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ADAPTATION OF THE INTERNATIONAL PERSONALITY DISORDER EXAMINATION AND SCREENING QUESTIONNAIRE INTO THE RUSSIAN LANGUAGE

Master's Thesis

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Running head: IPDE adaptation into Russian

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Adaptation of the International Personality Disorder Examination and Screening Questionnaire into the Russian language

Abstract

The purpose of the master thesis was to finish the process of adaptation of the International Personality Disorder Examination Interview (IPDE-ICD-10) and Screening Questionnaire (IPDE- SQ) into the Russian language and to measure its psychometric properties on the non-psychiatric sample. The sample consisted of 306 participants who filled in the questionnaire, 106 of whom were assessed with both the questionnaire and the interview. As a result of the study, modifications were made to questions from the interview and statements from the questionnaire to ensure that those items would be understood by the participants the way they should.

Psychometric properties of the interview and the questionnaire were estimated: the correlations between the items of the questionnaire, the correlations between the questions of the interview and the correlations of the subscales between the two instruments. The correlations between the interview questions were higher than the correlations within the screening questionnaire. The correlations between the same scales of the IPDE and IPDE-SQ were moderate.

The IPDE-SQ internal consistencies were quite low (ranging from 0.27 to 0.53). However, they were similar with the results of other studies. The reliability of three scales (anxious, histrionic, borderline) of the interview was at 0.7 and higher level, the Cronbach α of the other five scales (paranoid, schizoid, dissocial, impulsive and dependent) ranged from 0.5 to 0.6. The false positivity of the questionnaire appeared to be too high in case 3 points are selected as a cut-off.

Additionally, the principal component analysis was conducted over the IPDE-SQ questionnaire items. It was decided to retain 11 factors, which explained 44% of the variability.

Rahvusvahelise isiksusehäirete intervjuu ja sõelküsimustiku adapteerimine vene keelde

Kokkuvõte

Magistritöö eesmärgiks oli lõpetada Rahvusvahelise isiksusehäirete diagnostilise intervjuu (IPDE-ICD-10) ja Sõelküsimustiku (IPDE-SQ) adapteerimine vene keelde ning mõõta selle psühhomeetrilisi omadusi normvalimi peal. Valim koosnes 306 isikust, kes täitsid sõelküsimustiku, neist 106 läbisid ka IPDE intervjuu. Töö käigus sai arusaadavuse tagamiseks parandatud 10 intervjuuküsimuse ja 2 sõelküsimustiku väite sõnastust.

Mõõdeti IPDE sõelküsimustiku ja intervjuu psühhomeetrilisi omadusi: korrelatsioone küsimustiku väidete vahel ja intervjuu küsimuste vahel, ka kahe instrumendi skaalade vahelisi korrelatsioone. IPDE küsimuste vahelised korrelatsioonid olid paremad kui sõelküsimustiku omad. IPDE ja IPDE- SQ sama isiksusehäire skaalade vahelised korrelatsioonid olid mõõdukad.

Tulemused näitasid, et IPDE-SQ alaskaalade sisemised konsistentsused olid suhteliselt madalad (vahemikus 0,27-0,53), kuid ikkagi sarnased nendega, mis oli raporteeritud teistes uuringutes. Intervjuu skaalade reliaablused olid vaid kolme skaala puhul (vältiv, histrioониline, piirialane) 0,7 ja kõrgemad, viie skaala puhul (paranoidne, skisoidne, antisotsiaalne, impulsiivne ja sõltuv) varieerus Cronbachi α vahemikus 0,5-0,6. Küsimustiku valepositiivsuse määr oli liiga kõrge, kui võtta intervjuule suunamise alampiiriks 3 väidet.

Lisaks viidi läbi sõelküsimustiku (IPDE-SQ) uuriv faktoranalüüs. Otsustati jääda 11-faktorilise lahendi juurde, mis seletas ära 44% variatiivsusest

Introduction

The International Personality Disorder Examination Interview (IPDE; Loranger, 1999) is a semi-structured clinical interview and Screening Questionnaire (IPDE-SQ; Loranger, 1999) questionnaire suitable for the assessment of personality disorders both in ICD-10 (International classification of diseases, 10th edition; World Health Organization, 1992) and DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, 5th edition; American Psychiatric Association, 2013) classification systems, which makes it the universal tool for both clinical practice and research purposes all over the world. Moreover, within ICD-10 diagnostic nomenclature this is the only semi-structured interview designed to diagnose and assess personality disorders in adults. This psychodiagnostic assessment tool is developed and validated by the World Health Organization. The IPDE was developed by Dr. Armand W. Loranger from the World Health Organization (WHO) in cooperation with colleagues from the international psychiatric community (Loranger, 1999).

The purpose of the current work was to finish the process of adaptation of the IPDE and IPDE-SQ for the Russian-speaking population of Estonia, to assess the psychometric properties of the instrument on a non-clinical sample in order to prepare it for usage by clinical psychologists of Estonia.

According to the 2011 census, 29.6% of residents of the Republic of Estonia speak Russian as their mother tongue. In the capital of Estonia (Tallinn), 45.6% of the people are native Russian speakers (Statistical Yearbook of Tallinn, 2016). Overall, the critical role of clinical assessment in the mother tongue is well-known. Linguistic barriers in communication may impair the quality of mental healthcare. For example, Jackson (2006) claims that the language barrier can cause misdiagnosis and inappropriate treatment of the symptoms. Taking into consideration the findings of Gass & Varonis (1991) in addressing the topic of communication difficulties between the tester and the testee, scoring inaccuracy is usually the result of using the language which is different from the patient's mother tongue. In addition, "inability to express ideas in a second language may lead to the loss of salient information" (Gass & Varonis, 1991). All things considered, it seems reasonable to assume that the Russian version of the IPDE validated according to the Russian-speaking population of Estonia will be an asset both to the patient who will have an opportunity to pass this testing in the mother tongue and a valuable asset to the clinical psychologist. Since ICD-10 classification system is used in Estonia, the IPDE-ICD-10 module has been chosen for the adaptation.

This theoretical chapter consists of three parts. The first part gives an overview of the existing personality disorders (PDs) within worldwide used diagnostic nomenclatures and reviews research on the impact, prevalence, gender differences and comorbidity of PDs. The second part introduces diagnostic instruments for PDs, highlighting advantages and disadvantages of the semi-structured interviews. The third part provides an overview and comparison of the semi-structured interviews suitable for assessing ICD-10 or DSM-5, with special consideration to the IPDE-ICD-10.

Personality disorders within global diagnostic nomenclatures

At the moment, there are two globally accepted systems for classifying mental disorders—the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) developed by the American Psychiatric Association (APA, 2013) and Chapter V of the International Classification of Diseases (ICD-10), set up by the World Health Organization (WHO, 1992). Compared to DSM system, which is used mostly in the USA and Canada, ICD has got widespread usage all over the world. According to the data of survey on the usage of ICD-10 diagnostic system and related diagnostic systems conducted by the WHO committee, in which 205 psychiatrists from 66 different countries across all continents were involved, ICD-10 appeared to be more frequently used and more highly valued for research in comparison with DSM-IV (Mezzich, 2002).

According to the definition of ICD-10 “A personality disorder is a severe disturbance in the characterological constitution and behavioral tendencies of the individual, usually involving several areas of the personality, and nearly always associated with considerable personal and social disruption” (World Health Organization, 1992, p. 157).

DSM-5 definition is the following: “A personality disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment” (American Psychiatric Association, 2013, p. 629).

Both systems claim that PDs involve unhealthy and inflexible patterns of thoughts and behavior, which negatively affect various aspects of life and cause impairment in many areas of functioning, i.e. lead to personal problems such as stress and anxiety, cause social functioning difficulties across a broad range of personal and social situations like decrease of efficiency at work and troubles in relationships with other people.

In the APA classification, PDs are divided into three clusters based on descriptive similarities within each cluster. Cluster A is called the “odd, eccentric” cluster, it includes

paranoid, schizoid and schizotypal PD. Cluster B or "dramatic, emotional, erratic" cluster consists of antisocial, borderline, histrionic and narcissistic PDs. The last one, the "anxious, fearful" cluster or cluster C covers avoidant, dependent and obsessive-compulsive PDs.
ICD-10 places PD-s into F60 chapter, distinguishing between eight types of specific PDs (paranoid, schizoid, dissocial, impulsive, borderline, histrionic, anankastic, anxious, dependent) and an unspecified PD marked with a separate code. Diagnostic criteria of the personality disorders according to the ICD-10 could be found in the Appendix 1. Whereas ICD-10 requires at least three diagnostic criteria to be present for the diagnosis, the research version of ICD-10 (1993) allows to diagnose most of the PDs if at least 4 criteria are met.

DSM-5 differs from ICD-10 by having the schizotypal and narcissistic PDs, while ICD-10 includes the impulsive subtype of emotionally unstable PD. The names of several PDs also vary between the two systems: dissocial and antisocial PD, anxious and avoidant PD, anankastic and obsessive-compulsive PD.

Impact and comorbidity

PDs have a significant impact on the individual, family and society. According to many in the field, PDs are associated with a variety of problems on different levels. The most common of them were summarized by Ruegg and Frances: "Personality disorders are associated with crime, substance abuse, disability, increased need for medical care, suicide attempts, self-injurious behavior, assaults, delayed recovery from Axis I and a medical illness, institutionalization, underachievement, underemployment, family disruption, child abuse and neglect, homelessness, illegitimacy, poverty, STDs, misdiagnosis and mistreatment of medical and psychiatric disorder, malpractice suits, medical and judicial recidivism, dissatisfaction with and disruption of psychiatric treatment settings, and dependancy on public support" (Ruegg and Frances, 1995, p. 16).

Perceived quality of life and subjective well-being is also found to be lower in individuals with PDs. Cramer, Torgersen, & Kringlen (2006) have investigated the relationship between specific PDs and specific aspects of quality of life and have concluded that patients with an avoidant, schizotypal, paranoid, schizoid, and borderline PDs have reported the substantial decrease in the quality of life, whereas histrionic and obsessive-compulsive PSs were not. Research also appears to validate the view that the severity of PD is in negative correlation with the perceived well-being. The results confirm that the more PD criteria are fulfilled, the lower the quality of life reported. Moreover, the PDs appear to predict the quality of life more significantly than the general somatic health, socio-demographic variables and axis I disorders (Cramer et al., 2006).

A considerable amount of literature has been published on the PS comorbidity with other mental disorders. People with PDs are at heightened risk for many psychiatric disorders (Links & Eynan, 2013; Dolan-Sewell, Krueger, Shea, 2001; Links, Ansari, Fazalullasha, Shah, 2012). The PDs are also highly comorbid with each other, but the patterns of comorbidity tend to vary depending on a sample examined. For example, the comorbidity in the clinical samples is usually higher, and it is typical the patient receives more than one diagnosis. This may happen due to a variety of reasons starting from a significant overlap between the existing diagnoses and finishing with shared personality traits and patterns of behavior (Widiger & Trull, 2007). Summarizing different PD comorbidity studies, it could be concluded that some patterns are more typical. For example, dissocial and anankastic PDs show less covariance with other PD diagnoses, while patients with borderline, paranoid or dependent diagnoses are more likely to get an additional PD diagnosis (Trull, Scheiderer, Tomko, 2012).Taking into consideration an array of different negative outcomes of the PDs, their negative impact on the well-being and high comorbidity with other psychiatric disorders, and the significant impact on the treatment course, it is important to detect them as early as possible.

A substantial body of literature has been published on the relationships between each of the five-factor model personality dimensions and each of the personality disorders. Saulsman & Page (2004) consolidate the available literature in the meta analytic review and conclude that low agreeableness and high neuroticism are consistently interrelated with all PDs, with the exception of the dependent PD, while extraversion dimension plays a discriminating role, conscientiousness a much smaller role and openness to experience no role at all. (Saulsman & Page, 2004).

Prevalence

Numerous studies have been conducted on the prevalence of the PDs, and comparisons of the results made. The numbers appear to be quite similar across a wide range of studies, despite the differences in diagnostic system editions, sample sizes, and assessment instruments. The Oxford Handbook of personality disorders compares eleven different studies (Torgersen, 2012, p. 187-188) on the prevalence of PDs, assessed with different structured interviews. Despite the fact that the mentioned studies differ quite a lot, beginning with the assessment instruments themselves and the diagnostic system editions (DSM-III, DSM-III-R and DSM-IV were used) and finishing with the sample differences in size, age and the country of residence of the participants, the results appeared to be quite similar. On the average, the prevalence of PDs appeared to lay between 10.5% - 12% which is in accordance with the data gathered in the 1990s during an epidemiologic study

on the prevalence of PDs (Weissman, 1993). The studies based on DSM-IV and the IPDE diagnostic instrument indicate prevalence rates of 10% (Samuels and colleagues, 2002) and 11, 9% (Lenzenweger, Lane, Loranger, & Kessler, 2007). Overall, these findings suggest that approximately 1 in 10 adults in the community would meet the diagnostic criteria for at least one PD.

However, the prevalence of PD in clinical populations is much higher, which makes PDs one of the most frequent groups of disorders psychiatric clinics deal with. According to several studies conducted during two previous decades, reported prevalence rates of any PD in the clinical populations are 64.7% (Grilo et al., 1998), 71.9% (Fossati et al., 2000) and 45.5% (Zimmerman, Rothschild, & Chelminski, 2005). When the patients with not otherwise specified PD were also included, the number of personality disorder among these samples grew up to 76.9% (Grilo et al., 1998), 88.4% (Fossati et al., 2000) and 59.6% (Zimmerman et al., 2005).
One possible implication of this is that PSs should be assessed in all psychiatric patients, because their presence could strongly affect the course and the therapy (Zimmerman, et al., 2005).

Gender differences

Despite the consistency of the results on the prevalence of PDs in the population, there has been little agreement if men are more vulnerable to PDs or not. Recent findings indicate that there is no considerable difference between the overall prevalence rates of PD in men and woman in most PDs (Oltmanns and Powers, 2012). The major issues in gender research on PDs concerned gender biases of the interviewers which may affect the way they ask questions and the biases in the criteria of the assessment instruments themselves (Oltmans & Powers, 2012).

Nevertheless, a considerable amount of literature has been published on the prevalence differences of specific PDs in men and women. Even DSM-IV-TR version theorizes that antisocial, narcissistic, obsessive-compulsive, paranoid, schizotypal and schizoid PDs are more frequent in men, and borderline, histrionic and dependent are more frequently found in women (American Psychiatric Association, 2000). However, across a variety of studies a consensus has been obtained only over the antisocial PD, which is consistently more frequently diagnosed among men (across a vast majority of studies) (Cale & Lilienfeld, 2002). Recent evidence suggests that since there are gender differences in the core personality traits there should also be differences in the prevalence of PDs since personality pathology represents maladaptive forms of traits (Lynam and Widiger, 2007). According to their study the frequency of dependent PD should be higher in women and antisocial, schizoid and narcissistic more common among men.

Several studies have investigated the relationship between the educational level and PDs (Grant et al., 2004, Torgersen, Kringlen & Cramer, 2001), but there is still insufficient data regarding this interrelation, as it is noted by Torgersen (2009) in the "Essentials of Personality Disorders." Grant et al (2004) found that lower levels of education were related to all the PDs except the obsessive-compulsive PD, which was related to higher education (Torgersen et al., 2001).

Assessment instruments

There are several options for the personality pathology assessment: self-report inventories; structured, semi-structured and unstructured interviews; informant reports and projective tests (Miller, Few, Widiger, 2012). Some tools focus on general assessment of PDs and some focus on one specific personality disorder, such as the Diagnostic Interview for Borderline Patients-Revised (DIB-R; Zanarini, Gunderson, Frankenburg, & Chauncey, 1989), the Narcissistic Personality Inventory-16 (NPI-16; Ames, Rose & Anderson, 2006) or the Antisocial Personality Questionnaire (Blackburn & Fawcett, 1999). A selection of the appropriate instrument usually depends on how deep or broad assessment should be made or is there a need to distinguish between the subtypes of one specific personality disorder. According to Friedman, Oltmanns, & Turkheimer (2007), structured diagnostic interviews, rating instruments for clinicians, self-report questionnaires and other-report questionnaires are widely-used methods to assess PDs. Furnham, Milner, Akhtar and De Fruyt (2014) report that questionnaires and structured interviews are the most commonly used diagnostic instruments.

Self-report questionnaires

Self-report questionnaires vary by length and purpose. One group of self-report questionnaires enable to detect the presence of some potentially maladaptive personality traits and based on their number to decide if further assessment is necessary (Widiger & Samuel, 2005). Since the aim of such self-report inventories is to select patients for further assessment, they have a tendency to generate too much psychopathology. That is the reason McDermutt & Zimmerman (2005) do not recommend using them for making diagnoses but advise to apply them as screening tools. However, not all self-report questionnaires were developed as screening tools. Some self-report questionnaires consist of several hundreds of items and serve diagnostic or exploratory purposes. Such instruments include the Schedule for Nonadaptive and Adaptive Personality (SNAP-2; Clark, 1993), the Personality Inventory for DSM5 (PID-5; Krueger, Derringer, Markon, Watson, & Skodol, 2012) or the Omnibus Personality Inventory (OMNI; Loranger, 2002).

By contrast, there are also short screening tools consisting of several items only. An example would be the Standardized Assessment of Personality: Abbreviated Scale (SAPAS; Moran et al., 2003), which is an 8-item inventory to quickly assess if a personality disorder is possible.

However, the number of items in the PD screening questionnaires on the basis of DSM-IV system usually stay under 100 (Pomeroy, 2014; Hersen, 2004). These questionnaires include the Personality Diagnostic Questionnaire-4 with 99 items (PDQ-4; Hyler, 1994), the International Personality Disorder Examination Screen with 59 or 77 items depending on the diagnostic system (IPDE-SQ; Loranger et al., 1999), the PBQ-Short Form with 65 items (PBQ-SF; Butler, Beck, & Cohen, 2007), the Short Coolidge Axis-II Inventory with 70 items (SCATI; Coolidge, 2001).

Structured interviews

One of the key instruments in diagnosing PDs are structured interviews. They could be divided into fully structured and semi-structured, depending on how rigidly the structure of the interview is required to be followed and what degree of deviation from the structure is acceptable. Both in fully structured and in semi-structured clinical interviews questions are typically asked verbatim to the interviewee in a fixed order. In the fully structured assessment instruments all the following questions are to be asked word for word and the interviewer should not deviate from the structure. As concluded by Miller and colleagues (2012) and Hersen (2004), semi-structured interview is the most frequently used and preferred assessment method among clinical psychologists.

Advantages of semi-structured interviews

During semi-structured interview proceedings, the clinician has the discretion to modify some follow-up questions if it is needed for the better understanding and more accurate assessment of certain criteria (Segal, Coolidge, O'Riley, & Heinz, 2006). Semi-structured interview simplifies following a topical trajectory in the conversation and assess each symptom, which leads to more reliable and valid results. It helps to cover all the criteria systematically on the one hand and increases the inter-rater reliability due to the standardized questions on the other hand. This also makes it possible to compare a person’s condition across time, or self-report with an informant report (Segal & Williams, 2014). At the same time, a semi-structured interview allows to deviate from the guide if the clinician thinks it would be appropriate, which makes the conversation more natural, spontaneous and enables to elicit some important patterns of patient behavior which

altogether contributes to the diagnostic process (Tasman, Kay, Lieberman, First, & Riba, 2015). The flow of the questions from the general to the more personal facilitates the natural progress of the interview (Koerner, Hood, & Antony, 2014).

Additionally, manuals going along with the majority of semi-structured interviews contain valuable knowledge concerning the basis of each diagnostic criterion and gives instructions to making an accurate exclusion in case of difficulties, which is a valuable asset for clinicians (Tasman et. al., 2015). Furthermore, the semi-structured interview could also serve as a training tool for clinicians to improve their interviewing skills (Hersen et al, 2011). On the other hand, substantial training is required to learn the particular assessment method (Sarkar & Duggan, 2010). A number of authors have analysed trends in personality pathology assessment and found a significant difference between research and general clinical practice related to PDs. While the preferable method in the research of PDs is the fully structured or semi-structured interview, many clinicians still give preference to unstructured interview in their everyday practice (Widiger & Samuel, 2005).

Widiger & Samuel (2005) list the advantages of semi-structured interviews over unstructured ones. Perhaps the most serious of them is the systematic and thorough evaluation of the diagnostic criteria, replicability and objectivity of the assessment. Many scholars hold the view that unstructured interviews are linked with an array of problems including inaccurate and biased assessment, heightened attention to some symptoms while neglecting the others (Maddux, 2015). Overall, these studies highlight the need for equable and replicable assessment, which could be attained by using semi-structured interviews.

Disadvantages of semi-structured interviews

Although, semi-structured interviews have good empirical support, it is important to keep in mind that since they are based upon certain classification system, their validity is therefore dependent on the validity of the diagnostic system itself (Hersen et al, 2011). A significant amount of commonly used diagnostic instruments are based upon DSM classification. The criticism of much of the literature (Blais, 1998; Westen & Shedler, 1999; Blackburn, 2000) on DSM-IV classification system was connected mostly with the system's reliability, validity and clinical utility. This is summarized in the paper written by Sarkan & Duggan (2010) who note that one of the main problems of DSM-IV diagnostic system was the predominance of the clinical consensus over the empiricism in the chapter of PDs. This affected the validity, reliability, classification of the PDs, and the differences between the ICD and DSM systems regarding the number of PDs and

the diagnostic threshold of each of them. Sarkar and Duggan (2010) criticize the concurrent validity between the diagnostic instruments. In their opinion, inadequacies in the diagnostic instruments are mostly connected to the classification itself.

However, every diagnostic tool has its own disadvantages apart from the diagnostic system. In case of structured and semi-structured interviews one major criticism is that these diagnostic instruments are time consuming, which may not be relevant in clinical practice (Hersen, 2004). Another major concern is the influence of semi-structured interviews on rapport building. Since these diagnostic tools are more problem-centered than person-centered, the supposed form of communication may be quite challenging for developing trusting and empathetic relationships (Beidel, Frueh, & Hersen, 2014). Meanwhile, as noted by Denscombe (2007), there are many factors including sex, age, ethnicity influencing how honestly the interviewee would answer the questions and how much he or she would be ready to reveal. So, if there are any factors which could be manipulated by the interviewer when interacting, like the way questions are asked, this should be taken into consideration to facilitate the rapport. Hindered rapport during the conduct of the semi-structured interview is usually considered to be a problem of non-experienced or poorly trained psychologists (Segal et al., 2006). As a solution, Rogers (2003) suggests combining unstructured interviews with standardized ones. He suggests beginning an interview in an unstructured way which is beneficial to building the rapport and then continuing with the standardized interview.

Murphy and McVey (2010), however, hold the view that clinicians should not solely rely on formal assessment tools because this may lead to both diagnostic and treatment difficulties. Since widely used diagnostic instruments are mostly self-administrated and self-reported, they are consequently connected with the distortions of self-description. Participants may overstate or decrease their symptoms for a variety of reasons. Patient may believe that exaggerating the symptoms will probably bring more attention and care, or reversely, by decreasing the symptoms, they may be trying to avoid punishment, stigma, shame or further intervention. Debate continues about the best strategies for the management of inaccurate information which could be provided by the patient. This could happen for several reasons starting from the patient's inability to notice and acknowledge the behavior, and finishing with the conscious will to conceal the pathological traits. Those problems seem to be inevitable when it comes to self-report instrument. The question "Have people told you that you're like that?" asked from the patient helps to resolve the problem that the behavior is not acknowledged by the person himself or herself (Loranger, 1999).

Despite some of the disadvantages of semi-structured interviews, this is an invaluable tool for diagnosing a disorder of the personality. In the article "Evidence-Based Assessment of Personality Disorders" Widiger & Samuel (2005) have concluded that the combination of self-report questionnaire and semi-structured interview provide the most accurate assessment. Particularly, they suggest using integrated assessment, administrating a self-report questionnaire as a first step and then conducting an interview as a second step. In the same vein, Hersen (2004) in his book "Comprehensive Handbook of Psychological Assessment, Personality Assessment" notes that the combination of self-report and interview assessment could be an efficient solution to save time and get more valid results.

Informant reports

Klonsky, Oltmann and Turkheimer (2002) hold the view that the main problem of both self-report questionnaires and structured interviews is that they are based solely on self-report and usually on one opinion only. It is commonly assumed that several sources of information give more reliable information than the single one. Moreover, people with a personality pathology are not always capable of assessing themselves realistically and may not realize how their behavior affects others. This means, that their self-report may not be accurate and may contain biased information such as distortion of self-description, denials and exaggerations. An additional source of information such as a family member, a friend or a coworker can be used in clinical practice to provide adequate data. According to Bernstein and colleagues (1997) informant interview increases the accuracy of the diagnosis. Klonsky and colleagues (2002) also suggest collecting information from the informants to attain a more reliable and valid assessment. However, according to their research based on 30 different studies that compared self and informant reports on the domains of personality pathology, self/informant agreement on DSM PDs is moderate to low. Research also indicates that the concordance was higher in the studies which investigated non-DSM domains of personality. The agreement between self-report and informant descriptions seemed not to differ depending on the type of the diagnostic tool used (whether the interview or questionnaire was used as a diagnostic tool) or whether the sample was psychiatric or non-psychiatric) (Klonsky et al., 2002). This is consistent with the findings of Ready and Clark (2002) which showed that the influence of psychopathology on the self-assessment of interpersonal problems and personality traits is minimal. Despite relatively low agreement between patients and informants, most researchers still recommend including informants into the assessment when it is possible, since it sometimes helps to elicit pathological personality traits the patients themselves may not be aware

of (Skodol, 2014). Even though informants are not usually capable of providing full information about different areas of functioning of the patient (Widiger & Boyd, 2009), it may still reveal some maladaptive traits or behavior. It is important to keep in mind that informants tend to report more pathologic conditions than the patients themselves (Cooper, Balsis, & Oltmanns, 2012).

Research suggests that most diagnostic disagreements in psychological assessment are not due to the questions but rather to discrepancies in the application of diagnostic criteria (Widiger and Spitzer (1991) cited in Oldham, Skodol, & Bender (2005)).

For this reason, assessment tools with detailed administration and nuanced manuals like the International Personality Disorder Examination (IPDE; Loranger, 1999) and the Personality Disorder Interview (PDI-IV; Widiger, Mangine, Crobitt, Ellis, & Thomas, 1995) are valued among clinicians (Oldham at al., 2007).

The comparison of semi-structured interviews

According to "Psychiatry" edited in 2015 (Tasman et al., 2015) at the moment there are 5 semi-structured interviews which are suitable for the assessment of PD pathology according to DSM-5. These are: the Diagnostic Interview for Personality Disorders (DIPD-IV; Zanarini, Frankenburg, Sickel, & Yong, 1996), the International Personality Disorder Examination (IPDE; Loranger, 1999), the Personality Disorder Interview – IV (PDI-IV; Widiger, Mangine, Crobitt, Ellis, & Thomas, 1995), the Structured Clinical Interview for DSM-IV-TR Axis II Personality Disorders (SCID-II; First, Gibbon, Spitzer, Williams, & Benjamin, 1997), and the Structured Interview for DSM-IV-TR Personality Disorders (SIDP-IV; Pfohl, Blum, & Zimmerman, 1997). The overview of these diagnostic instruments is displayed in the table 1.

Table 1. ***The comparison of semi-structured interviews***

Name	Authors	Structure	Rating	Administration time	Scoring
Diagnostic Interview for Personality Disorders, DIPD-IV	Zanarini, Frankenburg, Sickel, & Yong, (1996).	Disorder-by-disorder basis	0“ - absent or clinically insignificant, „1“ - present but of uncertain clinical significance, „2“ indicates present and clinically significant, and „NA“ indicates not applicable	Is typically about 90 minutes.	Categorical diagnose (definite, probable, or negative)
International Personality Disorder Examination, IPDE	Loranger, (1999).	Thematic content	“0” - behavior or trait is absent or within normal limits, “1” - exaggerated or accentuated degree of the trait, “2” - criterion level or pathological, and “?” - the respondent refuses or is unable to answer.	Is 90 minutes for the interview	Both dimensional score (sum of individual scores for each disorder), and a categorical diagnose (definite, probable, or negative) for each personality disorder.
Personality Disorder Interview – IV, PDI-IV	Widiger, Mangine, Corbitt, Elis, & Thomas, (1995).	In two separate versions: by personality disorder and by thematic content.	Each criterion is rated on the following three-point scale: “0” indicates not present, “1” indicates present at a clinically significant level, and “2” indicates present to a more severe or substantial degree.	Is about 90 to 120 minutes	Both dimensional and categorical rating for each personality disorder
Structured Interview for DSM-IV-TR Personality Disorders, SIDP-IV	Pfohl, Blum, & Zimmerman, (1997)	In two versions: (1) items grouped by diagnosis and (2) items grouped topically.	each item is rated from 0 to 3 (0=not present, 1=subthreshold, 2=present, 3=strongly present)	Is between 60 and 90 minutes	Both categorically and dimensionally
Structured Clinical Interview for DSM-IV-TR Axis II Personality Disorders, SCID-II	First, Gibbon, Spitzer, Williams, Benjamin, (2004).	Organized by diagnosis	“1” indicates absent or false, “2” indicates subthreshold, “3” indicates threshold or true	Is typically 30 to 45 minutes	Categorically A dimensional scoring component has been added to the SCID-5-PD.

The IPDE, the SCID-II and SIDP-IV have been used in most empirical studies (Oldham at al., 2007). The IPDE stands out from other semi-structured interviews since it is based not only upon DSM classification system, but also upon ICD-10 (Loranger, 1999). Among other structured interviews for the personality pathology diagnosis, the IPDE is the only tool of this format which has separate manuals for both global diagnostic nomenclatures.

The SIDP-IV and PDI-IV are available in two structurally different versions. The items are grouped by the diagnosis in one version and topically in another version. The SCID-II and the DIPD-IV are organized by the diagnosis. The notable difference between the IPDE and other structured interviews is that the IPDE is organized by the thematic content only and does not have disorder by disorder organization, as other interviews do. Loranger notes that such organizational format makes the intent of the assessment less predictable and "attempts to provide the optimal balance between a spontaneous, natural clinical interview and the requirements of standardization and objectivity" (Loranger, 1999, p.116). Topical organizational format could also be beneficial in terms of reducing interviewer biases. Since the final scoring takes place in the very end and the number of criteria met is not obvious till that time, the interview will be less likely changing thresholds, which overall extenuates the halo-effects (Segal & Williams, 2014). The IPDE items are grouped according to 6 broad topical sections: work, self, interpersonal relationships, affects, reality testing, and impulse control. The version of the PDI-IV organized by thematic content reflects 9 topical areas: attitudes toward self, attitudes toward others, security and comfort with others, friendships and relationships, conflicts and disagreements, work and leisure, social norms, mood, and appearance and perception. The SIDP-IV contains even more topical areas which adds up to 10 different sections. These are interests and activities, work style, close relationships, social relationships, emotions, observational criteria, self-perception, perception of others, stress and anger, and social conformity (Hersen et al., 2011). Interviews with the topical organization have at least one more considerable advantage - they can easily be used also with the informant (Koerner et al., 2014).

In respect to the administration time, the SCID-II is considered to be the shortest interview which takes less than an hour and typically ranges between 30 and 45 minutes. However, its brevity has been the subject of criticism (Rogers, 2003). The administration time of the other structured and semi-structured interviews mentioned above is about 90 minutes on average. The PDI-IV may be the longest one, which administration time ranges from 90 minutes to two hours, though it contains the biggest number of items. The administration of the IPDE usually takes 1

to 2 hours, which is fairly time-consuming. Overall, the administration time of the structured interviews is frequently considered as a serious limitation for their use in the daily clinical practice. However, in comparison with the other semi-structured interviews, the IPDE proved to be less time-consuming than some other widely used semi-structured interviews (Oldham et al., 2007).

All DSM-5 assessment instruments have a similar mode of rating. Four interviews (with the exception of the SIDP-IV) are rated on a 3-point scale, where "0" indicates not present, "1" indicates present at a clinically significant level or a subthreshold, and "2" indicates present to a more severe or substantial degree or the presence of the criteria. Each item of the SIDP-IV is rated on a 4 point scale, where "0" indicates, "1" signifies subthreshold, "2" and "3" indicates present to a more severe or substantial degree (Segal et al., 2006). The logic behind scoring the IPDE is as follows: if a behavior or trait seems to be absent or normal, it gives 0 points to the total score and means "negative", in case the trait or behavior is exaggerated or accentuated it should be estimated as 1 or "probable", and if the level of the criterion is pathological, it should be rated as 2 or "definite". In case the criterion could not be applied to the patient for some reasons it gets the mark NA. For example, a subject who has never worked gets NA for the question 1 which addresses work life ("Do you spend so much time working that you don't have time left for anything else?"). Clinical judgement whether the patient is meeting the criteria should be based not only on the positive replies of the patient, but also include convincing examples and specifications (Loranger, 1999; Segal, Coolidge, & Rosowsky, 2006).

The IPDE and the SCID-II have also additional screening questionnaires, the IPDE-SQ and the SCID-II, respectively. According to Widiger (2005) the combination of a self-administrated screening questionnaire and a semi-structured interview provides the most accurate assessment. The screening questionnaire of the IPDE consists of items which should be chosen as "true" or "false." The number of them varies depending on the diagnostic system. For DSM-IV IPDE there are 77 dichotomous questions and for ICD-10 59 ones. The screening questionnaire usually takes around 15 minutes to administer and this is the first step to find individuals whose scores make the presence of a PD probable and who would need further examination. The SCID-II screening questionnaire is somewhat longer - it contains 119 items in a Yes-No format and takes 20 minutes to complete (Segal et al., 2006). All the above-mentioned diagnostic interviews ultimate outputs (with the exception the DIPD-IV) include both dimensional (number of criteria met or/and the sum of individual scores for each disorder) and a categorical diagnosis (definite, probable, or negative) for each PD, thus providing information

about the presence and severity of a PD. The DIPD-IV final output is categorical, indicated on a 3-point scale, where 2 means that the patient meets full criteria, 1 indicates a subthreshold, and 0 indicates that the patient has no disorder (Koerner et al., 2014).

The IPDE is the only interview based on the international field trials (Segal, Mueller, & Coolidge, 2011): 14 centres from 11 different countries in North-America, Europe, Africa and Asia were involved in the development of the IPDE (Loranger, 1999).

Adaptation

Adaptation of the psychological test is a complex procedure and consists of several important steps. This should always begin with an evaluation whether the instrument would be capable of measuring the same construct in the different cultural context. Then should follow the selection of the translators and of the relevant (appropriate) methods to create a fully adequate assessment instrument. Hambleton (2004) emphasizes that the translation is an important part of the adaptation process and it should not be limited to just the literal one - this is a procedure during which "the translators are trying to find concepts, words, and expressions that are culturally, psychologically and linguistically equivalent in a second language and culture" (p. 4). Several translations are usually made, compared with each other and combined with an objective to generate the most appropriate.

According to the guidelines for the cross-cultural adaptation of psychological instruments made by the International Test Commission (ITC; 2016), the appropriate judgmental designs should be applied to decide if the translated version are suitable and adequate for the intended population. The most popular methods are forward and back translations, asking opinion of the experts and different rating scales, for example Jeanrie and Bertrand (1999), Hambleton and Zenisky (2010), or Brislin (1986) ones. The pilot study will be helpful in finding whether all the items are easily understandable for all the testees and if the scoring categories and rating scales are adequate (ITC, 2016). To examine whether two instruments are compatible, the psychometric properties of the new version need to be compared with the previous ones. (Hambleton, 2004). Hambleton (2004) also highlights the main aspects which could lead to the instrument invalidity. These are linguistic and cultural differences, errors in the interpretation of results, and some technical aspects of method and design.

Adaptation of the IPDE

The IPDE has been initially worked out in English and adapted to an impressive number of different languages: Dutch, French, German, Hindi, Japanese, Kannada, Norwegian, Swahili,

Tamil, Danish, Italian, Spanish and Estonian (Loranger, 1999).

The IPDE was adapted into the Estonian language in 1995 and has been successfully used in clinical practice there after (Eensalu, 2002). Even though it was mentioned in the IPDE manual that the Russian version of the interview was produced, it has never been in use in Estonia and has not been adapted to the Russian-speaking population of Estonia. As far as the author knows, it is not widely used in Russia either and even a psychiatric book edited in 2016 suggests using the interview based on DSM system (Zhmurov, 2016), although the IPDE has been translated and back-translated according to a methodology with the same scientific terms. The assessment of psychometric characteristics was conducted until the 2014 when a psychiatric clinic in the Republic of Belarus administrated their Russian translation on a sample of 302 psychiatric patients. The table below (Table 2) gives an overview of Cronbach α of the scales of the IPDE of the Russian and Estonian versions reported in the studies of Assanovich (2014) and Eensalu (2002).

Table 2. *Cronbach α of the scales of the IPDE interview in the other studies*

	Assanovich	Eensalu
Paranoid	.75	.75
Schizoid	.63	.62
Dissocial	.64	.87
Impulsive	.64	.69
Borderline	.58	.66
Histrionic	.71	.71
Anankastic	.79	.72
Anxious	.79	.82
Dependent	.62	.74

Reported coefficient of reliability varied from .58 to the .75 for different scales in the Russian version. From the questions of the interview exemplified in the article, it was concluded that the translation was too verbatim or with a difficult word order. Some example questions:

«Испытываете ли Вы беспокойство, связанное с продолжением деятельности, если при этом не получаете немедленного вознаграждения?» (Do you have trouble sticking with a plan or course of action if you don't get something out of it right away?)

«Вы обычно стараетесь избегать занятий или вещей, которые Вам необходимо сделать на работе, вовлекающих Вас в контакт с другими людьми? », (Do you usually try to avoid jobs or things you have to do at work/school that bring you into contact with other people?)

«Ваше самолюбие легко задеть, если критикуют или не одобряют Вас?» (Are you easily slighted or offended?)

An adaptation process which took into consideration both cultural and linguistic peculiarities of the Russian population living in Estonia began in 2013 and was conducted by three students of the University of Tartu: Tatiana Kovaleva, Ksenia Kravtšenko and Pjotr Shevchenko under the supervision of Maie Kreegipuu (see Kovaleva, 2013; Kravtšenko, 2013; Shevchenko, 2013).

Methods

The data was collected in two stages. The first cohort of 122 participants completed the questionnaire during spring 2013, the interviews was conducted with 20 of them during the same time span by 3 bachelor students within the framework of their bachelor's theses (see Kovaleva; 2013 Kravtšenko; 2013 Shevchenko, 2013).

During the winter of 2016/2017, another portion of data was collected. This time, the IPDE- SQ questionnaire was completed by 184 respondents and 86 interviews were conducted by the author of the current work. Professional guidance was provided by the supervisor before the start of interviewing process, and emerging issues were discussed in between the interviews. The questionnaire was available in both paper and electronic versions (the latter conducted on the basis of google.docs). The link to the questionnaire was shared among colleagues, friends, relatives and via social media websites such as Facebook and Vkontakte. Generally, virtual snowball sampling and snowball sampling were used.

In total, 306 Russian-speaking adults aged between 19 and 86 answered the questionnaire, 71.7% of them being female and 28.3 % of them male. The average age of the sample was 33.18 (SD=10.39), for women 32.37 (SD=10.42) and for men 35.3 (SD=10,4). The two gender groups did not differ significantly by their age and level of education. Overall, 242 (79%) of the respondents had a higher education, 59 (19%) of the respondents were with a secondary education and 3 of all respondents (1%) had a basic education.

Altogether, the interview was conducted with 106 (92 of them by the current work's author) Russian speakers living in Estonia aged between 22 and 67 (M=34.2, SD=11.6). The proportion of men and women among the interviewees was 36.8% and 63.2%, respectively. Overall, the interest in the current research was significantly higher among women than among men.

An informed consent was obtained from every interviewee. The participation in the survey was voluntary, anonymous and confidential, all participants were informed about opportunity to stop or finish the interview at any moment and were allowed not to answer any question of the interview they did not want to. None of the respondents finished the interview prematurely,

though there were several times when the participants answered the question, but did not want to bring relevant examples. Mostly, the participants were interested in the feedback which was promised only after the interview. On average, each interview lasted an hour and 15 minutes. The shortest interview lasted around 50 minutes and the longest 2 hours.

An introductory text in the heading of the questionnaire encouraged the participants to make comments about the formulation of the questions and asked them to suggest alternatives which would better conform to their usual language. “Если Вам непонятен вопрос, или Вы считаете, что его формулировка неудачна, пожалуйста, отметьте это. Если возможно, предложите свою формулировку”. (If you do not understand the question, or you think that its wording could be better, please note this, and if possible suggest your own version of this question.)

Interviews were administered blind to exclude a potential bias of the questionnaire results on the interview scoring. The statistical analysis was performed using SPSS 23.0.

The correlations between the items and questions within each of the 9 scales of both the questionnaire and interview were calculated. The internal consistency of the questionnaire and interview was calculated for each nine subscales using Cronbach's α for the interview and KR-20 formula for the questionnaire.

Exploratory factor analysis (principal component method for the categorical data, CATPCA) was conducted over the questionnaire. The selection of this method was based on both theoretical (PD structure critics in the literature and empirical weakness of diagnostic criteria) and practical grounds (poor fit in the confirmatory factor analysis).

Additionally, both the questionnaire and interview adaptation were rated by an expert according to Hambleton and Zenisky (2010) 25-item translation and adaptation review form.

Results

Comments left by some respondents were the main source of information about the statements which seemed unclear and thereby needed to be changed. 7% of the participants made their comments, however typically difficulties were not connected with the phrases themselves but with the overall structure of the questionnaire. Typically, respondents asked to add a “not sure” option, since it was difficult to choose between “True” or “False”, especially when both types of behavior occurred. The instruction was as follows „Пожалуйста, не пропускайте ни одного вопроса. Если Вы не уверены в ответе, то выберите из вариантов «верно» или «неверно» тот, который вероятнее всего является справедливым. Ограничения по

времени нет, однако не раздумывайте над каждым отдельным вопросом слишком долго". (If you are not sure about the answer, then choose from the options "true" or "false" the one that is most likely to be regular. There is no time limit, but do not think about each individual item for too long). Some of the respondents have reported that they had difficulties answering question 36 "Думаю, мой(я) супруг(а) (возлюбленный(ая)), возможно, мне изменяет" (I think my spouse /lover may be unfaithful to me), since they were single at the moment of filling in the questionnaire.

The interviews were the biggest part of the process and 10 questions were edited. Additionally, two items of the questionnaire were slightly modified. The most problematic question of the interview was question 51 (Some people have a very strong need to feel safe from physical harm. That may affect the way they live their lives or prevent them from doing a lot of things. Are you like that?) from the anxious scale. Table 3 presents the questions of the IPDE interview which were changed to ensure that the questions would be understood the way they should. Table 4 contains the modifications of the questionnaire statements. The table contains the number, scale and text of the original question/statement, the previous and modified versions of the items in the Russian language and comments why the questions may have been problematic and what has been changed to ensure better understanding. Question 43 (Have people ever told you that you're a very angry person? or Do you sometimes get angrier than you should, or feel very angry without a good reason?) were changed to sound more grammatically correct, while the wording of other modified questions was changed to convey the meaning better than they previously did.

The new wording has been understood by all the participants the way it should.

The questionnaire and interview could be found in the appendix 5 in a separate file.

Table 3

Modifications of the problematic IPDE interview questions

№ , scale, english original	**Translations**	**Comment**
3 ANK Are you fussy about little details?	1.Беспокоитесь ли Вы о мелких деталях? 2.Беспокоитесь ли вы о мелочах?	It was frequently asked what was meant by "little details". The nature of the incomprehension of the word collocation "мелкие детали" (little details) may lie in the word "детали" (details) itself. Since in Russian language a word "detail" also can be used to refer to an item or particular, changing word collocation "мелкие детали" to "мелочи" (subtle things) has significantly improved the understanding of the question.
7 BRD Do you have deciding what's morally right and wrong?	1.Трудно ли вам решать, что морально и что нет? 2.Трудно ли вам решать, что правильно с точки зрения морали, а что нет?	This question needed an additional clarification from the interviewer in 25% of cases. A further explanation “что правильно, а что неправильно с точки зрения морали" usually resolved the misunderstandings. Therefore, the question has been modified closer to the original text. Such questioning signifies the interrelation of actions and moral. Before, they may have sounded too abstract.
23 ANX Are you willing to involved with people when you're not sure they really like you?	1. Согласны ли вы вступать в отношения с людьми, если не уверены, что вы им действительно нравитесь? 2. Готовы ли вы вступать в отношения с людьми, если не уверены в их ответной симпатии ?	Around 30% of the respondents answered that “they would definitely not get involved with the people they don’t like” which reveals wrong understanding of the question, which may arise due to the word "согласен" which may be perceived as "agreeing". The word "согласны ли" has been changed to "готовы ли", which is closer to the idea of the question. Another problem with this question was misperception of the collocation "вступать в отношения". In the Russian language this mostly means relationships. The diagnostic criterion, however, implies both romantic and friendly relationships. The phrase "в их ответной симпатии" has been added to make it clear that both romantic and friendly relationships are meant. Moreover, "ответная симпатия" refers to the presence of some degree of favorability towards those people.

29 DIS Some people are not too concerned about other people's feelings. Are you like that?	1.Некоторые люди не слишком обеспокоены чувствами других. Относитесь ли вы к таким людям? 2. Некоторых людей не слишком беспокоят чувства других. Относитесь ли вы к таким людям?	Almost half of the interviewees turned the question around and asked again "то есть меня не беспокоят чувства окружающих?" This may be due to the difference in the meaning of the words "обеспокоен" (anxious about) and "беспокоят" (be of concern). The initial question has been changed closer to the form that interviewees preferred and this helped to decrease the amount of "echo-questions".
36 PAR When you enter a room full of people do you often wonder whether they might be talking about you, or even making unflattering remarks about you?	1.Когда вы входите в полную людей комнату, часто ли вы задумываетесь, не говорят ли они о вас или даже делают нелестные комментарии на ваш счет? 2. Когда вы заходите в полную людей комнату, часто ли вы задумываетесь, говорили ли они о вас или может быть даже отпускали нелестные комментарии в ваш адрес?	"Входите" has been changed to "заходите" since this word collocation is two times more frequently used according to the most popular Russian web search engine yandex.ru It has been decided to change the second part of the sentence, since the word "might" refers to the past simple and it is much more likely that the potential discussion took place before he/she entered the room.
39 SCZ Some people rarely show affection or talk about it. Are you like that?	Некоторые люди редко демонстрируют (1.свою привязанность 2.свои теплые чувства) к другим или говорят о них. Вы тоже такой?	Some respondents did not understand the connotation of the word “привязанность”(attachment), since in the Russian language it could mean not only attachment towards people but also towards things. Word collocation "warm feelings" helps to narrow focus to subjects only.
43 IMP Do you sometimes get angrier than you should, or feel very angry without a good reason?	1.Случается ли, что вы иногда выходите из себя больше, чем нужно, или испытываете сильный гнев без достаточного на то основания? 2.Случается ли, что вы сердитесь больше, чем нужно или выходите из себя без достаточного на то основания?	According to the specifics of the Russian language it’s not correct to say „выходить из себя“ (lose temper) in superlative degree. The new version is more understandable.

43 IMP Have people ever told you that you're a very angry person?	1. Говорили ли вам, что вы очень яростный человек? 2. Говорили ли вам, что вы очень вспыльчивый человек?	"Яростный" (furious) is a rarely-used word and which is more important, it is almost never used to characterize a person. In the Russian language, it is rather more suitable to describe an emotional state or an action, not the personality characteristics. The word "вспыльчивый" better corresponds to the diagnostic criteria and semantic ties with the previous question.
51 ANX Some people have a very strong need to feel safe from physical harm. That may affect the way they live their lives or prevent them from doing a lot of things. Are you like that?	1.Некоторые люди испытывают очень сильную потребность чувствовать себя в безопасности от физического вреда. Это может влиять на то, как они живут, или мешать им делать многие вещи. 2. Некоторые люди испытывают очень сильную потребность чувствовать себя в безопасности. Это может влиять на то, как они живут, или мешать им делать многие вещи.	The word физический вред (physical harm) provoked additional questions from 70% of the respondents. The specification of the question by adding "например вреда для здоровья" (for example, health harm) was under consideration. However, such formulation of the question may trigger interviewees to talk about unhealthy habits. Consequently, it was decided in favor of the shortened version without the phrase "physical harm", because in the Russian language safety of a person includes lack of physical harm.
53 SCZ There are some people who have little or no desire to have sexual experiences with another person. Are you like that?	1. Есть люди, которые не испытывают особого желания или вообще не желают иметь сексуальные контакты с другим человеком. Относитесь ли вы к таким людям? 2. Есть люди, которые не испытывают особого желания или вообще не желают иметь сексуальные контакты. Относитесь ли вы к таким людям?	The difficulty was that many people reacted slowly or asked to repeat the question. Most probably the root of the problem was that the question in Russian was too long and complicated in structure. It was decided to remove words which did not make additional sense: "с другим человеком" (with another person), which was obvious due to the context.
2 ANK Are you more of a perfectionist than almost anyone you know?	1. Правда ли, что вы отличаетесь большим перфекционизмом, чем почти все, с кем вы знакомы?	20% of the participants asked to explain who a perfectionist is. An explanation that sounds as follows "человек, который стремится все делать идеально" (a person who strives to do everything perfectly all the time") was understood by everyone. It was decided to keep question the way it was, but to be aware that some interviewees may need an additional explanation.

Table 4. *Modifications of problematic IPDE-SQ statements*

№, English original	Translations	Comment
7 ANX I usually feel tense or nervous.	1.Обычно я испытываю напряженность или нервозность. 2. Я часто пребываю в состоянии напряженности или нервозности.	"Пребываю в состоянии"- emphasizes the lasting nature of the condition of tenseness and nervousness. "Часто" sounds better.
31 SCZ I have little or no desire to have sex with anyone.	1.Я испытываю слабое или не испытываю никакого желания заниматься сексом с кем-либо. 2. Я испытываю слабое или не испытываю никакого желания заниматься сексом с кем бы то ни было.	Some respondents misunderstood "с кем-либо" in the initial version like "хоть с кем то" (whomever). "С кем то ни было" sounds better and does not evoke misperception of this statement.

Table 5. *Cronbach's Alpha of the IPDE and KR-20 of the IPDE-SQ*

PD Scale	IPDE Cronbach's Alpha	IPDE-SQ Kuder Richardson 20
Paranoid	.60	.41
Schizoid	.61	.44
Dissocial	.46	.39
Impulsive	.50	.37
Borderline	.76	.32
Histrionic	.71	.26
Anankastic	.67	.47
Anxious	.70	.53
Dependent	.49	.45

Table 5 represents the internal consistencies for the scales of the questionnaire and interview. The Cronbach´s α of borderline, histrionic and anxious scales of the interview are satisfactory. The internal consistency of the other scales stays under the level of .70. The highest internal consistency is in the borderline scale (.76). The lowest internal consistency measured belongs to the dissocial scale (.46).

The correlation tables of the questionnaire statements within each subscale can be found in Appendix 2. Overall, correlations of the items with the whole scale were significant at the level of .05, but were mostly moderate and at moderate to low level. The statements of the subscales were weakly correlated with each other. The strongest correlations between the statements were between the following items: 14 and 52 (r=.3) from the paranoid scale, 46 and 58 (r=.28) from the schizoid scale, 47 and 11 (r=.28) from the dissocial scale, 53 and 56 (r=.19) from the impulsive scale, 9 and 25 (r=.17) from the borderline, 28 and 35 (r=.32) from the histrionic, 32 and 48 (r=.33) from the anankastic, 7 and 16 (r=.26) from the anxious 33 and 42 (r=.35) from the dependent scale.

Correlations of the scales of the IPDE and the IPDE-SQ were moderate to high, ranging from.43 for the histrionic and impulsive PDs scales and up to .65 for the dependent and borderline PDs. The correlations are displayed in Table 6.

Table 6. *Correlations of the scales of the IPDE interview and the IPDE-SQ*

	PAR SQ	SCZ SQ	DIS SQ	IMP SQ	BRD SQ	HIS SQ	ANK SQ	ANX SQ	DEP SQ	PAR IPDE	SCZ IPDE	DIS IPDE	IMP IPDE	BRD IPDE	HIS IPDE	ANK IPDE	ANX IPDE
PAR SQ																	
SCZ SQ	.229**																
DIS SQ	.248**	.114*															
IMP SQ	.349**	.163**	.360**														
BRD SQ	.224**	.308**	.287**	.423**													
HIS-SQ	.093	-.090	.148**	.299**	.217**												
ANK-SQ	.232**	.307**	-.128*	.038	.131*	.036											
ANX-SQ	.298**	.438**	.043	.302**	.413**	.068	.477**										
DEP-SQ	.125*	.258**	-.040	.207**	.348**	.099	.295**	.548**									
PAR-IPDE	**.606****	.392**	.101	.409**	.454**	0,047	.194*	.373**	,297**								
SCZ-IPDE	.271**	**.486****	.070	.192	.357**	-.198*	.138	.415**	.195	,258**							
DIS-IPDE	-.070	.115	**-.120**	-.06	.096	-0,140	.300	.038	.032	.009	.353*						
IPM-IPDE	.108	-.01	.281**	**.425****	.361**	,260**	.131	,240*	.101	.371**	.080	.377*					
BRD-IPDE	.368**	.178	.178	.504**	**.652****	,234*	.036	.400**	.332**	.480**	.353**	-.010	.507**				
HIS-IPDE	.167	.046	.211*	,451**	.350**	**.431****	.104	.277**	.130	.358**	-.080	-.040	.603**	.497**			
ANK-IPDE	.066	.163	-.100	.035	.023	.078	**.503****	.390**	.113	.061	.305**	.151	.194	.185	.122		
ANX-IPDE	.304**	.267**	.048	.370**	.449**	-.040	.217*	**.573****	.424**	.447**	.478**	.027	.320**	.599**	.319**	.332**	
DEP-IPDE	-.03	.07	0	.327	.317	.049	.061	.335	**.650****	.264	.111	-.090	.370*	.456*	.338	.038	.649**

* Correlation is significant at the 0.05 level (2-tailed).

** Correlation is significant at the 0.01 level (2 -tailed).

Notes: PAR, paranoid; SCZ, schizoid; DIS, dissocial; IMP, impulsive; BRD, borderline; HIS, histrionic; ANK, anankastic; ANX, anxious; DEP, dependent.

Questions of the interview were more strongly correlated with each other than the items of the IPDE-SQ. Correlations of the questions with the whole scale were mostly moderate. Some questions, however, strongly correlated with the whole scale, for example questions 62 (r=.86), 63 (r=.74) and 64 (r=.76) from the dissocial scale, question 50 (r=.75) from the impulsive scale, questions 5 (r=.71) and 6 (r=.72) from the borderline scale and question 33 (r=.73) from the dependent scale.

Most of the questions from the borderline and anxious subscales were correlated with each other at a moderate to low level which is in concordance with a good internal consistency of those scales. The correlation tables of the IPDE subscales can be found in Appendix 3.

Table 7 shows the number and rate of subjects passing the cut-off point in the IPDE-SQ which is referred to in the IPDE interview (N=306).

Table 7. *Number and rate of subjects passing the cut-off point in the IPDE-SQ*

	3≥	4 ≥
Paranoid	117 (38,5%)	65 (21,4%)
Schizoid	146 (48 %)	94 (27%)
Dissocial	29 (9,5%)	7 (2,3%)
Impulsive	101(33,2%)	44 (14,5%)
Borderline	33 (10,9%)	8 (2,6%)
Histrionic	151 (49,7%)	73(24%)
Anankastic	187 (61,5%)	130(42,7%)
Anxious	122 (40,1%)	69 (22,7%)
Dependent	105 (34,5%)	42 (13,8%)

According to the IPDE manual (Loranger, 1997, p.137), the subject has failed the screen for the disorder and should be interviewed "if 3 or more items from the disorder are circled". This cut-off corresponds to the clinicians' version of ICD-10, where 3 criteria met is sufficient to diagnose an PD. As Table 7 shows, the false positivity of the instrument in this case was too high. For example, more than half (61.5%) of the respondents were scored 3+ on the anankastic scale, and half of the respondents failed the screen for histrionic (49.7%) and schizoid (48%) PDs. If 4 items would be set as cut-off point (in correspondence with the research version of ICD-10), the rate of those who fail the screen is lower and lays between 13.8% and 21.4% for the present sample [with the exception of dissocial (2.3%) and anankastic PDs, which is still highly false-positive]. The only aspects were the mean scores of men and women were

significantly different were dissocial (female mean 0.83, male mean 1.45) and dependent (female mean 2.16, male mean 1.44).

Of the 106 subjects who completed the full IPDE assessment, 8 subjects were with the probability of a PD. 5 people fulfilled the criteria for a specific PD for referral to the IPDE interview: anxious, histrionic, dissocial and two cases of anankastic PD, while 3 subjects gained enough points (10 and higher) which according to the IPDE refers to the PD not specified. All of the above-mentioned respondents have also met the criteria for further assessment at the screening questionnaire. The only false-negative case was the subject who met the criteria for the dissocial PD during the interview, but he had a score of 4+ on three other scales, so in a clinical setting would be forwarded to further assessment anyway.

The sample of 306 respondents to the IPDE-SQ was sufficient for the exploratory factor analysis. The CATPCA with Oblimin rotation and Kaiser normalization has been chosen to identify the hypothetical factor structure. The sample adequacy confirmed the value of Kaiser-Meyer-Olkin (0.712). Bartlett's Test of Sphericity was statistically significant ($p<0.000$). 11 factors explaining 44% of the variance were retained according to the scree-plot and eigenvalues.

The first factor represents neuroticism. All the items taken together are connected with anxiety, worrying, emotional instability and frequent mood changes.

The second factor seemed to refer to the dissocial PD: item 11 with negative correlation (I have never been arrested) and item 29 (I will lie or con someone if it serves my purpose), item 44 (I have a reputation for being a flirt), 13 (I get into very intense relationships that don't last), item 24 and 55 (disparaging attitude of others) and 56 (I take chances and do reckless things)

Factor 3 incorporates the traits of the anankastic PD. Items № 32 (People think I am too strict abut rules and regulations), 48 (People think I am too stiff or formal), 10 (I am a very cautious person) and 23 (I spend too much time trying to do things perfectly) and 43 (A lot of things seem dangerous to me that don't bother most people) loaded under the third factor.

Factor 4 represents trust (low level trait of agreeableness) by the item №14 (Most people are fair and honest with me) and several negatively correlated items such as № 52 (I'm convinced there's a conspiracy behind many things in the world), 21 (When I'm praised or criticized I don't show others my reaction), 40 (I often feel "empty" inside), 34. (I won't get involved with people until I'm certain they like me) which refer to overall trust towards others and the world. Items characterizing suspiciousness (item 52 from the schizoid scale), uncertainty in the others' good attitude (items 34 from the anxious scale) and fear of showing

showing one's own feelings to others (item 21 from the schizoid scale) also characterize this personality trait.

Factor 5 represents the histrionic PD and contains either positively correlated items such as 28 (I like to dress so I stand out in a crowd), 5 (I show my feelings for everyone to see), as well as negatively correlated ones such as 35 (I would rather not be the centre of attention), 54 (It's hard for me to get used to a new way of doing things), 12 (People think I'm cold and detached) 35 (I would rather not be the center of attention) and 25 (I have never threatened suicide).

Factor 6 reflects tender mindedness (lower-level trait of agreeableness):18 (I usually feel bad when I hurt or mistreat someone), 57 (Everyone needs a friend or two to be happy), 15 (I find it hard to disagree with people if I depend on them a lot), 39 (I worry a lot that people may not like me).

Factor 7 (introversion) is represented by item № 58 (I'm more interested in my own thoughts than what goes on around me), item 45 (I don't ask favors from people I depend on a lot), 46 (I prefer activities that I can do by myself) and is in concordance with reflectiveness, not much interest in others, preference to solitary activities.

Factor 8 represents compliance (lower-level trait of agreeableness). All the items loaded under it, except the only positively correlated item 8 (I almost never get angry about anything) are negatively correlated: 2 (I don't react well when someone offends me), 37 (Sometimes I get so angry I break or smash things), 22 (I've held grudges against people for years), 19 (I argue or fight when people try to stop me from doing what I want) and 27 (Я борюсь за свои права, даже когда это раздражает людей).

Factor 9 represents dependent traits. These are № 33 (I usually feel uncomfortable or helpless when I'm alone), 36 (I think my spouse or lover may be unfaithful to me), 42 (I worry about being left alone and having to care for myself) and item 20 with negative correlation (At times I've refused to hold a job, even when I was expected to).

Factor 10 incorporates items which are in concordance with the schizoid PD diagnostic criteria and incorporates 31 (I have little or no desire to have sex with anyone), 50 (I keep to myself even when there are other people around), 59 (I usually try to get people to do things my way), 41(I work so hard I don't have time left for anything else).

Factor 11 represents impulsiveness (low level trait of neuroticism) such as 47 (1 lose my temper and get into physical fights), 9 (I go to extremes to try to keep people from leaving me); 30 (I don't stick with a plan if I don't get results right away) and 51 (It's hard for me to stay out of trouble) which refer to the tendency to act without much forethought and therefore a

heightened probability to get into trouble.

The Pattern matrix with the factor loadings could be found in Appendix 4.

Discussion

Together the results of the research describe the psychometric characteristics of the adapted instrument. The correlations of the questionnaire items stayed the same in the bigger sample (N=306) in comparison with the smaller sample (N=122) from the previous studies (Kovaleva, 2013; Kravtšenko, 2013; Shevchenko, 2013).

Overall, the internal consistencies of the scales of both the questionnaire and the interview were low. These results match those observed in earlier studies. For example, the reliability of the questionnaire scales was similar with the internal consistencies from the Estonian version, reported by Eensalu (2002). The reliabilities are quite similar on the paranoid, schizoid, histrionic and impulsive PD scales within these two samples. Other scales showed a bit lower results than in the Estonian version. There were no questionnaire scale reliabilities at 0.7 or higher level, while according to Eensalu (2002) the only scale where Cronbach's α exceeded the level of 0.7 was the anxious PD.

The similar situation occurred with the reliabilities of the interview subscales. They were higher than those from the questionnaire but still mostly insufficient (lower than .7). Again, comparison with the available data revealed similar problems in the other studies. For example, the reliability of the schizoid (.6) and histrionic (.71) scale was the same in all three studies (Assanovich & Derman, 2014; Eensalu, 2002). The borderline was the only scale which reliability (.76) was higher in the current study than in those reported by other authors. However, the dissocial, impulsive and dependent PD scales' internal consistencies were lower than it was reported by other researchers.

The lowest internal consistency had the dissocial PD scale (.46) which could be explained by the scale specifics itself, since it is the only PD which includes criminal behavior criteria. The questions from dissocial scale were among the most personal and intrusive of the whole interview. For example, question 60 (Have you ever hit or physically abused anyone in your family?) and question 61 (Have you ever done anything that you could have been arrested for, if you had been caught?) may not be easy to answer honestly.

The comparison within those three studies need to be done with caution due to the sample differences (clinical, non-clinical sampling method and the bias due to the sampling). As participation in the study is an effortful and time-consuming enterprise, some self-selection

might be involved, resulting in the overrepresentation of the conscientious subjects in the sample. This sampling bias could further compromise the variability, restricted already with the floor effect (use of clinical instrument on normal subjects). However, it is obvious that even though the IPDE is not invented for the normal sample, the low reliabilities could not be explained just by the sample differences. If the proportion of the acceptable and unacceptable reliabilities (0.7 or lower) still stays the same, like in the Belorussian study of the IPDE (Ассанович, 2014) on the clinical sample, there might be other reasons explaining these numbers. These findings further support the idea that the problem could be in the diagnostic criteria themselves upon which the instrument is based. This view is supported by a number of researchers criticizing the existing diagnostic criteria of a PD and addressed in the theoretical part of the work (Blais, 1998; Westen & Shedler, 1999; Blackburn, 2000, Sarkan & Duggan, 2010).

The correlations between the scales not belonging to the same cluster (according to DSM-5) show that diagnostic criteria of the PDs tend to overlap. The correlation table of the questionnaire and the interview subscale also reveal this pattern. Along with the moderate and high correlations between the same subscales of the IPDE and IPDE-SQ, there are several same-level correlations between unrelated scales, e.g. the correlation between schizoid-IPDE and impulsive-SQ, borderline-IPDE and anankastic-SQ (all r=.4). Between the subscales of IPDE and IPDE-SQ developed to measure the same disorder, the highest correlation appeared to be between dependent and borderline scales (r=.65). However, the same correlation coefficient appeared to be also between the anxious PD and the dependent PD interview scales. This may be explained by the high levels of comorbidity among the PDs. The levels of associations of the specific PDs are similar to those reported by Oltmans and Powers (2012) on the basis of different studies. It would be interesting to compare the reliabilities from current study with the ones of the original instrument, but this data is not presented in the IPDE-ICD manual.

There was no intention of conducting the interview with only those above cut-off in the screening questionnaire. However, most of the individuals received enough points to be forwarded to the diagnostic interview. Since the cut-off point of 3 proved to give too many false positive results, the author would suggest using cut-off point of 4 for all the scales except for the dissocial PD scale which corresponds to the recommendations of the IPDE-ICD-10 research version.

The gender differences appeared as expected: the mean scores of men and women were significantly different in the dissocial PD (female M=.83, male M=1.45) and dependent PD (female M=2.16, male M=1.44), which is in accordance with the gender differences (Cale &

Lilienfeld, 2002; Lynam & Widiger, 2007).

The proportion of the individuals with a probable PD according to the IPDE assessment (n=8) in the 106 individuals was similar (7.5%) to the data reported in the studies on the prevalence when the assessment was conducted with the same instrument (Torgersen, 2012).

As several correlations were found between items belonging to different PD scales, and the adequacy of the current classification of PDs has been under debate (Sarkar &Duggan, 2010; Widiger & Trull, 2007), an attempt was made to explore the structure of the PD symptomatology via exploratory factor analysis (CATPCA). Of emerging 11 factors 5 conformed to respective IPDE-SQ scales: the dissocial, anankastic, histrionic, dependent and schizoid PDs. However, not all of the emerged PDs were totally composed of the items of the corresponding scale. For example, the second factor referring to the dissocial PD contained only two items from the dissocial scale: Item 11 with negative correlation (I have never been arrested) and item 29 (I will lie or con someone if it serves my purpose). The rest of the items belonged to the other scales. Still, they represented important diagnostic criteria of the correspondent disorder. For example, item 44 (I have a reputation for being a flirt.) and 13 (I get into very intense relationships that don't last.) fit to the criterion "incapacity to maintain enduring relationships though with no difficulties in establishing them". Item 24 and 55 (disparaging attitude of others) may be connected with "marked proneness to blame others, or offer plausible rationalizations for the behavior that has brought the individual into conflict with society. Items 56 (I take chances and do reckless things.) from the impulsive scale may be interpreted as doing illegal things, which is also common for individuals with the dissocial PD.

Among other PDs from the hypothetical factor model, the diagnostic criteria of the anankastic PD were represented most adequately within the third factor. Four from five items loaded under it are from the anankastic scale. The remaining item 43 (A lot of things seem dangerous to me that don't bother most people) belongs to the anxious scale but is also connected with the anankastic PD diagnostic criteria "feeling of excessive caution" or "unwelcomed thoughts and impulses" and is there through the manifestation of the anankastic PD. Bringing together criteria of the anankastic PD and the item loaded under factor 3 (feelings of excessive doubt and caution (43, 10); preoccupation with details, rules, lists (32); perfectionism that impedes task fulfillment (23); excessive conscientiousness; pedantry; rigidity and stubbornness (48); unreasonable reluctance to allow others to do things their own way; unwelcomed thoughts or impulses (43)) shows that "unreasonable reluctance to allow others to do thing their own way" was the only criteria which was not confirmed within the factor.

The schizoid PD, emerging in the factor 10 is represented by 4 items and is most weakly associated with the items of the corresponding scale. This corresponds to the following diagnostic criteria: little interest in having sexual experiences (31); preference for solitary activities and lack of interest in social relationships (50); lack of close friends and also sensitivity towards social norms (59). In addition, those who do not have a family, close friends and activities which provide (diagnostic criteria "lack of activities providing pleasure" and "lack of close friends and interest in social relationships") would likely spend more time at work which could explain the loading of item 41 (working hard) in the factor.

The dependent DP is represented by 4 items loaded under the factor 9. Leading them together with the diagnostic criteria of the dependent PD shows that diagnostic criteria connected with both important life decisions and everyday decisions and concordance with others did not find confirmation within the factor. However, criteria such as "feeling uncomfortable or helpless when alone" (33); "fears of being abandoned or separated from important individuals" (36, 42) were represented. Item 20 may refer to "subordination of one's own needs to those on whom one is dependent" – for example, holding a job if another expects him/her to do so.

Most of the characteristics of the histrionic PD are found within factor 5. Diagnostic criteria brought together with items loaded under the factor look as follows: exaggerated expression of emotions (5); suggestibility (54); labile affectivity (12); continual seeking for attention (35, 28); inappropriate seductiveness and over-concern with physical attractiveness. According to García-Nieto, Blasco-Fontecilla, León-Martine & Baca-García (2014), the histrionic PD involves specific risk factors for suicide gestures, which may explain the presence of item 25 (threatening suicide) among others. The diagnostic criteria for the histrionic PD connected with inappropriate seductiveness was the only one not represented.

Also, 3 of the "big five" personality traits and their lower facets according to NEO-PI-R (Costa & McCrae, 1992; Costa & McCrae, 2008), such as neuroticism (factors 1 and 11 - impulsivness), agreeableness (factor 4 - trust, 6 - tender-mindedness, 8 - compliance) and extraversion (factor 7 - introversion dimension) appear in the hypothetical factor model. This corresponds to the findings of Saulsman & Page (2004), whose meta analytic review of the five factor model and personality disorder empirical literature indicates that agreeableness, neuroticism and extraversion dimensions are consistently interrelated with all PDs.

Limitations of the current study and further prospects

A limitation of this study is that the sample was non-clinical which restricts the variability of

the subjects in the PD symptoms and makes it difficult to compare the results with other studies. Taking into consideration the sample differences (clinical and non-clinical, sample size, possible sampling bias), the psychometric properties are expected to improve when conducted on the clinical population. Among the limitations is the sampling method (the snowball and virtual snowball sampling method) which has a biasing effect on the characteristics of the sample such as gender and educational level and possible motivational characteristics. One of the problems of the current sample is the prevalence of highly-educated participants. Some interviews were conducted with the participants with a secondary education, but there were no subjects with a basic education willing to participate in the interview. Further work is required to establish if all the interview questions are easily understandable to the people with a basic education and/or with lesser introspection abilities.

Another limitation of the study is the inability to compare the psychometric properties of the interview with the original version and the psychometric properties of the adaptations into other cultures, especially those conducted with the non-patient sample, since this data is not available.

During the current research, several problematic questions of the interview were identified and modified. As a result, 10 interview questions were modified, as well as two items of the questionnaire. The grounds for the all modifications are explained in the results section of this work.

Despite the fact that the internal consistency of several PD scales of the adapted instrument is below the acceptable level, the results are nevertheless similar to those reported in other studies of the same instrument. The reason could be concealed in the non-clinical sample, but on the other hand also in the imperfection of the current PD diagnostic system itself as also Sarkar & Duggan (2010) have argued in their discussion of the PD diagnostic instruments. Taking into consideration that the IPDE is the only structured interview at the moment suitable for the assessment of ICD-10 PD and under the auspices of the WHO is widely used all around the world, the author of the current work would still suggest using it in clinical practice.

Validation of the adapted instrument on a clinical sample is an important issue for future research. Research questions that should be asked include the investigation of concurrent validity (criterion groups with diagnosed PDs) and determining the adequate cut-off points of the questionnaire. Extension of the normative sample with better representation of less motivated subjects and overall amplification of the sample variability is also suggested.

It is hoped that the Russian version of the IPDE will be applicable and valid in Estonia for the benefit of both patients and psychologists.

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References:

American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders. (4th, text rev). Washington, DC.

American Psychiatric Association. (2013). Diagnostic and Statistical Manual of Mental Disorders (Fifth Edition). American Psychiatric Association.

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (DSM-5®). American Psychiatric Pub.

Ames, D. R., Rose, P., & Anderson, C. P. (2006). The NPI-16 as a Short Measure of Narcissism. Journal of Research in Personality, 40, 440-450.

Assanovich, M. A., & Derman, E. B. (2014). Оценка психометрических свойств «Исследования расстройств личности по международной схеме (IPDE)». Журнал Гродненского государственного медицинского университета, 4(48).

Bernstein, D.P., Kasapis, C., Bergman, A., Weld, E., Mitropoulou, V., Horvath, T., Siever, L.J. (1997). Assessing Axis II disorders by informant interview. Journal of Personality Disorders, 11:158–167.

Blackburn, R. (2000). Classification and assessment of personality disorders in mentally disordered offenders: A psychological perspective. Criminal Behaviour and Mental Health, 10(S1).

Blackburn, R., & Fawcett, D. J. (1999). The Antisocial Personality Questionnaire: An Inventory for Assessing Deviant Traits in Offender Populations. European Journal of Psychological Assessment, 15, 14-24.

Blais, M.A., Benedict, K.B., Norman, D.K. (1998). Establishing the psychometric properties of the DSM–III–R personality disorders: implications for DSM–V. Journal of Clinical Psychology 54: 795–802.

Brislin, R. W. (1986). The wording and translation of research instruments. In W. J. Lonner & J. W. Berry (Eds.), Field methods in cross-cultural psychology (pp. 137-164). Newbury Park, CA: Sage Publications.

Butler, A. C., Beck, A. T., & Cohen, L. H. (2007). The personality belief questionnaire-short form: Development and preliminary findings. Cognitive Therapy and Research, 31(3), 357-370.

Cale, E. M., & Lilienfeld, S. O. (2002). Sex differences in psychopathy and antisocial personality disorder: A review and integration. Clinical psychology review, 22(8), 1179-1207.

City Public Relations Service ed Peeter Kuulpak (2016) Statistical Yearbook of Tallinn.

Tallinn.

Clark, L. A. (2009). Schedule for Nonadaptive and Adaptive Personality—Second edition (SNAP-2).

Coolidge, F. L. (2001). Short-form of the coolidge axis II inventory (SCATI): Manual. Colorado Springs, CO: Author.

Cooper, L. D., Balsis, S., & Oltmanns, T. F. (2012). Self-and informant-reported perspectives on symptoms of narcissistic personality disorder. Personality Disorders: Theory, Research, and Treatment, 3(2), 140.

Costa, P. T., & McCrae, R. R. (1992). The five-factor model of personality and its relevance to personality disorders. Journal of Personality Disorders, 6(4), 343-359.

Costa, P. T., & McCrae, R. R. (2008). The revised neo personality inventory (neo-pi-r). The SAGE handbook of personality theory and assessment, 2, 179-198.

Cramer, V., Torgersen, S., & Kringlen, E. (2006). Personality disorders and quality of life. A population study. Comprehensive Psychiatry, 47(3), 178–184.

Denscombe, M., 3rd Edition (2007). The Good Research Guide: For Small-scale Social Research. Buckingham: Open University Press.

Dolan-Sewell, R.T., Krueger R.F., Shea, M.T. (2001). Co-Occurrence with Syndrome Disorders. In W. J. Livesley (Ed.), Handbook of personality disorders: Theory, research, and treatment (pp. 84-104). Guilford Press.

Eensalu, A. (2002). Vältiva isiksusehäire hindamine rahvusvahelise isiksushäirete intervjuu sõelküsimustiku abil. Tartu Ülikool. Bakalaureusetöö.

First, M. B., Gibbon, M., Spitzer, R. L., Benjamin, L. S., & Williams, J. B. (1997). Structured clinical interview for DSM-IV axis II personality disorders: SCID-II. American Psychiatric Pub.

Fossati, A., Maffei, C., Bagnato, M., Battaglia, M., Donati, D., Donini, M., ... & Prolo, F. (2000). Patterns of covariation of DSM-IV personality disorders in a mixed psychiatric sample. Comprehensive Psychiatry, 41(3), 206-215.

Friedman, J. N. W., Oltmanns, T. F., & Turkheimer, E. (2007). Interpersonal Perception and Personality Disorders. Journal of Research in Personality, 41, 667-688.

Furnham, A., Milner, R., Akhtar, R., & De Fruyt, F. (2014). A review of the measures designed to assess DSM-5 personality disorders. Psychology, 5(14), 1646.

García-Nieto, R., Blasco-Fontecilla, H., de León-Martinez, V., & Baca-García, E. (2014). Clinical features associated with suicide attempts versus suicide gestures in an inpatient sample. Archives of Suicide Research, 18(4), 419-431.

Gass S., Varonis, E. (1991). Miscommunication in Normative Speaker Discourse Miscommunication and problematic talk sage. Newbury Park, CA P. 121-145.

Grant, B. F., Hasin, D. S., Stinson, F. S., Dawson, D. A., Chou, S. P., Ruan, W., & Pickering,
R. P. (2004). Prevalence, correlates, and disability of personality disorders in the United States: results from the National Epidemiologic Survey on Alcohol and Related Conditions. The Journal of clinical psychiatry.

Grilo, C. M., McGlashan, T. H., Quinlan, D. M., Walker, M. L., Greenfeld, D., & Edell, W. S. (1998). Frequency of personality disorders in two age cohorts of psychiatric inpatients. American Journal of Psychiatry, 155(1), 140-142.

Hambleton, K.R. (2004). Issues, Designs and Technical Guidelines for Adapting Tests into Multiple Language and Cultures In R. K. Hambleton, P. F. Merenda, & C. D. Spielberger (Eds.). Adapting Educational and Psychological Tests for Cross-Cultural Assessment. (pp. 3-38). Psychology Press.

Hambleton, R. K., & Zenisky, A. (2010). Translating and adapting tests for cross-cultural assessment. In D. Matsumoto & F. van de Vijver (Eds.), Cross-cultural research methods (pp. 46-74). New York, NY; Cambridge University Press.

Hersen, M. (2004). Comprehensive Handbook of Psychological Assessment, Behavioral Assessment (Vol. 3). John Wiley & Sons.

Hyler, S. E. (1994). PDQ-4+ Personality Diagnostic Questionnaire-4+. New York: New York State Psychiatric Institute

International Test Commission. (2016). The ITC Guidelines for Translating and Adapting Tests (Second edition). [www.InTestCom.org]

Jackson, Y. (Ed.). (2006). Encyclopedia of multicultural psychology. Sage Publications.

Jeanrie, C., & Bertrand, R. (1999). Translating tests with the International Test Commission Guidelines: Keeping validity in mind. European Journal of Psychological Assessment, 15(3), 277-283.

Klonsky, E. D., Oltmanns, T. F., & Turkheimer, E. (2002). Informant-reports of personality disorder: relation to self-reports and future research directions. Clinical Psychology: Science and Practice, 9, 300-311.

Koerner, N., Hood H.K., & Antony M.M. (2014). Interviewing and Case Formulation. In D. H. Barlow (Ed.). The Oxford Handbook of Clinical Psychology: Updated Edition. (pp 227-255). Oxford University Press.

Kovaleva, T. (2013). IPDE intervjuu ärevate isisksuste skaalade kohandamine vene keelde. Tartu Ülikool. Seminaritöö.

Kravtšenko K. (2013). Rahvusvahelise Isiksushäirete diagnostilise intervjuu ja sõelküsimustiku adapteerimine vene keelde (dramaatiliste klaster). Tartu Ülikool. Seminaritöö.

Krueger, R. F., Derringer, J., Markon, K. E., Watson, D., & Skodol, A. E. (2012). Initial construction of a maladaptive personality trait model and inventory for DSM-5. Psychological medicine, 42(09), 1879-1890.

Lenzenweger, M. F., Lane, M. C., Loranger, A. W., & Kessler, R. C. (2007). DSM-IV personality disorders in the National Comorbidity Survey Replication. Biological psychiatry, 62(6), 553-564.

Links, P.S., Ansari J.Y., Fazalullasha, F., Shah, R. (2012). The Relationship of Personality Disorders and Axis I Clinical Disorders In T. Widiger (Ed.), The Oxford Handbook of Personality Disorders (pp. 237-259). Oxford University Press.

Links, P. S., & Eynan, R. (2013). The relationship between personality disorders and Axis I psychopathology: deconstructing comorbidity. Annual review of clinical psychology, 9, 529-554.

Loranger A.W. (1999). International Personality Disorder Examination (IPDE). Odessa, FL: Psychological Assessment Resources.

Loranger, A. W. (2002). OMNI Personality Inventory and OMNI-IV Personality Disorder Inventory Manual. Odessa, FL: Psychological Assessment Resources.

Lynam, D. R., & Widiger, T. A. (2007). Using a general model of personality to identify the basic elements of psychopathy. Journal of personality disorders, 21(2), 160-178.

Maddux, J. E. (2015). Psychopathology: Foundations for a contemporary understanding. Routledge.

McDermutt, W., & Zimmerman, M. (2005). Assessment instruments and standardized evaluation. In J. M. Oldham, A. E. Skodol, & D. S. Bender (Eds.), Textbook of personality disorders (pp. 89 –101). Washington DC, American Psychiatric Association Press.

Mezzich J.E. (2002). "International surveys on the use of ICD-10 and related diagnostic systems". Psychopathology. 35 (2–3): 72–5.

Miller, J.D, Few, L.R., Widiger, T.A. (2012). Assessment of Personality Disorders and Related Traits: Bridging DSM-IV-TR and DSM-5. In T. A. Widiger (Ed.), The Oxford handbook of personality disorders (pp. 108-140). Oxford University Press.

Moran, P., Leese, M., Lee, T., Walters, P., Thornicroft, G., & Mann, A. (2003). Standardized

Assessment of Personality— Abbreviated Scale (SAPAS): Preliminary Validation of a Brief Screen for Personality Disorder. British Journal of Psychiatry, 183, 228- 232.

Murphy, N., & McVey, D. (Eds.). (2010). Treating Personality Disorder: Creating Robust Services for People with Complex Mental Health Needs. Routledge.

Oltmanns, F. & Powers, A.D. (2012). Gender and personality disorders. In T. A. Widiger (Ed.), The Oxford handbook of personality disorders (pp 206-218). Oxford University Press.

Organization, W. H. (1992). The ICD-10 classification of mental and behavioral disorders: clinical descriptions and diagnostic guidelines. Geneva: World Health Organization.

Pfohl B., Blum N., & Zimmerman M. (1997). Structured Interview for DSM-IV Personality Disorder. Washington, DC: American Psychiatric Press.

Pomeroy, E. (2014). Clinical Assessment Workbook: Balancing Strengths and Differential Diagnosis. Cengage Learning.

Ready, R. E., & Clark, L. A. (2002). Correspondence of psychiatric patient and informant ratings of personality traits, temperament, and interpersonal problems. Psychological Assessment, 14(1), 39.

REL 2011: Eestis räägitakse emakeelena 157 keelt. Pressiteade nr 111 (30.08.2012) Statistikaamet. Retrieved from http://www.stat.ee/64628

Rogers, R. (2003). Standardizing DSM–IV diagnoses: The clinical applications of structured interviews. Journal of Personality Assessment, 81, 220 –225.

Ruegg, R., & Frances, A. (1995). New research in personality disorders. Journal of Personality Disorders, 9, 1–48.

Samuels, J., Eaton, W. W., Bienvenu, O. J., Brown, C. H., Costa, P. T., & Nestadt, G. (2002). Prevalence and correlates of personality disorders in a community sample. The British Journal of Psychiatry, 180(6), 536–542.

Sarkar, J., & Duggan, C. (2010). Diagnosis and classification of personality disorder: difficulties, their resolution and implications for practice. Advances in psychiatric treatment, 16(5), 388-396.

Saulsman, L. M., & Page, A. C. (2004). The five-factor model and personality disorder empirical literature: A meta-analytic review. Clinical psychology review, 23(8), 1055-1085.

Segal, D. L., Coolidge, F. L., O'Riley, A., & Heinz, B. A. (2006). Structured and semi-structured interviews. In M. Hersen (Ed.) Clinician's handbook of adult behavioral assessment (pp. 121-144). Boston, MA: Elsevier Academic Press.

Segal, D. L., Coolidge, F. L., & Rosowsky, E. (2006). Personality disorders and older adults:

Diagnosis, assessment, and treatment. John Wiley & Sons.

Segal D.L., Mueller E.M., Coolidge, F.L. (2011). In M. Hersen & D. C. Beidel (Eds.). Structured and Semistructured Interviews for Differential Diagnosis: Fundamentals, Applications and Essential Features. Adult Psychopathology and Diagnosis. (pp. 91-116). John Wiley & Sons.

Segal, D.L. & Williams, K. N. (2014). Structured and Semistructured Interview for differential diagnosis: Fundamental Issues, Applications and Features In D. C. Beidel, B. C. Frueh & M. Hersen (Ed.). Adult Psychopathology and Diagnosis: Seventh Edition. John Wiley & Sons. Hoboken, New Jersey.

Shevchenko, P. (2013). IPDE intervjuu paranoilise ja skisoidse skaala kohandamine vene keeled. Tartu Ülikool. Seminaritöö.

Skodol, A. E. (2014). Manifestations, Assessment and Differential Diagnosis In J. M. Oldham, A. E. Skodol & D. S. Bender (Eds.). The American Psychiatric Publishing textbook of personality disorders (pp. 131-164). American Psychiatric Pub.

Tasman, A., Kay, J., Lieberman, J.A., First, M.B., Riba, M. (2015). Psychiatry, 2 Volume Set, Volumes 1-2 (4). Somerset, GB: Wiley-Blackwell.

Torgersen, S. (2012). Epidemology In T. Widiger (Ed.), The Oxford Handbook of Personality Disorders (pp. 186-205). Oxford University Press.

Torgersen, S. (2009). Prevalence, Sociodemographics, and Functional Impairment In J. M. Oldham, A. E. Skodol, & D. S. Bender (Eds.). Essentials of personality disorders (pp. 83-102). American Psychiatric Pub.

Torgersen, S., Kringlen, E., & Cramer, V. (2001). The prevalence of personality disorders in a community sample. Archives of general psychiatry, 58(6), 590-596.

Trull, T.J., Scheiderer, E. M., Tomko, R.L. (2012). Axis II Comorbidity In T. Widiger (Ed.), The Oxford Handbook of Personality Disorders (pp. 219-236). Oxford University Press.

Weissman, M. M. (1993). The epidemiology of personality disorders: A 1990 update. Journal of Personality Disorders, Suppl 1, 44–62.

Westen, D., & Shedler, J. (1999). Revising and assessing Axis II, Part II: Toward an empirically based and clinically useful classification of personality disorders. American Journal of Psychiatry, 156(2), 273-285.

Widiger, A. & Boyd, S. E. (2009). Personality Disorders Assessment Instruments. In J. N. Butcher (Ed.) Oxford Handbook of Personality Assessment (pp. 336-363). Oxford University Press.

Widiger, T. A., Corbitt, E. M., Ellis, C. R., Mangine, S., & Thomas, G. V. (1995). Personality Disorder Interview--IV. Psychological assessment resources, Incorporated.

Widiger, T. A., & Samuel, D. B. (2005). Evidence-based assessment of personality disorders. Psychological Assessment, 17(3), 278.

Widiger, T. A., & Spitzer, R. L. (1991). Sex bias in the diagnosis of personality disorders: Conceptual and methodological issues. Clinical Psychology Review, 11(1), 1-22. Cited In J. M. Oldham, A. E. Skodol & D. S. Bender (Eds.). (2007). (p. 90). The American Psychiatric Publishing textbook of personality disorders. American Psychiatric Pub.

Widiger, T. A., & Trull, T. J. (2007). Plate tectonics in the classification of personality disorder: Shifting to a dimensional model. American Psychologist, 62(2), 71.

World Health Organization. (1993). The ICD-10 classification of mental and behavioural disorders: diagnostic criteria for research (Vol. 2). World Health Organization.

Zanarini, M. C., Frankenburg, F. R., Sickel, A. E., & Yong, L. (1996). The diagnostic interview for DSM-IV personality disorders (DIPD-IV). Belmont, MA: McLean Hospital, 340.

Zanarini, M. C., Gunderson, J. G., Frankenburg, F. R., & Chauncey, D. L. (1989). The revised diagnostic interview for borderlines: discriminating BPD from other axis II disorders. Journal of personality Disorders, 3(1), 10-18.

Zhmurov, V. A. (2012). Большая энциклопедия по психиатрии. 2-е изд. 2012. Национальная психологическая энциклопедия. Джангар.

Zimmerman, M., Rothschild, L., & Chelminski, I. (2005). The Prevalence of DSM-IV Personality Disorders in Psychiatric Outpatients. American Journal of Psychiatry, 162(10), 1911– 1918.

Appendix 1

Diagnostic criterions of ICD-10 manual include:

"Markedly disharmonious attitudes and behavior, generally involving several areas of functioning; e.g. affectivity, arousal, impulse control, ways of perceiving and thinking, and style of relating to others;

- The abnormal behavior pattern is enduring, of long standing, and not limited to episodes of mental illness;
- The abnormal behavior pattern is pervasive and clearly maladaptive to a broad range of personal and social situations;
- The above manifestations always appear during childhood or adolescence and continue into adulthood;
- The disorder leads to considerable personal distress but this may only become apparent late in its course;
- The disorder is usually, but not invariably, associated with significant problems in occupational and social performance (WHO, ICD-10, 1992, p.157-158).

It is also added that "For different cultures it may be necessary to develop specific sets of criteria with regard to social norms, rules and obligations" (WHO, ICD-10, p. 158).

At least three of the above-described diagnostic criteria should be clearly present for the diagnosis.

F60.0 The paranoid PD is characterized by: hypersensitivity to criticism; persistence in bearing resentments; combative and tenacious sense of personal rights; suspiciousness; belief that others are using or deceiving them; preoccupation with "conspiratorial" explanations of events.

F60.1 The schizoid PD is characterized by: lack of activities providing pleasure; emotional coldness and apathy; notable indifference to praise or criticism; little interest in having sexual experiences; limited capacity to express feelings towards others; preference for solitary activities; preoccupation with fantasy and introspection; lack of close friends and interest in social relationships; lack of sensitivity towards social norms.

F60.2 The dissocial PD is characterized by: unconcern for the feelings of others; irresponsibility and disregard for social norms, rules and obligations; incapacity to maintain enduring relationships; very low tolerance of frustration and a low threshold for discharge of aggression; incapacity to experience guilt or to profit from punishment; proneness to blame others.

F60.3 The emotionally unstable PD is characterized by impulsiveness and lack of self-

control and is divided into two types:

F60.30 The impulsive type: tendency to act unexpectedly; tendency to quarrelsome behavior; outbursts of violence; difficulties in maintaining any course of action without immediate reward; mood instability.

F60.31 The borderline type is characterized: unclear or disturbed self-image, aims, and internal preferences; intense and unstable relationships; excessive efforts to stop others from leaving; suicidal threats or acts of self-harm; chronic feelings of emptiness.

F60.4 The histrionic PD is characterized by: exaggerated expression of emotions; suggestibility; labile affectivity; continual seeking for excitement; inappropriate seductiveness; over-concern with physical attractiveness.

F60.5 The anankastic PD is characterized by: feelings of excessive doubt and caution; preoccupation with details, rules, lists; perfectionism that impedes task fulfillment; excessive conscientiousness; pedantry; rigidity and stubbornness; unreasonable reluctance to allow others to do things their own way; unwelcomed thoughts or impulses.

F60.6 The anxious [avoidant] PD is characterized by: persistent feelings of tension and apprehension; feelings of inadequacy and inferiority; extreme sensitivity to negative evaluation; avoidance of social interaction despite a strong desire to be close to others; strong need of having physical security; avoidance of social activities because of the fear of criticism or rejection.

F60.7 The dependent PD is characterized by: encouraging others to make the most of one's important life decisions; undue compliance with the needs of others on whom one is dependent; difficulties in expressing disagreement with whose one depends on; feeling uncomfortable or helpless when alone; fears of being abandoned or separated from important individuals; limited capacity to make everyday decisions without advice and reassurance from others (WHO, ICD-10).

Appendix 2

IPDE-SQ correlations

Table A2-1. *Correlations within the IPDE-SQ paranoid scale*

	2.	14.	22.	24.	27.	36.	52.
2.							
14.	.017						
22.	.107	.088					
24.	-.022	.299**	.170**				
27.	-.036	-.023	.078	-.056			
36.	-.019	.077	.121*	.089	.048		
52.	.005	.303**	.205**	.226**	.035	.165*	
Paranoid	.296**	.506**	.592**	.446**	.400**	.404*	.604**

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Table A2-2. *Correlations within the IPDE-SQ schizoid scale*

	1.	8.	12.	21.	31.	46.	55.	57.	58.
1.									
8.	-.147**								
12.	.190**	-.077							
21.	.062	.008	.147**						
31.	.166**	-.035	.119*	-.035					
46.	.161**	-.037	.225**	.143**	.067				
55.	.221**	-.029	.190**	.145**	-.001	.099*			
57.	.077	-.078	.071	.033	-.003	.04	.061		
58.	.120*	.067	.165**	.116*	.162**	.275**	.177**	0	
Schizoid	.436**	.210**	.503**	.450**	.364**	.548**	.475**	.248**	.583**

** Correlation is significant at the 0.01 level (1-tailed).

* Correlation is significant at the 0.05 level (1-tailed).

Table A2-3. *Correlations within the IPDE-SQ dissocial scale*

	11.	18.	38.	20.	29.	47.	51.
11.							
18.	.034						
38.	-.047	-.054					
20.	.127*	0	.105				
29.	.237*	.145*	.080	.137*			
47.	.280*	.112	-.044	.113*	.083		
51.	. 086	.115*	-.027	.075	.082	.051	
Dissocial	.547*	.319**	.242**	.626**	.602**	.382**	.409**

* Correlation is significant at the 0.05 level (2-tailed).

** Correlation is significant at the 0.01 level (2-tailed).

Table A2-4. *Correlations within the IPDE-SQ impulsive scale*

	19.	30.	37.	53.	56.
19.					
30.	-.024				
37.	.140*	.075			
53.	.072	.137*	.118*		
56.	.007	.171**	.168**	.187*	
Impulsive	.381**	.539**	.564**	.596*	.577**

* Correlation is significant at the 0.05 level (2-tailed).

** Correlation is significant at the 0.01 level (2-tailed).

Table A2-5. *Correlations within the IPDE-SQ borderline scale*

	4.	9.	13.	25.	40.
4.					
9.	.052				
13.	.078	0,059			
25.	-.001	.167**	.033		
40.	.155**	.121*	.052	.142*	
Borderline	.547**	.477**	.462**	.468**	.621**

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Table A2-6. *Correlations within IPDE-SQ histrionic scale*

	5	17	26	28	35 44	
5						
17	-.080					
26	-.011	,243**				
28	.158**	-,157**	.023			
35	.168**	-,127*	-.123*	.316**		
44	.060	-.018	.130*	.118*	.119*	
Histrionic	.464**	.329**	.461**	.520**	.498**	.492**

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Table A2-7. *Correlations within the IPDE-SQ anankastic scale*

	3	10	23	32	41	48	54	59
3								
10	.054							
23	.088	.192**						
32	.131*	.253**	,326**					
41	.026	.082	,121*	.109				
48	.040	.100	.190**	.325**	.052			
54	.170**	.059	.102	.05	.042	.078		
59	.022	.052	.056	.078	.020	.068	-.088	
Anankastic	.431**	.497**	.573**	.620**	.383**	.459**	.382**	.336**

* Correlation is significant at the 0.05 level (2-tailed).

** Correlation is significant at the 0.01 level (2-tailed).

Table A2-8. *Correlations within IPDE-SQ anxious scale*

	7.	16.	34.	39.	43.	50.
7.						
16.	.262**					
34.	.142*	.196**				
39.	.223**	.272*	.202**			
43.	.257**	.172*	.222**	.172*		
50.	.096	.384*	.255**	.194*	.085	
Anxious	.572**	.627*	.593**	.572*	.556**	.580**

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Table A2-9. *Table Correlations within IPDE-SQ dependent scale*

	6.	15.	33.	42.	45.	49.
6.						
15.	.101					
33.	.113	.055				
42.	181**	.187**	.347**			
45.	.052	.020	.007	0,082		
49.	.272**	.135*	.107	.191*	-.032	
Dependent	.506**	.525**	.453**	.637*	.405*	.559**

** Correlation is significant at the 0.01 level (2-tailed).

Appendix 3

Correlations within the scales of the IPDE interview by the subscales

Table A3-1. *Correlations within the IPDE interview paranoid scale*

	q31	q34	q35	q36	q38	q55	q57
q31							
q34	.095						
q35	.162	.435**					
q36	.081	.259**	.238*				
q38	.278**	.236*	.215*	.241*			
q55	.047	0,187	-.038	.047	.258**		
q57	.174	.059	.315**	.144	.168	-.024	
Paranoid	.529**	.634**	.622**	.511**	.671**	.383**	.411**

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Table A3-2. *Correlations within the IPDE schizoid scale*

	q18	q19	q22	q37	q39	q42	q44	q53	q66	q67
q18										
q19	.246*									
q22	.340**	.213*								
q37	.114	.045	.203*							
q39	.300**	-.017	.138	.497**						
q42	.329**	.207*	.158	.058	.108					
q44	.041	-.039	.183	.006	.138	-.073				
q53	.197*	.041	.226*	.026	.191	-.054	0,057			
q66	.112	.07	-.02	.058	.108	-.029	-0,073	-0,054		
q67	.203*	.02	.205*	.503**	.525**	.230*	.154	.09	-.038	
Schizoid	.646**	.376**	.672**	.357**	.604**	.335**	.240*	.410**	.05	.545**

* Correlation is significant at the
0.05 level (2-tailed). ** Correlation is significant at the 0.01 level (2- tailed).

Table A3-3. *Correlations within the IPDE dissocial scale*

	q15	q20	q29	q60	q61	q62	q63	q64
q15								
q20	.148							
q29	.046	.188						
q60	.142	.021	.057					
q61	.037	-.057	-.060	.407**				
q62	.187	.047	.254	.344*	.116			
q63	.322*	.086	.043	.270	.293	.714**		
q64	.218	-.109	.019	.236	.265	.799**	.691**	
Dissocial	.027	.071	.339*	.564**	.167	.863**	.736**	.760**

* Correlation is significant at the 0.05 level (2-tailed).

** Correlation is significant at the 0.01 level (2-tailed).

Table A3-4. *Correlations within the IPDE impulsive scale*

	q11	q30	q43	q50	q58
q11					
q30	0.109				
q43	0.134	0.141			
q50	.264**	.297**	.486**		
q58	0.119	0.079	0.022	.217*	
Impulsive	.520**	.588**	.615**	.751**	.414**

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Table A3-5. *Correlations within the IPDE borderline scale*

	q5	q6	q7	q25	q26	q45	q48	q56	q59
q5									
q6	.438**								
q7	.418**	.313**							
q25	.307**	.289**	.397**						
q26	.329**	.251**	.198*	.249*					
q45	.335**	.375**	.213*	.361**	.319**				
q48	.292**	.329**	.318**	.151	.134	.306**			
q56	.139	.335**	.296**	.392**	.218*	.179	-.028		
q59	.325**	.247*	.269**	.136	-.046	.316**	.216*	.200*	
Borderline	.710**	.717**	.631**	.599**	.549**	.680**	.542**	.405**	.483**

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed)

Table A3-6. *Correlations within the IPDE histrionic scale*

	q12	q16	q17	q40	q41	q49	q54
q12							
q16	--001						
q17	.050	.465**					
q40	.361**	.354**	.306**				
q41	.121	.248*	.217*	.424**			
q49	.176	.247*	.337**	.393**	-401**		
q54	.128	.132	.338**	.411**	.340**	.298**	
Histrionic	.445**	.583**	.613**	.771**	.637**	.671**	.553**

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Table A3-7. *Correlations within the IPDE anankastic scale*

	q1	q2	q3	q9	q14	q27	q28	q65
q1								
q2	.229*							
q3	.183	.465**						
q9	.093	.340**	.286**					
q14	-.044	.285**	.307**	.501**				
q27	.133	.205*	.245*	.109	.166			
q28	.179	.124	.309**	0	.102	.387**		
q65	.080	.191	.302**	.163	.250*	.224*	.286**	
Anankasti	.425**	.591**	.674**	.589**	.573**	.542**	.531**	.518**

* Correlation is significant at the 0.05 level (2- tailed).

** Correlation is significant at the 0.01 level (2- tailed).

Table A3-8. *Correlations within the IPDE anxious scale*

	q4	q13	q21	q23	q24	q51	q52
q4							
q13	.239*						
q21	.368**	.134					
q23	.287**	.345**	.369**				
q24	.072	.454**	.185	.299**			
q51	.239*	.039	.260**	.307**	.212*		
q52	.108	.294**	.252**	.140	.497*	.149	
Anxious	.492**	.607**	.596**	.650**	.691*	.461**	.637**

* Correlation is significant at the 0.05 level (2- tailed).

** Correlation is significant at the 0.01 level (2- tailed).

Table A3-9. *Correlations within the IPDE dependent scale*

	q8	q10	q32	q33	q46	q47
q8						
q10	.117					
q32	.391	-.061				
q33	.238	,574**	0,248			
q46	.110	.117	-.089	.257		
q47	.014	.098	-.118	.082	.466**	
Dependent	.211	.650**	.148	.734**	.649**	.580**

** Correlation is significant at the 0.01 level (2- tailed)

Appendix 4

Table 4-1. *Pattern Matrix of the CATPCA*

Item / Factors	1	2	3	4	5	6	7	8	9	10	11
4. I can't decide what kind of person I want to be.	**.928**	.205	-.009	-.081	-.069	-.085	.055	.161	-.298	.039	-.039
3. I'm not fussy about little details.	**-.763**	.191	-.133	-.299	.085	-.205	.220	.365	-.045	-.094	.096
49. I often seek advice or reassurance about everyday decisions.	**.704**	-.219	.099	-.076	.095	.195	-.104	.166	.017	.262	.437
17. I'm too easily influenced by what goes on around me.	**.689**	.074	.026	-.039	-.171	.386	-.202	.123	.085	.081	.291
7. I usually feel tense or nervous.	**.655**	.051	.157	-.133	-.102	.043	.084	-.378	.300	.062	-.309
26. My feelings are like the weather: they're always changing.	**.617**	.307	.031	.175	.058	.138	.456	-.052	.353	-.285	.026
53. I'm very moody.	**.616**	.124	-.018	.029	.089	.041	.458	-.332	.357	-.230	.037
6. I let others make my big decisions for me.	**.587**	-.067	-.039	-.154	-.408	-.093	.101	.385	.236	.146	.220
16. I feel awkward or out of place in social situations.	**.473**	-.072	.222	-.179	-.460	.140	.065	-.118	.121	.275	.165
44. I have a reputation for being a flirt.	-.008	**.896**	-.075	.113	.267	-.028	.167	-.054	.195	-.055	.002
13. I get into very intense relationships that don't last.	.003	**.868**	-.290	.177	.122	.000	.211	.025	.068	.202	.065
55. Most people think I'm a strange person.	.154	**.857**	.285	-.234	-.213	.087	-.035	.083	-.175	-.118	-.264
56. I take chances and do reckless things.	.210	**.760**	-.296	.018	.220	-.159	.208	.088	.026	.010	.238
24. People often make fun of me behind my back.	.073	**.673**	.203	-.462	-.096	.080	-.376	.085	.007	.214	.070
11. I've never been arrested.	.485	**-.660**	-.134	.075	.206	-.355	.111	.092	.022	.348	-.301
29. I will lie or con someone if it serves my purpose.	-.184	**.651**	-.171	-.130	-.112	-.152	-.301	-.108	-.159	.261	.397
32. People think I'm too strict about rules and regulations.	-.055	-.030	**.935**	.005	.122	.156	.002	.036	.080	.179	-.080
48. People think I'm too stiff or formal.	-.035	.158	**.917**	.049	-.338	-.068	-.002	.012	-.229	-.088	.059
10. I'm a very cautious person.	-.265	-.298	**.889**	.021	.041	.012	.021	-.123	-.021	-.042	-.136
23. I spend too much time trying to do things perfectly.	.400	-.151	**.807**	-.061	.141	-.081	.071	.209	.079	-.241	.313
43. A lot of things seem dangerous to me that don't bother most people.	.332	-.047	**.751**	-.034	.278	-.036	-.042	-.050	.355	.162	-.032

14. Most people are fair and honest with me.	-.038	-.111	.042	**.917**	.005	.268	.113	.065	-.187	-.073	.018
52. I'm convinced there's a conspiracy behind many things in the world.	-.184	-.003	.168	**-.892**	.055	-.266	.105	-.111	.205	-.075	.063
38.I've had close friendships that lasted a long time.	-.075	.152	.236	**.880**	-.153	-.154	.138	.013	.325	-.193	-.037
21. When I'm praised or criticized I don't show others my reaction.	-.135	-.039	.136	**-.715**	-.053	.171	.513	-.007	-.337	-.189	-.078
40. I often feel "empty" inside.	.345	.124	.067	**-.475**	-.109	.201	.145	-.302	.421	.090	-.055
34. I won't get involved with people until I'm certain they like me.	.155	-.056	.300	**-.424**	.135	.390	.342	-.158	-.063	.359	.163
28. I like to dress so I stand out in a crowd.	-.036	.152	.035	-.126	**.953**	-.051	-.007	-.106	.170	-.016	-.166
5. I show my feelings for everyone to see.	-.060	.230	.167	.225	**.751**	-.124	-.329	-.015	.252	-.239	-.032
35. I would rather not be the center of attention.	.046	-.251	.076	.147	**-.702**	.016	.574	.206	.072	.136	-.051
25. I've never threatened suicide or injured myself on purpose.	-.023	-.234	.162	-.051	**-.663**	.221	.181	.204	-.507	.231	-.102
54. R's hard for me to get used to a new way of doing things.	.205	-.185	.050	.073	**-.632**	.533	.193	-.058	.163	-.123	-.207
12. People think I'm cold and detached.	-.041	.104	.480	-.026	**-.591**	-.282	.197	-.063	-.025	.417	.107
1. I usually get fun and enjoyment out of life.	-.339	-.265	-.102	.332	**.485**	.000	-.089	.169	-.288	.148	.431
18. I usually feel bad when I hurt or mistreat someone.	.141	.002	-.001	.072	.258	**.907**	.098	.077	-.192	-.245	-.195
57. Everyone needs a friend or two to be happy.	-.153	-.003	-.015	.287	.146	**.904**	.108	-.064	.244	.032	.187
15. I find it hard to disagree with people if I depend on them a lot.	.084	.130	-.035	-.122	-.407	**.849**	-.047	-.042	-.032	.028	-.134
39. I worry a lot that people may not like me.	.405	.041	.245	-.247	-.039	**.467**	-.158	.060	.223	.161	.386
58. I'm more interested in my own thoughts than what goes on around me.	.040	.248	.142	.101	-.166	.089	**.820**	-.103	-.098	.285	.046
45. I don't ask favors from people I depend on	-.329	.028	-.047	-.439	.032	.054	**.769**	.108	.206	.083	-.195
46. I prefer activities that I can do by myself.	.211	.106	.429	-.027	-.124	-.053	**.604**	-.039	-.419	.312	-.041
2. I don't react well when someone offends me	.022	-.388	-.068	-.032	-.020	.430	-.032	**-.797**	-.002	.223	.162
8. I almost never get angry about anything.	-.549	.074	.159	.047	.057	.249	.192	**.795**	.090	-.036	.253

37.Sometimes I get m angry I break or smash things.	-.044	.560	-.195	-.142	-.019	.068	-.102	**-.737**	-.014	.060	.034
22. I've held grudges against people for years.	-.083	.152	.287	-.129	-.464	-.114	.026	**-.714**	.109	-.016	.033
19. I argue or fight when people try to stop me from doing what I want.	-.276	-.212	.081	-.134	.335	.041	.211	**-.710**	.033	-.263	.377
27. I fight for my rights even when it annoys people.	-.241	.172	.350	.123	.337	-.316	.253	**-.533**	-.078	-.282	-.033
33. I usually feel uncomfortable or helpless when I'm alone.	.037	.012	.155	.015	.120	.020	-.219	.009	**.932**	.128	.123
36. I think my spouse (or lover) may be unfaithful to me	-.116	-.050	-.063	-.142	-.141	-.140	.302	-.128	**.816**	-.066	.351
42. I worry about being left alone and having to care for myself.	.156	.142	-.041	.041	.108	.182	.089	.137	**.733**	.504	-.052
20. At times I've refused to hold a job, even when I was expected to.	.318	.347	-.061	-.066	.355	-.249	.170	-.168	**-.600**	.048	.413
31. I have little or no desire to have sex with anyone	.003	-.176	.064	-.108	.023	-.081	-.002	-.036	.353	**.859**	-.283
50. I keep to myself even when there are other people around.	.087	.262	-.017	-.127	-.222	-.060	.314	.011	-.066	**.772**	.032
59. I usually try to get people to do things my way.	-.126	.319	.203	.391	.144	-.233	.277	-.472	.040	**.473**	.239
41. I work so hard I don't have time left for anything else.	-.024	.271	.292	-.328	.244	.320	-.007	.226	.313	**.458**	-.366
47. 1 lose my temper and get into physical fights.	-.154	.165	.002	.173	-.238	.065	-.163	-.213	.132	-.057	**.840**
9. I go to extremes to try to keep people from leaving me.	.183	.143	.118	-.117	-.176	.021	-.321	-.001	.110	-.017	**.832**
30. I don't stick with a plan if I don't get results right away.	.091	.122	-.257	-.154	.010	.264	.323	-.029	-.080	.529	**.543**
51. It's hard for me to stay out of trouble.	.273	.080	-.155	-.284	-.003	-.296	.449	.185	.329	-.425	**.452**

Variable Principal Normalization.
Rotation Method: Oblimin with Kaiser Normalization.
(Convergence = ,002).

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