 3 – Exploratory factor analysis with Equamax rotation solution of the clinical sample	78

Tabelas do Estudo 3 (Capítulo III)

Table 1 – PID-5 scales' means (M), standard deviation (SD), and Cronbach's alphas (α) of the UAE and the portuguese samples	95
Table 2 – Facets difficulties: Means (M) and Cohen's d ' statistic of the community samples	99
Table 3 – Overall fit congruence and discrepancy indices per PID-5 facets in the community samples	100
Table 4 – Overall fit indices per PID-5 domains the community sample	101
Table 5 – Bias-corrected percentile intervals of residual variances per PID-5 facets in the community samples	101
Table 6 – Facets difficulties: Means (M) and Cohen's d ' statistic in the clinical samples	103
Table 7 – Overall fit congruence and discrepancy indices per PID-5 facets in the clinical sample	104
Table 8 – Overall fit indices per domain of the PID-5 in the clinical samples	105
Table 9 – Bias-corrected percentile intervals of residual variances per PID-5 facets in the clinical samples	105
Table 10 – Wilcoxon Signed Ranks test of the PID-5 scales in the community samples	107
Table 11 - Wilcoxon Signed Ranks test of the PID-5 scales in the clinical samples ..	110
Table 12 – Dependent t -test results of the PID-5 facets and domains with normal distribution in the clinical samples	111

Capítulo I

Introdução Teórica e Desenho de Investigação

1. Introdução

Após 14 anos de intensa preparação, revisões e estudos, a Associação Psiquiátrica Americana (APA) publica, em 2013, a 5ª edição do *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*. Apesar da sua relevância enquanto sistema de classificação e diagnóstico, a universalidade das categorias nosológicas do DSM está ainda por demonstrar (Bredström, 2019; La Roche et al., 2015; Lopez & Guarnaccia, 2000; Smolik, 1999; Van de Water et al., 2016). Isto é, não sabemos ainda até que ponto as nosologias anglo-saxónicas ocidentais, de cariz individualista e estandardizado, são extensíveis a culturas ditas não-ocidentais (um vasto grupo de culturas que não partilha os mesmos valores e crenças dos países do ocidente) (Hinton & Good, 2016; Kleinman, 1988; La Roche, 2013, 2015). Esta questão tem implicações diretas nos serviços de saúde mental, tendo em conta que cada pessoa, de acordo com a sua cultura e etnia, terá expectativas diferentes em relação ao tipo de serviços que lhe são prestados e à perceção e compreensão da saúde e da doença. A discrepância entre as necessidades e as expectativas dos que procuram ajuda psicológica e as dos próprios profissionais de saúde mental tem implicações importantes na eficácia e adesão ao tratamento (Balkir et al., 2012).

No que respeita ao diagnóstico tradicional-categorial das perturbações da personalidade (PP), a problemática adensa-se, não apenas do ponto de vista cultural, mas também devido a limitações metodológicas e conceptuais, tais como a elevada comorbilidade, arbitrariedade do diagnóstico e dos limites que o definem, heterogeneidade intradiagnóstica e excessiva prevalência de PP sem outra especificação (Hengartner et al., 2018; Tyrer et al., 2015; Widiger et al., 2007; Wright & Zimmermann, 2015).

Neste contexto e por forma a dar resposta a estas limitações, na Secção III do DSM-5, dedicada a estudo futuros, é proposto um Modelo Alternativo das Perturbações da

Personalidade (MAPP). Este modelo, assenta numa lógica empírica dimensional-categorial de conceptualização das PP que, por um lado, inclui a avaliação de défices no funcionamento da personalidade (critério A) e de traços desadaptativos de personalidade (critério B), e por outro, permite diferenciar seis PP específicas.

O critério B, que corresponde às manifestações estilísticas de cada perturbação, descreve 25 traços específicos ou facetas nos quais os indivíduos diferem e que, por sua vez, estão agrupados em cinco domínios superiores de variabilidade da personalidade: Afetividade negativa, Desprendimento, Antagonismo, Desinibição e Psicoticismo.

O instrumento que operacionaliza o modelo de traços de personalidade do DSM-5 é o *Personality Inventory for the DSM-5* (PID-5) (Krueger et al., 2012). Esta medida conta já com mais de 700 publicações (Watterts & Bagby, 2018) que confirmam a sua precisão, validade e utilidade clínica, bem como estudos de tradução e adaptação em diversas línguas (para uma revisão mais detalhada ver Al-Dajanie et al., 2016; Somma et al., 2019; Watters & Bagby, 2018; Zimmermann et al., 2019).

A literatura sugere que as dimensões do PID-5 podem ser consideradas como extremos patológicos dos domínios do Modelo dos Cinco Fatores (Costa & McCrae, 1992) ou seja, que as PP podem ser conceptualizadas como variantes desadaptativas dos cinco domínios que definem o funcionamento da personalidade normal (Anderson et al., 2013; Gore & Widiger, 2013; Krueger & Markon, 2014; Skodol et al., 2011; Widiger & Trull, 2007). Assim, tal como a estrutura de traços do MCF tem sido sistematicamente confirmada (McCrae & Terraciano, 2005; Schmitt et al., 2007), também grande parte dos estudos realizados com o PID-5, sobretudo com amostras ocidentais, têm demonstrado a consistência do modelo de traços do DSM-5 e confirmado a universalidade dos seus domínios superiores, apesar de se terem verificado variações transculturais em algumas facetas (Somma et al., 2019; Watters et al., 2019). Porém, alguns autores sugerem que esta universalidade está

limitada às culturas ocidentais-individualistas nas quais os traços são cruciais para explicar as diferenças individuais e menos relevante nas culturas coletivistas em que a estabilidade do grupo social de pertença se sobrepõe às necessidades individuais (Markus & Kitayama, 1991).

Na realidade, pouco sabemos acerca da utilidade do PID-5 na comparação de diferentes grupos sociais, ou seja, se os itens que compõem as facetas e domínios do PID-5 são entendidos do mesmo modo em diferentes culturas (Church et al., 2011; Eigenhuis et al., 2015; Sorrel et al., 2021). Atualmente, a equivalência de um instrumento de avaliação psicológica aplicado em várias populações ou grupos é estudada através da análise de invariância. Esta metodologia permite comparar grupos culturalmente distintos relativamente ao mesmo constructo, garantido que as diferenças encontradas se devem a características singulares de cada grupo e não a enviesamentos de natureza metodológica (e.g., Dong & Dumas, 2020; Jeong & Lee, 2019).

Em suma, a inclusão do modelo de traços de base dimensional proposto no DSM-5 representa um importante passo no sentido de melhorar a avaliação das PP, também do ponto de vista cultural, porém o instrumento que o operacionaliza carece ainda de validação em culturas e países não-ocidentais (Somma et al., 2019, Sorrel et al., 2021; Zimmermann et al., 2019)

A presente tese procurou colmatar algumas destas lacunas alargando o estudo do MAPP a um país do médio-orientes, os Emirados Árabes Unidos (EAU), e a uma população pouco estudada, a população emiritaense, através da realização de três estudos empíricos: o estudo da versão árabe do PID-5 numa amostra comunitária (Estudo 1) e clínica emiritaense (Estudo 2), e o estudo transcultural comparativo de um país ocidental (Portugal) com um país não-ocidental (EAU) utilizando o PID-5 (Estudo 3).

Tendo em vista estes objetivos, neste primeiro capítulo iremos apresentar uma reflexão sobre as especificidades da cultura árabe do médio-orient, em particular dos EAU, e o modo como estas especificidades influenciam a conceptualização e o funcionamento da personalidade. Em segundo lugar, iremos proceder à descrição dos aspetos mais relevantes do modelo alternativo do DSM-5, seguindo-se uma revisão bibliográfica dos estudos desenvolvidos com o PID-5. Por último, será apresentado o desenho de investigação. O segundo capítulo, será inteiramente dedicado aos três estudos empíricos desenvolvidos ao longo deste projeto de investigação. Por fim, no terceiro capítulo, iremos discutir os resultados mais relevantes e respetivas conclusões, sem esquecer as inerentes limitações metodológicas e propostas para estudos futuros.

1.1 A Cultura Árabe do Médio-Oriente e as Dimensões Culturais da Personalidade

Os conceitos de cultura árabe e de mundo árabe são bastante complexos na medida em que, de algum modo, pretendem abarcar uma vasta cultura distribuída por dois continentes (africano e asiático), que integra cerca de 26 países, entre eles os EAU. Inseridos no golfo pérsico, ou no mais recentemente denominado golfo da arábia, situado no médio-orient, os EAU são uma monarquia federal absoluta cuja religião é o islamismo e o árabe a língua oficial. Os EAU são atualmente uma das mais desenvolvidas economias do médio-orient, possuindo uma forte estabilidade política e são considerados um dos países mais liberais do médio-orient, sobretudo no que respeita à liberdade religiosa e à salvaguarda dos direitos humanos. Ainda que regida pela lei da *Sharia*, ou direito Islâmico, a sociedade plural dos EAU demarca-se de outras culturas desta região pela flexibilidade das normas sociais, pelas recentes políticas de igualdade de género, nomeadamente no acesso à educação e a carreiras profissionais até aqui interditas a mulheres. Neste sentido e numa tentativa de assegurar uma distribuição mais igualitária do acesso ao poder

governativo, o parlamento dos EAU é, por decreto, composto por igual percentagem de homens e mulheres, tornando-os mais próximos da cultura ocidental (Hills & Atkins, 2013).

A cultura árabe tem sido estudada através da antropologia cultural, da política internacional e até da literatura. Apesar de existir uma grande variedade de culturas dentro do mundo árabe, os estudos etnográficos têm sistematicamente salientado, como características comuns, a importância da família e dos laços de sangue, da honra, do respeito, da hierarquia, do patriotismo, da hospitalidade e da reciprocidade (Barakat, 1993; Gregg, 2005; Joseph, 1996; Shyock, 2004).

O modelo teórico mais utilizado na análise de diferenças culturais é o modelo de seis dimensões de Hofstede (Hofstede, 2011). Este modelo propõe seis dimensões nas quais as culturas variam: distância ao poder, evitamento da incerteza, masculinidade vs. feminilidade, orientação a curto vs. longo prazo, hedonismo vs. estoicismo e individualismo vs. coletivismo. De um modo geral, esta última dimensão tem suscitado um maior interesse no que diz respeito aos estudos de personalidade (Mulder, 2012, Triandis, 2002). No *continuum* individualismo-coletivismo, segundo a *Hofstede Insights dataset* (Hofstede, 2022), a cultura dos EAU situa-se mais próxima do extremo coletivista. Em termos práticos, isto significa que os objetivos e metas pessoais (a escolha da profissão, do parceiro ou até de trabalhar ou viver no estrangeiro) são estabelecidos em função do grupo de pertença, ou seja, as aspirações pessoais e as motivações servem propósitos e objetivos comuns e não individuais, como vulgarmente acontece nas sociedades ocidentais (Brislin & Lo, 2006). Nestas culturas, o grupo de pertença vai muito além da família nuclear e pode incluir a nação, a religião, a escola, entre outras organizações (Triandis, 1995). Esta dimensão cultural está relacionada com o que Markus e Kitayama (1991) designaram por interdependência da realização pessoal (*Self-held*), ou seja, a harmonia entre os membros

do grupo de pertença é colocada acima das aspirações pessoais, com implicações cognitivas, emocionais e motivacionais (Markus & Kitayma, 1991).

Neste sentido, McAdams e Olson (2010) propõem que ambas as dimensões culturais, coletivismo vs. individualismo e independência vs. interdependência, estão relacionadas com o que os autores designaram por dimensão motivacional da personalidade, na medida em que é mais evidente a relação entre cultura e personalidade no que respeita às motivações do que aos traços de personalidade (McAdam & Olson, 2010).

Hofstede e Hofstede (2005) sugerem que as culturas coletivistas são também caracterizadas por níveis elevados de distância ao poder, ou seja, o poder e a liderança pertencem a um grupo reduzido de pessoas a quem é prestada grande reverência e respeito.

A cultura emeritense pode ser caracterizada por indicadores elevados de distância ao poder (Hofstede, 2022) e por uma forte hierarquia. Nesta sociedade, os líderes políticos são vistos como modelos exemplares de conduta cuja história de vida é glorificada e cujo legado é transmitido através da tradição oral. Por exemplo, nos EAU, o líder que unificou a nação, é designado por “Pai da Nação” e é frequente verem-se pinturas dos líderes políticos nas residências particulares ou até nos automóveis. Uma outra característica importante da sociedade emeritense é o medo de “perder a face”, ou a perda da dignidade e respeito social. Assim, o autocontrolo e o conformismo são preferíveis à confrontação, de modo a manter a “face” (He & Zang, 2011), e evitar causar embaraço ou desconforto nas relações sociais.

Estas dimensões culturais poderão ser também relacionadas com a personalidade ao nível das narrativas de vida, isto é, do relato autobiográfico individual (McAdam & Olson, 2010). A cultura, para além de determinar o local e o cenário da ação dessas narrativas, designa também o carácter das suas personagens. Na cultura emeritense, o protagonismo das

histórias individuais é partilhado pelo grupo e as suas narrativas começam geralmente por fazer referência à nacionalidade e à religião. Estes relatos, distantes do “Sonho Americano” das culturas ocidentais e das ideias de emancipação e sucesso individual, traduzem-se, no geral, numa história individual bastante mais conformista.

Quanto à dimensão evitamento da incerteza, considerando que a sociedade emeritense é fortemente hierarquizada é natural que exista um maior número de regras de modo a garantir a estabilidade social. Triandis (2004) sugere que podemos estudar as diferenças culturais com base na quantidade e flexibilidade das regras sociais, ou seja, com base no grau de evitamento da incerteza. Nesta perspetiva, as regras e as normas sociais permitem reduzir a incerteza e gerir a incapacidade de prever o futuro. Assim, a reação à incerteza é ter o maior número de certezas sob a forma de normas e regras, ensinadas desde tenra idade, para que possam ser aplicadas na idade adulta. De um modo geral, nas culturas ocidentais observa-se uma maior flexibilidade e tolerância no modo como as normas sociais são encaradas, todavia, nas sociedades em que o grau de evitamento da incerteza é mais marcado, a quebra de alguns protocolos sociais pode ter consequências e sanções severas (Mulder, 2012). Por exemplo, a cultura emeritense obedece à lei islâmica, a qual proíbe o consumo de álcool e de carne de porco. Neste contexto, caso um muçulmano seja visto a consumir ou a adquirir algum destes produtos, incorre em multas pesadas ou até a prisão efetiva. Outro aspeto importante são as regras na comunicação entre géneros, as quais proibem o contacto físico direto entre homens e mulheres. A título de exemplo, nos EAU, no contexto de um acidente, nenhum homem pode tocar numa mulher muçulmana, nem mesmo para prestar cuidados de suporte básico de vida, sem que esta ou a sua família o consintam.

Desta forma, dado que as sociedades variam substancialmente naquilo que é considerado aceitável ou não, é provável que promovam também o desenvolvimento de

alguns traços de personalidade em detrimento de outros (Markus & Kitayama, 1998). Assim, a necessidade de estabelecer diagnósticos internacionalmente válidos para as PP requer também especial atenção à forma como os traços de personalidade podem ser influenciados e até determinados pela cultura (Alarcon et al., 1998; Mulder, 2012; Stone, 2012).

1.2. A Linguagem

A tradução de termos científicos em inglês para as línguas latinas é manifestamente difícil, especialmente no que toca à correspondência exata entre palavras do vocabulário da psicologia da personalidade, como o conceito de *self*, que muitas vezes vemos traduzidos por eu ou si. No entanto, a definição de *healthy self* ou eu saudável enquanto uma experiência interna de si como único, com limites claros entre si e os outros é claramente entendida e partilhada pelas diferentes línguas dos países do ocidente (Cushman, 1996; Oyserman et al., 2002; La Roche et al., 2015). Porém, a tradução deste conceito para línguas semitas, como o árabe, levanta questões que vão muito além da complexidade linguística, na medida em que a visão do eu saudável ou *ana*, tal como já referimos, resulta antes de uma experiência de si como parte de um grupo de pertença e pela relação com esse grupo, ou seja, uma definição de cariz coletivista, mais comum nas culturas asiáticas e do médio-orientes (Oyserman et al., 2002, Triandis, 1995)

O árabe é uma língua semita, próxima do hebraico e do aramaico e é o 5º idioma mais falado em todo o mundo (Ryding, 2005). Tal como outras línguas, também o árabe tem sofrido grandes transformações e existe em mais do que uma variante. Na presente tese, não obstante poderem existir outras, consideramos apenas as variantes principais da língua árabe, sendo estas o árabe clássico (AC), o árabe formal moderno (AFM) e, as variantes vernaculares (VA) ou dialetos próprios de cada país árabe. No estudo das

amostras emiritesas foram administradas as versões árabes do PID-5 (Al-Attayah et al., 2017), NEO-FFI (Alansari, 1997) e SCL-90-R (Al-Behairy, 1984) traduzidas no chamado AFM ou árabe standard. Esta versão deriva do árabe clássico, ou a língua do alcorão, e é a língua oficial de todos os documentos escritos e a expressão oral formal utilizada em mais de 26 países do mundo árabe (Al-Tamimi, 2011; Nations Online Project, 2015; Ryding, 2005). Cada um destes países possui a sua língua mãe ou variante vernacular, sendo esta a forma preferencial na expressão oral da linguagem quotidiana. Assim, o AFM poderá ser considerado como a linguagem literária e as formas vernaculares como a linguagem coloquial (Ryding, 2005). Importa salientar ainda que estas diferentes modalidades existem num *continuum*, o que significa que um termo pode ser utilizado em ambas as formas (vernaculares e AFM), ou ser considerado como uma expressão do AFM num determinado país e uma forma vernacular noutra, coexistindo no chamado estado de *diglossia* (duas línguas) (Kaye, 2001; Ryding, 2005). Todavia as formas vernaculares ou língua mãe carecem de um sistema formal de escrita, o que impede a sua utilização na tradução de questionários de personalidade (Ryding, 2005). Nesta perspetiva, e tendo em conta que a linguagem do pensamento e das emoções é a da língua mãe, uma tradução fiel de um inventário de personalidade teria de contemplar as especificidades de cada país, ou seja teria de ser traduzido nas formas vernaculares. Dado que isso não é possível, o AFM apresenta-se como o formato "possível" tendo em conta o seu cariz unificador permitindo a comparação de resultados com outros estudos lexicais (Ibrahim, 2008). Todavia, mesmo utilizando o AFM ou variante "unificadora", é especialmente complexa a tarefa de encontrar os termos mais adequados para a tradução de inventários de personalidade para a língua árabe, na medida em que a utilização do método de tradução-retroversão (Hambleton, 2001; ITC – Internacional Test Guidelines for Translating and Adapting Tests, 2020), ainda que adequado, não garante que o árabe utilizado na tradução para uma

determinada região seja plenamente percebido nos restantes países do mundo árabe ou pelas minorias árabes espalhadas por outros continentes. Neste sentido, será questionável assumir que um instrumento que revela propriedades psicométricas adequadas numa amostra árabe, seja válido para todas as amostras árabes, sem que para isso existam evidências de invariância linguística e cultural (Church, 2011; Van Hemert et al., 2002; Van de Vijver, 2002).

Esta diversidade linguística e cultural tem, de alguma forma, limitado a investigação na área da tradução e adaptação de instrumentos de avaliação psicológica e, em particular, da personalidade, no mundo árabe. Em resposta a estas limitações, Zeinoun e colaboradores (2017a) conduziram uma série de estudos em países do Árabe Levante, com base numa abordagem psicolexical do AFM, por forma a identificar uma taxonomia da personalidade semelhante à utilizada na construção do MCF (Costa & McCrae, 1992). O seu estudo inicial permitiu identificar 167 traços de personalidade agrupados numa estrutura composta por seis fatores: a moral, a conscienciosidade, a justiça, o relacionamento interpessoal positivo, a emocionalidade positiva e a dominância. Estas dimensões são semelhantes às do modelo HEXACO (Lee & Ashton, 2004) e do MCF (Costa & McCrae, 1992), porém o fator abertura à experiência não foi encontrado. Os autores apontaram como possível explicação, a ausência de termos na língua árabe que permitam descrever esta dimensão (Zeinoun et al., 2017a).

Partindo do estudo inicial, Zeinoun e colaboradores (2017b) procuraram aplicar a metodologia psicolexical também às formas vernaculares do árabe. Para isso, os autores recorreram ao designado *Arabic Chat* ou *ad hoc*. Esta forma de expressão escrita utiliza caracteres latinos para reproduzir o som das palavras das diferentes formas vernaculares e era utilizada para colmatar a ausência de caracteres árabes nos primeiros telemóveis e computadores. Assim, utilizando uma entrevista semiestruturada composta por nove

questões abertas desenvolvidas com base no *South African Personality Inventory* (SAPI; Net et al., 2012) e escritas em *Arabic Chat* pediram aos participantes que descrevessem diferentes tipos de pessoas quanto ao modo de pensar, sentir e de se comportar em variadas situações. A análise qualitativa das respostas obtidas permitiu identificar nove dimensões de personalidade: bondade, relacionamento social positivo, integridade, humildade vs. dominância, conscienciosidade, extroversão, estabilidade emocional, inteligência e abertura à experiência. Estas dimensões foram posteriormente operacionalizadas num inventário de personalidade de autorresposta, o *Arab Personality Inventory* (API; Zeinoun et al., 2017b), composto por 317 itens escritos em árabe vernacular. Os resultados da análise estatística deste instrumento permitiram definir uma estrutura composta por sete dimensões culturais da personalidade: amabilidade/bondade, honestidade/integridade, inconvenção, estabilidade emocional, conscienciosidade, extroversão/relacionamento social positivo e intelecto. A comparação desta medida com o *International Personality Item Pool Inventory* (IPIP; Goldberg, 1999), uma das poucas medidas dos *Big Five* validada em árabe (Abdullatifi, 2005), revelou uma sobreposição em cinco dos sete fatores, com exceção das dimensões honestidade/integridade e inconvenção (Zeinoun et al., 2017b). As conclusões deste estudo vêm confirmar a universalidade do MCF (Costa & McCrae, 1992) e abrem caminho ao desenvolvimento de estudos semelhantes noutros países árabes.

1.3 Estudos Transculturais da Personalidade nos EAU

Apesar da sua reconhecida importância económica, geopolítica, cultural e linguística, o médio-orient e, em particular, a cultura emirita dos Emirados Árabes Unidos parece ter sido esquecida pela psicologia transcultural. A escassez de estudos e dados empiricamente validados aliada a limitações metodológicas, têm condicionado a investigação e a prática clínica na região levando a suposições acerca do modo como estas pessoas conceptualizam a doença mental, expressam o sofrimento psicológico e procuram tratamento, as quais nem

sempre assentam na literatura empírica (Al Damarki & Sayed, 2009). Estas limitações traduzem-se, na prática, na adoção da versão original dos instrumentos (na sua maioria redigidos em inglês) na avaliação psicológica e na generalização aos cerca de 26 países árabes, divididos em dois continentes, as poucas traduções árabes disponíveis, cujos estudos de validação foram realizados apenas em dois ou três países específicos da região. Durante a nossa pesquisa deparámo-nos com alguns destes obstáculos, nomeadamente quando procurávamos dados acerca da prevalência das PP nos EAU, tendo sido possível identificar apenas um único estudo (El-Rufai et al., 2002). Por outro lado, para além dos fatores linguísticos já referidos, o acesso à literatura científica e ao tipo de estudos desenvolvidos nos países árabes na área da personalidade está também condicionado por limitações no acesso a revistas e jornais regionais da especialidade, dado que a maioria da investigação é escrita e publicada em revistas árabes, cuja consulta não se encontra acessível através dos motores de busca e bases de dados académicas (AlKailani et al., 2012). Para além destes aspetos, alguns autores sugerem que a aplicação a culturas não-ocidentais de modelos e sistemas de classificação desenvolvidos no ocidente, pode constituir uma ameaça à validade dos estudos transculturais (Kim et al., 2006).

Naquele que seria o primeiro estudo transcultural da personalidade a utilizar amostras árabes, McCrae e colaboradores (2005) compararam as pontuações do NEO - Inventário de Personalidade Revisto (NEO-PI-R; Costa & McCrae, 1992) em 50 países diferentes, entre eles Marrocos, Líbano e Kuwait. Neste estudo, os autores aplicaram a versão original em inglês do NEO-PI-R à amostra marroquina e à do Líbano, e a versão árabe à amostra do Kuwait. Os resultados obtidos revelaram problemas de ajustamento “between the assessment instrument and the cultural background and experience of the sample” (McCrae et al, 2005, p. 559). A análise da consistência interna demonstrou também limitações, revelando-se muito baixa na amostra marroquina e adequada na

amostra do Líbano e do Kuwait e, por outro lado, a concordância entre a estrutura fatorial obtida nestes países e a da amostra americana foi apenas moderada (McCrae et al., 2005). Uma possível explicação para estes resultados poderá ser a baixa equivalência linguística (entre amostras árabes e/ou entre as amostras árabes e as dos restantes países) ou a fraca concordância entre os constructos medidos pelo inventário de personalidade e os constructos relevantes nesses países (Van de Vijver & Tanzer, 2004).

Efetivamente, o conhecimento da invariância linguística e dos construtos de personalidade relevantes nos países árabes é ainda muito reduzido para que possamos extrair conclusões relevantes (Van de Vijver & Tanzer, 2004).

Mais recentemente, e no que ao PID-5 diz respeito, assistimos a um aumento significativo do número de estudos empíricos publicados em revistas internacionais nos países do mundo árabe: Tanto quanto se sabe, para além dos artigos que integram a presente tese e que serão apresentados no capítulo II, foram ainda publicados quatro estudos sobre amostras de países de expressão árabe, desenvolvidos na sua maioria com estudantes universitários. Entre estes, o estudo inicial de tradução do PID-5 para a língua árabe utilizando uma amostra de 710 estudantes universitários do Qatar, Kuwait e Bahrain (Al-Attiyah et al., 2017). Um segundo estudo que adaptou a versão breve de 25 itens PID-5-BF (Bach & El Abiddine, 2020) para o árabe argelino, utilizando uma amostra de estudantes universitários $N = 638$). Mais recentemente Aboul e Qonsua (2021) desenvolveram um estudo de tradução do PID-5 para árabe do Egipto, com estudantes universitários ($N = 845$) ao qual se seguiu o de Elsayed (2021). Este último é semelhante ao de Aboul e Qonsua (2021) e utiliza também o mesmo tipo de amostra ($N = 537$).

1.4. O Modelo Alternativo das Perturbações da Personalidade do DSM-5

An important scientific innovation rarely makes its way rapidly winning over and converting its opponents; it rarely happens that Saul becomes Paul. What does happen is that its opponents gradually die out and that the growing generation is familiarized with the idea from the beginning (Max Planck, p.97).

Atualmente, o maior desafio que se coloca à elaboração de um sistema de classificação e diagnóstico das PP é que seja clinicamente útil e empiricamente robusto (e.g., Bach et al., 2020; Newton-Howes et al., 2015). Clinicamente útil, do ponto de vista da facilidade de utilização na prática clínica; suficientemente claro, para auxiliar na comunicação com o paciente e seus familiares; e informativo no planeamento do tratamento (First & Gibson, 2004; Mullins-Sweatt & Widiger, 2009). Empiricamente robusto, no sentido de ultrapassar as conhecidas limitações da nosologia categorial (e.g., Clark, 2007; Krueger & Eaton, 2010; Samuel & Griffin, 2015; Trull & Durrett, 2005), às quais a abordagem dimensional promete dar resposta (e.g., Krueger & Eaton, 2010; Tyrer, 2012; Widiger et al., 2009), capaz de demonstrar a natureza dimensional dos traços que caracterizam a personalidade normal e patológica, e de clarificar em que medida estes construtos (enquanto diferenças individuais que se manifestam através de padrões relativamente estáveis e consistentes de pensamentos, emoções e comportamentos) são universais ou culturalmente especificados (e.g., Allik & McCrae, 2004; Bhugra, 2013; Ruth & Nikapota, 2002).

Aguardada com grande expectativa, a mais recente edição do DSM procurou dar resposta a alguns destes requisitos e simultaneamente refletir a complexa e heterogénea realidade das PP através da introdução de uma perspetiva dimensional na classificação destas perturbações (APA, 2013). Esta perspetiva integra um vasto corpo de conhecimento científico que tem demonstrado que as PP se relacionam com a estrutura da personalidade (Clark, 2005; DeYoung et al., 2016; Kotov et al., 2010; Widiger & Trull, 2007; Wright et

al., 2015), ou seja, que os traços desadaptativos podem ser conceptualizados como extremos patológicos dos traços da personalidade normal, num *continuum* de características adaptativas e desadaptativas (Tyrer et al., 2015). Por outro lado, dado que as várias PP podem traduzir manifestações estilísticas diferentes dos mesmos traços de personalidade, a abordagem dimensional permite explicar a comorbilidade e individualidade destas perturbações (Widiger & Simonsen, 2005). Do mesmo modo, a questão da heterogeneidade do sistema categorial pode também ser minimizada através da utilização de dimensões de traços mais homogéneas, traduzindo-se num aumento da sua utilidade clínica (Widiger & Samuel, 2005).

Outro aspeto relevante, realçado pela perspetiva dimensional de classificação da personalidade, é que o padrão de coocorrência das diferentes perturbações mentais parece estar relacionado com a estrutura de traços de personalidade (Krueger et al., 2012), isto é, o perfil individual de traços de personalidade pode explicar a presença simultânea de uma perturbação da personalidade (PP) (e.g., perturbação evitante da personalidade) e de outra perturbação mental (e.g., perturbação de ansiedade social).

No entanto, apesar da maioria dos clínicos e investigadores concordar com a adoção de um sistema nosológico dimensional para as PP (Hopwood et al., 2017; Keely et al., 2016; Morey et al., 2014), alguns autores colocam ainda algumas reservas a esta transição (Shelder et al., 2010; Spitzer et al., 2008; Verheul, 2012). Em particular no que se refere à perturbação estado-limite da personalidade (Amad et al., 2014) e à perturbação esquizotípica da personalidade (Mason, 2014), uma vez que ambas envolvem a presença de marcadores genéticos e neurobiológicos que qualitativamente se afastam da normalidade. Por exemplo, no caso da perturbação esquizotípica da personalidade, a sintomatologia negativa (Afetividade restrita e Afastamento) poderá ser melhor conceptualizada através de categorias, enquanto a sintomatologia positiva (Desregulação cognitiva e perceptual e

crenças ou Experiências incomuns), devido à sua natureza, poderá ser mais bem descrita por dimensões (Mason, 2014). Contudo, Batiaenes e colaboradores (2019) vêm refutar esta posição e salientar a utilidade clínica dos traços de personalidade também para discriminar entre pacientes com e sem perturbação psicótica. No estudo em questão, estes autores concluíram que os pacientes psicóticos podem ser caracterizados por baixos níveis de Desprendimento, baixa Afetividade negativa, baixa Desinibição e elevados níveis de Psicoticismo.

Apesar destas evidências empíricas, a APA decidiu ainda manter no DSM-5 a classificação categorial das perturbações da personalidade do DSM-IV-TR (APA, 2000), sendo esta a classificação oficial (Secção II), justificada com base em argumentos ligados à necessidade de assegurar uma certa continuidade na prática clínica, caracterizada fundamentalmente pelo modelo médico categorial, adotado pelo DSM desde a sua primeira edição (APA, 1953). Simultaneamente, na Secção III, dedicada às medidas e modelos emergentes, é proposto um sistema de classificação híbrido, dimensional e categorial, para o diagnóstico destas perturbações: o Modelo Alternativo das Perturbações da Personalidade do DSM-5 (MAPP) (APA, 2013). Este modelo, recebeu o nome de alternativo, por ser defendido pelo Grupo de Trabalho da Personalidade e Perturbações da Personalidade do DSM-5, mas ter sido rejeitado como classificação oficial, pouco tempo antes da sua publicação, pelo *Board of Trustees da APA* (para uma descrição mais detalhada deste processo ver Zachar et al., 2016).

O MAPP constitui um sistema simultaneamente tradicional e inovador de classificação e avaliação das PPs. Tradicional porque assume o legado dos principais paradigmas da personalidade e inovador dado que permite realizar diagnósticos psiquiátricos e simultaneamente criar perfis psicométricos de personalidade (Waugh et al., 2017).

Segundo o MAPP, o diagnóstico de PP é feito em função de sete critérios dos quais se destacam a presença de défices no funcionamento da personalidade (critério A) e de traços de personalidade patológicos (critério B). Os défices no funcionamento da personalidade e a expressão dos traços de personalidade devem ser inflexíveis e consistentes em diferentes situações (Critério C), estáveis ao longo do tempo (Critério D), não mais bem explicados por outra perturbação mental, condição médica geral (e.g., traumatismo craniano) ou efeitos fisiológicos do uso de substâncias, ou mais bem entendidos como função de um estágio de desenvolvimento ou contexto sociocultural específico (Critérios E, F e G, respetivamente) (APA, 2013).

O critério A diz respeito ao nível de funcionamento da personalidade e refere-se ao modo como a pessoa se relaciona consigo própria (identidade e autodireção) e com os outros (empatia e intimidade). Na medida em que as PP se caracterizam por dificuldades excessivas ao nível do relacionamento interpessoal e do funcionamento próprio, o critério A representa a base diagnóstica destas perturbações. No MAPP, este critério é operacionalizado pela *Level of Personality Functioning Scale* (LPFS; Bender et al., 2011) através da qual o clínico avalia o grau de comprometimento do funcionamento da personalidade, de acordo com cinco níveis de severidade (0 - *Pouco ou nenhum défice* a 4 - *Défice extremo*). Para o diagnóstico de uma PP é necessário pelo menos um nível moderado de défice no funcionamento da personalidade; quando mais grave for o défice mais provável é que a pessoa tenha mais do que uma PP.

Com o objetivo de melhor estudar o constructo medido pela LPFS (Bender et al., 2011) desenvolveram-se recentemente algumas versões em autorrelato, entre elas a *Personality Functioning Scale – Self Report* (LPFS-SR; Morey, 2017) composta por 80 itens e que tem recebido crescente suporte empírico (Hopwood et al., 2018; Morey, 2017); a *Level of Personality Functioning Scale Self-Report of Criterion A* (LPFS-SRA; Roche et

al., 2016), que compreende 12 itens extraídos da LPFS original e a *Level of Personality Functioning Scale – Brief Form* (LPFS-BF; Hutsebaut et al., 2016) também composta por 12 itens, mas de resposta dicotômica (sim ou não), que permite uma avaliação rápida da severidade da patologia da personalidade. Esta medida foi posteriormente melhorada por Weekers e colaboradores (2019) que desenvolveram a LPFS-BF 2.0. Mais recentemente, um estudo comparativo da LPFS-SR (Morey, 2017), da LPFS-SRA (Roche et al., 2016) e da LPFS-BF (Hutsebaut et al., 2016) desenvolvido por Bliton e colaboradores (2022) veio evidenciar que estas três medidas possuem qualidades psicométricas adequadas ao nível da sua validade estrutural e convergente com outras medidas de avaliação da personalidade.

O critério B descreve um conjunto de traços desadaptativos de personalidade que permitem caracterizar dimensionalmente as manifestações estilísticas de seis tipos de perturbações: perturbação estado-limite da personalidade, perturbação obsessivo-compulsiva da personalidade, perturbação evitante da personalidade, perturbação esquizotípica da personalidade, perturbação narcísica da personalidade e perturbação antissocial da personalidade. Porém, algumas das facetas que caracterizam determinadas PP, parecem sofrer de falta de especificidade. Por exemplo, Watters e colaboradores (2019) num estudo de meta-análise sugerem que a maioria das facetas do sistema de traços do MAPP se encontra fortemente associada à perturbação estado-limite da personalidade, e que a faceta Desregulação cognitiva e perceptual está mais associada à perturbação estado-limite da personalidade do que a faceta Envolvimento em comportamentos de risco, apesar desta última fazer parte da lista de facetas que definem esta PP no DSM-5. A razão pela qual se mantiveram estas seis PPs deve-se, por um lado, à sua relevância clínica e suporte empírico (e.g. Skodol et al., 2011; Waught et al 2017) e, por outro, ao interesse em manter uma certa continuidade e familiaridade na prática clínica, no sentido de facilitar a transição para abordagem dimensional por parte dos clínicos (APA, 2013). A possibilidade de

estabelecer um perfil específico de traços desadaptativos, para além de contribuir para um diagnóstico mais preciso destas perturbações (Appelbaum, 2017; Selbom et al., 2014), permite também caracterizar os diagnósticos de PPs da Secção II do DSM-5, não contemplados no MAPP, a saber as PPs paranóide, esquizoide, histriónica e dependente (Aluja et al., 2019; Bach et al. 2018; Bastiaens et al., 2016; Few et al., 2013; Fossati et al., 2013; Nysaeter et al., 2022; Pocnet et al., 2018; Somma et al., 2018). Permite ainda estabelecer o diagnóstico de perturbação da personalidade com traço especificado (PP-TE), que é feito quando existe uma PP mas não se cumprem os critérios para uma PP específica. Porém, apenas os traços e não as categorias de PP são empiricamente derivadas. Assim, o diagnóstico categorial é opcional e pode ser utilizado pelos clínicos durante o processo de transição para o modelo dimensional.

A presente tese, centrou-se no Critério B, que corresponde à identificação de traços desadaptativos de personalidade do MAPP avaliados pelo *Personality Inventory for the DSM-5* (PID-5) (Krueger et al., 2012), por conseguinte o nível de funcionamento da personalidade, as categorias de PP e os critérios gerais de diagnóstico (Critério C a G) não serão analisados

1.5. O Inventário de Personalidade para o DSM-5 (PID-5)

Em 2012, e pela primeira vez, a APA disponibilizava pública e gratuitamente um instrumento de avaliação da psicopatologia da personalidade, o PID-5 (Krueger et al., 2012). Esta medida, tem vindo a suscitar um interesse sem precedentes por parte da comunidade científica e é atualmente a medida de traços desadaptativos de personalidade mais estudada em todo o mundo (Watters et al., 2019). Trata-se de um extenso inventário de autorrelato, composto por 220 itens, aos quais se responde numa escala de Likert de quatro pontos, que varia entre (0 = *Muito falso ou muitas vezes falso* e 3 = *Muito*

verdadeiro ou muitas vezes verdade). Os itens que compõem o PID-5 caracterizam 25 traços desadaptativos, ou facetas, nos quais os indivíduos diferem e que, por sua vez, estão agrupados em cinco grandes domínios de variabilidade da personalidade: a Afetividade negativa, o Desprendimento, o Antagonismo, a Desinibição e o Psicoticismo.

No MAPP o domínio da Afetividade negativa caracteriza-se pela experiência frequente e intensa de emoções negativas (ansiedade, depressão e preocupação e/ou raiva) e das suas manifestações comportamentais e interpessoais. Deste domínio fazem parte as facetas Afetividade restrita, Ansiedade, Depressividade, Hostilidade, Insegurança de separação, Labilidade emocional, Perseveração, Suspeição e Submissão. O domínio Desprendimento, que se traduz por evitamento de interações interpessoais, expressão afetiva restrita e anedonia, é composto pelas facetas, Afastamento, Anedonia, Depressividade, Evitamento da intimidade e Suspeição. O domínio Antagonismo, que está relacionado com comportamentos que colocam o indivíduo em conflito com os outros, como, por exemplo, exagerada valorização de si, antipatia e insensibilidade em relação aos outros, inclui as facetas: Procura de atenção, Insensibilidade, Falsidade, Grandiosidade, Manipulação e Hostilidade. O domínio Desinibição que diz respeito à procura de uma gratificação imediata, que origina comportamentos impulsivos que ignoram experiências anteriores e/ou consequências futuras, compreende as facetas Distratibilidade, Irresponsabilidade, Impulsividade, Perfeccionismo rígido (ausência de) e Envolvimento em comportamentos de risco. Por último, o domínio Psicoticismo que envolve comportamentos e cognições estranhas, excêntricas, bizarras e incongruentes com a cultura. Esta dimensão inclui as facetas Excentricidade, Desregulação cognitiva e perceptual e Crenças ou experiências incomuns.

O processo inicial de construção do PID-5 baseou-se no conhecimento e experiência de clínicos e investigadores da personalidade que procuraram identificar as características

mais relevantes das PP e nos modelos da personalidade normal e patológica (e.g., Hopwood et al., 2018; Krueger et al., 2012; DeYoung et al., 2016). Mais do que intencionalmente replicar modelos ou estruturas pré-existentes, nomeadamente o MCF (Costa & MacCrae, 1992), os autores do PID-5 procuraram captar de forma abrangente o universo da personalidade patológica (Krueger et al., 2012; Suzuki et al., 2015). A análise fatorial das escalas do PID-5 revelou uma estrutura composta por cinco fatores, ou domínios, que de acordo com o próprio DSM-5 (APA, 2013) podem ser conceptualizados como variantes desadaptativas dos traços de personalidade do conhecido “*Big Five*” ou MCF (Costa & MacCrae, 1992). Esta hipótese tem sido confirmada por um grande número de estudos que demonstram uma associação entre a Afetividade negativa e o Neuroticismo, o Desprendimento e a baixa Extroversão, o Antagonismo e a baixa Amabilidade e, a Desinibição e a baixa Conscienciosidade (e.g., Ashton et al., 2012, Chmielewski et al., 2014, Crego et al., 2018, Crego & Widiger, 2017, De Fruyt et al., 2013, DeYoung et al., 2016, Gore & Widiger, 2013, Griffin & Samuel, 2014, Moorman & Samuel, 2018, Pires et al., 2017; Thomas et al., 2013). No entanto, a associação entre os domínios Psicoticismo e Abertura à experiência é menos clara e por isso questionável (e.g., Chmielewski et al., 2014; Quilty et al., 2013, Sleep et al., 2017; Suzuki et al., 2015, Watson et al., 2013, 2019; Wright & Simms, 2014). Uma possível explicação para a menor associação entre estes dois domínios poderá estar relacionada com a sua natureza conceptual e o modo como esta associação é estudada. Isto é, o Psicoticismo, avaliado pelo PID-5, é fundamentalmente um domínio desadaptativo da personalidade, composto por itens “*Sometimes I think someone else is removing thoughts from my head.*” (Item 192), “*Sometimes I feel “controlled” by thoughts that belong to someone else.*” (Item 154), or “*Sometimes I can influence other people just by sending my thoughts to them.*” (Item 150) que vão além da excentricidade ou inconveniência característica da PP esquizotípica, refletindo limites extremos de

patologia (Widiger & McCabe, 2020). Estes itens estão incluídos em duas das três facetas do domínio Psicoticismo (i.e., Desregulação cognitiva e perceptual e Crenças e experiências incomuns) e caracterizam sintomas de psicopatologia severa (alterações do pensamento).

A este propósito Crego e Widiger (2017) desenvolveram um estudo em que compararam as três escalas do Psicoticismo do PID-5 (i.e., Desregulação cognitiva e perceptual, Crenças ou experiências incomuns e Excentricidade) com as três escalas correspondentes do *Five-Factor Schizotypal Inventory* (FFSI; Edmundson et al., 2011) (i.e., Ideias aberrantes, Percepções aberrantes, e Bizarria e excentricidade). Ao contrário do PID-5, as escalas do FFSI não fazem referência a alterações do pensamento. Para além destas escalas, o estudo incluiu outras duas escalas de traços de personalidade: a escala de Imaginação do *International Personality Item Pool-NEO* (IPIP-NEO; Goldberg et al., 2006) e a escala de Inconvencionalidade do *Inventory of Personal Characteristics 5* (IPC-5; Tellegen & Waller, 2008) que medem a Abertura à experiência do MCF (Costa & McCrae). Os resultados obtidos revelaram uma relação de dimensão média a elevada entre as três escalas do FFSI e os traços de personalidade Imaginação e Inconvencionalidade, enquanto as facetas Desregulação cognitiva e perceptual e Crenças ou experiências incomuns do PID-5 não se relacionaram com os traços do MCF (Costa & McCrae, 1992). No entanto, a faceta Excentricidade do PID-5, que não inclui itens relacionados com sinais e sintomas do espectro da esquizofrenia, demonstrou uma relação de dimensão média a elevada com os traços do MCF (Costa & McCrae, 1992). Através de uma análise fatorial conjunta das três escalas de cognições e percepções esquizotípicas do FFSI, das facetas que compõem o domínio Psicoticismo do PID-5, da escala de Imaginação do IPIP e da escala de Inconvencionalidade do IPC-5, os autores, obtiveram a uma estrutura que agrupou em fatores distintos as três facetas do Psicoticismo. Especificamente, a faceta excentricidade emergiu no fator Abertura – Esquizotípico juntamente com as escalas do FFSI, a escala de

Imaginação do IPIP e a de Inconvencionalidade do IPC-5, enquanto que as facetas Desregulação cognitiva e perceptual e Crenças ou experiências incomuns do PID-5, emergiram num fator distinto (Crego & Widiger, 2017).

Outro aspeto importante para clarificar a relação entre a Abertura à experiência, avaliada pelo NEO-FFI, e o Psicoticismo, avaliado pelo PID-5, trata-se do modo como as subdimensões que compõem a Abertura à experiência (Abertura e Intelecto) se relacionam com o Psicoticismo. Isto é, o Psicoticismo parece relacionar-se com a Abertura, mas não se relaciona, ou relaciona-se negativamente com o Intelecto (Bain et al., 2019; De Young et al., 2012, 2014, 2016). A Abertura caracteriza-se sobretudo por interesses artísticos e estéticos, pela imaginação e pelas diferenças perceptivas individuais. O Intelecto, por outro lado, está associado ao convencionalismo intelectual (*intellectual security*) no que respeita à integridade do pensamento e da compreensão humana e à ausência de crenças ou preconceitos que conduzam a posições extremistas do ponto de vista social, político e religioso (Al-Dajah, 2019), à inteligência e a interesse por informação abstrata e semântica (De Young et al., 2016). Assim, a associação positiva entre a Abertura e o Psicoticismo poderá dever-se à combinação da tendência para detetar e apreciar padrões inovadores (Abertura) com a tendência para identificar padrões e conexões em dados não relacionados (Psicoticismo) (Blain et al., 2019, 2020; De Young et al., 2016). Isto é, se considerarmos que a apofenia ou tendência para identificar padrões e conexões onde estas não existem é um fator importante na criação de crenças e superstições e constitui a base do Psicoticismo, podemos dizer que este domínio do PID-5 pode ser caracterizado como uma disfuncionalidade dos mesmos mecanismos que caracterizam a Abertura (De Young et al., 2012). Já o Intelecto pode estar negativamente associado ao Psicoticismo na medida em que a análise lógica ajuda a distinguir padrões e conexões prováveis e reais de conexões fantasiosas (De Young et al., 2016). Deste modo, o Intelecto, ainda que amplamente

revelante para a psicopatologia enquanto fator de proteção para grande parte das formas de doença mental (Gale et al., 2010; Zammit et al., 2004), pode não estar relacionado especificamente com nenhum traço do PID-5 (De Young et al., 2016).

Para além do MCF (Costa & MacCrae), os domínios do PID-5 apresentam também fortes semelhanças com todos os cinco domínios descritos no modelo de Harkness (PSY5; Harkness & McNulty, 1994; Anderson et al., 2013; Krueger & Markon, 2014), assim como com outras medidas dimensionais da patologia da personalidade tais como o *Dimensional Assessment of Personality Pathology – Basic Questionnaire* (DAPP-BQ, Livesley & Jackson, 2009; Gutiérrez et al., 2019; Van den Broeck, 2013), o *Computer Adaptive Test of Personality Disorder* (CAT-PD; Simms et al., 2011), e também medidas de avaliação clínica mais gerais, tais como o *Minnesota Multiphasic Personality Inventory 2 – Restructured Form* (MMPI-2-RF; Ben-Porath & Tellegen, 2008; Anderson et al., 2013) e o *Personality Assessment Inventory* (PAI; Anderson et al., 2015; Hopwood et al., 2013, Rowinski et al., 2019).

Ao longo dos últimos anos têm surgido outras versões do PID-5, entre elas: a versão de 220 itens para jovens entre os 11 e os 17 anos (Krueger et al., 2013); a versão de heteroavaliação (PID-5-IRF; Markon et al., 2013) composta por 218 itens a preencher por observadores (familiares, colegas ou especialistas); a versão breve de 25 itens centrados nos cinco domínios superiores, para adultos (PID-5-BF-Adult; Krueger et al., 2013) e jovens entre os 11 e os 17 anos (PID-5-BF-Child Age 11-17; Krueger et al., 2013); a versão breve que avalia as 25 facetas e cinco domínios com apenas 100 itens (PID-5-SF; Maples et al., 2015) e, mais recentemente, uma versão de 36 itens (PID5BF+M; Bach et al., 2020) que avalia 18 facetas e seis domínios e permite captar os traços desadaptativos da classificação das PPs do DSM-5 e da CID-11, harmonizando assim os dois sistemas. Para além destas versões, e com o objetivo de garantir a autenticidade das respostas obtidas através do PID-5

em contexto clínico, pode também, aplicar-se a PID-5 *Inconsistency Scale* (Keeley et al., 2016), que permite identificar padrões aleatórios de resposta e, a PID-5 *Over-reporting Scale* (Sellbom et al., 2018), que capta tentativas deliberadas para exagerar a presença de psicopatologia ou falsos positivos, tornando-se especialmente útil em situações de análise pericial.

No que respeita aos estudos de tradução, o PID-5 encontra-se disponível nas mais diversas línguas, entre as quais se incluem: alemão (Zimmermann, et al., 2014), árabe (Al-Attiyah et al., 2017), checo (Riegel et al., 2019), dinamarquês (Bach et al., 2016), espanhol (Gutiérrez et al., 2017), francês (Roskam et al., 2015), holandês (De Fruyt et al., 2013; De Clercq et al., 2014), húngaro (Labancz et al., 2020), indonésio (Adhiatma, 2014), italiano (Fossati et al., 2013), mandarim (Zhang et al., 2021), norueguês (Thimm et al., 2016), persa (Soraya et al., 2017), polaco (Rowiński et al., 2019), português (Pires et al., 2017), português do Brasil (Barchi-Ferreira et al., 2019), romeno (Constantine et al., 2021), russo (Lozovanu et al., 2019) e sueco (Kajoniui, 2017).

A investigação desenvolvida com o PID-5, em particular dos seus parâmetros psicométricos e estrutura hierárquica, encontra-se resumida e acessível através de um conjunto de artigos de revisão e meta-análise (Al-Dajani et al., 2016; Bachi-Ferreira & Osório, 2020; Krueger & Markon, 2014; Somma et al., 2019; Watters & Bagby, 2018; Zimmermann et al., 2019). Estes estudos, não só confirmam a robustez empírica e a utilidade clínica da medida, mas também a sua convergência com outros instrumentos de avaliação da personalidade normal e patológica. Os traços desadaptativos de personalidade avaliados pelo PID-5 têm sido ainda associados a outras variáveis clinicamente relevantes como sejam o planeamento do tratamento (Morey & Benson, 2016), a severidade geral das PP (Fossati et al., 2016), os défices socio-cognitivos (Fossati et al., 2017b), a presença de esquemas desadaptativos (Bach et al., 2015) o alcoolismo (Creswell et al., 2016, Yalch et

al., 2019) e o uso de substâncias (Cavicchioli et al., 2020; Hashemi et al., 2019; Moraleda-Barreno et al., 2018; Somma et al., 2017) a agressividade (Somma et al., 2019), a ansiedade de separação e evitamento (Fossati et al., 2015; Lim et al., 2018; Rosa-Mendes et al., 2019; Schimmenti et al., 2019) e até a indicadores de qualidade de vida (Boland et al., 2018; De Caluwé et al., 2019), entre outros.

De um modo geral, os estudos de precisão do PID-5 têm revelado excelentes coeficientes de consistência interna, em particular, ao nível dos cinco domínios superiores e em amostras ocidentais e não-ocidentais (Al-Dajani et al., 2016; Bachi-Ferreira & Osório, 2020). A acompanhar esta tendência, também a maioria dos estudos desenvolvidos com o PID-5 em amostras de países de expressão árabe tem vindo a reportar coeficientes de consistência interna aceitáveis ($\geq .70$), quer ao nível das facetas quer ao nível dos domínios superiores (Aboul-ata & Qonsua, 2021; Al-Attiyah et al., 2017; Bach & El Abiddine, 2020; Elsayed, 2021). Embora parte das facetas do PID-5 apresente uma estrutura unidimensional, alguns estudos apontam para a multidimensionalidade de algumas facetas, em particular do Envolvimento em comportamentos de risco (Constantin et al., 2020; Labancz et al., 2020; Riegel et al., 2019), Hostilidade (Zimmermann et al., 2014), Manipulação (Zimmermann et al., 2014), Depressividade, Insensibilidade, Desregulação cognitiva e perceptual (Roskam et al., 2015), e Labilidade emocional (Bastiaens et al., 2016; Fossati et al., 2013; Gutierrez et al., 2017; Somma et al., 2017; Zimmermann et al., 2014).

No que se refere à estrutura fatorial, destacamos dois estudos de meta-análise do PID-5 (Somma et al., 2019; Watters & Bagby, 2018) desenvolvidos com base em mais de 25 amostras, clínicas e não clínicas, provenientes de países ocidentais e não ocidentais. Estes estudos vêm confirmar sistematicamente uma estrutura de cinco fatores semelhante à da amostra original (Krueger et al., 2012) nas diferentes traduções, grupos etários e nacionalidades. Porém, o número de amostras provenientes de países não-ocidentais é

manifestamente reduzido em relação ao número de amostras ocidentais. Por essa razão, os autores realçam a necessidade de se estudar a estrutura fatorial do PID-5 noutras culturas e em grupos minoritários (Somma et al., 2019).

Em relação às amostras árabes, a maioria dos estudos replicou a estrutura de cinco fatores do PID-5 (Aboul-ata & Qonsua, 2021; Al-Attiyah et al., 2017; Bach & El Abiddine, 2020; Elsayed, 2021). À semelhança dos resultados encontrados com outras populações (e.g., Riegel et al., 2019; Somma et al., 2017), e tal como previsto no MAPP (Krueger et al. 2012), nos estudos das amostras árabes algumas facetas parecem caracterizar mais do que um domínio. Por exemplo, no estudo de Aboul-ata e Qonsua (2021), 15 das 25 facetas do PID-5 têm pesos não negligenciáveis ($>.30$) em dois ou mais fatores. Por outro lado, algumas facetas que, de acordo com o MAPP, fazem parte de um determinado domínio parecem caracterizar melhor outros domínios nestas populações (Bach & El Abiddine, 2020)

Ainda que a literatura acerca do PID-5, de um modo geral, tenha vindo a demonstrar a replicabilidade da estrutura fatorial do MAPP nas mais diversas latitudes, este não é requisito suficiente para garantir a sua equivalência, e, por conseguinte, a sua utilidade na comparação de diferentes populações ou grupos. A análise da equivalência de um instrumento é habitualmente feita através do estudo da invariância, um procedimento estatístico composto por diversos tipos, cada vez mais exigentes, de precisão (Byrne, 2016; Van de Vijver & Tange, 2004). Tomando como exemplo o domínio Antagonismo do PID-5, para que possamos realizar comparações entre dois grupos distintos, é necessário verificar que 1) as facetas que definem este domínio sejam as mesmas nos dois grupos (invariância configuracional); 2) que o peso fatorial de cada faceta na definição do domínio Antagonismo, que revela a relação entre as facetas e o respetivo domínio, é idêntico em ambos os grupos (invariância métrica); e por último, 3) que o intercepto de cada faceta no

domínio é o mesmo nos dois grupos (invariância escalar) (Chen, 2008; Scholten et al., 2017). Em suma, concluir pela invariância do domínio Antagonismo significa que os valores obtidos neste domínio medem o mesmo nos diferentes grupos. Deste modo, e apesar da maior parte dos estudos confirmar apenas as invariâncias configuracional e métrica do PID-5 em diferentes grupos (e.g., Somma et al., 2019; Watters & Bagby, 2018), para que possamos interpretar ou extrair conclusões válidas acerca das comparações entre os grupos é ainda necessário demonstrar a sua invariância escalar.

A invariância do PID-5 tem sido demonstrada no que respeita à idade (Debas et al., 2018), sexo (Suzuki et al., 2019) e utilidade clínica (Bach et al., 2018), no entanto e tanto quanto sabemos, apenas três estudos analisaram a invariância do PID-5 comparando grupos culturalmente distintos. Thimm e colaboradores (2016) estudaram a invariância da versão norueguesa do PID-5, comparando amostras emparelhadas de estudantes universitários da população norueguesa e estadunidense. Este estudo veio demonstrar a equivalência entre a tradução norueguesa do PID-5 e o teste original, legitimando comparações entre as duas amostras na maioria das facetas e domínios do PID-5, com exceção das facetas Manipulação e Distratibilidade que se revelaram não-invariantes. Sorrel e colaboradores (2021) estudaram a invariância do PID-5 numa amostra de 4380 participantes de países europeus (Bélgica, Catalunha, França, Espanha e Suíça), utilizando as respetivas adaptações do instrumento. Os autores confirmaram a invariância configuracional e métrica do PID-5, embora a invariância escalar tenha sido apenas parcialmente validada. Por último, Bagby e colaboradores (2022) estudaram a invariância do PID-5 em diferentes grupos raciais de estudantes universitários dos EUA (estadunidenses afro-americanos e estadunidenses caucasianos). Os resultados deste estudo salientam a pouca utilidade do PID-5 na avaliação do grupo de estudantes estadunidenses afro-americanos, dada a

ausência de invariância configuracional neste grupo, uma vez que a estrutura de cinco fatores do PID-5 não foi replicada.

Atendendo a estas considerações, e ainda que os estudos acima referidos apontem para a invariância do PID-5 em países ocidentais, é igualmente necessário estender esta análise a países não-ocidentais e a grupos minoritários, de forma a assegurar a equivalência transcultural deste promissor instrumento para a comparação de amostras culturalmente distintas.

2. Desenho de Investigação

Ao longo deste capítulo procurámos descrever e refletir acerca dos aspetos mais relevantes da literatura sobre o PID-5 e das características culturais da população que serviu de base à presente tese. Nesta análise, identificámos limitações e caminhos de investigação que estimularam o nosso interesse pela validação do PID-5 num país e numa cultura ainda pouco estudada, a população emiratense, e nos motivaram a aferir se os traços de personalidade propostos no MAPP do DSM-5 são fundamentalmente universais ou culturalmente especificados. Para este efeito, realizamos três estudos quantitativos desenvolvidos com base em metodologias estatísticas que seguem as recomendações internacionais para a validação de testes psicológicos (ITC – Internacional Test Guidelines for Translating and Adapting Tests, 2018; Hambleton, 2001; Van de Vijver & Hambleton, 1996):

Estudo 1 - *Arabic version of the Personality Inventory for the DSM-5 (PID-5) in a community sample of United Arab Emirates Nationals.*

Estudo 2 - *The Arabic Version of the Personality Inventory for the DSM-5 (PID-5) in a Clinical Sample of United Arab Emirates (UAE) Nationals.*

Estudo 3 - *Cross-cultural Study of the Personality Inventory for the DSM-5 (PID-5) across the Portuguese and the United Arab Emirates (UAE) Community and Clinical Populations.*

Estes estudos têm os seguintes objetivos (gerais e específicos) e hipóteses:

Objetivo Geral 1: Validar a versão árabe do PID-5 (Al-Attiyah et al., 2017) nos EAU, numa amostra da comunidade e numa amostra clínica.

Objetivos Específicos: 1.1. Analisar descritivamente os resultados do PID-5 nos EAU e sua comparação com os resultados obtidos no Qatar, Kuwait e Bahrein e nos EUA; 1.2. Estudar a precisão (consistência interna e estabilidade temporal) do PID-5 nos EAU; 1.3. Estudar a validade convergente do PID-5 com o NEO-FFI e o SCL-90-R nos EAU; 1.4. Estudar a validade fatorial do PID-5 nos EAU; 1.5. Estudar a capacidade discriminativa do PID-5 em relação à população geral e à população clínica.

Hipóteses:

H1.1: Espera-se que não se verifiquem diferenças significativas entre os resultados do PID-5 nos EAU, no Qatar, Kuwait e Bahrein e nos EUA;

H1.2: Espera-se que os indicadores de precisão do PID-5 nos EAU garantam a fiabilidade da medida;

H1.3.1: Espera-se que o padrão de relações entre o PID-5 e o NEO-FFI na amostra comunitária dos EAU confirme as relações teóricas e empíricas que a literatura e a investigação mostram existir entre o MAPP e o FFM, operacionalizados respetivamente pelo PID-5 e pelo NEO-FFI;

H1.3.2: Espera-se que o padrão de relações entre o PID-5 e o SCL-90-R na amostra clínica dos EAU confirme as relações teóricas e empíricas que a literatura e a investigação mostram existir entre personalidade e perturbações clínicas;

H1.4.1: Espera-se que a estrutura fatorial do PID-5 na amostra comunitária dos EAU confirme a solução de cinco fatores encontrada na maioria da investigação com o PID-5;

H1.4.2: Espera-se que a estrutura fatorial do PID-5 na amostra clínica dos EAU confirme a solução de cinco fatores encontrada na maioria da investigação com o PID-5;

H1.5: Espera-se que a amostra clínica dos EAU apresente resultados mais elevados nas facetas e domínios do PID-5 comparativamente com a amostra comunitária dos EAU.

Objetivo Geral 2: Comparar transculturalmente amostras comunitárias e clínicas dos EAU e de Portugal através do PID-5.

Objetivos Específicos:

2.1. Estudar a invariância do PID-5 em amostras emparelhadas, clínicas e não-clínicas, da população emeritense e portuguesa;

2.2. Comparar os perfis médios de traços de personalidade do PID-5 em amostras clínicas e não-clínicas da população emeritense e portuguesa.

Hipóteses:

H2.1.1: Espera-se que as facetas e domínios do PID-5 sejam invariantes nas amostras comunitárias da população emeritense e portuguesa;

H2.1.2: Espera-se que as facetas e domínios do PID-5 sejam invariantes nas amostras clínicas da população emeritense e portuguesa;

H.2.2.1: Espera-se que existam diferenças nos perfis médios de personalidade do PID-5 nas amostras comunitárias da população emeritense e portuguesa passíveis de serem atribuídas a diferenças culturais entre os dois países;

H.2.2.2: Espera-se que existam diferenças nos perfis médios de personalidade do PID-5 nas amostras clínicas da população emeritense e portuguesa passíveis de serem atribuídas a diferenças culturais entre os dois países.

Objetivo Geral 3: Dotar os EAU de um instrumento de avaliação de traços desadaptativos de personalidade preciso e válido, que para além de auxiliar no diagnóstico das perturbações da personalidade, é útil no planeamento do tratamento e também na avaliação das intervenções.

Objetivo Geral 4: Contribuir para o alargamento dos estudos acerca do PID-5 e o MAPP, que nas últimas décadas se tem realizado em países ocidentais, a culturais e países não-ocidentais.

O Estudo 1 permitiu dar resposta aos objetivos gerais 1, 3 e 4, e aos objetivos específicos 1.1, 1.2, 1.3 e 1.4, bem como testar as hipóteses 1.1, 1.2, 1.3.1 e 1.4.1. Por sua vez, o Estudo 2 para além de responder aos objetivos gerais 1, 3 e 4, possibilitou estudar também os objetivos específicos 1.1, 1.2, 1.3, 1.4, e 1.5 e testar as hipóteses 1.3.2, 1.4.2, 1.5. Por último, o Estudo 3 abordou os quatro objetivos gerais, e ainda os objetivos específicos 1.1, 1.2, 2.1 e 2.2. Através deste terceiro estudo as hipóteses 1.2, 2.1.1, 2.1.2, 2.2.1, 2.2.2 foram testadas.

2.1 Participantes e Recolha da Amostra

Os três estudos são baseados em amostras sobrepostas, mas diferentes no que respeita à dimensão e distribuição dos participantes. Nesta secção são apresentadas as características e os procedimentos de recolha de dados próprios de cada um dos estudos. A recolha da amostra comunitária contou com o apoio de um grupo de assistentes de investigação emeritenses composto por alunos do curso de psicologia da *Zayed University* (campus do Dubai e do Abu Dhabi), que tinham completado o grau de licenciatura. A necessidade de recorrer a assistentes de investigação da própria instituição deveu-se às políticas muito restritivas de segurança da *Zayed University* no acesso aos alunos por elementos exteriores à universidade, mesmo para a recolha de dados para estudos científicos.

Foi possível obter um total de 1090 participantes, na sua maioria (88%) estudantes universitários (dos cursos de relações internacionais, psicologia, gestão e educação), e elementos da população geral (12%), maioritariamente do sexo feminino (89.5% mulheres e 10.5% homens), de nacionalidade emeritense, a residir no país, com um grau de escolaridade igual ou superior ao ensino primário e com idade compreendida entre os 18 e os 57 anos ($M = 22.44$, $DP = 6.63$). O predomínio de mulheres face aos homens, deve-se por um lado a uma participação mais ativa das mulheres dos EAU neste tipo de estudos, e por outro, ao predomínio das mulheres na população universitária, já que grande número de estudantes emeritenses do sexo masculino opta por estudar no estrangeiro. Os participantes foram informados dos objetivos do Estudo 1, através dos assistentes de investigação, que durante o período de aulas e com autorização dos docentes dos respetivos cursos, abordaram as diferentes turmas. Àqueles que aceitaram voluntariamente participar no estudo foi ainda pedido que posteriormente trouxessem dois questionários de familiares e amigos (de um homem e de uma mulher com idade superior a 30 anos). Importa ainda salientar que, no Estudo 1, 28 participantes responderam ao protocolo de investigação em

duas ocasiões distintas (com um intervalo de quatro semanas), o que nos permitiu estudar a estabilidade temporal teste-reteste do PID-5. O emparelhamento dos dados recolhidos realizou-se através de um código distribuído aos participantes na primeira sessão.

Todos os participantes assinaram o consentimento informado, o qual dava conta dos objetivos e relevância do estudo, garantia o anonimato, a possibilidade de desistir a qualquer momento da aplicação, e que os dados recolhidos seriam usados exclusivamente em estudos científicos. As sessões de recolha de dados dos estudantes universitários tiveram lugar coletivamente nas instalações da *Zayed University* e no período de abril a setembro de 2019.

Com base nesta amostra extraímos três subamostras. A primeira, composta por 156 participantes, homens (37.2%) e mulheres (62.8%), com idade compreendida entre os 18 e os 57 anos ($M = 31.43$, $DP = 9.52$), que permitiu desenvolver o Estudo 2, através do seu emparelhamento (com base no género e idade) com uma amostra clínica da população emeritense. A segunda, composta por 300 participantes, também maioritariamente composta por mulheres (80%) e com limites de idade semelhantes (18 e 57 anos, $M = 27.95$, $DP = 10.9$) possibilitou a realização do Estudo 3, através do seu emparelhamento com uma subamostra da população portuguesa.

No que concerne à amostra clínica do Estudo 2, o recrutamento dos participantes teve lugar em três instituições de saúde mental dos EAU, o hospital psiquiátrico *Al Amal*, o *National Rehabilitation Center* e o departamento de psiquiatria do *Rashid Hospital*. A seleção dos participantes foi feita pelos clínicos, através do seu parecer médico e/ou dos registos hospitalares dos pacientes que, no momento, recebiam tratamento psiquiátrico, quer em regime de ambulatório, quer em internamento nas referidas instituições. O diagnóstico dos participantes foi efetuado com base no DSM-5. A amostra clínica incluiu

pacientes de ambos os sexos que cumpriam critérios para pelo menos uma perturbação mental do DSM-5, com 18 ou mais anos, de nacionalidade emeritense, a viver nos EAU e que tinham completado pelo menos o ensino primário. Foram excluídos todos aqueles que sofriam de deficiência intelectual, esquizofrenia/perturbação esquizoafetiva e/ou perturbações neuro-cognitivas. Os pacientes, previamente selecionados pelos clínicos, foram convidados a participar no estudo no final das consultas de seguimento ou de alta médica, nas quais receberam informação acerca da natureza e objetivos do estudo, bem como da confidencialidade dos dados recolhidos. Tendo em conta a extensão do protocolo de investigação (aproximadamente uma hora), de acordo com a disponibilidade dos pacientes, foram agendadas as sessões necessárias para o preenchimento do protocolo. A participação no estudo foi voluntária e todos os pacientes assinaram o consentimento informado. De modo a tentar garantir que a condição clínica dos pacientes era tendencialmente equivalente (i.e., que os pacientes estavam em fases de evolução e de controlo da doença equiparáveis), os pacientes internados foram convidados a participar no estudo, apenas quando estavam prestes a receber alta médica. Assim, recolhemos uma amostra clínica composta por 156 pacientes, com idades compreendidas entre os 18 e os 61 anos ($M = 31.38$, $DP = 8.99$), que inclui homens (37.8%) e mulheres (62.2%), na sua maioria diagnosticados com perturbações relacionadas com substâncias e perturbações aditivas (35.3%), perturbações da ansiedade (21.8%), perturbações depressivas (14.7%) e perturbações bipolares e perturbações relacionadas (14.7%). Cerca de 76.9% apresentavam pelo menos uma comorbilidade, sobretudo perturbações depressivas (16.6%), perturbações da personalidade (6.6%) e perturbações obsessivo-compulsivas e perturbações relacionadas (2.5%). A recolha de dados decorreu no período de maio a setembro de 2019.

Desta amostra clínica emeritense foi subsequentemente extraída uma subamostra, ligeiramente mais pequena, composta por 150 pacientes, que foi posteriormente

emparelhada com uma amostra clínica portuguesa (com base no diagnóstico), e que nos permitiu realizar o Estudo 3.

As amostras portuguesas, comunitárias e clínicas, utilizadas neste doutoramento são também subamostras extraídas dos estudos de validação do PID-5 na população portuguesa e encontram-se descritas em Pires et al. (2017, 2019).

2.2 Instrumentos

O protocolo de investigação utilizado nos estudos que desenvolvemos incluiu o consentimento informado, o questionário sociodemográfico, a versão árabe do PID-5, a versão árabe do NEO-FFI (Estudo 1) ou a versão árabe do SCL-90-R (Estudo 2).

2.2.1. Questionário Sociodemográfico

O questionário sociodemográfico compreendeu questões relativas à nacionalidade, género, idade, estatuto laboral, profissão, estado civil, religião, nível de escolaridade, situação socioeconómica, com quem vive, se tem filhos, se sofre de alguma doença física ou mental e como considera o seu estado de saúde atual.

2.2.2 *Personality Inventory for the DSM-5* (Krueger et al., 2012; versão árabe de Al-Attiah et al., 2017)

Os traços desadaptativos de personalidade do MAPP (APA, 2014) foram medidos através da versão árabe do PID-5 de Al-Attiah e al. (2017). A autorização para utilizar esta versão nos estudos desenvolvidos nos EAU, e que suportam empiricamente este trabalho, foi solicitada aos autores, tendo sido por estes concedida. De acordo com os resultados obtidos no estudo de adaptação, esta versão do PID-5 revelou coeficientes moderados a bons de consistência interna, medidos através do alpha de Cronbach, tanto ao nível das facetas (entre .70 em Manipulação e .93 em Procura de atenção), como ao nível

dos domínios (entre .92 em Antagonismo e .96 em Desprendimento). Os autores confirmaram ainda uma estrutura fatorial composta por cinco fatores semelhante à do PID-5 original.

Esta tradução do PID-5, tal como referimos anteriormente, foi estudada numa amostra composta por 710 estudantes universitários do Qatar, Kuwait e Bahrain. Ainda que estes países sejam muito próximos dos EAU, tanto do ponto de vista cultural como da partilha da língua oficial, estas convergências não são suficientes para garantir a validade e utilidade clínica da medida na população emiritaense. Desde logo, por a amostra incluir estudantes universitários, pelas especificidades da língua árabe (como tivemos oportunidade de clarificar ao longo deste trabalho), mas sobretudo, pela ausência de dados da população clínica, para a qual o PID-5 foi desenvolvido. Do ponto de vista transcultural, os autores não desenvolveram estudos de equivalência ou invariância da medida nos três países árabes onde a medida foi validada.

A caracterização do PID-5 relativamente ao número de itens, variáveis medidas, escala de resposta, idades de aplicação e qualidades psicométricas encontra-se no ponto 1.5. (pág. 20) deste capítulo.

2.2.3 NEO-Five Factor Inventory (NEO-FFI; Costa & McCrae, 1992; versão árabe de Alansari, 1997).

O NEO-FFI é uma medida de autorrelato de avaliação dos cinco domínios da personalidade normal do MCF (Costa & McCrae, 1992), Neuroticismo, Extroversão, Abertura à experiência, Amabilidade e Conscienciosidade. Este instrumento é composto por 60 itens aos quais se responde numa escala de Likert de quatro pontos, que varia entre (0 = *discordo fortemente* e 4 = *concordo fortemente*). Na amostra emiritaense, a versão árabe do NEO-FFI apresentou indicadores de fiabilidade moderados a bons, com

coeficientes de consistência interna compreendidos entre .65 (Abertura à experiência) e .85 (Neuroticismo), semelhantes aos obtidos com a amostra original dos EUA (entre .68 e .86) (Costa & McCrae, 1992).

2.2.4 A *Sympom Checklist 90 – Revised* (SCL-90-R; Derogatis, 1977; versão árabe de Al-Behairy, 1984.

O SCL-90-R é um questionário de autorrelato que avalia a presença de sintomas psicopatológicos. É composto por 90 itens aos quais se responde numa escala de Likert de cinco pontos, que varia entre (0 = *Nunca* e 4 = *Extremamente*). Propõe-se aos participantes que respondam à prova assinalando o grau em que se sentiram afetados por cada um dos sintomas no decorrer dos últimos dois meses. Este instrumento é composto por nove escalas principais e sete itens que correspondem a escalas adicionais. Os principais construtos avaliados são a Ansiedade, Ansiedade Fóbica, Depressão, Hostilidade, Ideação Paranoide, Obsessões e Compulsões, Psicoticismo, Sensibilidade Interpessoal e Somatização. Na amostra emeritense, o inventário revelou valores de consistência interna (alpha de Cronbach) adequados, que variaram entre .77 na escala de Ansiedade Fóbica e .90 na escala de Depressão, porém ligeiramente inferiores aos obtidos no estudo original do instrumento, entre .84 e .90 (Derogatis, 1977).

2.3 Procedimentos Estatísticos

A análise estatística dos estudos que sustentam a presente tese foi conduzida através dos programas de análise estatística IBM SPSS Statistics (v.26, SPSS Inc., Chicago, IL) e do IMINCE (Lorenzo-Seva & Ferrando, 2003). Realizada a caracterização das várias amostras do estudo, iniciou-se o estudo da fiabilidade, no qual a consistência interna do PID-5 foi analisada através do coeficiente alpha de Cronbach. A consistência interna de um instrumento considera-se inaceitável se $\alpha < .50$, baixa se $.50 \leq \alpha < .60$, questionável se $.60$

$\leq \alpha < .70$, aceitável se $.70 \leq \alpha < .80$, boa se $.80 \leq \alpha < .90$ e excelente se $\alpha \geq .90$ (Cronbach, 1951). Relativamente à estabilidade teste-reteste, esta foi avaliada pelos coeficientes de correlação de Pearson ou ordinal de Spearman consoante a distribuição das variáveis em causa. Estes coeficientes, de Pearson ou de Spearman permitiram ainda estudar a validade convergente do PID-5 com o NEO-FFI e a SCL-90-R.

A análise da normalidade da distribuição das diversas variáveis em estudo foi realizada de acordo com os seguintes critérios: coeficientes de assimetria e de curtose, Teste de ajustamento de Kolmogorov-Smirnov ($N > 50$) e as representações gráficas Q-Q-plots. Nos casos em que as variáveis em análise apresentaram uma distribuição normal, utilizámos o Teste de igualdade de valores médios para amostras independentes (ou para amostras emparelhadas) e a medida de dimensão do efeito d de Cohen, que nos permitiu avaliar a dimensão do efeito na comparação das respostas médias ao PID-5. Deste modo, o efeito é considerado pequeno quando $d \leq 0.20$, médio quando $0.20 < d \leq 0.50$, grande quando $0.50 < d \leq 1.0$ e muito grande quando $d > 1.0$ (Cohen, 1988 citado por Marroco, 2010). Por outro lado, quando a distribuição das variáveis em estudo se revelou não-normal ou se verificou existir heterogeneidade de variâncias, aplicou-se o Teste de Wilcoxon para amostras emparelhadas (ou o Teste de Mann-Whitney para amostras independentes) e a dimensão do efeito na comparação dos resultados foi estudada pela medida $r = z/\sqrt{N}$, sendo N o número de pares não empatados e z a estatística do teste não paramétrico. Este efeito considera-se pequeno se $.10 \leq r < .30$, médio se $.30 \leq r < .50$ e grande quando $r \geq .50$ (Rosenthal, 1991, 1994).

Tendo em conta as variações culturais, alguns traços tendem a apresentar cruzamento dos pesos fatoriais, ocasionando desvios em relação à estrutura fatorial original. Assim, seguindo as indicações dos autores (Krueger et al., 2012), estudámos a estrutura fatorial do PID-5 nos EAU através da Análise Fatorial Exploratória (AFE),

utilizando uma rotação oblíqua *Equamax* e os seguintes critérios de extração e interpretação dos fatores: o critério de Kaiser (Yemans & Golder, 1982), o método de Velicer (Velincer, 1976; Velincer & Jackson, 1990) baseado nas correlações mínimas parciais (MAP) e o método de Análise Paralela (PA) (Horn, 1965).

Relativamente ao estudo da invariância, escolhemos um software específico e gratuito, o IMINCE (Lorenzo-Seva & Ferrando, 2003), que utiliza uma metodologia de *Exploratory Structural Equation Modeling* (ESEM) combinando as características de uma Análise Fatorial Exploratória (AFE) com as da Análise Fatorial Confirmatória (AFC). Atualmente, muitos investigadores, destacam o interesse da abordagem exploratória quando se dispõem de amostras de grande dimensão que levam frequentemente a que os *softwares* de AFC não convirjam para uma solução e, não menos importante, estes modelos adotam uma abordagem em que cada item tem peso fatorial não nulo apenas num único fator, o que não corresponde à realidade das aplicações práticas, particularmente em estudos na área da personalidade. No IMINCE, os testes de significância estatística para avaliar a invariância, que os modelos confirmatórios permitem, obtêm-se recorrendo às técnicas de reamostragem *Bootstrap*. Este software possui ainda a vantagem adicional de permitir a realização de análises fatoriais usando correlações policóricas ou tetracóricas, verdadeiramente adequadas para respostas a itens com resposta em escalas de Likert ou itens dicotómicos (Lorenzo-Seva & Ferrando, 2003).

2.4. Ética

Os três estudos que compõem a presente tese foram revistos e aprovados pela Comissão Deontológica da Faculdade de Psicologia da Universidade de Lisboa, pelo Comité de Ética e Investigação da *Zayed University*, pelo *Dubai Scientific Research Ethics Committee* e pelo Comité de Ética do Ministério da Saúde e da Prevenção dos Emirados

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Capítulo II - Estudios Empíricos

Estudo 1: The Arabic version of the Personality Inventory for the DSM-5 (PID-5) in a community sample of United Arab Emirates nationals¹

Abstract

Background: Section III of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) proposes a model for conceptualizing personality disorders in which they are characterized by impairments in personality functioning and maladaptive personality traits. The Personality Inventory for DSM-5 (PID-5) is a self-report measure that assesses the presence and severity of these maladaptive personality traits.

Objective: The current study examined the reliability and validity of the Arabic version of the Personality Inventory for DSM-5 (PID-5) to measure maladaptive personality traits in the Emirati population of the United Arab Emirates.

Method: The Arabic version of the PID-5 was administered to a community sample of 1,090 United Arab Emirates nationals (89.5% female and 10.5% male, $M_{age} = 22.44$ years old). The descriptive measures, internal consistency, test-retest reliability, convergent validity with NEO-Five Factor Inventory, as well as PID-5's factor structure, were all addressed.

Results: The PID-5 facets and domains mean scores were higher in the Emirati sample compared to the original US sample. Internal consistency of the PID-5 scales was acceptable to high and test-retest coefficients ranged from .84 (facets) to .87 (domains). As expected, the five domains of the Arabic version of the PID-5 correlated significantly with all Five-Factor Model domains of personality. Additionally, the Arabic version of the PID-5 confirmed a five-factor structure that resembles the PID-5 domains.

Conclusion: The findings of this study provided initial support for the use of the Arabic version of the PID-5 to assess maladaptive personality traits in the Emirati population of the United Arab Emirates.

Key words: Personality, DSM-5, personality trait model, PID-5, United Arab Emirates, psychometric properties.

¹Coelho, O., Pires, R., Sousa Ferreira, A., Goncalves, B., AlJassmi, M., & Stocker, J. (2020). Arabic version of the Personality Inventory for the DSM-5 (PID-5) in a community sample of United Arab Emirates nationals. *Clinical Practice & Epidemiology in Mental Health*, 16(1), 180-188. <https://doi.org/10.5993/AJHB.44.6.5>

Introduction

The Diagnostic and Statistical Manual of Mental Disorders (APA) and the International Classification of Mental and Behavioural Disorders (WHO) are currently shifting towards a more evidence-based dimensional conceptualization of Personality Disorders (PD), as the traditional categorical paradigm has proven to be conceptual and empirically problematic (Krueger & Markon, 2014; Tyrer et al., 2015) with limited clinical utility (Hopwood et al., 2018). This has resulted in many patients being undiagnosed, receiving multiple personality disorder diagnoses, or, most commonly, diagnosed with a PD not otherwise specified (APA, 2000).

A reflection of this was the inclusion of the Alternative DSM-5 Model for Personality Disorders (AMPD) in Section III of the DSM-5 (APA, 2000) and more than 200 publications on its main diagnose criteria: the assessment of impairment in personality function (Criterion A) and the presence of maladaptive personality traits (Criterion B), that followed its publication. The primary measure for the assessment of the AMPD (APA, 2013) maladaptive traits is provided by The Personality Inventory for the DSM-5 (PID-5) (Krueger et al., 2012), which is a self-rated inventory that characterizes 25 trait facets organized into five high order domains of personality variation (Negative Affectivity, Detachment, Antagonism, Disinhibition and Psychoticism).

The PID-5 psychometric properties have been extensively examined and review studies have consistently shown that it is a reliable measure with internal consistency coefficients ranging from acceptable at the trait facets level to high at the domain trait level (Al-Dajani et al., 2016), and with the ability to capture individual differences that were stable for four weeks up to four months intervals (Pires et al., 2017; Zimmermann et al., 2017). Furthermore, in regards to its factor structure, the PID-5 has confirmed a five-factor structure similar to the Five Factor Model (FFM), both in clinical and non-clinical studies

and across different countries (Somma et al., 2019). However, researchers have also reported that the loading pattern of some trait facets appeared to deviate from the model, such as Suspiciousness that belongs to the Detachment domain, but more often loaded in Negative affectivity, or Hostility that belongs to domain Negative affectivity but frequently loaded in the Antagonism domain (Watters et al., 2019).

The PID-5 facets and domains have conceptually and meaningfully converged with other established measures of personality and personality pathology (Crego et al., 2018; Hopwood et al., 2013; Sellbom et al., 2013), including The Personality Inventory for the ICD-11 (Oltmanns & Widiger, 2018). Also, a vast body of research has conceptualized the PID-5 trait domains as mal-adaptive extensions of the general personality traits and supports the continuum between adaptive and maladaptive personality trait models (DeYoung et al., 2016; Helle et al., 2017), established by the association between Negative affectivity with Neuroticism, Detachment with Extraversion, Antagonism with Agreeableness and Disinhibition with Conscientiousness. The relation between Psychoticism and Openness is less clear and debatable (Sleep et al., 2018).

Additionally, the PID-5 has proven its ability to capture the DSM-5 Section II PDs categories and symptoms (Bach et al., 2018), and other studies claimed its utility for treatment planning (Morey et al., 2016), as well as in predicting psychosocial impairment (Simms & Calabrese, 2016).

The PID-5 has been translated into different languages and cultures and can be found in Arabic (Al-Attayah et al., 2017), Czech (Riegel et al., 2019), Danish (Bach et al., 2016), Dutch (Bastiaens et al., 2016), French (Roskam et al., 2015), German (Zimmermann, et al., 2014), Indonesian (Adhiatma, et al., 2014), Italian (Fossati et al., 2013), Norwegian (Thimm et al., 2016), Persian (Soraya et al., 2017), Polish (Rowiński et al., 2019), Portuguese (Pires et al., 2017), Brazilian-Portuguese (Barchi-Ferreira et al.,

2019), Russian (Lozavanu et al., 2019), Spanish (Gutiérrez et al., 2017), and Swedish (Kajoniū, 2017).

The translation study of the Arabic PID-5 (Al-Attayah et al., 2017) was conducted with college students in three Middle East countries (Bahrain, Kuwait, and Qatar) and is written in Modern Standard Arabic (MSA), which is the formal written expression used in the literature as well as in the translation of psychological tests, common to all the Arabic speaking countries (Al-Tamimi, 2011; Ryding, 2005). However, the Arabic language is a *diglossic* language (Ibraim, 2008) that beyond the MSA, derived from the Classic Arabic, is also comprised of colloquial forms used to orally communicate ideas, feelings, and emotions, but for which there is no written form of expression, resulting in the inability to use it in the translation of psychological tools. The MSA, although useful as a standard form of the Arabic language, carries some limitations such as the use of outdated terms that are no longer used colloquially and some MSA words might have different meanings across countries (Ibraim, 2008; Zeinoun et al., 2017). In a recent lexical study on personality traits, using the MSA in the Arab Levant, the authors reported an underrepresentation of terms to describe some dimensions of general personality, such as Openness (Zeinoun et al., 2018), which is related with Fantasy, Aesthetics, Feelings, Actions, Ideas and Values (McCrae, 2013). These findings are not surprising considering that these topics, although extremely relevant for the psychological assessment, are more often communicated using the colloquial Arabic forms. Therefore, assuming the generalizability of the Arabic PID-5 (Al-Attayah et al., 2017), or other translated tests, to all Arabic speaking countries could carry important reliability and validity issues that might be minimized by validity studies, in Arabic speaking clinical and non-clinical samples, for which this study aims to contribute through the following objectives: (a) to test possible cultural variations between Western and non-Western cultures by comparing the Emirati community sample results as well as

ones obtained in the PID-5 Arabic translation study (Al-Attayah et al., 2017), with the original test data, (b) to address the PID-5 scales' internal consistency and test-retest reliability, as the PID-5 traits stability was not addressed in the Arabic translation study (Al-Attayah et al., 2017), (c) to explore the association between the PID-5 domains with the FFM, measured by the Arabic NEO-Five Factor Inventory (Alansari, 1997), and (d) to examine the PID-5's factor structure in the Emirati community sample.

Methods

Sample

The participants were a total 1,090 volunteers aged between 18 and 57 years old ($M = 22.44$, $SD = 6.63$, 89.5% female, 10.5% male) recruited from Zayed University students and their acquaintances. Test-retest reliability was studied with a sample of 28 students, 85.7% females, 14.3% males, $M_{age} = 28.6$, $SD = 9.64$. The inclusion criteria were Emirati native Arabic speakers aged 18 years old and above who have completed primary school or higher.

Procedures

Participation in this study was voluntary and all respondents signed a written informed consent form requesting their participation in the study, the possibility of giving up at any time, and that the data would be used exclusively in a scientific study. The experimental sessions were held collectively and conducted at Zayed University after obtaining approval from the Research Ethics Committee of Zayed University. In the temporal stability study, the interval between the first and the second application was four weeks and data was matched through a code given to the participants in the first session.

Measures

The Personality Inventory for the DSM-5 (PID-5, Krueger et al., 2012, Arabic version by Al-Attayah et al., 2017).

The PID-5 is a self-report measure composed of 220 items, rated on a four-point Likert scale ranging from 0 (*very false or often false*) to 3 (*very true or often true*) that characterize 25 empirically derived lower-level facets grouped into five major domains of maladaptive personality variation. Data from the Al-Attiyah et al., 2017 study showed that the Cronbach's alphas of the PID-5 scales were moderate to high, ranging from .70 (Manipulativeness) to .93 (Attention seeking) at the facet level, and .92 (Antagonism) to .96 (Detachment) at the domain level.

NEO-Five Factor Inventory (NEO-FFI, Costa & McCrae, 1992, Arabic version by Alansari, 1997).

The NEO-FFI is a measure of the five basic personality factors (Neuroticism, Extraversion, Openness to Experiences, Agreeableness, and Conscientiousness) composed by 60 items rated on a five-point Likert response format, ranging from 0 (*strongly disagree*) to 4 (*strongly agree*). The Arabic version of the NEO-FFI (Alansari et al., 1997) was used, and to prevent validity issues and ensure conceptual equivalence of the measure, a preliminary study was conducted in the Emirati population. Results confirmed a five-factor structure supporting the universality of the FFM. Cronbach's alpha ranged from acceptable .65 (Openness to experience) to high .85 (Neuroticism), in line with the results reported in the US sample, which ranged from .68 to .86 (Costa & McCrae, 1992).

Data Analysis

Analysis was conducted with the IBM SPSS Statistics (v.25, SPSS Inc., Chicago, IL). Cohen's d was used as a measure of effect size, in order to study the mean score differences between the Emirati and the original sample (Krueger et al., 2012). The effect size was considered small when $d \leq 0.20$, medium when $0.20 < d \leq 0.50$, large when $0.50 < d \leq 1.0$, and very large when $d > 1.0$. The internal consistency was measured by Cronbach's alpha, while test-retest and convergent validity analyses were conducted by the Pearson

coefficient or Spearman's rank coefficient if the dataset did not follow a normal distribution. Due to the complexity of the personality structure, in which traits present several cross-loadings, the PID-5 structure in the United Arab Emirates national population was examined through Exploratory Factor Analyses (EFA), using *Equamax* oblique rotation, and the number of factors to be extracted and interpreted was based on the Kaiser's, Velicer's minimum average partial test (MAP), and Parallel Analysis criteria.

Results

Descriptive Statistics

Descriptive statistics for the five domains and 25 facets were compared with the data from the original study (Krueger et al., 2012) through Cohen's d (Table 1). Small to medium effect sizes would reveal greater similarities between the original study and the Emiratis' response style. The domains Negative affectivity, Detachment, and Disinhibition showed medium effect sizes (≤ 0.50), and large effect sizes were obtained for Psychoticism (0.60) and Antagonism (0.95). At the facets level, medium effect sizes ($0.20 < d \leq 0.50$) were found for 13 of the facets, with nine facets showing large effect sizes (> 0.50). The smaller effect sizes (≤ 0.20) were found on Anhedonia, Rigid perfectionism, and Withdrawal, while the larger effect sizes (≥ 0.80) were displayed in Cognitive and perceptual dysregulation and Irresponsibility.

Table 1

Internal consistencies (α), means (M), standard deviations (SD) and Cohen's d between the three studies for the 25 facets and five domains

PID-5 Scales	Study 1			Study 2			Study 3			Studies 1 & 2	Studies 1 & 3
	Krueger et al., 2012			Al-Attayah et al., 2017			UAE data				
	α	M	SD	α	M	SD	α	M	SD	$d_{1,2}$	$d_{1,3}$
Anhedonia	.88	0.89	0.64	.88	1.00	0.52	.77	0.90	0.51	0.20	0.02
Anxiousness	.91	1.02	0.73	.89	1.52	0.60	.84	1.42	0.60	0.78	0.64
Attention seeking	.89	0.81	0.65	.93	1.37	0.66	.83	1.05	0.58	0.85	0.40
Callousness	.91	0.40	0.50	.92	0.71	0.50	.73	0.54	0.35	0.62	0.37
Cognitive and perceptual dysregulation	.86	0.44	0.48	.89	0.71	0.46	.80	0.91	0.48	0.58	0.98
Deceitfulness	.85	0.52	0.54	.88	1.01	0.54	.71	0.87	0.44	0.91	0.76
Depressivity	.95	0.53	0.62	.92	0.85	0.53	.87	0.70	0.49	0.58	0.33
Distractibility	.91	0.82	0.69	.88	1.17	0.55	.79	1.11	0.51	0.59	0.53
Eccentricity	.96	0.82	0.76	.92	0.63	0.46	.90	0.96	0.58	0.34	0.23
Emotional lability	.89	0.94	0.74	.86	1.27	0.58	.75	1.28	0.55	0.53	0.57
Grandiosity	.72	0.82	0.58	.82	1.40	0.58	.67	1.12	0.52	1.00	0.56
Hostility	.89	0.91	0.67	.89	1.27	0.57	.75	1.19	0.48	0.60	0.54
Impulsivity	.77	0.77	0.57	.87	1.27	0.62	.75	1.04	0.57	0.82	0.47
Intimacy avoidance	.84	0.61	0.65	.77	0.95	0.55	.71	0.85	0.54	0.59	0.43

Note. Krueger *et al.*, 2012; Al-Attayah *et al.*, 2017; Small effect $d \leq 0.20$, medium effect size $0.20 < d \leq 0.50$, large $0.50 < d \leq 1.0$, and very large

$d > 1.0$.

Table 1 (Cont.)

Internal consistencies (α), means (M), standard deviations (SD) and Cohen's d between the three studies for the 25 facets and five domains

PID-5 Scales	Study 1			Study 2			Study 3			Studies 1 & 2	Studies 1 & 3
	Krueger et al., 2012			Al-Attayah et al., 2017			UAE data				
	α	M	SD	α	M	SD	α	M	SD	$d_{1,2}$	$d_{1,3}$
Irresponsibility	.81	0.39	0.49	.84	0.99	0.53	.66	0.77	0.46	1.16	0.82
Manipulativeness	.81	0.80	0.67	.70	1.26	0.54	.67	1.01	0.55	0.80	0.37
Perseveration	.88	0.82	0.62	.85	1.23	0.49	.70	1.08	0.44	0.78	0.54
Restricted Affectivity	.73	0.97	0.56	.81	1.23	0.50	.61	1.17	0.47	0.50	0.41
Rigid perfectionism	.90	1.05	0.68	.90	1.45	0.57	.77	1.08	0.44	0.67	0.06
Risk taking	.85	1.05	0.51	.92	1.22	0.52	.79	1.22	0.44	0.33	0.37
Separation Insecurity	.85	0.80	0.68	.87	1.08	0.56	.76	0.98	0.56	0.47	0.31
Submissiveness	.78	1.17	0.66	.84	1.10	0.58	.67	0.96	0.57	-0.12	-0.36
Suspiciousness	.73	0.95	0.58	.78	1.16	0.47	.37	1.15	0.39	0.42	0.46
Unusual beliefs	.83	0.64	0.63	.90	0.45	0.45	.74	0.91	0.52	-0.38	0.50
Withdrawal	.93	1.01	0.72	.90	1.07	0.53	.80	1.08	0.51	0.10	0.13
Negative Affect.	.93	1.07	0.44	.94	1.25	2.18	.87	1.23	0.45	0.10	0.36
Detachment	.96	0.78	0.54	.96	1.02	2.08	.86	0.94	0.41	0.13	0.37
Antagonism	.95	0.61	0.46	.92	1.21	1.96	.81	1.00	0.40	0.36	0.95
Disinhibition	.84	1.06	0.30	.95	1.10	2.11	.85	0.97	0.41	0.02	-0.23
Psychoticism	.96	0.64	0.57	.95	0.89	1.79	.92	0.93	0.46	0.16	0.60

Note. Krueger et al., 2012; Al-Attayah et al., 2017; Small effect $d \leq 0.20$, medium effect size $0.20 < d \leq 0.50$, large $0.50 < d \leq 1.0$, and very large $d > 1.0$.

Reliability

The internal consistency of the Arabic PID-5 scales in the Emirati sample showed moderate ($.70 \geq \alpha < .80$ for 13 of the 25 facets) to high ($\geq .80$ for 6 of the 25 facets) coefficients, with a mean alpha of .74 (see Table 1). One facet showed a poor reliability coefficient of .37 (Suspiciousness). At the domain level, the alphas ranged from .81 (Antagonism) to .92 (Psychoticism) with an average of .86. These results showed that the majority of the facets and the five domains were reliable, although with coefficients slightly lower than the ones previously found with other Arabic-speaking samples (Al-Attiyah et al., 2017) and in the original study (Krueger et al., 2012).

Test-retest Reliability

The results of the test-retest reliability are displayed in Table 2. At the domain level, the correlation coefficients values range from .79 ($p < .01$) for Detachment to .92 ($p < .01$) for the Antagonism domain. At the facets level, the correlation coefficients values were higher than $\geq .80$ for 19 of the 25 facets, ranging from .73 ($p < .01$) for Restricted affectivity to .95 ($p < .01$) for the Eccentricity scale.

Table 2

Stability coefficients of the Arabic version of the PID-5 facets and domains

PID-5 scales	r ($N = 28$)
Anhedonia ^a	.84**
Anxiousness	.89**
Attention seeking	.94**
Callousness ^a	.82**
Cognitive and perceptual dysregulation	.78**
Deceitfulness	.91**
Depressivity	.76**
Distractibility	.85**
Eccentricity	.95**
Emotional lability	.87**

Note. r Pearson correlation coefficient; ^a Spearman correlation coefficient (r_s);

**Significant correlations $p < .01$. Four weeks interval between applications.

Table 2 (Cont.)*Stability coefficients of the Arabic version of the PID-5 facets and domains*

PID-5 scales	<i>r</i> (<i>N</i> = 28)
Grandiosity	.80**
Hostility	.92**
Impulsivity	.84**
Intimacy avoidance	.78**
Irresponsibility ^a	.76**
Manipulativeness	.92**
Perseveration	.77**
Restricted Affectivity	.73**
Rigid perfectionism	.88**
Risk taking	.87**
Separation Insecurity	.82**
Submissiveness	.80**
Suspiciousness	.83**
Unusual beliefs and experiences	.84**
Withdrawal	.83**
Negative affectivity	.88**
Detachment	.79**
Antagonism	.92**
Disinhibition	.91**
Psychoticism	.87**

Note. *r* Pearson correlation coefficient; ^a Spearman correlation coefficient (*r_s*);

**Significant correlations $p < .01$. Four weeks interval between applications.

Convergent Validity

The convergent validity of the Arabic PID-5 in the Emirati sample was investigated by correlating the five domains of the PID-5 with the five factors of the NEO-FFI (see Table 3). As expected, the domain Negative affectivity correlated moderate and positively with Neuroticism ($r = .57, p < .01$), Detachment correlated moderate and negatively with Extraversion ($r = -.49, p < .01$) as well as Antagonism with Agreeableness ($r = -.36, p < .01$) and Disinhibition with Conscientiousness ($r = -.50, p < .01$). The domain Psychoticism displayed a low positive relationship with the factor Openness to Experience ($r = .24, p < .01$).

Table 3*Correlations r of the Arabic version of the PID-5 with the NEO-FFI*

PID Domains	N	E	O	A	C
Negative Affectivity	.57**	-.05	.04	-.17**	-.11**
Detachment	.34**	-.49**	-.07*	-.29**	-.27**
Antagonism	.08**	.15**	.03	-.36**	.017
Disinhibition	.38**	-.17**	.01	-.37**	-.50**
Psychoticism	.32**	-.04	.24**	-.37**	.11**

Note. **Significant correlations $p < .01$.; *Significant correlations $p < .05$.

r Pearson correlation coefficient

Structure of the PID-5

The structure of the Arabic PID-5 in the Emirati community sample was tested through EFA of the 25 facets and considered the Kaiser, MAP and Parallel Analysis criteria to evaluate the number of factors to extract and interpret. A five factors solution was supported by the Kaiser and Parallel analysis. The model showed excellent fit indices (KMO = .90), with a total explained variance of 61.21%. Communalities showed that the percentage of variance explained by the extracted factor was above 50% for all but four facets (Hostility, Risk taking, Submissiveness and Suspiciousness). See Table 4.

Table 4

Exploratory factor analysis with Equamax rotation solution in an Emirati community sample

PID-5 facets	Factors					Communalities
	1	2	3	4	5	
Anhedonia	.41	.66	.18	.09	-.16	.68
Anxiousness	.73	.18	.19	-.08	.26	.68
Attention seeking	.37	-.26	.08	.59	.23	.62
Callousness	-.02	.46	.17	.63	-.00	.64
Emotional lability	.54	-.05	.50	.13	.22	.62
Cognitive and perceptual dysregulation	.21	.27	.62	.11	.40	.69
Deceitfulness	.19	.09	.27	.74	.11	.69
Depressivity	.48	.58	.37	.11	-.04	.72

Table 4 (Cont.)*Exploratory factor analysis with Equamax rotation solution in an Emirati community**sample*

PID-5 facets	Factors					Communalities
	1	2	3	4	5	
Distractibility	.50	.32	.51	.13	-.03	.63
Eccentricity	.03	.37	.62	.08	.39	.68
Grandiosity	.09	-.00	.01	.42	.60	.55
Hostility	.43	.14	.38	.34	.13	.49
Impulsivity	.20	-.01	.67	.32	-.08	.60
Intimacy avoidance	-.09	.70	.06	-.00	.11	.52
Irresponsibility	.23	.40	.43	.43	-.19	.62
Manipulativeness	-.03	-.02	.13	.72	.36	.67
Perseveration	.50	.26	.38	.10	.36	.61
Restricted Affectivity	-.14	.63	.08	.14	.33	.56
Rigid perfectionism	.26	.08	.04	.04	.79	.70
Risk taking	-.20	-.00	.56	.26	.22	.48
Separation Insecurity	.70	-.12	.12	.21	.09	.57
Submissiveness	.60	.09	-.07	.21	.11	.44
Suspiciousness	.39	.36	.03	.18	.30	.42
Unusual beliefs	-.02	.21	.47	.17	.59	.66
Withdrawal	.19	.75	.07	.02	.23	.66
Eigenvalues	8.14	2.38	2.02	1.58	1.17	
% variance explained	32.58	9.51	8.08	6.32	4.69	

Factor 1 was composed by the facets Anxiousness, Emotional lability, Hostility, Perseveration, Separation insecurity, Submissiveness, and Suspiciousness and matches the Negative affectivity domain structure.

Factor 2 was similar to Detachment and was composed of Anhedonia, Depressivity, Intimacy avoidance, Restricted affectivity, and Withdrawal. The only exception was the facet Suspiciousness, which loaded onto Factor 1. However, according to DSM-5 personality model, this facet together with Depressivity and Restricted affectivity, simultaneously characterized the domains Negative affectivity and Detachment.

The third Factor aggregated the facets Distractibility, Impulsivity, and Risk taking and resembled the Disinhibition domain, with the majority of the domain facets loaded. The

only exception was the facet Irresponsibility that loaded primarily in the fourth Factor (.43) but had its secondary load in (.43) Factor three.

The fourth Factor mirrored the Antagonism domain, with all the facets of the domain primary loaded in this factor. The exception was the facet Grandiosity (a facet of Antagonism), which unexpectedly also loaded primarily in Factor 5.

Finally, the factor that mostly deviated from the personality domain structure of the AMPD (APA, 2013), was the fifth one, onto the facets Grandiosity, Rigid perfectionism, and Unusual beliefs and experiences mainly weighted. However, both the facets Cognitive and perceptual dysregulation and Eccentricity ($\geq .30$) loaded on a second level in this factor, which might suggest that the fifth Factor is similar to the Psychoticism domain.

Ultimately, the Arabic PID-5 in the Emirati population revealed a five-factor solution similar to the DSM-5 AMPD (APA, 2013), although not entirely overlapped. Moreover, the internal consistency of the new factors was calculated based on all the facets loaded onto each factor. The mean reliability coefficient varied from .81 for the first Factor (Negative affectivity) to .68 for the fifth Factor (Psychoticism), being this last factor the outlier of the original structure and consequently less interpretable. Although, if we consider the three facets loaded in the fifth Factor in conjunction with the other two facets of Psychoticism, namely the Cognitive and perceptual dysregulation and Eccentricity (loaded secondarily onto it), an alpha of .75 was obtained.

Discussion

The current study aimed to examine the psychometric properties of the PID-5 in an Emirati community sample and addressed the cross-cultural replicability of its factor structure in a non-Western culture.

The findings in the Emirati sample were comparable to the original US study (Krueger et al., 2012), in terms of the PID-5 internal consistency, convergent validity with

the NEO-FFI and factor structure. However, significant differences were identified in the mean scores, with higher scores in most of the facets and domains, similar to the results found in the Arabic translation study (Al-Attayah et al., 2017). The facets Cognitive and perceptual dysregulation and the domain Antagonism showed the larger effect size (≥ 0.90). These results might suggest that the response style obtained could reflect situational factors or cultural specificities as if a certain numerical score represents the same absolute trait level in different cultures, and if the intensity or difficulty of a given item changes across languages (McCrae, 2013; Van de Vijver & Leung, 1997). Nevertheless, the PID-5 has demonstrated that it is a reliable measure and perhaps some specific items are compensated by the scales overall sum.

Moreover, the Arabic PID-5, beyond adequate internal consistency at the facet (mean alpha .74) and domain level (mean alpha .86), also demonstrated good temporal reliability, in line with previous studies (for a review see Al-Dajani et al., 2017).

As expected, the five domains of the Arabic PID-5 displayed meaningful associations with the five domains of the Arabic NEO-FFI (Al-Attayah et al., 2017; De Fruyt et al., 2013; Few et al., 2013). Nonetheless the positive relationship between Psychoticism and Openness to experience was rather small (Crego et al., 2018; Thomas et al., 2013), which might be related to the conceptual nature of these domains and how they are assessed. Openness is, mostly an adaptive domain of personality (measured by the NEO-FFI) whereas Psychoticism is entirely a maladaptive domain (measured by the PID-5), which might decrease the probability of both domains load in the same direction and in the same factor, once they have opposite functions, as one is adaptive and the other is maladaptive (Widiger et al., 2019).

With regards to the Arabic PID-5 factor structure in the Emirati sample, these findings confirmed a five-factors solution similar to the one displayed by Krueger et al.,

2012, and by Al-Attayah et al., 2017. The first four factors featured the domains Negative affectivity, Detachment, Distractibility, and Antagonism. Although the loading patterns of some facets deviated from the original structure, particularly in the fifth Factor, where Grandiosity, Rigid perfectionism, and Unusual beliefs and experiences primarily loaded, resembling an imperfect conjunction of the fifth (Compulsivity) and sixth (Schizotypy) domains, initially proposed by the AMPD (APA, 2013). However, if it is considered that the facets Cognitive and perceptual dysregulation and Eccentricity loaded secondarily in this factor, perhaps it might be also considered that this factor is similar to the Psychoticism domain.

One possible reason for this deviant factor could be that the Psychoticism, beyond encompassing the tendency to have unusual beliefs and experiences, behave eccentrically, and manifest cognitive dysregulation, might also enclosed some aspects of Antagonism and low Disinhibition, such as being self-centred or superior and having the need to impose a rigid and dogmatic order toward others and their environment (Hopwood et al., 2013). In this regard, some studies have found evidence for an association between some features of obsessive-compulsive PD with schizotypal PD (Chmielewski & Watson, 2008). In fact, although the domain Psychoticism primarily emerged from features of Negative affectivity, Disinhibition, and Detachment (Wright et al., 2012; Bo et al., 2016), it has been pointed as heterogeneous, and some studies found deviant facet loading in this domain (Adhiatma et al., 2014; Bach et al., 2018). Other even reported its absence from their factor structure in a clinical sample (Pires et al., 2019). Furthermore, studies that tried to harmonize the DSM-5 trait model with the ICD-11 personality model stated that in order to facilitate the communication between clinicians, the domain Psychoticism should not be conceptualized in terms of personality pathology, as it is considered under the spectrum of schizophrenia disorder by the World Health Organization (Bach et al., 2017; Lofti et al., 2018). However,

a trait profile does not correspond to arbitrary diagnose categories or syndromes, but instead denotes stylistic dimensions that contribute to the expression of the personality dysfunction under the umbrella of a more general factor of psychopathology (Skodol et al., 2011). On this note, a recent study by Bastiaens et al. 2019 which claimed the PID-5 clinical utility also to discriminate between patients with and without a psychotic disorder, concluded that the patients significantly differed on all PID-5 domains, except for Antagonism, and that lower Detachment, lower Negative Affect, lower Disinhibition, and higher Psychoticism are the trait profiles that best discriminated patients with a psychotic disorder from patients with other diagnoses.

Considering our findings, future studies in non-Western countries should try to establish normative values for the general population in order to better identify the presence of maladaptive traits and examine how the facet traits could help to the discriminate between what is normal and abnormal in a given culture or language.

This study has several limitations that should be considered in future research. First, the sample was predominantly composed by female college students and their acquaintances, which might have biased the results if we consider that women often report higher level of Neuroticism compared to men (Costa et al., 2001; Weisberg et al., 2011), and gender roles and expectations tend to be more clearly demarcated in Arabic cultures when compared to Western cultures (Al-Krenawi, 2012). Also, data was collected from a Governmental University in only two of the seven Emirates (Abu Dhabi and Dubai), and most of the participants had medium to high economic status as well as high educational levels, which might have influenced the response to the test. Second, the test-retest sample size was small due to many losses between the first and the second data collection sessions.

Finally, given that the PID-5 is a clinical diagnostic measure, the expansion of this research to clinical Emirati samples is a crucial endeavour, that will bridge the current

study limitations with future developments and provide relevant data on the PID-5's predictive validity.

Conclusions

Notwithstanding the aforementioned, this study concluded that Arabic version of the PID-5 is a valid measure to describe pathological personality traits in the Emirati population of the United Arab Emirates and provides additional evidence for the generalizability of the AMPD (APA, 2013) to other Arab countries.

Estudo 2: The Arabic Version of the Personality Inventory for the DSM-5 (PID-5) in a Clinical Sample of United Arab Emirates (UAE) Nationals²

Abstract

Objectives: We aimed to test the potential of the Arabic version of the PID-5 to distinguish between clinical and non-clinical participants, as well as to examine its convergent validity and factor structure in an Emirati clinical sample.

Methods: The Arabic version of the PID-5 was administered to a clinical sample comprised of 156 participants ($M_{age} = 31.38$, $SD = 8.99$, 37.8% males, 62.2% female) and a community sample also comprised of 156 participants ($M_{age} = 31.43$, $SD = 9.52$, 37.2% males, 62.8% females). We addressed the descriptive measures, internal consistency, mean rank scores differences, convergent validity with SCL-90-R, and PID-5's factor structure.

Results: As expected, the clinical sample presented statistically significant higher scores than the non-clinical sample, with medium to high effect sizes. In addition, all the PID-5 domains have showed positive correlations with most of the symptomatic constellations of the SCL-90-R as well as the PID-5 facets with all their SCL-90-R counterparts. However, our findings did not entirely replicate the PID-5 original five-factor structure, as only a four-factor solution was retained.

Conclusions: Future studies with the Arabic PID-5 in clinical samples are needed to understand its relevance and clinical utility in Arabic countries.

Key words: DSM-5 Alternative Model of Personality Disorders; Arabic PID-5; United Arab Emirates; clinical sample.

²Coelho, O., Pires, R., Sousa Ferreira, A., Goncalves, B., AlKhoori, S. A., Sayed, M. A., ElRasheed, A., Belhoul, S., Aljassmi, M., Stocker, J. (2020). The Arabic version of the Personality Inventory for the DSM-5 (PID-5) in a clinical sample of United Arab Emirates (UAE) nationals. *American Journal of Health Behavior*, 44(6), 794-806. <https://doi.org/10.5993/AJHB.44.6.5>

Introduction

Personality disorders (PDs) are among the most challenging psychiatric conditions to diagnose and treat, with patients receiving poor treatment to a life shortening condition (Folk et al., 2012; Skodol, 2015) which accounts for heavy social and economic costs (Tyrer et al., 2015; Bach & First, 2018). Currently considered a mental health priority, it is estimated to affect 7.8% of the general population worldwide (Winspei et al., 2020), 45% to 51% of psychiatric outpatients in the United States, and 40% to 92% in Europe (Beckwith, 2014). In the Arabic Gulf countries, epidemiologic studies are still limited with rates on PDs in primary healthcare services ranging from 3.1% in Saudi Arabia (Alosaimi et al., 2017) to 12.7% in the United Arab Emirates (El-Rufaie et al., 2002), and 14.1% in Qatar (Bener et al., 2015). A possible explanation to these differences could be related to methodological limitations, sampling methods, and diagnostic assessments (Volkert et al., 2018) that lack sufficient cross-cultural validity (Lofti et al, 2018). Such diagnostic inaccuracies, allied with the social stigma associated with the utilization of psychiatric and psychological services in the Middle East countries (Al-Darmaki et al, 2012; Al-Darmaki & Sayed, 2009), might delay treatment interventions and negatively impact the prognosis. Complicating matters further, in multicultural countries such as the United Arab Emirates where the number of expatriates accounts for more than 80% of the country's population (The World Bank, 2018), cross-cultural differences could easily be bypassed in clinical practice based on the assumption that Western cultural frameworks are applicable to collective societies where conformity to family values overrides any individual needs (Al-Adawi, 2017). From this perspective, despite the efforts to establish more culturally informed guidelines for the assessment and treatment of PDs (Ronningstam et al., 2018), the role of the interactive dynamics between clinical manifestations along with basic

biological rhythms of individuals with PDs, cultural idiosyncrasies, and relational dimensions is still to be unveiled (Sperandeo, 2020).

The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (APA, 2013) and the eleventh version of the International Classification of Mental and Behavioural Disorders (WHO, 2018) have shown a strong commitment to capturing the complex and heterogeneous reality of PDs, shifting towards a more evidence-based dimensional paradigm that acknowledges the pivotal importance of personality traits in clinical practice (Bach et al., 2017). Throughout this transition process The Personality Inventory for the DSM-5 (PID-5) (Krueger et al., 2012) assumed a leading role which empirically and conceptually supported the departure from a categorical based diagnosing system of PDs to a primarily dimensional method (Skodol, 2012; Watters et al., 2019). In fact, the PID-5 is currently the most researched measure of maladaptive personality traits, and its factor structure has been confirmed across languages and nationalities (e.g., for a review see Somma et al., 2019 and Watters et al., 2018). However, considering that personality traits can be differently promoted or suppressed across cultures (Kitayama et al., 1997), little is known about their relevance in non-Western clinical settings and minorities. As the authoritative measure for the assessment of criterion B of the Alternative Model for Personality Disorders (AMPD), published on DSM-5 Section III, the PID-5 is used to determine the PDs style through a hierarchical model of maladaptive personality traits. According to the AMPD the core features to determine a personality disorder diagnosis are the presence of maladaptive personality traits, along with the level of impairment on the personality function (criterion A).

The PID-5 is a self-rated inventory that characterizes 25 facets (maladaptive traits in which individuals differ) organized into five higher order domains of personality variation that seem to be maladaptive extremes of a normal personality's multidimensional structure,

as conceptualized by the Five-Factor Model (FFM) (Krueger & Markon, 2014; Skodol et al., 2011), therefore establishing an association between Negative affectivity with Neuroticism, Detachment with Extraversion, Antagonism with Agreeableness, Disinhibition with Conscientiousness, and Psychoticism with Openness. However, this last one is considered more ambiguous with some studies questioning the relation between Psychoticism and Openness (Sleep et al., 2018). Moreover, beyond strong psychometric properties (Al-Dajani et al, 2016; Zimmermann et al., 2017), the PID-5 also can be used as an adequate measure to capture DSM-5 Section II categorical PDs diagnosis (Bach et al., 2018).

Despite its worldwide popularity, extensive empirical research, and promising results, to date only three studies have been published with the PID-5 in Arabic countries. After the translation of the PID5 into Arabic that was conducted in Bahrain, Kuwait, and Qatar (Al-Attayah et al., 2017), a second study was conducted within the United Arab Emirates national population using the Arabic PID-5 (Coelho et al., 2020a), and a third study using the Arabic short version of the PID-5 (Bach & El-Abiddine, 2020) in Algeria. All these studies were conducted in community samples, and, to the best of our knowledge, there are no data on clinical Arabic speaking populations. Because the aim of the PID-5 is to measure pathological personality traits, it urges the need for studies on clinical samples, for whom this measure was originally developed.

To address some of these issues, the current study's aims were to (1) test the potential of the Arabic PID-5 to distinguish between clinical and non-clinical groups, by comparing the PID-5 results on two matched Emirati clinical and community samples as well as (2) examine its convergent validity by correlating the PID-5 scales with the psychopathological symptomatic dimensions of the Arabic SCL-90-R (Al-Behairy, 1984)

in the clinical sample, and finally, (3) examine the PID-5 factor structure in the Emirati clinical sample.

Methods

Study Design and Participants

The present study was limited to Emirati citizens and based on a clinical sample ($N = 156$) matched with a community sample ($N = 156$). The clinical sample was recruited from three mental health institutions in the United Arab Emirates – the Al Amal Psychiatric Hospital, the National Rehabilitation Centre, and the psychiatric department of Rashid Hospital. Selection of the clinical participants was carried out by the institutions' psychiatrists or psychologists among the patients that, at the time of the assessment, were receiving mental health treatment, and based on clinical authority and/or clinical records. In addition, the clinicians were asked to report each patient's main diagnosis as well as any other secondary diagnosis, using the DSM5 criteria. Patients that met at least one DSM-5 mental disorder were included in the clinical sample, and those experiencing intellectual disability, schizophrenia spectrum disorder, and major and mild neurocognitive disorders were excluded from the sample. A total of 156 inpatients and outpatients were selected, aged between 18 and 61 years ($M_{age} = 31.38$, $SD = 8.99$, 37.8% male, 62.2% female). With regards to marital status, most of the patients were single (49.4 %), that had completed high school (66.7%), and at the time of the assessment were unemployed/housewives (43.6%). The predominant diagnosis included substance-related and addictive disorders (35.3%), anxiety disorders (21.8%), and both depressive (14.7%) and bipolar related disorders (14.7%). The majority of the patients (76.9%) met the criteria for at least one comorbidity, with depressive disorders (16.6%), PD (6.6%) and obsessive-compulsive disorders (2.5%) being the most frequent comorbidities.

The clinical sample was subsequently matched, based on the composition of gender and age, with a community sample of 156 Emirati volunteers, aged between 18 and 57 years ($M_{age} = 31.43$, $SD = 9.52$, 37.2 % male, 62.8% female). At the time of the assessment 53.2% of the community participants were single, 57.1% had completed high school, 32.7% were employed, 22.4% were unemployed/ housewives, 42.3% were students, and 2.6% were retired/disabled. The community sample was selected from a large convenience sample of Emirati citizens ($N = 1090$) recruited from Zayed University Dubai and Abu Dhabi students and their acquaintances (Coelho, 2020). Only the participants that declared had no mental disorders were included in the community sample.

Data Collection

Patients selected by the mental health units' clinicians were invited to participate in the study at the end of the follow-up appointments or other consultation procedures. The nature of the study was explained, confidentiality was emphasized, and all participants signed a written consent form. Taking into consideration the time required to apply the test (approximately one hour), mutual convenient appointments were scheduled, dependent on the patients' condition and availability. Moreover, to ensure the accuracy of the responses to the test, inpatients participants were invited to take part in the study at the end of their hospitalization period, as at this stage most of the patients are free of severe psychopathological symptoms. Data collection sessions were held between May and September of 2019.

The community sample was recruited through email or in person by psychology graduate research assistants. All the community participants signed a written informed consent form, and the data collection sessions were held collectively at Zayed University Dubai and Abu Dhabi between April and September of 2019.

Instruments

Sociodemographic Questionnaire.

The sociodemographic questionnaire comprised questions regarding nationality, age, sex, occupational and marital status, religion, education, family, and financial situation. The participants were also asked to report if they suffered from any physical or mental disorder, and when applicable, to specify the diagnose.

Personality Inventory for DSM-5 (Al-Attiyah et al., 2017; original version of Krueger et al., 2012).

The PID-5 is a self-report measure which operationalizes the DSM-5 model of pathological personality traits. It is comprised of 220 items, rated on a four-point Likert scale, ranging from zero (*very false or often false*) to three (*very true or often true*) that characterizes 25 empirically derived lower-level facets grouped into five major domains of maladaptive personality variation. The instrument is to be use in adults (18 years or above) and takes 40 minutes or less to complete. The PID-5 has been studied worldwide, both in clinical and non-clinical samples, and has shown sound psychometric features such as replicable factor structure, internal consistency, convergence with personality measures, and with a broad range of psychopathological constructs (Al-Dajani et al., 2016). Data from the PID-5 Arabic translation study (Al-Attiyah et al., 2017) showed that the Cronbach's alphas of the PID-5 scales were moderate to high, ranging from .70 (Manipulativeness) to .93 (Attention-seeking) at the facet level, and to .92 (Antagonism) to .96 (Detachment) at the domain level.

Symptom Checklist-90 - Revised (Al-Behairy, 1984; original version of Derogatis, 1977).

The SCL-90-R is a multidimensional self-assessment questionnaire consisting of 90 items measured on a five-point Likert scale, ranging from zero (*Never*) to four (*Extremely*),

assessing the presence of psychopathology and psychological distress in individuals aged 13 year and above. It comprises nine principal symptomatic dimensions of psychopathology and three global indices. The dimensions are Somatization, Obsessions-compulsions, Interpersonal sensitivity, Depression, Anxiety, Hostility, Phobic anxiety, Paranoid ideation, and Psychoticism. The measure also comprises an additional item scale which is a severity indicator of the individual state, although it is not related to any specific symptomatic dimension. The three global indices assess global distress, hardiness, and symptom free. The SCL-90-R presents good internal consistency ranging from .84 to .90 and time stability, with correlations between .80 and .90.

Data Analysis

Statistical data analyses were performed with the IBM SPSS Statistics (v.26, SPSS Inc., Chicago, IL). To validate the PID-5 Arabic version in the Emirati population, descriptive statistics for the facets and domains were obtained and internal reliability was examined through Cronbach's alphas, in both community and clinical samples. Additionally, to test the PID-5 ability to distinguish between clinical and non-clinical samples, the mean rank score differences between the populations were calculated by the Wilcoxon Signed-Rank test, given that in both, community and clinical samples, the PID-5 scales scores in the Emirati population had shown to be highly heteroscedastic. The effect size was tested through $r = z/\sqrt{N}$, being N the number of pairs without ties. PID-5 and SCL-90-R convergent validity analyses were calculated by the Spearman correlation coefficient. Finally, to examine the Arabic PID-5 factor structure we employed an Exploratory Factor Analyses (EFA) using Equamax oblique rotation, and the number of factors to be selected were based on the Kaiser's, MAP, and parallel analysis criteria. The decision of how many factors to retain is crucial in EFA (Hayton et al., 2004), and there are several criteria to guide the factor retention decision, not always leading to the same number of factors. EFA

often is used with the correlation matrix and, in that case, one is the variance of each item/variable. Kaiser's criterion is the most used criterion, extracting only those factors with eigenvalues greater than one. Thus, Kaiser's selects factors that explain more than the variability of each item, however, this criterion tends to overestimate the number of factors (Horn, 1965). The minimum average partial (MAP) method (Velicer, 1976) uses the average of squared partial correlations after each component is out. When the minimum average squared partial correlation is reached, the residual matrix resembles an identity matrix, and no further components are extracted. Another factor retention method is the parallel analysis (PA), based on the rationale that nontrivial components from real data should have larger eigenvalues than parallel components derived from random data having the same characteristics. Therefore, PA involves the construction of correlation matrices of random variables, and the average eigenvalues from the random correlation matrices are then compared to the eigenvalues from the real data correlation matrix (the first observed eigenvalue is compared to the first random eigenvalue, and so on). The factors to be retained correspond to actual eigenvalues that are greater than the parallel average random eigenvalues. Several studies have shown that MAP and PA belong to the most accurate methods set (Hayton et al., 2004).

Results

Descriptive Statistics, Internal Consistency, and Group Differences

Table 1 presents the Arabic PID-5's scales means, *SDs*, and Cronbach alphas of the community and clinical samples, along with the Wilcoxon Signed Rank test which allowed to compare the two groups differences, and respective effect size.

The facets with the higher scores were rigid perfectionism in the community sample and anxiousness in the clinical sample, while the lower scores were found on the facet callousness for both community and clinical samples. According to Wilcoxon Signed-

Rank test results, the majority of the PID5 facets and domains mean ranks were higher in the clinical sample compared to the community sample. These comparisons were statistically significant for 20 of the 25 facets ($p < .001$) and 4 of the PID-5 domains ($p < .001$). Regarding the effect size, we have obtained medium (.30 to .50) to high ($\geq .50$) effect sizes for 20 of the 25 facets and the 5 PID5 domains. The smaller effect sizes were displayed by the facets Grandiosity and Manipulativeness ($\leq .20$) whereas the larger effect sizes were found on the facets Depressivity, Emotional lability, and Anhedonia as well as on the Negative affectivity and Disinhibition domains.

As for the internal consistency, the alpha coefficients were acceptable to good for the majority of the PID-5 scales in the community sample ($\geq .70$ for 19 of the facets and $\geq .80$ for the 5 domains) and in the clinical sample ($\geq .70$ for 22 of the facets and $\geq .85$ for the 5 domains). Overall, the reliability coefficients have shown to be higher in the clinical sample than in the community sample, particularly at the trait facet level. The lowest alphas for both samples were obtained on the facets Irresponsibility, Restricted affectivity, and Suspiciousness. These results have shown that most of the PID-5 facets and the five domains were reliable in both samples.

Table 1

PID-5 scales' descriptive statistic and Wilcoxon Signed Ranks test

PID-5 Facets	Sample	Samples measures					Community vs Clinical			
		<i>M</i>	<i>SD</i>	α	Ranks ^a	<i>N</i>	Mean Rank	<i>z</i>	<i>p</i>	<i>r</i>
Anhedonia	Community	0.90	0.52	.78	Neg.	114	84.97	-7.34	.00	.60
	Clinic	1.44	0.60	.79	Pos.	37	48.36			

Note. ^aNegative Ranks and Positive Ranks of the Difference of Community vs Clinic;

Small effect size $.10 \leq r < .30$, medium effect size $.30 \leq r < .50$, large $r \geq .50$.

Table 1 (Cont.)*PID-5 scales' descriptive statistic and Wilcoxon Signed Ranks test*

PID-5 Facets	Sample	Samples measures				Community vs Clinical				
		<i>M</i>	<i>SD</i>	α	Ranks ^a	<i>N</i>	Mean Rank	<i>z</i>	<i>p</i>	<i>r</i>
Anxiousness	Community	1.31	0.56	.83	Neg.	110	84.18	-6.55	.00	.53
	Clinic	1.83	0.65	.86	Pos.	41	54.06			
Attention seeking	Community	1.04	0.55	.81	Neg.	100	80.16	-4.80	.00	.39
	Clinic	1.38	0.67	.85	Pos.	48	62.72			
Callousness	Community	0.58	0.38	.78	Neg.	94	82.12	-4.23	.00	.35
	Clinic	0.80	0.51	.84	Pos.	54	61.24			
Cognitive and perceptual dysregulation	Community	0.80	0.47	.81	Neg.	101	86.50	-5.38	.00	.44
	Clinic	1.14	0.60	.86	Pos.	51	56.71			
Deceitfulness	Community	0.82	0.42	.71	Neg.	94	77.36	-4.10	.00	.34
	Clinic	1.04	0.57	.80	Pos.	50	63.36			
Depressivity	Community	0.63	0.45	.86	Neg.	120	83.39	-7.93	.00	.65
	Clinic	1.25	0.68	.91	Pos.	31	47.39			
Distractibility	Community	0.97	0.49	.78	Neg.	121	83.08	-7.38	.00	.59
	Clinic	1.49	0.58	.81	Pos.	33	57.05			
Eccentricity	Community	0.87	0.57	.90	Neg.	101	83.68	-5.04	.00	.41
	Clinic	1.25	0.66	.90	Pos.	50	60.49			
Emotional lability	Community	1.10	0.51	.71	Neg.	115	81.88	-7.48	.00	.61
	Clinic	1.66	0.66	.79	Pos.	33	48.79			
Grandiosity	Community	1.17	0.54	.70	Neg.	84	77.48	-2.24	.03	.19
	Clinic	1.32	0.65	.75	Pos.	62	68.11			
Hostility	Community	1.09	0.51	.79	Neg.	99	82.24	-4.84	.00	.40
	Clinic	1.43	0.72	.88	Pos.	50	60.67			
Impulsivity	Community	0.94	0.51	.72	Neg.	106	78.32	-5.95	.00	.49
	Clinic	1.38	0.67	.77	Pos.	39	58.54			
Intimacy avoidance	Community	0.78	0.48	.68	Neg.	87	84.18	-4.02	.00	.33
	Clinic	1.06	0.67	.75	Pos.	58	56.22			
Irresponsibility	Community	0.72	0.45	.66	Neg.	114	81.04	-7.14	.00	.59
	Clinic	1.20	0.56	.66	Pos.	34	52.59			
Manipulativeness	Community	1.00	0.52	.65	Neg.	77	77.42	-1.97	.05	.17
	Clinic	1.15	0.66	.75	Pos.	64	63.28			
Perseveration	Community	1.05	0.45	.73	Neg.	101	76.82	-4.87	.00	.40
	Clinic	1.41	0.63	.84	Pos.	44	64.24			

Note. ^aNegative Ranks and Positive Ranks of the Difference of Community vs Clinic; Small

effect size $.10 \leq r < .30$, medium effect size $.30 \leq r < .50$, large $r \geq .50$.

Table 1 (Cont.)*PID-5 scales' descriptive statistic and Wilcoxon Signed Ranks test*

PID-5 Facets	Sample	Samples measures				Community vs Clinical				
		<i>M</i>	<i>SD</i>	α	Ranks ^a	<i>N</i>	Mean Rank	<i>z</i>	<i>p</i>	<i>r</i>
Restricted affectivity	Community	1.12	0.46	.60	Neg.	94	78.50	-2.88	.00	.23
	Clinic	1.29	0.57	.65	Pos.	58	73.26			
Rigid perfectionism	Community	1.33	0.50	.78	Neg.	92	78.22	-3.05	.00	.25
	Clinic	1.53	0.65	.86	Pos.	57	69.81			
Risk taking	Community	1.14	0.43	.76	Neg.	93	81.45	-3.77	.00	.31
	Clinic	1.34	0.55	.83	Pos.	56	64.29			
Separation insecurity	Community	1.00	0.58	.78	Neg.	96	84.30	-5.34	.00	.44
	Clinic	1.37	0.68	.78	Pos.	50	52.77			
Submissiveness	Community	0.95	0.56	.67	Neg.	103	77.41	-5.11	.00	.42
	Clinic	1.33	0.67	.72	Pos.	43	64.14			
Suspiciousness	Community	1.15	0.40	.41	Neg.	103	78.17	-5.06	.00	.42
	Clinic	1.42	0.50	.52	Pos.	44	64.23			
Unusual beliefs and experiences	Community	0.91	0.53	.76	Neg.	90	83.92	-3.38	.00	.27
	Clinic	1.15	0.68	.82	Pos.	61	64.32			
Withdrawal	Community	1.02	0.50	.81	Neg.	103	80.29	-4.71	.00	.38
	Clinic	1.35	0.64	.84	Pos.	48	66.80			
Negative affectivity	Community	1.14	0.45	.88	Neg.	122	84.32	-7.58	.00	.61
	Clinic	1.62	0.55	.90	Pos.	33	54.65			
Detachment	Community	0.90	0.39	.86	Neg.	110	89.70	-6.63	.00	.53
	Clinic	1.28	0.53	.89	Pos.	46	51.71			
Antagonism	Community	1.00	0.39	.82	Neg.	90	87.61	-3.12	.00	.25
	Clinic	1.17	0.53	.88	Pos.	66	66.08			
Disinhibition	Community	0.88	0.39	.85	Neg.	121	86.63	-7.71	.00	.62
	Clinic	1.35	0.52	.88	Pos.	35	50.40			
Psychoticism	Community	0.86	0.45	.93	Neg.	104	85.91	-4.98	.00	.40
	Clinic	1.18	0.59	.94	Pos.	52	63.68			

Note. ^aNegative Ranks and Positive Ranks of the Difference of Community vs Clinic;

Small effect size $.10 \leq r < .30$, medium effect size $.30 \leq r < .50$, large $r \geq .50$.

Convergent Validity

The Arabic PID-5 convergent validity was studied by correlating the PID-5 scales with the psychopathological symptomatic dimensions of the Arabic SCL-90-R in the clinical sample. At the domain level, the PID-5 Negative affectivity, Detachment,

Disinhibition, and Psychoticism showed significant positive correlations with all the SCL90-R scales (Table 2) and the Antagonism domain with nine of the thirteen SCL-90-R scales. The PID-5 Negative affectivity presented the highest correlations with the SCL-90-R Global severity index ($r_s = .67, p < .01$), Anxiety ($r_s = .65, p < .01$) and Interpersonal sensitivity scales ($r_s = .62, p < .01$), and Detachment domain moderately and positively correlated with the SCL-90-R Depression ($r_s = .52, p < .01$), Global severity index ($r_s = .49, p < .01$) and Interpersonal sensitivity scales ($r_s = .48, p < .01$). Also, the PID-5 Antagonism domain displayed moderate positive correlations with the SCL-90-R Hostility ($r_s = .45, p < .01$) and Paranoid ideation scales ($r_s = .44, p < .01$), whereas the PID-5 Disinhibition domain presented moderate positive correlations with the SCL-90-R Hostility ($r_s = .61, p < .01$), Paranoid ideation ($r_s = .58, p < .01$), and Global severity index scales ($r_s = .57, p < .01$).

Finally, the PID-5 Psychoticism domain presented the highest correlations with the Global severity index, Paranoid ideation, and Psychoticism ($r_s = .68, p < .01$) SCL-90-R scales. In sum, we highlight that PID-5 dimensions of Negative affectivity, Disinhibition, and Psychoticism presented the strongest relations with the symptomatic constellations of the SCL-90-R as well as with the general psychopathologic indices.

With regards to the facet level, as expected, the strongest relations were found between the PID-5 and the SCL-90-R counterparts, namely the PID-5 Anxiousness have shown moderate positive correlation with the SCL-90-R Anxiety scale ($r_s = .61, p < .01$) and the PID-5 Depressivity facet displayed the highest correlation with the SCL-90-R Depression scale ($r_s = .78, p < .01$). Furthermore, the PID-5 Hostility showed substantial correlations with its peer scale, the SCL-90-R Hostility ($r_s = .72, p < .01$) as well as the PID-5 Suspiciousness with the SCL-90-R Paranoid ideation ($r_s = .68, p < .01$), and Interpersonal sensitivity ($r_s = .61, p < .01$).

Table 2

Spearman correlations of the Arabic PID-5 with the SCL-90-R in a UAE Clinical Sample

PID Scales	SCL-90-R Scales												
	S	OC	IS	D	A	H	PA	PI	P	AI	GSI	PST	PSDI
Negative affectivity	.52**	.55**	.62**	.58**	.65**	.53**	.58**	.58**	.62**	.55**	.67**	.55**	.52**
Detachment	.27**	.42**	.48**	.52**	.41**	.34**	.31**	.45**	.43**	.40**	.49**	.45**	.38**
Antagonism	.23**	.20*	.23**	.13	.28**	.45**	.08	.44**	.28**	.15	.31**	.30**	.14
Disinhibition	.35**	.44**	.52**	.46**	.53**	.61**	.32**	.58**	.55**	.42**	.57**	.50**	.42**
Psychoticism	.48**	.56**	.55**	.49**	.67**	.64**	.48**	.68**	.68**	.44**	.68**	.63**	.41**

*Significant correlations $p < .05$.; **Significant correlations $p < .01$.; S – Somatization; OC – Obsessive-compulsive; IS-Interpersonal

sensitivity; D – Depression; A – Anxiety; H – Hostility; PA - Phobic anxiety; PI – Paranoid ideation; P – Psychoticism; AI – Additional

items; GSI – Global severity index; PST - Positive symptom total; PSDI - Positive symptom Distress index.

Finally, perhaps due to the fact that SCL-90-R Psychoticism scale captures a wide scope of symptoms ranging from light psychotic features and schizoid personality style to severe symptoms of schizophrenia spectrum disorder, all the facets of the PID-5 Psychoticism domain presented moderate positive correlations with the SCL-90-R Psychoticism, namely cognitive and Perceptual dysregulation and Eccentricity, ($r_s = .65, p < .01$) along with Unusual beliefs and experiences ($r_s = .53, p < .01$). In addition, all the PID-5 facets and domains significantly correlated with the SCL-90-R Global severity index scale.

Factor Structure

The Emirati clinical sample presented a four-factor solution suggested by the Kaiser criterion, MAP, and parallel analysis criterion (Table 3). The model displayed an excellent fit (KMO = .88) and the total explained variance was (67.13%). Communalities showed that the percentage of variance explained by the extracted factors was above 50% for all the facets. Table 3 shows the four-factor Equamax rotated solution, factor loadings, eigenvalues, communalities, and the percentage of explained variance per factor in the clinical sample.

The first factor was comprised by the facets Attention-seeking, Callousness, Cognitive and perceptual dysregulation, Deceitfulness, Hostility, Impulsivity, Irresponsibility, Manipulativeness, Risk-taking, and Suspiciousness. Although this factor encompassed traits from the 5 PID-5 domains, it resembled a partial conjunction of the Antagonism domain, if we considered that the facet Grandiosity secondarily weighted (.53) on this factor, with the Disinhibition domain (Impulsivity, Irresponsibility, and Risk-taking). However, the facets cognitive and Perceptual dysregulation and Suspiciousness also weighed on this factor rendering its interpretation less clear.

Table 3*Exploratory factor analysis with Equamax rotation solution of the clinical sample*

PID-5 facets	Factors				Communalities
	1	2	3	4	
Anhedonia	-.01	-.00	.74	.39	.70
Anxiousness	-.06	.23	.33	.68	.63
Attention seeking	.49	.41	-.31	.48	.75
Callousness	.70	.21	.30	-.12	.63
Cognitive perceptual dysregulation	.55	.52	.34	.32	.79
Deceitfulness	.80	.17	-.07	.15	.70
Depressivity	.18	.08	.70	.53	.80
Distractibility	.38	.29	.48	.51	.71
Eccentricity	.38	.56	.38	.36	.73
Emotional lability	.25	.40	.27	.62	.68
Grandiosity	.53	.58	-.10	.08	.64
Hostility	.62	.32	.40	.19	.68
Impulsivity	.66	.11	.30	.25	.60
Intimacy avoidance	.04	.27	.67	-.10	.53
Irresponsibility	.70	-.08	.39	.30	.74
Manipulativeness	.71	.33	-.21	.04	.65
Perseveration	-.07	.72	.27	.31	.70
Restricted affectivity	.37	.57	.44	-.08	.66
Rigid perfectionism	-.14	.83	.19	.12	.76
Risk taking	.68	.00	.18	-.23	.55
Separation insecurity	.12	.24	-.07	.77	.67
Submissiveness	-.20	-.11	.05	.70	.54
Suspiciousness	.52	.25	.50	.06	.59
Unusual beliefs	.42	.64	.23	.19	.67
Withdrawal	.04	.36	.74	.11	.70
Eigenvalues	9.90	3.10	2.08	1.70	
% Variance explained	39.61	12.39	8.32	6.80	

As for the second factor onto the facets Eccentricity, Grandiosity, Preservation, Restricted affectivity, Rigid perfectionism, and Unusual beliefs and experiences primarily loaded, might be considered similar to the Psychoticism domain, if we bear in mind that the facet Cognitive and perceptual dysregulation (.52) weighted secondarily on this factor.

The third factor were the facets Anhedonia, Depressivity, Intimacy avoidance, and Withdrawal mainly loaded was akin to the Detachment domain.

Finally, the facets Anxiousness, Distractibility, Emotional lability, Separation insecurity, and Submissiveness all loaded onto factor four, which resembled the Negative affectivity domain once the facet Perseveration had its second main weight on this factor (.31). The facet Distractibility also weighted onto factor four (.51), although, according to the DSM-5 model, it belongs to the Disinhibition domain.

In the Emirati clinical sample, the Disinhibition domain did not clearly emerge as an independent factor, with its facets weighted jointly onto factors one, two, and four. Thus, to reproduce the DSM-5 AMPD structure, the factors extraction was limited to five-factors. However, the five-factors obtained did not fully match the original DSM-5 trait model. For this reason, the four-factor solution was deemed to be the most adequate and the internal consistency of its factors was calculated. The alphas obtained varied from .80 for the fourth factor (Negative affectivity) to .89 for the first factor (Antagonism/Disinhibition), thus proving good internal reliability of the new structure in the clinical sample.

Discussion

The purpose of this study was to examine the Arabic PID-5's ability to distinguish between nonclinical from clinical participants, with regards to pathological personality traits, as well as to examine its convergent validity, and factor structure cross-cultural replicability in an Emirati clinical sample.

Consistent with previous findings (e.g., for a review see Al-Dajani et al., 2016 and Zimmermann et al., 2017) the Arabic PID-5 appears to be a reliable measure of pathological personality traits in both community and clinical samples, with the internal consistency of its scales ranging from acceptable to good for the majority of the trait facets and for all the trait domains. However, the facets Irresponsibility, Restricted affectivity, and Suspiciousness require further research as they presented the lowest alphas. In fact, several studies reported similar results in Western and non-Western samples (Lofti et al., 2018; Roskam et al., 2015;

Rowiński et al., 2019) perhaps due to the use of allegorical expressions such as “cold fish,” “raw deal,” and “skipped town” in some of their items (e.g., 8, 133, 171). These expressions can be challenging to translate, especially into the Arabic language (Ghazala et al., 2002). Even when the meaning is preserved, the item intensity, difficulty, and standards of comparison might change across cultures and languages (McCrae, 2013; Van de Vijver & Leung, 1997).

As expected, the psychiatric patients sample presented statistically significant higher scores than the general community sample, with medium to high size effects in the majority of the PID-5 scales. The facets Grandiosity and Manipulativeness (facets of the Antagonism domain) displayed the smallest effect size ($\leq .20$), which could be related with situational or cultural factors, such as the tendency to respond in a socially desirable way, as social desirability tends to be higher in collectivistic cultures such as the Emirati, compared to more individualistic cultures (Bernardi, 2006; Mahmood et al., 2015; Van Hemert et al., 2002). For example, the Arabic word *Inshallah* means *if God wills* and it is used on a daily basis to show agreement; however, it could carry a double meaning as to say “yes, if God wills,” or an eloquent mean to avoid confrontation by imposing a certain sense of uncertainty towards the expected outcome. On the other hand, if we consider the high scores of Anhedonia, Depressivity, and Emotional lability (facets associated with internalization) and the percentage of Anxiety and Depressive disorders in the clinical sample, perhaps the facet Grandiosity has captured the vulnerable Narcissism (as a lower and internalized extreme of Grandiosity) of the patients sample as opposed to feelings of superiority and entitlement (as a higher and externalized extreme of Grandiosity) that could, in some extent, be adaptive (Miller et al., 2016; Witt et al., 2010) or culture-related. Overall, these results might be better explained by a continuum of common individual differences between normative and

pathological personality (Oltmanns et al., 2018) grafted in a socio-cultural context that can consubstantiate their meaning (La Roche et al., 2015).

With regards to the convergent validity of the Arabic PID-5, the domains Negative affectivity, Detachment, Disinhibition, and Psychoticism have shown positive correlations with all the symptomatic constellations of the Arabic SCL-90-R as well as the Antagonism domain with nine of its scales. Moreover, the PID-5 facets displayed strong correlations with all their SCL-90-R counterparts, particularly with Depression and Hostility, in line with previous studies (Dunne et al., 2018; Fowler et al., 2019; Hashemi, 2019; Skjernov et al., 2020) that confirmed important relations between pathological personality traits and mental health disorders.

These results suggest that the PID-5 has adequate criterion and convergent validity highlighting its importance in the assessment of maladaptive traits in clinical settings.

Concerning the PID-5 factor structure in the Emirati clinical sample, our findings did not reproduce a five-factor solution proposed by DSM-5 AMPD and replicated in most of the PID-5 studies (e.g., for a review see Somma et al., 2019 and Zimmermann et al., 2019). Instead, similarly to the study conducted by Pires et al., 2019 we identified a four-factor solution that resembled the domains Antagonism, Psychoticism, Detachment, and Negative affectivity, with some facets showing a deviant loading pattern from the original structure (Hopwood & Donnellan, 2010; Krueger & Markon, 2014; Turkheimer et al., 2008). Notably, in the first and second factors, the Disinhibition domain did not clearly emerge on the four-factor solution, with its facets loads mostly weighted on factor one, akin to the Antagonism domain.

A possible explanation for this unexpected conjunction of the Antagonism with the Disinhibition domain, could be that individuals with narcissistic personality trait profiles, beyond showing Grandiosity, Callousness, and Manipulativeness, can also be impulsive and

behave recklessly to stand out socially. Further, they can become hostile and suspicious towards the intentions and behaviours of others (Hopwood et al., 2013). On the other hand, from a psychopathological point of view, this first factor seemed to group traits that characterize DSM-5 Section II Cluster B Personality Disorders, particularly the anti-social, borderline, and narcissistic personality disorders that might be related with our clinical sample composition. In this regard, Kotov et al., 2010, in a meta-analysis study, found high correlations between some of the 'big' personality traits with anxiety, depressive, and substance use disorders which mostly profile our clinical sample diagnosis. Furthermore, the authors stressed the lack of specificity in the personality profiles identified and suggested that high order personality constructs are not exclusively linked to specific conditions, but they are rather meaningful under the umbrella of a more general factor of psychopathology (Kotov et al., 2010). On this note, several studies have pointed that Cluster B and Cluster C Personality Disorders are the most frequent neglected comorbidities among patients diagnosed with substance use disorder, anxiety, and depression in primary and secondary psychiatric care (Asp et al., 2020; De Carlo et al., 2016; Skodol et al., 2011). As such, clinical research might consider developing combined treatment plans able to intervene on both the personality domains and the disorder that results in part from the personality itself (Widiger et al., 2019).

Concerning factor two, an atypical factor loading was also obtained, which gathered traits that characterize both the schizotypal (Eccentricity, Unusual beliefs) and the obsessive-compulsive functioning (Preservation, Restricted affectivity, Rigid perfectionism) similar to an imperfect combination of the Compulsive and Schizotypal domains initially proposed by the AMPD (APA, 2013). However, as Cognitive and perceptual dysregulation secondary weighted on this factor, perhaps we might consider it similar to the Psychoticism domain. As noted by some studies, the Psychoticism domain has been pointed as heterogeneous with

deviant facet loadings (Adhiatma et al., 2014; Bach & Simonsen, 2019) and Pires et al., 2019 reported its absence in a clinical sample. These deviations might be conceptually meaningful in Arabic countries, as some studies with the FFM in Arabic samples have failed to identify the five domains of personality (Alansari, 1997; Latzman et al., 2015). Therefore, given the bipolar nature of personality traits, it is not surprising that its pathological extremes, assessed by the PID-5, could also present differences in our sample, reflecting the personality complexity (Gutierrez et al., 2017; Krueger et al., 2012; Krueger & Markon, 2014).

Overall, this study indicated that there was a great deal of interaction between the domains of personality measured by the PID-5 and the psychopathology of the clinical sample. The factor solutions found in the Emirati clinical sample seemed to identify a combination of trait constellations that might be linked to the mental disorders that characterize the Emirati clinical sample, rather than to a universal structure of personality.

The present findings should be considered in the light of several limitations, as this study was a first attempt to validate the Arabic PID-5 in an Emirati clinical sample. First, the small size of the community and clinical samples. Second, the predominance of substance-related and addictive disorders (35.3%), along with the severity of the psychiatric diagnosis and the multiple comorbidities of the inpatients, might have affected the range of PID-5 traits and symptoms. However, it is worth noting that all clinical participants were stable and about to be discharged when they completed the test. Third, although only the participants that had declared being mentally healthy were included in the community sample, no direct screening for psychopathology or previous history of utilizing mental health services has been performed. Considering the aforementioned, our results call for future studies in Arabic speaking countries, with larger samples, and with a broader spectrum of psychiatric disorders, to clarify these unexpected results and assess the PID-5 clinical utility in Arabic mental health settings.

Estudo 3 - Cross-cultural study of the Personality Inventory for the DSM-5 (PID-5) across the Portuguese and the United Arab Emirates (UAE) community and clinical populations³

Abstract

Aims: The present paper focused on compare the PID-5 mean score levels across two matched community and clinical samples of Portugal and the UAE.

Background: The generalizability and universality of the Alternative Model of Personality Disorders has been thoroughly studied through the Personality Inventory for DSM-5 (PID-5) across countries and languages. However, studies comparing Western and Middle Eastern countries are still limited, in particular those who assess the PID-5 measurement invariance.

Objectives: We examined measurement invariance of the PID-5 scales across matched Emirati and Portuguese clinical and nonclinical groups, as well as compare and contrast the PID-5 mean score levels across both countries and samples.

Methods: The Arabic and the Portuguese versions of the PID-5 was administered to Emirati community participants ($N = 300$, 80% women and 20% men, $M_{age} = 27.95$) which were matched with Portuguese community participants ($N = 300$, 80.3% women and 19.7% men, $M_{age} = 28.96$), as well as clinical participants of the UAE ($N = 150$, 61.3% women and 38.7% men, $M_{age} = 31.29$) and Portugal ($N = 150$, 52% male and 48% women, $M_{age} = 44.97$). We examined measurement invariance through an unrestricted Factor Analysis based program, and mean scores levels were compared and analysed.

Results: Our findings supported the PID-5 measurement invariance across the Emirati and Portuguese clinical samples pointing to the universality and generalizability of the Alternative Model of Personality Disorders. The Emirati psychiatric sample exhibited

somehow higher results than the Portuguese participants, albeit the small effect size for most of the PID-5 scales.

Conclusion: Further research is needed to examine the applicability of the PID-5 across non-clinical representative samples of Portugal and the UAE, and other Middle Eastern countries.

Key words: Cross-cultural Personality Study, Alternative Model of Personality Disorders, Personality Traits, Arabic version of the PID-5, Portuguese version of the PID-5, United Arab Emirates, Portugal.

³ Coelho, O., Pires, R., Pires, Sousa Ferreira, A., Gonçalves, B., Alkhoori, S. A., Sayed, M., ElRasheed, A., AlJassmi, M., Henriques-Calado, J., & Stocker J. Cross-cultural study of the Personality Inventory for the DSM-5 (PID-5) across the Portuguese and the United Arab Emirates (UAE) community and clinical populations. *Clinical Practice & Epidemiology in Mental Health*, 18(1), e174501792207130. <https://doi.org/10.2174/17450179-v18e2207130>

Introduction

The degree in which culture influences the assessment, diagnosis, and treatment of Personality Disorders (PD) is yet to be unveiled. Each culture ethos, history and dimensions create unique contingencies that help shaping the expressions of self and interpersonal functioning, as well as the promotion or suppression of specific behaviors and personality traits (Ronningstam et al., 2018). Consequently, what generates and perpetuates pathological patterns of personality is deeply intertwined in social conventions of emotional expression and regulation, along with behavior norms and personality traits, that goes beyond the salient obvious cross-cultural differences but are often found in more subtle and subjective cultural idiosyncrasies (Gawda et al., 2018; Ryder et al., 2015).

PD are not specific mental illness of Modern Western Societies, instead they are a severe psychiatric condition deemed to affect 7.8% of the world population (Winspei et al., 2020) and in Western clinical settings, prevalence rates range from 45% to 51% in the US and 40% to 92% in European psychiatric outpatients (Beckwith et al., 2014). As for the United Arab Emirates (UAE), data from primary healthcare services points to a global prevalence of 12.7% (El- Rufaie et al., 2002) contrasting with 52.7% found in Portugal (Carraça, 2012). However, despite the considerable variations in the prevalence of PD worldwide, and albeit that some types are rare or even absent in certain cultures (Ayinde & Gureje, 2020; Ryder et al., 2014), they all share a common denominator: the early onset, problematic diagnostic, and treatment resistance (Lotfi et al., 2018; Skodol, 2015; Tyrer et al., 2015). In fact, these differences, do not necessarily represent real cross-cultural differences, but instead mirror the difficulties in developing international guidelines and assessment tools that are scientifically valid and clinically useful to establish what can influence personality functioning and characterize PD, globally (Gawda et al., 2018; Sperando et al., 2020).

Traditional Islamic and patriarchal societies, such as the UAE, where religion overrides an act of faith but is embedded in every aspect of the individual's life (Al-Darmaki & Sayed, 2009), raise additional challenges to the diagnosis and treatment of PD, not often answered by Western diagnostic and healing models. In the Emirati society, seeking mental health treatment is mostly a family decision that often collides with the guilt and stigma associated with a lack of faith, as a cause of mental distress. Moreover, psychological discomfort is largely expressed through metaphoric expression and communicated using oral vernacular forms of the Modern Standard Arabic, not always easily captured by the clinicians in primary health care settings (Al-Darmaki & Sayed, 2009, Zeinoun et al., 2018). With that being said, in what extent have the recent efforts in developing more culturally sensitive and evidence-based PD nosology's carried out by the recent editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD), succeed in ways that are applicable to a Middle Eastern multicultural society, with a hybrid identity (brought about by the strong Western presence in the region), but rooted in religious and family-oriented traditions?

In both classification systems, the key innovation is the conceptualization of PD as a dyad of severity or impairment in self and interpersonal functioning, along with the presence of maladaptive personality traits that characterize the stylistic expression of PD. This dimensional approach, led by the Alternative Model for Personality Disorders (AMPD) published in Section III (for further studies) of the DSM-5 (APA, 2013), has achieved general support, in great extent, due to the extensive research conducted with the Personality Inventory for the DSM-5 (PID-5) (Krueger et al., 2012).

The PID-5 operationalizes Criterion B of the AMPD, or the presence of 25 maladaptive personality traits in which individuals differ (facets), subsequently organized within five high order domains: Negative Affectivity, Detachment, Antagonism,

Disinhibition and Psychoticism. These traits seem to be pathological extremes of the basic dimensions of normal personality, as stated by the Five-Factor Model (FFM), supporting its universality as well as the continuum, between normality and personality dysfunction (Krueger & Markon, 2014; Skodol et al., 2011). The PID-5 is a valuable and reliable tool that has confirmed adequate psychometric properties and replicated its factor structure across countries and samples (for a review see Somma et al., 2019 and Zimmerman et al., 2019).

With the present study, we were interested in testing if maladaptive traits measured by the PID-5, are culturally shaped in their intensity and expressions, across matched clinical and non-clinical groups from two distant countries and cultures, the Middle East culture of the United Arab Emirates and the Portuguese South European culture. In other words, can findings derived from the Portuguese and Arabic versions of the PID-5 be comparable and generalized to personality research and clinical practice?

Nevertheless, before cross-cultural differences can be examined and interpreted it is crucial to establish measurement invariance to ensure that the same underlying pathological personality traits, measured by the Portuguese and the Arabic version of the PID-5, are being assessed in similar ways and have the same meaning, across the two countries (Bach et al., 2018; Debast et al., 2018). On this note, the PID-5 literature has already demonstrated overall measurement invariance for age (Debast et al., 2018), clinical status (Bach et al., 2018), sex (Suzuki et al., 2019) and cross-cultural comparisons (Thimm et al., 2016). However, despite promising results, cross-cultural comparative studies with the PID-5 are still limited to Western countries (Thimm et al., 2016; Sorrel et al., 2021). To address this gap, our study intended to extend Sorrel et al., 2021 cross-cultural measurement invariance study, developed with large samples of college students from several European countries, to test the PID-5 measurement invariance also in a non-Western country, and in clinical samples.

Therefore, to examine measurement invariance (MI) of the PID-5 facets and domains, we used the IMINCE software (Lorenzo-Seva & Ferrando, 2003) a free unrestricted Factor Analysis-Based program that uses Exploratory Structural Equation Modelling (ESEM) methodology, which combines features of Exploratory Factor Analysis (EFA) and Confirmatory Factor Analysis (CFA), in the sense that an EFA model is submitted to an adjustment estimation of a CFA model. Moreover, this software is suitable for responses to items on Likert scales or dichotomic items, as it performs factor analysis using polychoric or tetrachoric correlations, and measures partial, strong, and strict invariance (Lorenzo-Seva & Ferrando, 2003).

Accordingly, our study goals were (1) to test MI of the PID-5 scales across matched Emirati and Portuguese clinical and nonclinical groups, and (2) to compare the PID-5 mean score levels across these countries and samples. Considering the previous studies in the Emirati and Portuguese populations, we expected that the clinical groups' mean scores would be higher than non-clinical groups.

Methods

Ethics

The present study was approved by the Research Ethics Committee of Zayed University Dubai (ref. ZU18_36a_F), Dubai Scientific Research Ethics Committee (ref. DSREC-02/2019_07), Ministry of Health and Prevention Research Ethics Committee (Ref. MOHAP/DXB-REC/No.10/MM/2019), Deontological Committee of Psychology Faculty of the University of Lisbon (ref. Acta n.2_CD_22Oct2020), Ethic Commission of the host Portuguese mental Health institutions. All participants were carefully informed about the study and gave written consent.

Samples

Community Samples.

The study included an Emirati and a Portuguese convenience community sample. The Emirati community sample comprised 300 volunteer Emirati college students from Zayed University Dubai and Abu Dhabi, and their acquaintances (80% women and 20% men). The participants were aged 18 to 57 years ($M = 27.95$, $SD = 10.19$) mostly single (66.7%), had completed high school (69.3%), and at the time of the assessment 56% were students.

The Portuguese community sample was matched based on the composition of gender and age with the Emirati community sample. A total of 300 Portuguese volunteer students and their acquaintances (80.3% women and 19.7% men), aged 18 to 60 years ($M = 28.96$, $SD = 11.12$), were recruited from Psychology Faculty of Lisbon University. The majority of the participants were single (75.3%), had completed high school (59.5%), and at the time of the assessment were students (56.7%).

Clinical Samples

The clinical samples, were convenience samples, composed by Emirati and Portuguese psychiatric patients. The Emirati clinical sample was recruited among volunteer patients that, at the time of the assessment, were receiving treatment in mental health institutions of the UAE, namely Rashid Hospital, Al Amal Psychiatric Hospital, and National Rehabilitation Centre. The selection process was conducted by the institutions' psychiatrists or psychologists and based on clinical records and/or clinical authority. The clinicians were asked to report the patient's diagnosis using the DSM-5 criteria, and those who met at least one DSM-5 mental disorder were included in the study. Patients that suffered from intellectual disability, schizophrenia spectrum disorder, and major and mild neurocognitive

disorders were excluded from the sample. A total of 150 inpatients and outpatients were selected, 61.3% female, 38.7% male, aged 18 to 61 years ($M = 31.29$, $SD = 8.88$). Most of the clinical participants were single (49.3%), had completed high school (66%), and at the time of the assessment, 37.3% were unemployed, 28% were employed, 15.3% were housewives, 14.7% were student, and 4% were retired.

The Portuguese clinical sample comprised 150 Portuguese volunteer psychiatric patients from mental health institutions across the country, subsequently matched (based on the diagnosis), with the Emirati clinical sample. The patients were primarily men (52%), aged 18 to 68 years old ($M = 44.97$, $SD = 11.6$). The participants were predominantly single (50%), unemployed (51.7%), and at the time of the assessment 28.2 % had completed high school, and 26.2% had a bachelor's degree or more. The predominate diagnoses for both countries' samples were substance related disorders, depressive disorders, obsessive-compulsive disorders, anxiety disorders and bipolar disorders.

Instruments

Personality Inventory for DSM-5 (PID-5, Krueger et al., 2012, Arabic version by Al-Attiyah et al. 2017)

The PID-5 is a self-report measure which operationalizes the trait system of the DSM-5 Alternative Model of Personality Disorders. It is composed by 220 items, rated on a four-point Likert scale, ranging from zero (*very false or often false*) to three (*very true or often true*) that characterizes 25 empirically derived lower-level facets grouped into five major domains of maladaptive personality variation. Approximately, the instrument takes 40 minutes or less to complete and it is to be used in adults (18 years old or above). The PID-5 has shown robust psychometric properties worldwide, in clinical and non-clinical samples, such as replicable factor structure, internal consistency, convergent validity with other

personality measures as well as with a broad range of psychopathological constructs. The UAE sample was assessed through the Arabic version of the PID-5 (Al-Attiyah et al., 2017), while the Portuguese sample was studied by the Portuguese version of the PID-5 (Pires et al., 2017). Both translated versions have proven their relevance in terms of internal consistency as well factorial validity in clinical, and non-clinical samples (Al-Attiyah et al., 2017, Coelho et al., 2020a; Coelho et al., 2020b; Pires et al., 2017, 2019).

Data Collection

The present study comprised two Emirati samples and two Portuguese samples. The Emirati community sample was recruited through email or in person by the researchers. The sessions were held collectively at Zayed University Dubai and Abu Dhabi. Regarding the Emirati clinical sample, the selection of the patients was performed by the mental health units 'clinicians and the participants were invited to take part in the study at the end of the follow-up appointments. The objectives of the study were explained, and confidentiality was emphasized. As the test requires approximately 40 minutes to apply, data collection sessions were scheduled dependent on the patients' conditions and availability. All the participants signed a written informed consent form. As for the Portuguese community and clinical samples, data was made available by the authors of the Portuguese version of the PID-5, who also mentored this research project, and details regarding data collection are published in Pires et al. (2017, 2019).

Data Analysis

Statistical analyses were undertaken with the IBM SPSS (v.26, SPSS Inc., Chicago, IL) and the IMINCE software (Lorenzo-Seva & Ferrando, 2003). In the current study descriptive statistics of the PID-5 facets and domains for both countries and samples were obtained, internal reliability was examined through Cronbach's alphas and gender effect sizes

were analysed. In order to explore the normality of the scales' distributions, the following criteria were applied: skewness, kurtosis, Kolmogorov-Smirnov Goodness-of-fit test ($N > 30$), and Q-Q-plots. Mean score differences between the UAE and the Portuguese (community and clinical) samples presenting a normal distribution, were investigated by means of paired samples t test and Cohen's d . The effect size was considered small when $d \leq 0.20$, medium when $0.20 < d \leq 0.50$, large when $0.50 < d \leq 1.0$, and very large when $d > 1.0$.

Accordingly, the mean rank scores differences of the scales that presented a heteroscedastic distribution were calculated by the Wilcoxon Signed-Rank test, for both countries and samples. The effect size was tested through $r = z/\sqrt{N}$, being N the number of pairs without ties, and effect size was considered small when $.10 \leq r < .30$, medium when $.30 \leq r < .50$ and large when $r \geq .50$.

Furthermore, we employed the IMINCE, a free unrestricted Factor Analysis based program which allows the assessment of MI in two populations, in this particular study, the Emirati and the Portuguese community and clinical samples. Although the program is more suitable for binary or Likert item scores, it can as well analyse sums of item scores (facets) and sets of test scores (domains). The IMINCE examines the following invariance forms: invariance of item difficulties or intercepts, factor loadings or discriminations (partial invariance), and residual variances (strict factor invariance). This is accomplished using 1) Cohen's d or univariate t tests or Hotelling's T-square and the corresponding F statistics, depending on the nature of the variables involved and the size of the samples. In our case, Cohen's d is the most appropriate given the large size of the UAE and the Portuguese community and clinical samples. Additionally, 2) factor loadings are obtained by an Exploratory Factor Analysis method and tested by factor congruence, factor discrepancy and approximate confidence intervals. Observed congruence and discrepancy indices are compared to the critical alpha values and, congruence indices are considered statistically

significant if they are smaller than α , while discrepancy indices are considered statistically significant if they are larger than α . Finally, 3) invariance of residual variances or strict factor invariance, is assessed through percentile intervals which are obtained from a Bootstrap resampling. Nonoverlapping intervals suggest that the residual variances of a certain item are not invariant over the two populations.

Results

Descriptive Statistics and Internal Consistency

Table 1 presents the PID-5's facets and domains mean, *SD*, and Cronbach alphas of the UAE and Portuguese community and clinical samples. Overall, the PID-5 presented acceptable to good ($\alpha \geq .70$) alpha coefficients, in all domains and most of the facets, for both countries and samples. Higher reliability coefficients were obtained in the clinical samples compared to the community samples. The lowest alpha values were found in the facet Suspiciousness for the UAE community (.35) and clinical samples (.48), as well as in the Portuguese clinical (.59) sample. Also, the facet Manipulativeness presented the lowest alpha (.37) in the Portuguese community sample along with the facets Submissiveness (.52) and Restrictive affectivity (.55). On the other hand, the highest alpha values for both UAE (.91) and Portuguese (.89) clinical samples, were observed on Depressivity, whilst Callousness and Eccentricity reported the highest alphas in the Portuguese (.83) and UAE (.90) community samples, respectively. As for the PID-5 domains, the lowest alphas were found in the domain Disinhibition for the Portuguese community sample (.81) and UAE clinical sample (.80), along with Antagonism in the UAE community sample and Negative affectivity in the Portuguese clinical sample. The highest alpha values were displayed in the domain Psychoticism for both countries and samples.

Table 1

PID-5 scales' means (M), standard deviation (SD) and Cronbach's alphas (α) of the UAE and the Portuguese samples

PID-5 scales	Community samples						Clinical samples					
	UAE			Portugal			UAE			Portugal		
	<i>M</i>	<i>SD</i>	α	<i>M</i>	<i>SD</i>	α	<i>M</i>	<i>SD</i>	α	<i>M</i>	<i>SD</i>	α
Anhedonia	0.94	0.52	.77	0.88	0.58	.69	1.45	0.60	.78	1.39	0.60	.74
Anxiousness	1.42	0.59	.84	1.52	0.65	.81	1.84	0.64	.85	1.83	0.59	.62
Attention seeking	1.11	0.54	.80	0.74	0.61	.71	1.41	0.67	.84	1.09	0.74	.84
Callousness	0.57	0.35	.73	0.30	0.30	.83	0.81	0.52	.84	0.65	0.51	.83
Cognitive and perceptual dysregulation	0.86	0.47	.80	0.51	0.42	.77	1.15	0.59	.86	0.97	0.61	.82
Deceitfulness	0.86	0.41	.69	0.43	0.41	.76	1.05	0.58	.80	0.75	0.56	.79
Depressivity	0.67	0.48	.87	0.61	0.53	.80	1.27	0.68	.91	1.10	0.68	.89
Distractibility	1.04	0.49	.78	0.98	0.62	.80	1.49	0.58	.81	1.33	0.64	.78
Eccentricity	0.90	0.57	.90	0.64	0.64	.81	1.27	0.65	.90	1.07	0.67	.87
Emotional lability	1.14	0.54	.76	1.26	0.64	.64	1.68	0.65	.79	1.57	0.68	.73
Grandiosity	1.18	0.55	.71	0.61	0.51	.59	1.33	0.65	.75	0.89	0.64	.72
Hostility	1.16	0.49	.76	1.02	0.51	.71	1.44	0.71	.88	1.17	0.65	.82
Impulsivity	1.00	0.55	.74	0.85	0.63	.62	1.38	0.66	.76	1.33	0.69	.80
Intimacy avoidance	0.89	0.53	.70	0.45	0.55	.58	1.08	0.67	.75	0.98	0.75	.79
Irresponsibility	0.74	0.42	.60	0.38	0.41	.71	1.21	0.56	.67	0.87	0.64	.77
Manipulativeness	1.05	0.51	.61	0.68	0.52	.37	1.17	0.66	.75	0.92	0.70	.73
Perseveration	1.09	0.43	.70	0.89	0.53	.67	1.43	0.62	.84	1.27	0.56	.76
Restricted affectivity	1.18	0.47	.60	0.86	0.59	.55	1.31	0.55	.64	1.17	0.56	.67

Table 1 (Cont.)

PID-5 scales' means (M), standard deviation (SD) and Cronbach's alphas (α) of the UAE and the Portuguese samples

PID-5 scales	Community samples						Clinical samples					
	UAE			Portugal			UAE			Portugal		
	<i>M</i>	<i>SD</i>	α	<i>M</i>	<i>SD</i>	α	<i>M</i>	<i>SD</i>	α	<i>M</i>	<i>SD</i>	α
Rigid perfectionism	1.38	0.48	.76	1.18	0.59	.79	1.55	0.63	.85	1.44	0.63	.80
Risk taking	1.18	0.40	.74	1.05	0.50	.74	1.36	0.54	.82	1.27	0.55	.81
Separation insecurity	1.06	0.56	.75	0.96	0.62	.57	1.39	0.68	.78	1.39	0.61	.66
Submissiveness	1.03	0.57	.68	0.92	0.67	.52	1.35	0.68	.73	1.14	0.67	.62
Suspiciousness	1.21	0.39	.35	0.96	0.51	.63	1.43	0.48	.48	1.43	0.51	.59
Unusual beliefs and experiences	0.94	0.53	.75	0.44	0.49	.68	1.16	0.67	.81	0.92	0.61	.74
Withdrawal	1.12	0.50	.80	0.70	0.59	.78	1.36	0.62	.83	1.18	0.65	.85
Negative affectivity	1.21	0.46	.88	1.25	0.52	.82	1.63	0.54	.90	1.60	0.51	.83
Detachment	0.98	0.41	.87	0.68	0.47	.83	1.30	0.51	.89	1.18	0.50	.87
Antagonism	1.03	0.38	.80	0.57	0.39	.82	1.18	0.54	.88	0.85	0.57	.90
Disinhibition	0.93	0.38	.83	0.73	0.45	.81	1.36	0.51	.80	1.18	0.54	.88
Psychoticism	0.90	0.46	.93	0.53	0.44	.90	1.20	0.58	.94	0.98	0.56	.93

Gender Effect Size

In order to prevent possible gender bias, due to uneven proportions of men and women in both, community and clinical samples, Cohen's d was calculated to determine gender effect sizes. Our results pointed to very small effect sizes ($d < 0.20$), in some facets and domains, in both, community, and clinical samples, of the Emirati and Portuguese populations. Specifically, in the domain Disinhibition, along with the facets Depressivity, Distractibility and Submissiveness, in the Emirati community sample. Also, the Negative affectivity domain as well as the facets Anxiety, Callousness, Deceitfulness, Emotional lability, Grandiosity, Irresponsibility, Restricted affectivity, and Risk taking in the Portuguese community sample. Concerning the clinical samples, the same results were found ($d < 0.20$) in the domain Negative affectivity in conjunction with the facets, Risk taking, Separation insecurity, and Submissiveness, in the Emirati clinical sample, together with the facets Deceitfulness and Callousness, in the Portuguese clinical sample.

Invariance Study of the UAE and Portuguese Community sample

Regarding Invariance of facet difficulties or intercepts (see table 2), Cohen's d statistic identified ten facets with large effect sizes, between the UAE and the Portuguese community populations, namely: Callousness, Cognitive and perceptual dysregulation, Deceitfulness, Grandiosity, Intimacy avoidance, Irresponsibility, Manipulativeness, Suspiciousness, Unusual beliefs and experiences, and Withdrawal. Moreover, in terms of Invariance of factor loadings or discriminations (partial invariance), significant differences were observed in the congruence coefficients of six of the PID-5 facets (Anhedonia, Callousness, Eccentricity, Irresponsibility, Restricted affectivity, Withdrawal), and in the discrepancy coefficients of nine facets (Anhedonia, Callousness, Cognitive and perceptual

dysregulation, Distractibility, Eccentricity, Perseveration, Restricted affectivity, Unusual beliefs and experiences, and Withdrawal) as presented in table 3.

As for the PID-5 domains, Detachment presented significant differences in the discrepancy coefficient along with Psychoticism in the congruence and discrepancy coefficients (table 4). Therefore, due to these differences, the overall congruence and discrepancy indices were also compromised. Concerning strict factor invariance in the community samples, the percentile intervals of residual variances of the PID-5 facets have shown overlapping for all facets, except for Grandiosity and Suspiciousness (see table 5). According to Lorenzo-Seva & Ferrando (2003), nonoverlapping intervals suggest that the residual variances of a particular variable are not invariant over the populations that are being compared.

In a nutshell, our results have shown that the facets Grandiosity and Suspiciousness, did not reach strict factor invariance, and other ten PID-5 facets (Anhedonia, Callousness, Cognitive and perceptual dysregulation, Distractibility, Eccentricity, Irresponsibility, Perseveration, Restricted Affectivity, Unusual beliefs and experiences, and Withdrawal) along with two domains (Detachment and Psychoticism) did not show partial invariance across the UAE and the Portuguese community samples.

Table 2

Facet difficulties: means (M) and Cohen's d' statistic of the community samples

PID-5 facets	UAE sample	Portugal sample	Cohen's <i>d</i>
	<i>M</i>	<i>M</i>	
Anhedonia	0.94	0.88	0.08
Anxiousness	1.42	1.52	-0.12
Attention Seeking	1.11	0.74	0.46
Callousness	0.57	0.30	0.57
Cognitive and perceptual dysregulation.	0.86	0.51	0.57
Deceitfulness	0.86	0.43	0.77
Depressivity	0.67	0.61	0.09
Distractibility	1.04	0.98	0.09
Eccentricity	0.90	0.64	0.31
Emotional lability	1.14	1.26	-0.15
Grandiosity	1.18	0.61	0.80
Hostility	1.16	1.02	0.21
Impulsivity	1.00	0.85	0.18
Intimacy avoidance	0.89	0.45	0.58
Irresponsibility	0.74	0.38	0.60
Manipulativeness	1.05	0.68	0.51
Perseveration	1.09	0.89	0.31
Restricted affectivity	1.18	0.86	0.42
Rigid perfectionism	1.38	1.18	0.27
Risk taking	1.18	1.05	0.21
Separation insecurity	1.06	0.96	0.11
Submissiveness	1.03	0.92	0.13
Suspiciousness	1.21	0.96	0.55
Unusual beliefs and experiences	0.94	0.44	0.69
Withdrawal	1.12	0.70	0.55

Note. Small effect $d \leq 0.20$, medium effect size $0.20 < d \leq 0.50$, large $0.50 < d \leq 1.0$,

and very large $d > 1.0$.

Table 3*Overall fit congruence and discrepancy indices per PID-5 facets in the community samples*

PID-5 facets	Congruence values		Discrepancy values	
	Observed	Critical value	Observed	Critical value
		($\alpha = .05$)		($\alpha = .05$)
Anhedonia	.92**	.96	.03**	.02
Anxiousness	.98	.96	.01	.02
Attention Seeking	.99	.96	.20	.03
Callousness	.79**	.86	.02**	.02
Cognitive and perceptual dysregulation	.92	.92	.03**	.02
Deceitfulness	.94	.90	.01	.02
Depressivity	.98	.95	.01	.02
Distractibility	.97	.95	.03**	.03
Eccentricity	.85**	.94	.07**	.03
Emotional lability	.98	.96	.02	.03
Grandiosity	.98	.90	.01	.03
Hostility	.89	.87	.03	.04
Impulsivity	.96	.91	.02	.03
Intimacy avoidance	.96	.83	.01	.04
Irresponsibility	.92**	.93	.02	.02
Manipulativeness	.98	.93	.01	.02
Perseveration	.96	.95	.02**	.02
Restricted affectivity	.93**	.96	.04**	.02
Rigid perfectionism	.98	.95	.01	.03
Risk taking	.88	.87	.03	.04
Separation insecurity	.98	.90	.01	.03
Submissiveness	.95	.93	.03	.05
Suspiciousness	.91	.88	.02	.02
Unusual beliefs and experiences	.95	.80	.03**	.03
Withdrawal	.96**	.97	.03**	.02

Note. **Significant differences.

Table 4*Overall fit indices per PID-5 domains in the community sample*

PID-5 Domains	Observed	Critical value	Observed	Critical value
	Congruence	($\alpha = .05$)	Discrepancy	($\alpha = .05$)
Negative affectivity	.96	.90	.09	.10
Detachment	.90	.88	.14**	.11
Antagonism	.98	.87	.08	.10
Disinhibition	.89	.87	.11	.11
Psychoticism	.85**	.86	.13**	.11
Overall Fit Index	.93**	.95	.55**	.40

Note. **Significant differences.**Table 5***Bias-corrected percentile intervals of residual variances per PID-5 facets in the community samples*

PID-5 facets	UAE sample	Portugal sample
Anhedonia	(.06; .11)	(.09; .15)
Anxiousness	(.10; .17)	(.10; .18)
Attention Seeking	(.11; .17)	(.07; .15)
Callousness	(.05; .08)	(.03; .05)
Cognitive and perceptual dysregulation	(.05; .08)	(.04; .08)
Deceitfulness	(.06; .10)	(.05; .09)
Depressivity	(.05; .09)	(.05; .08)
Distractibility	(.10; .14)	(.10; .16)
Eccentricity	(.06; .14)	(.12; .22)
Emotional lability	(.08; .14)	(.11; .20)
Grandiosity*	(.17; .25)	(.10; .16)
Hostility	(.09; .12)	(.08; .15)
Impulsivity	(.14; .21)	(.17; .26)
Intimacy avoidance	(.15; .22)	(.16; .25)
Irresponsibility	(.06; .10)	(.05; .08)
Manipulativeness	(.10; .15)	(.08; .13)
Perseveration	(.07; .11)	(.08; .12)
Restricted affectivity	(.09; .14)	(.08; .16)

Note. * No overlap.

Table 5 (Cont.)

Bias-corrected percentile intervals of residual variances per PID-5 facets in the community samples

PID-5 facets	UAE sample	Portugal sample
Rigid perfectionism	(.07; .12)	(.10; .19)
Risk taking	(.09; .13)	(.11; .18)
Separation insecurity	(.14; .20)	(.16; .26)
Submissiveness	(.18; .26)	(.15; .33)
Suspiciousness*	(.08; .12)	(.13; .19)
Unusual beliefs and experiences	(.10; .16)	(.10; .20)
Withdrawal	(.08; .14)	(.07; .12)

Note. * No overlap.

Invariance Study of the UAE and Portuguese Clinical samples

In respect to Invariance of facet difficulties or intercepts in the clinical populations, according to Cohen's d , no facets presented large effect sizes (see table 6). As for Invariance of factor loadings or discrimination (partial invariance), only the facet Separation insecurity presented significant differences in the discrepancy coefficient (see table 7 and 8). However, the overall discrepancy index was not compromised. Likewise, concerning strict factor invariance, the percentile intervals of residual variances of the PID-5 facets, in the clinical samples, showed overlapping for all the facets, apart from Grandiosity, Risk taking and Separation insecurity (see table 9). Taken together, as the residual variance is invariant over the UAE and the Portuguese populations, we can consider strict invariances for all facets and domains.

Table 6*Facet difficulties: means (M) and Cohen's d' statistic in the clinical samples*

PID-5 facets	UAE sample <i>M</i>	Portugal sample <i>M</i>	Cohen's <i>d</i>
Anhedonia	1.45	1.39	0.08
Anxiousness	1.84	1.83	0.01
Attention Seeking	1.41	1.09	0.32
Callousness	0.81	0.65	0.22
Cognitive and perceptual dysregulation	1.15	0.97	0.22
Deceitfulness	1.05	0.75	0.41
Depressivity	1.27	1.10	0.17
Distractibility	1.49	1.33	0.17
Eccentricity	1.27	1.07	0.22
Emotional lability	1.68	1.57	0.13
Grandiosity	1.33	0.89	0.48
Hostility	1.44	1.17	0.28
Impulsivity	1.38	1.33	0.05
Intimacy avoidance	1.08	0.98	0.08
Irresponsibility	1.21	0.87	0.43
Manipulativeness	1.17	0.92	0.29
Perseveration	1.43	1.27	0.19
Restricted affectivity	1.31	1.17	0.18
Rigid perfectionism	1.55	1.44	0.13
Risk taking	1.36	1.27	0.08
Separation insecurity	1.39	1.39	0.01
Submissiveness	1.35	1.14	0.23
Suspiciousness	1.43	1.43	0.00
Unusual beliefs and exp.	1.16	0.92	0.29
Withdrawal	1.36	1.18	0.20

Note. Small effect $d \leq 0.20$, medium effect size $0.20 < d \leq 0.50$, large $0.50 < d \leq 1.0$,

and very large $d > 1.0$.

Table 7*Overall fit congruence and discrepancy indices per PID-5 facets in the clinical samples*

PID-5 Domains	Observed	Critical value	Observed	Critical value
	Congruence	($\alpha = .05$)	Discrepancy	($\alpha = .05$)
Anhedonia	.97	.89	.02	.06
Anxiousness	.97	.89	.01	.07
Attention Seeking	.97	.93	.03	.06
Callousness	.87	.70	.05	.13
Cognitive and perceptual dysregulation	.92	.84	.04	.10
Deceitfulness	.97	.88	.02	.07
Depressivity	.96	.95	.03	.04
Distractibility	.99	.89	.01	.06
Eccentricity	.92	.87	.05	.07
Emotional lability	.96	.79	.02	.11
Grandiosity	.99	.87	.01	.08
Hostility	.93	.83	.04	.11
Impulsivity	.88	.77	.08	.15
Intimacy avoidance	.95	.66	.06	.13
Irresponsibility	.91	.86	.04	.08
Manipulativeness	.96	.92	.03	.06
Perseveration	.87	.84	.06	.08
Restricted affectivity	.94	.75	.02	.07
Rigid perfectionism	.97	.77	.02	.12
Risk taking	.90	.72	.03	.09
Separation insecurity	.85	.72	.12**	.08
Submissiveness	.85	.72	.06	.13
Suspiciousness	.78	.66	.05	.07
Unusual beliefs and experiences	.91	.72	.05	.11
Withdrawal	.98	.88	.01	.08

Note. **Significant differences.

Table 8

Overall fit indices per domain of the PID-5 in the clinical samples

PID-5 Domains	Observed	Critical value	Observed	Critical value
	Congruence	($\alpha = .05$)	Discrepancy	($\alpha = .05$)
Negative affectivity	.96	.69	.13	.38
Detachment	.96	.67	.16	.38
Antagonism	.93	.62	.15	.40
Disinhibition	.85	.64	.26	.38
Psychoticism	.81	.64	.27	.38
Overall Fit Index	.92	.90	.97	1.27

Note. **Significant differences.

Table 9

Bias-corrected percentile intervals of residual variances per PID-5 facets in the clinical samples.

PID-5 facets	UAE sample	Portugal sample
Anhedonia	(.10; .18)	(.05; .14)
Anxiousness	(.15; .25)	(.05; .13)
Attention Seeking	(.11; .19)	(.07; .16)
Callousness	(.08; .13)	(.05; .11)
Cognitive and perceptual dysregulation	(.05; .09)	(.05; .11)
Deceitfulness	(.09; .16)	(.03; .08)
Depressivity	(.07; .17)	(.06; .13)
Distractibility	(.08; .13)	(.08; .15)
Eccentricity	(.09; .16)	(.10; .20)
Emotional lability	(.14; .20)	(.12; .24)
Grandiosity*	(.16; .24)	(.06; .17)
Hostility	(.16; .25)	(.10; .18)
Impulsivity	(.18; .26)	(.11; .26)
Intimacy avoidance	(.07; .21)	(.13; .45)
Irresponsibility	(.07; .15)	(.11; .19)
Manipulativeness	(.03; .18)	(.08; .15)
Perseveration	(.11; .20)	(.06; .10)
Restricted affectivity	(.11; .17)	(.11; .19)

Note. * No overlap.

Table 9 (Cont.)

Bias-corrected percentile intervals of residual variances per PID-5 facets in the clinical samples.

PID-5 facets	UAE sample	Portugal sample
Rigid perfectionism	(.10; .19)	(.08; .25)
Risk taking*	(.14; .21)	(.09; .20)
Separation insecurity*	(.07; .09)	(.14; .30)
Submissiveness	(.16; .32)	(.16; .30)
Suspiciousness	(.07; .12)	(.11; .21)
Unusual beliefs and experiences	(.13; .21)	(.10; .21)
Withdrawal	(.11; .20)	(.10; .21)

Note. * No overlap.

Group differences

Concerning the aforementioned PID-5 scales distribution, both community and clinical samples, generally leaned to non-normality, particularly in the community samples, as only Anxiety and Emotional lability presented normal distribution. As for the clinical samples, scores were more normally distributed, specifically for 11 of the PID-5 facets and 4 of the domains.

Regarding facets and domains that shown non-normal distribution, in the community samples, table 10 presents the respective mean rank scores differences, Wilcoxon Signed-Rank test, and effect size coefficient. Non-invariant facets are presented in grey. Most of the PID-5 facets and domains results were higher and statistically significant in the UAE community sample ($p < .05$) compared to the Portuguese community sample. As for the effect size, we obtained small ($.10 < r \leq .30$) to medium ($.30 < r \leq .50$) effect size for 16 of the 23 PID-5 facets, with the highest effect sizes displayed by Deceitfulness (.62) and Grandiosity (.64).

At the domain level, except for Negative affectivity, the UAE community sample presented significant higher results ($p < .01$) than the Portuguese community sample, with the highest effect size (.66) being displayed by the domain Antagonism. In respect to the variables with normal distribution, no significant differences were reported for Anxiety, $t = 1.88$, $p = .07$, despite the Portuguese community sample presented higher mean scores ($M = 1.51$; $SD = 0.65$) than those in the UAE sample ($M = 1.42$; $SD = 0.59$). Conversely, Emotional lability obtained significantly higher scores in the Portuguese sample ($M = 1.25$; $SD = 0.65$) compared to the UAE sample ($M = 1.13$; $SD = 0.54$), $t = 2.43$, $p = .02$, albeit the small effect size.

Table 10

Wilcoxon Signed Ranks Test of the PID-5 Scales in the Community Samples

PID-5 scales	Portugal vs. UAE					
	Ranks	<i>N</i>	Mean Rank	<i>z</i>	<i>p</i>	<i>r</i>
Anhedonia	Neg.	163	137.51	-1.80	.07	.10
	Pos.	119	146.97			
Attention seeking	Neg.	198	153.42	-7.19	.00**	.41
	Pos.	87	119.29			
Callousness	Neg.	216	150.78	-9.21	.00**	.53
	Pos.	66	111.14			
Cognitive and perceptual dysregulation	Neg.	215	156.52	-9.08	.00**	.52
	Pos.	73	109.11			
Deceitfulness	Neg.	232	152.08	-10.71	.00**	.62
	Pos.	53	103.24			
Depressivity	Neg.	167	139.42	1.98	.05*	.11
	Pos.	119	149.22			
Distractibility	Neg.	151	154.15	-1.75	.08	.10
	Pos.	137	133.86			

Note. Non-Invariant facets/domains in grey. Neg. = Negative Ranks (Portuguese results < UAE results); Pos. = Positive Ranks (Portuguese results > UAE results); * $p < .05$;

** $p < .01$. Small effect $.10 < r \leq .30$; Medium effect size $.30 < r \leq .50$; High effect $r > .50$.

Table 10 (Cont.)*Wilcoxon Signed Ranks Test of the PID-5 Scales in the Community Samples*

PID-5 scales	Portugal vs. UAE					
	Ranks	<i>N</i>	Mean Rank	<i>z</i>	<i>p</i>	<i>r</i>
Eccentricity	Neg.	192	151.01	-5.14	.00**	.30
	Pos.	101	139.38			
Grandiosity	Neg.	226	151.24	-11.04	.00**	.64
	Pos.	52	88.46			
Hostility	Neg.	173	141.61	-3.69	.00**	.21
	Pos.	106	137.37			
Impulsivity	Neg.	168	143.20	-3.00	.00**	.17
	Pos.	114	138.99			
Intimacy avoidance	Neg.	211	149.15	-9.02	.00**	.52
	Pos.	67	109.10			
Irresponsibility	Neg.	213	142.58	-8.96	.00**	.52
	Pos.	60	117.20			
Manipulativeness	Neg.	204	142.68	-7.85	.00**	.45
	Pos.	70	122.40			
Perseveration	Neg.	186	149.19	-5.43	.00**	.31
	Pos.	98	129.81			
Restricted affectivity	Neg.	189	149.42	-6.47	.00**	.37
	Pos.	90	120.21			
Rigid perfectionism	Neg.	179	155.01	-5.04	.00**	.29
	Pos.	108	125.75			
Risk taking	Neg.	166	154.05	-3.49	.00**	.20
	Pos.	121	130.21			
Separation insecurity	Neg.	160	145.62	-2.10	.04*	.12
	Pos.	125	139.64			
Submissiveness	Neg.	151	137.73	-2.43	.02*	.14
	Pos.	115	127.95			
Suspiciousness	Neg.	184	155.60	-6.35	.00**	.37
	Pos.	98	115.02			
Unusual beliefs and experiences	Neg.	230	154.56	-10.43	.00**	.60
	Pos.	58	104.62			
Withdrawal	Neg.	217	153.73	-8.44	.00**	.49
	Pos.	74	123.33			

Note. Non-Invariant facets/domains in grey. Neg. = Negative Ranks (Portuguese results < UAE results); Pos. = Positive Ranks (Portuguese results > UAE results); **p* < .05;

***p* < .01. Small effect .10 < *r* ≤ .30; Medium effect size .30 < *r* ≤ .50; High effect *r* > .50.

Table 10 (Cont.)*Wilcoxon Signed Ranks Test of the PID-5 Scales in the Community Samples*

PID-5 scales	Portugal vs. UAE					
	Ranks	<i>N</i>	Mean Rank	<i>z</i>	<i>p</i>	<i>r</i>
Negative Affectivity	Neg.	150	143.38	-0.71	.48	.00
	Pos.	150	157.62			
Detachment	Neg.	209	166.01	-8.06	.00**	.47
	Pos.	91	114.87			
Antagonism	Neg.	244	162.24	-11.51	.00**	.66
	Pos.	55	94.59			
Disinhibition	Neg.	193	159.64	-5.64	.00**	.33
	Pos.	106	131.91			
Psychoticism	Neg.	217	167.99	-9.23	.00**	.53
	Pos.	83	104.78			

Note. Non-Invariant facets/domains in grey. Neg. = Negative Ranks (Portuguese results <

UAE results); Pos. = Positive Ranks (Portuguese results > UAE results); * $p < .05$;

** $p < .01$. Small effect $.10 < r \leq .30$; Medium effect size $.30 < r \leq .50$; High effect $r > .50$.

As for the UAE and Portuguese clinical samples, table 11 presents the 14 non-normal distributed facets and domain, along with the mean rank scores differences, Wilcoxon Signed-Rank test, and respective effect size coefficient. Similarly, to the community sample, also the UAE clinical sample presented higher and statistically significant results for most of the PID-5 facets and domain ($p < .05$), compared to the Portuguese sample. However, the effect size coefficients obtained were small ($.10 < r \leq .30$) for most part of the facets and domains. The exceptions were the facets Deceitfulness, Grandiosity, Irresponsibility, and the Antagonism domain, with medium effect sizes ($.30 < r \leq .50$). As for the variables with normal distribution in the clinical samples, as displayed in table 12, only the facets Distractibility, Hostility, Perseveration, Submissiveness and Withdrawal ($p < .05$), along with the Disinhibition and Psychoticism domains ($p < .01$) shown significant higher results in the

UAE clinical sample compared to the Portuguese, though with small effect sizes ($d \leq 0.28$).

As expected, the mean score values of the Emirati and the Portuguese clinical groups were higher than the community groups with medium ($0.20 < d \leq 0.50$) to very high effect sizes ($d > 1.0$).

Table 11

Wilcoxon Signed Ranks Test of the PID-5 scales in the clinical samples

PID-5 scales	Portugal vs. UAE					
	Ranks	<i>N</i>	Mean Rank	<i>z</i>	<i>p</i>	<i>r</i>
Anxiousness	Neg.	73	69.93	-0.35	.72	.03
	Pos.	67	71.12			
Attention seeking	Neg.	91	77.23	-3.61	.00**	.29
	Pos.	53	64.39			
Callousness	Neg.	84	73.38	-2.56	.01*	.21
	Pos.	56	66.18			
Cognitive and perceptual dysregulation	Neg.	84	79.35	-2.71	.01**	.22
	Pos.	61	64.26			
Deceitfulness	Neg.	89	76.83	-4.74	.00**	.39
	Pos.	47	52.73			
Depressivity	Neg.	82	80.36	-2.23	.03*	.18
	Pos.	65	65.98			
Eccentricity	Neg.	88	78.35	-2.65	.01**	.22
	Pos.	60	68.36			
Grandiosity	Neg.	98	75.57	-5.35	.00**	.44
	Pos.	41	56.70			
Intimacy avoidance	Neg.	76	76.82	-1.08	.28	.09
	Pos.	69	68.80			
Irresponsibility	Neg.	96	72.95	-5.31	.00**	.43
	Pos.	39	55.81			
Manipulativeness	Neg.	89	72.20	-3.48	.00**	.28
	Pos.	49	64.59			
Restricted affectivity	Neg.	90	73.66	-2.14	.03*	.17
	Pos.	58	75.80			
Risk taking	Neg.	81	74.29	-1.59	.11	.13
	Pos.	63	70.20			

Note. Neg. = Negative Ranks (Portuguese results < UAE results); Pos. = Positive Ranks

(Portuguese results > UAE results); * $p < .05$; ** $p < .01$. Small effect $.10 < r \leq .30$;

Medium effect size $.30 < r \leq .50$; High effect $r > .50$.

Table 11 (Cont.)*Wilcoxon Signed Ranks Test of the PID-5 scales in the clinical samples*

PID-5 scales	Portugal vs. UAE					
	Ranks	<i>N</i>	Mean Rank	<i>z</i>	<i>p</i>	<i>r</i>
Unusual beliefs and experiences	Neg.	84	78.38	-3.25	.00**	.27
	Pos.	57	60.12			
Antagonism	Neg.	102	81.57	-5.18	.00**	.42
	Pos.	47	60.74			

Note. Neg. = Negative Ranks (Portuguese results < UAE results); Pos. = Positive Ranks

(Portuguese results > UAE results); **p* < .05; ***p* < .01. Small effect .10 < *r* ≤ .30;

Medium effect size .30 < *r* ≤ .50; High effect *r* > .50.

Table 12

Dependent t-test results of the PID-5 facets and domains with normal distribution in the clinical samples.

PID-5 Scales	UAE		Portugal		<i>t-test</i>		
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>t-test</i>	<i>p</i>	<i>d</i>
Anhedonia	1.45	0.60	1.39	0.60	0.98	.33	0.08
Distractibility	1.49	0.58	1.33	0.64	2.11	.04*	0.17
Emotional Lability	1.68	0.65	1.57	0.68	1.46	.15	0.13
Hostility	1.44	0.71	1.17	0.65	3.39	.00**	0.28
Impulsivity	1.38	0.66	1.33	0.69	0.65	.52	0.05
Perseveration	1.43	0.62	1.27	0.56	2.25	.03*	0.19
Rigid Perfectionism	1.55	0.63	1.44	0.63	1.52	.13	0.13
Separation Insecurity	1.38	0.68	1.39	0.61	-0.11	.91	0.00
Submissiveness	1.35	0.67	1.14	0.67	2.8	.01*	0.23
Suspiciousness	1.43	0.48	1.43	0.51	0.02	.99	0.00

p* < .05, *p* < .01. Small effect *d* ≤ .20, medium effect size .20 < *d* ≤ .50, large .50 < *d*

≤ 1.0, and very large *d* > 1.0.

Table 12 (Cont.)

Dependent t-test results of the PID-5 facets and domains with normal distribution in the clinical samples.

PID-5 Scales	UAE		Portugal		<i>t-test</i>		
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>t-test</i>	<i>p</i>	<i>d</i>
Withdrawal	1.36	0.62	1.18	0.65	2.46	.02*	0.20
Negative affectivity	1.63	0.54	1.60	0.51	0.57	.57	0.05
Detachment	1.30	0.51	1.18	0.50	1.87	.06	0.15
Disinhibition	1.36	0.51	1.17	0.54	3.07	.00**	0.24
Psychoticism	1.20	0.58	0.98	0.56	3.30	.00**	0.27

* $p < .05$, ** $p < .01$. Small effect $d \leq .20$, medium effect size $.20 < d \leq .50$, large $.50 < d$

≤ 1.0 , and very large $d > 1.0$.

Discussion

The present manuscript addressed the applicability of the PID-5 for group comparisons across the Emirati and the Portuguese clinical and community populations. To draw valid inferences regarding the mean score differences across both countries, a MI study was previously conducted, which is a prerequisite for cross-cultural comparisons (Church et al., 2011; Eigenhuis et al., 2015).

Broadly, our findings have shown that all the PID-5 facets and domains can be properly compared across the Emirati and Portuguese clinical participants, but not entirely for the community participants, as just 15 of the 25 PID-5 facets, and three of the five domains proved partial invariance, from which only 13 facets, have proved strict invariance. Thus, considerable caution is needed in drawing conclusions from mean trait differences on the PID-5 non-invariant scales, as they may reflect potential cultural bias (Borsboom, 2006; Byrne, 2016; Guenole & Brown, 2014). More precisely, perhaps the two cultural/ethnic

groups may be attributing different meanings to the same set of items that comprises each facet or domain (Byrne & Watkins, 2003; Van de Vijver & Tanzer, 2004). Another possible explanation for these differences, could be that the general population has relatively low scores of pathological personality traits compared to the psychiatric population, which could prevent some dimensions of pathology from emerging in data from non-clinical groups (Morey & Glutting, 1994; Morey, 1997). The PID-5 is by nature a clinical measure (Wright et al., 2012) comprised by items such as: “Sometimes I think someone else is removing thoughts from my head.” (Item 192), “Sometimes I feel “controlled” by thoughts that belong to someone else.” (Item 154), or “Sometimes I can influence other people just by sending my thoughts to them.” (Item 150), that reflect the extreme end of personality dysfunction, so for that, it is more likely that clusters of maladaptive trait features emerge in the psychiatric populations, than among those who do not suffer from a mental disorder (Morey & Glutting, 1994, O’Connor, 2002).

Furthermore, it is quite common that the measurement error differs across clinical and non-clinical samples, particularly in scales assessing pathology, which impacts reliability coefficients in non-clinical groups (Bach et al., 2018) due to the presence of a limited number of individuals with high scores on maladaptive traits in the general population. In fact, although our results confirmed acceptable to good reliability coefficients across the Emirati and Portuguese clinical and non-clinical groups, for all the PID-5 domains and most of the facets, as previously reported (Al-Dajani et al., 2016; Zimmermann et al., 2019), the alphas of the community samples were lower than clinical samples, in both countries.

In this context, notwithstanding the importance of establishing MI, there is still little consensus on what minimum requirements would still grant practical and valid comparisons in cross-cultural personality research (Gregorich, 2006; Putnick & Bornstein, 2016).

Although ideally, strict MI should be proven to consider a measure invariant, a recent review study on personality invariance found that none of the 26 cross-cultural studies on personality assessment revised, demonstrated evidence of full scalar invariance (for a review see Dong & Dumas, 2020). Thus, some authors consider reasonable that instruments demonstrating at least partial strong invariance are suitable to establish unbiased group comparisons using personality measures (Van De Schoot et al., 2015). Concerning our results, we highlight the need for further research to address the lack of MI of some facets and domains in the community samples, as others international studies with the PID-5 have shown no such results (Aboul-Ata & Qonsua, 2020; Bach et al., 2018; Suzuki et al., 2019). Still, we might as well consider that variation of the PID-5 structure across countries and languages could more often reflect cultural variations, instead of simply structural non-invariance (Thimm et al., 2017).

Regarding the facets that shown partial invariance in the community samples, with the exception of Anxiousness and Emotional lability, all the facets presented higher mean scores in the Emirati group, though only Attention seeking, Deceitfulness, Grandiosity, Intimacy avoidance, and Manipulativeness presented medium to high effect sizes ($r > .40$). A plausible interpretation could be related with the tendency for collectivistic cultures, such as the Emirati, in adopting an acquiescent response style, which might have biased the results (He et al., 2014; Rammstedt et al., 2017). However, considering that each society develops structures that promote different personality developments and tailor unique functional patterns (Paris et al., 1998; Millon, 2020), perhaps we should only realize that the PID-5 is capturing traits of two different natures, that are not necessary undesirable, but simply mirror differences in how certain traits are cross-culturally promoted or suppressed (Kitayama et al., 1997). For instance, in traditional and family-oriented societies, certain features of

manipulativeness and deceitfulness, could serve as a social adaptative mean to avoid direct confrontation and a diplomatic way to solve every day social conflicts.

On the other hand, the popularity of the Western culture in the UAE, fast economic growth, and globalization, helped to create a hybrid identity, mainly among the new generations, which impacts personality functioning and consequently PDs (Al-Darmaki & Sayed 2009). The need for adjustment due to the acculturation process caused by the gap between the traditional and family-oriented social norms, of the Emirati society, and the European-American individualistic values and conventions (Pan & Wong, 2011; Togashi, 2007), might impose additional psychological challenges. If acculturation and multicultural co-existence, can ideally result in personal growth through a balanced integration of aspects from different cultures (Ronningstam et al., 2018), it can also cause substantial distress when personal expectations collide with family-related expectations and social demands. Such stress has been related with anxiety disorders, substance related disorders, and increased suicide risk (Ehlers et al., 2009; Van Leeuwen et al., 2010). In this context, slightly higher scores in facets related with the Antagonism domain, could mirror an adjustment process in response to new family structures, gender roles, job expectations and high educational levels, particularly among women, that have started to target leadership positions and deviate from more traditional female roles, usually linked to education or healthcare, in the Emirati society.

As for the psychiatric samples, the Emirati participants exhibited somehow higher results than the Portuguese participants, albeit the small effect size for most of the PID-5 scales. The noteworthy exceptions were Deceitfulness, Grandiosity, Irresponsibility, and the domain Antagonism, which could be mirroring relevant cultural differences, as they presented medium effect sizes ($p < .01$; $r \geq .39$). If we bear in mind that the Emirati and the Portuguese samples were closely matched based on diagnosis, these results may be

conceptually meaningful as they reveal cultural specificities in the intensity and expression of universal maladaptive traits across the Emirati and the Portuguese population, in clinical settings.

An important outcome of our findings could be related with the stigma associated with seeking professional mental health support in the Arab cultures. The fear of showing weakness or lack of faith, restrain some patients from seeking early treatment, which often happens in late stages of mental disorders (Al-Darmaki & Sayed, 2009). In such cases, the symptoms severity and the level of impairment is already high, which directly impacts treatment, and prognosis. Considering the dimensionality of mental disorders, and specifically of PD, our results might be explained by differences in the level of severity of the two clinical samples.

Moreover, as expected clinical groups' mean scores were higher than the community groups in the Emirati and in the Portuguese samples, confirming the PID-5 utility to distinguish between clinical and non-clinical individuals.

The present study has several strengths and limitations, mostly related with our sample's composition. The major strengths were the inclusion of closely matched community and clinical samples of both countries, as well as the exclusion of non-Emirati participants, to overcome possible cultural bias, due to the high number of expats living in the UAE. On the other hand, as community and clinical samples were composed by uneven proportions of men and women, with a strong predominance of women in the community samples, *Cohen's d* was calculated to determine gender effect sizes. Only very small effect sizes ($d < 0.20$) were found in some facets and domains in both countries and samples. Therefore, gender effect sizes did not seem to directly impact our results. However, our findings should be considered in light of some limitations, specifically, the young age of our participants, the high number

of college students in the community samples, along with the predominance of substance related disorder diagnosis in the clinical samples. Finally, the community samples were not screened for psychopathology.

Conclusions

The present study supports the PID-5 measurement invariance across the Emirati and Portuguese clinical samples pointing to the universality and generalizability of the Alternative Model of Personality Disorders trait model. Nevertheless, future research should examine the applicability of the PID-5 across representative samples of the UAE and Portugal, as well as extending our study comparisons to other Arabic and Portuguese speaking countries.

Capítulo III – Discussão Integrada e Considerações Finais

3. Discussão Integrada e Considerações Finais

Esta tese foca-se em três pontos fulcrais:

I - Será a versão árabe do PID-5 uma medida precisa e válida para identificar a presença e medir a severidade de traços desadaptativos de personalidade na população dos EAU?

II - Será o PID-5 uma medida útil para distinguir grupos clínicos de não-clínicos na população emeritense?

III - Serão as versões árabe e portuguesa do PID-5 equivalentes, permitindo desta forma comparar estas duas populações e extrapolar conclusões sobre a eventual influência da cultura nos resultados?

Para dar resposta a estas questões, desenvolvemos um projeto de investigação inovador e desafiante, que procurou em última análise alargar as fronteiras do estudo da personalidade e das suas perturbações à cultura emeritense dos EAU, de forma a que esta população possa dispor de instrumentos de avaliação psicológica empiricamente válidos e clinicamente úteis. Neste capítulo final iremos apresentar as principais conclusões e de que modo os diferentes resultados se relacionam e abrem caminho para estudos futuros.

De um modo geral os estudos de precisão que desenvolvemos com o PID-5 (Estudo 1, 2 e 3), revelaram indicadores de consistência interna medidos através do alpha de Cronbach, de aceitáveis a bons ao nível das facetas e dos domínios, à semelhança dos resultados encontrados na maior parte dos estudos com o PID-5 (para uma revisão mais detalhada ver Al-Dajanie et al., 2016 e Zimmermann et al., 2019). As amostras clínicas revelaram consistentemente coeficientes mais elevados do que as amostras comunitárias (Estudos 2 e 3), o que poderá estar relacionado com a presença de um número reduzido de indivíduos com

pontuações elevadas nos traços desadaptativos de personalidade na população geral. Esta particularidade dá origem a diferenças no erro de medição dos vários grupos (clínicos e não-clínicos) e tem impacto direto nos coeficientes de consistência interna das amostras comunitárias (Bach et al., 2018). No entanto algumas facetas requerem mais estudos, em particular a Afetividade restrita, a Irresponsabilidade, a Manipulação, a Submissão e a Suspeição, porque apresentaram coeficientes de consistência interna muito reduzidos nos diferentes estudos e amostras, em conformidade com resultados encontrados por outros autores (Roskam et al., 2015; Rowiński et al., 2019; Van den Broeck et al., 2014). No caso da tradução árabe do PID-5, estes valores de alfa de Cronbach mais baixos podem estar relacionados com diferenças culturais e linguísticas no tipo de expressões idiomáticas utilizadas na construção dos itens, e até com diferentes interpretações do seu grau de severidade (Ghazala, 2002; McCrae, 2013; Van de Vijver & Leung, 1997). A utilização de expressões ocidentais, como por exemplo: “*cold fish*,” “*raw deal*,” ou “*skipped town*” em alguns itens do PID-5 (e.g., 8, 133, 171) coloca dificuldades adicionais à tradução deste instrumento de avaliação, sobretudo na língua árabe (Ghazala, 2002), na qual este tipo de expressões é apenas utilizado na linguagem quotidiana e nas variantes vernaculares, como referimos na introdução deste trabalho.

Ainda no que concerne à precisão do PID-5, mas no que respeita à estabilidade temporal teste-reteste, analisada no Estudo 1, a medida revelou bons indicadores de estabilidade temporal num intervalo de quatro semanas, com coeficientes de correlação entre .79 ($p < .01$) no domínio Desprendimento e .92 ($p < .01$) no domínio Antagonismo. Já ao nível das facetas, os coeficientes variaram entre .73 ($p < .01$) na Afetividade restrita e .94 ($p < .01$) na Procura de atenção. Tendo em conta que uma das críticas apontadas à classificação categorial das PP é a instabilidade diagnóstica destas perturbações, os nossos resultados, concordantes com os de Pires et al. (2017), Wright et al. (2015) e Zimmermann et al. (2017),

apontam para a estabilidade temporal dos traços de personalidade descritos no MAPP, e sustentam a transição deste modelo para a classificação oficial das PP.

Quanto aos estudos de convergência da tradução árabe do PID-5 com outros instrumentos de avaliação psicológica, no Estudo 1 analisámos a convergência do PID-5 com uma medida de traços de personalidade, a versão árabe do NEO-FFI, e no Estudo 2 com uma medida de dimensões de sintomas psicopatológicos, a versão árabe da SCL-90-R. Tal como esperado, e tendo em conta a literatura que sugere que as dimensões do PID-5 podem ser consideradas variantes desadaptativas dos cinco domínios que definem o funcionamento da personalidade normal (Anderson et al., 2013; Gore & Widiger, 2013; Krueger & Markon, 2014; Skodol et al., 2011; Widiger & Trull, 2007), os nossos resultados confirmaram padrões relacionais que apontam também no sentido de uma continuidade entre a personalidade normal e a patológica, dado que obtivemos relações significativas entre todos os domínios do PID-5 e os do NEO-FFI. Porém, a relação entre a Abertura à experiência e o Psicoticismo é menos forte, à semelhança de estudos anteriores (e.g., Crego et al., 2018; Thomas et al., 2013).

Esta relação menos forte poderá estar ligada ao reduzido número de termos disponíveis no MCF para descrever a Abertura à experiência (McCrae, 1990; Saucier, 1997), e neste caso, o PID-5 pode não estar a medir o extremo desadaptativo da mesma variável latente que os itens da Abertura à experiência, enquanto as outras quatro dimensões medem claramente o mesmo construto nos dois instrumentos (Suzuki et al., 2015). Por outro lado, e como já foi mencionado no Capítulo I (pág. 22 a 25) tendo em conta que a Abertura à experiência medida pelo NEO-FFI é composta pelas facetas Abertura e Intelecto, o domínio Psicoticismo pode não estar relacionado com a Abertura à experiência, enquanto dimensão global (Chmielewski et al., 2014), mas, em vez disso representar uma variante desadaptativa específica da faceta Abertura (DeYoung et al., 2016).

Relativamente à convergência das escalas do PID-5 com as constelações de sintomas da SCL-90-R, e em consonância com estudos anteriores (e.g., Dunne et al., 2018; Skjernov et al., 2020), os nossos resultados demonstraram evidências de que os traços desadaptativos de personalidade estão intimamente ligados com as diversas perturbações mentais. Os domínios Afetividade negativa, Desprendimento, Desinibição e Psicoticismo mostraram relações diretas com todas as escalas da SCL-90-R, assim como o domínio Antagonismo com nove das suas escalas. No que respeita às facetas do PID-5, observaram-se relações fortes com as escalas homólogas da SCL-90-R, sobretudo no caso das escalas de Depressão e Hostilidade. Face ao exposto, concluímos que o PID-5 revelou bons indicadores de validade convergente na população emeritense, o que contribui para a relevância deste instrumento na avaliação de traços desadaptativos nos EAU.

Outro aspeto determinante para a validação de um inventário de personalidade é a replicação da sua estrutura fatorial em diferentes culturas e línguas.

A literatura acerca do PID-5 tem confirmado uma estrutura de cinco fatores nas muitas traduções existentes (para uma revisão detalhada ver os estudos de meta-análise de Somma et al., 2019; Watters & Bagby, 2018; Zimmermann et al., 2019) quer ao nível de países ocidentais quer dos não-ocidentais. Porém, as amostras emeritenses evidenciaram algum afastamento do modelo no que respeita ao padrão fatorial de algumas facetas (Estudo 1 e 2) e ao número de fatores encontrados (Estudo 2). O estudo desenvolvido com a população comunitária emeritense (Estudo 1) revelou uma estrutura fatorial composta por cinco fatores, dos quais quatro se assemelham à Afetividade negativa, Antagonismo, Desprendimento e Desinibição, apesar do padrão desviante de algumas facetas, em particular no quinto fator. Este último, composto pelas facetas Crenças ou experiências incomuns, Grandiosidade e Perfeccionismo rígido, assemelha-se a uma conjugação imperfeita do quinto (Esquizotípico) e sexto (Compulsivo) domínios, inicialmente propostos no MAPP (Skodol et al., 2011). Esta

formulação inicial veio a sofrer alterações por via de subsequentes análises fatoriais, que evidenciaram grandes semelhanças entre alguns dos traços que compunham o modelo (Krueger et al., 2012) e destes dois domínios, apenas o domínio Esquizotípico ficou retido passando a designar-se por Psicoticismo. Atendendo a que as facetas Desregulação cognitiva e perceptual e Excentricidade saturaram secundariamente neste fator, podemos considerar que se assemelha ao domínio Psicoticismo. De facto, este domínio tem-se revelado bastante heterógeno e até ausente da estrutura fatorial de alguns estudos em grupos clínicos e não-clínicos (Adhiatma et al., 2014; Bach et al., 2019; Pires et al., 2019). Em termos conceptuais, o padrão desviante das facetas que compõem o domínio Psicoticismo, e também o dos restantes domínios do PID-5, na população emeritense, parece refletir especificidades culturais na forma como os traços de personalidade se manifestam e são interpretados (Church et al., 2011; Eigenhuis et al., 2015; Sorrel et al., 2021). A este propósito, dois estudos realizados com o NEO-FFI em amostras árabes do Kuwait e do Egito apresentaram uma estrutura fatorial desviante da original, composta apenas por três (Alansari, 1997) ou quatro (Latzman et al., 2015) dos cinco domínios que compõem o MCF. Tendo em conta que, como já referimos, os domínios do PID-5 podem ser conceptualizados como extremos desadaptativos do MCF, seria de algum modo expectável que os seus extremos psicopatológicos apresentassem também uma estrutura fatorial atípica, tendo em conta a proximidade cultural e linguística entre as amostras estudadas e a amostra da população emeritense.

Já no se refere ao estudo da população clínica emeritense (Estudo 2), e à semelhança dos resultados encontrados por Pires e colaboradores (2019), a estrutura fatorial do PID-5 não foi inteiramente replicada, na medida em que, em vez de cinco, apenas quatro dos cinco fatores ficaram retidos. Estes quatro fatores assemelham-se à Afetividade negativa,

Antagonismo, Desprendimento e Psicoticismo, embora o padrão fatorial das suas facetas também se afaste do modelo original.

O domínio Desinibição não emergiu e as suas facetas saturaram conjuntamente no primeiro fator, que se assemelha ao Antagonismo.

Tendo em conta que o domínio Antagonismo é uma dimensão central do narcisismo e por conseguinte da perturbação narcísica da personalidade (Lynam & Miller, 2019), esta inesperada conjugação de facetas no fator Desinibição/Antagonismo poderá ser explicada pelo facto de alguns indivíduos com traços narcísicos de personalidade, para além de apresentarem pontuações elevadas nos traços de Grandiosidade, Insensibilidade e Manipulação, poderem também ser impulsivos, no sentido em que a impulsividade lhes proporciona maior destaque social, e até tornar-se hostis e desconfiados em relação às intenções e comportamentos dos outros (Hopwood et al., 2013). Por outro lado, de um ponto de vista psicopatológico, este fator reúne características típicas das PP antissocial, estado limite e narcísica, da Secção II do DSM-5, que podem estar relacionadas com a composição da amostra, atendendo aos elevados indicadores de comorbilidade entre estas PP e as perturbações da ansiedade, depressivas e de uso de substâncias (Sperandeo et al., 2020), que correspondem à maioria dos perfis diagnósticos da nossa amostra clínica.

Para além deste, também o segundo fator revelou um padrão atípico de saturação, muito idêntico ao encontrado na amostra comunitária (Estudo 1) e que poderá ser considerado semelhante ao domínio Psicoticismo. Face a estas evidências, a combinação de fatores e facetas encontrada na amostra clínica parece identificar constelações de traços de personalidade que caracterizam as perturbações mentais dos pacientes que a compõem, mais do que uma estrutura universal da personalidade.

Em suma, os resultados da estrutura fatorial do PID-5 na amostra comunitária da população emeritense vêm demonstrar que este inventário é um instrumento adequado para avaliar traços desadaptativos de personalidade, no entanto, são ainda necessários mais estudos para que possamos caracterizar a estrutura fatorial da sua versão árabe em amostras clínicas dos EAU.

Foi também objetivo deste projeto de investigação proceder à comparação transcultural de dois países, um ocidental (Portugal) e outro do médio-oriente (EAU), através do PID-5. Para alcançar este objetivo, realizou-se previamente um estudo de invariância desta medida em amostras comunitárias e clínicas de ambos os países.

Tal como descrito nos capítulos anteriores, para que possamos utilizar o PID-5 na comparação de grupos culturalmente distintos é necessário, em primeiro lugar, garantir que os itens que o compõem são entendidos do mesmo modo pelos grupos que pretendemos comparar (Church et al., 2011; Eigenhuis et al., 2015; Sorrel et al., 2021). Só desta forma podemos analisar possíveis diferenças à luz de especificidades culturais, ao invés de enviesamentos de natureza metodológica (e.g., Dong & Dumas, 2020; Jeong & Lee, 2019). Assim, através da análise de invariância, ou equivalência, do PID-5 e utilizando um software específico, o IMINCE (Lorenzo-Seva & Ferrando, 2003), verificámos que o PID-5 é invariante na população clínica emeritense e portuguesa, permitindo-nos realizar comparações empiricamente válidas entre grupos clínicos destes dois países, culturalmente distintos, e eventualmente, no futuro, estender a comparação dos resultados obtidos com o PID-5 árabe a outros países ocidentais.

No entanto, na amostra comunitária, apenas 15 das 25 facetas provaram invariância escalar parcial, das quais só 13 possuem invariância estrita (métrica e escalar). Tendo em conta que a invariância escalar parcial é o requisito mínimo para que possamos comparar traços de personalidade em grupos culturalmente distintos (Bach et al., 2017; Dong & Dumas, 2020), a

equivalência das versões árabe e portuguesa do PID-5 na população geral não foi inteiramente demonstrada.

Perante estes resultados propomos duas possíveis explicações: por um lado, é provável que a população emeritense tenha atribuído significados diferentes aos itens que compõem cada umas das facetas e domínios do PID-5 (Byrne et al., 2003; Van de Vijver & Tanzer, 2004), e por outro, poderá dever-se a características próprias das amostras da população geral, que pela sua natureza podem impedir que algumas dimensões psicopatológicas possam emergir. Como já referimos, o PID-5 é fundamentalmente uma medida clínica (Wright et al., 2012) composta por itens como: *“Sometimes I think someone else is removing thoughts from my head.”* (Item 192), *“Sometimes I feel “controlled” by thoughts that belong to someone else.”* (Item 154), or *“Sometimes I can influence other people just by sending my thoughts to them.”* (Item 150), que refletem dificuldades extremas no funcionamento da personalidade. Deste modo, é mais provável que surjam agrupamentos de traços desadaptativos nas populações psiquiátricas, do que entre aqueles que não têm diagnóstico de perturbação mental (Morey & Glutting, 1994; O’Connor, 2002).

Neste contexto da análise dos estudos de invariância, realçamos a utilidade da versão árabe do PID-5 para efetuar comparações fidedignas entre grupos clínicos culturalmente diferenciados, no entanto colocam-se algumas reservas no que respeita à utilização das facetas não-invariantes para realizar comparações em grupos da população geral, já que estas estão mais sujeitas a enviesamentos culturais e metodológicos (Borsboom, 2006; Byrne, 2016; Guenole & Brown, 2014).

Por último, destacamos os principais resultados obtidos nos estudos comparativos que realizámos com o PID-5 ao longo deste projeto. Especificamente: a) o estudo comparativo relativo aos traços desadaptativos entre a amostra comunitária emeritense e a amostra original (Krueger et al., 2012), na qual o PID-5 foi inicialmente desenvolvido (Estudo 1); b) o estudo

comparativo entre grupos clínicos e não clínicos da população emeritense (Estudo 2); e o c) estudo transcultural comparativo das amostras comunitárias e clínicas dos EAU e de Portugal (Estudo 3).

De um modo geral, as amostras comunitárias e clínicas emeritenses revelaram resultados médios significativamente mais elevados quando comparadas com as amostras ocidentais (estadunidense, no Estudo 1 e portuguesa, no Estudo 3). No Estudo 1, as facetas Desregulação perceptual e cognitiva e o domínio Antagonismo revelaram efeitos de grandes dimensões ($d \geq 0.90$), na comparação entre os resultados médios obtidos pela amostra emeritense e os da amostra original do PID-5. Todavia, os resultados médios apresentados, apesar de mais elevados do que os da amostra original, são próximos dos alcançados por Al-Attiyah et al. (2017), talvez explicados pela maior proximidade cultural das amostras do médio-orientes. O estilo de resposta das amostras árabes poderá refletir fatores situacionais ou especificidades culturais e vem questionar se um determinado valor numérico, obtido num inventário de personalidade, poderá representar o mesmo valor absoluto em culturas diferentes (McCrae, 2013; Van de Vijver, 1997).

Já no que toca à comparação de amostras emparelhadas, clínicas e não clínicas, da população emeritense (Estudo 2), a versão árabe do PID-5 revelou-se particularmente útil para distinguir grupos clínicos e não clínicos, dado que a amostra clínica apresentou resultados médios mais elevados e estatisticamente significativos em 20 das 25 facetas ($p < .001$) e em quatro dos domínios superiores ($p < .001$), quando comparados com a amostra comunitária. Não obstante, o domínio Antagonismo e duas das suas facetas, Grandiosidade e a Manipulação, revelaram um efeito de reduzida dimensão ($\leq .30$), que, na população geral, poderá estar relacionado com a tendência para responder de um modo socialmente desejável e para concordar com os itens independentemente do seu conteúdo, dado os elevados indicadores de desejabilidade social em culturas coletivistas, como a emeritense (Bernardi,

2006; Mahmood et al., 2015; Van Hemert et al., 2002). Outro aspeto a realçar é o facto de o confronto direto ser mal-aceite e sempre que possível evitado na cultura árabe dos EAU, recorrendo-se muitas vezes à utilização de expressões ambíguas como “*Inshallah*” que significa “se essa for a vontade de Deus”, em vez de respostas diretas do tipo sim/não, perante questões relacionadas com a disponibilidade para atender a um determinado pedido ou realizar uma tarefa. Esta prática é uma maneira diplomática e socialmente aceite de “manipular” o outro, através de um sentimento de incerteza face ao que é esperado, evitando assim possíveis conflitos sociais.

Não menos relevante para contextualização dos resultados da população geral é o elevado estatuto social conferido aos cidadãos de nacionalidade emiritense, que lhes permite aceder a um conjunto importante de direitos, regalias e até compensações governamentais, totalmente inacessíveis à comunidade expatriada, que representa a maioria dos habitantes dos EAU. Existem, por assim dizer, os direitos dos cidadãos emiritenses e os dos restantes cidadãos autorizados a viver no país, o que confere aos primeiros um sentido de superioridade e até “grandiosidade”, enquanto descendentes diretos do “Pai da Nação”, nome dado ao fundador dos EAU (um dos países com maior índice de riqueza do mundo) e que unificou os sete emirados que o compõem (Zahlan, 1978).

Noutra perspetiva, se considerarmos os resultados médios das facetas Anedonia, Depressividade e Labilidade emocional (facetas associadas à internalização) conjuntamente com as percentagens de perturbações depressivas e da ansiedade da amostra clínica, talvez a faceta Grandiosidade esteja a captar aspetos relacionados com características do narcisismo vulnerável (enquanto extremo inferior e internalizante da Grandiosidade) dos pacientes, em vez de sentimentos de superioridade (relacionados com o extremo superior e externalizante da Grandiosidade) (Lynam & Miller, 2019; Miller et al., 2016, 2017). Igualmente relevante para explicar estes resultados na amostra clínica, é o papel do domínio Antagonismo e das

facetras que o compõem, enquanto dimensões fortemente relacionadas com o uso de substâncias (e.g., Lynam & Miller, 2019), na medida em que as perturbações relacionadas com substâncias e perturbações aditivas representam o diagnóstico mais frequente dos participantes da amostra psiquiátrica (35.3%).

Importa ainda lembrar que a existência de elevações dos traços desadaptativos do PID-5 não sinaliza necessariamente a presença de uma PP, mas apenas diferentes graus de manifestações dimensionais da personalidade (Bach et al., 2017; Skodol et al., 2011), dado que o diagnóstico das PP, segundo o MAPP, é feito com base no grau de severidade dos défices no funcionamento da personalidade e na presença de traços desadaptativos (APA, 2013).

Quanto aos estudos transculturais comparativos, e atendendo aos resultados obtidos através da análise de invariância, a comparação das escalas do PID-5 que obtiveram invariância escalar parcial nas amostras comunitárias dos EAU e de Portugal revelou resultados médios mais elevados no grupo emeritense, embora apenas as facetras Procura de atenção, Falsidade, Grandiosidade, Evitamento da intimidade e Manipulação tenham apresentado efeitos de dimensão média a elevada ($r > .40$). Estes resultados devem ser analisados à luz das diferenças no modo como cada sociedade molda o desenvolvimento de determinados tipos de funcionamento da personalidade (Paris, 1998; Millon & Davis, 2000). O PID-5 poderá simplesmente estar a captar traços de personalidade que em determinadas culturas poderão não ser necessariamente desadaptativos, mas apenas refletirem o modo como certas características da personalidade são suprimidas ou promovidas (Kitayama et al., 1997). Tal como já referimos, alguns aspetos das facetras invariantes, nomeadamente a Manipulação e a Falsidade, podem constituir um meio adaptativo de resolver pequenos conflitos sociais da vida quotidiana.

No entanto, a popularidade da cultura ocidental nos EAU, o rápido crescimento económico e a globalização ajudaram a criar uma identidade híbrida, sobretudo entre as novas gerações, com impacto no funcionamento da personalidade e consequentemente nas suas perturbações (Al Darmaki & Sayed, 2009). A necessidade de ajustamento devido ao processo de aculturação promovido pela distância entre as normas sociais tradicionais da sociedade emirita e a importação de valores, convenções e até ideais de beleza das sociedades europeias e estadunidense colocam desafios psicológicos acrescidos (Pan & Wong, 2011; Togashi, 2007). Idealmente, a coexistência multicultural e o processo de aculturação resultam na integração equilibrada, por parte dos indivíduos, de características das diferentes culturas (Ronningstam et al., 2018), porém podem também dar origem a dificuldades psicológicas acrescidas, sobretudo quando as expectativas individuais colidem com as exigências sociais e familiares. Alguns estudos têm demonstrado relações importantes entre estas dificuldades e o desenvolvimento de perturbações da ansiedade, uso de substâncias e até aumento do risco de suicídio (Ehlers et al., 2009; Van Leeuwen et al., 2010). Neste contexto, resultados mais elevados em facetas relacionadas com o domínio Antagonismo, na população geral dos EAU, podem espelhar um processo de ajustamento em resposta às novas estruturas familiares, papéis sociais em função do género e expectativas profissionais, bem como ao aumento dos níveis de escolaridade, em particular entre as mulheres, que só recentemente começaram a ocupar posições de liderança, em vez dos tradicionais papéis ligados ao ensino, cuidados de saúde, e tarefas domésticas.

A título de exemplo, nos últimos dez anos o recurso à cirurgia estética tem vindo a aumentar significativamente no médio-orient. Atualmente, o número de cirurgias estéticas, por habitante no Dubai, ultrapassa países como os EUA e o Brasil (Dubai Health Authority, 2019). A necessidade de corresponder aos ideais de beleza ocidentais talvez possa explicar a procura deste tipo de procedimentos e de algum modo contribuir para o aumento dos

resultados médios das facetas do PID-5 ligadas às PP narcísica (Procura de atenção, Falsidade, Grandiosidade e Manipulação) e obsessivo-compulsiva (Evitamento da intimidade) da população geral. Estes traços, têm sido também identificados como os mais comuns entre as pessoas que recorrem à cirurgia estética no médio-oriente (Belli et al., 2013; Golshani et al., 2015; Zojaji et al., 2014).

Porém, ainda que a relação entre o recurso à cirurgia estética e a presença de determinadas características de personalidade não possa ser inteiramente justificada com base nas diferenças de médias em questionários de autorrelato, não apenas por razões éticas, mas também metodológicas, vem em última análise materializar as palavras de Marsella (2005):

The importation of popular Western culture to Middle Eastern cultures becomes more than “harmless” importation of clothing, food, and entertainment, it becomes a threat to a traditional fabric of life rooted within a culturally constructed reality embedded in a religion that penetrates all aspects of daily life and behaviour. (p. 657)

No que respeita à comparação transcultural das amostras psiquiátricas dos EAU e de Portugal, os pacientes emeritenses obtiveram também resultados médios mais elevados do que os portugueses, embora estas diferenças sejam pouco relevantes, dado o pequeno efeito obtido na maioria das escalas do PID-5 ($p < .01$; $r \geq .39$). Contudo, se considerarmos que as amostras clínicas, emeritense e portuguesa, foram emparelhadas com base no diagnóstico, estes resultados podem ser conceptualmente significativos, na medida em que revelam especificidades culturais na intensidade e expressão de traços desadaptativos universais, em contexto clínico, destas duas populações. Um outro dado relevante para a leitura das diferenças encontradas nas duas amostras poderá estar ligado ao estigma social associado à procura de serviços de saúde mental, na cultura árabe. O medo de demonstrar fraqueza ou falta de fé leva alguns pacientes a procurar tardiamente ajuda psicológica ou psiquiátrica

profissional (Al-Darmaki & Sayed, 2009) com repercussões importantes no tratamento e até no prognóstico da doença. Considerando a dimensionalidade das perturbações mentais, e em particular das PP, os nossos resultados podem indicar diferenças nos níveis de severidades destas perturbações, sendo mais elevados na amostra clínica emeritense.

Em termos globais, os estudos realizados com as amostras comunitárias e clínicas da população dos EAU e de Portugal, vêm evidenciar diferenças culturais acentuadas no modo como o domínio Antagonismo e as suas facetas, sobretudo Grandiosidade, Falsidade e Manipulação, são interpretadas pela população emeritense em relação à população portuguesa, e por extrapolação, a outras culturas ocidentais. Nos três estudos que desenvolvemos, colocámos diversas hipóteses explicativas que, em última análise, denotam que cada sociedade possui uma conceptualização específica do que é o desenvolvimento saudável da personalidade e das manifestações das suas perturbações. Se na cultura portuguesa o recurso à ajuda médica especializada é comum, na sociedade emeritense as dificuldades da personalidade são em primeiro lugar um assunto de família, e é esta quem dita o recurso aos serviços de saúde mental.

Cada sociedade possui sistemas próprios de controlo comportamental, que regem o que é considerado aceitável ou uma ameaça aos padrões normativos instituídos (Paris, 1998; Ronningstam et al., 2018; Triandis & Sue, 2002), mas que simultaneamente conferem mecanismos de proteção, que suprimem vulnerabilidades psicobiológicas (Ronningstam et al., 2018) contribuindo para a prevenção do desenvolvimento de características típicas das PP (e.g., Desregulação emocional). Em países como os EAU, a coexistência multicultural pode fragilizar a ação destes mecanismos de proteção e contribuir para a manifestação de um maior grau de psicopatologia da personalidade na população emeritense.

Cabe assim aos clínicos e aos investigadores da personalidade, o desenvolvimento de estudos transculturais que contribuam para o desenvolvimento de modelos de classificação, avaliação e tratamento das PP, clínica, empírica e culturalmente sensíveis, que para além das diferenças culturais mais evidentes, possam também captar subjetividades e idiosincrasias menos óbvias, mas igualmente relevantes para dar uma resposta eficaz a todos aqueles que sofrem de uma PP, ainda que pertençam a populações ou a culturas não ocidentais.

3.1. Limitações dos estudos

Ao longo da presente tese salientámos algumas das vantagens e potencialidades do PID-5 na identificação de traços patológicos de personalidade e a sua relevância enquanto instrumento de auxílio ao diagnóstico das PP em culturas ocidentais e não-ocidentais. Não obstante, seguidamente apresentamos algumas limitações de natureza metodológica, bem como possíveis direções para estudos futuros.

As limitações deste trabalho estão fortemente relacionadas com a composição das amostras em estudo. A opção de estudar exclusivamente a população emeritense permitiu, por um lado, recolher dados acerca de uma população pouco estudada e por outro, prevenir possíveis enviesamentos culturais causados pela inclusão de indivíduos de expressão árabe de outras nacionalidades. A utilização de amostras emparelhadas (Estudo 2 e 3), clínicas e não clínicas, da população emeritense e de Portugal, permitiu-nos também realizar comparações mais equilibradas do ponto de vista das características da amostra e menos suscetíveis a enviesamentos metodológicos. No entanto, nos três estudos desenvolvidos foram utilizadas apenas amostras de conveniência, o que constitui uma limitação importante. Além disso, as amostras comunitárias dos EAU (Estudo 1 e 3) são maioritariamente compostas por jovens estudantes universitários do género feminino, com um elevado grau de ensino e estatuto socioeconómico. Não obstante, o estudo do impacto do género nos resultados, no Estudo 3,

sugeriu que o género, não parece ($d < 0.20$) ter efeitos diretos nos nossos resultados. Ainda no que concerne às amostras comunitárias, a inclusão de elementos da população geral relacionados com as estudantes (familiares e amigos) representa também uma limitação, assim como o facto dos participantes não terem sido rastreados quanto à presença de psicopatologia.

Relativamente às amostras clínicas (Estudo 2 e 3), a predominância do diagnóstico de perturbações relacionadas com substâncias e aditivas, a severidade dos diagnósticos e as múltiplas comorbilidades, sobretudo dos pacientes internados, representam uma limitação significativa deste trabalho.

3.2. Propostas para estudos futuros

Atendendo às grandes semelhanças entre os principais modelos dimensionais de classificação e diagnóstico das PP, nomeadamente, o MAPP da Secção III do DSM-5 (APA, 2013) e o qualificador de traços de personalidade da mais recente edição da Classificação Internacional de Doenças – CID (OMS, 2022), instrumentos inicialmente desenvolvidos para avaliar o MAPP, como o PID-5, têm vindo a ser utilizados para operacionalizar ambos os modelos, e até para estudar a validade das novas medidas desenvolvidas para avaliar o modelo de personalidade do CID -11 (Oltmans & Widiger, 2018; 2020). Embora estes dois modelos partilhem quatro dos cinco domínios que os compõem, nomeadamente Afetividade negativa, Desprendimento, Antagonismo/*Dissociality* e Desinibição, apresentam também diferenças importantes, das quais se destaca a inclusão do domínio Anancástico/Obsessivo-compulsivo no CID-11, bem como a exclusão do domínio Psicoticismo. Estas diferenças dificultam o papel dos clínicos sempre que estes têm de alternar na utilização das duas nomenclaturas na descrição dos seus pacientes, sobretudo em países como os EAU, cuja classificação oficial é o CID-11, mas em que grande parte das instituições de saúde mental

privadas utilizam o DSM-5. Neste sentido, a harmonização dos dois sistemas de classificação das PP é uma necessidade e um objetivo futuro para o qual já estão a ser dados passos, nomeadamente, na utilização de instrumentos que derivam do PID-5 e que permitem caracterizar as PP à luz dos dois modelos (Pires et al., 2021). Exemplo disso é o PID5BF+M que para além de visar uma avaliação parcimoniosa da personalidade permite dar resposta à necessidade de harmonizar os dois modelos dimensionais (o qualificador de traços do CID-11 e o MAPP). Este instrumento é composto por 36 itens que avaliam 18 facetas e seis domínios superiores (Afetividade Negativa, Desprendimento, Antagonismo, Desinibição, Anancástico/Obsessivo-compulsivo e Psicoticismo), e deriva de uma tentativa anterior de criar um algoritmo que avaliasse ambos os modelos, o PID-5BF+ (Kerber et al., 2020). A proposta de Bach et al. (2020) veio dar resposta a algumas das limitações identificadas no PID-5BF+, nomeadamente a incapacidade para captar o domínio Anancástico/Obsessivo-compulsivo. Através de estudos internacionais desenvolvidos com dezasseis amostras, o PID-5BF+M veio demonstrar ser uma medida adequada para avaliar os seis domínios superiores, incluindo o domínio Anancástico/Obsessivo-compulsivo, e as 18 facetas que o compõem (Bach et al., 2020).

Com base nestes dados e no sentido de dar continuidade a este projeto de investigação propomo-nos desenvolver a versão árabe do PID-5BF+M, com base na versão árabe do PID-5, no sentido de determinar o seu potencial e avaliar a sua adequação na população emeritense. Esta versão reduzida, poderá até vir a sobrepor-se à forma original, contribuindo para a investigação acerca dos modelos dimensionais de classificação das PP, na população emeritense, e como instrumento válido e útil na prática clínica.

Ainda no que se refere à utilização do PID-5 na prática clínica, para além dos desafios que já referimos (extensão e tempo de aplicação), acrescem ainda a falta de escalas de validade que permitam identificar enviesamentos nas respostas (Hopwood & Sellbom, 2013),

e também alguma controvérsia em torno dos pontos de corte, no que respeita à determinação do grau de severidade dos traços desadaptativos (Al-Dajani et al., 2016). Atendendo a que segundo o MAPP, a elevação na pontuação de traços desadaptativos é fundamental para determinar a presença de uma das seis PP retidas, esta tarefa torna-se especialmente difícil atendendo à ausência de valores normativos e ao reduzido número de estudos desenvolvidos a respeito dos pontos de corte em diferentes países e culturas (e.g., Miller et al., 2022; Samuel et al., 2013; Waugh et al., 2017). Neste sentido, com base nos estudos que desenvolvemos com a população comunitária e clínica emeritense procuraremos padronizar os resultados obtidos nos EAU e assim obter normas para a interpretação local do PID-5. Através da análise de curvas de ROC (*Receiver Operating Characteristic*) propomo-nos ainda a determinar os pontos de corte do PID-5, que conduzem à melhor sensibilidade e especificidade da medida nos EAU.

3.3 Considerações finais

A presente tese concluiu que a versão árabe do PID-5 é uma medida precisa, válida e clinicamente útil para medir a presença e severidade de traços desadaptativos do MAPP na população emeritense, bem como para efetuar comparações transculturais com a população portuguesa principalmente em amostras clínicas.

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Apêndice A

General Population Informed Consent Form

(Consentimento informado da população geral em árabe e inglês)

INFORMED CONSENT FORM

My name is Olga Coelho, and I'm currently working on a research project in Clinical Psychology, from The Lisbon University's doctorate course in Clinical Psychology, coordinated by Professor Bruno Gonçalves.

The scope of this study it is focused on Personality and Psychopathology.

In a first stage, I would like to ask for your volunteer participation by answering to (3) questionnaires. There are no "right" or "wrong" answers. What matters is that they should reflect your own experience. Your participation on this study it will take approximately 60 minutes. Please be aware that if you decide to participate, you may stop doing so at any time and you may also decide not to answer to any specific question(s).

In a second stage I would also ask you to collect from your relatives or friends (*excluding college students*), aged 30 years old or above, a male and a female, both UAE national, the answers to this same questionnaire.

The data collected will be analyzed and presented with total confidentiality and destroyed at the end of this investigation. If you wish, after the end of this research project, you can be provided with a brief information about the results of the study through: olgacoelho.crossaction@gmail.com

By signing this form, you've stated that you are 18 years old or above, that you have read and understood the information above and agree to freely and voluntarily participate in this research project.

Dubai, _____ de 2017

Participant's signature

استمارة الموافقة

اسمي أولغا سولهو، وأنا حالياً أعمل على مشروع بحثي في علم النفس، من دورة دكتوراه لجامعة ليزبون في علم النفس السريري بتنسيق من البروفيسور برونو غونكالفس. يتركز هذا النطاق على دراسة الشخصية

في المرحلة الأولى، أود أن أطلب مشاركتكم التطوعية بالإجابة على (3) استبيانات. لا توجد اجابات صحيحة أو خاطئة، ما يهم هو أنها تعكس تجربتك الخاصة. ستستغرق مشاركتك في هذه الدراسة حوالي 60 دقيقة. يرجى العلم بأنه إذا قررت المشاركة، يمكنك التوقف عن القيام بذلك في أي وقت ويمكنك أيضاً أن تقرر بعدم الإجابة على أي سؤال محدد

في المرحلة الثانية، أود أن أطلب منكم أن تجمعوا من أقاربكم أو أصدقائكم (باستثناء طلاب الجامعات) الذين يبلغون من العمر 30 عاماً أو أكثر، ذكور وإناث، من مواطني دولة الإمارات العربية المتحدة، الإجابة على هذه الاستبيانات نفسها

وسيتم تحليل البيانات التي يتم جمعها وعرضها بسرية تامة والتخلص منها في النهاية

بعد الإنتهاء من هذا المشروع البحثي، إذا كنت ترغب بالمعرفة عن نبذة عامة لنتائج الدراسة يمكنك أن تحصل عليها من خلال:

olgacoelho.crossaction@gmail.com

وبتوقيع هذا النموذج، ذكرت أنك تبلغ من العمر 18 عاماً أو أكثر، وأنت قرأت وفهمت المعلومات الواردة أعلاه وتوافق على المشاركة بحرية وطوعية في هذا المشروع البحثي

2017, _____

توقيع المشارك

Apêndice B

General Population Sociodemographic Questionnaire

(Questionário sociodemográfico da amostra comunitária em árabe e inglês)

استبيان الاجتماعي والديموغرافي

Sociodemographic Questionnaire

- _____ رقم البروتوكول / Protocol Number 1
- _____ تاريخ / Date 2
- _____ جنسية / Nationality 3
- _____ عمر / Age 4
- _____ أنثى / Female ذكر / Male جنس / Gender 5
- _____ الموظفين / Employed
_____ عاطلين عن العمل / Unemployed
_____ ربه منزل / House wife
_____ متقاعد / Retired or disabled غير قادر على الحركة
_____ طالب علم / Student حالة العمل / Working satus 6
- _____ مهنة / Profession 7
- _____ اعزب / Single
_____ متزوج / Married
_____ مطلق / Divorced
_____ أرملة / Widow (er) الحالة الاجتماعية / Marital Status 8
- _____ مسلم / Muslim
_____ كاثوليكي / Catholic
_____ دين آخر / Other Religion دين / Religion 9
- _____ المدرسة الابتدائية / Primary School
_____ المدرسة الثانوية / High School
_____ طالب جامعي / College Student
_____ حاصل على شهادة البكالوريا / Bachelor
_____ دراسات عليا / Post-graduated
_____ ماجستير / Master
_____ دكتوراه / PhD. المستوى التعليمي الانتهاء / Completed educational level 10
- _____ غير قابل للتطبيق / Not applicable
_____ أ ب ع / ABP – 1^o year
_____ تعليم عام / General Education – 2^o year
_____ رائد / Major – 3^o year مستوى درجة / Degree level 11

رجاء حدد / Please specify: _____

<input type="checkbox"/> وحده/Alone	مع من تعيش /Who do you live with	12
<input type="checkbox"/> الآباء/Parents		
<input type="checkbox"/> الزوج/Spouse		
<input type="checkbox"/> الزوج والوالدين/Spouse and parents		
<input type="checkbox"/> الزوج وغيرها/Spouse and others		
<input type="checkbox"/> الآخرين/Others		
<input type="checkbox"/> لا /No	هل لديك ابناء /Do you have children	13
<input type="checkbox"/> نعم فعلا/Yes		
<input type="checkbox"/> جيد جدا/Very Good	الوضع المالي/Financial situation	14
<input type="checkbox"/> جيد/Good		
<input type="checkbox"/> سيئة/Bad		
<input type="checkbox"/> سيئ جدا/Very Bad		
<input type="checkbox"/> لا /No	هل تعاني من أي اضطراب جسدي / العقلي /Do you suffer from any physical/mental disorder	15
<input type="checkbox"/> نعم فعلا/Yes		
ما اضطراب / What disorder _____		
<input type="checkbox"/> جيد جدا/Very Good	كيف تنظرالى وضعك الصحي الحالي /	16
<input type="checkbox"/> جيد/Good	16. How you consider your current health status	
<input type="checkbox"/> سيئة/Bad		
<input type="checkbox"/> سيئ جدا/Very Bad		

Apêndice C

Diagnostic Report Sheet

(Ficha diagnóstica da amostra clínica)



Study of the Arabic version of the Personality Inventory for DSM-5 (PID-5) in the UAE clinical and non-clinical population: A cross-cultural study between the UAE and the Portuguese population

FOR TECHNICIANS USE ONLY

Sheet A. In order to allow the correct pairing of clinical diagnoses, we ask to the attendant psychiatrist/clinical psychologist to match the Protocol number from the left column to the patients ID and use Sheet B to pair the diagnostics. In order to guarantee the right to anonymity, make sure that **only Sheet B** is returned to the research team, without there being any element that allows the identification of the participants.

Table A.

Protocol Number	Identification
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	



Study of the Arabic version of the Personality Inventory for DSM-5 (PID-5) in the UAE clinical and non-clinical population: A cross-cultural study between the UAE and the Portuguese population

FOR TECHNICIANS USE ONLY

Sheet B. Use the following table to make the correct pairing between Protocol Number and the clinical diagnoses. To ensure the right to anonymity, make sure that only this sheet is returned to the research team, without there being any element that allows the identification of the participants.

Table B.

Protocol Number	Clinical Diagnosis ^{1,2}
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	



Faculdade de Psicologia
UNIVERSIDADE DE LISBOA



جامعة زايد
ZAYED UNIVERSITY

¹ *According to the 5th Edition of the Diagnostic and Statistical Manual of Mental Disorder - DSM-5 (APA, 2013)*

² *Whenever possible, discriminate the presence of Personality Disorder, even if it does not correspond to the main diagnosis*

Thank you for you cooperation.

Apêndice D

Clinical Population Consent Form

(Consentimento informado da amostra clínica em árabe e inglês)



نموذج موافقة المشارك PARTICIPANT CONSENT FORM

Prospective Research Subject: you are requested to read the patient information sheet carefully before you sign this consent form. You are free to ask questions at any time before, during or after your participation in this research.

بحث موضوعي
نطلب منك قراءة ورقة معلومات المريض بعناية قبل التوقيع على استمارة الموافقة. أنت حر في طرح الأسئلة في أي وقت قبل أو أثناء أو بعد مشاركتك في هذا البحث.

عنوان المشروع:

دراسة النسخة العربية من قائمة الجرد الشخصية للـ (PID-5) DSM-5 في الإمارات العربية المتحدة للفئات الإكلينيكية وغير الإكلينيكية: دراسة متعددة الثقافات بين سكان الإمارات والبرتغال

Project Title: Study of the Arabic version of the Personality Inventory for DSM-5 (PID-5) in the UAE clinical and non-clinical population: A cross-cultural study between the UAE and the Portuguese population

رقم المشروع : Project Number:	رقم الموقع / المركز: Site / Center Number:
رقم تعريف المريض : Patient Identification Number:	كفيل / Sponsor: جامعة زايد / Zayed University كلية علم النفس بجامعة لشبونة / Faculdade de Psicologia da Universidade de Lisboa
الباحث الرئيسي / Principal Investigator: Joana Stocker	منظمة / Organization: جامعة زايد / Zayed University
موقعك / Location: دبي / Dubai	هاتف / Phone: 044021864

1. I confirm that I have read and understand the **information sheet/contents of the consent form** for the above study
2. I have had the opportunity to ask questions and have received answers.

1. أؤكد أنني قمت بقراءة وفهم ورقة المعلومات ومحتويات استمارة الموافقة للدراسة المذكورة.
2. لقد أتيت لي الفرصة لطرح الأسئلة وتلقي الإجابات.

3. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

3. أدرك أن مشاركتي تطوعية وأني حر بالانسحاب في أي وقت دون إبداء أي سبب، دون أن تتأثر رعايتي الطبية أو حقوقي القانونية.

4. I agree to take part in the above study.

4. أوافق على المشاركة في الدراسة المذكورة.

5. A copy of this consent form will be provided to me after I sign it.

5. ستقدم لي نسخة من استمارة الموافقة بعد أن أقوم بتوقيعها.

Participant:

Name:

Signature: _____

Date: _____

Investigator:

Name:

Signature: _____

Date: _____

Copies: *1 for participant; 1 for researcher; 1 to be kept in hospital notes*

Apêndice E

Patients Information Sheet (example)

(Exemplo da ficha informativa do paciente em árabe e inglês)

Patient Information Sheet

استمارة موافقة على المشاركة

Study of the Personality Inventory for DSM-5 – PID-5 for the UAE Clinical and Non-clinical National Population – A Cross-cultural study between the UAE and the Portuguese Population.

دراسة مدى توافق اختبارات الشخصية الخاصة بالدليل التشخيصي والإحصائي الخامس مع المجتمع المحلي الإماراتي – دراسة ثقافية شاملة بين المجتمع الإماراتي والمجتمع البرتغالي.

Researchers:

الباحثون:

- Ms. Olga Coelho
ocoelho@campus.ul.pt

- اولغا كويلهو
ocoelho@campus.ul.pt

- Ms. Maryam AlJassmi
Maryam.AlJassmi@zu.ac.ae

- مريم الجسمي
Maryam.AlJassmi@zu.ac.ae

- Dr. Samia Abul AlKhoori
SaAbul@dha.gov.ae

- د. سامية الخوري
SaAbul@dha.gov.ae

- PhD. Joana Stocker
Joana.Stocker@zu.ac.ae

- د. جوانا ستوكر
Joana.Stocker@zu.ac.ae

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

أنت مدعو للمشاركة في دراسة بحثية. قبل المشاركة، من المهم أن تكون على علم بغرض هذه الدراسة البحثية وأهدافها. يرجى أخذ الوقت الكافي لقراءة المعلومات التالية بعناية ومناقشتها مع الآخرين إن كنت ترغب بذلك. يمكنك طرح الأسئلة علينا إن كانت إحدى النقاط المذكورة غير واضحة، أو إذا رغبت بالحصول على المزيد من المعلومات. خذ وقتك لتقرر ما إذا كنت تريد المشاركة أم لا. نشكرك على القراءة.

الغرض من المشروع:

Purpose of the project:

Adapt and validate a Self-report
Questionnaire of Personality Traits to the
UAE clinical and non-clinical population.

التحقق من صحة استبيان تقرير الذات الخاص بالسمات
الشخصية لسكان دولة الإمارات العربية المتحدة من
الفئات الإكلينيكية والغير إكلينيكية.

Why are we asking you to participate in this study:

نطلب منك المشاركة في هذه الدراسة:

Because you are a patient of Rashid
Hospital and therefore eligible for our
clinical sample. A total of 350 patients will
be participating in this study.

لأنك تراجع مستشفى راشد وبالتالي تعتبر مؤهل
للمشاركة في دراستنا البحثية. سوف يشارك في هذه
الدراسة ما يقارب ٣٥٠ شخصاً.

If you participate, you will be asked to:

إذا شاركت ، سيُطلب منك:

Answer a sociodemographic questionnaire
and two questionnaires which assess
Personality Traits.

الإجابة على استبيان اجتماعي ديموغرافي، واثنين من
الاستبيانات التي تقيس سمات الشخصية.

Time required for participation:

الوقت اللازم للمشاركة:

Approximately one hour.

ما يقارب ساعة واحدة.

Potential Risks of Study:

المخاطر المحتملة للدراسة:

The research team believes there are no
meaningful risks associated with this study.
Nevertheless, in case of discomfort the
patient will be referred the Psychology
Department of Rashid Hospital

يعتقد فريق البحث بأنه لا توجد مخاطر مرتبطة بهذه
الدراسة. ومع ذلك، في حالة الشعور بالاستياء سيتم
إحالة المريض إلى قسم الطب النفسي في مستشفى راشد
الاتصالات
(دبي)

Contacts:

800-DHA (800342) (Dubai)

wasselotak@dha.gov.ae

800-DHA (800342)

wasselotak@dha.gov.ae

Benefits:

Contribute to the advance of Psychology Science in the field of Personality and its disorders and also to provide health care providers and patients the access to the most recent personality assessment tool.

Confidentiality will be maintained by:

All responses are confidential, and in no case will responses from individual participants be identified. Rather, all data will be pooled and published in aggregate form only and will be stored in a locked cabinet and office.

What will happen to the results of the study:

The results of this study will be published in Scientific Mental Health Journals.

Sponsors:

Zayed University
Faculdade de Psicologia da Universidade de Lisboa

If you have any questions concerning your participation in this project you may also contact:

Dr. Joana Stocker, Assistant-Chair of the Psychology department
College of Natural and Health Sciences
Joana.Stocker@zu.ac.ae

If you have any concerns of the way you have been approached or treated during the course of this study, you can contact **Dubai Scientific Research Ethics Committee, DHA** on +97142191961/1965 or email on DSREC@dha.gov.ae

فوائد الدراسة:

سوف تساهم هذه الدراسة في تطوير علم دراسة الشخصيات وأمراضها. سوف تساهم أيضاً في مساعدة المختصين في المجال الصحي في الوصول إلى أحدث أدوات تقييم الشخصية المعتمدة.

سيتم الحفاظ على سرية البيانات:

جميع الإجابات سرية ولن يتم تحديد الإجابات الفردية بأي حال من الأحوال. وبدلاً من ذلك، سيتم تجميع البيانات ونشرها بشكل إجمالي فقط وتخزينها في خزانة ومكتب مقفلين.

ماذا سيحدث لنتائج الدراسة:

سيتم نشر نتائج هذه الدراسة في المجلات العلمية للصحة النفسية.

الرعاية:

جامعة زايد
كلية علم النفس بجامعة لشبونة

إذا كان لديك أي أسئلة بخصوص مشاركتك في هذا المشروع ، يمكنك أيضاً الاتصال بـ:
الدكتورة جوانا ستوكر ، مساعدة رئيسة قسم علم النفس
كلية العلوم الطبيعية والصحية
Joana.Stocker@zu.ac.ae

إذا كانت لديك أية مخاوف بشأن الطريقة التي تم بها التعامل معك أو معالجتها خلال هذه الدراسة ، يمكنك الاتصال بلجنة أخلاقيات البحث العلمي في دبي ، هيئة الصحة بدبي على الرقم +97142191961/1965 أو عبر البريد الإلكتروني على DSREC@dha.gov.ae

**This research project has been reviewed
by Dubai Scientific Research Ethics
Committee, DHA.**

تمت مراجعة هذا المشروع البحثي من قبل لجنة
أخلاقيات البحث العلمي في دبي ، DHA.

Voluntary Participation:

التاريخ:

Participation in this study is completely voluntary, it is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign the attached consent form. If you decide to take part you are still free to withdraw at any time without giving a reason, will not affect the standard of care you receive now or in the future.

تعتبر المشاركة في هذه الدراسة اختيارية تمامًا، حيث يرجع قرار المشاركة إليك. إذا قررت المشاركة، سيتم إعطاؤك ورقة المعلومات هذه ليتم الاحتفاظ بها. سيطلب منك أيضاً التوقيع على نموذج الموافقة المرفق. إذا قررت المشاركة، سيتوفر لديك خيار الانسحاب من الدراسة في أي وقت بدون الحاجة لإبداء أي سبب، ولن يؤثر ذلك على مستوى الرعاية التي تتلقاها الآن أو في المستقبل.

Apêndice F

Clinical Population Sociodemographic Questionnaire

(Questionário sociodemográfico da amostra clínica em árabe e inglês)

الاستبيان الاجتماعي والديموغرافي

Sociodemographic Questionnaire

-----		1. Protocol number	1. رقم البروتوكول
-----		2. Date	2. التاريخ
-----		3. Nationality	3. الجنسية
-----		4. Age	4. العمر
○ Male	○ ذكر	5. Gender	5. الجنس
○ Female	○ أنثى		
○ Employed	○ موظف	6. Working status	6. الحالة المهنية
○ Unemployed	○ عاطل عن العمل		
○ Housewife	○ ربة منزل		
○ Retired or disabled	○ متقاعد أو غير قادر على الحركة		
○ Student	○ طالب علم		
-----	-----		
○ Single	○ أعزب	8. Marital status	8. الحالة الاجتماعية
○ Married	○ متزوج		
○ Divorced	○ مطلق		
○ Widow(er)	○ أرمل		
○ Muslim	○ مسلم	9. Religion	9. الدين
○ Catholic	○ كاثوليكي		
○ Other Religion	○ دين آخر		
○ Primary school	○ الابتدائي	10. Completed educational level	10. المستوى التعليمي النهائي
○ High school	○ الثانوي		
○ Diploma	○ دبلوم		
○ Bachelor's Degree	○ البكالوريوس		
○ Master's Degree	○ الماجستير		
○ PhD	○ الدكتوراه		
○ Alone	○ لوحدي	11. Who do you live with?	11. مع من تعيش؟
○ With Parents	○ مع والدي		
○ With Spouse	○ مع الزوج / الزوجة		
○ With Spouse and Parents	○ مع زوجي ووالدي		
○ With Spouse and Others	○ مع زوجي وأشخاص آخرين		

<input type="radio"/> With Others <input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> مع أشخاص آخرين <input type="radio"/> نعم <input type="radio"/> لا	12. Do you have children?	12. هل لديك أبناء؟		
<input type="radio"/> Very Good <input type="radio"/> Good <input type="radio"/> Bad <input type="radio"/> Very Bad	<input type="radio"/> جيد جداً <input type="radio"/> جيد <input type="radio"/> سيء <input type="radio"/> سيء جداً			13. Financial situation	13. الوضع المادي
<input type="radio"/> Yes <input type="radio"/> No <p>يرجى التحديد: ----- Please specify: -----</p>	<input type="radio"/> نعم <input type="radio"/> لا				
<input type="radio"/> Very Good <input type="radio"/> Good <input type="radio"/> Bad <input type="radio"/> Very Bad	<input type="radio"/> جيد جداً <input type="radio"/> جيد <input type="radio"/> سيء <input type="radio"/> سيء جداً	15. How do you consider your current health status?	15. كيف تعتبر مستواك الصحي حالياً؟		

Apêndice G

Personality Inventory for DSM-5 (PID-5)

(Original e tradução árabe)

The Personality Inventory for DSM-5 (PID-5)—Adult, continued

Instructions to individual receiving care: Please continue to complete the questionnaire. Remember, this is a list of things different people might say about themselves. We are interested in how you would describe yourself. There are no "right" or "wrong" answers. So you can describe yourself as honestly as possible, we will keep your responses confidential. We'd like you to take your time and read each statement carefully, selecting the response that best describes you.					Clinician Use	
		Very False or Often False	Sometimes or Somewhat False	Sometimes or Somewhat True	Very True or Often True	Item score
37	Sometimes I get this weird feeling that parts of my body feel like they're dead or not really me.	0	1	2	3	
38	I am easily angered.	0	1	2	3	
39	I have no limits when it comes to doing dangerous things.	0	1	2	3	
40	To be honest, I'm just more important than other people.	0	1	2	3	
41	I make up stories about things that happened that are totally untrue.	0	1	2	3	
42	People often talk about me doing things I don't remember at all.	0	1	2	3	
43	I do things so that people just have to admire me.	0	1	2	3	
44	It's weird, but sometimes ordinary objects seem to be a different shape than usual.	0	1	2	3	
45	I don't have very long-lasting emotional reactions to things.	0	1	2	3	
46	It is hard for me to stop an activity, even when it's time to do so.	0	1	2	3	
47	I'm not good at planning ahead.	0	1	2	3	
48	I do a lot of things that others consider risky.	0	1	2	3	
49	People tell me that I focus too much on minor details.	0	1	2	3	
50	I worry a lot about being alone.	0	1	2	3	
51	I've missed out on things because I was busy trying to get something I was doing exactly right.	0	1	2	3	
52	My thoughts often don't make sense to others.	0	1	2	3	
53	I often make up things about myself to help me get what I want.	0	1	2	3	
54	It doesn't really bother me to see other people get hurt.	0	1	2	3	
55	People often look at me as if I'd said something really weird.	0	1	2	3	
56	People don't realize that I'm flattering them to get something.	0	1	2	3	
57	I'd rather be in a bad relationship than be alone.	0	1	2	3	
58	I usually think before I act.	0	1	2	3	
59	I often see vivid dream-like images when I'm falling asleep or waking up.	0	1	2	3	
60	I keep approaching things the same way, even when it isn't working.	0	1	2	3	
61	I'm very dissatisfied with myself.	0	1	2	3	
62	I have much stronger emotional reactions than almost everyone else.	0	1	2	3	
63	I do what other people tell me to do.	0	1	2	3	
64	I can't stand being left alone, even for a few hours.	0	1	2	3	
65	I have outstanding qualities that few others possess.	0	1	2	3	
66	The future looks really hopeless to me.	0	1	2	3	
67	I like to take risks.	0	1	2	3	
68	I can't achieve goals because other things capture my attention.	0	1	2	3	
69	When I want to do something, I don't let the possibility that it might be risky stop me.	0	1	2	3	
70	Others seem to think I'm quite odd or unusual.	0	1	2	3	
71	My thoughts are strange and unpredictable.	0	1	2	3	
72	I don't care about other people's feelings.	0	1	2	3	

The Personality Inventory for DSM-5 (PID-5)—Adult, continued

Instructions to individual receiving care: Please continue to complete the questionnaire. Remember, this is a list of things different people might say about themselves. We are interested in how you would describe yourself. There are no “right” or “wrong” answers. So you can describe yourself as honestly as possible, we will keep your responses confidential. We’d like you to take your time and read each statement carefully, selecting the response that best describes you.						Clinician Use
		Very False or Often False	Sometimes or Somewhat False	Sometimes or Somewhat True	Very True or Often True	Item score
73	You need to step on some toes to get what you want in life.	0	1	2	3	
74	I love getting the attention of other people.	0	1	2	3	
75	I go out of my way to avoid any kind of group activity.	0	1	2	3	
76	I can be sneaky if it means getting what I want.	0	1	2	3	
77	Sometimes when I look at a familiar object, it’s somehow like I’m seeing it for the first time.	0	1	2	3	
78	It is hard for me to shift from one activity to another.	0	1	2	3	
79	I worry a lot about terrible things that might happen.	0	1	2	3	
80	I have trouble changing how I’m doing something even if what I’m doing isn’t going well.	0	1	2	3	
81	The world would be better off if I were dead.	0	1	2	3	
82	I keep my distance from people.	0	1	2	3	
83	I often can’t control what I think about.	0	1	2	3	
84	I don’t get emotional.	0	1	2	3	
85	I resent being told what to do, even by people in charge.	0	1	2	3	
86	I’m so ashamed by how I’ve let people down in lots of little ways.	0	1	2	3	
87	I avoid anything that might be even a little bit dangerous.	0	1	2	3	
88	I have trouble pursuing specific goals even for short periods of time.	0	1	2	3	
89	I prefer to keep romance out of my life.	0	1	2	3	
90	I would never harm another person.	0	1	2	3	
91	I don’t show emotions strongly.	0	1	2	3	
92	I have a very short temper.	0	1	2	3	
93	I often worry that something bad will happen due to mistakes I made in the past.	0	1	2	3	
94	I have some unusual abilities, like sometimes knowing exactly what someone is thinking.	0	1	2	3	
95	I get very nervous when I think about the future.	0	1	2	3	
96	I rarely worry about things.	0	1	2	3	
97	I enjoy being in love.	0	1	2	3	
98	I prefer to play it safe rather than take unnecessary chances.	0	1	2	3	
99	I sometimes have heard things that others couldn’t hear.	0	1	2	3	
100	I get fixated on certain things and can’t stop.	0	1	2	3	
101	People tell me it’s difficult to know what I’m feeling.	0	1	2	3	
102	I am a highly emotional person.	0	1	2	3	
103	Others would take advantage of me if they could.	0	1	2	3	
104	I often feel like a failure.	0	1	2	3	
105	If something I do isn’t absolutely perfect, it’s simply not acceptable.	0	1	2	3	
106	I often have unusual experiences, such as sensing the presence of someone who isn’t actually there.	0	1	2	3	
107	I’m good at making people do what I want them to do.	0	1	2	3	
108	I break off relationships if they start to get close.	0	1	2	3	
109	I’m always worrying about something.	0	1	2	3	
110	I worry about almost everything.	0	1	2	3	

The Personality Inventory for DSM-5 (PID-5)—Adult, continued

Instructions to individual receiving care: Please continue to complete the questionnaire. Remember, this is a list of things different people might say about themselves. We are interested in how you would describe yourself. There are no “right” or “wrong” answers. So you can describe yourself as honestly as possible, we will keep your responses confidential. We’d like you to take your time and read each statement carefully, selecting the response that best describes you.					Clinician Use	
		Very False or Often False	Sometimes or Somewhat False	Sometimes or Somewhat True	Very True or Often True	Item score
111	I like standing out in a crowd.	0	1	2	3	
112	I don’t mind a little risk now and then.	0	1	2	3	
113	My behavior is often bold and grabs peoples’ attention.	0	1	2	3	
114	I’m better than almost everyone else.	0	1	2	3	
115	People complain about my need to have everything all arranged.	0	1	2	3	
116	I always make sure I get back at people who wrong me.	0	1	2	3	
117	I’m always on my guard for someone trying to trick or harm me.	0	1	2	3	
118	I have trouble keeping my mind focused on what needs to be done.	0	1	2	3	
119	I talk about suicide a lot.	0	1	2	3	
120	I’m just not very interested in having sexual relationships.	0	1	2	3	
121	I get stuck on things a lot.	0	1	2	3	
122	I get emotional easily, often for very little reason.	0	1	2	3	
123	Even though it drives other people crazy, I insist on absolute perfection in everything I do.	0	1	2	3	
124	I almost never feel happy about my day-to-day activities.	0	1	2	3	
125	Sweet-talking others helps me get what I want.	0	1	2	3	
126	Sometimes you need to exaggerate to get ahead.	0	1	2	3	
127	I fear being alone in life more than anything else.	0	1	2	3	
128	I get stuck on one way of doing things, even when it’s clear it won’t work.	0	1	2	3	
129	I’m often pretty careless with my own and others’ things.	0	1	2	3	
130	I am a very anxious person.	0	1	2	3	
131	People are basically trustworthy.	0	1	2	3	
132	I am easily distracted.	0	1	2	3	
133	It seems like I’m always getting a “raw deal” from others.	0	1	2	3	
134	I don’t hesitate to cheat if it gets me ahead.	0	1	2	3	
135	I check things several times to make sure they are perfect.	0	1	2	3	
136	I don’t like spending time with others.	0	1	2	3	
137	I feel compelled to go on with things even when it makes little sense to do so.	0	1	2	3	
138	I never know where my emotions will go from moment to moment.	0	1	2	3	
139	I have seen things that weren’t really there.	0	1	2	3	
140	It is important to me that things are done in a certain way.	0	1	2	3	
141	I always expect the worst to happen.	0	1	2	3	
142	I try to tell the truth even when it’s hard.	0	1	2	3	
143	I believe that some people can move things with their minds.	0	1	2	3	
144	I can’t focus on things for very long.	0	1	2	3	
145	I steer clear of romantic relationships.	0	1	2	3	
146	I’m not interested in making friends.	0	1	2	3	
147	I say as little as possible when dealing with people.	0	1	2	3	
148	I’m useless as a person.	0	1	2	3	

The Personality Inventory for DSM-5 (PID-5)—Adult, continued

Instructions to individual receiving care: Please continue to complete the questionnaire. Remember, this is a list of things different people might say about themselves. We are interested in how you would describe yourself. There are no “right” or “wrong” answers. So you can describe yourself as honestly as possible, we will keep your responses confidential. We’d like you to take your time and read each statement carefully, selecting the response that best describes you.						Clinician Use
		Very False or Often False	Sometimes or Somewhat False	Sometimes or Somewhat True	Very True or Often True	Item score
149	I’ll do just about anything to keep someone from abandoning me.	0	1	2	3	
150	Sometimes I can influence other people just by sending my thoughts to them.	0	1	2	3	
151	Life looks pretty bleak to me.	0	1	2	3	
152	I think about things in odd ways that don’t make sense to most people.	0	1	2	3	
153	I don’t care if my actions hurt others.	0	1	2	3	
154	Sometimes I feel “controlled” by thoughts that belong to someone else.	0	1	2	3	
155	I really live life to the fullest.	0	1	2	3	
156	I make promises that I don’t really intend to keep.	0	1	2	3	
157	Nothing seems to make me feel good.	0	1	2	3	
158	I get irritated easily by all sorts of things.	0	1	2	3	
159	I do what I want regardless of how unsafe it might be.	0	1	2	3	
160	I often forget to pay my bills.	0	1	2	3	
161	I don’t like to get too close to people.	0	1	2	3	
162	I’m good at conning people.	0	1	2	3	
163	Everything seems pointless to me.	0	1	2	3	
164	I never take risks.	0	1	2	3	
165	I get emotional over every little thing.	0	1	2	3	
166	It’s no big deal if I hurt other peoples’ feelings.	0	1	2	3	
167	I never show emotions to others.	0	1	2	3	
168	I often feel just miserable.	0	1	2	3	
169	I have no worth as a person.	0	1	2	3	
170	I am usually pretty hostile.	0	1	2	3	
171	I’ve skipped town to avoid responsibilities.	0	1	2	3	
172	I’ve been told more than once that I have a number of odd quirks or habits.	0	1	2	3	
173	I like being a person who gets noticed.	0	1	2	3	
174	I’m always fearful or on edge about bad things that might happen.	0	1	2	3	
175	I never want to be alone.	0	1	2	3	
176	I keep trying to make things perfect, even when I’ve gotten them as good as they’re likely to get.	0	1	2	3	
177	I rarely feel that people I know are trying to take advantage of me.	0	1	2	3	
178	I know I’ll commit suicide sooner or later.	0	1	2	3	
179	I’ve achieved far more than almost anyone I know.	0	1	2	3	
180	I can certainly turn on the charm if I need to get my way.	0	1	2	3	
181	My emotions are unpredictable.	0	1	2	3	
182	I don’t deal with people unless I have to.	0	1	2	3	
183	I don’t care about other peoples’ problems.	0	1	2	3	
184	I don’t react much to things that seem to make others emotional.	0	1	2	3	
185	I have several habits that others find eccentric or strange.	0	1	2	3	
186	I avoid social events.	0	1	2	3	

The Personality Inventory for DSM-5 (PID-5)—Adult, continued

Instructions to individual receiving care: Please continue to complete the questionnaire. Remember, this is a list of things different people might say about themselves. We are interested in how you would describe yourself. There are no “right” or “wrong” answers. So you can describe yourself as honestly as possible, we will keep your responses confidential. We’d like you to take your time and read each statement carefully, selecting the response that best describes you.						Clinician Use
		Very False or Often False	Sometimes or Somewhat False	Sometimes or Somewhat True	Very True or Often True	Item score
187	I deserve special treatment.	0	1	2	3	
188	It makes me really angry when people insult me in even a minor way.	0	1	2	3	
189	I rarely get enthusiastic about anything.	0	1	2	3	
190	I suspect that even my so-called “friends” betray me a lot.	0	1	2	3	
191	I crave attention.	0	1	2	3	
192	Sometimes I think someone else is removing thoughts from my head.	0	1	2	3	
193	I have periods in which I feel disconnected from the world or from myself.	0	1	2	3	
194	I often see unusual connections between things that most people miss.	0	1	2	3	
195	I don’t think about getting hurt when I’m doing things that might be dangerous.	0	1	2	3	
196	I simply won’t put up with things being out of their proper places.	0	1	2	3	
197	I often have to deal with people who are less important than me.	0	1	2	3	
198	I sometimes hit people to remind them who’s in charge	0	1	2	3	
199	I get pulled off-task by even minor distractions.	0	1	2	3	
200	I enjoy making people in control look stupid.	0	1	2	3	
201	I just skip appointments or meetings if I’m not in the mood.	0	1	2	3	
202	I try to do what others want me to do.	0	1	2	3	
203	I prefer being alone to having a close romantic partner.	0	1	2	3	
204	I am very impulsive.	0	1	2	3	
205	I often have thoughts that make sense to me but that other people say are strange.	0	1	2	3	
206	I use people to get what I want.	0	1	2	3	
207	I don’t see the point in feeling guilty about things I’ve done that have hurt other people.	0	1	2	3	
208	Most of the time I don’t see the point in being friendly.	0	1	2	3	
209	I’ve had some really weird experiences that are very difficult to explain.	0	1	2	3	
210	I follow through on commitments.	0	1	2	3	
211	I like to draw attention to myself.	0	1	2	3	
212	I feel guilty much of the time.	0	1	2	3	
213	I often “zone out” and then suddenly come to and realize that a lot of time has passed.	0	1	2	3	
214	Lying comes easily to me.	0	1	2	3	
215	I hate to take chances.	0	1	2	3	
216	I’m nasty and short to anybody who deserves it.	0	1	2	3	
217	Things around me often feel unreal, or more real than usual.	0	1	2	3	
218	I’ll stretch the truth if it’s to my advantage.	0	1	2	3	
219	It is easy for me to take advantage of others.	0	1	2	3	
220	I have a strict way of doing things.	0	1	2	3	

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

PID-5 - Al-Attiyah, Megreya, Alrashidi, Dominguez-Lara & Al-Sheerawi (2017)

التعليمات: تحتوي هذه القائمة على عبارات قد يستخدمها بعض الناس لوصف أنفسهم، نحن مهتمون بمعرفة الطريقة التي تستخدمها أنت لوصف نفسك. ليس هناك جواب "صحيح" أو جواب "خاطئ". لذلك تستطيع ان تصف نفسك بحرية وبصراحة، نحن نضمن بأن أجوبتك سوف تحفظ بسرية تامة، نرجو منك التأييد في القراءة وقراءة جميع العبارات بحذر حتى تختار الجواب الأقرب لوصف شخصيتك.

أوافق بشدة	أوافق	لا أوافق	لا أوافق بشدة	
3	2	1	0	1 أستمتع بالأشياء أقل مما يستمتع بها الآخرون.
3	2	1	0	2 يريد العديد من الناس إيدائي.
3	2	1	0	3 يصفني الناس بالتهور.
3	2	1	0	4 أشعر بأنني اتصرف دائماً باندفاعية (بدون تخطيط).
3	2	1	0	5 في كثير من الأحيان، تكون عندي أفكار غريبة جداً، ولا أستطيع تفسيرها لأي شخص.
3	2	1	0	6 أفقد التركيز في المحادثات لأن أشياء أخرى تلفت انتباهي.
3	2	1	0	7 أتجنب المواقف الخطرة.
3	2	1	0	8 عندما يتعلق الأمر بمشاعري، يصفني الناس بالبرود.
3	2	1	0	9 أغير ما أفعل بناءً على ما يريده الآخرون.
3	2	1	0	10 أفضل ألا أكون قريباً جداً من الناس.
3	2	1	0	11 أدخل في خناقات كثيرة (معارك جسدية).
3	2	1	0	12 أخاف الحياة بدون وجود شخص يحبني.
3	2	1	0	13 كوني فظ وغير ودود هو مجرد جزء من شخصيتي.
3	2	1	0	14 أقوم بأشياء لكي ألفت انتباه الآخرين.
3	2	1	0	15 في العادة، أفعل الأشياء التي يعتقد الآخرون أنني لا بد أن أفعلها.
3	2	1	0	16 في العادة، أفعل أشياء بشكل مندفع وبدون التفكير بما قد يحدث من نتائج.
3	2	1	0	17 لا أستطيع التوقف عن اتخاذ قرارات متهورة على الرغم من كوني على علم بذلك.
3	2	1	0	18 مشاعري تتغير في بعض الأحيان بدون وجود سبب وجيه.
3	2	1	0	19 فعلاً لا أبالي لو جعلت الآخرين يعانون.
3	2	1	0	20 أحتفظ برأيي لنفسى.
3	2	1	0	21 أقول كثيراً أشياء يعتبرها الآخرون شاذة أو غريبة.
3	2	1	0	22 أفعل دائماً أشياء بشكل مفاجئ وبدون تخطيط.
3	2	1	0	23 لا شيء يثير اهتمامي بدرجة كبيرة.
3	2	1	0	24 يعتقد الناس أن سلوكي غريب.
3	2	1	0	25 يقول الناس أنني أفكر في الأشياء بطريقة غريبة.
3	2	1	0	26 لا أستمتع أبداً بالحياة في معظم الأحيان.
3	2	1	0	27 في كثير من الأحيان أشعر أنه ليس هناك شيء يستحق الاهتمام.
3	2	1	0	28 أفقد أعصابي مع الآخرين عندما يقومون بعمل أشياء صغيرة تزعجني.

أوافق بشدة	أوافق	لا أوافق	لا أوافق بشدة		
3	2	1	0	29	لا أستطيع التركيز في أي شيء.
3	2	1	0	30	أنا شخص نشيط مملوء بالطاقة.
3	2	1	0	31	يعتبرني الآخرون شخصاً غير مسؤول.
3	2	1	0	32	يمكن أن أكون فظاً عند الضرورة.
3	2	1	0	33	تذهب أفكاري كثيراً إلى اتجاهات غريبة أو غير عادية.
3	2	1	0	34	قيل لي أنني أقضي كثيراً من الوقت لأضمن أن الأشياء متواجدة في الأماكن الصحيحة.
3	2	1	0	35	أتجنب الأنشطة أو الألعاب الرياضية الخطرة.
3	2	1	0	36	لدي صعوبة في التفريق بين الأحلام والواقع.
3	2	1	0	37	أحياناً ينتابني شعور غريب بأن بعض أجزاء جسمي ميتة أو أنها أجزاء لا تنتمي إلي.
3	2	1	0	38	أغضب بسهولة.
3	2	1	0	39	لا يوجد عندي حدود عند القيام بالأشياء الخطرة.
3	2	1	0	40	للأمانة، أنا أكثر أهمية من الأشخاص الآخرين.
3	2	1	0	41	اخترع قصصاً غير حقيقية عن أمور حدثت.
3	2	1	0	42	في كثير من الأحيان يقول الناس أنني قمت ببعض الأفعال التي لا أتذكرها أبداً.
3	2	1	0	43	أقوم بأشياء لكي أجعل الناس تعجب بي.
3	2	1	0	44	بشكل غريب، تبدو لي أحياناً الأشياء العادية في أشكال مختلفة عن المؤلف.
3	2	1	0	45	لا توجد لدي ردود فعل عاطفية طويلة المدى نحو الأمور.
3	2	1	0	46	من الصعب أن أتوقف عن عمل ما، حتى عندما أكون مجبراً على ذلك.
3	2	1	0	47	لا أجد التخطيط للمستقبل.
3	2	1	0	48	أقوم بأشياء كثيرة يعتبرها الآخرون خطيرة.
3	2	1	0	49	يقول الناس أنني أركز كثيراً على التفاصيل الصغيرة.
3	2	1	0	50	أقلق كثيراً بأن أكون وحيداً.
3	2	1	0	51	لقد فاتتني أشياء بسبب انشغالي في شيء ما كنت أفعله بإتقان.
3	2	1	0	52	في كثير من الأحيان لا يستطيع الآخرون فهم أفكاري.
3	2	1	0	53	كثيراً ما اخترع أشياء عن نفسي للحصول على ما أريد.
3	2	1	0	54	حقاً لا أنزعج عندما أرى أشخاصاً آخرين يتألمون.
3	2	1	0	55	كثيراً ما ينظر لي الناس كأنني قد قلت شيئاً غريباً جداً.
3	2	1	0	56	لا يلاحظ الناس أنني أقوم بمدحهم لكي أحصل على شيء ما.
3	2	1	0	57	أفضل أن أكون في علاقة سيئة على أن أكون بمفردي.
3	2	1	0	58	عادةً أفكر قبل القيام بعمل ما.
3	2	1	0	59	أرى كثيراً صوراً حية تشبه الأحلام عندما أشعر بالنوم أو عند اليقظة.
3	2	1	0	60	استمر في التصرف بنفس الطريقة على الرغم من فشلي المتكرر.

أوافق بشدة	أوافق	لا أوافق	لا أوافق بشدة		
3	2	1	0	أنا مستاء (غير راضي) جداً من نفسي.	61
3	2	1	0	لدي ردود فعل عاطفية أقوى بكثير من معظم الناس.	62
3	2	1	0	أفعل ما يقوله لي الآخرون.	63
3	2	1	0	لا أحتمل أن أكون بمفردي، حتى لساعات قليلة.	64
3	2	1	0	لدي صفات رائعة، يمتلكها فقط قليل من الناس.	65
3	2	1	0	يبدو لي أنه لا أمل في المستقبل.	66
3	2	1	0	أحب المخاطرة.	67
3	2	1	0	لا أستطيع تحقيق هدفي لأن أشياء أخرى تخطف انتباهي.	68
3	2	1	0	عندما أريد عمل شيء ما، لا توقني عنه احتمالية تضمينه بعض المخاطر.	69
3	2	1	0	يبدو أن الناس يعتقدون أنني شخص غريب جداً وغير عادي.	70
3	2	1	0	أفكاري غريبة ولا يمكن التنبؤ بها.	71
3	2	1	0	لا أهتم بمشاعر الآخرين.	72
3	2	1	0	أحتاج أن أستغل بعض الناس لكي أحصل على ما أريد.	73
3	2	1	0	أحب أن أحصل على انتباه الآخرين.	74
3	2	1	0	أبذل قصارى جهدي لكي أتجنب أي نوع من الأنشطة الجماعية.	75
3	2	1	0	أستطيع أن أكون مخادعاً لو أن ذلك يعني الحصول على ما أريد.	76
3	2	1	0	أحياناً عندما أنظر إلى شيء مألوف، أشعر وكأنني أنظر إليه لأول مرة.	77
3	2	1	0	من الصعب علي الانتقال من نشاط إلى آخر.	78
3	2	1	0	أقلق كثيراً من الأشياء السيئة التي من الممكن أن تحدث.	79
3	2	1	0	أجد صعوبة في تغيير طريقة أدائي لشيء ما، حتى لو كان ما أفعله لا يسير بطريقة صحيحة.	80
3	2	1	0	سوف يكون العالم أفضل حالاً لو كنت ميتاً.	81
3	2	1	0	أحافظ على المسافة بيني وبين الآخرين.	82
3	2	1	0	في كثير من الأحيان لا أستطيع التحكم فيما أفكر به.	83
3	2	1	0	لا آخذ الأمور بانفعالية.	84
3	2	1	0	أكره أن يقول لي الآخرون ما أفعل، حتى ولو كانت لديهم السلطة.	85
3	2	1	0	أنا محرج جداً لأنني خذلت العديد من الناس بطرق صغيرة وعديدة.	86
3	2	1	0	أتجنب أي شيء يتضمن الخطر حتى لو كان الخطر بسيطاً جداً.	87
3	2	1	0	أجد صعوبة في السعي وراء أهدافي حتى ولو كانت أهدافاً قصيرة المدى.	88
3	2	1	0	أفضل أن تكون الرومانسية بعيدة عن حياتي.	89
3	2	1	0	لا يمكن أبداً أن أضر شخصاً آخر.	90
3	2	1	0	لا أظهر مشاعري بقوة.	91
3	2	1	0	أغضب بمنتهى السهولة.	92

أوافق بشدة	أوافق	لا أوافق	لا أوافق بشدة		
3	2	1	0	في كثير من الأحيان أقلق أن تحصل لي أشياء سيئة بسبب أخطاء ارتكبتها في الماضي.	93
3	2	1	0	لدي قدرات غير عادية، فمثلاً أحياناً أعرف تماماً ما الذي يفكر فيه الآخرون.	94
3	2	1	0	أقلق كثيراً عندما أفكر في المستقبل.	95
3	2	1	0	نادراً ما أقلق على الأشياء.	96
3	2	1	0	استمتع بالشعور بالحب.	97
3	2	1	0	أفضل أخذ الحذر على أن آخذ فرصاً غير ضرورية.	98
3	2	1	0	أسمع أحياناً أشياء لا يستطيع الآخرون سماعها.	99
3	2	1	0	أثبت على أشياء معينة ولا أستطيع التوقف.	100
3	2	1	0	يخبرني الناس بأن هناك صعوبة في معرفة ما أشعر به.	101
3	2	1	0	أنا شخص عاطفي جداً.	102
3	2	1	0	يمكن أن يستغني الآخرون، لو كان باستطاعتهم ذلك.	103
3	2	1	0	أشعر كثيراً بالفشل.	104
3	2	1	0	لو لم يكن الشيء الذي أفعله في قمة الامتياز، بكل بساطة لا أقبله.	105
3	2	1	0	أمر بكثير من التجارب الغير عادية، مثل الإحساس بوجود شخص لا يكون موجوداً بالفعل.	106
3	2	1	0	أنا ماهر في جعل الناس يفعلون ما أريده منهم.	107
3	2	1	0	أقطع علاقتي بالناس إذا بدأت تتعمق.	108
3	2	1	0	أقلق دائماً على شيء ما.	109
3	2	1	0	أقلق على كل شيء تقريباً.	110
3	2	1	0	أحب أن أكون ملفتاً للنظر عند وجودي مع مجموعة من الناس.	111
3	2	1	0	لا أمانع القيام ببعض الأنشطة ذات الخطر المنخفض بين الحين والآخر.	112
3	2	1	0	يكون سلوكي جريئاً ويخطف انتباه الناس في الكثير من الأحيان.	113
3	2	1	0	أنا أفضل من كل الأشخاص الآخرين تقريباً.	114
3	2	1	0	يشكو الناس من حاجتي إلى جعل جميع الأشياء مرتبة تماماً.	115
3	2	1	0	لو أساء أحد إلي، أسئ له بالمثل تماماً.	116
3	2	1	0	أحترس دائماً بشكل جيد من أي شخص يحاول خداعي أو إيذائي.	117
3	2	1	0	أجد صعوبة في التركيز على ما يجب فعله.	118
3	2	1	0	أتكلم عن الانتحار كثيراً.	119
3	2	1	0	أنا غير مهتم بالعلاقة الحميمة.	120
3	2	1	0	أثبت على الأمور كثيراً (لا أستطيع تجاوز بعض الأمور).	121
3	2	1	0	أصبح انفعالياً بسهولة، وغالباً ما يكون ذلك لأسباب تافهة.	122
3	2	1	0	أصر على الكمال المطلق في كل شيء أقوم به، على الرغم من أن ذلك قد يقود الآخرين إلى الجنون.	123
3	2	1	0	لا أشعر بالسعادة أبداً في أنشطتي اليومية.	124

أوافق بشدة	أوافق	لا أوافق	لا أوافق بشدة		
3	2	1	0	الكلام المعسول مع الناس يساعدي على الحصول على ما أريد.	125
3	2	1	0	قد تحتاج إلى المبالغة في بعض الأحيان لكي تحقق النجاح (أو التقدم).	126
3	2	1	0	أخاف أن أكون وحيداً في الحياة أكثر من أي شيء آخر.	127
3	2	1	0	أثبت على طريقة واحدة في فعل الأشياء، حتى عندما يكون من الواضح أنها لن تنجح.	128
3	2	1	0	أكون في كثير من الأحيان مهملاً جداً للأشياء التي تخصني أو تخص الآخرين.	129
3	2	1	0	أنا شخص قلق جداً.	130
3	2	1	0	الناس جديرة بالثقة بشكل أساسي.	131
3	2	1	0	ينتشتت انتباهي بسهولة.	132
3	2	1	0	أحصل دائماً على معاملة سيئة من الآخرين.	133
3	2	1	0	لا أتردد في الغش إن كان ذلك سيحقق لي النجاح أو التقدم.	134
3	2	1	0	أقوم بمراجعة الأشياء عدة مرات لكي أتأكد أنها صحيحة تماماً.	135
3	2	1	0	لا أحب قضاء الوقت مع الآخرين.	136
3	2	1	0	أجد نفسي مضطراً للاستمرار في بعض الأمور حتى عندما لا يكون هناك أي أهمية للقيام بذلك.	137
3	2	1	0	لا أعرف مطلقاً كيف ستتغير انفعالاتي (أو مشاعري) من لحظة إلى أخرى.	138
3	2	1	0	رايت أشياء لم تكن موجودة بالفعل.	139
3	2	1	0	من المهم لدي أن يتم عمل الأشياء بطريقة معينة.	140
3	2	1	0	أتوقع دائماً حدوث أسوأ الأمور.	141
3	2	1	0	أحاول أن أقول الحقيقة حتى عندما يكون ذلك صعباً.	142
3	2	1	0	أنا أؤمن بوجود بعض الأشخاص الذين يستطيعون تحريك الأشياء بعقولهم.	143
3	2	1	0	لا أستطيع التركيز في الأشياء لفترة طويلة.	144
3	2	1	0	أتجنب العلاقات الرومانسية.	145
3	2	1	0	أنا غير مهتم بإقامة علاقات صداقة.	146
3	2	1	0	أتكلم قليلاً عند التعامل مع الناس.	147
3	2	1	0	كشخص أنا عديم الفائدة.	148
3	2	1	0	قد أقوم بأي شيء لكي لا يتخلى عني الآخرون.	149
3	2	1	0	في بعض الأحيان أستطيع التأثير على الناس الآخرين بمجرد إرسال افكاري إليهم.	150
3	2	1	0	تبدو لي الحياة كنيبة جداً.	151
3	2	1	0	أفكر في الأشياء بطريقة غريبة لا يفهمها معظم الناس.	152
3	2	1	0	لا أبالي إن أدت أفعالي الآخرين.	153
3	2	1	0	في بعض الأحيان أشعر أن أفكار شخص آخر تتحكم فيني.	154
3	2	1	0	أستمتع بحياتي على أكمل وجه.	155
3	2	1	0	أقدم وعوداً لا أنوي فعلاً الالتزام بها.	156

أوافق بشدة	أوافق	لا أوافق	لا أوافق بشدة		
3	2	1	0	لا يوجد شيء قد يشعرني بالسعادة.	157
3	2	1	0	أنزعج بسهولة من كل أنواع الأشياء.	158
3	2	1	0	أفعل ما أريد بغض النظر عن مقدار الخطر المحتمل.	159
3	2	1	0	في كثير من الأحيان أنسى دفع فواتيري.	160
3	2	1	0	لا أحب أن أقرب كثيراً من الناس.	161
3	2	1	0	أجيد خداع الناس.	162
3	2	1	0	تبدو لي كل الأشياء بلا فائدة.	163
3	2	1	0	لا أخاطر أبداً.	164
3	2	1	0	أصبح انفعالياً (عاطفياً) في كل المواقف حتى البسيطة.	165
3	2	1	0	لا أهتم لو جرحت مشاعر الآخرين.	166
3	2	1	0	لا أظهر أبداً مشاعري للآخرين.	167
3	2	1	0	أشعر بالتعاسة في الكثير من الأحيان.	168
3	2	1	0	لا قيمة لي كشخص.	169
3	2	1	0	عادة أكون عدائياً جداً.	170
3	2	1	0	أختفي لكي أتجنب المسؤوليات.	171
3	2	1	0	قيل لي أكثر من مرة أن لي عدداً من العادات أو التصرفات الغريبة.	172
3	2	1	0	أحب أن أكون شخصاً ينتبه له الآخرون.	173
3	2	1	0	أخاف دائماً من الأشياء السيئة التي قد تحدث.	174
3	2	1	0	لا أريد أبداً أن أكون وحيداً.	175
3	2	1	0	أحاول باستمرار أن أجعل الأشياء مثالية، حتى عندما تكون على نفس مستوى الجودة المتوقع.	176
3	2	1	0	نادراً ما أشعر أن الناس الذين أعرفهم يحاولون استغلالني.	177
3	2	1	0	أعرف أنني سوف أنتحر عاجلاً أم آجلاً.	178
3	2	1	0	أنجزت أكثر من معظم الأشخاص الذين أعرفهم.	179
3	2	1	0	بكل تأكيد أستطيع أن أستخدم مواهبي لكي أحصل على ما أريد.	180
3	2	1	0	لا يمكن التنبؤ بانفعالاتي (العاطفية).	181
3	2	1	0	لا أتعامل مع الناس إلا إذا اضطررت لذلك.	182
3	2	1	0	لست مهتماً بمشاكل الناس.	183
3	2	1	0	لا أتأثر كثيراً بالأشياء التي قد توتر أو تقلق الآخرين.	184
3	2	1	0	لدي عادات كثيرة يعتبرها الآخرون غريبة.	185
3	2	1	0	أتجنب المناسبات الاجتماعية.	186
3	2	1	0	أستحق الحصول على معاملة خاصة.	187
3	2	1	0	أغضب بشدة عند إهانة الناس لي، حتى ولو كانت الإهانة بسيطة.	188

أوافق بشدة	أوافق	لا أوافق	لا أوافق بشدة	
3	2	1	0	189 نادراً ما أتحمس لأي شيء.
3	2	1	0	190 حتى الذين اعتبرهم "أصدقاء" أشك أنهم يخونوني كثيراً.
3	2	1	0	191 أحب الحصول على اهتمام الآخرين.
3	2	1	0	192 في بعض الأحيان أعتقد أن شخصاً ما يقوم بسحب الأفكار من رأسي.
3	2	1	0	193 تأتي فترات أشعر بها بأنني منفصل عن العالم وعن نفسي.
3	2	1	0	194 في كثير من الأحيان أرى ارتباطات (أو علاقات) غريبة بين الأشياء، يفشل في ملاحظتها معظم الناس.
3	2	1	0	195 لا أفكر في الإصابة بأذى عندما أقوم بأشياء قد تكون خطيرة.
3	2	1	0	196 لا أتحمّل أن تكون الأشياء في غير مكانها الصحيح.
3	2	1	0	197 في كثير من الأحيان أضطر إلى التعامل مع أشخاص أقل شأنًا مني.
3	2	1	0	198 في بعض الأحيان استخدم أسلوب الضرب مع الناس لكي أذكرهم بمن لديه المسؤولية.
3	2	1	0	199 أنصرف عن إتمام أي مهمة بسبب مشتتات تافهة.
3	2	1	0	200 أستمتع بجعل الناس المتحكمين يظهرون بصورة غبية.
3	2	1	0	201 أتجاهل مواعيدي أو اجتماعاتي لو لم يكن مزاجي جيداً.
3	2	1	0	202 أحاول أن أفعل ما يريده مني الآخرون.
3	2	1	0	203 أفضل أن أعيش بمفردي ولا أرتبط.
3	2	1	0	204 أنا مندفع جداً (أتصرف بتلقائية).
3	2	1	0	205 في كثير من الأحيان توجد لدي أفكار تبدو لي واضحة ولكن يستغريها الآخرون.
3	2	1	0	206 أقوم باستخدام الناس للحصول على ما أريد.
3	2	1	0	207 لا أرى فائدة من الشعور بالذنب على أشياء فعلتها قد أدت الآخرين.
3	2	1	0	208 في معظم الأوقات لا أرى فائدة من أن أكون شخصاً ودوداً.
3	2	1	0	209 توجد لدي تجارب غريبة جداً، من الصعب جداً تفسيرها.
3	2	1	0	210 أقوم بإنجاز التزاماتي (مسؤولياتي).
3	2	1	0	211 أحب أن ألفت انتباه الناس إلي.
3	2	1	0	212 أشعر بالذنب في معظم الأوقات.
3	2	1	0	213 في كثير من الأحيان أستغرق في "أحلام اليقظة" وبعدها أكتشف فجأة أن وقتاً طويلاً قد مضى.
3	2	1	0	214 أستطيع الكذب بسهولة.
3	2	1	0	215 أكره اغتنام الفرص.
3	2	1	0	216 أكون غير مهذب وعصبي مع أي شخص يستحق ذلك.
3	2	1	0	217 في كثير من الأحيان أشعر أن الأشياء حولي تبدو غير واقعية، أو تبدو أكثر واقعية من المعتاد.
3	2	1	0	218 أميل إلى المبالغة إذا كان ذلك في مصلحتي.
3	2	1	0	219 يسهل علي استغلال الآخرين.
3	2	1	0	220 لدى طريقة غير مرنة لفعل الأشياء.

Apêndice H

NEO-Five Factor Inventory (NEO-FFI)

(Original e tradução árabe)

NEO-FFI - Instructions: Carefully read each of the statements below and choose the answer that best describes you.

		Strongly disagree	Disagree	Neutral	Agree	Strongly agree
1	I am not a worrier.					
2	I like to have a lot of people around me.					
3	I don't like to waste my time daydreaming.					
4	I try to be courteous to everyone I meet.					
5	I keep my belongings neat and clean.					
6	I often feel inferior to others.					
7	I laugh easily.					
8	Once I find the right way to do something, I stick to it.					
9	I often get into arguments with my family and co-workers.					
10	I'm pretty good about pacing myself so as to get things done on time.					
11	When I'm under a great deal of stress, sometimes I feel like I'm going to pieces.					
12	I don't consider myself especially "light-hearted".					
13	I am intrigued by the patterns I find in art and nature.					
14	Some people think I'm selfish and egotistical.					
15	I am not a very methodical person.					
16	I rarely feel lonely or blue.					
17	I really enjoy talking to people.					
18	I believe letting students hear controversial speakers can only confuse and mislead them.					
19	I would rather cooperate with others than compete with them.					
20	I try to perform all the tasks assigned to me conscientiously.					
21	I often feel tense and jittery.					
22	I like to be where the action is.					
23	Poetry has little or no effect on me.					
24	I tend to be cynical and sceptical of others' intentions.					
25	I have a clear set of goals and work toward them in an orderly fashion.					

		Strongly disagree	Disagree	Neutral	Agree	Strongly agree
26	Sometimes I feel completely worthless.					
27	I usually prefer to do things alone.					
28	I often try new and foreign foods.					
29	I believe that most people will take advantage of you if you let them.					
30	I waste a lot of time before settling down to work.					
31	I rarely feel fearful or anxious.					
32	I often feel as if I'm bursting with energy.					
33	I seldom notice the moods or feelings that different environments produce.					
34	Most people I know like me.					
35	I work hard to accomplish my goals.					
36	I often get angry at the way people treat me.					
37	I am cheerful, light-spirited person.					
38	I believe we should look to our religious authorities for decisions on moral issues.					
39	Some people think of me as cold and calculating.					
40	When I make a commitment, I can always be counted on to follow through.					
41	Too often, when things go wrong, I get discouraged and feel like giving up.					
42	I am not a cheerful optimist.					
43	Sometimes when I am reading poetry or looking at a work of art, I feel a chill or wave of excitement.					
44	I'm hard-headed and tough-minded in my attitudes.					
45	Sometimes I'm not as dependable or reliable as I should be.					
46	I am seldom sad or depressed.					
47	My life is fast-paced.					
48	I have little interest in speculating on the nature of the universe or the human condition.					
49	I generally try to be thoughtful and considerate.					
50	I am a productive person who always gets the job done.					

		Strongly disagree	Disagree	Neutral	Agree	Strongly agree
51	I often feel helpless and want someone else to solve my problems.					
52	I am a very active person.					
53	I have a lot of intellectual curiosity.					
54	If I don't like people, I let them know it.					
55	I never seem to be able to get organized.					
56	At times I have been so ashamed I just wanted to hide.					
57	I would rather go my own way than be a leader of others.					
58	I often enjoy playing with theories or abstract ideas.					
59	If necessary, I am willing to manipulate people to get what I want.					
60	I strive for excellence in everything I do.					

تعليمات: اقرأ من فضلك كل عبارة مما يلي بعناية، وقرر إلى أي حد تمثل مشاعرك وسلوكك وأرائك، ثم ضع دائرة O حول أحد الكلمات التالية للعبارة، ولا تترك أي عبارة دون إجابة.

1.	أنا شخص قلق.	لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً
2.	أحب أن يكون حولي عدد كبير من الناس.	لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً
3.	أكره أن أضيع وقتي في أحلام اليقظة.	لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً
4.	أحاول أن أكون لطيفاً مع كل فرد ألتقي به.	لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً
5.	أحافظ على ممتلكاتي نظيفة ومرتبّة.	لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً
6.	أشعر بأنني أقل من الآخرين.	لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً
7.	أضحك بسهولة.	لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً
8.	عندما أجد الطريقة الصحيحة لعمل شيء ما فإنني أستمر في استخدامها.	لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً
9.	أدخل في نقاش حاد مع أفراد عائلتي وزملائي.	لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً
10.	أنا جيد في دفع نفسي لإنجاز الأشياء في وقتها المحدد.	لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً
11.	عندما أكون تحت قدر كبير من الضغوط، أشعر كأنني على وشك الانهيار.	لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً
12.	أعتبر نفسي شخصاً فرحاً.	لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً
13.	تجذبني الأشكال الفنية التي أجدّها في الفن والطبيعة.	لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً
14.	يعتقد بعض الناس أنني أناني ومغرور.	لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً
15.	أنا شخص يحافظ جداً على منهج أو أسلوب معين.	لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً
16.	أشعر بالوحدة أو الكآبة.	لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً
17.	أستمع حقاً بالتحدث مع الناس.	لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً
18.	أعتقد أن جعل الطلاب يستمعون إلى متحدث حوله جدل، يمكن أن يشوش تفكيرهم ويضلّهم.	لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً
19.	أفضل التعاون مع الآخرين على التنافس معهم.	لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً
20.	أحاول إنجاز الأعمال المطلوبة مني بإخلاص.	لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً
21.	أشعر بالتوتر والنفرة.	لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً
22.	أحب أن أكون في مكان حيث توجد الأحداث والنشاطات.	لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً
23.	للشعر تأثير عليّ.	لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً
24.	أميل إلى الشك والسخرية من نوايا الآخرين.	لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً
25.	لدي مجموعة أهداف واضحة أسعى إلى تحقيقها بطريقة منظمة.	لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً
26.	أشعر بأنه لا قيمة لي على الإطلاق.	لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً
27.	أفضل عمل الأشياء بمفردي.	لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً
28.	أجرب الأكلات الجديدة والأجنبية.	لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً

لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً	29. أعتقد أن معظم الناس سوف تستغلك إذا سمحت لهم بذلك.
لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً	30. أضيع الوقت قبل أن أبدأ العمل.
لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً	31. أشعر بالخوف أو القلق.
لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً	32. أشعر كأنني ملئ بالقوة والنشاط.
لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً	33. ألاحظ المشاعر أو الحالات المزاجية التي تنتج عن البيئات المختلفة.
لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً	34. يحبني معظم الناس الذين أعرفهم.
لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً	35. أعمل باجتهاد في سبيل تحقيق أهدافي.
لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً	36. أغضب من الطريقة التي يعاملني بها الناس.
لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً	37. أنا شخص مبتهج ومرح.
لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً	38. أعتقد أنه يجب أن نلجأ إلى أحكام الدين للوصول إلى قرارات في الأمور الأخلاقية.
لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً	39. يعتقد بعض الناس أنني بارد وحذر.
لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً	40. عندما أتعهد بشيء، فإنني أستطيع الالتزام به ومتابعته حتى النهاية.
لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً	41. عندما تسوء الأمور تضعف همتي وأشعر بالاستسلام.
لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً	42. أنا شخص متفائل.
لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً	43. عندما أقرأ شعراً أو أنظر إلى عمل فني أشعر برغبة وحالة من الاستثارة.
لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً	44. أنا عنيد ومتشدد الرأي في موافقي.
لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً	45. أنا شخص يوثق به ويُعتمد عليه كما ينبغي أن أكون.
لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً	46. أنا حزين ومكتئب.
لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً	47. حياتي تسير بسرعة.
لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً	48. أتأمل في طبيعة الكون أو أحوال الناس.
لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً	49. أحاول بشكل عام أن أكون حذراً ومراعياً لمشاعر الآخرين.
لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً	50. أنا إنسان منتج ودائماً أنهى العمل.
لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً	51. أشعر بالعجز وبحاجة إلى شخص ليحل مشاكلي.
لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً	52. أنا شخص نشيط جداً.
لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً	53. أحب الاستطلاع الفكري.
لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً	54. إذا كنت لا أحب بعض الناس، فإنني أجعلهم يعرفون ذلك.
لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً	55. أنا شخص منظم.
لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً	56. شعرت بالخجل.
لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً	57. أفضل أن أكون قائداً للآخرين.
لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً	58. أستمتع بالتفكير في النظريات أو الأفكار المجردة.
لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً	59. عند الحاجة أستخدم الحيلة للحصول من الناس على ما أريد.
لا	قليلاً	متوسطاً	كثيراً	كثيراً جداً	60. أكافح من أجل التميز في كل شيء أقوم به.

Apêndice I

Symptom Checklist 90 – Revised (SCL-90-R)

(Original e tradução árabe)

Study _____

ID _____
Date ____/____/____**Symptom Checklist 90-R**

Below is a list of problems and complaints that people sometimes have. Please read each one carefully and **enter the number** that best describes how much you were bothered by that problem during the past week.

Please enter only ONE.

FOR THE PAST WEEK, HOW MUCH WERE YOU BOTHERED BY:

	Not At All	A Little Bit	Moderately	Quite A Bit	Extremely
1. Headaches	0	1	2	3	4
2. Nervousness or shakiness inside	0	1	2	3	4
3. Unwanted thoughts, words, or ideas that won't leave your mind	0	1	2	3	4
4. Faintness or dizziness	0	1	2	3	4
5. Loss of sexual interest or pleasure	0	1	2	3	4
6. Feeling critical of others	0	1	2	3	4
7. The idea that someone else can control your thoughts	0	1	2	3	4
8. Feeling others are to blame for most of your troubles	0	1	2	3	4
9. Trouble remembering things	0	1	2	3	4
10. Worried about sloppiness or carelessness	0	1	2	3	4
11. Feeling easily annoyed or irritated	0	1	2	3	4
12. Pains in heart or chest	0	1	2	3	4
13. Feeling afraid in open spaces or on the streets	0	1	2	3	4
14. Feeling low in energy or slowed down	0	1	2	3	4
15. Thoughts of ending your life	0	1	2	3	4
16. Hearing words that others do not hear	0	1	2	3	4
17. Trembling	0	1	2	3	4
18. Feeling that most people cannot be trusted	0	1	2	3	4
19. Poor appetite	0	1	2	3	4
20. Crying easily	0	1	2	3	4

Study _____

Date _____ / _____ / _____ ID _____

FOR THE PAST WEEK, HOW MUCH WERE YOU BOTHERED BY:

	Not At All	A Little Bit	Moderately	Quite A Bit	Extremely
21. Feeling shy or uneasy with the opposite sex	0	1	2	3	4
22. Feeling of being trapped or caught	0	1	2	3	4
23. Suddenly scared for no reason	0	1	2	3	4
24. Temper outbursts that you could not control	0	1	2	3	4
25. Feeling afraid to go out of your house alone	0	1	2	3	4
26. Blaming yourself for things	0	1	2	3	4
27. Pains in lower back	0	1	2	3	4
28. Feeling blocked in getting things done	0	1	2	3	4
29. Feeling lonely	0	1	2	3	4
30. Feeling blue	0	1	2	3	4
31. Worrying too much about things	0	1	2	3	4
32. Feeling no interest in things	0	1	2	3	4
33. Feeling fearful	0	1	2	3	4
34. Your feelings being easily hurt	0	1	2	3	4
35. Other people being aware of your private thoughts	0	1	2	3	4
36. Feeling others do not understand you or are unsympathetic	0	1	2	3	4
37. Feeling that people are unfriendly or dislike you	0	1	2	3	4
38. Having to do things very slowly to insure correctness	0	1	2	3	4
39. Heart pounding or racing	0	1	2	3	4
40. Nausea or upset stomach	0	1	2	3	4
41. Feeling inferior to others	0	1	2	3	4
42. Soreness of your muscles	0	1	2	3	4
43. Feeling that you are watched or talked about by others	0	1	2	3	4
44. Trouble falling asleep	0	1	2	3	4

Study _____

Date _____ / _____ / _____ ID _____

FOR THE PAST WEEK, HOW MUCH WERE YOU BOTHERED BY:

	Not At All	A Little Bit	Moderately	Quite A Bit	Extremely
45. Having to check and double-check what you do	0	1	2	3	4
46. Difficulty making decisions	0	1	2	3	4
47. Feeling afraid to travel on buses, subways, or trains	0	1	2	3	4
48. Trouble getting your breath	0	1	2	3	4
49. Hot or cold spells	0	1	2	3	4
50. Having to avoid certain things, places, or activities because they frighten you	0	1	2	3	4
51. Your mind going blank	0	1	2	3	4
52. Numbness or tingling in parts of your body	0	1	2	3	4
53. A lump in your throat	0	1	2	3	4
54. Feeling hopeless about the future	0	1	2	3	4
55. Trouble concentrating	0	1	2	3	4
56. Feeling weak in parts of your body	0	1	2	3	4
57. Feeling tense or keyed up	0	1	2	3	4
58. Heavy feelings in your arms or legs	0	1	2	3	4
59. Thoughts of death or dying	0	1	2	3	4
60. Overeating	0	1	2	3	4
61. Feeling uneasy when people are watching or talking about you	0	1	2	3	4
62. Having thoughts that are not your own	0	1	2	3	4
63. Having urges to beat, injure, or harm someone	0	1	2	3	4
64. Awakening in the early morning	0	1	2	3	4
65. Having to repeat the same actions such as touching, counting, washing	0	1	2	3	4
66. Sleep that is restless or disturbed	0	1	2	3	4
67. Having urges to break or smash things	0	1	2	3	4
68. Having ideas or beliefs that others do not share	0	1	2	3	4

Study _____

Date _____ / _____ / _____ ID _____

FOR THE PAST WEEK, HOW MUCH WERE YOU BOTHERED BY:

	Not At All	A Little Bit	Moderately	Quite A Bit	Extremely
69. Feeling very self-conscious with others	0	1	2	3	4
70. Feeling uneasy in crowds, such as shopping or at a movie	0	1	2	3	4
71. Feeling everything is an effort	0	1	2	3	4
72. Spells of terror or panic	0	1	2	3	4
73. Feeling uncomfortable about eating or drinking in public	0	1	2	3	4
74. Getting into frequent arguments	0	1	2	3	4
75. Feeling nervous when you are left alone	0	1	2	3	4
76. Others not giving you proper credit for your achievements	0	1	2	3	4
77. Feeling lonely even when you are with people	0	1	2	3	4
78. Feeling so restless you couldn't sit still	0	1	2	3	4
79. Feelings of worthlessness	0	1	2	3	4
80. Feeling that familiar things are strange or unreal	0	1	2	3	4
81. Shouting or throwing things	0	1	2	3	4
82. Feeling afraid you will faint in public	0	1	2	3	4
83. Feeling that people will take advantage of you if you let them	0	1	2	3	4
84. Having thoughts about sex that bother you a lot	0	1	2	3	4
85. The idea that you should be punished for your sins	0	1	2	3	4
86. Feeling pushed to get things done	0	1	2	3	4
87. The idea that something serious is wrong with your body	0	1	2	3	4
88. Never feeling close to another person	0	1	2	3	4
89. Feelings of guilt	0	1	2	3	4
90. The idea that something is wrong with your mind	0	1	2	3	4

SCL-90R*

ورقة الأسئلة

التعليمات

فيما يلي قائمة بالمشاكل والشكاوى التي قد يعاني منها عامة الناس. اقرأ كل عبارة بدقة. وبعد التأكد من درجة انطباق العبارة عليك أرجو أن تضع دائرة حول أحد الأرقام الموجودة إلى يسار السؤال والتي تصف معاناتك أحسن وصف، أي إلى أي مدى تنطبق عليك هذه المشكلة خلال الأسبوع الماضي حتى اليوم. ضع دائرة واحدة فقط على أحد الأرقام بعد كل مشكلة مع عدم اغفال الإجابة عن أي عبارة. وإذا غيرت رأيك في الاستجابة، امسح الدائرة الأولى تماماً وضعها حول الرقم المناسب. اقرأ المثال الآتي قبل أن تبدأ.

مثال	مطلقاً	نادراً	أحياناً	كثيراً	دائماً
ما مقدار معاناتك من الأعراض الآتية:					
1- الشعور بالألم في أسفل الظهر	صفر	1	2	3	4

مثال	مطلقاً	نادراً	أحياناً	كثيراً	دائماً
ما مقدار معاناتك من الأعراض الآتية:					
1- الصداع	صفر	1	2	3	4
2- سرعة الانفعال أو الاضطراب الداخلي	صفر	1	2	3	4
3- وجود أفكار أو خواطر أو الفاظ غير مرغوب فيها لا تفارق بالك	صفر	1	2	3	4
4- الشعور بالإعياء أو الإغماء أو الدوخة	صفر	1	2	3	4
5- فقدان الاهتمام الجنسي أو اللذة الجنسية	صفر	1	2	3	4
6- الشعور بالحساسية تجاه الآخرين	صفر	1	2	3	4
7- الاعتقاد بأن شخصاً ما يستطيع السيطرة على أفكارك	صفر	1	2	3	4
8- إلقاء اللوم على الآخرين في معظم متاعبك	صفر	1	2	3	4
9- الصعوبة في تذكر الأشياء	صفر	1	2	3	4
10- الانشغال الزائد فيما يتعلق بالقذارة والإهمال	صفر	1	2	3	4

إلى الصفحة التالية

ما مقدار معاناتك من الاعراض الآتية:

دائماً	كثيراً	أحياناً	نادراً	مطلقاً	
4	3	2	1	صفر	11- الشعور بسرعة المضايقة والاستثارة
4	3	2	1	صفر	12- الإحساس بالألم في القلب أو الصدر
4	3	2	1	صفر	13- الشعور بالخوف في الأماكن المفتوحة أو الشوارع
4	3	2	1	صفر	14- الشعور بالخمول أو قلة النشاط
4	3	2	1	صفر	15- التفكير في إنهاء حياتك
4	3	2	1	صفر	16- سماع أصوات لا يسمعونها الآخرون
4	3	2	1	صفر	17- رعشة بالجسم
4	3	2	1	صفر	18- الشعور بعدم الثقة في معظم الناس
4	3	2	1	صفر	19- ضعف الشهية للطعام
4	3	2	1	صفر	20- البكاء بسهولة
4	3	2	1	صفر	21- الشعور بالخجل أو الاضطراب مع الجنس الآخر
4	3	2	1	صفر	22- الشعور بأنك محبوس أو مقيد الحركة
4	3	2	1	صفر	23- رعب مفاجئ بدون سبب
4	3	2	1	صفر	24- ثورات مزاجية لا يمكنك السيطرة عليها
4	3	2	1	صفر	25- الشعور بالخوف من أن تخرج من المنزل بمفردك
4	3	2	1	صفر	26- لوم نفسك على الأحداث التي تمر بك
4	3	2	1	صفر	27- الإحساس بالألم أسفل الظهر
4	3	2	1	صفر	28- عدم القدرة على إتمام أعمالك
4	3	2	1	صفر	29- الإحساس بالوحدة
4	3	2	1	صفر	30- الإحساس بالانقباض
4	3	2	1	صفر	31- القلق على الأشياء بصورة مبالغ فيها
4	3	2	1	صفر	32- الشعور بعدم الاهتمام بما حولك
4	3	2	1	صفر	33- الشعور بالخوف
4	3	2	1	صفر	34- الإحساس بأن مشاعرك يمكن تجرح بسهولة
4	3	2	1	صفر	35- الاعتقاد بأن الآخرين يطلعون على أفكارك الخاصة
4	3	2	1	صفر	36- الشعور بأن الآخرين لا يفهمونك أو لا يتعاطفون معك
4	3	2	1	صفر	37- الشعور بعدم صداقة الناس لك أو أنهم لا يحبونك
4	3	2	1	صفر	38- الاضطرار إلى أداء أعمالك ببطء شديد حتى تتأكد من دقتها
4	3	2	1	صفر	39- الإحساس بضربات القلب وزيادة سرعتها
4	3	2	1	صفر	40- الإحساس بالغثيان واضطراب المعدة

ما مقدار معاناتك من الاعراض الآتية:

دائماً	كثيراً	أحياناً	نادراً	مطلقاً	
4	3	2	1	صفر	41- الإحساس بأنك أقل من الآخرين (الشعور بالنقص)
4	3	2	1	صفر	42- الشعور بالآلام في العضلات
4	3	2	1	صفر	43- الشعور بأن الآخرين يراقبونك أو يتحدثون عنك
4	3	2	1	صفر	44- صعوبة الاستغراق في النوم
4	3	2	1	صفر	45- الاضطرار إلى إعادة التأكد من أفعالك (تعيد وتزيد)
4	3	2	1	صفر	46- صعوبة اتخاذ القرارات
4	3	2	1	صفر	47- الشعور بالخوف عند السفر بالقطارات أو الأتوبيسات
4	3	2	1	صفر	48- الصعوبة في التقاط أنفاسك
4	3	2	1	صفر	49- الإحساس بنوبات من السخونة أو البرودة في جسمك
4	3	2	1	صفر	50- الاضطرار إلى تجنب أشياء أو أفعال أو أماكن معينة لأنها تسبب لك الإحساس بالخوف
4	3	2	1	صفر	51- الإحساس بأن ذهنك خالي من الأفكار
4	3	2	1	صفر	52- تميل أو شكشكة في أجزاء من جسمك
4	3	2	1	صفر	53- الشعور بانغلاق الحلق وعدم القدرة على البلع
4	3	2	1	صفر	54- الإحساس باليأس من المستقبل
4	3	2	1	صفر	55- صعوبة في التركيز
4	3	2	1	صفر	56- الشعور بضعف في أجزاء من جسمك
4	3	2	1	صفر	57- الشعور بالتوتر أو أنك مشدود داخلياً
4	3	2	1	صفر	58- الشعور بثقل في ذراعيك أو رجليك
4	3	2	1	صفر	59- التفكير في الموت
4	3	2	1	صفر	60- الإفراط في تناول الطعام
4	3	2	1	صفر	61- الشعور بالاضطرابات والضييق عندما يتحدث الناس عنك أو يراقبونك
4	3	2	1	صفر	62- الشعور بأن أفكارك ليست من صنعك
4	3	2	1	صفر	63- الإحساس بدافع ملح لأن تضرب أو تجرح أو تؤذي شخص معين
4	3	2	1	صفر	64- الاستيقاظ من النوم في الساعات المبكرة من الصباح
4	3	2	1	صفر	65- الاضطرار إلى تكرار نفس الأفعال كاللمس والعد والغسيل
4	3	2	1	صفر	66- نوم مضطرب أو غير مريح
4	3	2	1	صفر	67- الشعور بدافع ملح لتكسیر أو تخريب الأشياء
4	3	2	1	صفر	68- وجود أفكار أو معتقدات لديك لا يشاركك فيها الآخرون
4	3	2	1	صفر	69- الإحساس بالخجل والهيبية في وجود الآخرون
4	3	2	1	صفر	70- الشعور بضييق في الأماكن المزدحمة كالأسواق والسينما

ما مقدار معاناتك من الاعراض الآتية:

مطلقاً	تأثيراً	أحياناً	كثيراً	دائماً	
صفر	1	2	3	4	71- الشعور بأن كل شيء عناء في عناء (الدنيا تعب في تعب)
صفر	1	2	3	4	72- نوبات من الفزع أو الذعر بدون سبب معقول
صفر	1	2	3	4	73- الإحساس بالضيق عند تناول طعام أو شراب في مكان عام
صفر	1	2	3	4	74- الدخول في كثير من الجدل والمناقشات
صفر	1	2	3	4	75- الشعور بالتوتر عندما تكون بمفردك
صفر	1	2	3	4	76- الشعور بأن الآخرين لا يعطونك ما تستحق من ثناء وتقدير على أعمالك وإنجازاتك
صفر	1	2	3	4	77- الشعور بالوحدة حتى في وجود الآخرين
صفر	1	2	3	4	78- الشعور بعدم الاستقرار لدرجة لا تمكنك من الجلوس هادئاً في مكان
صفر	1	2	3	4	79- الشعور بأنك عديم الأهمية
صفر	1	2	3	4	80- الشعور بأن الأشياء المألوفة تبدو غريبة أو غير حقيقية
صفر	1	2	3	4	81- نوبات من الصراخ وقذف الأشياء
صفر	1	2	3	4	82- الشعور بالخوف من الإغماء في الأماكن العامة
صفر	1	2	3	4	83- الإحساس بأن الناس سوف يأخذون فرصتك لو مكنتهم من ذلك
صفر	1	2	3	4	84- أفكار عن الجنس تسبب لك اضطراباً شديداً
صفر	1	2	3	4	85- أفكار تسيطر عليك بأنك لابد وأن تعاقب على ذنوبك
صفر	1	2	3	4	86- الاعتقاد بأنك مدفوع لعمل أشياء معينة
صفر	1	2	3	4	87- الاعتقاد بأن هناك شيئاً خطيراً قد حل بجسمك
صفر	1	2	3	4	88- عدم الشعور بأنك قريب من أي إنسان آخر
صفر	1	2	3	4	89- الشعور بالذنب
صفر	1	2	3	4	90- الاعتقاد بأن هناك تغييراً غريباً قد طرأ على أفكارك

Apêndice J

Research Protocol

(Fundamentação do projeto entregue às instituições)

Research Protocol

Study of the Arabic version of The Personality Inventory for DSM-5 (PID-5) - Adult in the UAE population

Abstract

The DSM-5 proposes a model for conceptualizing personality disorders in which they are characterized by impairments in personality functioning and maladaptive personality traits. The Personality Inventory for DSM-5 (PID-5) is a self-report measure that assesses the presence and severity of the maladaptive personality traits. Although there are numerous studies developed with this instrument, this is the first cross-cultural comparative study of the general and clinical population of the UAE and Portugal that aims to answer the following research questions: Are there differences in the mean profiles of personality traits among these populations? Is it acceptable to attribute these differences to cultural differences?

Key words: Cross-cultural Studies, Personality Assessment, PID-5, United Arab Emirates, Portugal.

Literature Review

Personality tests or assessments are a standardized set of questions that evaluate a person's personality characteristics, traits, and pathologies (Hopwood, Thomas, Markon, Wright, & Krueger, 2012). These assessments can be used in a variety of contexts, such as clinical and organizational (work places). In a clinical setting, they are used for mental health assessment, in order to reach a diagnosis. In an organizational setting, they can be used in interviews and HR assessments for selection, placement, recruitment, professional development, and promotion purposes.

In 2013 the APA published an updated Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5) which included an alternative model for personality disorders based on personality dysfunction and pathological traits. The Personality Inventory for DSM-5 (PID-5) was designed, tested, and validated in the USA in order to assess the personality traits in the light of this new dimensional-categorical model of personality and its disorders (Krueger et al., 2012).

The PID-5 (Krueger et al., 2012) is a self-report measure composed by 220 items that characterize 25 traits, in which individuals differ, that can be grouped into five major domains of personality variability: Detachment, Negative Affectivity, Disinhibition, Antagonism, and Psychoticism. The literature suggests that the dimensions of PID-5 can be considered pathological extremes of the previously used Five-Factor Model domains (FFM - e.g., Anderson et al., 2013; Krueger & Markon, 2014), that is, personality disorders can be conceptualized as mal-adaptations of the five domains that define normal personality functioning (Widiger & Trull, 2007).

Although the universality of the FFM trait structure has been systematically confirmed in the diverse cultures some authors suggest that such conclusions may be limited to

individualistic Western cultures such as USA and Portugal (McCrae & Terraciano, 2005; Schmitt, Allik, McCrae, & Benet-Martinez, 2007). In fact, personality traits seem to be crucial to explain differences in populations from individualistic cultures but less relevant when analyzing differences in collectivist cultures, such as the culture of the UAE (moderately collectivist) and the KSA (strongly collectivist), in which individuality is often indexed to a social group (Markus & Kitayama, 1991).

Indeed, a recent study by Zeinoun, Daouk-Öyry, Choueiri and Van de Vijver (2017) conducted in the Arabian Levant, using a psycholexical approach of the Modern Formal Arabic, identified not five but six personality dimensions (morality was the sixth one), questioning the universality of the FFM in collectivist cultures.

However, the number of studies about personality and its pathologies in Arab countries is still very limited to draw conclusions. Methodological constraints allied to the specificities of the Arabic language have limited knowledge about the relevant personality constructs in this region (AlKailani, Azzam, & Athmneh, 2012; Ibraim, 2008). Considering the Arabic version of the PID-5 (Al-Attiyah, Megreya, Alrashidi, Dominguez-Lara, & Al-Sheerawi, 2017), which was studied with college students from three Arabic countries (Bahrain, Kuwait and Qatar - Al-Attiyah, Megreya, Alrashidi, Dominguez-Lara, & Al-Sheerawi, 2017) there is no available data from the general population, and most important from the Clinical Arabic Speaking population. Since the aim of the PID-5 is to measure Pathological Personality Traits, it urges the need of studies using clinical samples, for whom this measure was originally developed. We aim to address this vulnerability by contributing with the adaptation, test, and validation of this measure. Furthermore, a collaboration with Portugal will enable a cross-cultural study, comparing PID-5 psychometric properties and clinical and non-clinical population personality traits across the two countries.

Objectives

1. Adaptation and validation of the PID-5 for the clinical and non-clinical UAE population and study of its psychometric properties
2. Cross-cultural study of the PID-5 in the UAE and the Portuguese population in terms of PID-5 psychometric properties and gender differences and personality traits

Methodology:

Sample

UAE Sample: We will be using a convenience sample for both – clinical and non-clinical population, for a total population of 1850 participants.

Clinical population: 350 in patients and out-patients, recruited from Rashid Hospital, Al Amal Hospital and National Rehabilitation Centre, of both genders, diagnosed with a mental disorder as per the DSM-5, aged above 18 years old, proficient in written and spoken Arabic that completed primary school, except those suffering from intellectual **disability, major and mild neurocognitive disorders, schizophrenic spectrum disorder** or any **vulnerable patient** that cannot make their own medical decisions).

Inclusion Criteria for the Clinical Population: Emirati in patients and out-patients, of both genders diagnosed with a mental disorder, aged above 18 years old, proficient in written and spoken Arabic that completed at least primary school.

Exclusion criteria for the Clinical Population: Patients suffering from intellectual disability, dementia, schizophrenic spectrum disorder or any vulnerable patient that cannot make their own medical decisions).

Non-Clinical population: 1500 participants recruited students and staff of Zayed University and from the general population aged above 18 years old, from both genders, proficient in written and spoken Arabic that completed primary school, with any level of income, capable to make decisions for themselves.

Inclusion Criteria for the Non-Clinical Population: Emirati college students and general population participants, from both genders, proficient in written and spoken Arabic that completed at least primary school.

Exclusion criteria for the Non-Clinical Population: Participants bellow 18 years old, or those not capable to make decisions for themselves.

Instruments

The assessment tools for the non-clinical sample are composed by the socio-demographic questionnaire (16 questions) and two personality instruments: Arabic PID-5 (Al-Attiyah et al., 2017) and NEO Five-Factor Inventory (NEO-FFI; Alansari, 1997). The PID-5 is the questionnaire that will be under assessment and the NEO-FFI will be used for PID-5's external validation, once it is the most studied measure of the 5 domains of normal/functional personality, and its Arabic version has shown good psychometric properties.

For the clinical sample, the instruments are the same but instead of the NEO-FFI, there is the Arabic version of Symptom Checklist-90 Revised (SCL-90-R; Al-Behairy, 1984). The decision of using the SCL-90 for external validation for the clinical sample was based on the fact that it is a measure of personality pathology, used in clinical settings for diagnosis of personality disorders. This instrument is also translated and validated in several Arab countries.

Personality Inventory for DSM-5 (PID-5)

PID-5 is a self-assessment inventory that operationalizes the DSM-5 alternative model for personality disorders proposed in Section III of the 5th Edition of the Diagnostic and Statistical Manual of Mental Disorders (APA, 2013). It is intended for adults 18 years and older of the general population and the population with physical or mental illnesses. It measures five personality domains and 25 pathological traits or facets. It consists of 220 items, quoted on a Likert scale of 4 points, ranging from 0 (very false or often false) and 3 (very true or often true). The reliability studies with the original sample revealed indicators of internal consistency measured by Cronbach's α between .72 and .96. All facets are strongly and positively correlated (Krueger, Derringer, Markon, Watson, & Skodol, 2012).

NEO-Five Factor Inventory (NEO-FFI)

The NEO-FFI is a self-assessment questionnaire composed of 60 items quoted on a five-point Likert scale, ranging from 1 (strongly disagree) to 5 (strongly agree). This measure evaluates the five personality domains of the Five Factors Model (Neuroticism, Extroversion, Openness to Experience, Agreeableness and Conscientiousness) and presents a high degree of reliability, with internal consistency indicators measured by Cronbach's α between .68 and .86 (Costa & McCrae, 1992) and temporal stability between .86 and .90 (Robins, Fraley, Roberts, & Trzesniewski, 2001).

Symptom Checklist-90 - Revised (SCL-90-R)

The SCL-90-R is a multidimensional self-assessment questionnaire consisting of 90 items measured on a five-point Likert scale ranging from 0 (Never) to 4 (Extremely) assessing the presence of psychopathology and psychological distress in clinical populations above 13 years old. It comprises nine symptomatic dimensions of psychopathology and three global indices. The dimensions are somatization (12 items), obsessions-compulsions (10 items), interpersonal sensitivity (9 items), depression (13 items), anxiety (10 items), hostility), paranoid ideation (6 items) and psychoticism (10 items). The three global indexes measure global wellness, hardiness, and symptom free. The SCL-90-R presents good internal consistency between .84 and .90 and time stability, with correlations between .80 and .90 (Derogatis, 1977).

Procedure

Data collection

ZU ethical clearance was obtained, and the questionnaires take in average one hour to complete. The sample will be recruited through a convenience method. Specifically, the non-clinical sample will be recruited among students/teachers/staff from different colleges from ZU (convenience sample) and from the community (snow-ball sample through ZU participants).

The clinical sample will be recruited from Rashed Hospital, Al Amal Hospital and National Rehabilitation Centre. The attendant physician will select the participants according to the

inclusion and exclusion criteria as well as the patients' conditions. However, we propose the following: the selected patients will be invited to participate by their attendant physician, and the research team will apply and collect the questionnaires. All questionnaires are anonymous, voluntary, and confidential. In order to assure the confidentiality and anonymity of the participant, it will be requested to the attendant physician to use the Diagnostic Report Sheet to write the patient's diagnosis. This form is composed of sheet A, which will be used by the attendant physician to attribute a code number to the patient's identification, and Sheet B which will be returned to the research team where the attendant physician will write the code number of the patient and his/her clinical diagnosis (attached). This should not take more than 2 minutes per patient.

Risks and Benefits:

The research team believes there are no meaningful risks associated with this study. The participation in this study is voluntary and no incentives or economic compensations will be offered.

Consent Setting:

For both, Clinical and non-Clinical population the Informed Consent form will be obtained face-to-face. For the Clinical population the attendant physician of Al Amal Hospital, Rashid Hospital and National Rehabilitation Centre will read the Informed consent form and if the patient would like to participate, he can do it after his consultation. For the Non-Clinical population, the students will be asked to participate in this study during classes.

Privacy and Confidentiality:

The participation in this study is voluntary and anonymous. The questionnaires are anonymous and will only be identified by an order code number (Questions such as name, emirates card number, address or any questions that may identify the subject will not be asked). For the clinical population, in order to have access to the clinical diagnosis and simultaneously maintain the anonymity of the participant, it will be asked to the attendant physician to fill the Diagnosed Report Sheet (attached) to assure that the research team will not be able to identify any participant in particular. All data (hard and softcopy) will have a code (instead of the name) and will be stored in a locked cabinet and office and this is explained in the Patients Information Sheet of the Informed Consent. All data (hard and softcopy) will have a code (instead of the name) and will be stored in a locked cabinet and office and this is explained in the Patients Information Sheet of the Informed Consent form. The data of the participants who may wish to withdraw part way through the study will be immediately destroyed.

Data analysis

Data will be analyzed through advanced software and statistics analysis. Specifically, AMOS (for Structural Equation Modeling) and SPSS will be used in the following studies:

- Study 1 – Psychometric Analysis of the Arabic PID-5 and its comparison across UAE and Portugal. Statistical analyses such as internal consistency, convergent validity, exploratory factor analysis, confirmatory factor analysis, amongst others, will allow us to understand how well the questionnaire fits UAE population, what items need to be adjusted/removed (if any). It will also enable to compare results across countries and understand its potential generalization.
- Study 2 - Comparative cross-cultural study of the UAE and Portugal population using PID-5: We intend to compare the two cultural contexts regarding gender differences and personality traits in three sub-studies: clinical sample; non-clinical sample; and full sample. This will be done through a study of invariance and t-test for independent samples.

Data Safety Monitoring

The Principal Investigator in conjunction with the research team will monitor the data collected (answers to the following instruments: The Arabic version of the PID-5, The Symptom Checklist-90-Revised and the NEO-FFI) once a week and the responses to the research protocol will be reviewed to monitor for clarity (i.e., the same question is skipped by 5 or more participants). In that case, the question will be revised, and an amendment will be submitted to the REC for the items identified as difficult to answer or not clear. The Principal Investigator will be responsible to inform the REC in case any changes or alterations will take place in order to assure the reliability and validity of the study.

Timeline

Spring 19	Activities
February-March	<ul style="list-style-type: none"> - Promotion of collaborations and partnerships with health and mental health institutions. - Request research to be approved by health institutions Ethical Committee. - Selection of patients (according to their condition) to voluntarily participate in the study.
March-May	<ul style="list-style-type: none"> - Data collection of clinical sample according to each institution's guidelines.

	- Data collection of non-clinical sample by personally contacting ZU local faculty and staff, and contacts in the community given by previous participants.
May-June	- Data coding on SPSS and statistical analysis (SPSS and AMOS)
June-July	- Results writing-up for the aforementioned studies 1 and 2, and papers' preparation for submission (conference and journal).

Note: The Timeline for collecting the clinical sample will depend on the REC's reviews of this study project and the number of participants available. For this reason, the research team will keep on collecting data until the minimum number of participants is achieved.

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