The Inter-Rater Reliability and Validity of the Italian Translation of the Structured Clinical Interview for *DSM-5* Alternative Model for Personality Disorders Module I and Module II: A Preliminary Report on Consecutively Admitted Psychotherapy Outpatients.

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Abstract

To evaluate the reliability and convergent validity of the Structured Clinical Interview for *DSM-5* Alternative Model for Personality Disorders (SCID-5-AMPD) Module I and Module II, 88 adult psychotherapy participants were administered the Italian translations of the SCID-5-AMPD Module I and Module II, Level of Personality Functioning Scale-Brief Form (LPFS-BF), Level of Personality Functioning Scale-Self Report (LPFS-SF), Personality Inventory for *DSM-5* (PID-5), Personality Diagnostic Questionnaire-4+ (PDQ-4+), and Structured Clinical Interview for *DSM-5* Personality Disorders (SCID-5-PD) relying on a Williams cross-over design. SCID-5-AMPD Module I and Module II showed excellent inter-rater reliability (median intraclass correlation coefficients [ICCs] = .85 and .82, respectively). In terms of convergent validity, meaningful associations were observed between SCID-5-AMPD Module I scores and self-report measures of Criterion A; similarly, SCID-5-AMPD Module II trait scores were meaningfully related to PID-5 trait scores. The correlation patterns between SCID-5-AMPD Module II and PID-5 were pretty similar across different methods for assessing *DSM-5* Section II PDs. In terms of *DSM-5* AMPD Criterion A and Criterion B inter-relationships, the SCID-5-AMPD Module I LPFS scores were significantly associated with the majority of the SCID-5-AMPD Module II domain scores, whereas all SCID-5-AMPD Module II domain scores were significantly associated with both self-reported and interview-based measurers of general personality impairment. As a whole, our preliminary findings supported the clinical utility of *DSM-5* AMPD.

Keywords: SCID-5-AMPD; Criterion A; Criterion B; PID-5; LPFS; Personality Disorders.

The fifth edition of the American Psychiatric Association (2013) *Diagnostic and Statistical Manual of Mental Disorders* (*DSM–5*) includes an Alternative Model of Personality Disorder (AMPD) in Section III, in an attempt to address concerns that were raised about the Section II Personality Disorder (PD) categories (e.g., lack of empirically validated cut-offs, high co-occurrence rates among PDs, within-PD heterogeneity; see for a review Widiger, Livesley, & Clark, 2009). Based on previous findings on the incremental value of taking into account the combination of disturbances of self and interpersonal relations and trait concepts (see, for a review, Morey, Benson, Busch, & Skodol, 2015), the *DSM-5* Personality and Personality Disorders Work Group proposed a substantially revised diagnostic model for PDs (Zachar, Krueger, & Kendler, 2016).

Indeed, the *DSM-5* AMPD adopts a dimensional conceptualization of personality pathology, which is based on two main criteria: (A) personality-functioning impairment, and (B) personality-trait pathology. Personality-functioning impairment (i.e., Criterion A) considers two higher order domains: (a) self, including the two subdomains of identity and self-direction; and (b) interpersonal, including the two subdomains of empathy and intimacy (APA, 2013). Criterion B, personality-trait pathology, is based on a hierarchical trait model with five dysfunctional personality domains and 25 dysfunctional personality traits. A score of 2 (i.e., moderate impairment) or greater on the Levels of Personality Functioning Scale (LPFS; APA, 2013) and one or more dysfunctional personality traits listed in the *DSM-5* AMPD Criterion B redefined the core features of a PD (APA, 2013).

The LPFS assesses impairments of 12 subdomains of personality functioning organized within four main domains: identity, self-direction, empathy, and intimacy (APA, 2013) LPFS scores range from *0* (*little or no impairment*) to *4* (*extreme impairment*). The threshold for PD diagnosis was set at LPFS Level 2 (*moderate impairment*), because Morey Bender, and Skodol (2013) showed that a “moderate” or greater rating of impairment in personality functioning maximized the sensitivity and specificity of PD identification in a sample of 337 patients assessed by mental health clinicians. To assess *DSM-5* AMPD Criterion B, a dimensional model of pathological personality

traits was constructed along with a corresponding instrument named the Personality Inventory for *DSM-5* (PID-5; Krueger et al., 2012).

Thus, according to the AMPD, PDs are characterized by impairments in personality functioning and pathological personality traits (APA, 2013; Clark et al., 2015). Specific PD diagnoses may be derived from this model and include antisocial, avoidant, borderline, narcissistic, obsessive-compulsive, and schizotypal PDs. The AMPD also includes a diagnosis of personality disorder—trait specified (PD-TS) that "can be made when a personality disorder is considered present but the criteria for a specific PD are not met" (APA, 2013; p. 761).

The Structured Clinical Interview for *DSM-5* Alternative Model for Personality Disorders

To facilitate adoption of the *DSM-5* AMPD in applied settings where clinician's ratings are key to PD assessment, First and colleagues (First, Skodol, Bender, & Oldham, 2018a) developed the Structured Clinical Interview for *DSM-5* Alternative Model for Personality Disorders (SCID-5-AMPD). The SCID-5-AMPD is composed of three distinct components. The SCID-5-AMPD Module I (Bender, Skodol, First, & Oldham, 2018) was designed to assess three major sub-domains for each Criterion A domain – i.e., Identity, Self-Direction, Empathy, and Intimacy (APA, 2013). The four SCID-5-AMPD domain scale scores are averaged to provide the SCID-5-AMPD LPFS score; an integer score of 2.00 or greater on the SCID-5-AMPD LPFS is required to consider PD diagnosis (APA, 2013; Bender et al., 2018). The SCID-5-AMPD Module II (Skodol, First, Bender, & Oldham, 2018) aims at providing clinician's ratings for the 25 dysfunctional personality traits and 5 maladaptive personality domains (namely, Negative Affectivity, Detachment, Antagonism, Disinhibition, and Psychoticism) that were included in the *DSM-5* AMPD Criterion B. The SCID-5-AMPD Module II provides ordinal ratings for the individual *DSM-5* AMPD Criterion B traits; the SCID-5-AMPD trait scores are averaged to provide the SCID-5-AMPD domain scale scores (Skodol et al., 2018). Finally, the SCID-5-AMPD Module III (First, Skodol, Bender, & Oldham, 2018b) was developed to facilitate the evaluation of the specific diagnoses listed in *DSM-5* AMPD

allowing to assess Criterion A (required impairments in personality functioning) and Criterion B (required pathological personality trait facets) for each of the six specific diagnoses of the AMPD.

If full criteria are not met for any of the specific PDs, the SCID-5-AMPD considers the possibility to diagnose PD-TS based on a determination of at least moderate impairment in personality functioning from the Criterion A assessments and the presence of at least one pathological personality trait based on the Criterion B trait evaluation (First et al., 2018b). For instance, clinicians can diagnose PD-TS based on the results of the Module I and II assessments (First et al., 2018b). The SCID-5-AMPD modules were developed to be administered as separate interviews, depending on clinical necessities (First et al., 2018a). Indeed, although both *DSM-5* AMPD Criterion A and Criterion B should be assessed to provide a PD diagnosis based on the *DSM-5* AMPD criteria, the modular format of the SCID-5-AMPD that are most directly relevant to the patient being evaluated (First et al., 2018a).

Available Evidence on the Psychometric Properties of the SCID-5-AMPD

To the best of our knowledge, very limited evidence on the reliability and convergent validity of the SCID-5-AMPD scores is currently available. Buer Christensen and colleagues (2018) focused on the SCID-5-AMPD Module I and examined its reliability showing that it exhibited adequate interrater reliability with intraclass correlation coefficient (ICC) values ranging from .89 to .95 for LPFS domains (ICC = .96 for the LPFS total score), at least when it was assessed relying on the 17 video-recorded interviews. Moreover, ICCs ranging from .59 to .90 were observed for LPFS domains (LPFS total score ICC value = .75) when the SCID-5-AMPD Module I test–retest reliability was assessed according to a short term (maximum interval between interviews = 2 weeks) design (Buer Christensen et al., 2018). In a subsequent study, Buer Christensen and colleagues (2020) evaluated the association between the SCID-5-AMPD LPFS as a measure of PD severity and psychosocial functioning in a sample of 317 subjects, including 282 clinical participants and found that the SCID-5-AMPD LPFS score was a stronger predictor for psychosocial impairment than the sum of *DSM–IV* PD criteria. Based on videotaped assessments of

30 psychotherapeutic in- and outpatients with both SCID-5-AMPD Module I and the Structured Interview of Personality Organization (Clarkin, Caligor, Sterne, & Kernberg, 2003), Kampe and colleagues (2018) observed significant correlations between overall scores and domain scales of the two interviews. Finally, Somma and colleagues (2019) reported that in a sample of 84 psychotherapy participants the SCID-5-AMPD Module III PD diagnoses exhibited adequate inter-rater reliability (median Cohen's $\kappa = .83$) and encouraging convergent validity (median Cohen's $\kappa = .54$). Currently, no study has provided data on SCID-5-AMPD Module II psychometric properties.

The Present Study

Against this background, we designed the present study to yield preliminary evidence for the reliability and convergent validity of the SCID-5-AMPD Module I and Module II scores using a Williams design (1949) in a sample of consecutively admitted psychotherapy outpatients, who were seeking treatment for problem personality features. We focused simultaneously on SCID-5-AMPD Module I and Module II because in applied settings they are likely to be administered to the same clients to obtain accurate assessment of *DSM-5* AMPD Criterion A and Criterion B. In particular, we aimed at testing the inter-rater reliability of the SCID-5-AMPD Module I and Module II scores using a pairwise interview design.

In the present study, we tried to take into account method biases in single-source personality assessment and research (McCrae, 2019). Thus, we tried to evaluate the convergent validity of the SCID-5-AMPD Module I and Module II scores using psychometrically-sound measures of the same constructs based on different methods of administration. As a further evidence for the validity of the SCID-5-AMPD interview scores, in line with previous studies (Buer Christensen et al., 2020), we tested the associations between the SCID-AMPD Module I LPFS score and both self-reported and interview-based measure of overall amount of *DSM-5* Section II PD symptoms. To this aim, we relied on the Italian translations of the Structured Clinical Interview for *DSM-5* Personality Disorders (SCID-5-PD; First et al., 2016; Italian translation: Somma et al., 2017) and Personality Diagnostic Questionnaire-4+ (PDQ-4+; Hyler, 1994; Italian translation: Fossati et al., 1998) as

interview-based and self-report measures, respectively, of *DSM-5* Section II PDs. Based on Buer Christensen and colleagues' (2020) findings, we expected substantial and significant association with measures of the overall amount of *DSM-5* Section II PD symptoms. Indeed, the SCID-AMPD Module I LPFS score is thought to represent a measure of impairment in general personality functioning, Similarly, based on meta-analytic data (Samuel & Widiger, 2008), we expected that both self-report and interview-based measures of the overall amount of *DSM-5* Section II PD symptoms show substantial and significant correlations with the SCID-5-AMPD Module II domain scale scores.

Moreover, because personality trait profiles are important in differentiating specific manifestations of personality pathology (APA, 2013; Samuel & Widiger, 2008), in the present study we correlated the SCID-5-AMPD Module II trait scores with the number of symptoms that were met by each participant on the 10 PDs that were included in the *DSM-5* Section II. In particular, our expectation was that the correlations that were observed in our study between the number of SCID-5-PD symptoms for *DSM-5* Section II Antisocial, Avoidant, Borderline, Narcissistic, Obsessive-Compulsive, and Schizotypal PDs and the SCID-5-AMPD Module II trait scores closely matched the pattern of relationships detailed in Watters, Bagby, and Sellbom's (2019) meta-analysis.

Finally, we formally assessed the similarity of this correlation pattern with the correlation pattern that was observed between the SCID-5-AMPD Module II trait scores and self-report measures (i.e., symptom counts) of the 10 *DSM-5* Section II PDs. To evaluate the impact of assessment method on the relationships between *DSM-5* AMPD Criterion B traits and *DSM-5* Section II PDs, we also formally assessed the similarity of the correlation pattern between the SCID-5-AMPD Module II trait scores and the SCID-5-PD symptom counts, and the correlation pattern between the PID-5 trait scale scores and the SCID-5-PD symptom counts.

Methods

Participants

Participants were 88 Italian adult participants, who were consecutively admitted from September 2019 to January 2020 to the Clinical Psychology and Psychotherapy Unit of the San Raffaele Hospital of Milan. All participants were admitted to the Clinical Psychology and Psychotherapy Unit in order to receive psychotherapy treatment for interpersonal difficulties and/or problems with behavior and emotional regulation on a strictly voluntary basis. All participants met for the following inclusionary criteria: (a) speak Italian as their first language; (b) age higher than 18 years; (c) IQ higher than 80; (d) education level higher than elementary school; (e) no diagnosis of neurocognitive disorders according to *DSM-5* diagnostic criteria; and (f) no diagnosis of schizophrenia spectrum and other psychotic disorders according to *DSM-5* diagnostic criteria.

Forty-eight (54.5%) participants were female and 40 (45.5%) were male; participants' mean age was 36.47 years, *SD* = 14.04 years. Seven (8.0%) participants were unmarried, 55 (62.5%) were married, 22 (25.0%) were divorced, and 4 (4.5%) were widowed. Nineteen (21.5%) participants had a junior high school degree, 40 (45.5%) had a high school degree, 29 (33.0%) had a University degree. Participants were administered the Italian translations of the Structured Clinical Interview for *DSM-5* Personality Disorders (SCID-5-PD; First, Williams, Benjamin, & Spitzer, 2016), and all the other measures as part of their routine clinical assessment. According to SCID-5-PD assessment, the most frequently diagnosed PDs were Borderline PD, *n* = 17, 19.3%, Narcissistic PD, *n* = 16, 18.2%, Obsessive-Compulsive PD, *n* = 12, 13.6%, Avoidant PD, *n* = 12, 13.6%, and Paranoid PD, *n* = 10, 11.4%,. Rather, Dependent PD, *n* = 6, 6.8%, Histrionic PD, *n* = 5, 5.7%, Antisocial PD, *n* = 5, 5.7%, Schizoid PD, *n* = 3, 3.4%, and Schizotypal PD, *n* = 2, 2.3%, represented the least frequently observed *DSM-5* Section II PD diagnosis in our sample.

Thirty (34.1%) participants received at least one *DSM-5* non-PD psychiatric disorder diagnosis. In this sample, mood disorders (*n* = 15, 17.0%) and anxiety disorders (*n* = 5, 5.7%) were the most frequently diagnosed *DSM-5* non-PD psychiatric disorders. Non-PD psychiatric disorder diagnoses were assessed by the clinicians who were following the participants in treatment. In the

present study, non-PD psychiatric disorder diagnoses were not the focus of this research and were not assessed using standardized interviews; thus, they were used only for descriptive purposes.

Procedures

All participants volunteered to take part in the study after being presented with a detailed description and all were treated in accordance with the Ethical Principles of Psychologists and Code of Conduct. Participants were asked to sign a written informed consent form to take part in the study. All measures were administered as part of routine clinical assessment; none of the participants received any direct or indirect incentive for participating. Participants with non-PD psychiatric disorder diagnoses were administered the measures by expert trained raters after acute symptom remission according to the judgment of the clinicians who were following them in treatment to avoid confounding effects of psychiatric disorders on these measures (Zimmerman, 1994).

For all participants (n = 88), SCID-5-AMPD interviewers and the observers sit in on the same live interviews. Participants were administered the three interviews and the self-report set at 48-72 hours intervals. Six interviewers were independently randomized to each interview and they were randomly assigned the role of interviewer and observer so that no interviewer could administer or rate more than one interview for each participant. To reduce the impact of clinician's experience on psychometric property estimates for the SCID-5-AMPD Module I and Module II measures, only licensed clinical psychologists with 1-3 years of experience in PD assessment were allowed to participate as raters in the present study. Raters took part in courses organized by the Italian publisher of *DSM-5* and related instruments, and then received a 6-month training for each interview. During the training, participants were supervised during the administration and scoring of the interviews by course instructors. In the present study, each interview was scored independently by the interviewer and the observer (i.e., we employed the Williams design, a balanced, uniform cross-over design). Interviewers and observers were kept blind to all other

measure scores. Self-report measures were scored by undergraduate psychology students who were blind to the interview scores and to the aim of the study.

Study Design

In the present study, we relied on Williams design (1949) to assess the inter-rater reliability and convergent validity of the SCID-5-AMPD Module I and Module II. This study design was chosen to consider the administration of SCID-5-AMPD Module I and Module II in the context of a larger test battery. Indeed, it allows controlling for carry-over effects that may frequently occur in applied research as well as in clinical practice, while allowing each rater administering and/or scoring only one interview for each subject.

Williams design was chosen to generate a balanced, uniform cross-over design. In its simplest version, a Williams design consists of three treatments (i.e., measures) and three periods (3 x 3) in six sequences (e.g., ABC, ACB, BAC, BCA, CAB, and CBA). Subjects are randomized in equal numbers to six possible sequences of each of the three treatments (i.e., measures) being administered. If more than six participants should be included in the study, the Williams design should be replicated the desired number of times; for instance, 10 replications are needed to allocate 60 subjects. Computer programs makes it easy to construct at random a Williams design and to randomly assign to the subjects the appropriate sequences of treatments (Sailer, 2005; Wang et al., 2009).

Because each participant of the present study was expected to be independently administered three different interviews and a set of self-report measures, a four-treatment, four-period Williams design was used to obtain a balanced, uniform cross-over design. We relied on 'crossdes' (Sailer, 2005) *R* package to construct 4x4 random Williams designs that were replicated to allocate all participants. A randomization scheme was independently generated using random digits to randomly assign each participant to Williams sequences. The study design, allocation table, and randomization scheme were generated by two authors who were not involved in the administration and scoring of the measures.

Measures

In the present study, all measures were administered to participants in their Italian translations. In the translation process, the authors closely followed Denissen, Geenen, van Aken, Gosling, and Potter's (2008) indications. The translation procedures are detailed elsewhere (Fossati et al., 2013; Fossati et al., 1998; Somma et al., 2017; Somma et al., 2019).

Structured Clinical Interview for the *DSM-5* Alternative Model for Personality Disorders (SCID-5-AMPD; First et al., 2018).

SCID-5-AMPD Module I (Bender et al., 2018). The SCID-5-AMPD Module I is a semistructured diagnostic interview to guide the assessment of the severity of impairment in personality functioning (self and interpersonal) according to the Level of Personality Functioning Scale. After the General Overview, SCID-5-AMPD Module I begins with the eight Preliminary Questions About View of Self and Quality of Interpersonal Relationships (Bender et al., 2018). Following these questions, the interviewer makes a global clinical judgment on the LPFS score (between 0 and 4) based on the interviewee's answers to the General Overview for the SCID-5-AMPD and the Preliminary Questions (Bender et al., 2018). The Module I assessment then continues with a comprehensive evaluation of the individual's impairment in personality functioning for each of the four domains (i.e., Identity, Self-Direction, Empathy, and Intimacy) and their corresponding subdomains. At the end of the assessment of the three subdomains of personality functioning that comprise a domain, the subdomain scores are summed and divided by three to obtain an average score for the domain (Bender et al., 2018). Finally, at the end of the module, the interviewer sums the domain averages and divides by four to calculate the overall LPFS rating derived from the interview (Bender et al., 2018). In the present study, we relied on the Italian translation of the SCID-5-AMPD (Fossati, Borroni, Somma, 2019).

SCID-5-AMPD Module II (Skodol et al., 2018). The SCID-5-AMPD Module II is a semistructured diagnostic interview to guide the assessment of the dimensional trait component of the *DSM-5* AMPD (i.e., Criterion B). *DSM-5* AMPD Module II allows to assess each of the five trait domains

with standardized questions to elicit information about how each of the trait facets within each of these trait domains is characteristic of the interviewee (Skodol et al., 2018). The interviewer should ask all of the questions for each facet and then make a single, overall rating of the degree to which each facet describes the interviewee. For each question, the interviewer should ask for specific examples and elaboration until the interviewer has sufficient information to make a judgment as to the presence of the trait facet (Skodol et al., 2018). Personality facets within each domain then are rated on a four-point scale of descriptiveness, from *0* = "*Very little or not at all descriptive*," to 3 = "*Very descriptive*". The facets should describe the interviewee's current personality and be descriptive for at least the past 2 years; the cut-point for rating a trait as present is *2* = "*Moderately descriptive*" (Skodol et al., 2018). At the end of each trait domain section, the interviewer should record the scores for the individual trait facets in that domain and calculate a total score and an average for the trait domain (Skodol et al., 2018). At the conclusion of Module II, the interviewer completes the Personality Trait Domain Profile, which allows the interviewer to create a graphical profile of the five personality trait domains. Although in *DSM-5* AMPD some facets appear in more than one trait domain and could thus be included in the total scores for all the domains in which they appear, in the present study we relied on Krueger and colleagues (2012) algorithm in order to compute SCID-5-AMPD Module II scores. In the present study, we relied on the Italian translation of the SCID-5-AMPD (Fossati, Borroni, Somma, 2019).

DSM-5 AMPD Criterion A Measures

Level of Personality Functioning Scale-Brief Form (LPFS-BF; Hutsebaut et al., 2016). The LPFS-BF is a 12-item self-report measure that aims to assess the LPFS as described in Section III of the *DSM–5* (APA, 2013). Each LPFS-BF item is measured on a four-point scale (0 = *very false or often false* to 3= *very true or often true*). The LPFS-BF includes two subscales, Self-Functioning and Interpersonal Functioning scales, as well as a total score indexing the subject's general level of personality functioning. For each LPFS-BF scale, higher scores indicate higher levels of personality

dysfunction. Support for the psychometric properties of the LPFS-BF have been provided also for its Italian translation (Somma et al., 2019).

Levels of Personality Functioning Scale-Self Report (LPFSR-SR; Morey, 2017). The LPFS-SR is an 80-item self-report questionnaire, with each item answered on a 4-point scale ranging from *Totally False*, *not at all True* to *Very True*. Each item is weighted according to its putative severity within the LPFS conceptualization (Morey, 2017). Because the *DSM-5* LPFS Level 0 indicators imply "little or no impairment" whereas all other indicators imply some impairment, the items on the LPFS-SR were weighted as follows: Level 0 items are weighted –.5, Level 1 items ("some impairment") are weighted +.5, Level 2 items ("moderate impairment") are weighted +1.5, Level 3 items ("severe impairment") are weighted +2.5, and Level 4 items ("extreme impairment") are weighted +3.5 (Morey, 2017). This weighting provides a direct match to the *DSM–5* characterization of different indicators reflecting different levels of severity, and effectively deals with the fact that some *DSM-5* LPFS descriptors are positively related to health, whereas most are negatively related to health. Previous studies documented the psychometric properties of the LPFS-SR (Hopwood et al., 2018; Morey, 2017), also in its Italian translation (Somma et al., 2019).

DSM-5 AMPD Criterion B Measures

Personality Inventory for DSM-5 (PID-5; Krueger et al., 2012). The PID-5 is a 220-item self-report measure that assess pathological personality traits as defined in the Criterion B of the AMPD included in *DSM-5* Section III. The PID-5 consists of 25 primary scales that load onto five (Negative Affect, Detachment, Antagonism, Disinhibition and Psychoticism) higher order trait domains (Krueger et al., 2012; Somma et al., 2019). PID-5 items are rated on a 4-point Likert-type scale (0 = *very false or often false* to 3 = *very true or often true*) and they are summed to compose PID-5 trait scale scores. The reliability and construct validity of the Italian translation of the PID-5 have been demonstrated (Fossati et al., 2013).

DSM-5 Section II Personality Disorder Measures

Structured Clinical Interview for DSM-5 Personality Disorders (SCID-5-PD; First et al., 2016). The SCID-5-PD is a 119-item semi-structured interview designed to assess the 10 *DSM-5* PDs in Clusters A, B, and C. In the present study, the SCID-5-PD was preceded by the administration of its self-report screening questionnaire (SCID-5-SPQ). The validity of the personality questionnaire as a measure for screening SCID-II PD psychopathology has been previously reported (Richman & Nelson-Gray, 1994), and SCID-5-PD enables direct probing of negative SCID-5-SPQ answers when this is considered clinically relevant for the assessment for the 10 *DSM-5* PDs. In the present study, we computed a SCID-5-PD total score (i.e., the sum of the ratings given to each of the 10 *DSM-5* PDs) as an overall index of pathology. The inter-rater reliability of the Italian translation of the SCID-5-PD has been previously reported (Somma et al., 2017).

Personality Diagnostic Questionnaire-4+ (PDQ-4+; Hyler, 1994). The PDQ-4+ is a self-report questionnaire with 99 true/false items, and is designed to measure the 10 PDs in *DSM-IV* Axis II/*DSM-5* Section II PD as well as passive-aggressive PD and depressive PD. The translation procedure, internal consistency reliability estimates, and construct validity of the PDQ-4+ scales in Italian adult participants were previously published (e.g., Fossati et al., 1998). In the present study, we considered only the PDQ-4+ scale scores of the 10 PDs that were retained also in the *DSM-5* Section II; thus, we computed PDQ-4+ total score summing only the items that are included in the PDQ-4+ scales that measure the 10 *DSM-5* Section II PDs.

Data analysis

The intraclass correlation coefficient (*ICC*) for absolute rater agreement based on random-effect, one-way ANOVA was computed in order to assess the inter-rater reliability of the SCID-5-AMPD Module I and Module II scores, as well as of the SCID-5-PD symptom counts of the *DSM-5* Section II PDs. Although alternative, albeit arbitrary approaches have been suggested (e.g., Koo & Li, 2016), Cicchetti (1994) proposed that *ICC* values <.40 were suggestive of poor agreement, *ICC* values in the .40-.59 range were suggestive of fair agreement, *ICC* values in the .60-.74 range were suggestive of good agreement, and *ICC* values between .75 and 1.00 range were suggestive of

excellent agreement. The Cronbach's α coefficient was used to estimate measure internal consistency reliability.

The moderate size of our clinical sample prevented us from performing multivariate analyses; thus, only bivariate comparisons were carried out. Because the *DSM-5* AMPD traits are ordinally scored in the SCID-5-AMPD Module II, the significance of median score differences between the PID-5 trait scale scores and the corresponding SCID-5-AMPD trait scores was assessed computing the Wilcoxon paired-sample test; Rosenthal's (1991) *r* index was used to evaluate Wilcoxon test effect size. Similarly, the convergent validity between each SCID-5-AMPD trait measure and the corresponding PID-5 trait scale was tested using Spearman *r* coefficient. The mean comparisons between the SCID-5-AMPD domain scale scores and the corresponding PID-5 domain scale scores were carried out computing paired-sample *t*-tests; paired-sample Cohen *d* coefficient was used to evaluate the effect size in paired-sample *t*-tests.

Consistent with previous indications (Wright, Pincus, & Lenzenweger, 2012), Spearman *r* coefficient was used to evaluate the associations between SCID-5-PD and PDQ-4+ symptom counts of the individual *DSM-5* PD diagnoses, and the SCID-5-AMPD Module II trait scores and PID-5 trait scale scores, respectively. To reduce the risk of capitalizing on chance, for each *DSM-5* Section II PD that was assessed by administering the SCID-5-PD, the nominal significance level (i.e., $p < .05$) of the 25 Spearman *r* values was corrected according to the Bonferroni procedure and set at $p < .002$; in our sample, only Spearman *r* values $\geq |.33|$ were significant at $p < .002$.The Pearson *r* coefficient was used to evaluate the relationships between continuous variables (e.g., the SCID-5-AMPD Module I LPFS scores and the SCID-5-AMPD Module II domain scale scores). The significance of the differences between overlapping correlations was tested using Steiger (1980) *z*-test.

The unbiased versions of the dCor and RV coefficients were used to assess the similarity between correlation matrices (Josse & Holmes, 2016); to overcome problems with upward bias in coefficient estimation, we relied on Meyer, Lorent, and Horgan's adjusted RV (RV_{adj}) coefficient

and Székely and Rizzo's (2013) dCor* coefficient. RV coefficient ranges from 0.00 to 1.00, whereas the dCor* coefficient may attain negative values while achieving 1.00 as its maximum value. Permutations tests with Pearson type III approximation were carried out to assess the significance of the RV_{adj} coefficient (Josse, Pagés, & Husson, 2008), whereas the nonparametric *t*-test of multivariate independence in high dimension was used to evaluate the significance of dCor* (Székely & Rizzo, 2013). In the present study, we relied on 10,000 random permutations. The RV coefficient is a standard measure to assess matrix similarity in many fields (Josse & Holmes, 2016), including neuroscience (e.g., Shinkareva et al., 2008). Recent simulation data showed that the dCor* and RV_{adj} represents the best-performing indices to assess matrix similarity, particularly when jointly used (Josse & Holmes, 2016).

Finally, the McNemar chi-square test for paired samples was used to evaluate the significance of the difference between the proportion of participants who received any PD diagnosis based on SCID-5-PD assessment and the proportion of participants who received a *DSM-5* AMPD PD diagnosis based on the SCID-5-AMPD Module I LPFS cut-off score (i.e., LPFS score ≥2.00). Cohen's *h* coefficient was used to estimate the effect size of McNemar chi-square test.

Results

SCID-5-AMPD Module I and Module II: Inter-Rater Reliability

The descriptive statistics and random-effect, one-way ANOVA *ICC* for absolute rater agreement values for the SCID-5-AMPD Module I and SCID-5-AMPD Module II scale scores are summarized in Table 1 and in Table 2, respectively. The *DSM-5* AMPD Criterion B dysfunctional personality traits are listed in SCID-5-AMPD Module II order.

SCID-5-AMPD Module I: Convergent Validity

The Pearson *r* values for the correlations between the SCID-5-AMPD Module I domain scale and LPFS scores, based on Rater 1 assessment, and the LPFS-SR and LPFS-BF scores are summarized in Table 3. Bold highlights convergent validity coefficients. In our sample, the LPFS-SR and LPFS-BF total scores were substantially inter-correlated, $r = .78$, $p < .001$.

The four SCID-5-AMPD Module I domain scale score were substantially inter-correlated, median *r* value = .69, *SD* = .07, min. *r* value = .62 (Self-direction and Empathy), max. *r* value = .79 (Empathy and Intimacy), all *p*s <.001. Similarly, the four LPFS-SR scale scores were substantially and homogeneously inter-correlated, with *r* values ranging from .70 (LPFS-SR Identity and LPFS-SR Empathy) to .80 (LPFS-SR Identity and LPFS-SR Self-direction), median *r* value = .73, *SD* = .04, all *p*s <.001.

In our study, the SCID-5-AMPD Module I LPFS scores ranged from 0.50 to 3.41. When we considered a SCID-5-AMPD Module I LPFS score of 2.00 or greater as indicating the presence clinically relevant personality impairment (i.e., PD diagnosis), 41 (46.6%) subjects qualified for a possible *DSM-5* AMPD PD diagnosis. This proportion was significantly smaller than the proportion of participants that received any *DSM-5* Section II PD diagnosis (*n* = 64, 72.7%) according to SCID-5-PD assessment, McNemar $\chi^2(1) = 16.13$, $p < .001$, Cohen's $h = -0.54$.

SCID-5-AMPD Module II: Convergent Validity

The median/mean comparisons and convergent validities between the PID-5 and SCID-5-AMPD Module II trait and domain scale scores are listed in Table 4. The *DSM-5* AMPD Criterion B dysfunctional personality traits are listed in SCID-5-AMPD Module II order. On average, the SCID-5-AMPD Module II trait ratings were modestly inter-correlated with a median Spearman *r* value of .11, *SD* = .21, min. Spearman *r* value = -.49 (Submissiveness and Grandiosity), max. Spearman *r* value = .72 (Eccentricity and Cognitive and perceptual dysregulation). A moderate median correlation value was observed for the SCID-5-AMPD Module II domain scales, median *r* value = .21, *SD* = .16, with Pearson *r* values ranging from -.05 (Antagonism and Detachment) to .43 (Negative Affectivity and Disinhibition). The median *r* value among the PID-5 trait scale sores was .35, SD =.18, with bivariate *r* values ranging from -.18 (Emotional lability and Restricted affectivity) to .78 (Anxiousness and Depressivity). On average, the PID-5 domain scale scores were substantially inter-correlated, median *r* value = .52, SD = .06, with the individual *r* values ranging from .42 (Negative Affectivity and Antagonism) to .63 (Disinhibition and Psychoticism). The

median correlation coefficient value for PID-5 trait scale score inter-correlations was significantly larger than the median correlation value for the SCID-5-AMPD Module II trait score intercorrelations, Steiger $z = 2.48$, $p < .05$; similar considerations held also for the difference in the median r value for the domain scale inter-correlations, Steiger $z = 3.83$, $p < .0001$.

In our study, the SCID-5-AMPD LPFS score was significantly and substantially correlated with both self-reported amount of *DSM-5* Section II PD symptoms (i.e., PDQ-4+ total score; $M = 23.73$, $SD = 13.60$, Cronbach's $\alpha = .95$), $r = .60$, $p < .001$, as well as the overall number of clinician-rated SCID-5-PD PD symptoms ($M = 12.94$, $SD = 7.13$; random-effect one-way ANOVA *ICC* for absolute rater agreement = .86, $p < .001$), $r = .64$, $p < .001$. Marginally, in our sample the PDQ-4+ total score and the overall number of clinician-rated SCID-5-PD PD symptoms were also substantially inter-correlated, $r = .68$, $p < .001$.

The descriptive statistics and inter-rater reliability (random-effect, one-way ANOVA *ICC* for absolute rater agreement) of the SCID-5-PD PD scale scores (i.e., number of diagnostic criteria) and the bivariate association coefficient (i.e., Spearman *r* coefficient) values between the number of SCID-5-PD PD criteria and the SCID-5-AMPD Module II trait scores are reported in Table 5. The *DSM-5* AMPD Criterion B dysfunctional personality traits are listed in SCID-5-AMPD Module II order. To reduce the risk of capitalizing on chance, for each set of 25 correlations, the nominal significance level (i.e., $p < .05$) was corrected according to the Bonferroni procedure and set at $p < .002$; Spearman *r* values $\geq |.33|$ were significant at $p < .002$. Bold highlights Bonferroni-significant Spearman *r* values. For SCID-5-PD Schizotypal, Antisocial, Borderline, Narcissistic, Avoidant, and Obsessive-Compulsive PD ratings, the trait correlations that were expected to be significant based on the *DSM-5* AMPD description are underlined.

In our sample, several non-negligible and significant Spearman *r* values were observed among the SCID-5-PD scale scores. For instance, the number of *DSM-5* Section II Paranoid PD criteria based on SCID-5-PD assessment was significantly associated with the number of Schizotypal, Spearman $r = .50$, $p < .001$, Antisocial, Spearman $r = .33$, $p < .01$, Borderline,

Spearman r = .44, p <.001, Narcissistic, Spearman r = .35, p <.001, and Avoidant, Spearman r = .31, p <.01, PDs. The number of SCID-5-PD Schizotypal PD features was significantly associated with the number of SCID-5-PD Schizoid, Spearman r = .37, p <.001, and Borderline, Spearman r = .37, p <.001, PD features. SCID-5-PD Antisocial PD ratings and Borderline PD ratings were significantly and moderately inter-correlated, Spearman r = .33, p <.001, whereas the SCID-5-PD ratings for Histrionic PD and Narcissistic PD were substantially and significantly associated, Spearman r = .52, p <.001.

The overall similarity between the correlation (i.e., Spearman r coefficient) matrix was computed in our study for SCID-5-PD Antisocial, Avoidant, Borderline, Narcissistic, Obsessive-Compulsive, and Schizotypal PDs, and the corresponding correlation matrix that was reported in Watters and colleagues' (2019) meta-analysis was non-negligible, RV_{adj} = .82, permutation test p <.001,; dCor* = .81, dCor* $t(274) = 14.65$, p <.001. With respect to the empirical trait profiles (i.e., correlation coefficient patterns) that were reported in Watters and colleagues' (2019) study for the individual PDs, poor similarity coefficient values were observed for Obsessive-Compulsive PD, RV_{adj} = .36, permutation test p <.05, dCor* = .30, dCor* $t(274) = 1.52$, p >.05, whereas modest similarity coefficient values were observed for Antisocial PD, RV_{adj} = .69, permutation test p <.01, dCor* = .49, dCor* $t(274) = 4.11$, p <.001. Rather, non-negligible correspondence with Watter and colleagues' (2019) correlation patterns was observed for Borderline, RV_{adj} = .74, permutation test p <.001, dCor* = .67, dCor* $t(274) = 8.36$, p <.001, Schizotypal, RV_{adj} = .75, permutation test p <.001, dCor* = .73, dCor* $t(274) = 10.26$, p <.001, Narcissistic, RV_{adj} = .73, permutation test p <.001, dCor* = .79, dCor* $t(274) = 13.34$, p <.001, and Avoidant, RV_{adj} = .78, permutation test p <.001, dCor* = .89, dCor* $t(274) = 22.00$, p <.001, PDs.

As a whole, the correlation matrix reported in Table 5 was pretty consistent with the correlation (i.e., Spearman r coefficient) matrix for the PDQ-4 PD scale scores, which represent the number of self-reported symptoms for the 10 *DSM-5* Section II PDs, and the SCID-5-AMPD Module II trait scores, RV_{adj} = .78, permutation test p <.001, dCor* = .78, dCor* $t(274) = 10.29$, p

<.001. Moreover, the pattern of correlations reported in Table 5 was fairly similar to the correlation (i.e., Spearman *r* coefficient) matrix for the PID-5 trait scale scores and the SCID-5-PD *DSM-5* Section II PD symptom counts, RV_{adj} = .78, permutation test *p* <.001, dCor* = .71, dCor* *t*(274) = 9.72, *p* <.001.

SCID-5-AMPD Module I and Module II Inter-Relationships

The Pearson *r* coefficient values for the associations between the SCID-5-AMPD Module II domain scale scores, and the *DSM-5* AMPD Criterion A impairment and *DSM-5* Section II PD overall amount of symptoms measures, respectively, are listed in Table 6. For ease of comparison, the Pearson *r* values for the association between the PID-5 domain scale scores and the general personality dysfunction variables are reported between brackets. The Pearson *r* values for the relationships between the LPFS measure scores and the overall amount of PD symptoms are also reported in Table 6. RV_{adj} and dCor* coefficient values and their significance levels suggested poor similarity between the SCID-5-AMPD Module II domain scale correlation matrix and the PID-5 domain scale correlation matrix. Although the RV_{adj} value was .94, the permutation test *p* was .23; similarly, the dCor* value was .55, dCor* *t*(4) = 0.64, *p* >20.

Discussion

To the best of our knowledge, our study represents the first attempt at testing the reliability and convergent validity of both SCID-5-AMPD Module I and Module II in a sample of consecutively admitted psychotherapy outpatients. Although our sample size was limited, we relied on accurate experimental design, psychometrically-sound criterion measures, and extensive rater training to provide at least preliminary evidence of the psychometric properties of the SCID-5-AMPD Module I and Module II in applied clinical setting.

SCID-5-AMPD Module I and Module II Inter-Rater Reliability

As a whole, our data suggest that both *DSM-5* AMPD Criterion A and Criterion B constructs can be reliably assessed also using semi-structured interviews, at least in a sample of Italian psychotherapy outpatients. Confirming and extending previous reports (Buer Christiansen et al.,

2018), our findings suggested that the SCID-5-AMPD Module I scores were provided with adequate inter-rater reliability. On average, very good (i.e., *ICC* values in the .60-.74 range; Cicchetti, 1994) rater agreement was observed for the SCID-5-AMPD Module I sub-domain scale scores (median *ICC* value = .74), with the possible exception of the Tolerance of Perspective scale. In our study, excellent (i.e., *ICC* values in the .75-1.00 range) agreement was reported for all the SCID-5-AMPD Module I domain scale scores, as well as for the SCID-5-AMPD LPFS total score. The latter finding was particularly important for the clinical use of the SCID-5-AMPD Module I. Indeed, *DSM-5* AMPD Criterion A requires a single rating across the four LPFS domains of self and interpersonal functioning (APA, 2013). Notably, Buer Christensen and colleagues (2020), showed that that LPFS outperformed number of *DSM–IV*/ *DSM–5* Section II PD criteria in predicting the presence of PD and associated other outcomes, such as impairment in psychosocial functioning.

It may be argued that our ICC values for the SCID-5-AMPD Module I scale scores were somewhat larger than the corresponding values that were reported in Buer Christiansen and colleagues' (2018) study. Besides differences in sample characteristics and rater experiences, we feel that this difference may be at least partially explained by the difference in the designs for assessing inter-rater reliability (i.e., pairwise interview design vs. video-taped interview design). Indeed, method effects on inter-rater reliability estimates were documented (e.g., Chmielewski, Clark, Bagby, & Watson, 2015).

According to our findings, the *DSM-5* AMPD Criterion B dysfunctional personality traits and domains could be reliably assessed among psychotherapy outpatients even by raters with limited clinical experience using the SCID-5-AMPD Module II, at least in its Italian translation. On average, the inter-rater reliability of the 25 SCID-5-AMPD Module II trait scores was good (Cicchetti, 1994). Indeed, fair agreement was observed only for the SCID-5-AMPD Callousness and Deceitfulness trait scores (n = 2, 8.0%). Rather, *ICC* values were suggestive of excellent

agreement for all the SCID-5-AMPD Module II domain scale scores, although method issues may have inflated our findings (Chmielewski et al., 2015).

SCID-5-AMPD Module I Convergent Validity

Confirming previous reports (e.g., Waugh et al., 2020), our findings seemed to support the hypothesis that the *DSM-5* AMPD Criterion A LPFS could be reliably assessed also using self-reports among psychotherapy outpatients. The substantial inter-correlation that we observed between the LPFS-SR and LPFS-BF total score was consistent with previous findings suggesting adequate content validity of the *DSM-5* AMPD Criterion A LPFS measures (Waugh et al., 2020). Even controlling for the effect of shared method variance and keeping raters blind to self-report scores, we observed substantial convergent validity correlations between the SCID-5-AMPD LPFS scores, and the LPFS-SR and LPFS-BF total scores.

Interestingly, in our psychotherapy sample the use of SCID-5-AMPD LPFS scores ≥2.00 to identify clinically relevant PD diagnoses yielded a significantly lower proportion (46.6% vs. 72.7%) of PD diagnoses when compared to the SCID-5-PD. Thus, relying on reliably assessed LPFS scores is likely to result in significant and moderate reduction of PD base rate rather than in PD overestimation, at least in psychotherapy outpatient samples.

Convergent validity results were somewhat controversial when the SCID-5-AMPD Module I domain scale scores were taken into account. In particular, the SCID-5-AMPD Module I Empathy scale score showed only moderate *r* values (Cohen, 1988) for the association with the LPFS-SR Empathy scale score, as well as with the LPFS-BF Interpersonal scale score; moreover, it showed its largest correlation ($r = .50$) with the LPFS-SR Intimacy scale score. Notwithstanding its adequate reliability, it should be observed that in our study the SCID-5-AMPD Empathy scale showed the lowest *ICC* value among the SCID-5-AMPD Module I domain scales. These findings seemed to be consistent with Garcia and colleagues' (2018) data, suggesting a possible problem with the operationalization of the *DSM-5* AMPD Criterion A Empathy construct. All the other SCID-5-AMPD Module I domain scale scores showed convergent validity (i.e., Pearson *r*)

coefficient values that were equal to, or greater than .50. This finding seemed to suggest a large convergent validity effect (Cohen, 1988) for SCID-5-AMPD Module I Identity, Self-Direction, and Intimacy scale scores, although the SCID-5-AMPD Module I showed its largest and positive correlations with the LPFS-SR Self-Direction scale score.

Of course, our convergent validity findings may have been highly influenced by several method factors, ranging from substantial overlap among the four SCID-5-AMPD Module I domain scale scores, as well as among the LPFS-SR domain scale scores and between the LPFS-BF Self and Interpersonal scale scores, to the controversies surrounding the latent structure of the DSM-5 AMPD Criterion A LPFS and its measures (Sleep, Lynam, Widiger, Crowe, & Miller, 2019). As a whole, our findings are consistent with the view of focusing on the LPFS total score in clinical assessment (Morey, 2019), at least when the SCID-5-AMPD Module I is used. Notably, it should be observed that according to the DSM-5 AMPD the LPFS total score is the most important variable in identifying the presence of clinically significant PD (APA, 2013).

SCID-5-AMPD Module II Convergent Validity

Notwithstanding McCrae's (2019) stressed the importance of multiple informants in personality assessment, as a whole our findings suggested that the SCID-5-AMPD Module II trait and domain scale scores were largely congruent with the corresponding PID-5 trait scale and domain scale scores. On average, the SCID-5-AMPD Module II dysfunctional personality trait scores and domain scale scores were substantially correlated with the corresponding PID-5 trait, median Spearman *r* value = .57, *SD* = .15, and domain scale scores, median *r* value = .66, *SD* = .04. These findings confirmed and extended Nuzum, Ready and Clark's (2019) results on the comparability of self- and other-rated personality measures. Indeed, with the possible exception of Intimacy Avoidance, our findings seemed to suggest that the *DSM-5* Criterion B dysfunctional personality traits and domains may be reliably and validly assessed using semi-structured interview ratings, as well as self-report questionnaires, at least when the Italian translation of the SCID-5-AMPD Module II and the PID-5 were administered to a study group of psychotherapy outpatients. Moreover, it should be

acknowledged that differences in the correlations between PID-5 traits and Module II traits may be related to differences in how these instruments were developed. Indeed, the construction of the PID-5 was grounded in an empirical study from which it was derived a set of 25 reliably measured core elements of personality description starting from a larger initial list of maladaptive traits (Krueger et al., 2012). In contrast, items for SCID-5-AMPD Module II trait assessment were based on the exact wording of the trait definitions in the *DSM-5* AMPD (First et al., 2018a).

Consistent with previous observations on the overlap among *DSM-5* Section II PD diagnoses (e.g., Widiger, Livesley, & Clark, 2009), in our study several significant and non-negligible associations were observed among the SCID-5-PD symptom counts. Confirming and extending Buer Christiansen and colleagues' (2020) results, our data suggested that the SCID-5-AMPD Module I LPFS score was significantly and substantially associated also with the overall amount of both interview-based and self-reported *DSM-5* Section II PD symptoms in psychotherapy outpatients, at least when they were assessed using the SCID-5-PD and the PDQ-4+, respectively. In other terms, our data seemed to suggest that the SCID-5-AMPD Module I LPFS score represents a valid measure of impairment in general personality functioning. Notably, these findings may be considered compelling also in the light of the increased research interest on the impact of personality pathology severity on psychosocial functioning across diagnostic categories (e.g., Wright, Hopwood, Skodol, & Morey, 2016).

Although the *DSM-5* AMPD was developed to address the shortcomings of the panoply of signs and symptoms that constitute the categorical PD model, it was also conceived to provide continuity with the *DSM-IV*/*DSM-5* Section II PD model in order to facilitate the transitions from a categorical to fully dimensional approach to PD diagnosis (e.g., Hopwood, Mulay, & Waugh, 2019). From this perspective (see also, Watters et al., 2019), it may be useful to assess the convergence between *DSM-IV*/*DSM-5* Section II PD with respect to trait criterion profiles in order to provide further evidence on the convergent validity of the SCID-5-AMPD Module II. As a whole, 20 (80.0%) SCID-5-AMPD Module II trait scores showed at least one significant and non-

negligible correlations (i.e., Spearman $r \geq |.33|$) with one ore more *DSM-5* Section II PD symptom counts that were assessed using the Italian translation of the SCID-5-PD. Only SCID-5-AMPD Separation Insecurity, Submissiveness, Perseveration, Anhedonia, and Irresponsibility trait scores showed no significant associations with the SCID-5-PD symptom counts.

Notably, all SCID-5-PD symptom counts for the 10 *DSM-5* Section II PDs showed significant and non-negligible Spearman *r* values with at least one SCID-5-AMPD Module II trait score. In a sense, our data could be useful in extending our knowledge on the relationships between the *DSM-5* AMPD Criterion B traits and the *DSM-5* Section II PDs (Krueger & Markon, 2014; Watters & Bagby, 2018). Indeed, in our sample several *DSM-5* Section II PDs that have no counterpart in the *DSM-5* AMPD showed substantial, non-negligible, and clinically meaningful associations with SCID-5-AMPD Module II scores of selected *DSM-5* AMPD Criterion B dysfunctional personality traits. For instance, in our study the SCID-5-PD Paranoid PD ratings were significantly associated with the SCID-5-AMPD Module II ratings of *DSM-5* AMPD Criterion B Suspiciousness, Hostility, and, to a lesser extent, Withdrawal dysfunctional personality traits. Notwithstanding the small size of our sample, the relevance of these findings should not be overlooked, because in our design each participant was administered the SCID-5-AMPD Module II and the SCID-5-PD (as well as the SCID-5-AMPD Module I) by different raters that were kept blind to the scores of the other interview(s), and each rater administered and/or scored a single interview for each subject. As a whole, these findings seemed to suggest that *DSM-IV*/*DSM-5* Section II PDs not included in the AMPD could be described relying on the *DSM-5* AMPD and might even precludes the need for any specific PD types in the AMPD (e.g., Clark et al., 2015).

In our study, the percentages of expected correlations based on the *DSM-5* AMPD trait descriptors for the six specific PDs that were actually observed in our study with respect to the overall mount of *DSM-5* AMPD trait descriptors for the six specific PDs were 57.1%, 71.4%, 100.0%, and 50.0% for Schizotypal, Borderline, Narcissistic, and Avoidant PDs, respectively. Rather, only 28.5% and 25.0% of the expected relationships with the SCID-5-AMPD Module II

ratings of the *DSM-5* AMPD Criterion B dysfunctional personality traits was empirically supported for Antisocial and Obsessive-Compulsive PDs, respectively, at least when they were assessed using the SCID-5-PD. However, with the exception of Obsessive-Compulsive PDs, several additional significant associations were observed between the SCID-5-PD ratings of the *DSM-5* Section II PDs that were included also in the *DSM-5* AMPD and the SCID-5-AMPD Module II trait scores; this finding was consistent with Watters, Bagby, and Sellbom's (2019) meta-analysis results. Indeed, correlation matrix similarity analysis results showed that our bivariate correlation analysis findings were non-negligibly similar to the set of correlation coefficients that were reported in Watters and colleagues' (2019), with the exception of Antisocial and Obsessive-Compulsive PDs. Notably, it should be observed that in the *DSM-5* AMPD, the Obsessive-Compulsive PD definition was deliberately expanded beyond the description listed in *DSM-IV* and focused on rigidity and perfectionism (APA, 2013). Indeed, not surprisingly, Obsessive-Compulsive PD differed markedly from the *DSM-5* AMPD trait description also in Watters and colleagues' (2019) study. Finally, in our study SCID-5-PD Antisocial PD diagnosis was rarely reported, and treatment-seeking Antisocial PD subjects may be different from typical remorseless (i.e., callous), irresponsible, deceitful, and aggressive antisocial seen in other (e.g., forensic) settings..

As a further evidence of the convergent validity and clinical usefulness of the SCID-5-AMPD Module II trait scores, it should be observed that our correlation matrix similarity analyses yielded evidence of non-negligible consistency of the overall pattern of correlations between *DSM-5* Section II PD ratings and *DSM-5* AMPD Criterion B dysfunctional personality trait measures even when the PID-5 trait scale scores were used to measure the *DSM-5* AMPD Criterion B dysfunctional personality traits, and even when the *DSM-5* Section II PDs were assessed using PDQ-4 self-report ratings.

SCID-5-AMPD Module I and Module II Inter-Relationships

Consistent with meta-analytic evidence (Samuel & Widiger, 2008; Saulsman & Page, 2004) and *DSM-5* AMPD expectations, in our study several significant and non-trivial correlations were

observed between the SCID-5-AMPD Module II domain scale scores and different interview-based and self-report measures of general personality impairment constructs. With the exception of the SCID-5-AMPD Module II Antagonism domain scale score, all other SCID-5-AMPD Module II domain scale scores showed significant and non-negligible correlation with the SCID-5-AMPD Module I LPFS score, as well as with LPFS self-report scores (i.e., the LPFS-SR and LPFS-BF total scores). As a whole, these findings lent further support to the validity of the SCID-5-AMPD Module II domain scales.

It should be observed that all PID-5 domain scale scores were also significantly and substantially correlated with the SCID-5-AMPD Module I LPFS score, the LPFS-SR total score, the LPFS-BF total score, as well as with the PDQ-4+ total score and the total number of *DSM-5* Section II PD symptoms based on the SCID-5-PD interview. Moreover, in our sample the median *r* values for the correlations between the PID-5 trait scales and the measures of global personality impairment were significantly larger than the corresponding SCID-5-AMPD Module II domain scale median *r* values for the LPFS-SR, Steiger $z = 3.49$, $p < .001$, LPFS-BF, Steiger $z = 2.62$, $p < .01$, and PDQ-4+, Steiger $z = 4.21$, $p < .001$, total scores; no significant difference in median *r* value was observed for the SCID-5-AMPD Module I LPFS score and the total number of *DSM-5* Section II PD symptoms based on the SCID-5-PD interview. Not surprisingly, the RV_{adj} and dCor* values suggested that the two set of correlation coefficients were not similar. Confirming and extending Widiger and colleagues' (2019) considerations, our data seems to suggest that the PID-5 domain profile elevation may capture both salience of the individual *DSM-5* AMPD Criterion B dysfunctional personality domain and severity of perceived personality dysfunction. In turn, this finding may explain the difference in median scale inter-correlation between the PID-5 and the SCID-5-AMPD Module II.

Conclusions

Our preliminary data on the reliability and convergent validity of the SCID-5-AMPD Module I and Module II highlight the clinical usefulness of the *DSM-5* AMPD in routine clinical

assessment. Overcoming the well-known problems with convergent validity of the *DSM-IV* axis II/*DSM-5* Section II measures (e.g., Widiger & Simonsen, 2005), the *DSM-5* AMPD seemed to have prompted the development of reliable and reasonably convergent self-report and interview-based measure to assess both Criterion A and Criterion B dimensions. This allow clinicians to rely on flexible assessment strategies in which the client's perspective (i.e., self-report measures) and the clinician's view may be combined in the personality assessment process (McCrae, 2019) and subsequent treatment planning..

Limitations

Of course, our findings should be considered in the light of several limitations. Although we relied on sound experimental methods, the sample was limited in size. This inherently limits the power of statistical tests and increase the risk of sampling error; thus, further studies are badly needed before accepting our conclusions. In the present study, we relied exclusively on psychotherapy outpatients. Although psychotherapy represents the treatment of choice for PDs (Leichsenring et al., 2011), PD are frequently observed in several other populations, including psychiatric and forensic population; consequently, care should be used in extending our findings, particularly to psychiatric samples. Moreover, our sample was more akin to a convenience study group than to a sample of randomly selected subjects, although the use of consecutive admissions may have increased its representativeness.

In our study, we were able to administer multiple self-reported measures and interviews of both Criterion A and Criterion B; however, our findings should not be uncritically extended to other Criterion A measures, particularly context-sensitive measures (e.g., the DLPFSQ; Huprich et al., 2018), or the clinician-rated LPFS (Bender, Morey, & Skodol, 2011). Similar considerations held for Criterion B alternative measures (e.g., the informant version of the PID-5; Markon et al., 2013).

It may be argued that SCID-5-AMPD Module III could represent a more adequate comparison measure than SCID-5-PD. However, we would like to respectfully point out that SCID-5-AMPD Module III assesses for each *DSM-5* AMPD PD diagnosis the same constructs – i.e.,

DSM-5 AMPD Criterion A and Criterion B – that are covered also in the SCID-5-AMPD Module I and Module II while capitalizing the same assessment method, not to say on the same questions. Moreover, the SCID-5-AMPD Module III provides only categorical assessment of six PDs where PD latent structure has been consistently shown to be dimensional in nature (Haslam et al., 2019). Finally, we wished to assess the convergent validity of the SCID-5-AMPD Module I and Module II avoiding any circularity in hypotheses and methods. In terms of nomological network, we expected that the SCID-5-PD Module I LPFS would capture the overall amount of PD symptoms, without limiting our consideration only to those included in the *DSM-5* AMPD. Similar considerations held also for the SCID-5-AMPD Module II domain scales. Rather, we expected that the SCID-5-AMPD Module II trait scale could contribute to significantly differentiating all PDs available in the DSM-5 systems, over and above the limited subset that was included in the *DSM-5* AMPD.

In terms of convergent validity of the SCID-5-AMPD Module I dimensions, we focused mainly on the SCID-5-AMPD Module I LPFS score because the limited size of our sample led us to restrict our focus on few aspects. In the *DSM-5* AMPD the LPFS score plays a crucial role in clinical decision-making (APA, 2013). This is not to say that the individual Criterion A domains have no relevant implications of their own; recent data suggest that using information on the different DSM- Criterion A domains may be important to understand the latent variables of personality pathology (Sleep et al., 2019). These considerations underscore the need for further studies on the nomological network validity of the SCID-5-AMPD Modul I domain scale scores.

To avoid boosting our findings capitalizing on raters' clinical experience, only raters with limited clinical experience were allowed to participate in this study. Further studies including either long-experienced raters and researchers with no clinical background may be useful to obtain a definitive picture of SCID-5-AMPD Module I and Module II psychometric properties. Although we relied on sound self-report measures of *DSM-5* Criterion A, only a sub-set of all available instruments was included in the present study. Although adequate content validity for Criterion A measures has been documented (Waugh et al., 2020), we cannot exclude that relying on different

measures would result in different findings. Similar considerations hold also for all other comparison measures that were used in our study.

Even keeping these limitation in mind, we feel that our preliminary findings may provide useful data on the reliability and convergent validity of the SCID-5-AMPD Module I and Module II scores in a sample of psychotherapy outpatients, while showing the potential usefulness of the *DSM-5* AMPD in the clinical setting.

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Table 1
Structured Clinical Interview for DSM-5 Alternative Model for Personality Disorders Module I: Descriptive Statistics and Random Effect One-Way ANOVA Intraclass Correlation Coefficient for Absolute Agreement (i.e., Inter-Rater Reliability Coefficient) Values (N = 88).

	Rater 1		Rater 2		
SCID-5-AMPD Module I Scales	*M*	*SD*	*M*	*SD*	*ICC*
Sub-domain Scale Scores					
Sense of Self (Identity)	1.71	1.04	1.70	1.01	.75
Self-esteem (Identity)	2.06	0.90	2.07	0.86	.68
Emotional regulation (Identity)	1.96	0.96	1.87	0.91	.71
Meaningful goals (Self-direction)	1.96	1.03	2.07	1.09	.88
Standards of behavior (Self-direction)	1.67	0.96	1.65	0.88	.76
Self-reflective functioning (Self-direction)	2.04	0.86	2.02	0.95	.78
Others' experiences/motivations (Empathy)	1.85	1.03	1.78	1.14	.67
Tolerance of perspectives (Empathy)	1.56	0.87	1.67	0.91	.55
Understanding effects on others (Empathy)	1.67	0.93	1.62	0.98	.72
Depth/duration of connections (Intimacy)	2.00	1.02	1.95	1.10	.81
Desire/capacity for closeness (Intimacy)	1.97	0.93	1.90	0.93	.83
Mutuality of regard (Intimacy)	1.69	1.07	1.68	1.14	.73
Median *ICC* value	--	--	--	--	.74
ICC value *SD*	--	--	--	--	.09
Domain Scale Scores					
Identity	1.92	0.81	1.88	0.79	.83
Self-direction	1.87	0.79	1.93	0.81	.87
Empathy	1.70	0.77	1.70	0.87	.77
Intimacy	1.88	0.86	1.85	0.96	.88
Median *ICC* value	--	--	--	--	.85
ICC value *SD*	--	--	--	--	.05
Levels of Personality Functioning Scale	1.85	0.72	1.83	0.77	.87

Note. SCID-5-AMPD: Structured Clinical Interview for *DSM-5* Alternative Model for Personality Disorders; *ICC*: Random effect one-way ANOVA intraclass correlation coefficient for absolute agreement; --: Statistic not computed; all ICC *p*s <.001

Table 2

Structured Clinical Interview for DSM-5 Alternative Model for Personality Disorders Module II: Descriptive Statistics and Random Effect One-Way ANOVA Intraclass Correlation Coefficient for Absolute Agreement (i.e., Inter-Rater Reliability Coefficient) Values (N = 88).

	Rater 1		Rater 2		
SCID-5-AMPD Module II Scores	*M*	*SD*	*M*	*SD*	*ICC*
Trait Scores					
Emotional lability	1.51	1.01	1.24	0.61	.86
Anxiousness	1.85	1.01	0.96	0.71	.81
Separation insecurity	0.94	1.11	0.86	0.56	.82
Submissiveness	1.01	1.01	0.84	0.72	.79
Hostility	1.23	1.06	0.56	0.76	.67
Perseveration	0.80	0.95	1.24	0.61	.62
Depressivity	1.52	1.00	0.96	0.71	.77
Suspiciousness	1.13	0.98	0.86	0.56	.76
Withdrawal	0.96	1.02	0.84	0.72	.69
Intimacy avoidance	0.85	0.99	0.56	0.76	.64
Anhedonia	0.77	0.94	1.24	0.61	.71
Restricted affectivity	0.66	0.92	0.96	0.71	.70
Manipulativeness	0.62	0.90	0.86	0.56	.86
Deceitfulness	0.45	0.82	0.84	0.72	.54
Grandiosity	1.15	1.05	0.56	0.76	.83
Attention seeking	1.39	1.02	1.24	0.61	.68
Callousness	0.41	0.73	0.96	0.71	.49
Irresponsibility	0.44	0.79	0.86	0.56	.72
Impulsivity	1.10	1.11	0.84	0.72	.89
Distractibility	0.75	0.95	0.56	0.76	.73
Risk taking	0.62	1.02	1.24	0.61	.87
Rigid Perfectionism	1.15	1.11	0.96	0.71	.62
Unusual beliefs	0.51	0.84	0.86	0.56	.86
Eccentricity	0.41	0.71	0.84	0.72	.69
Perceptual dysregulation	0.65	0.88	0.56	0.76	.82
Median *ICC* value	--	--	--	--	.73
ICC value *SD*	--	--	--	--	.11
Domain Scale Scores					
Negative Affectivity	1.35	0.99	1.24	0.61	.80
Detachment	1.00	0.65	0.96	0.71	.82
Antagonism	0.88	0.69	0.86	0.56	.79
Disinhibition	0.74	0.71	0.84	0.72	.92
Psychoticism	0.55	0.75	0.56	0.76	.85
Median ICC value	--	--	--	--	.82
ICC value *SD*	--	--	--	--	.05

Note. SCID-5-AMPD: Structured Clinical Interview for *DSM-5* Alternative Model for Personality Disorders; *ICC*: Random effect one-way ANOVA intraclass correlation coefficient for absolute agreement; --: Statistic not computed; all *ICC p*s <.001

Table 3

Pearson r Values for the Correlations between the Structured Clinical Interview for DSM-5 Alternative Model for Personality Disorders Module I Domain Scale and Levels of Personality Functioning Scale Scores, and the Levels of Personality Functioning Scale-Self Report and Levels of Personality Functioning Scale-Brief Form Scores (N = 88).

	Levels of Personality Functioning Scale – Self-Report Scale Scores					Levels of Personality Functioning Scale – Brief Form Scale Scores		
SCID-5-AMPD-I	Identity	Self-direction	Empathy	Intimacy	Total	Self	Interpersonal	Total
Identity	**.54** ***	.57 ***	.39 ***	.47 ***	.56 ***	**.56** ***	.30 **	.50 ***
Self-direction	.53 ***	**.59** ***	.45 ***	.44 ***	.57 ***	**.54** ***	.33 **	.50 ***
Empathy	.47 ***	.38 ***	**.39** ***	.50 ***	.49 ***	.32 **	**.30** **	.35 ***
Intimacy	.56 ***	.47 ***	.53 ***	**.68** ***	.63 ***	.47 ***	**.50** ***	.54 ***
LPFS	.59 ***	.55 ***	.49 ***	.58 ***	**.62** ***	.52 ***	.41 ***	**.53** ***
M	85.80	66.06	41.79	68.05	261.70	8.48	6.45	14.94
SD	23.94	22.38	15.63	22.91	75.99	5.81	4.75	9.59
Cronbach's α	.86	.83	.82	.75	.94	.89	.84	.91

Note. SCID-5-AMPD-I: Bold highlights convergent validity coefficients; ** p <.01; *** p <.001.

Table 4.
Structured Clinical Interview for DSM-5 Alternative Model for Personality Disorders Module II and Personality Inventory for DSM-5 Scale Scores: Median/Mean Comparisons and Convergent Validity Correlations (N = 88).

	PID-5		SCID-5-AMPD-II		*Mdn*/*M* Comparisons		Validity
DSM-5 Alternative Models Traits and Domains	*Mdn*/*M*	*SD*	*M*/*Mdn*	*SD*	*z*/*t*(87)	Rosenthal's *r*/Cohen's *d*	$r_{Spearman}$/*r*
Emotional lability	1.50	0.86	1.00	1.01	0.34	.04 [a]	.67 ***
Anxiousness	1.67	0.85	2.00	1.01	-2.30 *	-.25 [a]	.65 ***
Separation insecurity	0.86	0.86	0.00	1.11	0.02	.00 [a]	.57 ***
Submissiveness	0.75	0.70	1.00	1.01	-1.12	-.12 [a]	.30 **
Hostility	0.80	0.72	1.00	1.06	-1.71	-.18 [a]	.67 ***
Perseveration	1.06	0.67	1.00	0.96	1.71	.18 [a]	.35 ***
Depressivity	1.04	0.80	2.00	1.00	-3.62 ***	-.39 [a]	.66 ***
Suspiciousness	1.00	0.67	1.00	0.98	0.08	.01 [a]	.52 ***
Withdrawal	0.90	0.70	1.00	1.02	-0.29	-.03 [a]	.60 ***
Intimacy avoidance	0.50	0.60	0.00	1.00	1.26	.13 [a]	.10
Anhedonia	1.50	0.76	0.00	0.94	4.86 ***	.52 [a]	.60 ***
Restricted affectivity	0.71	0.66	0.00	0.92	1.93	.21 [a]	.33 **
Manipulativeness	0.50	0.58	0.00	0.90	0.40	.04 [a]	.33 **
Deceitfulness	0.40	0.59	0.00	0.82	1.98 *	.21 [a]	.47 ***
Grandiosity	0.33	0.53	1.00	1.05	-4.95 ***	-.53 [a]	.59 ***
Attention seeking	0.94	0.67	2.00	1.03	-3.29 ***	-.35 [a]	.62 ***
Callousness	0.29	0.47	0.00	0.73	0.99	.11 [a]	.56 ***
Irresponsibility	0.57	0.65	0.00	0.79	3.58 ***	.38 [a]	.51 ***
Impulsivity	1.00	0.88	1.00	1.11	-0.38	-.04 [a]	.68 ***
Distractibility	0.94	0.82	0.00	0.95	3.78 ***	.40 [a]	.63 ***
Risk taking	1.14	0.66	0.00	1.02	5.32 ***	.57 [a]	.61 ***
Rigid Perfectionism	0.90	0.66	1.00	1.11	-0.36	-.04 [a]	.41 ***
Unusual beliefs	0.38	0.70	0.00	0.88	1.50	.16 [a]	.56 ***
Eccentricity	0.96	0.80	0.00	0.71	3.57 ***	.38 [a]	.32 **
Perceptual dysregulation	0.46	0.62	0.00	0.88	1.49	.16 [a]	.62 ***
Negative Affectivity	1.34	0.50	1.14	0.53	3.12 **	0.40 [b]	.66 ***
Detachment	1.06	0.54	0.90	0.72	1.70	0.22 [b]	.59 ***
Antagonism	0.63	0.44	0.81	0.70	-2.88 **	-0.37 [b]	.62 ***
Disinhibition	1.24	0.47	0.76	0.53	8.80 ***	1.16 [b]	.66 ***
Psychoticism	0.71	0.64	0.52	0.70	1.95	0.25 [b]	.67 ***

Note. PID-5: Personality Inventory for *DSM-5*; SCID-5-AMPD-II: Structured Clinical Interview for *DSM-5* Alternative Model for Personality Disorders Module II; a: Rosenthal's *r* effect size; b: Cohen's *d* effect size; * p <.05; ** p <.01; *** p <.001.

Table 5.

Descriptive statistics and Inter-rater Reliability of the Structured Clinical Interview for DSM-5 Personality Disorders Scale Scores (i.e., Number of Personality Disorder Diagnostic Criteria), and Bivariate Association Coefficient Values Between the Number of Personality Disorder Criteria based on the Structured Clinical Interview for DSM-5 Personality Disorder and the Structured Clinical Interview for the DSM-5 Alternative Model for Personality Disorders Module II Trait Scores (N = 88).

SCID-5-AMPD-II Trait Scores	PPD	SzPD	SPD	ASPD	BPD	HPD	NPD	APD	DPD	OCPD
Emotional lability	.19	**.38**	-.06	.15	**.37**	.24	.16	.22	.24	.20
Anxiousness	.22	**.37**	.10	-.09	.24	.05	-.03	**.43**	**.39**	-.01
Separation insecurity	.29	.22	.08	.07	.22	.02	-.01	.24	**.41**	-.03
Submissiveness	-.12	.06	.06	-.01	.02	-.05	-.22	.22	.21	-.18
Hostility	**.52**	**.33**	.04	.30	**.45**	.06	**.45**	.18	-.05	.28
Perseveration	.06	.01	.04	.11	.21	-.09	.12	.21	.10	.16
Depressivity	.27	.32	.29	-.02	**.35**	-.09	.03	**.41**	.25	-.01
Suspiciousness	**.65**	**.58**	.18	.11	.27	.23	.26	.23	.04	.06
Withdrawal	**.33**	.31	**.43**	.14	.26	-.26	.01	**.50**	-.01	.03
Intimacy avoidance	.22	.04	.15	.08	.00	-.21	-.01	.32	-.11	.04
Anhedonia	.14	.03	.21	.13	.12	-.12	.21	.24	.11	-.03
Restricted affectivity	.09	.12	**.33**	.25	-.06	-.15	.04	.00	-.24	.16
Manipulativeness	.00	.03	-.06	.25	.03	**.33**	**.35**	-.30	-.13	.00
Deceitfulness	-.03	-.04	-.18	**.33**	.10	**.38**	**.34**	-.15	-.20	.01
Grandiosity	.08	.17	-.13	.22	-.07	**.49**	**.51**	**-.36**	-.21	.21
Attention seeking	.17	.17	-.26	.05	.20	**.69**	**.47**	-.29	-.08	.17
Callousness	.19	.18	-.12	.08	-.13	**.41**	**.42**	-.08	-.05	-.15
Irresponsibility	.11	-.07	-.18	.25	.14	.32	.18	.04	.03	-.07
Impulsivity	.18	.18	-.11	**.34**	**.57**	**.39**	.11	-.05	.17	.00
Distractibility	.28	.12	.06	.16	**.42**	-.02	.05	.31	.14	-.09
Risk taking	.24	.11	-.13	.24	**.35**	**.36**	.25	-.09	-.07	.12
Rigid Perfectionism	.14	.21	**.33**	.04	.05	-.07	.16	.11	-.19	**.48**
Unusual beliefs	.13	**.55**	.14	-.05	.27	.11	.08	.08	-.10	.25
Eccentricity	.18	**.57**	.26	.07	.24	.11	.10	**.33**	.00	.16
Perceptual dysregulation	.28	**.53**	.13	.01	**.36**	.07	.14	.32	.05	.16
M	1.22	1.06	0.26	0.45	2.09	1.29	2.23	1.42	1.17	1.86
SD	1.48	1.30	0.71	1.38	2.39	1.48	2.12	1.65	1.67	1.53
ICC	.79	.78	.77	.91	.91	.84	.88	.82	.76	.72

Note. SCID-5-AMPD-II: Structured Clinical Interview for *DSM-5* Alternative Model for Personality Disorders Module II; PD: Personality disorder; PPD: Paranoid PD; SzPD: Schizotypal PD; SPD: Schizoid PD; ASPD: Antisocial PD; BPD: Borderline PD; HPD: Histrionic PD; NPD: Narcissistic PD; APD: Avoidant PD; DPD; Dependent PD; OCPD: Obsessive-Compulsive PD; *ICC*: random-effect, one-way ANOVA intraclass correlation coefficient for absolute rater agreement; all *ICC p*s <.001. For each set of 25 correlations, the nominal significance level (i.e., $p < .05$) was corrected according to the Bonferroni procedure and set at $p < .002$; Spearman r values ≥|.33| were significant at $p < .002$. Bold highlights Bonferroni-significant r values. For SCID-5-PD Schizotypal, Antisocial, Borderline, Narcissistic, Avoidant, and Obsessive-Compulsive PD ratings, the trait correlations that were expected to be significant based on the DSM-5 AMPD description are underlined.

Table 6.

Pearson r Coefficient Values for the Associations Between the Structured Clinical Interview for DSM-5 Alternative Model for Personality Disorders Module II Domain Scale Scores, and the DSM-5 Alternative Model of Personality Disorders Criterion A Impairment and DSM-5 Section II Personality Disorder Overall Amount of Symptoms Measures, Respectively. For Ease of Comparison, the Pearson r Values for the Association Between the Personality Inventory for DSM-5 Domain Scale Scores and General Personality Impairment Variables Are Reported Between Brackets (N = 88).

	Criterion A Levels of Personality Functioning			Section II PD Overall Number of Symptoms	
	Interview	Self-Reports		Interview	Self-Report
SCID-5-AMPD Module II Domain Scales	SCID-5-AMPD Module I LPFS Score	LPFS-SR Total Score	LPFS-BF Total Score	SCID-5-PD Overall N. of PD Symptoms	PDQ-4+ Total Score
Negative Affectivity	.44 *** (.43 ***)	.58 *** (.69 ***)	.36 *** (.63 ***)	.60 *** (.59 ***)	.58 *** (.78 ***)
Detachment	.43 *** (.56 ***)	.51 *** (.80 ***)	.29 ** (.70 ***)	.36 *** (.59 ***)	.28 ** (.65 ***)
Antagonism	.19 (.31 ***)	.11 (.53 ***)	.12 (.38 ***)	.27 ** (.45 ***)	.34 *** (.62 ***)
Disinhibition	.53 *** (.53 ***)	.36 *** (.62 ***)	.35 *** (.49 ***)	.53 *** (.42 ***)	.54 *** (.62 ***)
Psychoticism	.34 *** (.44 ***)	.07 (.56 ***)	.11 (.50 ***)	.45 *** (.48 ***)	.18 (.67 ***)
Median *r* Value	.43 (.44)	.36 (.62)	.29 (.50)	.45 (.48)	.34 (.65)
SCID-5-PD Overall N. of PD Symptoms	.60 ***	.66 ***	.47 ***	--	--
PDQ-4+ Total Score	.64 ***	.86 ***	.68 ***	.68 ***	--

Note. SCID-5-AMPD: Structured Clinical Interview for *DSM-5* Alternative Model for Personality Disorders; LPFS: Levels of Personality Functioning Scale; LPFS-SR: LPFS-Self Report; LPFS-BF: LPFS-Brief Form; SCID-5-PD: Structured Clinical Interview for *DSM-5* Personality Disorders; PD: Personality disorder; --: Statistic not computed;. ** p <.01; *** p <.001.