Searching the person behind the addiction

Assessment of personality pathology in Dutch opioid-dependent patients

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The Cover:
The picture at the cover is a mask which is hidden behind Poppy's. Opioids can be extracted from Poppy-seeds by a chemical process. Mask is the English word 'persona' (latin). In the picture, 'Persona', or in other words, *personality*, is hidden *behind the addiction*.

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Assessment of personality pathology in Dutch opioid-dependent patients

een wetenschappelijke proeve op het gebied van de Sociale Wetenschappen

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De Wens

Kan iemand mij vertellen,
Wanneer een schutter rust
Wanneer zijn boog zich mag ontspannen
Z'n pijl het laatste doelwit kust

Wanneer is een mens tevreden
Merkt hij voor een keer als hij kijkt
Over de schutting van de buren
Dat 't gras niet net iets groener lijkt

Zeg me waar moeten we zoeken
En wat is nou die wens
Waarna we niet meer verder hoeven
Waar en wanneer ligt die grens?

En waarom wil ik alsmaar verder
Als ik ergens ben
Wat maakt het onbekende beter
Dan al hetgeen wat ik ken?

En waarom ben ik nooit compleet gelukkig
Met wat er hoort bij mij
Waarom moet er toch steeds weer iets bij
Waarom nooit eens een keer
Ietsje minder dan meer
Wanneer laat dat verlangen me vrij?

J. Ewbank

Contents

I. Introduction

This study aims to establish the prevalence of personality pathology in opioid-dependent patients in different treatment modalities in Dutch addiction care. In Chapter 1 of this thesis it is illustrated that opioid-dependence is a worldwide phenomenon which forms a problem for society. In the Netherlands there are a variety of treatment modalities and facilities for addiction care which each have a different focus of treatment and differ in the extent to which attention is given to co-existing psychopathology. There is considerate comorbidity of psychiatric problems in opioid-dependent patients, in particular personality pathology. Several methods are available for the assessment of personality pathology. The pros and cons of these assessment methods are discussed in this chapter. Chapter 2 particularly deals with the assessment based on clinical judgement.

In Part II the instrument which was administered for the establishment of the prevalence of personality pathology, the SIDP-IV, is psychometrically evaluated on aspects of reliability and validity.

In Part III an alternative for the DSM approach is explored, studying the convergence between the Interpersonal Behavioral Model and the DSM-IV.

The fourth part deals with the prevalence of personality pathology in a variety of treatment modalities in Dutch addiction care. In addition, based on these results recommendations are provided for assessment of PDs in a variety of facilities in addiction care.

The final part (part V) of the dissertation consists of a summary of the results, presented in the first four parts. Implications for the assessment of personality pathology in Dutch addiction care are discussed.

Chapter 1. Opioid-dependence

1.1 Epidemiology[1]

Despite their illegal character, for many people harddrugs are part of everyday life. In the European Union, there are approximately 1,500,000 (0.3%) problematic opioid or cocaine users in the age of 15 to 64 years (European Monitoring Center for Drugs and Drug Addiction, 2003). In the Netherlands there is less problematic opioid use (0.26%) compared to other European counties like Luxembourg (0.93%) and Portugal (0.9%) (European Monitoring Center for Drugs and Drug Addiction, 2003), but it still has its impact on society in terms of criminality and mental health costs. The costs for drug-addiction care have increased in the last couple of years to € 16,000,000 in the year 2002 (Dutch Ministry of Health, Welfare and Sports, 2001).

An estimated group of several thousand drug-using suspects is regularly arrested by the police for a wide range of violations, the principal crime being against property. Drug crime offenders can be divided into three main categories:

- offenders of (more serious) forms of organized crime
- drug offenders (Opium Act) with a relatively low level of involvement in organized drug crime
- persistent, chronically addicted recidivists, mostly committing property crimes.

Important aims in the Dutch drug policy are limiting the production and trade of illegal drugs and, in addition, the prevention of problematic use. This prevention is supported by education and prevention activities. The policy primarily aims to prevent health risks. Drug abusers are, compared to their non-abusing peers, much more at risk for admission to general hospitals, HIV contamination through the use of needles, AIDS, Hepatitis B and C, overdose, and sexual risk behavior. In the Netherlands the number of recorded deaths from opiate overdoses is low and relatively stable, with an annual average of approximately 64 deaths (Source: Cause of death statistics, CBS).

Besides prevention, treatment of substance dependent patients and related problems and behavior, is an important part of the Dutch drug policy. In the Netherlands there are 32 drug care and cure providers (GGZ Nederland, 2001) consisting of 144 facilities for outpatient care (e.g. methadone maintenance programs; assistance in detoxification; prevention) or counseling; 22 facilities for outpatient/

[1] This paragraph is largely based on data presented in the National Drug Monitor, 2003 Annual Report

semi-inpatient treatment or counseling; and 65 facilities for inpatient treatment (e.g. crisis intervention services; physical detoxification; treatment). Besides these facilities in the drug care and cure sector, there are several institutions involved in the rehabilitation (e.g. Dutch Salvation Army; Dutch Probation Service; penitentiary institutions), social care (e.g. boarding houses; user rooms), and general health care (e.g. general practitioners; medical facilities) for drug users (source; NDM, 2003).

1.2 Opioid-dependence and comorbidity of psychiatric disorders

Opioids are often used by people with sleeping problems, anxiety disorders, personal problems, or problems concerning social relationships or employment. Moreover, it is not surprising that there is high comorbidity with psychiatric disorders, which should be addressed in the treatment of the addictive behavior. Several studies have addressed the prevalence of Axis-I pathology in opioid-dependent patients and found substantial comorbidity with anxiety disorders (Milby, Sims, M.K., Khuder, S., Schumacher, J.E., Huggins, N., McLellan, A.T., Woody, G., Haas, N.,1996 [55%]; Kokkevi & Stefanis [31.8%]), and mood disorders (Ahmad, Mufti & Farooq, 2001 [30%]). In their study, Merikangas and her colleagues (1998), presented a cross-national approach to psychiatric epidemiology. They investigated patterns of comorbidity between substance use and psychiatric disorders in six studies participating in the International Consortium in psychiatric Epidemiology (ICPE). Data were derived from six epidemiologic sites in Europe and North America. The prevalence of a mood-disorder in subjects with a drug dependence in countries other than the Netherlands, was found to range from 30.0% (OR=3.5; Fresno, USA; Mexican American Prevalence and Services Survey [MAPSS]) to 40.0% (OR=3.3; USA:National Comorbidity Study [NCS]). Anxiety disorders were found in 31.1% (OR=4.6; Mexico City, Mexico: Epidemiology of Psychiatric Comorbidity Project [EPM]) to 55.4% (OR=3.3; USA:NCS) of the subjects with a substance dependence. Conduct disorder was found in 40.0% (OR=5.6; USA:NCS) to 59.3% (13.9; Ontario, Canada: Ontario Mental Health supplement Survey) of the substance-dependent subjects. Finally, in 41.1% (OR=14.1; Ontario, Canada: Ontario Mental Health supplement Survey) to 72.4% (OR=15.2; Fresno, USA: MAPSS) of the subjects with a substance-dependence, adult antisocial behavior was found. The size off the Odds

ratio's (OR) mentioned above, which compare the observed co-occurrence of the two disorders with their expected co-occurrence considering their prevalence in the population, indicate that comorbidity between substance dependence and mood disorders, anxiety disorders, conduct disorders and antisocial behavior, is higher than could be expected from their mere co-occurrence in the population. Moreover, the odds ratio's also show, there is higher comorbidity between conduct disorders and antisocial behavior on one end and substance dependence on the other, compared to the comorbidity of mood and anxiety disorders and substance dependence.

Data from the Netherlands Mental Health Survey and Incidence Study (which was one of the six studies participating in the ICPE), a prospective epidemiologic study in which a representative sample of 7.076 adults age 18-64 were interviewed with the Composite International Diagnostic Interview, give an impression of substance dependence disorder and comorbidity with anxiety and mood disorders in the Netherlands. Results show that 24.6% of subjects with a substance dependence disorder (alcohol or drugs) had a comorbid disorder (de Graaf, Bijl, Smit, Vollenbergh, & Spijker, 2002). For people with a substance dependence disorder, 51% (OR=4.6) met the criteria for a mood disorder and 56.0% (OR=5.2) met the criteria for an anxiety disorder (Bijl, Van Zessen, Ravelli, de Rijk, & Langendoen, 1998).

Besides comorbidity with Axis-I psychopathology, research has shown there is even a higher comorbidity with personality pathology in opioid-dependent patients. Estimates of the prevalence of personality pathology in opioid-dependent patients vary across studies and seem to be influenced by assessment procedures (e.g. time of measurement, interviewer characteristics and training), and methodological issues, such as *DSM*-edition and instrument of use (Verheul, 1997). Prevalence rates of personality disorders (PD's) found in studies focusing on opioid-dependent patients range from 34.2% (Cacciola, Alterman, Rutherford, McKay, & Mulvaney, 2001) to 91% (DeJong, van den Brink, Harteveld, & van der Wielen, 1993). In the treatment of substance-dependent patients, this pathology cannot be disregarded (Haro, Mateu, Martinez-Raga, Valderama, Castellano & Cervera, 2004).

Several models of comorbidity between Axis-I and Axis-II pathology exist. The majority of the existing literature underscores the possibility that causal influences in both directions (Axis-I causing Axis-II and the other way around) may exist

simultaneously (Kessler, Crum, Warner, Nelson, Schulenberg & Anthony, 1997; Swendsen & Merikangas, 1998). Results are influenced by the numerous disorder subtypes and comorbidity combinations. For instance, specifically for opioid-dependence, results of the study of Kokkevi and his collegues (1998) show, that subjects with a PD had twice the odds of having a comorbid AXIS I diagnosis and three times the odds of having a mood disorder than those without a PD.

1.3 Assessment methods

Three methods are available for the assessment of personality pathology in opioid-dependent patients. The first method is concerned with the assessment through clinical judgement based on observations and questions in a non-standardized manner. The second method is assessment through the administration of a self-report questionnaire. There are seven self-report measures designed to assess the whole spectrum of *DSM* PD diagnoses. These are the Coolidge Axis II Inventory (CATI; Coolidge & Mervin, 1992); Millon Clinical Multiaxial Inventory (MCMI-III; Millon, Davis & Millon,1994); Minnesota Multiphasic Personality Inventory- PD Scales (MMPI-PD; Morey, Waugh & Blashfield, 1985); Personality Diagnostic Questionnaire-IV (PDQ-IV; Hyler, 1994); Schedule of Nonadaptive and Adaptive Personality (SNAP; Clarck, 1993); the ADP-IV (Schotte, deDoncker, Vanderkerckhoven, Vertommen & Cosyns, 1998); the VKP-4 (Duijsens, Haringsma & Eureling-Bontekoe, 1999); and Wisconsin PD Inventory-IV (WISPI-IV; Klein, Benjamin, Rosenfeld, Treece, Justed & Greist, 1993). The third method is the use of a semi-structured interview. Several semi-structured interviews are available, which can be divided into two categories based on the interview format. In the Diagnostic Interview for DSM-IV PDs (DIDP-IV; Zanarini, Frankenburg, Sickel, & Yong, 1996) and Structured Clinical Interview for DSM-IV Axis II PDs (SCID-II; First, Gibbon, Spitzer, Williams &Benjamin, 1997), questions are grouped diagnostically, while in the Interpersonal Personal Disorder Examination (PDE; Loranger, 1999) questions are arranged by topic (e.g. work, interpersonal relation, impulse control). In the PD Interview-IV (PDI-IV; Widiger, Mangine, Corbitt, Ellis & Thomas, 1995) and the Structured Interview for DSM-IV Personality (SIDP-IV; Pfohl, Blum & Zimmerman, 1995) there is a combination of these formats. This interview format has to be

considered in selecting an interview for clinical or research purposes (First, Spitzer, Gibbon, & Williams, 1995). When questions are grouped so as to facilitate recognition of a given diagnosis (as is the case in diagnostically grouped criteria interviews like the DIDP-IV and SCID-II), even if the clinician is able to avoid biased judgement, patients' responses may be affected by whether they do or do not "identify with" that particular disorder (Clarck & Harrison, 2001).

There is no such thing as a “golden standard” for the measurement of personality, but semi-structured interview procedures facilitate a more systematic, replicable and informed assessment through the provision of a consequent set of questions. They have been found to have a superior reliability compared to self-report measures and clinical judgment (Widiger et al., 1995). Clinical judgment procedures often seem to lead to underestimation of the actual pathology, while self-report measures give an overestimation compared to semi-structured interview measures (Verheul, 1997).

1.4 Research focus and aims

From the data presented in this chapter, it can be concluded that opioid-dependence is a substantial problem in both society and mental health care, with high comorbidity of axis-II psychiatric disorders. Comorbidity of substance use and personality pathology is a problem in the treatment of substance dependent patients. It leads to higher drop-out rates and limited treatment results (Cacciola, Rutherford, Alterman, McKay, & Snider, 1996; Compton, Cottler, Jacobs, Ben-Abdella & Spitznagel, 2003). In their study, Haro and his collegues (2004), concluded that personality disorders need to be considered when planning effective interventions for opiate dependent individuals. This pathology should be treated along with the opioid-dependence. Efficient and effective care in addiction treatment facilities should be attuned to patient characteristics, which differ across treatment modalities. When, for instance, there is high comorbidity with axis-II pathology in a certain setting, it is important for workers in this setting to have substantial knowledge of this pathology. It is plausible that it is necessary to provide additional training.

The first aim of this dissertation is to establish the prevalence of personality pathology in opioid-dependent patients, across treatment modalities in Dutch addiction care.

A semi-structured interview which is administered for the assessment of personality pathology has to be psychometrically evaluated in the patient population for which it is used. In this study we chose a user-friendly semi-structured interview with questions grouped diagnostically and by topic, often administered in Dutch addiction care; the Structured Interview for *DSM-IV* Personality (SIDP-IV; Pfohl, Blum & Zimmerman,1995).

The second aim of this study is to evaluate different facets of reliability and validity of the SIDP-IV.

First, the interrater reliability is studied (Chapter 3). In addition, internal consistence and diagnostic efficiency of the criteria sets is established (Chapter 4). Construct validity (Chapter 5) refers to the extent to which the construct of the *DSM-IV* is represented by the instrument. The *DSM-IV* has an empirical basis and is constructed from expert consensus. The model is compared with a more theoretical interpersonal behavioral model (Chapter 6), by studying the convergence between the SIDP-IV and Interpersonal Checklist-Revised, in order to see whether or not the SIDP-IV could be replaced by, or completed with, a theory based instrument. Through this psychometric evaluation of the SIDP-IV in an opioid-dependent patient sample, the usefulness of the instrument in opioid-dependent patients is established. When it is found to be reliable and valid, the prevalence of personality pathology in opioid-dependent patients across a variety of treatment modalities can be established by the administration of the SIDP-IV (first aim; Chapter 7). In order to develop an efficient and evidence-based stepped-assessment procedure, which can be implemented in Dutch addiction care, possibilities for the use of screening instruments are explored (Chapter 8).

Besides the two main aims of this study, focusing on a more systematic form of assessment, we were interested in the nature of the less structured, but nevertheless intriguing clinical judgment in PD assessment. In order to learn more about the way

this clinical judgment is related to the empirical model of the *DSM-IV*, a critical review at criterion level is needed. Therefore, an important question to answer is: "Is the (under) estimation by clinicians of their patients' pathology consistent with the efficacy of the *DSM-IV* criteria?" This question is addressed as an intermezzo to the core of the dissertation, in Chapter 2.

In this study the prevalence of personality pathology is established in three treatment modalities in Dutch addiction care. These modalities are considered representative for a large spectrum of treatment modalities in the Netherlands. As mentioned in paragraph 1.1, Dutch addiction care consists of inpatient treatment, methadone maintenance programs, and outpatient/semi inpatient treatment. In our study data on the inpatient sample was collected in four inpatient treatment facilities of Novadic, Network for Addiction Treatment services and Parnassia[1]. Patients admitted for treatment in these facilities had a wish for abstinence, met the *DSM–IV*-criteria for opioid dependency, had good knowledge of the Dutch language, and were free of drugs at the time of assessment. Overt Axis-I pathology (with the exception of substance dependence) was considered an exclusion criterion[2]. Outpatient data on patients participating in a methadone maintenance program were collected from two methadone maintenance programs of the addiction clinics "Novadic" and "the Grift". Patients participating in such a program did not have a wish for detoxification, met the *DSM–IV*-criteria for opioid dependency, had good knowledge of the Dutch language, and were not experiencing any detoxification stress at the time of administration. Moreover, they were not too sedated to answer questions in a reliable way. Data from outpatient treatment was collected in a sample consisting of patients participating in a rapid-detoxification program followed by a psychosocial outpatient treatment program based on the Community Reinforcement Approach (CRA; Budney & Higgins, 1998)[3]. An alternative method of detoxification to the traditional methadone tapering

[1] Patients were recruited in consecutive order from the following facilities; Emilie Hoeve (Parnassia); Long-term treatment facility (Novadic), Inpatient-care facility (Novadic), Short-term inpatient facility (Novadic).

[2] Details about each patient sample are given in each chapter of this thesis. These chapters are derived from articles, which are, or will be published in scientific journals. Because of the differences in the type of research questions and the differences between the journals' requirements for the description of the method section, patient characteristics and focus, the description of patients is not entirely consistent throughout this thesis.

[3] In the Netherlands, the effectiveness of rapid detoxification was studied. Patients were recruited in this study, called EDOCRA (Randomised multi-centre study on the **E**ffectiveness of two methods of **D**etoxification combined with the administration of an **O**pioid antagonist and biopsychosocial rehabilitation based on the **C**ommunity **R**einforcement **A**pproach). An extensive description is given elsewhere (DeJong, 1999)

procedure is to treat patients with the administration of an opioid antagonist, which results in rapid detoxification and permits the almost immediate cessation of the use of opioids, in order to clear the way for bio-psycho-social rehabilitation. Relapse rates after detoxification may be reduced by an opioid-antagonist (e.g. naltrexone) maintenance treatment combined with psychosocial treatment such as the Community Reinforcement Approach. It is presumed that relapse prevention with naltrexone will only prove to be effective if it is integrated into a comprehensive adaptation program which focuses on psychological, relational and social issues. Patients in this treatment condition had a wish for abstinence, met the *DSM–IV*-criteria for opioid dependency, had good knowledge of the Dutch language, and were free of drugs at the time of assessment. Overt Axis-I pathology (with the exception of substance dependence) was considered an exclusion criterion.

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Chapter 2 Weighting of *DSM-IV* Criteria in the Assessment of Personality Disorders; Suggestions for *DSM-V*[1]

Abstract

In this study, hierarchy in the weighting of personality disorder criteria by Dutch clinicians was investigated. In addition, the convergence of this hierarchy with hierarchy based on diagnostic efficacy as stated in the fourth edition of the *Diagnostic Statistical Manual* (*DSM-IV*; APA, 1994) was established. The influence of therapist variables on this weighting of the Axis-II criteria, was explored. Results indicate, that the weighting of the criteria by clinicians resembles the *DSM-IV* order, but is influenced by theoretical background, gender, and *DSM*-training methods. A suggestion for *DSM-V* is, to weigh the criteria sets, thereby validating the implicit weighting in current assessment. Furthermore, in order to enhance the reliability of assessment, clinical judgment should be combined with standardized assessment methods.

[1] This chapter is the equivalent of the manuscript with the title " Weighting of *DSM-IV* Criteria in the Assessment of Personality Disorders; Suggestions for *DSM-V* ", which is submitted to European Journal of Personality assessment. Authors: K.F.M. Damen, C.A.J. DeJong, M.H.M. Breteler, & C.P.F. Vanderstaak.

Weighting of *DSM-IV* Criteria in the Assessment of Personality Disorders; Suggestions for *DSM-V*

Since the innovating development of the *Diagnostic and Statistical Manual of Mental Disorders, DSM* (APA, 1980; 1987; 1994), considerable attention has been paid to reliability and validity issues in defining the various mental disorders. Numerous studies have addressed the assessment of personality disorders by clinicians (see Farmer, 2002). One of the revolving issues in the assessment of personality is the lack of convergence between *DSM*-criterion assessment and clinical judgment. Morey and Ochoa (1989) found that clinicians did not follow *DSM-III* (APA, 1980) criteria when making personality disorder (PD) diagnoses. For *DSM-III-R* (APA, 1987), Blashfield and Herkov (1996) replicated Morey and Ochoa's 1989 study. Results supported earlier findings on variables that predict the overdiagnosis of PDs.

Davis, Blashfield and McElroy (1993), focused on how clinicians combine symptom information about narcissistic PD to make a diagnosis. In their study, making use of case histories, three models of how criteria might be combined to form a diagnosis were compared: the polythetic model, the additive model, and the weighting model. The polythetic model (Beckner, 1959), is the implicit model adopted in *DSM*, in that it lists a number of criteria for each disorder. For the diagnosis of a PD in the case of an individual patient, there is a threshold for the number of criteria that have to be met, but multiple combinations of criteria can occur. The additive model states that clinicians should diagnose a PD more frequently as the number of criteria in a case increases. Finally, the weighting model assumes that some criteria are more highly weighted (more typical) when making a diagnosis than other criteria. The results were most consistent with the weighting model. This implies that patients with a few, highly important criteria are more often diagnosed as having a PD, constituting of those criteria, than patients meeting more less-prototypical criteria of the same PD.

Evans, Herbert, Nelson-Gray, & Guadiano (2002), evaluated important determinants of the diagnostic process pertaining to PDs. One of them being the extent to which the features of PDs are typical of the category. The results revealed strong effects of typicality, or, in other words, hierarchy in the weighting of features belonging to the PD categories.

In *DSM-IV*, the items in each criteria set were reordered based on the diagnostic efficiency (i.e., the extent to which diagnostic criteria discriminate those patients from those patients who do not meet criteria for a given diagnosis) of each item, listing most efficient items first (Frances, First, & Pincus, 1995). In most cases, the rank order was based on the correlation of the item to the presence versus absence of the diagnosis, as provided by the *DSM-IV* MacArthur studies, in which the data were derived by the solicitation of four semi-structured interviews (Frances, Pincus, Widiger, Davis, & First, 1990). This means that some criteria are better predictors for the presence or absence of a specific disorder than others. However, in some cases emphasis was given to specificity values (i.e., the extent to which the item was unique to that diagnosis) and/ or clinical theory (e.g., the placement of "frantic efforts to avoid real or imagined abandonment" [APA, 1994, p.654] at the top of the list for borderline PD diagnosis) (Widiger, Mangine, Corbitt, Ellis, Thomas, 1995). Also, new criteria were put in the end of the list. Findings mentioned above, give rise to the following question about the clinical use of the *DSM-IV*: "What is the hierarchy in the weighting of criteria by clinicians in the diagnosis of PDs and does this hierarchy converge with the order of the criteria based on diagnostic efficacy as stated *DSM-IV*?" In this study we apply the findings on the weighting model to the full range of PD criteria, of the fourth edition of the *DSM*(the *DSM-IV*). The aim is to explore the way clinicians give weight to criteria in diagnosing PDs, based on a number therapist variables, in order to gain more information about, and enhancing the reliability of, assessment in clinical practice. In previous research, case histories were used to study the clinical judgment in diagnosis of PDs. This study is the first in which clinicians are explicitly asked to reflect on their decision-making.

In addition, this study seeks to explore variables of influence on clinical judgment in personality assessment. Literature on clinical judgment suggests that it is related to variables such as theoretical orientation (Murphy & Medin, 1985), and age. Davis et al. (1993), found dynamically oriented therapists to be more likely to use narcissistic PD as diagnosis for cases than were non-dynamically oriented therapists. Gender of the patient has also been found to be of influence on the diagnosis made by therapists (DeJong, Van den Brink & Jansen, 1993; Loring & Powel, 1988). Based on the results of previous studies, we expect theoretical background to be a variable that

influences the diagnosis. We also want to investigate gender of the therapist in addition to gender of the patient, to see if this is also of influence in the assessment of PDs.

Method

Participants

A total of 849 registered clinicians (psychologists [54.4%] and physicians and psychiatrists [45.6%]), consisting of 573 clinicians working in general Dutch mental health care, and 276 working in addiction clinics, were asked to participate in a study on the classification of PDs. For clinicians working in the field of general mental health care, we made a selection for general mental health care, consisting of institutions situated in small towns as well as larger cities, with a variance of treatment facilities. Of these clinicians, 213 clinicians volunteered to participate and completed a questionnaire.

The sample of participating clinicians consisted of 50 psychologists and 27 physicians or psychiatrists in addiction care, and 88 psychologists and 48 physicians or psychiatrists in mental health care. Demographic and background variables of the clinicians are shown in Table A.

Instrument

Clinicians were asked to rank the criteria for each PD in order of importance by completion of a questionnaire. “Importance” was defined as the criterion that is most characteristic of a disorder and most informative in the assessment of the personality disorder. The questionnaire consisted of two sections. In the first section clinicians were asked about demographic and background variables; age, gender, theoretical background, discipline, clinical experience, and professional setting. The second part consisted of a list of the ten *DSM-IV* PD criteria sets. In a pilot which was performed prior to this study we examined the applicability of this questionnaire, and found that clinicians were influenced by the order in which criteria were presented (in *DSM*-order). Therefore, we decided to scramble the criteria of each disorder. The order in which the criteria were presented, was the same for all clinicians. Clinicians were asked to weigh the criteria by ranking them with a number, ranging from 1 ("most important/ characteristic") to 7,8, or 9 ("least important/ characteristic"), consistent

with the number of criteria for the disorder. The questionnaire contained an example in which the procedure was explained for the *DSM-IV* criteria for "stuttering".

Procedure

The clinicians were sent packets containing the questionnaire, a letter explaining the purpose of the study stating the data to be processed anonymously, and a stamped, addressed mailer in which to return the completed questionnaire. A code number was included on the envelope to enable the researchers to discriminate between subjects who had returned data and those who had not. In the letter, explaining the purpose of the study, the clinicians were asked to complete the questionnaires. As a reward for participating, clinicians were promised an abstract of the results. Two and four months after the original mailing, a reminding letter was send to those clinicians who had not returned the questionnaire.

Results

For the establishment of the hierarchy in the criteria for each disorder according to the clinicians, we conducted a Friedman analysis on each criteria set. This non-parametric test was conducted because the level of the data was ordinal. The asymptotic significance was calculated for the difference between the ranks, to see whether the ranks significantly differed. The hierarchical order of the criteria for each criteria set of *DSM-IV* PDs according to the clinicians is shown in Table B. For each PD we determined whether there was a significant ($p<.01$) association between the ranking order according to *DSM*, compared to the ranking according to the clinicians. For this purpose, for each disorder, we calculated Kendalls Tau-c's for the correlation between the *DSM* criteria order and the ranking order according to each of the clinicians. Some of the correlations will be reduced simply because the clinicians rank the criterion high, but there were arbitrarily put at the end of the list for *DSM-IV,* simply because there was no data on the diagnostic efficiency; there is not necessarily any disagreement in such cases between the ranking of the *DSM* and the clinicians. In order to control for this reduction in correlation, the new criteria were excluded from the analysis. The mean Tau-c's (of all the clinicians'ratings) were calculated for each disorder, and transformed into z-scores.

Results (as presented in Table B) show that the clinicians in this sample agree with the order of criteria for most PDs, as stated in *DSM-IV*. Lack of association

between *DSM-IV* and the clinicians was found for the antisocial (z=-1.72; p=.04) PD . The least efficient criterion of the antisocial PD, according to *DSM* ranking ("lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another"), is the most characteristic one according to the clinicians. This criterion was not a new criterion. This finding is quite striking. When clinicians think about antisocial, they really think about lack of remorse. Yet, the *DSM-IV* research did not support this clinical judgment. This could be interpreted as a classic example of research-based ranking versus theoretical ranking. However, the low diagnostic efficiency of this criterion could easily be a result of difficulties in assessment. Indifference toward one's victims is so clearly morally wrong that many antisocial/psychopathic persons will fake an expression of remorse or guilt, which is a problem in the assessment (Widiger et al., 1995). Lack of remorse was traditionally considered to be the central trait of psychopathy (Hare, 1992) relating more to the affective state, instead of interpersonal behavior, which gives rise to the question whether a change in the weight of this item is needed and may lead to a change in position in the order of criteria. In addition, criterion #3 (impulsivity or failure to plan ahead) was seen as least characteristic by clinicians. Perhaps because impulsivity is also seen as more characteristic of borderline PD.

To explore the influence of the demographic and background variables on the ranking, we performed a Kruskal-Wallis (for k related samples) or Mann-Whitney (for two related samples) test. For this purpose we combined the variable "professional setting" and "discipline" into four categories, psychologists in addiction care; physicians in addiction care; psychologists in general mental health care; and physicians in general mental health care. For all criteria sets, except for the antisocial and obsessive compulsive criteria sets, clinicians with differences in therapeutic background, seemed to agree on the ranking positions of the criteria. As we hypothesized, theoretical orientation was found to be of influence on the way clinicians think about the criteria used in the assessment of the antisocial PD (Chi square=15.9; df=5; p=.007). A Psychodynamic orientation leads to a ranking of the criteria related to this disorder different from other theoretical orientations. Psychodynamically trained therapists put less emphasize on irritation and aggressiveness and more on recklessness. In addition, we found that for female

therapists, the criteria ranking varied across therapists who had studied the *DSM* thoroughly and had experience with it, as compared to therapist who did not have extensive experience and training in the classification system (Chi-square=15.4; df=3; *p*=.001). Female clinicians who studied *DSM* more thoroughly, found scrupulousness to be more characteristic of the obsessive-compulsive disorder and rigidity and stubbornness to be of less important. Other therapeutic and background variables were not found to be of influence on the way clinicians think about the diagnostic criteria.

A comment should be made with regard to the sample of clinicians in this study. Because 26% of the clinicians who were asked to participate, completed the questionnaire, bias is a concern for this sample. Bias was investigated studying the distribution within this sample in relation to the sample of non-responding clinicians, with regard to gender, discipline, and institutional setting. For this purpose, we conducted a relative risk analysis, rendering odds ratios for each therapist variable, to determine whether or not particular therapist variables were relatively over- or underrepresented in the participating sample, compared to the presence of these variables in the non-responding sample. In addition Pearson's Chi-square was calculated to test this difference. We found no significant difference between the proportion of female clinicians compared to the proportion of male clinicians represented in the participating sample (χ^2=1.99 (1), *p*=.16; OR= 1.2 [*CI*=.92-1.71]). Also no significantly unequal proportion of clinicians in addiction care was represented in the sample, compared to clinicians in general mental health care (χ^2=3.52 (1), *p*=.06; OR= .73 [*CI*=.53-1.02]). However, for "discipline" we found a significant difference in the proportion of psychologists, represented in this sample, compared to physicians and psychiatrists (χ^2=11.87 (1), *p*=.001; OR= 1.75 [*CI*=1.27-2.42]). The response rate among psychologists was 30%, against 19.6% for the physicians and psychiatrists group. When we study these differences more closely, combining gender, setting and discipline, we find there is a significant difference for these groups (χ^2=20.39 (7); *p*=.005). Only 14% of the male physicians and psychiatrists in mental health care, against over 35% of the female psychologists in addiction care completed the questionnaire. It is not clear whether results of this study would be different when more male physicians and psychiatrists would have

responded. However, given the fact that in our study clinicians from different disciplines do not give a different weighting to the criteria, this is not to be expected.

Discussion

Clinical judgment seems to be consistent with the weighting model, which implies that patients with a few, highly important criteria relating to a specific PD category, are more often diagnosed as having that PD, than patients meeting more or an equal number of less prototypical criteria. As the results of our study show, on the overall, those criteria with the greatest diagnostic efficiency according to *DSM-IV*, , are also thought of as most characteristic by clinicians. However, as mentioned in the introduction, there is a great gap between clinical and criterion diagnosis which does not seem to be the result of a difference in weighting of these criteria by clinicians as compared to the *DSM-IV*, but a result of adherence to the total criterion set in the assessment procedure. With the use of a semi-structured interview, clinicians systematically evaluate the whole range of criteria in the establishment of a classification. It seems that without this structured method, clinicians do base their classification on the most efficient criteria (according to *DSM-IV*), but do no attempt to do a systematic check of the less prototypal criteria in the full range of criteria sets for the PDs. This bias therefore results in a difference between a criterion diagnosis and a clinical diagnosis. When further investigating this asymmetry in clinical and criterion diagnosis, it is striking to find that both empirical findings, and findings derived from clinical judgment suggest that there is a weighting in the criteria sets, but still this weighting remains implicit. When in the diagnoses of a PD the most efficient criteria would be more heavily weighted than less efficient criteria, the diagnosis would come to resemble the diagnosis of clinicians. A suggestion for the future *DSM-V* would be then, to weigh the criteria sets, based on their diagnostic efficiency, thereby doing justice to implicit weighting in current assessment.

As hypothesized, we found theoretical background and gender of the therapist in combination with the *DSM*-training method to be of influence on the weighting of criteria by the clinicians. This phenomenon leads to a reduction in reliability of the assessment based on clinician's judgment. Psychodynamically orientated therapists seem to have a different perspective on the weighting compared to their colleges with a different theoretical background. Whether or not this finding can be explained from

the perspective of psychoanalytic theory could be a topic for future research. To control for this effect of therapist variables, combining clinical judgment with a more standardized assessment method like semi-structured interviewing, should be considered to enhance reliability.

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Appendix

Table A
Demographic and background variables of clinicians participating in the study (N=213)

Demographic & background variables		
Male participants		48.8%
Age (mean)		41.9 years (SD=9.6)
Discipline & setting		
Addiction care		36%
Female Psychologists		34%
Male Psychologists		31%
Female Physicians & psychiatrists		12%
Male Physicians & psychiatrists		23%
General mental health care		64%
Female Psychologists		36%
Male Psychologists		29%
Female Physicians & psychiatrists		18%
Male Physicians & psychiatrists		17%
Theoretical background		
Psychodynamic		8.4%
Behavioristic		30.9%
Rogerian		3.1%
Systemic		1.0%
Combined/eclectic		56.6%
Clinical Activities:		
Assessment:	0 hours	10.4%
	<10 hours	54.0%
	>10 hours	35.5%
Therapy:	0 hours	9.9%
	<10 hours	18.4%
	>10 hours	71.7%

Table B

Ranking of DSM-IV personality disorder items by the total sample of clinicians (N=213)

DSM Category	Ranking *DSM*-category									
DSM-order	PAR**	SZD*	SZT**	ASP	BRD**	HST**	NRC**	AVD	DEP**	COM**
Criterion 1	1	1	4	2	4	3	1	6	2	1
Criterion 2	4	4	1	3	1	8	5	4	1	2
Criterion 3	5	6	5	7	3	2	2	5	8	5
Criterion 4	2	7	2	4	5	4	6	1	4	3
Criterion 5	7	3	8	5	7	5	3	2	5	8
Criterion 6	3	5	6	6	2	1	7	3	3	6
Criterion 7	6	2	3	1	6	(7)	4	(7)	7	7
Criterion 8			9		8	(6)	9		6	(4)
Criterion 9			7		(9)		(8)			

Note. Table should be read as follows: For each disorder the rank of all criteria is mentioned, ranging from rank 1 to rank 9 (rank 1 for the most typical criterion; rank 9 for the least typical criterion). In the table, criteria were shown in *DSM* order. New criteria appear in parentheses because they were excluded from the analysis in order to control for the reduction in correlation between diagnostic efficiency according to clinicians and *DSM*, because these criteria were arbitrarily put at the end of the diagnostic efficiency list for *DSM-IV,* simply because there was no data on the diagnostic efficiency yet.

Abbreviations: PAR=Paranoid personality disorder; SZD=Schizoid personality disorder; SZT=Schizotypal personality disorder; ASP= Antisocial personality disorder; BRD=Borderline personality disorder; HST=histrionic personality disorder; NRC= Narcissistic personality disorder; AVD=Avoidant personality disorder; DEP= Dependent personality disorder; COM= Obsessive/compulsive personality disorder

*Correlation between the ranking according to the clinicians and the ranking according to *DSM* is significant at $p<.01$

**Correlation between the ranking according to the clinicians and the ranking according to *DSM* is significant at $p<.001$

II. A psychometric evaluation of the Structured Interview for DSM-IV Personality

Chapter 3. Interrater reliability of the Structured Interview for DSM-IV Personality in an opioid-dependent patient sample[1]

Abstract

We examined the interrater reliability of Structured Interview for *DSM-IV* Personality (*SIDP-IV)*, in an opioid-dependent patient sample, on criterion - as well as a diagnostic level, for both categorical and dimensional data. At a criterion level (Cohen's kappa [κ] ranging from .76 to .93, and Intraclass Correlation Coefficient [*ICC*] ranging from .67 to .97), as well as on a diagnostic level (κ ranging from .66 to 1.00, and *ICC* ranging from .88 to .99), the reliability was excellent. The results suggest the *SIDP-IV* to be an adequate instrument for the assessment of personality disorders in opioid-dependent patients.

[1] This chapter is the equivalent of the manuscript with the title " Interrater reliability of the Structured Interview for DSM-IV Personality in an opioid-dependent patient sample", which is published in *European Addiction Research* (2004), Vol 10 (3), , pp 99-104. Authors: K.F.M. Damen, P.J.A. Van der Kroft, C.A.J. DeJong.

Studies on opioid-dependent patients, report high comorbidity with personality pathology [1, 2]. Since psychiatric comorbidity is related to poorer treatment outcome and drop-out [3], the assessment of personality pathology is of utmost importance for these patients. For this purpose a reliable and valid instrument is needed that can be used in addiction treatment services. It important to establish these psychometric properties of the instrument for the patient population in which the instrument is administered.

For the assessment of PDs according to the Diagnostic Statistical Manual-(*DSM*) [4, 5, 6] criteria, several structured interviews are available. Reliability is a key element in choosing a diagnostic instrument. Interrater reliability represents the agreement between different raters in rating the same patient material, and should be established in the setting for which the instrument is used. To our knowledge, the interrater reliability of instruments covering *DSM*-criteria, has not been established for an opioid-dependent patient population, yet.

The Structured Interview for *DSM-IV* Personality (*SIDP-IV*) [7] is an instrument that is very user-friendly and can be used for personality assessment in clinical practice and research purposes. The instrument is implemented and often used in Dutch addiction care. The interview consists of sections, corresponding to different life-areas, in which the criteria of the *DSM-IV* are pooled. So the interviewer can assess the patient's personality by having a very natural conversation based on subjects of interest to the patient, instead of just asking questions to score the criteria. The questions, in contrast to many of the *DSM*-criteria, are formulated in a positive way, so that the interview gets a non-threatening character. In addition, not only the categorical scores on the disorders can be calculated, but also a dimensional profile can be derived from the criterion scores, focusing more on patient characteristics than on disorder categories.

In his thesis VandenBrink [8] has given an overview of studies before 1990 focusing on the interrater reliability of the Structured Interview for *DSM-III* Personality (*SIDP*)[9] and Structured Interview for *DSM-III-R* Personality (*SIDP-R*) [10] . Studies after 1990 are shown in Table 1. The results indicate the *SIDP* and *SIDP-R* to have good interrater reliability for patient samples with different psychiatric pathology.

The aim of this study is to establish the interrater reliability for the most recent edition of the *SIDP (SIDP-IV)* in an opioid dependent patient sample. The fourth edition of the *SIDP* contains the two optional disorders; depressive and negativistic PD, yet to be psychometrically evaluated on reliability and validity aspects. Therefore an additional aim is to focus on interrater reliability for the full range of *DSM-IV* PDs.

Method

Participants

A consecutive series of participants were recruited from one of the inpatient treatment units of two addiction clinics in order of admission. Patients in this study met the *DSM–IV*-criteria for opiate dependency, had good knowledge of the Dutch language and were free of drugs at the time of assessment. Overt Axis-I pathology (with the exception of substance dependence) was considered an exclusion criterion.

Out of the 50 patients in this study 40 were male and 10 were female. The mean age was 35.6 years (*SD*= 6.9: range 22 to 50). The European version of the Addiction Severity Index (*ASI*) [17, 18] , was used for the description of the sample characteristics. Composit Scores (range 0-1) were derived on seven areas of functioning: *Medical , Employment, Alcohol, Drugs, Legal Problems, Family/Social relations, and Psychiatric problems*. *ASI* dimensional measures have acceptable psychometric measures [19]. Table 2 shows the problem severity of seven life-areas within this population. The average duration of the addiction was 9.7 (*SD*= 6.7 years; range 0.5-25 years). The average number of prior outpatient treatments attended by the patients was 2.6 (*SD*=3.9; range 0-20). The number of prior inpatient treatments attended was 1.82 (*SD*=3.1; range 0-13).

Instruments

The Dutch version of the *SIDP-IV* [20] was used for the assessment of personality pathology. The structure of the *SIDP-IV* corresponds to the structure of the Dutch Structured Interview for *DSM-III* Personality (*SIDP-R*) and the Dutch Structured Interview for *DSM-III-R* Personality (*SIDP-R**) [21]. The order of the questions is based on corresponding sections and not on *DSM* categories. In contrast to prior versions, the interviewer can rate or refer to the specific *DSM-IV* criterion that is associated with the related section. The *SIDP-IV* consists of ten sections (A to J). In every section questions relate to a particular subject:

A Activities and interests	D Social contacts	G Self-perception
B Work	E Emotions	H Perception of others
C Close relationships	F Observational	I Stress and anger
		J Social conformism

This means, in the interview, the questions and criteria are connected to each other. E.g., a question that is used to assess and rate a criterion is: “What kind of things do you enjoy?” This question is related to the following criterion “Takes pleasure in few, if any activities". Each criterion is rated with a score ranging from 0-3, 0=*not present*; 1=*almost present;* 2=*present*; 3=*strongly present*. Finally, for each PD, the number of criteria rated as present (criteria rated 2 or 3) determines whether or not the disorder is present. The translation was made in parts. Two couples of two independent translators, who each came to a consensus about part of the interview and discussed the differences in the translation bilaterally in order to come to a final consensus about the whole of the translated interview. The average time it takes to administer the interview for an experienced interviewer is about one and a half hour. Psychometric properties of the *SIDP-IV* are yet to be evaluated.

Procedure

We informed patients participating in the study about the purpose of the study and asked to sign informed-consent. Within this study a joint-interview, observer/rater design was used, in which rater A and B both interviewed 25 patients each. Both raters were present at all 50 interview sessions and rated independently. Raters were blind for each other's ratings.

Patients were interviewed within a period of eight months. The interviewers have a Masters degree in Clinical Psychology, and are experienced interviewers. Prior to the study they participated in a two-day interview training. The second author of this article, who was one of the translators of the Dutch *SIDP-R*, *SIDP-R** and *SIDP-IV,* and has extensive experience in the training of the instrument, provided for this training.

Statistical analysis

We established the prevalence of PDs in this sample for the categorical diagnosis on each disorder by deriving the mean of estimated frequencies of PD ratings according to rater A and rater B. For the establishment of the reliability at a criterion level, the

agreement between the raters was calculated for both categorical data (i.e., individual symptom ratings) as well as the dimensional data (i.e., based on scores that indicate the degree of pathology present). Categorical data were calculated by dichotomisation of the ordinal ratings. (0 and 1 became 0 [=*not present*]; 2 and 3 became 1 [= *present*]). For each PD the mean was calculated for the agreement in the total set of criteria for that specific disorder.

For the establishment of the diagnostic reliability, the agreement for dimensional data (based on the number of criteria present for each disorder) as well as for the categorical data (diagnostic judgments), was established. We dichotomized the ratings (0=*not present*; 1=*present*), for the agreement on the categorical data.

The agreement coefficient kappa (κ) was used for the categorical data and is calculated as follows:

κ = (sum of f.diag – sum of e.diag)/(n- sum of e.diag); in which f.diag stands for cell frequencies on the crosstab's diagonal and e.diag stands for the same with cell frequency e = (f row . f column)/ n.

Not all kappa coefficients for each disorder could be defined due to lack of variance in the ratings of a disorder (e.g. when a rater classifies a disorders as "present" [defined as "1"] in all 50 observations, a two by two crosstab can not be derived which is needed for the calculation of κ). The Intraclass correlation coefficient (*ICC*), is calculated for the dimensional data and is defined as follows:

ICC = (MSB-MSW)/ MSB + (K-1) MSW, in which MSB stands for the variance caused by the variability of scores between the observed patients caused by the differences in the presence of the characteristics for the raters, and MSW stands for variance caused by the variability of scores within the same raters, caused by the variability in ratings of the different rates with an observed patient. K is the number of raters.

In the interpretation of kappa and *ICC* coefficients, values of .75 or greater are indicative of *excellent agreement* beyond chance; those less than .75 but greater than .40 are reflective of *good to fair agreement* beyond chance, and those falling below .40 are regarded as indicative of *poor agreement* [22]. The statistical package used for the analysis was SPSS/PC+ version 10.0.

Results

Prevalence of personality disorders

The prevalence of personality disorders for this sample is shown in Table 3. Within the study sample 70% of the patients met the criteria for at least one PD. The antisocial PD was the most prevalent within this group (55%), followed by obsessive-compulsive PD (32%). These results are in line with findings from other studies [23].

Interrater reliability

Reliability of the criteria.

Results are presented in Table 4 for categorical- as well as dimensional data. On a categorical level there was an overall agreement of .84. In the full range of criteria, 73 criteria (78%) had a κ coefficient >. 75, and 14 criteria (15%) had a value in between .40 and .75. For one (1%)criterion (the second *DSM*-criterion for narcissistic PD) the agreement was <. 40. There were six (6 %) undefined values. Based on dimensional data, the average *ICC* for the overall interview was .89. In the total criteria set, 85 (90 %) had an *ICC* > .75. Two criteria (2%) had a coefficient in between .40 and .75. Three (3 %) criteria (the sixth criterion of the schizoid PD; the fourth and seventh criteria of the schizotypal PD) had an *ICC* < .40. There was one undefined *ICC* (1 %).

Reliability of the disorders (diagnostic reliability)

In Table 4 the agreement for the disorders is shown for categorical and dimensional data. The overall agreement for categorical data was .86 (range .65-1.00). The average *ICC* (.96; range .88-.98) again was higher than the average κ.

Discussion

In this study the interrater reliability of the *SIDP-IV* has been established within a sample of 50 opioid addicted patients. The overall reliability for this interview was found to be excellent for categorical as well as dimensional data, at both criterion and diagnostic level. The optional disorders, for which the interrater reliability has not been established in prior research, show excellent reliability coefficients, which forms a solid base for further psychometric evaluation of these scales, with a focus on validity issues.

The four “critical” criteria, with reliability coefficients below .40 are in need of revision. That κ could not be defined for the criteria with a low *ICC* indicates that

there was little variance within the scores of the separate patients for those specific criteria. This could be a plausible factor in explaining the low *ICC*s. For most disorders *ICC* was higher than κ, which, like Cohen [24] pointed out, is a result of dichotomizing a Likert-type continuous score, which discards information and creates a variable that, due to a loss of variance, produces lower power and leading to lower reliability or validity coefficients.

In prior studies covering the *SIDP*, insufficient reliability coefficients were found for the schizotypal and schizoid PD. The schizotypal criteria are part of *Section F* of the interview. This is the observational section. Knowing that structured interview methods are more reliable than observational impressions it is not surprising that criteria in this section are less reliable. Revision of this section by replacing the observational ratings by semi-structured questions, could be a consideration.

The results of this study are difficult to compare to prior research on the interrater reliability of the *SIDP* (as mentioned in Table 1), for they differ on several methodological aspects (e.g., sample characteristics and methodology). The studies mentioned are limited to one specific patient sample, which differ greatly in their primarily pathology. The choice of an observer/rater-joint interview design (OR design) over a video taping design has a practical advantage, for no crucial information is lost by bad taping quality. As Grove and his colleagues [25] pointed out in their 1981 study on the reliability of psychiatric diagnoses, there are no substantial differences that could lead to differences in the established reliability between the two designs. Advantages as well as disadvantages of this method, opposed to vignette and other designs are also discussed in detail.

All taken into consideration, one could come to the cautious conclusion, however, that at least the overall reliability of the *SIDP-IV* for this sample was found to be higher compared to the reliability found in studies on prior editions of the *SIDP* for different patient samples. This can be accounted for by the setting, but also the difference in interview-structure. In contrast to prior versions of the *SIDP*, the *SIDP-IV* is designed in such a way, the interviewer can rate or refer to the specific *DSM* criteria that are connected to the relating section, in the interview. This means that the questions and criteria are connected to each other. Because of this structure, the rating

of the criteria becomes less complicating, probably enhancing the reliability of the interview.

In conclusion, the results suggest that the *SIDP-IV* is a very reliable instrument for the assessment of PDs in opioid-dependent patients. Covering the full range of *DSM-IV* PDs and given the possibility for dimensional as well as categorical diagnostics, it is very useful for the assessment in addiction treatment and research purposes.

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Appendix

Table 1
Interrater reliability studies on SIDP for different editions of DSM (after 1990)

Study	A [11]	B [12]	C [13]	D [14]	E [15]	F [16]
DSM edition	III	III	III	III	III-R	III-R
Coefficient	κ	*R*	*ICC/* κ	κ	κ	*ICC/* κ
N	23	21	104	39	80	54
Design	V	O/R	O/R + V	O/R	O/R	O/R
Overall	. 49	.54	.91 *ICC*			.82-.90
Paranoid PD	.58	.26		.54	.74	
Schizoid PD	1.00	.65				
Schizotypal PD	.45	.40	1.00 (κ)	.72	.65	
Obs./Compuls. PD	.32	.54	.66 (κ)		.86	
Histrionic PD	.61	.53	1.00 (κ)	.80	.83	
Dependent PD	.43	.19	1.00 (κ)	.48	.84	
Antisocial PD		.89	.66 (κ)	1.00		
Narcissistic PD	.46	.77			1.00	
Avoidant PD	.36	.75			.80	
Borderline PD	.24	.74		.66		
Pass./Agress. PD	.42	.19	.80 (κ)	.72	.79	
Self def. PD					.55	
Negativistic PD						
Depressive PD						
Any disorder			.93 (κ)			.58 (κ)

Note.PD = Personality Disorder; O/R= Joint interview-Observer/rater design; V=Video or audio taping design; *R*= Pearson's correlation coefficient
Primary pathology in these studies:
Study A: Adolescents with mood disorder
Study B: Schizophrenic patients
Study C: Relatives of patients with schizophrenia, psychoses and non-psychotic depression
Study D: Patients with mood disorders
Study E: Patients with Axis-I obsessive-compulsive disorder
Study F: Patients with a mood disorder

Table 2

ASI Composit score (N=50)

ASI category	Composit Scores (CS) (*M*)	*SD*
Medical CS	.34	.34
Employment CS	.68	.41
Alcohol CS	.23	.35
Drugs CS	.47	.16
Legal CS	.30	.26
Family and social relations CS	.21	.26
Psychiatric CS	.39	.24

Table 3
Prevalence of personality disorders (N=50)

DSM-IV personality disorder	*F*	%
Number of patients with no axis II diagnose	15	30
Number of patients with an axis II diagnose	35	70
One PD	10	20
Two/more PDs	25	50
Specific personality disorders:		
Cluster A:		
Paranoid PD	2	3
Schizoid PD	3	5
Schizotypal PD	2	3
ClusterB:		
Antisocial PD	28	55
Borderline PD	10	19
Histrionic PD	0	0
Narcissistic PD	3	6
Cluster C :		
Avoidant PD	5	9
Dependant PD	1	2
Obsessive/compulsive PD	16	32
Optional disorders:		
Depressive PD	7	13
Negativistic PD	1	2

Note.Prevalence based on the average ratings of rater A and B
PD= Personality Disorder

Table 4
Average criterion reliability and diagnostic reliability for SIDP-IV (N=50)

	Criterion reliability		Diagnostic reliability	
DSM-IV Classification	κ	ICC	κ	*ICC*
Cluster A				
Paranoid PD	.83[a]	.84	.66	.94
Schizoid PD	.80[a]	.76	.79	.95
Schizotypal PD	.76[a]	.67[a]	-	.88
Cluster B				
Antisocial PD	.78	.93	.88	.94
Borderline PD	.84	.95	.94	.97
Histrionic PD	.87[a]	.92	-	.98
Narcissistic PD	.81	.93	.65	.97
Cluster C				
Avoidant PD	.93	.97	.88	.99
Dependent PD	.92	.95	1.00	.98
Obs./compuls. PD	.84	.93	.91	.96
Optional disorders				
Depressive PD	.91	.90	.91	.97
Negativistic PD	.84	.92	1.00	.95

*Note.*PD=Personality Disorder
[a]Undefined κ / *ICC/ Y* excluded

Chapter 4. Stepped Assessment in Opioid-Dependent Patients; Diagnostic Efficiency of the Structured Interview for *DSM-IV* Personality[1]

Abstract

The objective of this study is to establish the internal consistence and diagnostic efficiency of *DSM-IV* Axis-II criteria-sets, assessed by the Structured Interview for *DSM-IV* Personality (Pfohl, 1995), in a Dutch opioid-dependent patient sample. In order to develop a stepped assessment model, we critically examined the criteria. The results show the SIDP-IV to constitute an adequate and reliable instrument with acceptable internal consistency and good diagnostic efficiency. To reliably identify the presence of PDs in opioid-dependent patients the instrument should be administered as a whole. However, a set of 7-criteria can be used for screening purposes and thus to decide whether the entire instrument should be further administered or not.

[1] This chapter is the equivalent of the manuscript with the title " Stepped Assessment in Opioid-Dependent Patients; Diagnostic Efficiency of the Structured Interview for *DSM-IV* Personality ", which is in press at *Substance Use and Misuse*. Authors: K.F.M. Damen, C.A.J. DeJong, M.H.M. Breteler & C.P.F. VanderStaak.

Introduction

A number of studies have focused on the psychiatric comorbidity in substance-dependent patients and found that it was related to poorer treatment outcome and drop-out (Cacciola, Rutherford, Alterman, McKay, & Snider, 1996). Given the high rates of such comorbidity reported for opioid-dependent patients (Brooner, King, Kidorf, Schmidt, & Bigelow, 1997; Cacciola, Alterman, Rutherford, McKay, & Mulvaney, 2001), the treatment of these patients must obviously address not only substance dependence but also personality pathology. For this purpose, in professional-based addiction care, an assessment instrument related to an empirically based classification system is needed. Several structured interviews are now available to assess personality disorders (i.e., PDs) in terms of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM; APA, 1980, 1987, 1994). Reliability and validity are key elements in choosing an instrument, which should be established for the intended setting and patient population.

The Structured Interview for *DSM-IV* Personality (SIDP-IV; Pfohl, 1995), is often used within the domain of Dutch addiction care. The SIDP-IV covers the full range of PD criteria sets, is very user-friendly and can be applied for both clinical and research purposes. The interview consists of different sections corresponding to different areas of life and thereby different pools of DSM-IV criteria. The interviewer assesses the patient's personality in a structured but natural conversation based on topics of interest to the patient and not just questions aimed to attain scores for the various criteria. The questions, in contrast to many of the *DSM*-criteria, are formulated in a positive way, so that the interview has a non-threatening character. The SIDP-IV provides a clear overview of those aspects of personality which are less adaptive and thus less modifiable during treatment. In addition to the calculation of categorical scores for various disorders, a dimensional profile with more of a focus on patient characteristics than on categories of disorders can be derived from the criterion scores. The fourth edition of the SIDP contains two optional disorders— namely, depressive and negativistic PDs — which have yet to be psychometrically evaluated for their reliability and validity (Damen, DeJong & VanderKroft, in press).

Pfohl, Coreyell, Zimmerman, and Strangl (1986) found the overall diagnostic sensitivity, specificity and negative predictive power of the different sets of PD criteria

used in prior editions of the SIDP to be excellent (i.e., .72, .86, and .98, respectively). Less positive results were found for the overall positive predictive power of the SIDP (i.e., .33). Thereafter, Miller, Streiner, and Parkinson (1992) found not only the sensitivity, specificity and positive predictive power but also the negative predictive power of the SIDP to be excellent for all three *DSM-IV* with the exception of sensitivity for the criteria in the "Odd" cluster (.48) and positive predictive power for the criteria in the "Anxious" cluster (.00). To our knowledge, the internal consistency and diagnostic efficiency of *DSM*-Axis-II criteria sets for the SIDP-IV have yet to be established for a population of opioid-dependent patients. The first objective of the present study was therefore to establish the internal consistency and diagnostic efficiency of the DSM-IV Axis-II criteria sets when applied to a population of opioid-dependent patients using the SIDP-IV.

The results of prior research using semi-structured interviews to asses the psychometric properties of the *DSM* PD categories suggest that, although the sets of criteria associated with a particular PD appear to have moderate levels of internal consistency when evaluated individually, clear problems arise when all of the DSM PD criteria are considered together in — for example — factor analytic studies. That is, the various symptoms associated with a particular PD are clearly related but only very modest in their ability to distinguish one PD from another (Farmer, 2000). The diagnostic efficiency of the *DSM*-criteria sets, refers to the ability of the individual criteria to represent the core features of the PD, in other words, how many of those criteria are needed to make an efficient diagnosis. The diagnostic efficiency of the different sets of DSM criteria or the ability of individual criteria to represent the core features of a single PD thus appears to be rather limited. In many PD concepts, some diagnostic criteria failed to uniquely discriminate individuals with specific PDs from those without (Farmer & Chapman, 2002). It has also been found that each PD can be optimally diagnosed using fewer criteria than is currently required (Nurnberg, Martin, & Pollack, 1994).

In line with the stepped care model of addiction, as described by Schippers, Schramade, & Walburg (2002), stepped assessment of personality psychopathology in substance-dependent patients contributes to the improvement of the professionalism, effectivity, and efficiency of both assessment and treatment. Such time-consuming

assessment methods as semi-structured interviews are not particularly efficient for most patients which means that the development of a reliable screening instrument to predict the presence of personality pathology on the basis of patient characteristics could greatly improve addiction care.

The second objective of the present study was therefore to build a stepped assessment model for PDs. More specifically the following questions were posed with regard to a population of opioid-dependent patients;

A) Can each PD be optimally diagnosed with fewer criteria than currently required by structured interviews (as suggested by Nurnberg, Martin, & Pollack, 1994)?;
B) Can an effective screener, based on a limited number of DSM-IV criteria, be derived from the SIDP-IV?

Method

Participants

The 279 patients who agreed to participate in this study were all opioid-dependent patients participating in one of three treatment programs. The treatment programs were chosen in such a manner that the total sample was highly representative of the patient population for Dutch addiction care. Detoxified outpatients coming from a multi-centre program comparing two methods of rapid detoxification, non-detoxified outpatients and inpatients participated in the study.

The first setting included 183 patients initially detoxified in a hospital setting and participating in an outpatient treatment program involving ten therapy sessions based on the Community Reinforcement Approach. An extensive description of this program is provided elsewhere (DeJong, 1999). From the 279 patients originally recruited for the study, 96 refused to participate in the study. The second setting included 50 patients in a drug-free inpatient treatment facility in a Dutch addiction centre. The third setting included 46 patients in a treatment program involving an outpatient methadone-maintenance program. There were no dropouts once the patients from the different settings agreed to participate in the study.

The characteristics of the sample are shown in Table 1. The patients were predominantly male and single, with a mean age of 35.9 years (SD = 6.5). Patients in this study met the *DSM–IV*-criteria for opioid-dependency and had good knowledge of

the Dutch language. Overt Axis-I pathology other than substance dependence constituted an exclusion criterion. Drug use history varied from a mean of 5.9 years (*SD* = 5.9) for methadone to 10.4 years (*SD* = 6.6) for heroine. The median number of treatment efforts was four for the outpatient treatment (range 0-30) and two for inpatient treatment (range 0-20). The European version of the Addiction Severity Index (ASI; McLellan, 1992; Kokkevi, A., & Hartgers C., 1995) was used to characterise the sample. Composite Scores (range 0-1) were derived for seven areas of functioning: *Medical, Employment, Alcohol and/or Drug use, Legal Problems, Family/Social relations and Psychiatric problems*. ASI dimensional measures have acceptable psychometric qualities (Kosten, Rounsaville, & Kleber, 1993). The severity of the problems in the different areas of functioning for the present sample is also indicated in Table 1.

Instrument

The Dutch version of the SIDP-IV (DeJong, Derks, Van Oel & Rinne, 1996) was used for the assessment of personality pathology. The structure of the SIDP-IV (Structured Interview for *DSM-IV* Personality) can be compared to the structure of the SIDP (Structured Interview for *DSM-III* Personality; Pfohl, 1983) and SIDP-R (Structured Interview for *DSM-III-R* Personality; Pfohl, Blum, Zimmerman & Strangl, 1989) and addresses personality characteristics covering a period of time of five years preceding the interview date. The order of the questions is based on ten interrelated sections and not on *DSM* categories. In contrast to prior versions, the interviewer can directly rate or refer to the specific *DSM-IV* (1994) criterion that is associated with the related section. This means that the questions and criteria are intertwined in the interview and correspond directly to each other. For example, the SIDP question of "What kinds of things do you enjoy?" is associated with the DSM-IV criterion of "Takes pleasure in few, if any activities". Each criterion is assigned a score, which can range from 0 to 3: 0=*not present*; 1=*almost present;* 2=*present*; 3=*strongly present*. And for each PD, the number of criteria rated as present within the last five years (i.e., the number of criteria assigned a score of 2 or 3) is then examined to determine the presence of that PD or not (DeJong, et al. 1996). The scoring of the SIDP and SIDP-R was more complex than the scoring of the SIDP-IV because the original questions were used to rate not just one but several DSM criteria (i.e., a single question could

apply to more than one criterion and several questions had to be answered for a single criterion). The SIDP-IV consists of ten sections: Activities and interests; Work; Close relationships; Social contacts; Emotions; Observational; Self-perception; Perception of others; Stress and anger; and Social conformism.

Different parts of the SIDP-IV were translated from English into Dutch by two pairs of independent translators. Each pair came to a consensus on the relevant parts of the interview and then discussed any differences or inconsistencies in the translation bilaterally in order to reach a final consensus on the entire translation of the interview.

The average time needed to administer the interview by an experienced interviewer is about one and a half hours. The psychometric properties of the SIDP-IV have yet to be determined. In their study, Damen et al. (in press), investigated the interrater reliability of the *DSM-IV* criteria in an opioid dependent patient sample, using the SIDP-IV, and found it to be excellent. The same authors studied the convergent validity of the SIDP-IV with the Interpersonal Checklist -Revised, which reflects an interpersonal behavioural approach to personality, and found significant correlations for all 10 of the 12 DSM-IV personality disorders covered by the ICL-R (Damen, DeJong, Nass, Breteler & VanderStaak., in press).

Procedure

In order to control for detoxification-related stress, the SIDP-IV was administered one month after the subject started in one of the three treatment conditions. The participation in this study was voluntary. We informed patients about the purpose of the study and asked them to sign informed-consent. In return for participation, the patients were given a description of their personality style. The two interviewers have a Masters degree in Clinical Psychology, and have extensive experience in psychological testing. Prior to this study they followed a two-day SIDP-IV training course. The interviews were conducted in the clinics where patients were admitted. The design of this study was approved by the Dutch Medical Ethical Commission.

Statistical Analysis

Prevalence of personality pathology was established for each of the 12 PDs. For those sets of criteria with a prevalence rate >5%, diagnostic efficiency and reliability measures were calculated. To establish the internal consistency of the different sets of

PD criteria, the Cronbach's alphas were calculated. Regression analyses were then performed to attain missing value estimates.

In order to establish the diagnostic efficiency measures, we dichotomized the ordinal ratings. Scores of 0 and 1 were recoded as 0 (= criterion not present) and scores of 2 and 3 were recoded as 1 (= criterion present). Sensitivity (i.e., SEN) refers to the probability of the SIDP-IV criterion being scored as present when a positive diagnosis for the corresponding DSM category of PD was present. For example, a sensitivity of .70 indicates a 70% chance of the SIDP-IV criterion being rated as present when a positive DSM diagnosis for the relevant PD is present. Specificity (i.e., SPC) refers to the probability of a SIDP-IV criterion being rated as not present when a negative DSM diagnosis for the corresponding DSM category of PD occurs. Positive predictive power (i.e., PPP) refers to the ratio of true positive ratings (i.e., a SIDP-IV criterion is rated as present and the DSM diagnosis for the corresponding category of PD is also positive) to all cases involving a rating of the SIDP-IV criterion as present. Finally, negative predictive power (i.e., NPP) refers to the ratio of true negative criterion ratings (i.e., a SIDP-IV criterion is rated as not present and there is simultaneously no DSM diagnosis for the corresponding category of PD) to all cases with the SIDP-IV criterion judged as not present.

Stepwise logistic regression analyses were next performed to establish the discriminant validity of the SIPD-IV criteria sets (i.e., determine the extent to which a particular criterion could serve as a predictor and thus distinguish between positive and negative diagnoses for a particular PD). This technique provides weighting of the criteria as they apply to their corresponding PD diagnosis and a multivariate measure of the criteria that improve chi-square analysis in a stepwise fashion (Nurnberg at al., 1994). The chi-square coefficients for improved fit and significance of the variable statistics were calculated as well as the percentage of cases accurately classified using the stepwise logistic regression model. In addition, the odd- ratios were calculated for combinations of criteria derived from the stepwise logistic regression model to determine the relative probability of a criterion being absent in light of a negative diagnosis and a criterion being present in light of a positive diagnosis.

In order to derive a screening device from the total set of criteria, logistic regression analyses were next undertaken with the presence of a (irrelevant which) PD

as the dependent variable and the SIDP-IV criteria as the independent variables. In addition probabilities were derived on the basis of the regression weights and these probabilities then served as the independent variables in a Receiver Operator Characteristics analysis (ROC; Egan, 1975). The ROC method is useful for the identification of the most optimal set of risk factors and also provides a cut-off point for the best discrimination of a dichotomous outcome (i.e., the presence versus absence of a PD).

Results

The prevalence of the different PDs is shown in Table 2. Out of 263 patients, 133 (48.0%) met the criteria for at least one Axis II disorder. Of these patients, 61 (46%) had two or more PDs. The most prevalent disorder was the antisocial PD, while the schizotypal PD was not found at all.

In Table 3, the statistics regarding the diagnostic efficiency are shown for those PDs with a prevalence greater than 5%. For the *antisocial* PD, SEN values were found to be moderate to good with a range of .40 to .86. The SPC values ranged from .76 to .95. The PPP values ranged from .59 to .93. And the NPP values ranged from .75 to .96. The individual DSM criteria for the antisocial PD thus appear to be fairly discriminative in the sense that the criteria are not present in cases of a negative diagnosis; however, not all criteria are equally efficient in cases of a positive diagnosis. The logistic regression results show all of the DSM criteria to be needed to make a reliable diagnosis, which is indicative of the construct's diversity. The internal consistency of the antisocial PD scale was found to be acceptable (α=.66).

For the *borderline* PD, the SEN values ranged from .41 to .88. The SPC values ranged from .54 to .96. The PPP was low with a range of .12 to .44. And the NPP was excellent with a range of .96 to .98. The logistic regression results show at least four of the DSM criteria to be needed to make a diagnosis. The internal consistency of the borderline scale was found to be acceptable (α=.72).

For the *avoidant* PD, the SEN values ranged from .50 to .89. The SPC values were excellent with a range of .89 to .95. The PPP was again low with a range of .30 to .48. And the NPP was excellent with a range of .96 to 1.00. The logistic regression results show three of the four DSM criteria to contribute significantly to the prediction

of a diagnosis. The internal consistency of the scale was found to be acceptable (α=.67).

For the *obsessive-compulsive* PD, the SEN values ranged from .12 to .89. The SPC values were good with a range of .70 to .98. The PPP values ranged from .21 to.53, and the NPP was again excellent with a range of .91 to .99. The logistic regression results showed four of the eight DSM criteria to contribute significantly to the prediction of a reliable diagnosis. The internal consistency was found to be acceptable (α=.60).

Finally, the optional *depressive* PD was found to have very good diagnostic efficiency and internal consistency when assessed with the SIDP-IV. The only less efficient criterion was criterion 5 (i.e., *being critical of others*), which is in line with the results of Farmer and Chapman (2002). The criteria for the depressive PD are thus well-formulated and well-represented in the SIDP-IV. The SEN values for this PD were quite good with a range of .78 to .96 and criterion 5 as an exception (SEN=.26). The SPC values were good with a range of .73 to .90. The PPP values were low with a range of .14 to .44, and the NPP values were high with a range of .92 to .99. The logistic regression results showed three of the seven DSM criteria to be needed to make a reliable diagnosis. The internal consistency, as already mentioned, was also found to be good (α=.73).

The results show personality pathology to generally not go undetected using the present assessment methodology. However, the SIDP-IV also appears to falsely indicate the presence of a PD when used with a population of patients with substance dependence. One explanation for the particularly low PPP values may stem from the dimensional character of personality. Stated quite simply, the absence of a particular PD does not mean that certain characteristics related to such a PD may not be present within the individual at times. And low PPP does not necessarily mean that the SIDP-IV is prone to generate false positives and thus errors; the dimensional nature of personality is, rather, clearly reflected by such findings. In other words, patients can display certain personality traits without meeting the clinical threshold for a disorder. More generally, the present findings suggest that PDs cannot be reliably assessed using a limited set of DSM criteria.

The question now is whether it is possible to screen for the presence of personality pathology or not. As indicated by the results of the logistic regression analyses performed using the entire set of DSM criteria and presented in Table 4, a total of seven criteria were found to contribute significantly to the prediction of the presence of personality pathology. These seven criteria considered together explained some 69% of the variance in the presence of personality pathology. Based on the regression results, a formula was next derived to calculate the probability of a patient receiving a positive PD diagnosis (Formula 1).

Formula 1:

$$P.\text{PD present} = e^{(-.443 + 1.1 * \text{ASP1} + 1.31 * \text{ASP3} + 1.23 * \text{BRD1} + .84 * \text{BRD 8} + 0.76 * \text{AVD5} + 1.11 * \text{DPS6} + 0.83 * \text{ASP5})} / e^{(-.443 + 1.1 * \text{ASP1} + 1.31 * \text{ASP3} + 1.23 * \text{BRD1} + .84 * \text{BRD 8} + 0.76 * \text{AVD5} + 1.11 * \text{DPS6} + 0.83 * \text{ASP5})} + 1$$

The calculated probability values for all of the patients were next entered into a ROC analysis to determine a cut-off point for full administration of the SIDP-IV. Stated differently, a decision rule was established using the seven criteria identified as particularly important for the discrimination of personality pathology and thereby a clear indicator of when more in-depth examination using the SIDP-IV appears to be called for or not.

The ROC results are depicted in Figure 1 and show a *P*.PD present of .48 or greater to call for further assessment. That is, when the cut-off point of SEN=.880 and 1-SPC=.104 is surpassed, the SIDP-IV should constitute part of the assessment procedure.

Discussion

The results of the present study revealed considerable personality pathology among a population of patients with opioid dependence. Just how this prevalence of personality pathology relates to the results of prior research (with other patient populations) will be addressed elsewhere. Suffice it to say here that mainly personality pathology which was antisocial, borderline, avoidant, obsessive-compulsive or depressive in nature was observed for a population of patients coming from a broad range of settings for addiction care. The psychometric evaluation of the SIDP-IV within the context of the present study was therefore concentrated on these categories

and it was attempted to derive a more limited set of DSM criteria for the screening of the relevant PDs.

As a whole, the diagnostic efficiency of the SIPD-IV in terms of specificity (i.e., SPC) and negative predictive power (i.e., NPP) was found to be excellent. The sensitivity (i.e., SEN) values were generally found to be moderate to good, which shows the DSM criteria to be reliable for the diagnosis of PDs. The generally low values found for positive predictive power (i.e., PPP) may be due to the generally low prevalence of PDs — with the exception of the antisocial PD — and the multidimensional character of personality mentioned above. Along these lines, the results of the logistic regression analyses and the efficiency measures showed most of the PDs to *not* be optimally predicted using fewer of the DSM criteria than currently required. This finding is in contrast to the results of prior research by Nurnberg et al. (1994) and in keeping with the results of other studies showing the PPP of the DSM Axis-II criteria to continually be a problem (Pfohl et al., 1986; Miller et al., 1992; Farmer & Chapman, 2002). In other words, personality pathology may not go undetected — when present — but may also be falsely indicated when using the SIDP-IV assessment methodology.

In order to develop an initial screening device for use in actual clinical practice, a formula based on the assessment of only seven DSM criteria using the SIDP-IV was derived. More specifically, it was possible to identify a small set of DSM criteria to assess whether the SIDP-IV should be completely administered or not. In other words, an evidence-based decision can now be made with regard to whether or not the SIDP-IV should be administered in full and to establish a reliable diagnosis of personality pathology.

The objective of the present study was to establish the internal consistency and diagnostic efficiency of the *DSM-IV* Axis-II sets of criteria for PD within an opioid-dependent patient sample using the SIDP-IV. The results show the SIDP-IV to be an adequate and reliable instrument with sufficient internal consistency and diagnostic efficiency for the assessment of PDs in opioid-dependent patients. In line with the development of stepped assessment, the decision to fully administer this time-consuming instrument can be made on the basis of merely seven of the DSM criteria addressed within the SIDP-IV. When indicated for a particular individual, however,

the SIDP-IV should always be administered as a whole; only in such a manner can a reliable diagnosis of personality pathology be made.

Some possible limitations on the present research should be mentioned at this point. Users of the SIDP-IV should be warned that the low positive predictive power (i.e., PPP) of the SIDP-IV means a high possibility of identification of patients who actually meet only a few of the criteria as having a particular PD. In addition, there is still not sufficient baseline data regarding use of the SIDP-IV with the "normal" Dutch population to enable comparison. Furthermore, the focus of the SIDP is on personality pathology and thereby the negative aspects of personality to be modified during treatment. However, integral psychological assessment should include further measures of an individual's capacities, potentials and resources and therefore multidimensional, multilevel assessment.

In closing and in light of the high prevalence of PDs observed for the population of opioid-dependent patients studied here, it is recommended that clinicians working with such substance-dependent patients be trained on the nature and assessment of PDs. And such training — in light of the promising nature of the present results — should include learning to administer or at least interpret the SIDP-IV for both screening and diagnostic purposes.

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Appendix

Table1.

Demographic characteristics and ASI composite scores

Demographic Variables	In total sample (*N*=279)[1]
% Male	81.3
Age[2]	35.9 (*SD*=6.5)
Education[2]	10.8 years (*SD*=2.9)
Employment	
% Employed	54.5
% Unemployed	45.5
Drug use	
Heroin use[2]	10.4 years (*SD*=6.6)
Methadone use[2]	5.9 years (*SD*=6.0)
Polydrug use[2]	9.2 years (*SD*=77)
Prior Treatment	
Number of prior Outpatient treatments[3]	4 (range 0-30)
Number of prior inpatient Treatments[3]	2 (range 0-20)
ASI Composite scores (CS)[2]	
Medical CS	0.21 (*SD*=0.27)
Employment CS	0.18 (*SD*=0.30)
Alcohol CS	0.11 (*SD*=0.20)
Drug CS	0.46 (*SD*=0.12)
Legal CS	0.16 (*SD*=0.20)
Family/social CS	0.10 (*SD*=0.16)
Psychiatric CS	0.18 (*SD*=0.19)
ASI Severity Index [2]	
Medical SI	1.3 (*SD*=1.5)
Employment SI	2.5 (*SD*=2.3)
Alcohol SI	1.2 (*SD*=1.8)
Drug SI	6.0 (*SD*=1.4)
Legal SI	2.0 (*SD*=2.1)
Family/social SI	2.8 (*SD*=2.0)
Psychiatric SI	2.5 (*SD*=2.0)

Note:

[1]Missing values excluded

[2]Mean

[3]Median

Table 2.

DSM-IV PD descriptive statistics (N=263)

Diagnostic concept	Number of criteria	Prevalence (%)
Any PD	-	48.0
PAR	7	2.9
SZD	7	1.4
SZT	9	0.0
ASP	7	35.8
BRD	9	7.5
HST	8	1.1
NAR	9	2.2
AVD	7	7.5
DEP	8	1.8
COM	8	9.7
DPS	7	9.7
NGT	8	1.8

Abbreviations: PAR= Paranoid PD ; SZD= Schizoid PD ; SZT=Schizoid PD ; ASP=Antisocial PD; BRD= Borderline PD; HST=Histrionic PD; NAR=Narcissistic PD; AVD=Avoidant PD; DEP=Dependent PD; COM=Obsessive-compulsive PD; DPS=Depressive PD; NGT=Negativistic PD

Table 3.

Indices for diagnostics efficiency of PD criteria assessed by the SIDP-IV (N=279)

PD criteria*	Diagnostic Efficiency Statistics					Logistic regression analyses‡			
	SEN	SPC	PPP	NPP	α if item deleted	Step entered	χ^2	*p*	Classification
ASP1	.86	.76	.66	.91	.59	1	121.7	<.001	.81
ASP2	.54	.85	.66	.76	.65	7	12.7	<.001	.92
ASP3	.49	.95	.83	.80	.62	2	46.9	<.001	.84
ASP4	.40	.95	.80	.75	.64	5	16.1	<.001	.90
ASP5	.48	.91	.73	.76	.64	4	28.1	<.001	.88
ASP6	.62	.87	.59	.81	.62	6	14.1	<.001	.91
ASP7	.55	.94	.82	.80	.64	3	26.4	<.001	.87
Overall α					.66				
BRD1	.47	.96	.44	.96	.69	4	6.9	.009	97.1
BRD2	.65	.91	.33	.97	.69	2	18.8	<.001	95.3
BRD3	.65	.88	.28	.97	.73	-	-	-	-
BRD4	.88	.54	.12	.98	.70	-	-	-	-
BRD5	.77	.93	.42	.98	.68	1	57.3	<.001	94.6
BRD6	.82	.87	.30	.98	.66	-	-	-	-
BRD7	.65	.86	.24	.97	.69	-	-	-	-
BRD8	.65	.82	.20	.97	.70	-	-	-	-
BRD9	.41	.96	.44	.96	.69	3	15.8	<.001	96.4
Overall α					.72				
AVD1	.56	.95	.43	1.00	.70	-	-	-	-
AVD2	.61	.93	.38	.97	.30	-	-	-	-
AVD3	.72	.92	.41	.98	.28	3	12.9	<.001	95.7
AVD4	.67	.89	.30	.97	.29	2	17.8	<.001	95.7
AVD5	.89	.91	.41	.99	.21	1	69.6	<.001	92.5
AVD6	.82	.94	.45	.98	.23	-	-	-	-
AVD7	.50	.93	.35	.96	.31	-	-	-	-
Overall α					.67				
COM1	.54	.94	.50	.99	.48	1	37.8	<.001	89.2
COM2	.89	.83	.53	.99	.49	-	-	-	-
COM3	.58	.87	.33	.95	.50	2	30.1	<.001	91.4
COM4	.46	.90	.21	.98	.47	4	12.9	<.001	94.6
COM5	.54	.87	.32	.94	.51	-	-	-	-
COM6	.89	.70	.22	.98	.42	3	20.5	<.001	93.5
COM7	.12	.98	.33	.91	.53	-	-	-	-
COM8	.65	.80	.25	.95	.50	-	-	-	-
Overall α					.60				
DPS1	.83	.83	.32	.98	.72	-	-	-	-
DPS2	.87	.83	.33	.99	.43	-	-	-	-
DPS3	.96	.76	.28	.99	.38	-	-	-	-
DPS4	.91	.80	.31	.99	.44	2	38.7	<.001	95.0
DPS5	.26	.84	.14	.92	.51	-	-	-	-
DPS6	.78	.90	.44	.99	.43	1	61.7	<.001	91.8
DPS7	.91	.73	.24	.99	.44	3	18.8	<.001	95.3
Overall α					.73				

Note: Criteria in *DSM-IV* order. Classification: percentage of cases accurately classified as a result of the stepwise logistic regression model.

‡Logistic Regression analyses could not be performed for the paranoid, schizoid, schizotypal, histrionic, narcissistic, dependent and negativistic PD, because there were less than five classifications in this sample.

Abbreviations: SEN= Sensitivity; SPC= Specificity; PPP= Positive Predictive Power; NPP= Negative Predictive Power; *B*= Estimate of the change in the dependent variable that can be attributed to a change of one unit in the independent variable; ASP=Antisocial PD; BRD= Borderline PD; AVD=Avoidant PD; COM=Obsessive-Compulsive PD; DPS=Depressive PD.

Table 4

Criteria contributing to the prediction of the PD diagnosis (N=279)

DSM-IV PD criteria	Logistic Regression analysis				
	Step entered	B (SE)	χ^2	*p*	Classification
ASP1	1	1.096 (.23)	60.2	<.001	71.5
ASP3	3	1.311 (.27)	33.1	<.001	79.4
ASP5	6	0.829 (.23)	12.4	<.001	86.3
BRD1	5	1.231 (.41)	13.8	<.001	85.2
BRD8	4	0.947 (.21)	23.9	<.001	83.8
AVO5	7	0.760 (.22)	12.6	<.001	88.4
DPS6	2	1.111 (.24)	43.5	<.001	74.0
Nagelkerke Pseudo R^2			.69		

Abbreviations:

ASP1= "Failure to conform to social norms with respect to lawful behaviours as indicated by repeatedly performing acts that are ground for arrest"

ASP3= "Impulsivity or failure to plan ahead"

ASP5= "Reckless disregard for safety of self or others"

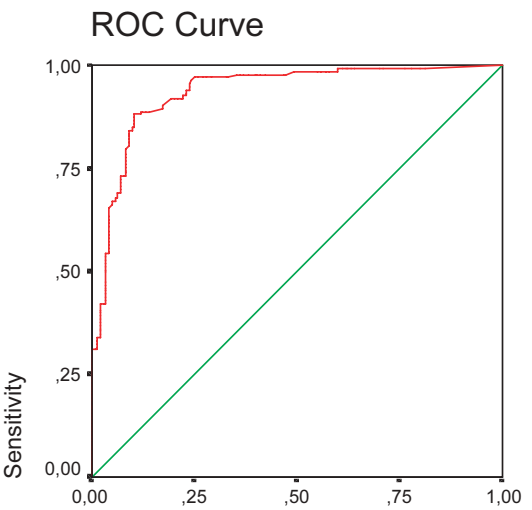
BRD1= "Frantic efforts to avoid real or imagined abandonment"

BRD8= "Inappropriate, intense anger or difficulty controlling anger"

AVO5= "Is inhibited in new interpersonal situations because of feelings of inadequacy"

DPS6= "Is pessimistic"

Figure 1
ROC curve for the predicted probability of a positive PD, based on formula 1



Diagonal segments are produced by ties.

Area under the curve=.94 (p<.001)

Chapter 5. Construct Validity of the SIDP-IV in an Opioid-Dependent Patients Sample[1]

Aims

Studies on opioid-dependent patients, report high comorbidity with personality pathology. Since psychiatric comorbidity is related to poorer treatment outcome and dropout in opioid-dependent patients, in this study, the underlying structure of the *DSM-IV* personality disorders in an opioid-dependent patient sample (N=263), assessed by the Structured Interview for *DSM-IV* Personality, was explored in order to contribute to the construct validity of this instrument.

Design

Explorative factor analysis yielded a three-factor solution, largely resembling the *DSM-IV* Cluster model.

Findings

The optional disorders, depressive and negativistic personality disorder, did not detract from the presumed model. *Confirmatory Fit Analysis* did not confirm a good fit of the model to the data, which is due to the paranoid PD which groups with cluster B PDs.

Conclusions

Overall, the underlying structure of *DSM-IV* PDs resembles the presumed *DSM-IV* Cluster model, thereby suggesting good construct validity of the SIDP-IV in opioid-dependent patients.

[1] This chapter is the equivalent of the manuscript with the title " Construct validity of the SIDP-IV in an opioid-dependent patient sample", which is in press in Journal of Substance Use. Authors: K.F.M. Damen, C.A.J. DeJong, M.H.M. Breteler & C.P.F. Vanderstaak.

Studies on opioid-dependent patients, report high comorbidity with personality pathology (Brooner, King, Kidorf, Schmidt, & Bigalow,1997; Cacciola, Alterman, Rutherford, McKay, & Mulvaney, 2001). In their study, Cacciola, Rutherford, Alterman, McKay, & Snider (1996) found that opioid-dependent patients with a personality disorder (PD), entered treatment with more severe self-reported drug, alcohol, psychiatric, and legal problems, and despite progress, remained more problematic in those areas relative to subjects without PDs. Since psychiatric comorbidity is related to poorer treatment outcome and dropout in opioid-dependent patients, and given the fact that patients with PDs may warrant additional treatment services if they are to approach the functional level of patients without PDs (Cacciola, et al., 1996) the assessment of personality pathology is of utmost importance for these patients. For this purpose, in addiction care, an assessment instrument relating to a psychometrically evaluated classification system is needed. For the assessment of PDs according to the *Diagnostic and statistical manual of mental disorders* (DSM; American Psychiatric Association, 1980; 1987; 1994) criteria, several structured interviews are available. Reliability and validity are key elements in choosing an instrument, which should be established in the setting and patient population for which the instrument is used.

An instrument which is implemented and often used in Dutch addiction care, is the Structured Interview for *DSM-IV* Personality (SIDP-IV; Pfohl, Blum,& Zimmerman, 1995). The SIDP-IV is a very user-friendly instrument and can be used for personality assessment in clinical practice and research purposes. The interview consists of a number of sections, corresponding to different life-areas, in which the criteria of the DSM-IV are pooled. The interviewer can assess the patient's personality in a natural conversation based on subjects of interest to the patient, instead of just asking questions in order to score the criteria. The questions, in contrast to many of the DSM-criteria, are formulated in a positive way, so that the interview has a non-threatening character. In addition, not only can the categorical scores (whether or not a disorder is present) on the disorders be calculated, but also a dimensional profile (the extent to which the disorder is present) can be derived from the criterion scores, focusing more on patient characteristics than on disorder categories. The fourth edition

of the SIDP contains two optional disorders; depressive and negativistic PD, yet to be psychometrically evaluated on reliability and validity aspects (Damen, DeJong, & VanderKroft, 2004).

Psychometric evaluation of the DSM PD categories with the use of semi-structured interviews has had its primary focus in internal consistency (reliability of the scales), interrater reliability (agreement between two or more raters about the pathology of patient x), diagnostic efficiency (of the criteria as formulated in DSM), and construct validity. Construct validity refers to the degree to which PD concepts are useful in realizing predictions to different constructs to which they should be theoretically related, such as the DSM-Cluster model (Messick, 1980).

Results of studies focusing on the structure of prior editions of the SIDP -SIDP (Pfohl, Strangl & Zimmerman 1983) and SIDP-R (Pfohl, Blum, Zimmerman & Strangle, 1989)- have found that, in assessing PDs using this instrument, although there is considerable overlap between the disorders, generally, items clustered within the three clusters (Bell & Jackson, 1992; DeJong, van den Brink, Harteveld, & van der Wielen, 1993). Since validity of an instrument is associated with its reliability, the validity cannot be established without establishing reliability. For the SIDP-IV, reliability has been established in an opioid-dependent patients sample. In their study, Damen, DeJong, & VanderKroft (2004)., investigated the interrater reliability of the DSM-IV criteria in an opioid dependent patient sample, as measured by the SIDP-IV, and found it to be excellent. Internal consistency and diagnostic efficiency were established by the same researchers (Damen, DeJong, Breteler & VanderStaak, in press) in the same sample, which resulted in a critical review of DSM-IV criteria. Internal consistency was found to be low ($\alpha<.40$) to good ($\alpha<.70$). Values for sensitivity (the percentage of positive ratings by the criterion, given a positive PD diagnosis), specificity (the percentage of ratings by the criterion, given a negative PD diagnosis), and negative predictive power (the chance that the diagnosis is negative, given a negative score on the criterion) were found to be good, although most disorders could be optimally diagnosed with fewer criteria than currently required. Overall, results indicated the Structured Interview for *DSM-IV* Personality, to be an adequate and reliable instrument for the assessment of personality disorders in opioid-dependent patients.

To our knowledge, the construct validity of DSM-IV Axis-II criteria sets has not been established for an opioid-dependent patient sample. The main objective of this study is to contribute to the establishment of the construct validity of the SIDP-IV in this patient population, by testing the presumed DSM-cluster model of the DSM-IV PDs, in an opioid-dependent patient sample. Based on results of prior research on the *DSM-IV* cluster Model, in our study, we expect substantial overlap for the disorders and we hypothesize our results to be supportive of the structure as represented by the DSM-clusters. In addition, we explore on the relation of the optional disorders to the ten DSM-IV disorders.

Method

Participants

The 263 patients participating in this study are all opioid dependent patients who participated in one of three treatment programs. We chose these programs in such a way that the total sample is highly representative of the patient population in Dutch addiction care, consisting of detoxified outpatients, non-detoxified outpatients and inpatients. The first is a multi-center study in which two methods of rapid detoxification are compared. Patients (*N*=184) in this study detoxified in a hospital setting, but participated in an outpatient treatment program, containing ten therapy sessions (based on the Community Reinforcement Approach), with the main aim of fostering abstinence. An extensive description of this program is given elsewhere (DeJong, 1999). The second setting is an inpatient treatment facility in a Dutch addiction center (*N*=50). The third treatment program consists of an outpatient methadone-maintenance program (*N*=29).

The characteristics of the sample are shown in Table 1. The patients were predominantly male and single, with a mean age of 36.2 years (*SD* = 6.7). Patients in this study met the DSM–IV criteria for opiate dependency, had good knowledge of the Dutch language, and were free of drugs at the time of assessment. Overt Axis-I pathology (with the exception of substance dependence) was considered an exclusion criterion. Drug use history varied from a mean of 6.8 years (*SD* = 5.9) for methadone use to 11.4 years (*SD* = 6.0) for heroine use. Median number of outpatient treatments was three (range 0-30), and 1 (range 0-20) for the number of inpatient treatments.

Instrument

The Dutch version of the Structured Interview for *DSM-IV* Personality (SIDP-IV; DeJong, Derks, van Oel & Rinne, 1996) was used for the assessment of personality pathology. The structure of the SIDP-IV can be compared to the structure of the SIDP and SIDP-R. The order of the questions is based on ten interrelated sections and not on DSM categories. These sections are: Activities and interests; Work; Close relationships; Social contacts; Emotions; Observational; Self-perception; Perception of others; Stress and anger; and Social conformism. In contrast to prior versions, the interviewer can directly rate or refer to the specific DSM-IV (APA, 1994) criterion that is associated with the related section. This means that the questions and criteria are pooled in the interview and correspond directly to each other. For example, a question that is used to assess and rate a criterion is: "What kind of things do you enjoy?" This question is related to the following criterion "Takes pleasure in few, if any activities". In the SIDP and SIDP-R, the instructions were more complex, because the questions in the sections are used for the rating of not one but several criteria and for each criterion, several questions had to be answered. In the SIDP-IV, there is only one item for each DSM-IV criterion. Each criterion is rated with a score ranging from 0-3, 0=*not present*; 1=*almost present;* 2=*present*; 3=*strongly present*. Finally, for each PD the number of criteria rated as present (criteria rated 2 or 3) determines whether the disorder is present (DeJong, et al. 1996). The translation was made in parts by two couples of two independent translators, who each came to a consensus about part of the interview and discussed the differences in the translation bilaterally in order to come to a final consensus about the whole of the translated interview. The average time it takes to administer the interview for an experienced interviewer is about one- and- a- half hours. Interrater reliability of the SIDP-IV was found to be excellent; κ ranging from .76 to .93 at a criterion level and κ ranging from .66 to 1.00 at a diagnostic level (Damen, DeJong & VanderKroft, 1994).

Procedure

In order to control for substance use effects and detoxification-related stress the SIDP-IV was administered one month after the patient had started in one of the three treatment conditions. The two interviewers have a Masters degree in Clinical

Psychology, and have extensive experience in psychological testing. In preparing for this study, they followed a two-day SIDP-IV training course.

Statistical analysis

Pearson correlation coefficients were obtained for the 12 PD's with the use of the dimensional scores. In order to explore the underlying structure of the ten PD constructs, we performed a factor analysis on the DSM-IV PDs, with the use of principal axis factoring. Factors with eigenvalues ≥ 1 were retained. These factors were orthogonally rotated to provide maximum separation and enhanced interpretability. The reliability of the PD scales, based on the criteria pertaining to each disorder, was established by the calculation of the internal consistency measure Chronbach's Alpha. Confirmatory factor analysis (*CFA*), performed on the dimensional personality disorder scores, was conducted in order to test the DSM-IV Cluster Model for Axis II PDs. We utilized the 4.01 version of *AMOS* software (Arbuckle, 1999). The following fit indices were established; the comparative fit index (*CFI*) and the root mean square error of approximation (*RMSEA*). The *CFI* and the *NFI* (Normed Fit Index) both measure the fit of the model relative to the null model, but the *CFI* is less affected by sample size (Bentler, 1990). The *RMSEA* was included because it is a measure of fit that takes model parsimony into account (i.e. goodness-of-fit values can sometimes be inflated artificially as the number of parameters in the model are increased). The *CFI* ranges from 0 (poor fit) to1 (good fit). For the *RMSEA*, values less than .08 indicate an acceptable fit (Bentler, 1990). Finally, Chi-square indices were calculated.

Results

For the prevalence of personality pathology in the study sample, we refer to results in the manuscript of Damen, DeJong, Breteler & VanderStaak (submitted for publication).

The correlation matrix for the DSM-IV PDs is presented in Table 2. Correlations with an absolute value of >.30 were designated as being both clinical and statistical significant (*p* value for correlations at .30 is <.001). Table 2 shows that all 12 PDs except for the obsessive/compulsive PD, had consistent association with more than one PD. Moreover, there is substantial convergence between disorders within DSM-IV cluster A (odd/eccentric), cluster B (dramatic/emotional), and cluster C

(anxious/fearful). The paranoid and borderline PD were significantly associated with nine other PDs. The histrionic and dependent PD were associated with six other PDs. In addition, the schizotypal, antisocial, narcissistic, and avoidant PD were each associated with five PDs. Finally, the schizoid PD was associated significantly with three PDs.

The DSM-Clusters

Since DSM-III, the PDs have been provided with a separate diagnostic Axis and have been grouped into three broad clusters. These clusters were based on rational consensus about common or shared clinical features. Despite concerns regarding the validity of the DSM PD clusters, these clusters have been retained in DSM-IV. Cluster A contains the paranoid, schizoid, and schizotypal PDs, representing the "odd/eccentric" Cluster. Cluster B, representing the dramatic or emotional personality, is comprised of the antisocial, borderline, histrionic, and narcissistic PDs. The avoidant, dependent, and obsessive-compulsive PDs are represented in cluster C, the "anxious or fearful" cluster.

In the explorative factor analysis, a three factor solution was extracted, which accounted for 61% of the original variance. The three-factor solution, as shown in Table 3, greatly resembles the presumed DSM-IV cluster division. Two PDs did not seem to cluster into the superordinate Clusters. The obsessive-compulsive PD did not belong to one single factor and the paranoid PD clustered with cluster B PDs, instead of cluster A PDs.

Internal consistency of the clusters was established for this sample and was found to be modest (α=.56; .72; and .56 for cluster A, cluster B, and cluster C). Fit indices for the presumed underlying cluster division of the PDs indicated a poor fit to the data (χ^2 (32)= 150.87, p<.001 ; *CFI*=.59; *RMSEA*= .12).

The Optional Disorders

The depressive PD correlated significantly with seven other PDs. The negativistic correlated significantly with six other PDs. In addition, we repeated the factor analysis procedure for the complete range of DSM-IV PDs, including the two optional disorders. Exploration of the underlying structure of the PDs, including the optional disorders, led to a three-factor solution, accounting for 62% of the total variance. The presumed cluster division was retained, and results indicate that the depressive PD

seems to be conceptually related to the avoidant DP and dependent PD (cluster C). The negativistic PD is more affiliated to the paranoid, antisocial, borderline, histrionic, and narcissistic PDs (cluster B).

Discussion and conclusions

Results indicate that for this sample of opioid-dependent patients, the DSM-IV PDs, measured by the SIDP-IV, are substantially intertwined. There is considerable overlap between disorders within each of the three presumed clusters (cluster A, B, and C), but there is also some overlap between the disorders in the three separate clusters. This association is also found in the *CFA* on the DSM-IV presumed cluster grouping of the ten original PDs. This cluster model did not seem to fit our data. However, results of the explorative factor analysis, largely resemble the presumed DSM-IV cluster model, with the exception of the obsessive-compulsive PD and paranoid PD, which grouped with the disorders in custer B. This poor fit and deviation from the presumed cluster model should not be seen as an indication that the model is not acceptable and valid in classifying personality pathology in opioid-dependent patients. Moreover, the detraction of the paranoid PD from the cluster model, possibly stems from the characteristic patient variables in the study sample. To support their addiction financially, a majority of opioid-dependent patients engages in a lifestyle for which it pays to be vigilant, especially when it involves participating in criminal activities. This type of lifestyle is also often associated with antisocial (e.g. stealing and other illegal activities), narcissistic (e.g. exploitive behavior) behavior, and borderline traits (e.g. unstable relations and impulsivity), and to a lesser extent to schizotypal (e.g. odd behavior or looks) or schizoid behavior. Therefore, traits from the paranoid PD (e.g. suspiciousness) can easily co-occur with other prevalent traits (like antisocial, narcissistic or borderline traits) in patients who are engaged in criminal activities. In their study DeJong et al. (1993), found a correlation of .50 between the narcissistic and paranoid PD and a correlation of .45 between borderline and paranoid PD in a sample of polydrug-abusing patients, much higher than the correlation of .21 between the narcissistic and paranoid PD and a correlation of .35 between the borderline an paranoid PD, in an alcohol-dependent patient sample. Since criminal activities are more prevalent among (poly)drug-dependent patient than among alcohol-dependent patients, results are confirmative of our assumption that engagement in criminal

activities in opioid-dependent sample could be an explanation for the deviating clustering of the paranoid PD from the presumed cluster model.

As for the obsessive-compulsive PD, a plausible explanation for the detraction from the DSM model could lie in the anxious, but active nature of the disorder. The disorder differs from the disorders in the fearful and eccentric cluster, in the way in which fearful situations are approached. Patients with avoiding, schizotypal, schizoid or dependent personality styles behave themselves in a more passive and withdrawn manner, while patients with an obsessive-compulsive PD are more controlling in, and active towards the fearful situation. They also lack the impulsive and instable nature of patient with cluster B diagnosis.

We conclude that, with the exception of the paranoid and obsessive-compulsive PD, the underlying structure of DSM-IV personality disorders resembles the presumed DSM-*IV* cluster model, thereby suggesting good construct validity of the SIDP-IV. In addition, the optional disorders did not seem to detract from the DSM model, but each clustered within the presumed clusters, thereby also lending support for the DSM-IV cluster model.

A limitation of this study should be addressed. Results of a number of studies on the latent structure of DSM-criteria sets, lend support for the structure assumed by the DSM model (Bell & Jackson, 1992; Arntz, 1994). However, in contrast to these results, a large number of studies have failed to reproduce the presumed cluster division and have suggested alternative descriptions of abnormal personality variants (O'Conner & Dyce, 1998; Cloninger, 1987; Widiger& Sanderson, 1995). Results of our study, pertaining to the assessment of opioid-dependent patients, should therefore be seen in the context of, and contributing to, the discussion on this controversial topic.

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Table 1.

Demographic characteristics and ASI composite scores

Demographic Variables	In total sample (*N*=263)[1]
% Male	81.4
Age[2]	36.2 (6.7)
Marital status	
% Single	87.8
% Married	12.2
Education[2]	10.8 years (3.2)
Employment	
% Employed	54.5
% Unemployed	45.5
Drug use	
Heroin use[2]	11.4 years (6.0)
Methadone use[2]	6.8 years (5.9)
Polydrug use[2]	10.6 years (6.2)
Prior Treatment	
Number of prior Outpatient treatments[3]	3 (0-30)
Number of inpatient Treatments[3]	1 (0-20)

Note: [1]Missing values excluded
[2]Mean (*SD*)
[3]Median (range)
Abbreviations: CS=Composite Score; SS=Severity Score

Table 2

DSM-IV PD descriptive statistics and personality disorders symptom correlation matrix (N=263)

	Prevalence		Symptom Correlation											
PD	Diag	Dim (SD)	PAR	SZD	SZT	ASP	BRD	HST	NAR	AVD	DEP	COM	DPS	NGT
Any	47.5 %	-												
PAR	2.7 %	10.8 (12.8)	-	-	.40	.39	.52	.30	.34	.38	.41	-	.45	.35
SZD	1.5 %	12.0 (11.9)		-	.39	-	-	-	-	.31	-	-	.33	-
SZT	0.0 %	9.1 (8.8)			-	-	.45	-	-	-	.34	-	.33	-
ASP	34.6 %	27.2 (19.5)				-	.48	.35	.47	-	-	-	-	.33
BRD	6.5 %	18.6 (16.7)					-	.43	.32	.32	.47	-	.51	.33
HST	0.8 %	8.2 (11.0)						-	.38	-	.41	-	-	.32
NAR	1.9 %	9.9 (11.9)							-	-	-	-	-	.54
AVD	6.8 %	12.8 (18.6)								-	.57	-	.59	-
DEP	1.5 %	12.1 (13.7)									-	-	.50	-
COM	9.9 %	18.8 (14.9)										-	-	-
DPS	8.7 %	24.8 (22.7)											-	.42
NGT	1.9 %	13.9 (13.1)												-

Note: Only correlations ≥ .30 that are significant at $p < .001$ are shown

Abbreviations: Diag= Diagnostical Prevalence; Dim= Mean dimensional score ; PAR= Paranoid PD ; SZD= Schizoid PD ; SZT=Schizotypal PD ; ASP=Antisocial PD; BRD= Borderline PD; HST=Histrionic PD; NAR=Narcissistic PD; AVD=Avoidant PD; DEP=Dependent PD; COM=Obsessive-Compulsive PD; DPS=Depressive PD; NGT=Negativistic PD

Table 3

Explorative factor analysis; loadings of the PDs onto three extracted factors for 12 DSM-IV PDs (ten original and two optional PDs)(N=263)

	Factorial design					
	10 Origional PDs			12 PDs including optional PDs		
PD	1	2	3	1	2	3
Cluster A						
PAR	.51	-	-	.51	-	-
SZD	-	-	.67		-	.84
SZT	-	-	.52		-	.66
Cluster B						
ASP	.70	-	-	.79	-	-
BRD	.61	-	-	.59	-	-
HST	.57	-	-	.61	-	-
NAR	.62	-	-	.76	-	-
Cluster C						
AVD	-	.58	-	-	.84	-
DEP	-	.85	-	-	.82	-
COM	-	-	-	-	-	-
Optional						
DPS	-	-		-	.75	-
NGT	-	-	-	.54	-	-

Extraction Method: Principal Axis Factoring. Rotation Method: Orthogonal with Kaiser Normalization. Only factor loadings <.40 were shown (there were no loadings >.40 and <.50)

Abbreviations: PD=Personality Disorder; PAR= Paranoid PD; SZD= Schizoid PD; SZT=Schizotypal PD; ASP=Antisocial PD; BRD= Borderline PD; HST=Histrionic PD; NAR=Narcissistic PD; AVD=Avoidant PD; DEP=Dependent PD; COM= Obsessive-compulsive PD; DPS=Depressive PD; NGT=Negativistic PD

III. The Interpersonal Behavioural Model; an alternative approach to DSM-IV classification

Chapter 6. Interpersonal aspects of personality disorders; the convergence of the ICL-R and the SIDP-IV[1]

Abstract

This study aims to establish the convergence of the empirically-based Diagnostic Statistical Manual and theory-based Interpersonal behavioral approaches to personality, in opioid-dependent patients (*N*=110), with the use of the Structured Interview for *DSM-IV* Personality [1] and the Interpersonal Checklist-Revised, ICL-R [2]. As hypothesized, based on prior research, we found the two approaches to be complementary rather than interchangeable. However, some overlap was found between the SIDP-IV dimensions and the ICL-R, mainly with rebellious/distrustful, reserved/silent and masochistic/self-effacing styles. Results indicate that drug-dependence in itself is not a predictor of interpersonal style, while personality pathology is. Patients with a PD perceive themselves as hostile and submissive, while patients without a PD view themselves as friendly and controlling. The SIDP-IV seems informative in classifying PDs, in addition guidelines for behavioral change, in addicted patients, where provided based on the ICL-R.

[1] This chapter is the equivalent of the manuscript with the title "Interpersonal aspects of personality disorders; the convergence of the ICL-R and the SIDP-IV", which is in press at *European Addiction Research.* Authors: K.F.M. Damen, C.A.J. DeJong, G. Nass, M.H.M. Breteler, C.P.F. VanderStaak.

Literature on substance dependent patients suggests personality pathology is a substantial problem in substance-dependent patients [3,4]. A number of studies on *DSM* axis II have shown that the current method of PD classification has many shortcomings [5,6,7]. One of such shortcomings is the limited theoretical foundation for the PD categories. Another highly debated flaw of the *DSM* axis II classification system is the limited empirical support for the categories as they are now formulated. The diagnostic criteria and disorder categories are based on the clinical judgment of the Task Force and its Advisory Committees and not on empirical evidence [8].

The above-mentioned shortcomings result in limited reliability and validity of the classification system. Thus, many alternatives have been proposed, such as Costa and McCrea's NEO 5 factor model [9], a three-factor model [10] and a two-dimensional, interpersonal circumplex model [5].

A substantial amount of research has focused on the compatibility of the *DSM* classification of PDs and the theoretically based interpersonal behavior model proposed by Leary in 1957 [11]. This dimensional model, which has proven to be very useful in addiction treatment [12], is based on the interpersonal circumplex, which has a rich clinical [13], theoretical [14], and empirical [15] foundation. In this respect, the *DSM-IV* [16] system seems to have an informative function in the classification of PDs, whereas the interpersonal behavioral model provides us with guidelines for clinical practice in addiction treatment [17]. These guidelines are based on the complementarity of the interpersonal model [18]. Submissive behavior leads to controlling behavior and vice versa (complementarity); friendly behavior is likely to re-enact friendly behavior, whereas hostile behavior will lead to a hostile counter-reaction (correspondence).

The model is also evaluated extensively on psychometric properties and was found to have good reliability and validity measures [17]. Leary and Coffey [19] and Widiger & Kelso [20] suggested the compatibility of classic psychiatric classification (*DSM*) and the interpersonal model and investigated the theoretical relationship between *DSM* and interpersonal classification. They defined classic psychiatric classification categories in terms of interpersonal factors and linked the psychiatrically classified PDs (*DSM-I*) to eight interpersonal variables (Table 1). Morey [5] was the first to empirically compare the interpersonal and *DSM* approaches to the

classification of PDs. He did this using the Millon's Clinical Multiaxial Inventory (MCMI) [21] and the Interpersonal Checklist (ICL) [22]. He found that convergence of the two methods for personality taxonomy was not as high as expected or predicted by other authors (Table 1). It appeared that the *DSM-III* PDs were not as differentiated with regard to affiliative needs as had been hypothesised by other researchers. He did conclude however, "that the interpersonal model of personality is pertinent to the disorders which the *DSM-III* (axis II) seeks to classify and should be continued to be considered as a promising alternative" [5].

In their 1989 study, DeJong and his associates also studied the relationship between the two classification approaches, using other instruments and an alcohol-dependent patient sample. This study corroborated Morey's main findings (Table 1), although they did find the *DSM-III* PDs to be even less differentiated with regard to affiliative needs than Morey did [12]. They suggest, that interpersonal and *DSM-III* approaches to personality taxonomy should be regarded as complementary rather than interchangeable and stress the use of interpersonal approaches in therapy.

Since opioid-dependent patients often engage in social situations and activities, they have a different personality structure and pathology [23], quite different from alcohol-dependent patient, and are more often involved in illegal activities as a result of the illegal and socially unaccepted status of the substance of use, its plausible to assume their interpersonal behavior and personality profiles, will also differ in a substantial manner from those of alcoholics. Therefore, the present study aims to establish the interpersonal behavior of opioid-dependent patients with and without PDs.

The second aim of this study is to investigate the convergence of the Structured Interview for DSM-IV PDs (SIDP-IV; [1]) and a revision of the interpersonal model, the Interpersonal Checklist-Revised, ICL-R [2], in order see whether these instruments are complementary or interchangeable, thereby updating prior studies and deriving guidelines for clinical practice.

For the assessment of PDs according to the Diagnostic Statistical Manual-[8,24,16] criteria, several structured interviews are available. In this study, the Structured Interview for *DSM-IV* Personality was administered, because it is an

instrument that is very user-friendly and can be used for personality assessment in clinical practice and for research purposes.

The present study is the first to focus on the association between the *DSM-IV* PDs and interpersonal aspects of personality including the optional disorders; depressive- and negativistic PD, yet to be psychometrically evaluated in opioid-dependent patients. We expect our findings to be partly in line with the results of Morey [5] and DeJong [12], in a sense that the models are complementary rather than interchangeable, but differ with regard to the new behavioral styles and optional PDs. We expect the negativistic PD, like the former passive/aggressive PD in *DSM-III* to be convergent with a rebellious/ distrustful style and the depressive PD, given the passive but less aggressive character, to be associated with a reserved/ silent and masochistic/ self-efficacing style. In addition, we expect opioid-dependent patients to be more withdrawn and distrustful, given the illegal character of the drug.

Method

Participants

The 110 patients participating in this study are all opioid dependent patients who participated in one of three treatment programs. We chose these programs in such a way, that the total sample is highly representative of the patient population in Dutch addiction care, consisting of detoxified outpatients, non-detoxified outpatients, and inpatients. The first sub-sample consists of patients participating in a rapid detoxification program. Patients (*N*=40) in this program detoxified in a hospital setting, but participated in an outpatient treatment program, containing ten therapy sessions (based on the Community Reinforcement Approach). An extensive description of this program is given elsewhere [25]. All participating patients in this new alternative program were asked to participate in this study. The second setting is a drug-free inpatient treatment facility in a Dutch addiction center (*N*=45). A consecutive series of participants were recruited from one of the inpatient treatment units of two addiction clinics in order of admission. The third treatment program consists of an outpatient methadone-maintenance program (*N*=25). A consecutive series of participants were recruited from methadone maintenance units of addiction clinics in order of admission. Patients in this study met the *DSM–IV*-criteria for opioid

dependency and had good knowledge of the Dutch language. Overt Axis-I pathology, other than substance dependence, was considered an exclusion criterion.

Patients in this study were predominantly male and single, with a mean age of 36.8 years (*SD* = 6.3). Drug use history varied from a mean of 6.1 years (*SD* = 5.9) for methadone use to 11.6 years (*SD* = 6.3) for heroine use. Median number of outpatient treatments was 4.6 (*SD* = 5.2), and 2.3 (*SD* =3.9) for the number of inpatient treatments.

Instruments

The Interpersonal Checklist-Revised, ICL-R, is based on the interpersonal behavioral model. This model is two-dimensional. The scales are ordered in a circular arrangement around the orthogonal dimensions of control verses submission and nurturance versus hostility [28]. The four quadrants formed by these axes can, in turn, be divided into circularly ordered interpersonal behavior modalities. The checklist consists of 160 dichotomous items related to interpersonal style that clients can agree or disagree with, in order to describe themselves. The styles are: managerial/ autocratic (PA); narcissistic/ competitive (BC); sadistic/ aggressive (DE); rebellious/ distrustful (FG); reserved/ silent (nFnG); masochistic/ self-effacing (HI); dependent/ docile (JK); co-operative/ conventional (LM). The revised version of the interpersonal model contains two new, theoretically based interpersonal behavior styles, nFnG (reserved/ silent) and nNnO (social/ extravert) [26], that fill the breaches repeatedly found in the lower left and upper right quadrants [14,27] hyper normal/ responsible (NO); sociable/ extravert (nNnO). These scales can be placed in a circumflex model as proposed by Leary [11]. DeJong and colleagues [29] found the psychometric properties of the ICL-R in a substance-dependent patient sample to be fair to good. Internal consistency of the total checklist, in this patient sample, was .83, and test-retest reliability ranged from .57 to .81.

The Dutch version of the SIDP-IV [30] was used for the assessment of personality pathology. The structure of the *SIDP-IV* (Structured Interview for *DSM-IV* Personality) can be compared to the structure of the SIDP (Structured Interview for *DSM-III* Personality;) [31] and SIDP-R (Structured Interview for *DSM-III-R* Personality;) [32]. The order of the questions is based on ten interrelated sections and not on *DSM* categories. In contrast to prior versions, the interviewer can directly rate

or refer to the specific *DSM-IV* criterion that is associated with the related section. This means that the questions and criteria are intertwined in the interview and correspond directly to each other. For example, a question that is used to assess and rate a criterion is: “What kind of things do you enjoy?” This question is related to the following criterion “Takes pleasure in few, if any activities". In the SIDP and SIDP-R the instructions were more complex, because the questions in the sections were used for the rating of not one but several criteria and for each criterion, several questions had to be answered. The SIDP-IV consists of ten sections: Activities and interests; Work; Close relationships; Social contacts; Emotions; Observational; Self-perception; Perception of others; Stress and anger; and Social conformism. Moreover, the interviewer can assess the patient’s personality in a natural conversation based on subjects of interest to the patient, instead of just asking questions to score the criteria. The questions, in contrast to many of the DSM-criteria, are formulated in a positive way, so that the interview has a non-threatening character. Each criterion is rated with a score ranging from 0-3, 0=*not present*; 1=*almost present;* 2=*present*; 3=*strongl*y *present*. For each PD the number of criteria rated as present (criteria rated 2 or 3) determine whether or not the disorder is present [30]. In addition, not only the categorical scores on the disorders can be calculated, but also a dimensional profile can be derived from the criterion scores, focusing more on patient characteristics than on disorder categories, by dividing the total score on the criteria by the maximum score that can be obtained for each disorder. The translation was made in parts by four independent translators, who came to a consensus about each part of the interview. Interrater reliability of the SIDP-IV in opioid-dependent patients, as described elsewhere, was found to be excellent; κ ranging from .76 to .93 at a criterion level and κ ranging from .66 to 1.00 at a diagnostic level [33]. Construct validity, diagnostic efficiency and internal consistence have also been described elsewhere and found to be good [34;35]

Procedure

In order to control for substance use effects and detoxification-related stress, the SIDP-IV and ICL-R were administered one month after the subject completed detoxification (except for patients in the methadone maintenance program). We informed patients participating in the study about the purpose of the study and asked

to sign informed-consent. Prior to this study, two interviewers followed a two-day SIDP-IV training course. The interviewers have a Masters degree in Clinical Psychology, and have extensive experience in psychological testing. The instructions for administration as set in the Dutch ICL-R manual [29] were followed.

Statistical analysis

Because of the non-normal distribution of both the categorical and the dimensional scores, the correlations between the 12 dimensional SIDP-IV scores and the 10 ICL-R sum scores were calculated using Kendall's tau-c. The scores on the ICL-R were factor analysed (principle component analysis with varimax rotation). The dimensional scores on the SIDP-IV were then correlated to the factor-scores. These correlations were used to plot the PDs onto the interpersonal circumplex. Analysis showed the residues of the skewed variables to have a normal distribution, allowing a multiple regression analysis for the prediction of scores on each of the ICL-R scales by the SIDP-IV and vice versa. The scores on the 10 Interpersonal Checklist scales were used to predict each SIDP score, and all 12 dimensional SIDP scores were used to predict each interpersonal scale score. Finally, to explore the overlap between the two personality approaches, canonical redundancy analysis was done. This is a way to determine the extent to which the *DSM-IV* and the interpersonal model contribute uniquely to the classification of persons with PDs.

Results

Prevalence rates were established for each of the 12 PDs. Both categorical (disorder present versus disorder absent) prevalence rates and mean dimensional (percentage present) scores were determined and are shown in Table 2. Fifty-eight patients (53%) met the criteria for at least one Axis II disorder. Of these 58 patients, 34 (59%) had two or more PDs. The most prevalent disorder was the antisocial PD (40.9%). Dimensional SIDP-IV scores were somewhat higher than the categorical prevalence rates for all disorders except antisocial PD.

Table 2 also shows the mean ICL-R scores found in our sample. The three highest mean scores are found in the upper right quadrant (co-operative/ conventional, hypernormal/ responsible, sociable/ extravert) of the circumplex. The lowest mean score was found for the reserved/ silent (nFnG) interpersonal behavioral style. Findings indicate that, as a whole, the subjects in this sample reported a tendency

towards a dominant and nurturing interpersonal style. However, patients with a PD seemed to have a tendency towards a more submissive and hostile interpersonal style, as patients without PD, and perceive themselves as more masochistic/self-effacing (t=-3.37 (df=108); p=. 001) and rebellious/distrustful (t=-2.72 df=108; p<. 008).

Correlations are shown in Table 2. It is apparent that there is some shared variance between the two instruments. For ease of interpretation only correlation coefficients > .20 (p< .01) are mentioned. For all disorders, but the schizotypal PD, association was found with the domains of the rebellious/distrustful, reserved/silent and masochistic/self-effacing styles (respectively FG, nFnG and HI). The rebellious/ distrustful style has the greatest convergence; it is associated with seven of the 12 SIDP-IV dimensions. ICL-R scale nFnG (reserved/ silent) is associated with four PDs and masochistic/self-effacing (HI) with three. For the PD scales, most convergence was found for the depressive (HI, nFnG, FG) and dependent PDs (HI, JK [dependent/ docile], and nFnG), which means these disorders are the ones most optimally differentiated by the interpersonal model. Avoidant and narcissistic PDs can be characterized as self-efficacing/dependent and competitive/rebellious respectively. The other PDs correlate significantly with either FG or nFnG, with the exception of schizotypal PD that has no significant correlation with any of the interpersonal behavioral styles.

The scores on the ICL-R were factor analysed (principle component analysis with varimax rotation) extracting two factors, representing the control (eigenvalue 3.0) and affiliation (eigenvalue 2.4) dimensions. These factors explained 53.1% of the variance. The factor loadings of the ICL-R scales on the two factors were presented on two axes, as shown in Figure 1. The vertical axis represents the control dimension (factor 1), with on one end the concept of control and on the other end submission, the horizontal axis (factor 2) represents affiliation with nurturance on the right and hostility on the left. From Figure 1, one can conclude that the circumplex structure is largely confirmed. The ten behavioral styles have been placed in a circle in the theoretically assumed order with the exception of the co-operative/ conventional and hypernormal/ responsible behavioral styles. These have switched position compared to the presumed order. DeJong et al. [12] found similar results for a substance dependent patient sample and a sample of patients with psychiatric disorders; these results can be

found in the Dutch ICL-R manual [29]. In our circumplex model, the self-effacing/masochistic (HI) domain is positioned farther into the lower right quadrant than expected, which means that people with this interpersonal style see themselves as more friendly than assumed.

The dimensional scores on the SIDP-IV were then correlated to the factor-scores (as shown in Table 2). These correlations were used to plot the PDs onto the interpersonal circumplex as represented in Figure 1. The scores on SIDP-IV dimension avoidant, schizoid, and dependent were negatively associated with the control dimension (r=. 30;.23;.21, respectively) A negative association was found between the depressive PD and the affiliation dimension (r=-.26). In addition a positive association was found between the scores on histrionic and dependent personality and affiliation (r=.25 and r=.25, respectively) dimension scores.

Results of the multiple regression analysis are shown in Table 2. The amount of variance in SIDP-IV scores as explained by the ICL-R variables ranges from 14% for schizotypal PD to 42% for dependent PD. The amount of variance in ICL-R scores explained by the SIDP-IV ranges from 19% for the managerial/ autocratic and sadistic/ aggressive behavior dimension to 42% for the HI behavior dimension.

Results from the canonical redundancy analysis show 26% of the variance of the ICL-R variables could have been explained if SIDP-IV scores were known. Redundancy for the SIDP-IV variables, given the ICL-R data, was 24%.

Discussion

Results indicate that drug-dependent patients with a PD perceive themselves as more hostile and submissive, compared to patients without PD. In everyday life, a more rebellious/distrustful style, could easily lead to acting-out, social withdrawal, unemployment, and problems with law, which, in turn is plausible to result in aggravation of addiction severity. Therefore, in addiction treatment, this finding, should be an issue of attention.

The results show some convergence between the SIDP-IV dimensions and the ICL-R. It seems that the behavioral styles found in the lower quadrants of the ICL-R (rebellious/distrustful, reserved/silent, and masochistic/self-effacing styles) show the greatest overlap with the 12 PDs, in fact these three interpersonal behavioral styles significantly correlate with 10 of the 12 PDs.

Our findings, in part, corroborate the conclusions of Morey [5] and DeJong et al. [12]. Our findings also suggest that the two approaches to personality have a certain level of convergence, mainly found in the bottom left quadrant. Morey, however finds that PDs converge with a more divers number of interpersonal behavioral styles. In the studies of DeJong et al. and Morey, the sadistic/ aggressive interpersonal style correlates significantly with several PDs. We found no significant correlations between this style and any of the PDs. When Table 2 is studied more closely, however, it appears that where DeJong et al. found an overlap between PDs (paranoid, narcissistic, and compulsive) and the sadistic/ aggressive, we find the paranoid, narcissistic, and obsessive-compulsive PDs to converge with interpersonal style FG. Therefore, there seems to have been a shift in the overlap from the lower left interpersonal quadrant, to the (right) submissive half of the quadrant. This shift can easily be the result of the positioning of the new interpersonal style nFnG (reserved/ silent) between HI (masochistic/ self-effacing), and FG (rebellious/ distrustful), thereby shifting the position of FG compared to DE. An additional explanation addresses the differences in social environments between alcoholics and drug-abusers and the physiological effect of the drugs itself. Drug-dependent patients more often engage in criminal activities for which it serves to be distrustful more than sadistic or aggressive. Opioids also tend to have a sedative effect, which could lead to passivity and withdrawal, in contrast to alcohol, which is often found to lead to aggression. Thus in our sample, having a PD, other than histrionic or schizotypal, increases the chance of having a predominantly submissive interpersonal behavioral style. This is also illustrated by the correlations between the SIDP-IV dimensions and the factor 1 (representing the control dimension) scores. Most of these correlations (nine out of 12) are negative. The MCMI and the SIDP do not tap exactly the same constructs [36]. Both DeJong and colleagues' and our results indicate that the convergence was concentrated mostly around the more submissive interpersonal behavioral styles. The SIDP-IV dimensions are located near the origin of the circumplex. This indicates a limited amount of differentiation in interpersonal behavioural styles between the PDs. These findings are in contradiction with the findings of Morey and the findings of DeJong et al. They find higher correlations between the control and affiliation dimension as represented by the two factors drawn, and the PDs.

In considering the two optional PDs, we found that depressive PD converged with three interpersonal behavioral styles (FG, nFnG, and HI) and is somewhat more hostile as hypothesized. The negativistic PD, as hypothesized, converged with the rebellious/distrustful interpersonal style. This suggests the depressive PD can be better substantiated by the interpersonal behavioral theory than the negativistic PD.

These results of this study suggest that the interpersonal and *DSM* approaches to personality have more value as supplements than alternatives for one another. As redundancy is low for these instruments, one can acquire more information when using both the SIDP-IV and the ICL-R. Personality pathology constitutes of a rigid pattern of thinking, feeling, and acting. This pattern can be classified with the use of a semi-structured interview like the SIDP-IV. In addition, the interpersonal checklist does not address personality pathology in itself, but provides guidelines to break through the rigid behavioral patterns related to personality pathology. With regard to the patients with a PD in this sample, predominantly displaying interpersonal behavior characterized by styles positioned in the lower left quadrant, an optimal change of interpersonal behavior occurs when the patient is stimulated to display behavior, which is positioned on the right upper side of the model. The therapist can evoke this type of behavior by displaying friendly but submissive behavior, not giving in to the urge to react in a dominant hostile way, which is predicted by the complementarity hypothesis. When treatment is progressing, the therapist can stimulate further change, by displaying anti-complementary behavior, like dominant behavior, or submissive but hostile behavior (this should only be done when a firm therapeutic relation has been established). In a heterogeneous population such as opiate addicts, this is of special interest, especially when one takes into account that rigid or maladaptive patterns in interpersonal behavior could easily aggravate the severity of addiction.

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Appendix

Table 1.

Hypothetical and empirical relationships between interpersonal and psychiatric categories.

Interpersonal Category	**Proposed Psychiatric Equivalent (DSM)**		**Empirically found correlations**[1]	
	Leary & Coffey (1955) *DSM*-I	Widiger & Kelso (1983) *DSM-III*	*Morey (1985) DSM-III*	DeJong et al. (1989) *DSM-III*
Managerial/ Autocratic	None (they suggest Compulsive)	None	Paranoid, Histrionic, Antisocial, Narcissistic	Narcissistic, Compulsive, Borderline^{o}, Dependent^{o}, Avoidant^{o}, Passive-Aggressive^{o}
Narcissistic/ Competitive	None (they suggest Manic)	Narcissistic, Paranoid	Histrionic, Antisocial, Narcissistic, Schizoid^{o}, Schizotypal^{o}, Borderline^{o}, Dependent^{o}, Avoidant^{o}	Narcissistic, Schizotypal^{o}, Dependent^{o}, Avoidant^{o}, Passive-Aggressive^{o}
Sadistic/ Aggressive	Psychopathic, Sadistic	Antisocial, Paranoid	Histrionic, Antisocial, Narcissistic Compulsive^{o}	Paranoid, Narcissistic, Compulsive, Dependent^{o}
Rebellious/ Distrustful	Schizoid	Schizoid, Avoidant, Schizotypal	Schizoid, Schizotypal, Borderline, Avoidant, Passive-Aggressive Compulsive^{o}	Paranoid, Schizoid, Schizotypal, Antisocial, Borderline, Avoidant,
Masochistic/ Self-effacing	Masochistic, Psychasthenic, Obsessive	Passive-Aggressive, Borderline	Schizoid, Schizotypal, Borderline, Dependent, Avoidant, Passive-Aggressive Histrionic^{o}, Antisocial^{o}, Narcissistic^{o}	Schizotypal, Dependent, Avoidant, Passive-Aggressive, Narcissistic^{o}
Dependent/ Docile	Neurosthenic, mixed neurosis, anxiety neurosis, anxiety hysteria, Phobic	Dependent, Borderline	Schizotypal, Borderline, Dependent, Avoidant, Passive-Aggressive	Dependent, Schizoid^{o}
Co-operative/ Conventional	Hysterical	Histrionic, Borderline	Paranoid, Dependent	Paranoid^{o}
Hypernormal/ Responsible	Psychosomatic	Compulsive, Borderline	Paranoid, Histrionic, Narcissistic	Paranoid^{o}, Schizoid^{o}, Antisocial^{o}, Avoidant^{o}

Note: [1]Only correlation coefficients ≥ .30 and ≤ -.30, all correlations are significant ($p<.05$) for Morey and ($p\leq.01$) for DeJong et al.
^{o} Negative correlation

Table 2.

Prevalence rates; correlations between DSM-IV personality dimensions and interpersonal style (Kendall's tau- c); and explained variance in multiple regression analysis (N=110)

DSM-IV Axis II			Interpersonal Scales										Correlations		
	Prevalence	_*M*	PA 7.3	BC 6.6	DE 7.9	FG 7.7	nFnG 5.9	HI 7.4	JK 6.7	LM 8.4	NO 9.7	nNnO 9.2	Factor 1 (control)	Factor 2 (affiliation)	R^{2+}
	P%	D (*SD*)	3.1	2.6	2.2	2.9	2.8	3.5	2.6	2.9	2.8	2.5			
PAR	3.6	11.2 (14.1)				.34*							-.13	-.04	.25
SZD	1.8	12.9 (12.8)					.26**						-.23	-.01	.18
STP	0.0	9.5 (8.9)											-.16	.01	.14
ASP	40.9	30.0 (21.6)				.22**							.03	.05	.27
BRD	10.9	21.1 (20.0)				.37**							-.09	.00	.27
HST	0.0	8.6 (11.6)										.22**	.09	.25	.39
NAR	4.5	10.3 (13.9)		.23**		.23**							.06	-.08	.34
AVD	8.2	14.9 (19.2)					.32**	.33**					-.30	.11	.31
DPN	0.9	13.6 (12.8)					.24**	.38**	.32**				-.21	.25	.42
COM	13.6	20.6 (16.2)				.21*							-.01	-.01	.16
DPS	11.8	29.5 (24.9)				.25**	.29**	.35**					-.14	-.26	.32
NGT	0.9	14.1(13.3)				.20*							-.12	-.02	.16
Factor-Loadings		Factor 1 (control)	.63	.61	.10	-.40	-.72	-.68	-.16	.20	.06	.73			
		Factor 2 (affiliation)	-.15	-.43	-.60	-.21	-.01	.45	.73	.81	.81	.39			
R^{2++}			.19	.30	.19	.31	.40	.42	.37	.23	.23	.28			

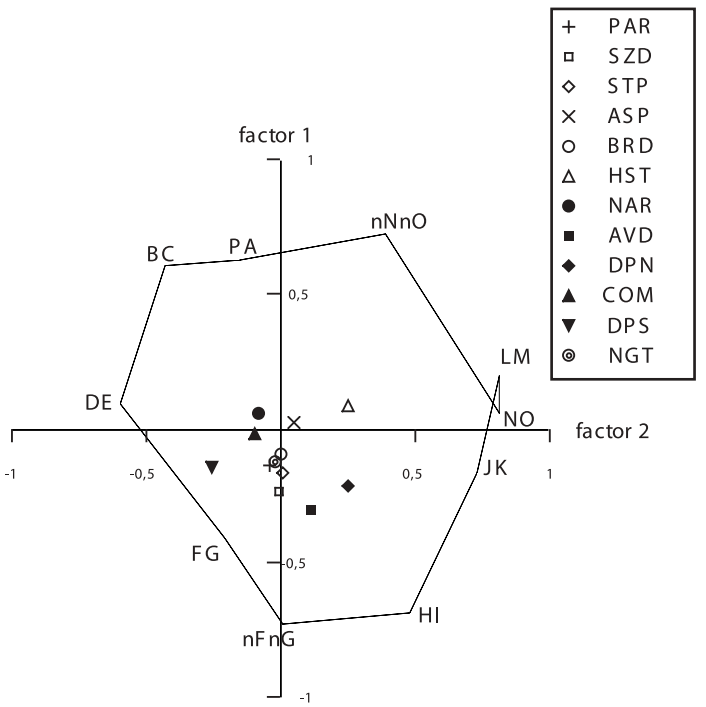
Note: Only correlations ≥ .20 and ≤ -.20 are included in the Table. R^{2++} = variance of ICL-R scores explained by SIDP PD scores. R^{2+} = variance of SIDP-IV PDs explained by interpersonal scores. P = Prevalence rates. D=Dimensional ratings (mean). *= p< .01. **= p< .001

Abbreviations:

PAR=paranoid PD
SZD=schizoid PD
STP=schizotypal PD
ASP=antisocial PD
BRD=borderline PD
HST=histrionic PD
NAR=narcissistic PD
AVD=avoidant PD
DPN=dependent PD
DPS=depressive PD
NGT=negativistic PD
PA=managerial/ autocratic
BC=narcissistic/ competitive
DE=sadistic/ aggressive
FG=rebellious/ distrustful
nFnG=reserved/ silent
HI=masochistic/ self-effacing
JK=dependent/ docile
LM=co-operative/ conventional
NO=hypernormal/ responsible
nNnO=sociable/ extravert

Figure 1.

Correspondence of the DSM-IV personality scales and ICL-R scales, with the primary dimensions of interpersonal behavior, in an opioid-dependent patient sample.



Abbreviations:

PAR=	paranoid PD	PA=	managerial/ autocratic
SZD=	schizoid PD	BC=	narcissistic/ competitive
STP=	schizotypal PD	DE=	sadistic/ aggressive
ASP=	antisocial PD	FG=	rebellious/ distrustful
BRD=	borderline PD	nFnG=	reserved/ silent
HST=	histrionic PD	HI=	masochistic/ self-effacing
NAR=	narcissistic PD	JK=	dependent/ docile
AVD=	avoidant PD	LM=	co-operative/ conventional
DPN=	dependent PD	NO=	hypernormal/ responsible
COM=	obsessive-compulsive PD	nNnO=	sociable/ extravert
DPS=	depressive PD		
NGT=	negativistic PD		

IV. Prevalence of personality pathology in Dutch addiction care

Chapter 7. Personality pathology in opioid-dependent patients across addiction cure and care facilities in the Netherlands[1]

Abstract

The aim of this study was to establish the prevalence of personality pathology across three treatment modalities, which are representative for general addiction care (rapid detoxification followed by outpatient treatment, outpatient methadone maintenance program, and an inpatient treatment facility) in the Netherlands, with the use of the Structured Interview for *DSM-IV* Personality (SIDP-IV; Pfohl, Blum & Zimmerman,1995). Prevalence rates were found to vary substantially across treatment facilities. In the inpatient facility, 70.0% of the patients have at least one personality disorder. In the outpatient detoxification and methadone maintenance facilities, the prevalence was substantially lower (43.2% and 44.3%, respectively). Additional recommendations and implications for treatment in addiction care are given.

[1] This chapter is the equivalent of the manuscript with the title "Personality pathology in opioid-dependent patients across addiction cure and care facilities in the Netherlands", which is in submitted for publication in *Substance Use and Misuse* . Authors: K.F.M. Damen, C.A.J. DeJong, M.H.M. Breteler. C.P.F. VanderStaak.

Introduction

Numerous studies have shown that *DSM* (APA, 1980; 1987; 1994) personality disorders (PDs) are highly prevalent among patients with substance use disorders in general, and opioid dependent patients in particular (Brooner, King, Kidorf, Schmidt & Bigelow, 1997; Cacciola, Alterman, Rutherford, McKay, & Mulvaney, 2001). The term *comorbidity* refers to the description of coexisting disorders, and when applied to substance-using populations, it usually implies the coexistence of a substance disorder with mood disorders or PDs. Concerning Axis-II comorbidity, most studies have covered comorbidity in patients participating in methadone maintenance programs or otherwise residing in regular mental health services. Table 1 gives an overview of studies reporting on the prevalence of *DSM* PDs in opioid dependent patient samples with the use of (semi) structured interviews. Comparing results across studies, is difficult, for prevalence rates appear to range widely across studies, using different methods, treatment settings and patient samples. When comparing the results of studies in in-patient modalities, to studies on patients in methadone maintenance programs, prevalence rates appear to be substantially higher for the inpatient samples. For patients admitted to alternative treatment programs, like rapid detoxification programs, comorbidity hasn't been subject of study yet.

A number of studies have shown that psychiatric comorbidity in substance-dependent patients is related to poorer treatment outcome and drop-out (Cacciola, Rutherford, Alterman, McKay, & Snider, 1996). Efficient and effective care in addiction treatment facilities, should be attuned to patient characteristics, which differ across treatment modalities. Therefore, it is important to have a good description of patients across various modalities. When, for instance, there is high comorbidity with axis-II pathology in a certain setting, it is important for workers in this setting to have substantial knowledge of this pathology. It is plausible that it is necessary to provide additional training.

The estimation of prevalence rates is known to be influenced by assessment procedures (e.g. time of measurement, interviewer characteristics and training), and methodological issues, such as *DSM*-edition and instrument of use (Verheul, 1997).

Semi-structured interview procedures facilitate a more systematic, replicable and informed assessment through the provision of a consequent set of questions, and are found to have a superior reliability compared to self-report measures and clinical judgment (Widiger, Mangine, Corbitt, Ellis, & Thomas, 1995). A user-friendly semi-structured interview often administered in Dutch addiction care, is the Structured Interview for *DSM-IV* Personality (SIDP-IV; Pfohl, Blum & Zimmerman,1995).

The aim of this study is to establish the prevalence of personality pathology across different treatment modalities in addiction care, with the use of the SIDP-IV.

Method

Participants

The 279 patients participating in this study are opioid dependent patients who participated in one of three treatment modalities. We chose these programs in such a way, that the total sample is highly representative of the patient population in Dutch addiction care, consisting of detoxified outpatients, non-detoxified outpatients, and inpatients. The first sub-sample consists of patients participating in a rapid detoxification program. Patients (*N*=183) in this program detoxified in a hospital setting, but participated in an outpatient treatment program, containing ten therapy sessions (based on the Community Reinforcement Approach). An extensive description of this program is given elsewhere (DeJong, 1999). All participating patients in this program were asked to participate in this study. The second modality is a drug-free inpatient treatment modality (*N*=50). A consecutive series of participants were recruited from one of the inpatient treatment units of Dutch clinics in order of admission. The third treatment program consists of an outpatient methadone-maintenance program (*N*=46). A consecutive series of participants were recruited from methadone maintenance units in order of admission. Patients in this study met the *DSM–IV*-criteria for opioid-dependency and had good knowledge of the Dutch language. Overt Axis-I pathology, other than substance dependence, was considered an exclusion criterion.

A description of demographic variables and problem severity is shown in Table 2. Patient characteristics like gender, history of abuse, educational level, employment, prior treatment, and addiction severity vary across treatment setting. In the total sample,

patients were predominantly male and single, with a mean age of 35.9 years (*SD* = 6.5). Drug use history varied from a mean of 6.8 years (*SD* = 5.9) for methadone use to 11.4 years (*SD* = 6.0) for heroine use. Median number of prior outpatient treatments was 4 (range 0-30), and 2 (range 0-20) for the number of prior inpatient treatments.

Instrument

The Dutch version of the SIDP-IV (DeJong, Derks, Van Oel & Rinne, 1996) was administered for the assessment of personality pathology. The structure of the *SIDP-IV* corresponds to the structure of the SIDP (Structured Interview for *DSM-III* Personality; Pfohl, Stangl, & Zimmerman, 1983) and SIDP-R (Structured Interview for *DSM-III-R* Personality; Pfohl, Blum, Zimmerman, & Strangl, 1989) and addresses personality characteristics covering a period of time of five years preceding the interview date. The order of the questions is based on corresponding sections and not on *DSM* categories. In contrast to prior versions, the interviewer can rate or refer to the specific *DSM-IV* criterion that is associated with the related section. The SIDP-IV consists of ten sections (A to J). In every section questions relate to a particular subject:

A Activities and interests	D Social contacts	G Self-perception
B Work	E Emotions	H Perception of others
C Close relationships	F Observational	I Stress and anger
		J Social conformism

This means, in the interview, the questions and criteria are connected to each other. E.g., a question that is used to assess and rate a criterion is: “What kind of things do you enjoy?” This question is related to the following criterion “Takes pleasure in few, if any activities". Each criterion is rated with a score ranging from 0-3, 0=*not present*; 1=*almost present;* 2=*present*; 3=*strongly present*. Finally, for each PD, the number of criteria rated as present (criteria rated 2 or 3) determines whether or not the disorder is present. The translation was made in parts by two couples of two independent translators, who each came to a consensus about part of the interview and discussed the differences in the translation bilaterally in order to come to a final consensus about the whole of the translated interview. The average time it takes to administer the interview for an experienced interviewer is about one and a half hours. Interrater reliability of the

SIDP-IV has been established by the two interviewers who were involved in the assessment of PDs in this study, and was found to be excellent; $\underline{\kappa}$ ranging from .76 to .93 at a criterion level and $\underline{\kappa}$ ranging from .66 to 1.00 at a diagnostic level (Damen, DeJong & VanderKroft, in press). Diagnostic efficiency as well as construct validity of the SIDP-IV were found to be acceptable for the use in opioid-dependent patients (Damen, K.F.M., DeJong, C.A.J., Breteler, M.H.M., VanderStaak, C.P.F, submitted for publication; Damen, K.F.M., DeJong, C.A.J., Breteler, M.H.M., VanderStaak, C.P.F.[a], submitted for publication).

The European version of the Addiction Severity Index (Europ*ASI*; McLellan, 1992; Kokkevi & Hartgers, 1995), was used for the description of the sample characteristics. Composite Scores (range 0-1) and Severity Scores (range 0-9) were derived for seven areas of functioning: *Medical , Employment, Alcohol, Drugs, Legal Problems, Family/Social relations, and Psychiatric problems*. EuropASI dimensional measures have acceptable psychometric measures (Kosten, Rounsaville & Kleber, 1993).

Procedure

To control for substance use effects and detoxification-related stress, in the inpatient and rapid-detoxification sub-samples, the Structured Interview for *DSM-IV* PDs was administered one month after detoxification by one of two interviewers. The interviewers have a Masters degree in Clinical Psychology, and are experienced interviewers. Prior to the study they had participated in a two-day interview training, in which they practiced the SIDP-IV. This training was provided by the second author of this article, who has extensive experience with administration as well as with the training of the SIDP, SIDP-R and SIDP-IV. We informed patients participating in the study about the purpose of the study and asked to sign informed-consent.

Statistical Analysis

Prevalence of personality pathology was established for the three samples. Mean dimensional (i.e., based on the number of criteria present for each disorder) as well as categorical (i.e., diagnostic judgments) prevalence rates were calculated. In addition, differences in categorical prevalence rates of personality pathology between different

treatment settings, were established by Chi-square for overall differences and Mann-Whitney U analysis for a two by two comparison. Significance of differences in mean dimensional scores was established by one way Anova analyses with post-hoc LSD test. In order to provide not only a variable-oriented approach to the data, a person-centered approach was obtained by the use of cluster-analyses. This analysis was done on all PD scores and patient descriptive variables. A description was given of the cluster solutions. Finally, for each treatment modality, the number of patients from each cluster was given, in order to make a profile for patients in each setting.

Results

Table 3 shows the prevalence rates for each PD in this study. In the total patient sample, 48.2 % of the patients have at least one PD. The data indicate that antisocial PD is the most prevalent diagnosis (35.8 %), followed by obsessive compulsive PD (9.7%), and depressive PD (9.7 %). As a whole, there was a statistically significant difference in personality pathology across the three sub-samples (R^2=.039; p=.004). In the inpatient sample 70.0% (sub-sample 2) of the patients have a positive PD diagnosis. In the outpatient treatment facility (sub-sample 1) and outpatient methadone maintenance program (sub-sample 3), the prevalence was substantially lower (43.2% and 44.3%, respectively). Comparing these sub-samples two by two, substantially more personality pathology was found in the inpatient sample (sub-sample 2), compared to the prevalence found in the methadone tapering sample (sub-sample 3; p<.05) and the outpatient sample (sub-sample 1) (p<.01). No significant difference was found between the outpatient sample and methadone maintenance sub-sample.

Results for individual PDs indicate, that across these samples there is no difference in the percentage of patients with a schizoid, schizotypal, histrionic, narcissistic, avoidant, dependent, and negativistic PD (p>.01). In sub-sample 2, there are more patients with antisocial (Z=3.6; p<.001), borderline (Z=3.5; p<.001), and obsessive-compulsive PD (Z=5.0; p<.001), compared to sub-sample 1. In sub-sample 3, there are more patients with paranoid (Z=2.9; p=.004) and depressive PD (Z=3.3; p=.001), compared to sub-sample 1. In addition, in sub-sample 2, there are more patients with obsessive-compulsive PD (Z=3.3; p=.001), compared to sub-sample 3.

Patients in the inpatient sample, have higher dimensional scores on the antisocial (p=.001), borderline (p<.001), narcissistic (p=.005), avoidant (p=.003), obsessive-compulsive (p<.001), and depressive (p<.001) PD, compared to patients in the outpatient sample. Patients in the methadone program have higher dimensional scores on the paranoid (p=.002), histrionic(p=.002), avoidant (p=.003), and depressive PD (p=.004), compared to patients in the rapid-detoxification sample. Finally, patients in the inpatient sample have higher dimensional sores on the obsessive-compulsive PD, compared to patients in the methadone sample (p<.001).

No significant association was found between PD pathology and patient characteristics (r<.30). Two clusters were derived from cluster analysis. Cluster one represents patients with little personality pathology, with less problems in life areas of employment and psychiatric problems. Cluster two represents patient with more severe personality pathology and greater psychiatric and employment problems. The three most discriminating variables between the clusters were the dimensional scores on the depressive PD (F=352,1; p<.001), the dependent PD (F=166.8; p<.001), and the avoidant PD(F=140.4; p<.001). In the inpatient setting 38.0 % of the patients belong to cluster two (the most severe patients). In the methadone sample 33.3% of the patients belong to cluster two. In the rapid-detoxification sample 20.8 % of the patients belong to cluster two. These person-oriented results, confirm the results found by the variable centred approach, in that severe personality pathology was found in the inpatient sample, and less severe pathology in the methadone and rapid-detoxification (daytime treatment) groups.

Discussion

This study largely reproduces results from prior studies on Axis-II prevalence among opioid dependent patients. Results of this study indicate prevalence of personality pathology to differ substantially between inpatient and outpatient modalities. In an inpatient setting, the prevalence of PDs was found to be very high. Clinicians working in such facilities should have extensive knowledge of and be experienced with personality pathology, in particular antisocial, obsessive/compulsive, depressive, borderline narcissistic, and avoidant PD. For these patients, given the

intensity of treatment, personality pathology, should be treated along with the addictive behavior. In the outpatient treatment sample there was less, but still substantial comorbidity. The nature of treatment for these patients is less intensive. Clinicians in this type of setting should have knowledge about personality pathology and be able to provide patients with, for instance, psycho-education on personality pathology, in particular about the antisocial and obsessive-compulsive PD. Finally, in the methadone maintenance program, there is about as much personality pathology as in the outpatient treatment sample. Patients in this program particularly display antisocial and depressive, and to a lesser extent borderline and avoidant personality traits. Because patients in this kind of treatment facility, do not often have a wish to become clean or participate in psycho-therapy, for clinicians in this kind of facility it is important to have some knowledge about personality pathology, but they do not particularly have to be able to base therapeutic interventions or psycho-education on this knowledge.

Study limitations

A structured interview was used for the assessment. The study relied largely on self-report. No informant information was used, though the interview contains informant questions. In future research the reliability of informant information should be addressed, and used in the assessment.

Although Table 2 would suggest that there are differences across treatment settings in the ratio of patients that are employed, the average years of the substance use, problem severity, etcetera, we did not find patient characteristics to be associated substantially with personality pathology. Whether it is possible that the presence and severity of personality pathology can be predicted by a combination of patients characteristics, such as age, onset of drug abuse or problem severity, remains an interesting subject for further research.

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Table 1

Studies reporting Axis-II comorbidity in opioid dependent patient samples

Study	Brooner et al., 1993	Brooner et al., 1997	Cacciola et al., 2001	Chen et al., 1999	DeJong et al., 1993	Rutherford et al., 1994	Thomas et al., 1999
N	203	716	278	47	86	179	20
DSM- edition	III-R	III-R	III-R	III-R	III	III-R	III-R
Method†	SCID-II	SCID-II	**SIDP-R**	**SIDP-R**	**SIDP**	**SIDP-III-R**	SCIDII
Setting	Out-patient	Out-patient	Out-patient	In/out-patient	In-patient	Out-patient	In-patient
Mean Age	33.8	34.8	40.5	35.2	25.9	39	???
% Male	45.8	52.8	86.3	100	73	???	40
PD diagnosis (%)							
Any [a]PD	37.4	34.8	34.2[1]	66.0	91	65.9	60
PAR	3.9	3.2	1.4	10.6	26.7	< 5	0
SZD	0	.3	2.2	-	7.0	< 5	0
STP	0	.3	0.0	-	40.7	< 5	0
ASP	22.6	25.1	19.8	29.0	47.7	38.3	10
BRD	7.9	5.2	2.9	-	65.1	10.0	5
HST	3.4	1.4	4.7	-	64.0	6.1	0
NAR	.5	.8	1.4	-	12.8	< 5	0
AVD	8.4	5.2	1.8	-	26.7	7.8	15
DEP	2.5	1.7	1.1	-	34.9	< 5	15
COM	1.0	.7	1.4	-	25.6	< 5	20
NGT	3.4	4.1	4.0	-	48.8	< 5	0
SAD	-	-	1.8	-	-	5.6	-
Mixed	-	-	-	-	-	11.1	-

To be included in this overview, studies had to address the following issues:

- Reporting of full range of DSM-III, DSM-III-R or DSM-IV PD(s).
- Assessment with a standardized (semi-) structured interview
- Opioid-dependent patient sample
- Adult patient sample
- Published in English
- Patients in voluntary setting

Abbreviations: PAR= Paranoid PD; SZD= Schizoid PD; STP=Schizotypal PD; ASP=Antisocial PD; BRD= Borderline PD; HST=Histrionic PD; NAR=Narcissistic PD; AVD=Avoidant PD; DEP=Dependent PD; COM=Obsessive-compulsive PD; DPS=Depressive PD; NGT=Negativistic PD; SAD=Sadistic PD; SCID-II= Structured Clinical Interview for DSM-IV Axis II Personality Disorders

Table 2
Demographic characteristics and ASI composite scores

Demographic Variables	Total sample (N=279)	Sub-sample 1 (rapid detox; *N*=183)	Sub-sample 2 (inpatient; N= 50)	Sub-sample 3 (Methadone maint.;(N= 46)
% Male	81.3	83.1	80.0	72.4
Age[2]	35.9 year (*SD*=6.5)	36.4 year (*SD*=6.6)	34.0 year (*SD*=6.5)	36.1 year (*SD*=5.9)
History of abuse				
% mental	38.7	41.0	34.0	34.8
% physical	19.8	19.2	18.0	23.9
% sexual	12.9	12.0	10.0	19.6
Education[2]	10.8 years (*SD*=2.9)	10.6 years (*SD*=3.0)	11.6 years (*SD*=2.9)	10.5 years (*SD*=2.3)
Employment				
% Employed	56.7	65.0	41.2	34.1
% Unemployed	43.3	35.0	58.8	65.9
Drug use[1]				
Heroin use[2]	10.4 (*SD*=6.6) years	11.3 (*SD*=6.3) years	7.6 (*SD*=6.7) years	10.1 (*SD*=6.7) years
Methadone use[2]	5.9 (*SD*=6.0) years	6.8 (*SD*=5.7) years	3.2 (*SD*=5.7) years	5.3 (*SD*= 6.1) years
Polydrug use[2]	9.2 (*SD*=7.7) years	10.2 (*SD*=7.8) years	4.8 (*SD*=6.2) years	9.9 (*SD*=5.9) years
Onset of drug abuse	21.5 (*SD*=5.1)	21.1 (*SD*=5.0)	22.8 (*SD*=4.9)	22.1 (*SD*=5.5)
Prior Treatment				
Number of prior Outpatient treatments[3]	4 (range 0-30)	4	3	5
Number of prior inpatient Treatments[3]	2 (range 0-20)	2	2	2
ASI Composite scores (CS)[2]				
Medical CS	.21 (*SD*=.27)	.19 (*SD*=.26)	.29 (*SD*=.26)	.22 (*SD*=.29)
Employment CS	.18 (*SD*=.30)	.14 (*SD*=.29)	.32 (*SD*=.30)	.22(*SD*=.29)
Alcohol CS	.11 (*SD*=.20)	.09 (*SD*=.18)	.16 (*SD*=.27)	.09 (*SD*=.15)
Drug CS	.46 (*SD*=.12)	.47 (*SD*=.12)	.45 (*SD*=.11)	.42 (*SD*=.13)
Legal CS	.16 (*SD*=.20)	.13 (*SD*=.19)	.25 (*SD*=.21)	.20 (*SD*=.21)
Family/social CS	.10 (*SD*=.16)	.08 (*SD*=.15)	.16 (*SD*=.19)	.08 (*SD*=.12)
Psychiatric CS	.18 (*SD*=.19)	.15 (*SD*=.17)	.27 (*SD*=.20)	.21 (*SD*=.20)
ASI Severity Index (SI)[2]				
Medical SS	1.3 (*SD*=1.5)	1.2 (*SD*=1.4)	1.5 (*SD*=1.5)	1.4 (*SD*=1.5)
Employment SS	2.5 (*SD*=2.3)	2.2 (*SD*=2.1)	3.0 (*SD*=1.8)	3.2 (*SD*=2.0)
Alcohol SS	1.2 (*SD*=1.8)	1.0 (*SD*=1.7)	2.1 (*SD*=2.1)	1.0 (*SD*=1.3)
Drug SS	6.0 (*SD*=1.4)	6.2 (*SD*=1.1)	5.5 (*SD*=2.1)	5.8 (*SD*=1.3)
Legal SS	2.0 (*SD*=2.1)	1.6 (*SD*=1.8)	3.1 (*SD*=2.3)	2.6 (*SD*=2.2)
Family/social SS	2.8 (*SD*=2.0)	2.6 (*SD*=1.8)	3.4 (*SD*=2.0)	2.8 (*SD*=1.4)
Psychiatric SS	2.5 (*SD*=2.0)	2.1 (*SD*=1.9)	3.4 (*SD*=1.8)	3.2 (*SD*=2.3)

Note: [1]Missing values excluded
[2]Mean
[3]Median
Abbreviations: CS=Composite Score; SS=Severity Score

Tabel 3

*Categorical prevalence rates and dimensional scores for PDs**

PD diagnosis	Subsample 1 (N=183)		Subsample 2 (N=50)		Subsample 3 (N=46)		Mann-Whitney test for MDS	Test for Prev
	MDS (*SD*)	Prev *%*	MDS (*SD*)	Prev *%*	MDS (*SD*)	Prev *%*		
Any PD	-	43.2	-	70.0	-	44.4	-	-
One PD	-	30.6	-	20.0	-	15.6	-	-
More than one PD	-	12.6	-	50.0	-	40.0	-	-
PAR	9.2 (10.7)	1.1	14.1 (14.0)	4.0	15.7 (18.2)	8.7	3>1 (*F*=6.4 ; *p*=.002)	3>1(χ^2=7.9; *p*<.05)
SZD	12.5 (12.1)	1.6	13.0 (12.1)	2.0	8.3 (8.1)	0.0	-	-
SZT	8.8 (8.4)	0.0	11.6 (10.0)	0.0	8.7 (10.4)	0.0	-	-
ASP	25.2 (18.1)	30.6	35.5 (17.1)	58.0	27.7 (28.5)	32.6	2>1 (*F*=5.2; *p*=.006)	2>1(χ^2=13.1 ; *p*=0.001)
BRD	16.2 (14.2)	3.8	27.9 (20.9)	18.0	20.9 (21.2)	10.9	2>1 (*F*=9.7; *p*<.001)	2>1(χ^2=12.2 ; *p*=0.002)
HST	6.9 (10.0)	0.5	10.3 (12.2)	2.0	12.6 (13.6)	2.2	3>1 (*F*=5.6; *p*=.004)	-
NAR	8.3 (9.1)	0.0	13.6 (16.0)	6.0	13.2 (15.2)	6.5	2>1 (*F*=6.1; *p*=.003)	2>1; 3>1 (χ^2=11.7; *p*=0.003)
AVD	10.3 (17.2)	6.0	19.1 (20.8)	10.0	18.4 (22.3)	10.9	2>1; 3>1 (*F*=6.5; *p*=.002)	-
DEP	10.2 (13.1)	1.6	18.2 (15.7)	2.0	12.3 (12.8)			
COM	16.6 (13.2)	5.5	28.5 (17.9)	30.0	16.0 (12.9)	4.3	2>1; 2>3 (*F*=14.8; *p*<.001)	2>3 ; 2>1 (χ^2=28.8; *p*<0.001)
DPR	20.7 (21.2)	6.0	34.6 (20.9)	12.0	31.5 (28.0)	21.7	2>1; 3>1 (*F*= 9.9 ; *p*<.001)	2>1; 3>1 (χ^2=10.8; *p*=0.005)
NGT	13.7 (13.0)	2.2	15.5 (13.7)	2.0	14.7 (12.4)	0.0	-	-

*Multiple diagnoses possible

MDS=Mean dimensional score

Prev=prevalence rate

For abbreviations see Table 1

Chapter 8. Stepped Care and Assessment; The Addiction Severity Index as a Screener for Personality Pathology in Opioid-dependent Patients.

Abstract

In this study the diagnostic efficiency of the EuropASI as a screening device for personality pathology in Dutch opioid-dependent patients, was investigated. The Dutch version of the SIDP-IV (DeJong, Derks, Van Oel & Rinne, 1996) was used for the assessment of personality pathology. Two variables were found to contribute to the prediction of the presence of personality pathology; the composite score of *psychiatric problems* and the duration of the heroine addiction. Nonetheless, results lend little support for the diagnostic efficiency of the EuropASI as a screening device for personality pathology. For clinical practice in addiction care, this means alternative assessment procedures for personality pathology in all opioid-dependent patients should be added to the standard EuropASI assessment procedure.

Personality pathology is a substantial problem in opioid-dependent patients, which is related to poorer treatment outcome and drop-out (Cacciola, Rutherford, Alterman, McKay, & Snider, 1996). Efficient and effective care in addiction treatment facilities should be attuned to patient characteristics. In line with the stepped care model, as described by Schippers, Schramade, & Walburg (2002), stepped assessment of psychopathology in substance-dependent patients contributes to the improvement of professionalism, effectivity, and efficiency of assessment and treatment in addiction care. Therefore, time-consuming assessment methods like semi-structured interviewing are probably not efficient for all kinds of patients, so a proper screening device, which can predict personality pathology based on patient characteristics, could contribute to the innovation of addiction care.

In Dutch Addiction Care, The European version of the Addiction Severity Index (EuropASI; McLellan, 1992; Kokkevi, & Hartgers, 1995) is administered in order to assess these patient characteristics. It is a clinical interview designed to assess current problem severity in substance abusing patients, in seven areas: *Medical, Employment, Alcohol and/or Drug use, Legal Problems, Family/Social relations, and Psychiatric problems*. When EuropASI-variables could be of use in predicting personality pathology, this instrument could serve as a screener for personality pathology in order to make a decision about the next step in the process of assessment; the administration of a semi-structured interview.

The focus of this study is as follows. In Dutch addiction treatment, patients are appointed to different treatment settings based on the severity and duration of there addiction, as well as treatment history, age, and employment status. We expect the EuropASI to be a predictor of the prevalence of psychopathology in these treatment settings. Therefore, the efficiency of the EuropASI as a screening device for personality pathology is established. Research suggests that there is a relation between the presence of personality disorders and functioning with respect to employment status, illegal involvement, family/social problems, emotional difficulties and alcohol related problems (Rutherford, Cacciola, Alterman, 1994). Substance abuse patients with a PD

were found to differ significantly from patients without a PD in several ways; they had greater involvement with illegal drugs, had different patterns of alcohol use, and were less satisfied with their lives and more isolated (Nace, Davis, & Gaspari, 1991). In a study by Franken and Hendriks (2000), onset of drug abuse, was found to be associated with greater axis-II comorbidity. Other EuropASI variables hypothized to predict personality pathology include gender, age, educational level, polydrug use, treatment history, history of abuse.

Method

Participants

The 279 patients participating in this study are all opioid-dependent patients who participated in one of three treatment programs. We chose these programs in such a way, that the total sample is highly representative of the patient population in Dutch addiction care, consisting of detoxified outpatients, inpatients, and non-detoxified outpatients participating in a methadone maintenance program. The first program is a multi-center program in which two methods of rapid detoxification were compared. Patients (*N*=183) in this study detoxified in a hospital setting, but participated in an outpatient treatment program, containing ten therapy sessions (based on the Community Reinforcement Approach). An extensive description of this program is given elsewhere (DeJong, 1999). The second setting is a drug-free inpatient treatment facility in a Dutch addiction center (*N*=50). The third treatment program consists of an outpatient methadone-maintenance program (*N*=46). Patients in this study met the *DSM–IV*-criteria for opioid dependency and had good knowledge of the Dutch language. Overt Axis-I pathology, other than substance dependence, was considered an exclusion criterion.

Instruments

Two instruments were conducted in this study. The European version of the Addiction Severity Index (*ASI*), was used for the description of the sample characteristics. Composit Scores (range 0-1) and Severity Scores were derived for seven areas of functioning: *Medical , Employment, Alcohol, Drugs, Legal Problems, Family/Social relations, and Psychiatric problems*. For the calculation of the composite

cores, core variables from each section of the EuropASI are used. The severity scores are established by the interviewer, through the judgment of problem severity based on a weighting of the items for each section. EuropASI dimensional measures have acceptable psychometric measures (Kosten, Rounsaville, Kleber, 1993*).*

The Dutch version of the SIDP-IV (DeJong, Derks, Van Oel & Rinne, 1996) was used for the assessment of personality pathology. The structure of the SIDP-IV (Structured Interview for *DSM-IV* Personality) can be compared to the structure of the SIDP (Structured Interview for *DSM-III* Personality; Pfohl, 1983) and SIDP-R (Structured Interview for *DSM-III-R* Personality; Pfohl, Blum, Zimmerman, & Strangl, 1989) and addresses personality characteristics covering a period of time of five years preceding the interview date. The order of the questions is based on ten interrelated sections and not on *DSM* categories. In contrast to prior versions, the interviewer can directly rate or refer to the specific *DSM-IV* (1994) criterion that is associated with the related section. This means that the questions and criteria are intertwined in the interview and correspond directly to each other. For example, the SIDP-IV question of "What kinds of things do you enjoy?" is associated with the DSM-IV criterion of "Takes pleasure in few, if any activities". Each criterion is assigned a score, which can range from 0 to 3: 0=*not present*; 1=*almost present;* 2=*present*; 3=*strongly present*. And for each PD, the number of criteria rated as present within the last five years (i.e., the number of criteria assigned a score of 2 or 3) is then examined to determine the presence of that PD or not (DeJong, et al. 1996). The scoring of the SIDP and SIDP-R was more complex than the scoring of the SIDP-IV because the original questions were used to rate not just one but several DSM criteria (i.e., a single question could apply to more than one criterion and several questions had to be answered for a single criterion). The SIDP-IV consists of ten sections: Activities and interests; Work; Close relationships; Social contacts; Emotions; Observational; Self-perception; Perception of others; Stress and anger; and Social conformism.

Different parts of the SIDP-IV were translated from English into Dutch by two pairs of independent translators. Each pair came to a consensus on the relevant parts of

the interview and then discussed any differences or inconsistencies in the translation bilaterally in order to reach a final consensus on the entire translation of the interview. The average time needed to administer the interview by an experienced interviewer is about one and a half hours. The psychometric properties of the SIDP-IV have yet to be determined. In their study, Damen, et. al (in press), investigated the interrater reliability of the *DSM-IV* criteria in an opioid dependent patient sample, using the SIDP-IV, and found it to be excellent. The same authors studied the convergent validity of the SIDP-IV with the Interpersonal Checklist -Revised, which reflects an interpersonal behavioural approach to personality, and found significant correlations for all 10 of the 12 DSM-IV personality disorders covered by the ICL-R (Damen, DeJong, Nass, Breteler & VanderStaak., in press)

Procedure

To control for substance use effects and detoxification-related stress, in detoxified the outpatient sample and the inpatient sample, the Structured Interview for DSM-IV Personality Disorders was administered one month after detoxification by one of two interviewers. The interviewers have a Masters degree in Clinical Psychology, and are experienced interviewers. Prior to the study they had participated in a two-day interview training, in which they practiced the SIDP-IV (Dutch version). This training was provided by Dr. Cor deJong, who has extensive experience with the SIDP, SIDP-R and SIDP-IV as well as with the training of the instrument. We informed patients participating in the study about the purpose of the study and asked to sign informed-consent.

Statistical Analysis

In order to give a description of the participating samples, average age, addiction severity, years of employment, drug use, and number of prior treatments were calculated. Regression analysis was performed for the establishment of missing value estimates. In addition, prevalence of personality pathology was established. Dimensional (i.e., based on the number of criteria present for each disorder) as well as categorical (i.e., diagnostic judgments) prevalence rates were calculated. In order to explore the association between demographic characteristics and addiction severity on

one side, and personality pathology on the other side, Pearson's correlation coefficient was calculated. We performed stepwise multiple regression analysis in order to make a prediction of personality pathology based on demographic patient characteristics and addiction severity. Finally, Receiver Operistic Curve (ROC; Egan, 1975) analysis was performed. This method is useful in the selection of an optimal set of risk factors and a cut-point which gives the best discrimination for the dichotomous outcome, in this case, the presence of a PD. ROC analysis was performed serving as a quantitative indicator of the information content of the model and establish the ability of the variables in the regression model to discriminate between patients with and without personality pathology as measured by the SIDP-IV.

Results

Demographic variables and addiction Severity

A description of demographic variables and problem severity, is shown in Table 1. Patient characteristics like gender, history of abuse, educational level, employment, prior treatment, and addiction severity vary across treatment setting. In the total sample, patients were predominantly male, with a mean age of 35.9 years (*SD* = 6.5). Drug use history varied from a mean of 5.9 years (*SD* = 5.9) for methadone use to 10.4 years (*SD* = 6.6) for heroine use. Median number of outpatient treatments was 4 (range 0-30), and 2 (range 0-20) for the number of inpatient treatments.

Prevalence of personality disorders

Table 2 shows the prevalence rates for each personality disorder in this study. In the total patient sample, 48.2 % of the patients have at least one personality disorder. The data indicate that antisocial personality disorder is the most prevalent diagnosis (35.8 %), followed by obsessive compulsive personality disorder (9.7%), and depressive personality disorder (9.7 %). This study largely reproduces results from prior studies on Axis-II prevalence among opioid dependent patients, as shown in Table 2.

Association between demographic characteristics, addiction severity, and personality pathology.

As shown in Table 3, there is a substantial positive association between the *psychiatric* SI and CS of the EuropASI, and personality pathology. Furthermore, there

is a negative association between age and the dimensional scores for the borderline (r=-.23; p<.01) and antisocial (r=-.31; p<.01) PD, which indicates the reduction of personality pathology as patients get older. However, age is not associated with the presence or absence of a –regardless of which- PD. In addition, *family* and *employment* severity does also seem to be related to personality pathology in the domain of the paranoid, antisocial, dependent and depressive personality traits. Again, these scales do not seem to be associated with the presence or absence of a PD. No association was found for history of abuse, drug and alcohol problems, gender, medical status, onset of drug abuse, and polydrug use, with personality pathology (r<.20).

EuropASI as a screener for personality pathology

Logistic regression analysis was performed, with EuropASI items and severity scales as the predicting or independent variables, and the presence or absence of a PD as the dependent variable. Two variables were found to contribute to the prediction of the presence of personality pathology; the composite score of *psychiatric problems* (B=4.08; p<.001)and the duration of the heroine addiction (B=-0.92; p<.001). Together these variables explained 20 percent of the variance (Nagelkerke R^2; correct classification=67.3%).

The probabilities derived from the regression analysis, were used to perform ROC analysis. ROC results are shown in Figure 1. Based on the EuropASI variables the cut-off point for which the sensitivity and specificity of the EuropASI in discriminating between the absence or presence of a PD, are optimalised, is .43 (Sensitivity=.64; Specificity=.66). This indicates that when the probability of the formula which can be derived from the regression weights (B's) and scores on the variables (psychiatric composite score and duration of drug use) is equal to or greater than .43, personality pathology is present in this individual patient. For this indication, there is a chance of .64% that when a PD is present, the screening (based on the EuropASI, will also have indicated that there is a positive diagnosis. In 36% of the cases, the EuropASI as a screener will have indicated that there is no PD, while in fact there is. In addition, when there is a negative diagnosis according to the SIDP-IV, there is a chance of 66%, the

screener would also have classified the patient with a negative diagnosis and in 34% of the cases, there will be a false positive diagnosis.

Discussion

Results of prior research concerning the relation between patient characteristics and personality pathology, were partly reproduced. It was confirmed that the severity of psychiatric problems, familial problem, and employment problems are associated with personality pathology. However, results do not confirm the hypothesis that there is a relation between personality pathology and history of abuse, drug and alcohol problems, gender, medical status, onset of drug abuse, and polydrug use. Results lend little support for the use of the EuropASI as a screening device for personality pathology. Too little variance of personality pathology is explained by patient characteristics, and moreover, the EuropASI items and scales are not discriminative enough for the presence of a PD. Given the fact that the EuropASI gives a description of patient characteristics and problem severity, it can be concluded, that it is not possible to make an evidence-based decision about personality pathology assessment, based on knowledge about these variables. For clinical practice in addiction care, this means that personality pathology assessment should be provided for all types of patients. The decision whether or not to administer a time-consuming instrument such as the SIDP-IV should be based, either on pragmatic reasoning (such as efficiency) or argumentation concerning the type of treatment. For instance, for patients in a methadone maintenance program, who have no clear wish for treatment or abstinence, it is probably not efficient or even ethical to administer a time consuming instrument.

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Table 1
Demographic characteristics and ASI composite scores

Demographic Variables	Total sample (N=279)
% Male	81.3
Age[2]	35.9 year (*SD*=6.5)
History of abuse	
% mental	38.7
% physical	19.8
% sexual	12.9
Education[2]	10.8 years (*SD*=2.9)
Employment	
% Employed	56.7
% Unemployed	43.3
Drug use[1]	
Heroin use[2]	10.4 (*SD*=6.6) years
Methadone use[2]	5.9 (*SD*=6.0) years
Polydrug use[2]	9.2 (*SD*=7.7) years
Onset of drug abuse	21.5 (*SD*=5.1)
Prior Treatment	
Number of prior Outpatient treatments[3]	4 (range 0-30)
Number of inpatient Treatments[3]	2 (range 0-20)
Type of current treatment	
% Rapid detoxification	65.6
% Clinical treatment setting	17.9
% Methadone Tapering	16.5
ASI Composite scores (CS)[2]	
Medical CS	.21 (*SD*=.27)
Employment CS	.18 (*SD*=.30)
Alcohol CS	.11 (*SD*=.20)
Drug CS	.46 (*SD*=.12)
Legal CS	.16 (*SD*=.20)
Family/social CS	.10 (*SD*=.16)
Psychiatric CS	.18 (*SD*=.19)
ASI Severity Index (SI)[2]	
Medical SS	1.3 (*SD*=1.5)
Employment SS	2.5 (*SD*=2.3)
Alcohol SS	1.2 (*SD*=1.8)
Drug SS	6.0 (*SD*=1.4)
Legal SS	2.0 (*SD*=2.1)
Family/social SS	2.8 (*SD*=2.0)
Psychiatric SS	2.5 (*SD*=2.0)

Note: [1]Missing values excluded
[2]Mean
[3]Median
Abbreviations: CS=Composite Score; SS=Severity Score

Table 2

Categorical prevalence rates and dimensional scores for personality disorders

PD diagnosis	Total Sample	
	MDS (*SD*)	Prevalence *%*
Any PD	-	48.2
One PD	-	26.3
More than one PD	-	21.9
PAR	11.1 (13.1)	2.9
SZD	11.9 (11.6)	1.4
SZT	9.3 (9.1)	0.0
ASP	27.5 (20.3)	35.8
BRD	19.1 (17.4)	7.5
HST	8.4 (11.3)	1.1
NAR	10.0 (12.0)	2.2
AVD	13.2 (19.1)	7.5
DEP	12.0 (13.9)	1.8
COM	18.7 (14.8)	9.7
DPR	24.9 (23.1)	9.7
NGT	14.2 (13.0)	1.8

*Multiple diagnoses possible
MDS=Mean dimensional score
PD= personality disorder
For abbreviations see Table 1

Table 3

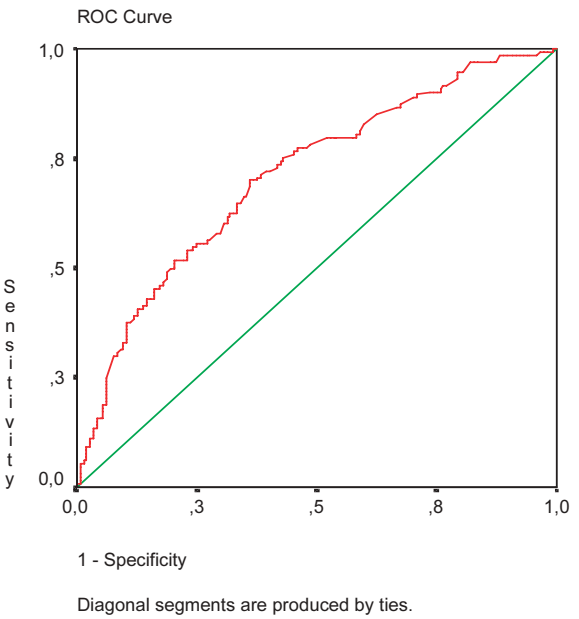
Correlation matrix for the association between demographic variables and addiction severity, and personality pathology (N=279)

	EMs	EMc	ED	PSYs	PSYc	Age	LEGc	FAs	FAc
PAR%	.27	.26	-.28	-	-	-	-	-	-
ASP	-	-	-	-	.35	-	-	-	-
ASP%	-	-	-	.29	.35	-.31	.26	-	-
BRD%	-	-	-	.34	.38	-.23	-	.26	-
HST%	-	-	-	.29	.34	-	-	-	-
DEP%	-	-	-	.27	.28	-	-	-	.31
DPS%	-	-	-	.32		-	-	.26	
NGT%	-	-	-	.26	.31	-	-	-	-
PPD	-	-	-	.25	.37	-	-	-	-

*Association was shown when $p<.01$ and $r>.25$

Abbreviations: PAR= Paranoid PD; ASP=Antisocial PD; BRD= Borderline PD; HST=Histrionic PD; DEP=Dependent PD; DPS=Depressive PD; NGT=Negativistic PD; %=refers to dimensional score; PPD= Presence of a PD; EMs=Employment SS; FAs=Family SS; PSYs=Psychiatric SS; EMc=Employment CS; LEGc=Legal CS; FAc=Family CS; PSYc=Psychiatric CS; ED= Years of education

Figure 1.
ROC curve for the predicted probability of a positive PD



Area under the curve=.71 (p<.001)

V. Conclusion

Chapter 9. Summary and implications for clinical practice

The main aim of this study was to establish the prevalence of personality pathology across treatment modalities in Dutch addiction care in a reliable and valid way. We studied the clinical judgment in personality disorder assessment and found this judgment to be in line with the diagnostic efficiency of the criteria as presented in the DSM-IV. However, this clinical judgment was influenced by therapist variables such as theoretical background and therefore found to be less reliable. In order to establish the prevalence of personality pathology, an instrument which is valid and reliable should be administered. The establishment of the prevalence of personality pathology was therefore preceded by the psychometric evaluation of different facets of reliability and validity of the Structured Interview for *DSM-IV* Personality (Pfohl, Blum & Zimmerman,1995) in an opioid-dependent patient sample, which was the second aim of the study (Part II). An alternative theory-based behavioral model (Interpersonal behavioral model) was compared with the SIDP-IV (Part III), by studying the convergence between the SIDP-IV and Interpersonal Checklist-Revised, in order to see whether or not the SIDP-IV could be replaced by, or completed with, a theory based instrument. In Part IV results allow for not only an extensive description of patient characteristics of opioid-dependent patients in several modalities, but also provide us with recommendations for effective and efficient assessment strategies in (new) treatment programs and facilities, focusing on dual-diagnosis pathology.

Results will be discussed in the order in which they were presented throughout this thesis.

9.1 Summary

9.1 .1 Results from the psychometric evaluation of the SIDP-IV

Results from the psychometric evaluation of the SIDP-IV indicate that the instrument is valid and reliable for the assessment of personality pathology in opioid-dependent patients. The reliability was investigated by the establishment of the interrater reliability, internal consistence, and diagnostic efficiency for the total criteria

set. At a criterion level (Cohen's kappa [κ] ranging from .76 to .93, and Intraclass Correlation Coefficient [*ICC*] ranging from .67 to .97), as well as on a diagnostic level (κ ranging from .66 to 1.00, and *ICC* ranging from .88 to .99), the interrater reliability was found to be excellent. In addition, the establishment of the internal consistency and diagnostic efficiency of *DSM-IV* Axis-II criteria-sets in an opioid-dependent patient sample, as assessed by the SIDP-IV, has led us to critically review of the *DSM-IV* criteria. Results indicate that the SIDP-IV seems to have acceptable internal consistency and good diagnostic efficiency for the assessment of PDs in opioid-dependent patients.

Construct validity of the SIDP-IV was established with the *DSM-IV* axis-II clusters as underlying constructs. Explorative factor analysis yielded a three-factor solution, on the overall resembling the *DSM-IV* Cluster model, thereby suggesting good construct validity of the SIDP-IV in opioid-dependent patients. The optional disorders, depressive and negativistic PD, did not detract from the three factor solution, and should therefore be included in the DSM Cluster model.

9.1.2 Personality pathology and interpersonal behavior

The SIDP-IV was found to be a reliable and valid instrument based on the a-theoretical *DSM-IV* approach to personality pathology. The theory-based Interpersonal Behavioral Model does not appear to be an adequate alternative for the *DSM-IV* in this patient population. Although there is considerable overlap, the ICL-R and SIDP-IV tap on different constructs. There appears to be a clear distinction in the type of interpersonal behavior between opioid-dependent patients with a PD and opioid-dependent patients without a PD. Patients without substantial personality pathology describe themselves as friendly/controlling, while patients with one or more PDs think of themselves as more hostile/submissive. Recommendations for behavioral change in substance dependent patients were provided based on the ICL-R.

9.1.3 Results from the prevalence study

In this study, the SIDP-IV was administered to patients in different treatment modalities (outpatient methadone maintenance program; rapid detoxification followed by outpatient treatment and inpatient treatment). As hypothesized, substantial personality pathology was found in all patient groups. Antisocial PD was the most

prevalent disorder. This is not surprising, considering the fact that engagement in illegal activities is one of the criteria of the antisocial PD, because opioid-dependent patients often engage in illegal activities in order to provide in the daily costs of the addiction. Prevalence rates were found to vary substantially across treatment facilities. In the inpatient facility, 70.0% of the patients have at least one PD. In the outpatient and methadone maintenance facilities, the prevalence was substantially lower (43.2% and 44.3%, respectively). Moreover, except for the antisocial PD, which was found in each sub-sample, the patients in the different groups were characterized by different PD profiles. In the inpatient sample, there are more patients with antisocial, borderline, and obsessive-compulsive PD, compared to the detoxified outpatient sample. In the methadone maintenance sample, there are more patients with paranoid and depressive PD, compared to outpatient treatment sample. In addition, in the inpatient sample, there are more patients with obsessive-compulsive PD, compared to methadone maintenance sample.

9.2 Discussion

9.2.1 Personality pathology and assessment issues.

Administration of the SIDP-IV in three treatment modalities representative of Dutch addiction care, rendered an interesting description of patients participating in these modalities. Prior studies focusing on the prevalence of personality pathology have all investigated only one type of modality. Our study, then, was the first to focus on - and compare the pathology of- substance-dependent patients across modalities, measured by an instrument which has been psychometrically evaluated in the patient population in which it is administered.

As hypothesized, the majority of the patients could be classified with one or several *DSM-IV* PDs. Differences were found for patients across the modalities. Because of these differences in pathology, the focus of treatment in these settings should be attuned to the specific pathology found. Treatment should be preceded by reliable, valid and efficient assessment procedures. Because the administration of a semi-structured interview is time consuming, it is impossible to administer this instrument across all

treatment modalities and patients. As demonstrated in chapter 4, the interview cannot be administered in part, but has to be administered as a whole. Moreover, as found in chapter 8, the presence of personality pathology cannot be predicted in a reliable way by the patient characteristic as measured by the EuropASI. Nonetheless, (as found in chapter 4) the decision whether or not it is advisable to administer the instrument in the case of the individual patient, can be made with sufficient sensitivity and specificity by the administration of a set questions based on merely seven criteria. This limited set of questions can serve as a screener for the presence of personality pathology.

From literature, we know of two screening interviews for the presence of personality disorders. These are the Standardised Assessment of Personality-abbreviated scale (SAPAS; Moran, Leese, Lee, Walters, Thornicroft & Mann, 2003) and the Iowa Personality Disorder Screen (IPDS; Langbehn, Pfohl, Reynolds, Clarck, Battaglia, Bellodi, Cadoret, Grove, Pilkonis & Links, 1999). These instruments were found to have good sensitivity and specificity measures in samples of patients with a wide range of psychiatric pathology. For the establishment of the presence of personality pathology in Dutch opioid-dependent patients, in our study, we found a set of seven criteria, which form the bases of a screening interview. So our screening criteria set is not as developed for the administration in a general psychiatric population, like the two other instruments, but more specifically applicable in Dutch opioid-dependent patients. Table 1 gives an overview of the criteria sets in the three instruments. The three screeners differ remarkably in their content of the criteria. The IPDS includes a number of criteria from the histrionic PD, while our screener, focuses more on antisocial behavior. The SAPAS, just like our screener includes impulsivity, dependence, difficulties in new interpersonal relations and intense anger. Explanations for the great difference between the IPDS and our screener, can be found in the edition of the original instrument from which the screener was derived. The IPDS was derived from the SIDP-R, while our screener was derived from the SIDP-IV, consisting of different criteria and disorder categories. The SAPAS did also not include criteria from the antisocial PD. It is plausible that there are more criteria from the antisocial PD in our screener because of the high prevalence of this disorder in opioid-dependent

patients. We can come to the conclusion that the content of the screeners is influenced by the patient population for which it is used. Therefore, our screener should solely be used in opioid-dependent patients and not in general psychiatry, until further research is done. Moreover, for the same reason, it is not advisable to administer the SAPAS and IPDS in opioid-dependent patients.

Concerning the three treatment modalities described in this thesis, several issues contribute to the development of efficient assessment procedures which can be conducted in everyday practice of addiction care. These issues are related to the intensity and stage of care in which the individual patient is positioned. In their publication, van den Brink and van Ree (2003) mention three treatment stages. The first stage is called "crisis intervention" (e.g. in case of an overdose). The second stage is called "cure". This cure phase includes detoxification and relapse prevention (e.g. longterm traditional biopsychosocial treatment or opioid-antagonist maintainence). The final stage is called the "care" stage, which focuses on stabilization and harm reduction (e.g. methadone maintenance). The inpatient treatment and daytime treatment modalities we described can be categorized in the "cure" stage, while the methadone maintenance program can be categorized as a "care" facility. Depending on the type of facility and treatment stage, effective and efficient assessment strategies of personality pathology can be developed. First, in a crisis intervention situation, interventions are primarily directed toward survival of the patient in agony. Perhaps somewhat superfluous to mention that no assessment of personality pathology should take place. After the crisis situation has ameliorated, patients should be referred to cure or care facilities and go through PD assessment procedures accordingly.

Second, patients in methadone maintenance programs do not need personality assessment, unless the treatment appears to be insufficient (e.g., when a patient shows dangerous, extremely hostile or reluctant behavior; when there is continued use of heroine). As it is a facility, in which little efforts are required from patients, PD assessment should only be done in the case of a problematic treatment course, with the use of a screening instrument. Problematic in the assessment in these patients could be

the use of opioids at the time of assessment. There is no literature on the effects of opioid-use on PD assessment.

Third, patients participating in outpatient treatment programs, often do not have an extensive treatment history. Therefore, the first step in assessment of patients in this type of treatment facility should not be too extensive. When there has been prior treatment which has not lead to a positive treatment outcome (e.g. abstinence), a PD screening should be done. When, in the course of the outpatient treatment, the program does not appear to be effective, a screening should also be administered.

Finally, patients in inpatient treatment facilities often have substantial problems on several life areas, a longer history of treatment and participate in a more intensive treatment program. Therapists in such a setting should have substantial information about these patients in order to formulate proper treatment goals and limitations. Therefore, in this type of treatment, all patients should receive extensive PD assessment through the administration of the SIDP-IV. Even if a patient does not have an actual PD, personality traits can nonetheless give direction to the treatment. In Figure 1 a decision tree is presented for assessment procedures in the three types of addiction care facilities. This decision tree can help to make a decision about whether or not to administer the SIDP-IV in the PD assessment in the individual patient. It contains strategies which are both efficient, and attuned to individual patient characteristics.

When a patient displays problematic interpersonal behavior, which worsens the prognosis for effective treatment of substance dependence and/or personality pathology, besides the SIDP-IV, the ICL-R should be administered. Based on the profile which can be derived from this assessment method, recommendations for the clinician(s) as well as the patient, can be formulated through which more flexible interpersonal behavior is fostered, contributing to better interpersonal relationships, which in turn can contribute in remaining abstinent.

9.2.2 Study limitations and considerations

This study has some limitations and considerations. First, we did not address the predictive validity of the SIDP-IV. This means we have no data on treatment outcome for patients who were interviewed with the SIDP-IV prior to their treatment. We chose

to study one topic (assessment and establishment of the prevalence of personality pathology in Dutch opioid-dependent patients) as thoroughly as possible. Treatment issues deserve extensive study in itself. As illustrations of treatment procedures for addiction and personality pathology we refer to studies of Strain (2002); Linehann, Dimeff, Reynolds, Comtois, Welch, Heagerty & Kivlahan (2002); and Ball (1998). The predictive validity, even as the test-retest reliability and content validity, which were not established due to limited financial and time resources, deserve recommendation for further research .

A second limitation of this study concerns the validity of the Axis II diagnosis, given the axis I diagnosis (opioid-dependence). The question is whether the PD classification can be seen as separate from or as a consequence of the substance dependence. For example, when a patient steels in order to be able to finance his or her addiction, should this then be seen as a symptom of the axis-I disorder or as a part of the personality? The same question can be asked when a patient becomes depressed in the cause his/her addiction. It is a question which is difficult to answer. As mentioned in paragraph 1.2, there are several models on comorbidity, so this issue cannot be resolved conclusively. The following issues are in defence of the establishment of personality pathology as it was done in this study. First, the questions in the SIDP-IV refer to personality as it was in the last five years. One could reason that if thoughts, feelings, and behavior consist over such a long period of time, it is or has become part of one's personality and goes beyond a temporary condition. Second, the fact that the addictive behaviour, mood, or thoughts are so persistent, even though they are problematic for the patient's everyday functioning, leads us to think that the inability to change or stop the dependence stems from the personality. Third, the *DSM* recognizes that the causal relationship between substance usage and for instance antisocial personality is often mutually interactive. Substance abuse will often be the result of antisocial personality traits and the other way around. So it is not at all justified to automatically assume that personality pathology is always a consequence of the substance dependence and can therefore not be established in the presence of substance dependence. This is illustrated by the *DSM* requirement that antisocial PD can be diagnosed only when there has been

a history of antisocial behavior prior to the age of 15, which will usually set the onset of antisocial PD prior to the onset of substance dependence (Widiger, Mangine, Corbitt, Ellis, & Thomas, 1995).

Finally, there are limitations inherent to the *DSM-IV* model and the personality disorder classification. As mentioned in Chapter 6, one of such shortcomings is the limited theoretical foundation for the PD categories. Another highly debated flaw of the *DSM* axis II classification system is the limited empirical support for the categories as they are now formulated. The diagnostic criteria and disorder categories are based on the clinical judgment of the Task Force and its Advisory Committees and not on empirical evidence. In Chapter 5 on construct validity, we did not find evidence for the PD categories, nonetheless we did find evidence for the Cluster model. In addition, in *DSM-IV* the classification and description of personality and personality pathology remains a categorical one. This categorical approach is highly criticized, for the cut-off point for the presence of a disorder is not evidence based and highly subjective. An alternative approach is the description of personality disorders on a continuum with on one end the absence of a trait or style and on the other end an "abnormal" or extreme manifestation of a trait or style. A "normal" manifestation lies somewhere in between, but no cut-off point is used here. In line with a more dimensional approach, the instrument we administered for the personality pathology assessment (SIDP-IV) contains a dimensional classification possibility besides the categorical PD classification. By means of this dimensional rating, a personality profile can be construed, which is based on the extent to which the person meets the criteria of each individual style.

From an historical point of view, there has been a shift in the way personality pathology is formulated in the *DSM*. It has only been since the third edition, that PDs were put on a separate Axis. Moreover, throughout DSM-III, DSM-III-R and DSM-IV, several changes in both the diagnoses and the criteria sets were made. For instance, DSM-III-R included 11 officially recognized PDs (i.e., paranoid, schizoid, schizotypal, antisocial, borderline, histrionic, narcissistic, avoidant, dependent, obsessive-compulsive, and passive/aggressive) and two within the appendix of proposed

diagnostic categories needing further study (i.e., self-defeating and sadistic). The self-defeating and sadistic PDs have been deleted entirely from the manual in DSM-IV, passive-aggressive (negativistic) PD has been shifted from an officially recognized PD to the appendix of optional disorders, and depressive PD has been added also to this appendix (Widiger, Mangine, Corbitt, Ellis, & Thomas, 1995). It is still unclear with regard to *DSM-V*, what kind of changes there will be in the classification system, like for instance the abolishment of the separation between Axis-I and Axis-II or the inclusion of more dimensional models in the classification system, the acceptance or rejection of the optional PD diagnoses.

Suggestions for further research

In this study we focused on personality pathology in opioid-dependent patient, because the prevalence of personality pathology in these patients is substantial. Further research is needed concerning this pathology in patients with different types of substance dependence. For instance, cocaine dependence also has a high comorbidity with personality pathology, but perhaps, the nature of the pathology and also the way assessment in these patients should be provided, could be quite different from patients with an opioid-dependence.

In addition, the effective and efficient assessment strategies as presented in figure 1, were based on the results of our study. It would be very interesting to investigate the extent to which these strategies are in line with nowadays clinical practice in addiction cure and care facilities in the Netherlands. When substantial differences exist, it is advisable to inform these institutes about our findings in order to develop more efficient procedures.

9.2.3 Conclusion

In this thesis, we have searched for the person behind the addiction. In order to give direction to this search, we formulated two goals. This first aim was to establish the personality pathology in opioid-dependent patients across treatment modalities in Dutch addiction care. In order to make a good estimation about the prevalence of personality pathology in substance-dependent patients, a second goal was formulated, the psychometric evaluation of the SIDP-IV. This instrument appeared to be reliable

and valid for the use in opioid-dependent patients and can preferable be combined with the Interpersonal Checklist-revised, in order to give direction to the treatment of both the PD and personality pathology. After this evaluation, we started of searching for the personality of opioid-dependent patients, by the administration of the SIDP-IV in a large sample of patients in three facilities for addiction care in the Netherlands. Did we find the person behind the addiction? The question can be answered with a yes and a no. We did not find "the person" behind the addiction, for patients appear to display a wide variety of feelings, thoughts, and behavioural patterns. These aspects of personality could not be predicted by other patient characteristics such as employment status, severity of drug-abuse, treatment history, age, socio-economic status, etcetera. What we did find were methodologies and recommendations on how to make a fairly good portrait of the person, in an efficient way, which fits the patient's situation, motivational phase and treatment goals.

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Figure 1:
Decision tree PD assessment procedures

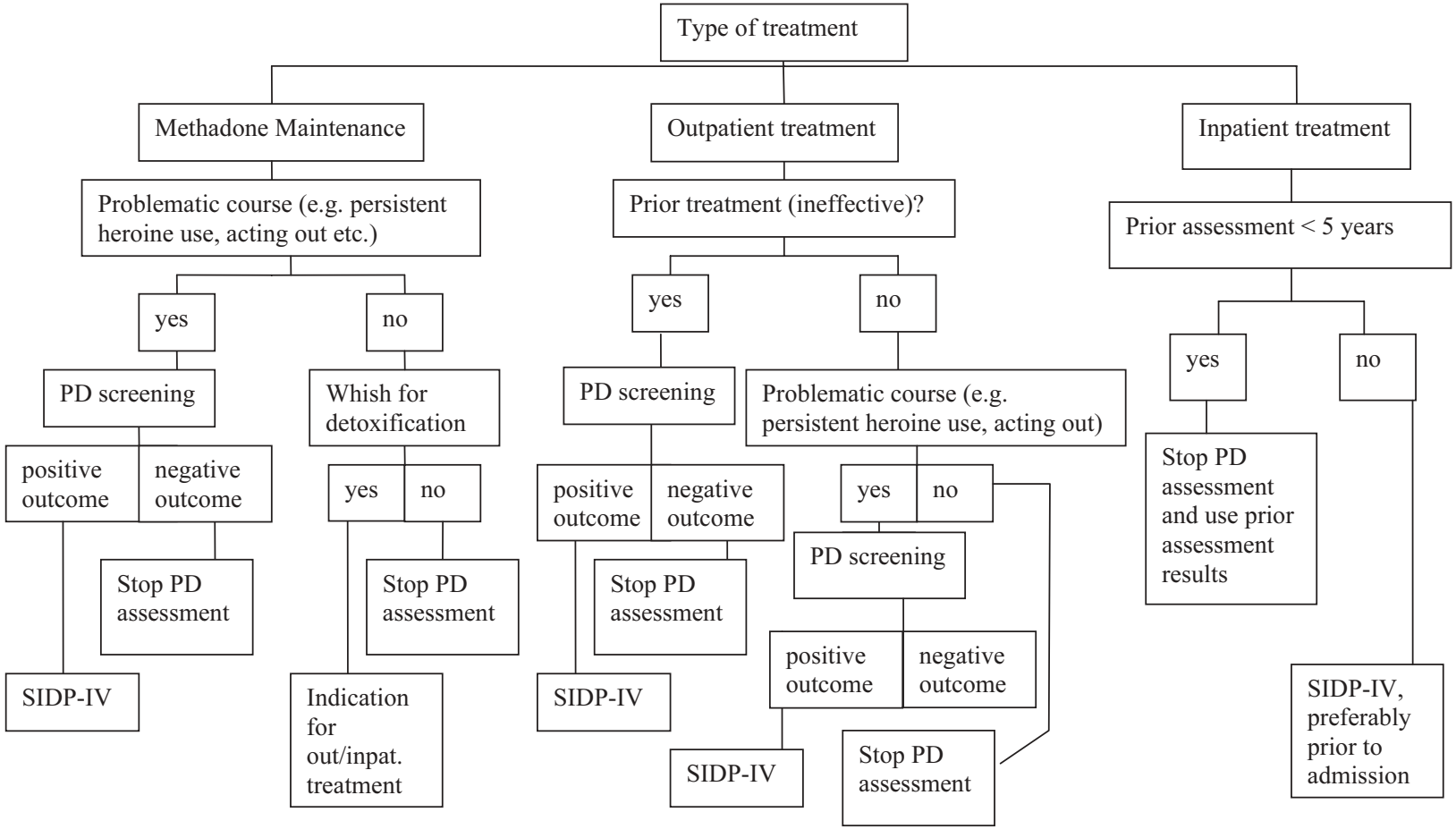

Table 1.
Criteria sets in each of the PD screening interviews

IPDS	SAPAS	Damen & DeJong screener
Marked shifts in mood	Difficulty making and keeping friends	Is inhibited in new interpersonal situation because of feelings of inadequacy
Uncomfortable when not in the centre of attention	Usually a loner	Failure to conform to social norms with respect to lawful behaviors
Actions directed toward immediate satisfaction	Normally loses temper easily	Inappropriate intense anger or difficulty controlling anger
Reluctant to confide in others	Trusting others	Reckless disregard for the safety of self or others
Excessive social anxiety	Normally impulsive	Impulsivity or failure to plan ahead
Unwilling to get involved unless certain of being liked	Normally a worrier	Is pessimistic
Lack of stable image	Depends on others a lot	Frantic efforts to avoid real or imagined abandonment
Prone to overemphasize importance	Generally a perfectionist	
Expects to be exploited or harmed by others		
Bears grudges or is unforgiving of insults		
Insensitive to concerns of others		

Appendix: SIDP-IV•

- De SIDP-IV vragenlijst is verkrijgbaar bij Dr. C.A.J. De Jong. Schijndelseweg 46. 5491 TB St. Oedenrode. Tel: 0413-485858
- De “Damen en deJong screener” is verkrijgbaar bij drs. K.F.M. Damen en Dr. C.A.J. De Jong Schijndelseweg 46. 5491 TB St. Oedenrode. Tel: 0413-485858
- Het software pakket voor de SIDP-IV, inclusief scoringsprogramma, verslagleggingsprogramma en positief geformuleerde patiënten informatie brochures.zijn verkrijgbaar bij Dr. C.A.J. De Jong en drs. K.F.M. Damen Schijndelseweg 46, 5491 TB St. Oedenrode. Tel: 0413-485858
- SIDP-IV trainingen worden verzorgd door Dr. C.A.J. De Jong en drs. K.F.M. Damen. Schijndelseweg 46, 5491 TB St. Oedenrode. Tel: 0413-485858

Inleiding op het SIDP-IV interview

Ik ga u een aantal vragen stellen over wat u doet en denkt in allerlei normale en alledaagse situaties. Ik wil graag weten hoe u zich gedraagt als u in uw normale doen bent.
De bedoeling is om inzicht te krijgen in wat men zo noemt 'de aard van het beestje'.
We zullen daarbij spreken over uw eigenaardigheden, onaardigheden maar zeker ook over uw aardigheden. Als er net op dit moment met u iets bijzonders aan de hand is - bijvoorbeeld als u net bent opgenomen, of ziek bent, of er is net iets bijzonders gebeurd - dan moet u bij het antwoorden ervan uit gaan hoe u zich in normale omstandigheden zou gedragen.

De vragen staan allemaal in dit boekje. We zullen dat helemaal door werken. U kunt er vanuit gaan dat de gegevens vertrouwelijk behandeld zullen worden.

Indien contact zal worden opgenomen met een informant:

Om te beginnen wil ik uw toestemming vragen om contact op te nemen met iemand die u goed kent en die mij iets kan vertellen over wat voor iemand u bent. Ik zal hem of haar een aantal van de vragen uit dit boekje stellen. Meestal kost dat z'n 15 a 20 minuten tijd, en ook over dat gesprek zal ik met niemand praten. Wie zou mij iets kunnen vertellen over wat voor persoon u bent? U kunt er vanuit gaan dat de gegevens vertrouwelijk behandeld zullen worden.

Vul hier de naam van de informant in _____

Richtlijnen voor scoring:

0. Niet aanwezig of beperkt tot zeldzame, incidentele voorbeelden.

1. Bijna aanwezig – enige aanwijzingen voor de trek, maar deze zijn niet voldoende overheersend of ernstig om het criterium aanwezig te achten.

2. Aanwezig – het criterium is duidelijk aanwezig, voor het grootste deel van de laatste vijf jaar (d.w.z. aanwezig tenminste 50% van de tijd, gedurende de laatste vijf jaar).

3. Sterk aanwezig – het criterium is geassocieerd met subjectief lijden of met enige beperkingen in het sociaal of beroepsmatig functioneren, of in intieme relaties.

SECTIE A: INTERESSES EN BEZIGHEDEN

In het eerste deel van het interview zal ik u vragen stellen over belangstellingen, bezigheden en hobby's. Denk eraan dat het erom gaat hoe u zich gedraagt als u in uw gewone doen bent.

---

1. Beleeft weinig of geen genoegen aan activiteiten **4-SZOID** **0 1 2 3**

Kunt u mij een aantal dingen noemen die u plezierig vindt om te doen? Hoe brengt u uw vrije tijd door?

(Indien patiënt slechts één of twee activiteiten noemt):

- Als u om de een of andere reden niet kunt ..... of .....(noem de aangegeven activiteiten), wat doet u dan graag?

---

2. Kiest vrijwel altijd activiteiten die alleen gedaan worden **2-SZOID** **0 1 2 3**

---

* Sommige mensen doen graag dingen samen met anderen, maar er zijn ook mensen die liever dingen alleen doen. Wat bent u voor iemand?

(Indien liever alleen):

- Kiest u er bijna altijd voor om dingen alleen te doen?

---

3. Is uitzonderlijk onwillig om persoonlijke risico's te nemen of betrokken te raken bij nieuwe activiteiten omdat deze hem of haar in verlegenheid zouden kunnen brengen **7-AVOID** **0 1 2 3**

Bent u iemand die graag iets nieuws wilt proberen of houdt u het liever bij het oude?

(Indien bij het oude):

- Houdt u het bij het oude omdat u bang bent dat anderen iets nieuws misschien raar zullen vinden?
- Komt dat vaak voor?

(Indien vaak):

- Kunt u mij daarvan een paar voorbeelden geven?

---

4. **Kan moeilijk alledaagse beslissingen nemen zonder overdreven veel advies en geruststelling door anderen** **1-DEPEN** **0 1 2 3**

Sommige mensen hebben er plezier in om zelf beslissingen te nemen. Anderen hebben liever dat iemand hen zegt wat ze moeten doen. Waar geeft u de voorkeur aan?

* Overlegt u vaak met een ander over alledaagse beslissingen, zoals wat u zal eten of wat voor soort kleren u zal kopen?

5. **Heeft anderen nodig die de verantwoordelijkheid overnemen voor de meeste belangrijke gebieden van zijn of haar leven** **2-DEPEN** **0 1 2 3**

Bent u iemand die er behoefte aan heeft dat een ander voor u belangrijke beslissingen neemt?
(Indien ja):
- Laat u anderen dan ook werkelijk de beslissingen nemen?
- Wat weerhoudt u ervan om dat soort beslissingen zelf te nemen?

6. **Heeft moeilijkheden ergens alleen aan te beginnen of dingen alleen te doen (eerder als gevolg van een gebrek aan zelfvertrouwen in eigen oordeel of mogelijkheden dan uit gebrek aan motivatie)** **4-DEPEN** **0 1 2 3**

Hebt u meestal de hulp of een zetje van een ander nodig om met iets nieuws te beginnen, of om dingen zelfstandig aan te pakken?
(Indien ja):
- Waar komt dat door?

(Indien hij/zij niet weet waar dat door komt):
- Komt dat misschien doordat u denkt dat u het niet kunt?

---

7. **Heeft zich een stijl van gierigheid eigen gemaakt ten aanzien van zichzelf en anderen; geld wordt gezien als iets dat opgepot moet worden voor toekomstige catastrofes** **7-OBCMP** **0 1 2 3**

Waar geeft u graag uw geld aan uit als u uw noodzakelijke rekeningen heeft betaald? Vindt u het moeilijk geld uit te geven aan leuke dingen voor uzelf? Vindt u het moeilijk geld uit te geven voor anderen?

* Sommige mensen zijn bezorgd dat er in de toekomst iets vreselijks zal gebeuren en bewaren daarom zoveel mogelijk geld voor moeilijke tijden. Hebt u dat ook?
(Indien ja):
- Kunt u me daar iets meer over vertellen?

GA NAAR SECTIE B ALS U DE FACULTATIEVE DIAGNOSE <u>ZELFONDERMIJNENDE PERSOONLIJKHEIDSSTOORNIS</u> WENST OVER TE SLAAN

8. **Wijst mogelijkheden om plezier te hebben af, of wil niet graag toegeven ergens plezier in te hebben; de betrokkene heeft wel voldoende sociale vaardigheden en heeft de mogelijkheden plezier te hebben** **5-SLFDF** **0 1 2 3**

Als u de mogelijkheid krijgt om iets leuks te doen, is het dan moeilijk voor u ervan te genieten?

Vindt u het moeilijk toe te geven dat u ergens plezier aan hebt beleefd?

(Indien ja op een van beiden):
- Bent u altijd zo geweest?
- Wat weerhoudt u ervan om ergens plezier aan te beleven?
- Gebeurt het vaak dat u de kans niet grijpt om plezier te hebben?

Richtlijnen voor scoring:

0. Niet aanwezig of beperkt tot zeldzame, incidentele voorbeelden.

1. Bijna aanwezig – enige aanwijzingen voor de trek, maar deze zijn niet voldoende overheersend of ernstig om het criterium aanwezig te achten.

2. Aanwezig – het criterium is duidelijk aanwezig, voor het grootste deel van de laatste vijf jaar (d.w.z. aanwezig tenminste 50% van de tijd, gedurende de laatste vijf jaar).

3. Sterk aanwezig – het criterium is geassocieerd met subjectief lijden of met enige beperkingen in het sociaal of beroepsmatig functioneren, of in intieme relaties.

SECTIE B: MANIER VAN WERKEN

De volgende vragen gaan over de manier waarop u uw werk doet. Het doet er niet toe of dat een betaalde baan is, of vrijwilligerswerk, of huishoudelijk werk.

---

1. Is overmatig toegewijd aan werk en productiviteit met uitsluiting van ontspannende bezigheden en vriendschappen, niet te verklaren door een duidelijke economische noodzaak **3-OBCMP** **0 1 2 3**

---

* Zou u zichzelf een 'workaholic' noemen? (Alternatief: iemand die 'verslaafd' is aan werken)?

Hebben anderen er wel eens over geklaagd dat u zoveel werkt?

(Indien ja op een van beide):
- Besteedt u zoveel tijd aan uw werk dat er geen tijd meer over blijft om met uw familie of vrienden door te brengen, of om andere leuke dingen te doen?

---

2. Vermijdt beroepsmatige activiteiten die belangrijke intermenselijke contacten met zich meebrengen vanwege de vrees voor kritiek, afkeuring of afwijzing **1-AVOID** **0 1 2 3**

Geeft u de voorkeur aan werk waarbij u veel in contact komt met andere mensen, of werkt u liever alleen?
(Indien 'alleen'):
- Waarom werkt u liever alleen?

(Indien hij/zij niet weet waarom):
- Bent u misschien bang dat anderen kritiek op u zullen hebben of u zullen afwijzen?

Is het ooit voorgekomen dat u een andere baan afwees omdat u in die baan meer contact zou krijgen met andere mensen?
(Indien ja):
- Waarom deed u dat toen?

---

3. Exploiteert anderen, dat wil zeggen maakt misbruik van anderen om zijn of haar eigen doeleinden te bereiken **6-NARCI** **0 1 2 3**

Lukt het u meestal wel om anderen zover te krijgen dat ze doen wat u graag wil?
(Indien ja):
- Hoe krijgt u dat voor elkaar?
- Doet u wel eens net alsof u iemand aardig vindt zodat hij of zij iets voor u doet?

Hebt u wel eens iemand gebruikt omdat dat de enige manier was om te krijgen wat u nodig had of waar u recht op had?
(Indien ja):

- Kunt u die situatie beschrijven?
- Hoe vaak hebt u zo iets gedaan?

* Staat u er bij anderen om bekend dat u zorgt dat u krijgt wat u wil, ook al gaat dat ten koste van anderen?

---

4. Toont perfectionisme dat het afmaken van een taak bemoeilijkt (bijvoorbeeld onvermogen iets af te maken omdat het niet aan eigen overtrokken eisen voldoet) **2-OBCMP** **0 1 2 3**

Vinden andere mensen u een perfectionist (Alternatief: 'pietje precies')?

Vindt u zichzelf een perfectionist (of: een 'pietje precies')?

(Indien ja op één van beide):
- Hoe vaak komt het voor dat u iets niet op tijd af hebt omdat u zulke hoge eisen stelt?
- Kunt u mij daarvan voorbeelden geven?

---

5. Is onwillig taken te delegeren of om met anderen samen te werken, tenzij deze zich geheel onderwerpen aan zijn of haar manier van werken **6-OBCMP** **0 1 2 3**

---

* Draait het er vaak op uit dat u allerlei werkzaamheden zelf maar doet omdat iemand anders het toch niet zou doen op de manier die u graag wil?

Neemt u vaak taken van andere mensen over om er zeker van te zijn dat het werk goed gedaan wordt?

(Indien ja):
- Kunt u mij daarvan een voorbeeld geven?

---

6. Is gepreoccupeerd met details, regels, lijsten, ordening, organisatie of schema's, hetgeen zover gaat dat het eigenlijke doel uit het oog verloren wordt **1-OBCMP** **0 1 2 3**

---

* Komt het voor dat u zo bezig bent met details dat u de grote lijn van waar u mee bezig bent uit het oog verliest? (Alternatief: Door de bomen het bos niet meer zien)
(Indien ja):
- Kunt u mij daarvan een voorbeeld geven?

Bent u vaak zolang bezig om te bedenken hoe u het werk moet aanpassen dat u er moeite mee heeft om het werk af te krijgen?

Bent u iemand die lijstjes maakt van dingen die u moet doen?
(Indien ja):
- Hebben anderen wel eens gezegd dat u daar teveel tijd aan besteedt?

GA NAAR SECTIE C ALS U DE FACULTATIEVE DIAGNOSES OVERSLAAT

7. Verzet zich passief tegen het vervullen van alledaagse en beroepsmatige taken. **1-NEGTV** **0 1 2 3**

Als mensen er genoeg van krijgen om gewoon maar hun dagelijkse dingen te doen, bijvoorbeeld thuis of op hun werk dan proberen ze daar onderuit te komen. Bijvoorbeeld door een smoes te verzinnen, of door net te doen of ze het vergeten zijn, of door met opzet te treuzelen. Komt dat ook bij u wel eens voor?
(Indien ja):
- Hebben andere mensen daar wel eens iets van gezegd?

8. Slaagt er niet in taken te volbrengen die essentieel zijn voor persoonlijke belangen ondanks aangetoonde capaciteiten dat wel te kunnen; (helpt bijvoorbeeld met succes medestudenten met het schrijven van een scriptie maar kan het niet voor zichzelf) **6-SLFDF** **0 1 2 3**

Sommige mensen zijn heel goed in staat om iets voor een ander te doen, maar kunnen het niet voor zichzelf te doen. Ze doen bijvoorbeeld het werk voor iemand anders maar krijgen hun eigen werk niet af. Hebt u dat ook wel eens?
(Indien ja):
- Kunt u mij daarvan een voorbeeld geven?

Maakt u vaak plannen waarvan de uitvoering mislukt, terwijl u het best wel zou kunnen uitvoeren?
(Indien ja):
- Kunt u mij daarvan een voorbeeld geven?
- Wat lijkt het in de weg te staan?

9. Wijst pogingen van anderen af hem/haar te helpen of ondermijnt die pogingen **2-SLFDF** **0 1 2 3**

* Vindt u het moeilijk om de hulp van anderen te aanvaarden, zelfs als u weet dat u hulp nodig heeft?
(Indien ja):
- Laat u zichzelf dan meestal toch helpen?
- Kunt u daar een voorbeeld van geven?

Als u iemand anders toestaat om u te helpen, merkt u dan dat u zichzelf ervan probeert te overtuigen dat het ondanks die hulp toch niet zal lukken?
(Indien ja):
- Vertelt u daar eens iets meer over?

Richtlijnen voor scoring:

0. Niet aanwezig of beperkt tot zeldzame, incidentele voorbeelden.

1. Bijna aanwezig – enige aanwijzingen voor de trek, maar deze zijn niet voldoende overheersend of ernstig om het criterium aanwezig te achten.

2. Aanwezig – het criterium is duidelijk aanwezig, voor het grootste deel van de laatste vijf jaar (d.w.z. aanwezig tenminste 50% van de tijd, gedurende de laatste vijf jaar).

3. Sterk aanwezig – het criterium is geassocieerd met subjectief lijden of met enige beperkingen in het sociaal of beroepsmatig functioneren, of in intieme relaties.

SECTIE C: HECHTE RELATIES

Dit deel van het interview gaat over de relatie met uw vrienden en familieleden. Ik wil u er nog eens aan herinneren dat ik er in ben geïnteresseerd hoe u bent als u in uw gewone doen bent.

---

1. Heeft noch behoefte aan, noch plezier in hechte relaties, inclusief het tot een gezin of familie behoren — **1-SZOID** **0 1 2 3**

---

* Heeft u een goed contact met uw familie of met vrienden?
(Indien ja):
- Wat vindt u plezierig aan deze relaties?

(Indien nee):
- Zou u graag een hechte relatie met uw familie of met vrienden willen hebben?

---

2. Heeft geen intieme vrienden of vertrouwelingen buiten eerstegraads familieleden — **5-SZOID** **0 1 2 3**; **8-STYPL** **0 1 2 3**

Als u uw familie niet meetelt heeft u vrienden in wie u vertrouwen stelt?

---

3. Toont gereserveerdheid binnen intieme relaties uit vrees vernederd of uitgelachen te worden — **3-AVOID** **0 1 2 3**

Vermijdt u te zeggen wat u denkt of voelt omdat u bang bent dat anderen u dan niet serieus zullen nemen?
(Indien ja):
- Heeft u dat ook bij familieleden of vrienden?

---

4. Vindt het moeilijk een verschil van mening tegen anderen te uiten uit vrees steun of goedkeuring te verliezen; (NB: reken hier niet toe de realistische vrees voor vergelding) — **3-DEPEN** **0 1 2 3**

Hoe moeilijk is het voor u om te laten merken dat u het ergens mee oneens bent?
(Indien ja):
- Waar bent u bang voor in een dergelijke situatie?

* Doet u vaak net of u het ergens mee eens bent zodat andere mensen u aardig zullen vinden en niet afwijzen?

---

5. Een patroon van instabiele en intense intermenselijke relaties gekenmerkt door wisselingen tussen overmatig idealiseren en devalueren — **2-BORDL** **0 1 2 3**

Zijn uw relaties met vrienden en partners in het algemeen intens en stormachtig, met veel hoogte- en dieptepunten?

* Bent u iemand die het ene moment andere mensen erg kan bewonderen, maar het andere moment dezelfde mensen weer snel kan laten vallen.
(Indien ja):
- Komt dat vaker voor?

---

6. Is op een onrealistische wijze gepreoccupeerd met de vrees aan zichzelf te worden overgelaten **8-DEPEN** **0 1 2 3**

Bent u bang dat andere mensen u wel eens in de steek zouden kunnen laten?
(Indien ja):
- Komt het wel eens voor dat u nergens anders meer aan kunt denken dan hierover?
- Waarom bent u daar zo bang voor?
- Bent u bang dat u niet voor uzelf kunt zorgen?

---

7. Krampachtig proberen te voorkomen om feitelijk of vermeend in de steek gelaten te worden; (NB: reken hier niet het suïcidale of automutilerend gedrag toe, aangegeven in criterium 5-BORDL) **1-BORDL** **0 1 2 3**

Is het wel eens voorgekomen dat u helemaal overstuur was omdat u dacht dat iemand anders bij u weg zou kunnen gaan?
(Indien ja):
- Wat hebt u gedaan om te voorkomen dat de ander weg zou gaan?

(Indien hij/zij alleen suïcidale neigingen of automutilatie noemt):
- Hebt u nog andere dingen gedaan om te zorgen dat ze niet zouden weggaan?

Bent u er veel mee bezig om te bedenken hoe u er voor kunt zorgen dat andere mensen niet bij u weg gaan?

---

8. Zoekt hardnekkig naar een andere relatie als een bron van verzorging en steun als een intieme relatie tot een einde komt **7-DEPEN** **0 1 2 3**

Hoe reageert u als een hechte vriendschap of een relatie eindigt?

Probeert u dan koste wat kost een nieuwe relatie krijgen, ook als u dat die niet de beste keuze is?
(Indien ja):
- Waarom doet u dat?

---

9. Is terugkerend achterdochtig, zonder rechtvaardiging, betreffende de trouw van de echtgenoot of partner **7-PARND** **0 1 2 3**

Maakt of maakte u zich er vaak zorgen over dat uw partner u niet trouw was?
(Indien dit wel eens voor kwam):
- Was er een bepaalde reden om dat te denken?
- Hebt u wel eens kunnen bewijzen dat u gelijk had?

10. Heeft weinig of geen belangstelling voor seksuele ervaringen met een ander **3-SZOID** **0 1 2 3**

Is seksueel contact in het algemeen belangrijk voor u, of zou u net zo goed zonder seks kunnen?
(Indien hij/zij zegt dat seks niet belangrijk is of dat hij/zij op dit moment geen seksuele relatie heeft):
- Zou u het vervelend vinden de rest van uw leven geen seksuele relaties te hebben?

GA NAAR SECTIE D ALS U DE FACULTATIEVE DIAGNOSES OVERSLAAT

11. Zoekt mensen en situaties op die leiden tot teleurstelling, mislukking of mishandeling zelfs als er duidelijk betere alternatieven mogelijk zijn **1-SLFDF** **0 1 2 3**

Lijkt het er op alsof u zichzelf, vaak zonder het te willen, in situaties begeeft waarin u slecht behandeld zult worden? (Alternatief: Lijkt het soms wel of u narigheid aantrekt?)
(Indien ja):
- Kunt u mij daarvan een voorbeeld geven?
- Gebeurt dat vaker?
- Waarom is het moeilijk voor u om zulke situaties te vermijden?

* Is het wel eens net of u op de een of andere manier altijd mensen treft die u na verloop van tijd teleurstellen of in de steek laten?
(Indien ja):
- Kunt u mij daarvan een voorbeeld geven?

Heeft u wel eens een slechte relatie opgegeven om een andere aan te gaan die uiteindelijk net zo slecht bleek te zijn? Heeft u het gevoel dat u telkens de verkeerde partijen treft.
(Indien ja):
- Is dat vaker voor gekomen?

12. Is niet geïnteresseerd in mensen die hem/haar altijd goed behandelen of wijst ze af; voelt zich bijvoorbeeld niet aangetrokken tot een zorgzame echtgenoot of partner **7-SLFDF** **0 1 2 3**

Hoe vindt u het als mensen goed voor u zorgen? (Overkomt het u weleens dat u beter behandeld wordt dan u denkt dat u verdient?

Heeft u er moeite mee in contact te blijven met mensen die u beter behandelen dan u denkt dat u eigenlijk verdient?
(Indien ja):
- Hoe vaak is dat voor gekomen?

Richtlijnen voor scoring:

0. Niet aanwezig of beperkt tot zeldzame, incidentele voorbeelden.

1. Bijna aanwezig – enige aanwijzingen voor de trek, maar deze zijn niet voldoende overheersend of ernstig om het criterium aanwezig te achten.

2. Aanwezig – het criterium is duidelijk aanwezig, voor het grootste deel van de laatste vijf jaar (d.w.z. aanwezig tenminste 50% van de tijd, gedurende de laatste vijf jaar).

3. Sterk aanwezig – het criterium is geassocieerd met subjectief lijden of met enige beperkingen in het sociaal of beroepsmatig functioneren, of in intieme relaties.

SECTIE D: SOCIALE CONTACTEN

De volgende vragen gaan over wat u denkt en doet in situaties waarbij andere mensen zijn betrokken.

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1. Ziet zichzelf als sociaal onbeholpen en voor anderen onaantrekkelijk of minderwaardig **6-AVOID** **0 1 2 3**

Wat vindt u van de manier waarop u met andere mensen omgaat?

Zelfs als u op uw best bent heeft u dan toch het gevoel dat anderen het niet leuk vinden om met u om te gaan?

---

2. Voelt zich niet op zijn/haar gemak in situaties waarin hij/zij niet in het middelpunt van de belangstelling staat **1-HISTR** **0 1 2 3**

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* Sommige mensen staan graag in het middelpunt van de belangstelling, anderen houden zich liever afzijdig. Wat bent u voor iemand?
(Indien in het middelpunt van de belangstelling):
- Hoe voelt het om niet in het middelpunt van de belangstelling te staan?

---

3. De interactie met anderen wordt vaak gekenmerkt door ongepast seksueel verleidelijk of uitdagend gedrag **2-HISTR** **0 1 2 3**

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* Staat u bij andere mensen bekend als een 'charmeur' of als iemand die zich verleidelijk gedraagt?

Komt het wel eens voor dat u alleen maar vriendelijk probeert te zijn en dat de ander dan denkt dat u haar (hem) probeert te versieren?
(Indien ja):
- is dat vaker voorgekomen?

F NB: LET OOK OP HET GEDRAG TIJDENS HET INTERVIEW

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4. Maakt voortdurend gebruik van het eigen uiterlijk om de aandacht op zichzelf te vestigen **4-HISTR** **0 1 2 3**

Heeft u de indruk dat het voor u belangrijker is dan voor anderen mannen/vrouwen van uw leeftijd dat u met uw uiterlijk opvalt?

Hoe vaak probeert u door uw uiterlijk de aandacht van andere mensen te trekken?
(Indien vaak):
- Hoe doet u dat?

Bent u teleurgesteld wanneer mensen geen aandacht schenken aan hoe u er uit ziet?

FNB: LET OOK OP HET UITERLIJK TIJDENS HET INTERVIEW

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5. Gelooft dat hij of zij 'heel speciaal' en uniek is en alleen begrepen kan worden door, of hoort om te gaan, met andere heel speciale mensen (of instellingen) met een hoge status **3-NARCI** **0 1 2 3**

Sommige mensen zijn zo creatief en bijzonder dat ze maar moeilijk andere mensen kunnen vinden die net als zijzelf de moeite waard zijn om mee om te gaan. Hebt u dat ook?
(Indien ja):
- Wat voor soort mensen is in staat u te begrijpen, of met wat voor soort mensen zou u bevriend kunnen zijn?

---

6. Is in nieuwe intermenselijke relaties geremd vanwege het gevoel tekort te schieten **5-AVOID** **0 1 2 3**

Heeft u meer moeite dan de meeste mensen met het voeren van een gesprek met mensen die u net ontmoet?
(Indien ja):
- Wat maakt het zo moeilijk?

(Indien hij/zij het niet weet):
- Komt het misschien omdat u denkt dat u in het contact met anderen toch tekort schiet?

Bent u vaak verlegen en stil in sociale situaties die nieuw voor u zijn?

---

7. Buitensporige sociale angst die niet afneemt in een vertrouwde omgeving en die eerder de neiging heeft samen te gaan met paranoïde angst dan met een negatief oordeel over zichzelf **9-STYPL** **0 1 2 3**

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* Voelt u zich in het algemeen slecht op uw gemak in het gezelschap van andere mensen?
(Indien ja):
- Hebt u daar erge last van?
- Bent u dan gespannen omdat u zich zorgen maakt over wat die mensen van u willen, of omdat u denkt dat u de mindere bent?
- Gaat dit over als u die mensen na een tijdje beter kent?

---

8. Heeft onwil om bij mensen betrokken te raken, tenzij er zekerheid bestaat dat men hem/haar aardig vindt **2-AVOID** **0 1 2 3**

Hoe vaak komt het voor dat u het uit de weg gaat mensen te leren kennen omdat u denkt dat ze u niet mogen?
(Indien vaak):
- Heeft dit invloed op het aantal van uw vrienden?

---

9. Neemt anderen met tegenzin in vertrouwen, op grond van de ongegronde vrees dat de informatie op een kwaadaardige manier tegen hem/haar gebruikt zal worden **3-PARND** **0 1 2 3**

Denkt u dat het maar het beste is als andere mensen u niet al te goed leren kennen?
(indien ja):
- Waarom denkt u dit?

---

10. Heeft gebrek aan empathie: is niet bereid de gevoelens en behoeften van anderen te erkennen of zich ermee te vereenzelvigen **7-NARCI** **0 1 2 3**

Hoe vindt u het als andere mensen u vertellen wat voor problemen ze allemaal hebben?

* Kunt u goed inschatten hoe een ander zich voelt?
(Indien nee):
- Heeft dat u wel eens problemen opgeleverd?

Hebben andere mensen wel eens gezegd dat u niet echt meeleeft met hun problemen?

---

11. Verlangt buitensporige bewondering **4-NARCI** **0 1 2 3**

Vindt u het belangrijk dat uw vrienden u waarderen. Zijn er ook redenen waarom u bewonderd zou kunnen worden?

Voelt u zich wel eens onbegrepen en gekwetst omdat u niet de waardering en bewondering krijgt die u volgens u verdient?

---

12. Is gepreoccupeerd met de gedachte in sociale situaties bekritiseerd of afgewezen te worden **4-AVOID** **0 1 2 3**

Maakt u er zich wel eens zorgen over dat anderen kritiek op u zouden kunnen hebben of dat ze u afwijzen?
(Indien vaak/veel):
- Kunt u die gedachte dan gemakkelijk van u af zetten?

13. Lijkt ongevoelig voor lof of kritiek van anderen **6-SZOID** **0 1 2 3**

* Hoe reageert u als anderen kritiek op u hebben?
(Indien hij/zij niet reageert):
- Dus dat raakt u niet?

* Hoe reageert u als anderen u een compliment maken?
Denkt u daar graag nog aan terug?

14. Beschouwt relaties als meer intiem dan deze in werkelijkheid zijn **8-HISTR** **0 1 2 3**

Voelt u snel een hechte band met mensen die u nog niet zo lang kent?
(Indien ja):
- Komt dat vaker voor?

* Voelt u zich weleens gekwetst omdat volgens de anderen de relatie minder hecht vinden dan u?

Hebt u vaak het gevoel dat u een heel persoonlijk contact hebt met uw baas of collega's terwijl u die mensen eigenlijk nog niet zo lang kent?
(Indien ja):
- Kunt u mij daarvan een voorbeeld geven?

15. Gaat tot het uiterste om verzorging en steun van anderen te krijgen, kan zelfs aanbieden vrijwillig dingen te doen die onplezierig zijn **5-DEPEN** **0 1 2 3**

Doet u zichzelf wel eens tekort door dingen voor anderen te doen in de hoop dat zij u zullen helpen als dat nodig is?
(Indien ja):
- Biedt u wel eens vrijwillig aan dingen te doen die u eigenlijk onplezierig vindt, omdat u hoopt dat anderen dan ook goed voor u zullen zijn?

GA NAAR SECTIE E ALS U DE FACULTATIEVE DIAGNOSES OVERSLAAT

16. Klaagt niet begrepen en niet gewaardeerd te worden door anderen **2-NEGTV** **0 1 2 3**

* Klaagt u er vaker bij anderen over dat mensen u niet begrijpen of waarderen?
(Indien ja):
- Hoe reageren ze daar dan op?

---

17. Heeft onredelijk kritiek op en veracht autoriteiten **4-NEGTV** **0 1 2 3**

Iedereen heeft wel eens te maken met mensen die het ergens voor het zeggen hebben, zoals bijvoorbeeld artsen, leraren, of werkgevers. Vindt u dat die mensen u in het algemeen goed behandeld hebben?
(Indien nee):
- Bent u iemand die snel kritiek heeft op zijn bazen of leraren? Kunt u mij daarvan een voorbeeld geven?

Heeft u een hekel aan de meeste bazen en leraren die u in uw leven bent tegen gekomen?

Richtlijnen voor scoring:

0. Niet aanwezig of beperkt tot zeldzame, incidentele voorbeelden.

1. Bijna aanwezig – enige aanwijzingen voor de trek, maar deze zijn niet voldoende overheersend of ernstig om het criterium aanwezig te achten.

2. Aanwezig – het criterium is duidelijk aanwezig, voor het grootste deel van de laatste vijf jaar (d.w.z. aanwezig tenminste 50% van de tijd, gedurende de laatste vijf jaar).

3. Sterk aanwezig – het criterium is geassocieerd met subjectief lijden of met enige beperkingen in het sociaal of beroepsmatig functioneren, of in intieme relaties.

SECTIE E: EMOTIES

Ik wil u nu een paar vragen stellen over uw gevoelens of emoties.

1. Toont dramatiserende, theatrale en overdreven uitingen van emoties **6-HISTR** **0 1 2 3**

Sommige mensen laten hun gevoelens gemakkelijk zien. Zij huilen bij huwelijken, omhelzen mensen, laten zien dat ze bang, boos of vrolijk zijn. Bent u iemand die gemakkelijker dan andere mensen zijn gevoelens uit, of juist moeilijker?
(Indien gemakkelijker):
- Heeft dat u wel eens in moeilijkheden gebracht? Bijvoorbeeld dat u zich opgelaten voelde over de manier waarop u zich uitte.

Hebben mensen wel eens opmerkingen gemaakt over de manier waarop u uw gevoelens uit?
(Indien ja):
- Wat zeiden ze daar dan over?
- Bent u het daar mee eens?

NB: LET OOK OP UITINGEN VAN EMOTIES TIJDENS HET INTERVIEW

2. Toont snel wisselende en oppervlakkige emotionele uitingen **3-HISTR** **0 1 2 3**

* Veranderen uw emoties en gevoelens snel?
(Indien ja):
- Hebt u dat altijd al gehad?
- Valt dat andere mensen op?

Hebben mensen wel eens tegen u gezegd dat uw gevoelens niet echt of oprecht over komen?
(Indien ja):
- kunt u daar meer over vertellen?

3. Voelt zich onbehaaglijk of hulpeloos wanneer hij/zij alleen is, vanwege de overmatige vrees niet in staat te zijn voor zichzelf te zorgen **6-DEPEN** **0 1 2 3**

Hoe voelt u zich als u alleen bent?
(Indien onprettig):
- Waar heeft u last van als u alleen bent?
- Bent u weleens bang dat u niet voor uzelf kunt zorgen?

Indien ja:

- Hoe bedoelt u dat?

---

4. Affectlabiliteit als gevolg van duidelijke reactiviteit van de stemming (bijvoorbeeld periodes van intense somberheid, prikkelbaarheid of angst meestal enkele uren durend en slechts zelden langer dan een paar dagen) **6-BORDL** **0 1 2 3**

Heeft u ooit gemerkt dat uw stemming snel wisselt bijvoorbeeld van somber naar normaal, naar boos, naar angstig en dat allemaal op één dag?
(Indien ja):
- Zijn dat kleine stemmingswisselingen of grote?
- Is er altijd een aanleiding voor die wisseling van stemming?
- Hoe vaak gebeurt dat gemiddeld per week?
- Hoe lang duren die stemmingswisselingen?

Hebben mensen wel eens tegen u gezegd dat u zich snel ergert of dat uw stemming vaak wisselt?
(Indien ja):
- Kunt u daar meer over vertellen?

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5. Chronisch gevoel van leegte **7-BORDL** **0 1 2 3**

Voelt u zich vaak leeg of verveeld?
(Indien ja):
- Hoe vaak?
- Duurt dat dan lang?

GA NAAR SECTIE F ALS U DE FACULTATIEVE DIAGNOSES OVERSLAAT

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6. De gebruikelijke stemming wordt gekenmerkt door neerslachtigheid, zwaarmoedigheid, gebrek aan vrolijkheid, vreugdeloosheid **1-DEPRS** **0 1 2 3**

Hoe is uw stemming in het algemeen?
(Indien onduidelijk):
- Is het gemakkelijk om u aan het lachen te krijgen?

Voelt u zich vaak teneer geslagen of ongelukkig? (Alternatief: down of rot)
(Indien disfoor):
- Vanaf welke leeftijd voelt u zich zo?
- Was dat alleen maar in tijden dat u zich echt depressief en anders dan normaal voelde?

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7. Is geneigd zich schuldig of berouwvol te voelen **7-DEPRS** **0 1 2 3**

Voelt u zich snel schuldig of verantwoordelijk als er iets mis gaat?
Indien ja:
- Hebt u dat ook als andere mensen u zeggen dat u er helemaal niets aan kunt doen?

Hebben mensen wel eens tegen u gezegd dat u zich gemakkelijk verontschuldigt voor iets dat fout gaat, ook al is het helemaal niet uw schuld? Bent u het daar mee eens?

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8. Is kritisch, zichzelf beschuldigend of geringschattend over zichzelf **3-DEPRS** **0 1 2 3**

Zeggen andere mensen weleens tegen u dat u zichzelf te snel de schuld geeft van dingen die verkeerd gaan?

Bent u iemand die zichzelf snel naar beneden haalt en zichzelf bekritiseert?

F NB: GEBRUIK OOK DE ANTWOORDEN OP HET VOORGAANDE ITEM 7 OM DIT ITEM TE SCOREN

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9. Reageert met depressie, schuld of gedrag resulterend in pijn (bijvoorbeeld een ongeluk) op positieve persoonlijke gebeurtenissen (bijvoorbeeld nieuw succes) **3-SLFDF** **0 1 2 3**

Als dingen goed gaan, komt het dan wel eens voor dat u er toch een vervelend gevoel aan overhoudt?
(Indien ja):
- Hoe komt dat?

Als dingen goed gaan, heeft u dan wel eens het gevoel dat u dat eigenlijk niet verdient?
(Indien ja):
- Betekent dat dan dat u er eigenlijk niet van kunt genieten?

Als er iets prettigs gebeurt, lijkt het dan wel eens of er meteen iets vervelends op moet volgen?

10. Wisselt tussen vijandig (verzet) en wroeging of berouw **7-NEGTV** **0 1 2 3**

Bent u iemand die weleens weigert om iets te doen maar die zich daar later schuldig over voelt en het vervolgens toch doet?
(Indien ja):
- Hoe laat u dat merken?

Als u de moed hebt opgebracht over iemand iets naar te vertellen of te klikken voelt u zich daar later dan schuldig over en probeert u het weer goed te maken?

Richtlijnen voor scoring:

0. Niet aanwezig of beperkt tot zeldzame, incidentele voorbeelden.

1. Bijna aanwezig – enige aanwijzingen voor de trek, maar deze zijn niet voldoende overheersend of ernstig om het criterium aanwezig te achten.

2. Aanwezig – het criterium is duidelijk aanwezig, voor het grootste deel van de laatste vijf jaar (d.w.z. aanwezig tenminste 50% van de tijd, gedurende de laatste vijf jaar).

3. Sterk aanwezig – het criterium is geassocieerd met subjectief lijden of met enige beperkingen in het sociaal of beroepsmatig functioneren, of in intieme relaties.

F: CRITERIA TER OBSERVATIE

We zijn nu op de helft van het interview. Laten we een paar minuten pauzeren.
(EEN KORTE ONDERBREKING IS BELANGRIJK OM ER ZEKER VAN TE ZIJN DAT ZOWEL DE INTERVIEWER ALS DE GEÏNTERVIEWDE VOLDOENDE ALERT BLIJVEN. EEN TUSSEN-PERIODE VAN EEN DAG KAN OVERWOGEN WORDEN ALS DE PATIËNT TE MOE WORDT OF HET OP EEN ANDERE MANIER MOEILIJK VINDT OM ZICH TE CONCENTREREN). DE ITEMS VAN DEZE SECTIE, DIE ZIJN GEBASEERD OP DE OBSERVATIES DIE U DOET (EN NIET OP DE ANTWOORDEN VAN DE RESPONDENT) WORDEN HIER GESCOORD.

De vragen die voorafgegaan worden door een asterisk (*) moeten bij voorkeur ook aan de informant worden gesteld.

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1. Zonderling, excentriek of vreemd gedrag of uiterlijk **7-STYPL** **0 1 2 3**

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* Ziet hij/zij er in enig opzicht vreemd of eigenaardig uit?
(Indien ja):
- Beschrijven.

* Kleedt hij/zij zich op een vreemde of eigenaardige manier die niet verklaard kan worden door de huidige modetrends?
(Indien ja):
- Denkt u dat hij/zij zich zo kleedt om aandacht te trekken of om erbij te horen?

SCORINGSINSTRUCTIE: GEDRAG OF KLEDING DAT WORDT GEKOZEN OM DE AANDACHT TE TREKKEN OF JUIST NIET UIT DE TOON TE VALLEN BIJ VRIENDEN WORDT NIET GESCOORD. EEN DERGELIJKE MANIER VAN DOEN PAST MEER BIJ EEN THEATRALE PERSOONLIJKHEID.

* Heeft hij/zij vreemde of eigenaardige maniertjes, of gedraagt hij/zij zich op een vreemde of eigenaardige manier?
(Indien ja):
- Beschrijven.

* Praat hij/zij vaak in zichzelf?

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2 Merkwaardige gedachten en spraak (b.v. vaag, wijdlopig, metaforisch, met een overmaat aan details, of stereotiep) **4-STYPL** **0 1 2 3**

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* Praat hij/zij op een vreemde of ongebruikelijke manier?
(Indien ja):
- Beschrijven.

3 Het affect is emotioneel kil, afstandelijk of afgevlakt **7-SZOID** **0 1 2 3**

* Als hij/zij iets vertelt, vindt u het dan moeilijk om te volgen wat hij/zij zegt?

* Vertoont hij/zij weinig gezichts- of stemuitdrukking zelfs wanneer er onderwerpen aan de orde komen die doorgaans gepaard gaan met enige emoties?

* Kijkt hij/zij u weinig aan als u met hem/haar praat?

* Glimlacht of knikt hij/zij u toe tijdens een gesprek?

- Toont hij/zij weinig emoties?

4	**Inadequaat of ingeperkt affect**	**6-STYPL**	**0 1 2 3**

* Komt het vaak voor dat de emoties die hij/zij vertoont, niet passen bij wat hij/zij zegt?

* Glimlacht of lacht hij/zij op momenten zonder dat er een reden voor is?

! (SCORINGSINSTRUCTIE: BEOORDEEL INGEPERKT AFFECT AAN DE HAND VAN DE VRAGEN BIJ F3)

5	**Heeft een manier van spreken die overdreven impressionistisch is en waarbij details ontbreken**	**5-HISTR**	**0 1 2 3**

- Geeft hij/zij concrete voorbeelden met voldoende detail, met name wanneer hij/zij een duidelijke mening verkondigt?

Richtlijnen voor scoring:

0. Niet aanwezig of beperkt tot zeldzame, incidentele voorbeelden.

1. Bijna aanwezig – enige aanwijzingen voor de trek, maar deze zijn niet voldoende overheersend of ernstig om het criterium aanwezig te achten.

2. Aanwezig – het criterium is duidelijk aanwezig, voor het grootste deel van de laatste vijf jaar (d.w.z. aanwezig tenminste 50% van de tijd, gedurende de laatste vijf jaar).

3. Sterk aanwezig – het criterium is geassocieerd met subjectief lijden of met enige beperkingen in het sociaal of beroepsmatig functioneren, of in intieme relaties.

G: ZELF-PERCEPTIE

De vragen in deze sectie gaan over de manier waarop u over uzelf denkt en hoe u denkt dat anderen u zouden beschrijven. Nogmaals het gaat vooral om hoe u gewoonlijk bent en niet over periodes dat u ziek of opgenomen bent.

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1 Identiteitsstoornis: duidelijk en aanhoudend instabiel zelfbeeld of zelfgevoel **3-BORDL** **0 1 2 3**

Verandert de manier waarop u over uzelf denkt zo vaak, dat u niet precies weet wie u bent?
(Indien ja):
- Kunt u beschrijven hoe dat voor u is?

Heeft u ooit het gevoel gehad dat u iemand anders bent, of dat u slecht bent of misschien zelfs dat u niet bestaat?
(Indien ja):
- Kunt u hier meer over vertellen?

Sommige mensen denken veel na over hun seksuele voorkeur. Ze twijfelen er aan of ze al dan niet homofiel of lesbisch zijn. Houden dit soort zaken u vaak bezig?

---

2 Heeft een gevoel bijzondere rechten te hebben dat wil zeggen onredelijke verwachting van een uitzonderlijk welwillende behandeling of een automatisch meegaan met zijn of haar verwachtingen **5-NARCI** **0 1 2 3**

Sommige mensen hebben op grond van hun afkomst of hun verdiensten recht op een speciale behandeling. Geldt dit ook voor u?
(Indien ja):
- Kunt u hier meer over vertellen?

Wordt u vaak boos of geïrriteerd omdat men anders met u omgaat dan u verdient?
(Indien ja):
- Kunt u enkele voorbeelden geven?

* Staat u erom bekend dat u zonder discussie van anderen verwacht dat zij doen wat u zegt?

---

3 Heeft een opgeblazen gevoel van eigen belangrijkheid (bijvoorbeeld overdrijft eigen prestaties en talenten, verwacht als superieur erkend te worden zonder de erbij horende prestaties) **1-NARCI** **0 1 2 3**

Zoudt u uzelf beschrijven als iemand die grote dingen tot stand heeft gebracht - prestaties waardoor u zich onderscheidt van uw gelijken?
(Indien ja):
- Kunt u daar meer over vertellen?

* Hebben mensen wel eens gezegd dat u een te hoge dunk van uzelf hebt?

(Indien ja):
- Waarom denkt u dat ze dat zeiden?

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4 **Is gepreoccupeerd met fantasieën over onbeperkte successen, macht, genialiteit, schoonheid of ideale liefde** **2-NARCI** **0 1 2 3**

Als mensen zich voorstellen hoe hun leven zou zijn als ze alles konden krijgen wat ze wilden, dan denken ze nog al eens aan zaken zoals macht, succes, schoonheid, perfecte relaties en dergelijke. Kunt u mij vertellen wat uw dagdromen zijn?

Zit u vaak te dagdromen?

Heeft u dat elke dag?

Hoeveel tijd besteedt u per dag aan dit soort zaken? . . . . uren.

Zorgt het dagdromen ervoor dat u zich moeilijk kunt concentreren op uw werk of dat u dingen niet of moeilijk af krijgt?

---

5 **Is overdreven gewetensvol, scrupuleus en star over moraliteit, ethiek of waarden (niet te verklaren vanuit cultuur of religie)** **4-OBCMP** **0 1 2 3**

---

* Hecht u meer dan de meeste andere mensen die u kent, aan morele en ethische waarden?

Klagen andere mensen erover dat u te streng oordeelt over morele zaken?
(Indien ja):
- Waar klagen zij over?

Hoe vaak maakt u zich er zorgen over, dat u iets immoreels of onethisch heeft gedaan?

---

6 **Toont starheid en koppigheid** **8-OBCMP** **0 1 2 3**

Beschrijven andere mensen u als koppig of vastgeroest in uw gewoonten?
(Indien ja):
- Waarom zeggen ze dat van u?
- Bent u het daarmee eens?

---

7 **Is niet in staat versleten of waardeloze voorwerpen weg te gooien, zelfs als ze geen gevoelswaarde hebben** **5-OBCMP** **0 1 2 3**

Sommige mensen kunnen moeilijk iets weggooien, zelfs als het oud en versleten is. Is dat iets dat bij u past? Bent u een echte hamsteraar?
(Indien ja):
- Wat voor een soort dingen bewaart u?
- Waarom bewaart u ze?

Hebben anderen hier ooit over geklaagd of u er mee geplaagd?

---

8 **Is vaak afgunstig of jaloers op anderen of meent dat anderen afgunstig of jaloers op hem/haar zijn** **8-NARCI** **0 1 2 3**

Zijn er mensen die u echt benijdt of op wie u jaloers bent?
(Indien ja):
- In welk opzicht benijdt u hen?
- Hoe vaak denkt u hieraan?
- Heeft u daar last van?

(Indien ja):
- In welk opzicht heeft u daar last van?

Zijn mensen vaak jaloers op u of benijden ze u?
(Indien ja):
- Waarom denkt u dat ze jaloers zijn?

(GA DOOR MET SECTIE H ALS FACULTATIEVE DIAGNOSES NIET WORDEN ONDERZOCHT)

---

9 **Uit zich afgunstig en met wrevel over mensen die blijkbaar meer geluk hebben** **5-NEGTV** **0 1 2 3**

Heeft u het er vaak met anderen over hoe oneerlijk het is dat sommige mensen het beter hebben dan uzelf?

(SCORINGSINSTRUCTIE: GEBRUIK OOK DE ANTWOORDEN OP VRAAG 8 BIJ DE SCORING)

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10 **Is overmatig zelf opofferend in situaties waarin door anderen niet om een dergelijk offer wordt gevraagd** **8-SLFDF** **0 1 2 3**

---

* Hoe vindt u het om anderen een plezier te doen?

Heeft u het gevoel dat u meer voor anderen doet, dan zij voor u terugdoen?
(Indien ja):
- Doet u vaak uw uiterste best om anderen te helpen, zelfs al hebben ze niet om uw hulp gevraagd?

Offert u zich wel eens voor andere mensen op?
(Indien ja):
- Kunt u hier iets meer over vertellen?
- Wordt dit door anderen gewaardeerd?
- Vragen zij hierom?

---

11 **Roept boze of afwijzende reacties op en voelt zich dan gekwetst, verslagen of vernederd (bijv.: houdt echtgeno(o)t(e) en plain public voor de gek, roept daarmee een boze tegenzet op en voelt zich dan verschrikkelijk)** **4-SLFDF** **0 1 2 3**

Doet u vaak dingen waarvan u weet dat anderen daar boos door worden of waardoor zij u afkeuren?
(Indien ja):
- Wat voor een soort dingen doet u dan?
- Hoe voelt u zich wanneer zij boos worden of u afkeuren?

12 Is negativistisch, kritisch en veroordelend over anderen **5-DEPRS** **0 1 2 3**

* Staat u snel klaar met kritiek op anderen?

Heeft u de neiging om eerder iemands fouten dan iemands goede kanten te zien?

Als het gaat om dingen die de meeste mensen bewonderen, ziet u dan snel de fouten of gebreken daarin en wijst u anderen daarop?
(Indien ja):
- Kunt u me een voorbeeld geven?

(SCORINGSINSTRUCTIE: SCOOR GEEN ZELFKRITIEK)

13 In het zelf-beeld staan gevoelens van onvermogen, waardeloosheid en een laag gevoel van eigenwaarde centraal **2-DEPRS** **0 1 2 3**

Zou u zichzelf beschrijven als iemand die een lage dunk heeft van zichzelf?

Als u zich vergelijkt met andere mensen, heeft u dan doorgaans het gevoel dat u even goed bent als anderen, of heeft u het gevoel dat zij beter zijn dan u?

14 Is pessimistisch **6-DEPRS** **0 1 2 3**

* Bent u gewoonlijk een optimist of een pessimist?

Heeft u de neiging om altijd het ergste te verwachten?

15 Is nors en twistziek **3-NEGTV** **0 1 2 3**

Heeft u vaak het gevoel dat elk gesprek op een woordenwisseling uitloopt?

Klagen andere mensen erover dat een gesprek met u vaak uitloopt op een woordenstrijd?

* Als u zichzelf zou moeten omschrijven, vindt u dat u dan meestal humeurig bent of juist opgewekt?

16 Is tobberig en zorgelijk van aard **4-DEPRS** **0 1 2 3**

Bent u iemand die altijd wel iets vindt om zich zorgen over te maken?

Zeggen mensen wel eens tegen u dat u zich teveel zorgen maakt? (Alternatief: bent u een piekeraar?)

---

17 Uit overdreven en aanhoudende klachten over persoonlijke misère **6-NEGTV** **0 1 2 3**

Denkt u dat u minder geluk in het leven heeft dan de meeste mensen?

* Wanneer u pech heeft, laat u dat dan snel aan anderen weten of lijdt u in stilte?

Klagen mensen er ooit over dat u alleen maar over uw problemen praat?

Zeggen mensen wel eens van dat u uw problemen overdrijft?

(SCORINGSINSTRUCTIE: GA NA OF DE PERSOON ELDERS IN HET INTERVIEW PROBLEMEN OVERDRIJFT)

H: PERCEPTIE VAN ANDEREN

De vragen in dit deel van het interview gaan over ervaringen die u met andere mensen kunt hebben gehad. Denk eraan dat ik geïnteresseerd ben in hoe u gewoonlijk over deze situaties denkt, en niet tijdens een periode van ziekte of als u bent opgenomen.

---

1 **Vermoedt, zonder gegronde redenen dat anderen hem of haar uitbuiten, schade berokkenen of bedriegen** **1-PARND** **0 1 2 3**

Heeft u meegemaakt dat mensen die deden alsof ze uw vrienden waren, u probeerden uit te buiten?
(Indien ja):
- Wat gebeurde er?
- Hoe vaak is dit gebeurd?

Heeft u snel door of iemand u probeert te bedriegen of op te lichten?
(Indien ja):
- Kunt u voorbeelden geven?

---

2 **Is gepreoccupeerd met ongerechtvaardigde twijfels omtrent de trouw of betrouwbaarheid van vrienden of collega's** **2-PARND** **0 1 2 3**

---

* Maakt u zich er zorgen over dat bepaalde vrienden of collega's niet werkelijk loyaal of te vertrouwen zijn?
(Indien ja):
- Hoeveel tijd besteedt u hier aan?
- Waarom maakt u zich daar zorgen over?
- Bent u veel met dat soort vragen bezig?

---

3 **Bespeurt kritiek op zijn/haar persoon of reputatie die niet opgemerkt werd door anderen en reageert snel boos of met een tegenaanval** **6-PARND** **0 1 2 3**

Maken mensen vaak indirecte opmerkingen maken om u aan te vallen of te kleineren in plaats van dat ze u rechtstreeks zeggen wat ze tegen u hebben?
(Indien ja):
- Hoe reageert u dan?
- Wordt u boos?
- Probeert u het die ander betaald te zetten?

---

4 **Zoekt achter onschuldige opmerkingen of gebeurtenissen verborgen vernederingen en bedreigingen** **4-PARND** **0 1 2 3**

Doen mensen vaak dingen met de bedoeling u te ergeren?
(Indien ja):
- Kunt u me voorbeelden geven?

Neemt u in het algemeen de dingen die mensen zeggen voor waar aan, of probeert u vaak uit te vinden wat ze eigenlijk bedoelen?
(Indien ja):
- Blijken die opmerkingen vaak verborgen bedreigingen of kleineringen te zijn?

* Zeggen andere mensen dat u teveel achter dingen zoekt en in de aanval gaat bij dingen die niet kritisch waren bedoeld?
(Indien ja):
- Kunt u me een voorbeeld geven?

---

5 Betrekkingsideeën (met uitsluiting van betrekkingswanen) 1-STYPL 0 1 2 3

Is het u ooit overkomen dat mensen in uw omgeving over algemene zaken spraken, maar dat u zich plotseling realiseerde dat hun opmerkingen op u betrekking hadden?
(Indien ja):
- Hoe wist u dat ze over u aan het praten waren?

Heeft u ooit gedacht dat iemand die de leiding had de regels speciaal vanwege u veranderde, maar dat die persoon dat niet wilde toegeven?

* Heeft u wel eens het gevoel dat onbekenden op straat naar u kijken en over u aan het praten zijn?
(Indien ja):
- Waarom denkt u dat er speciaal op u wordt gelet?

---

6 Is suggestibel, dat wil zeggen gemakkelijk te beïnvloeden door anderen of door omstandigheden 7-HISTR 0 1 2 3

---

* Sommige mensen worden zo sterk door anderen beïnvloedt dat ze hun mening erg snel aanpassen of veranderen. Past u uw mening gemakkelijk aan die van mensen in uw omgeving?
(Indien ja):
- Hoe vaak gebeurt dit?

Als mensen zeggen dat ze last van hoofdpijn hebben, dat hun maag van streek is, of dat ze een bepaalde emotie sterk voelen, voelt u dat dan plotseling ook?
(Indien ja):
- Kunt u me een voorbeeld geven?

---

7 Eigenaardige overtuigingen of magisch denken die het gedrag beïnvloeden en niet overeenstemmen met subculturele normen, (bijvoorbeeld: bijgelovigheid, geloof in helderziendheid, telepathie of 'zesde zintuig'; bij kinderen bizarre fantasieën of preoccupaties) 2-STYPL 0 1 2 3

Er zijn mensen die vertellen dat zij soms iets waarnemen buiten hun zintuigen om. Gedachten lezen of de toekomst voorspellen. Heeft u ooit zelf dergelijke ervaringen gehad?

(Indien ja):
- Kunt u me voorbeelden geven?
- Hebben uw vrienden en familieleden ook dergelijke ervaringen gehad?
- Zijn deze ervaringen erg belangrijk voor u?

(Indien ja):
- Op welke manier?

Bent u een bijgelovig persoon?
(Indien ja):
- In welk opzicht?
- Op welke manier beïnvloedt dit uw beslissingen of uw doen en laten?
- Geloven uw vrienden en familieleden dit ook?

Sommige mensen geloven dat ze bijvoorbeeld het weer of voetbalwedstrijden met hun gedachten kunnen beïnvloeden. Gelooft u dat het mogelijk is om dingen te laten gebeuren door er alleen maar aan te denken?
(Indien ja):
- Kunt u mij daar meer over vertellen?

* Gelooft u in horoscopen, heksen, vervloekingen, voorspellingen, voodoo, enz.
(Indien ja):
- Heeft dit invloed op uw beslissingen of op uw gedrag?
- Geloven uw vrienden en familieleden hier ook in?

---

8 Ongewone perceptuele waarnemingen, met inbegrip van lichamelijke illusies **3-STYPL** **0 1 2 3**

Heeft u ooit de ervaring of het gevoel gehad dat er een persoon of een ongewone kracht bij u in de kamer was?

(Indien ja):
- Kunt u beschrijven hoe dit was?
- Wat had dit volgens u te betekenen?
- Hoe vaak is dit gebeurd?

Heeft u ooit het gevoel gehad dat u óf de wereld om u heen veranderd was of anders leek dan normaal?
(Indien ja):
- Kunt u mij beschrijven wat er aan de hand was?
- Gebruikte u toen drugs of alcohol?

Heeft u wel eens de ervaring gehad dat uw ogen u voor de gek hielden; bijvoorbeeld dat uw gezicht of lichaam of dat van een ander er anders uitzag?
(Indien ja):
- Kunt u me daar iets over vertellen?

---

9 Achterdocht of paranoïde ideeën **5-STYPL** **0 1 2 3**

(SCOOR DIT ITEM POSITIEF ALS ER TENMINSTE 2 CRITERIA VOOR PARANOÏDE PERSOONLIJKHEIDSSTOORNIS AANWEZIG ZIJN, MET UITZONDERING VAN CRITERIUM 5

SCOOR DIT PAS NADAT HET HELE INTERVIEW IS GESCOORD

I: STRESS EN WOEDE

Dit gedeelte gaat over de manier waarop u normaal gesproken uw woede uit of hoe u reageert op stressvolle situaties. Denk eraan dat ik vooral geïnteresseerd ben in de manier waarop u gewoonlijk reageert.

1 Inadequate, intense woede of moeite kwaadheid te beheersen (bijv. frequente driftbuien, aanhoudende woede of herhaaldelijk vechtpartijen) **8-BORDL** **0 1 2 3**

* Hoe vaak verliest u uw zelfbeheersing?

Welke dingen maken u echt kwaad?

* Vertelt u mij eens hoe u bent als u echt kwaad bent?

Hoelang blijft u gewoonlijk boos?

Gooit u met dingen of maakt u dingen kapot?

Heeft u ooit iemand geslagen terwijl u kwaad was?

Raakt u slaags met anderen?

Als u boos bent, zwijgt u dan wel eens met opzet een tijd lang?
(Indien ja):
- Bent u geneigd iemand dood te zwijgen als u boos bent?
- Hoe lang kunt u dat volhouden?
- Is dat een gebruikelijke reactie voor u?

Komt het voor dat u zeer boos bent, maar dit niet laat merken?
(Indien ja):
- Hoe lang blijft het dan zeuren van binnen?

2 Is arrogant of toont hooghartig gedrag of houdingen **9-NARCI** **0 1 2 3**

Hebben andere mensen u wel eens gezegd dat uw houding of opstelling niet goed is of niet deugt?
(Indien ja):
- Wat bedoelen ze daarmee?

(SCORINGSINSTRUCTIE: HOUDT OOK REKENING MET HET GEDRAG TIJDENS HET INTERVIEW)

3 Is halsstarrig rancuneus, dat wil zeggen vergeeft geen beledigingen, aangedaan onrecht of kleineringen **5-PARND** **0 1 2 3**

Hoe lang blijft u kwaad op iemand die u kwetst of beledigt?
Kunt u een voorbeeld geven van zo'n situatie?
(Indien geen reactie):

- Bijvoorbeeld uw verjaardag vergeten?

Bent u iemand die lang een wrok koestert tegenover mensen?
Zijn er mensen die u nooit hebt vergeven?
(Indien ja op een van beide vragen):
- kunt u daar iets meer over vertellen?

---

4 Voorbijgaande, aan stress gebonden paranoïde ideeën of ernstige dissociatieve verschijnselen **9-BORDL** **0 1 2 3**

Er zijn mensen die als ze onder spanning staan ervaringen hebben die erg moeilijk zijn uit te leggen aan andere mensen. Heeft u, als u onder spanning stond, wel eens het gevoel gehad dat de dingen om u heen u enigszins vreemd voorkomen, of van grootte of vorm veranderd waren?
(Indien ja):
- Kunt u beschrijven hoe dat is?

Als u onder spanning staat, heeft u dan wel eens het gevoel dat uw lichaam of een deel er van op de een of andere manier veranderd was of vreemd of niet echt was?

Heeft u ooit het gevoel gehad dat u van een afstand naar uw lichaam kon kijken?
(Indien ja):
- Kunt u beschrijven hoe dat is?

Heeft u last van korte perioden dat u afwezig was en dat u dan vergeten bent wat er is gebeurd? (Alternatief: Heeft u last van korte black-outs en bent u dan vergeten wat er is gebeurd?)

Als u gespannen bent, gaat u dan wel eens mensen wantrouwen die u normaal gesproken vertrouwd of wordt u dan achterdochtig?
(Indien NEE):
- Bent u wel eens bang dat iemand u bespiedt of u pijn wil doen?

(INDIEN EEN VAN BOVENSTAANDE VRAGEN BEVESTIGEND IS BEANTWOORD, VRAAG DAN:)

U zei dat u ... (noem de dissociatieve of paranoïde ervaringen) heeft meegemaakt. Gebruikte u op dat moment drugs of alcohol?
(Indien ja):
- Gebeurt dit alleen als u drugs of alcohol gebruikt?

(Indien het plaats vindt zonder alcohol- of druggebruik):
Hoe lang duren deze ervaringen dan?
Heeft u dergelijke ervaringen ook als u niet onder spanning staat?

---

5 Recidiverende suïcidale gedragingen, gestes of gedragingen, of auto-mutilaties **5-BORDL** **0 1 2 3**

Bent u ooit zo van streek geweest dat u tegen iemand gezegd hebt dat u uzelf wilde verwonden of doden?
(Indien ja):
- Kunt u me hier iets over vertellen?
- Hoe vaak heeft u dat gedaan?

* Heeft u ooit een zelfmoordpoging gedaan, zelfs een poging die niet ernstig was?
(Indien ja):
- Wat heeft u gedaan?
- Hoeveel pogingen heeft u ondernomen?

Bent u ooit zo van streek of gespannen geweest dat u zichzelf met opzet pijn ging doen door bijvoorbeeld uzelf te snijden, uw hand door een raam te slaan, uzelf te branden, of iets dergelijks.
(Indien ja):
- Wat heeft u gedaan?
- Hoe vaak?

1	**Impulsiviteit op tenminste twee gebieden die betrokkene mogelijk schade kunnen berokkenen (bijv. geld verkwisten, seks, misbruik van middelen, roekeloos rijden, vreetbuien) [NB reken hier niet het suïcidale of auto-mutilerende gedrag toe zoals omschreven in 83.A5]**	**4-BORDL**	**0 1 2 3**

Ik lees u een lijst van gedragingen voor waardoor mensen soms in problemen kunnen komen. Hoe vaak is het de afgelopen 5 jaar voorgekomen dat u:

Let op: Indien ja, vraag dan <u>hoe vaak</u>, <u>hoeveel</u>, of <u>hoe erg</u>.

* 1 __ meer geld vergokte dan u zich kon veroorloven?
* 2 __ onnodige dingen had gekocht die u zich niet kon veroorloven?
* 3 __ (one-night-stands of) kortdurende seksuele relaties gehad?
* 4 __ dronken bent geweest?
* 5 __ stoned bent geweest of onder invloed van andere drugs?
* 6 __ winkeldiefstallen heeft gepleegd of iets van iemand heeft gestolen?
* 7 __ auto-ongelukken veroorzaakte, bonnen kreeg i.v.m. te hard rijden of aangehouden werd wegens roekeloos rijden?
* 8 __ een auto bestuurde terwijl u dronken was (teveel alcohol op had), stoned was, of bijvoorbeeld onder invloed van XTC?
* 9 __ vreetbuien had, waarbij u soms zoveel at dat u buikpijn kreeg of dat u moest overgeven?
* 10 __ iets anders in een impuls heeft gedaan, waardoor u mogelijk in de problemen zou kunnen komen?

(SLA DE REST VAN DEZE SECTIE OVER ALS ANTI-SOCIALE PS MET EEN ANDER INSTRUMENT WORDT GESCREEND)

2	**Prikkelbaarheid en agressiviteit zoals blijkt uit bij herhaling komen tot vechtpartijen of geweldpleging**	**4-ANTSO**	**0 1 2 3**

(SCORINGSINSTRUCTIE: GEBRUIK DE ANTWOORDEN OP DE VRAGEN BIJ ITEM #1 IN SECTIE I, BLADZIJDE 38, OM DIT ITEM TE SCOREN)

3	**Niet in staat zich te conformeren aan de maatschappelijke norm dat men zich aan de wet moet houden, zoals blijkt uit het bij herhaling tot handelingen komen die een reden tot arrestatie kunnen zijn**	**1-ANTSO**	**0 1 2 3**

Ik ben er niet in geïnteresseerd details te horen die u in problemen zouden kunnen brengen, maar ik wil wel graag weten hoe vaak u betrokken bent geweest bij:

(Indien jonger dan 20 jaar): sinds uw vijftiende
(Indien 20 jaar of ouder): de afgelopen 5 jaar

Let op: vraag hoe vaak, hoeveel, hoe erg indien ja

__ kopen of verkopen van gestolen goederen
__ geld verduisteren
__ gokken
__ drugshandel
__ winkeldiefstallen of inbraken
__ prostitutie
__ andere dingen waarvoor je gearresteerd kunt worden

* Bent u ooit gearresteerd?
(Indien ja):
- Hoe vaak?
- Wat was er gebeurd?

---

4 Constante onverantwoordelijkheid zoals blijkt uit het herhaaldelijk niet in staat zijn geregeld werk te behouden of financiële verplichtingen na te komen **6-ANTSO** **0 1 2 3**

Is het ooit voorgekomen dat u niet in staat was om noodzakelijke dingen zoals eten, huur of de elektriciteitsrekening te betalen, omdat u het geld had uitgegeven aan dingen die u niet echt nodig had?

* Bent u wel eens niet in staat geweest rekeningen te betalen of andere financiële verplichtingen na te komen?
(Indien ja):
- Onder welke omstandigheden was dat?

Is het ooit voorgekomen dat u niet aan uw wettelijk verplichte betalingen voldeed zoals voorzien in het onderhoud van kinderen, het betalen van alimentatie, schikkingen of boetes die voortkwamen uit een rechtszaak?
(Indien ja):
- Kunt u mij daar meer over vertellen?

Heeft u ooit in uw werk problemen gehad, omdat u te laat op uw werk kwam, vaak afwezig was, uw werk niet deed of u niet aan de regels hield?

---

5 Oneerlijkheid, zoals blijkt uit herhaaldelijk liegen, het gebruik van valse namen, of anderen bezwendelen ten behoeve van eigen plezier of voordeel **2-ANTSO** **0 1 2 3**

Liegt u gemakkelijk als dat zo uitkomt?
Heeft u ooit gebruik gemaakt van een valse naam of een plan gemaakt om mensen op te lichten?

---

6 Impulsiviteit of onvermogen 'vooruit te plannen' **3-ANTSO** **0 1 2 3**

Hoe vaak nam u zelf ontslag of bent u ergens weg gegaan, zonder verdere plannen te hebben gemaakt?
(Indien aanwezig):
- Kunt u daar meer over vertellen?

Hoe vaak heeft u zomaar rond gezworven zonder van te voren iets geregeld te hebben en niet te weten hoelang u ergens zou blijven of waar u daarna heen zou gaan?

(Indien aanwezig):
- Kunt u daar meer over vertellen?

* Komt u vaak in de problemen, omdat u niet vooruit gepland heeft?

(VERWIJS NAAR VRAAG #1 IN DEZE SECTIE VOOR ANDER GERELATEERD GEDRAG)

---

7 Roekeloze onverschilligheid voor de veiligheid van zichzelf of anderen **5-ANTSO** **0 1 2 3**

Bent u iemand die bekend staat als een waaghals bij sport of hobbies?
(Indien ja):
- Hoe komt u aan zo'n naam?

Bent u op uw werk ooit in de problemen geraakt omdat u dingen deed die voor u zelf of voor anderen gevaarlijk waren?
(Indien ja):
- Wat gebeurde er?

(VERWIJS NAAR VRAAG #1 IN DEZE SECTIE VOOR ANDER GERELATEERD GEDRAG)

---

8 Ontbreken van spijtgevoelens, zoals blijkt de ongevoeligheid voor of het rationaliseren van het feit anderen gekwetst, mishandeld of bestolen te hebben **7-ANTSO** **0 1 2 3**

(NB OVERSLAAN ALS GEEN ANTI-SOCIAAL GEDRAG WERD GENOEMD)

U vertelde dat u (... vat het anti-sociale gedrag samen, met name het schenden van andermans rechten). Als we het daar nu over hebben, hoe voelt u zich dan?
(Indien geen wroeging):
- Heeft u er ooit spijt van gehad of heeft u zich er schuldig over gevoeld?
- Heeft u vaak het gevoel dat uw daden gerechtvaardigd worden door de situatie?

(Indien ja):
- Kunt u dat uitleggen?

---

9 Er zijn aanwijzingen voor een Gedragsstoornis beginnend voor het vijftiende jaar **C-ANTSO** **0 1 2 3**

(NB DEZE SECTIE KAN WORDEN OVERGESLAGEN INDIEN DE ANTI-SOCIALE CRITERIA VOOR VOLWASSENEN NIET IN VOLDOENDE MATE AANWEZIG ZIJN)

Om te begrijpen hoe uw huidige situatie gerelateerd is aan bepaald gedrag uit uw jeugd, wil ik vragen hoe vaak u de volgende dingen deed voor uw vijftiende.

Hoe vaak is het voor uw vijftiende voorgekomen dat:
1 u later thuis kwam dan u van uw ouders mocht of met hen had afgesproken?
2 spijbelde?

3 een nacht van huis wegbleef?
(Indien één keer): ging u weer thuis wonen nadat u een keer was weggelopen?
4 andere kinderen bedreigde of dingen van ze afpakte?
5 een (fysieke) vechtpartij begon?
6 een mes, pistool, knuppel of iets anders gebruikte waardoor iemand gewond zou kunnen raken?
7 met opzet andere mensen pijn deed, terwijl u niet aan het vechten was?
8 met opzet een dier pijn deed?
9 iemand dwong seks met u te hebben?
10 met opzet iemands eigendommen beschadigde?
11 met opzet brand stichtte die veel schade veroorzaakte?
12 in moeilijkheden kwam doordat u veel leugens vertelde of beloften verbrak?
13 winkeldiefstallen heeft gepleegd, van uw ouders of van andere mensen heeft gestolen?
14 iemand overviel of bedreigde indien de persoon niet gaf wat u wilde hebben?
15 u bij iemand thuis, in een gebouw of in een auto heeft ingebroken?

(CRITERIUM C VOOR ANTI-SOCIALE PERSOONLIJKHEIDSSTOORNIS IS AANWEZIG INDIEN 3 OF MEER VAN BOVENSTAANDE DINGEN DUIDELIJK AANWEZIG ZIJN)

Summary

Aims

This thesis deals with the personality of opioid-dependent patients. In a sense we search for "the person behind the addiction". Opioid-dependence is a worldwide phenomenon which forms a problem for society.

An important aim in Dutch drug policy is limiting the production and trade of illegal drugs and in addition prevention of problematic use. From a mental health perspective, prevention, treatment of substance dependent patients and related problems and behavior, is important. In the Netherlands there are 32 drug treatment providers (GGZ Nederland, 2001) consisting of 144 facilities for outpatient treatment (e.g. methadone maintenance programs; assistance in detoxification; prevention) or counselling, 22 facilities for semi-inpatient treatment or counseling (e.g.daycare) and 65 facilities for inpatient treatment (e.g. crisis intervention services; physical detoxification; treatment).

Opioids are often used by people with sleeping problems, anxiety disorders, personal problems or problems concerning social relationships or employment. It is therefore not surprising that there is high comorbidity with psychiatric disorders, in particular personality disorders, which should be addressed in the treatment of substance use disorders. In the Netherlands there are a variety of treatment modalities and facilities for addiction care which each have a different focus of treatment and differ in the extent to which attention is given to co-existing psychopathology. It is important to gain information about the prevalence and type of pathology in these different settings in order to develop adequate treatment programs. Therefore the first aim of this dissertation is to establish the prevalence of personality pathology in opioid-dependent patients, across treatment modalities, which can be regarded as representative for Dutch addiction care (N=279).

Several methods are available for the assessment of personality pathology. There is no such thing as a "golden standard" for the measurement of personality, but semi-structured interview procedures facilitate a more systematic, replicable and informed assessment through the provision of a consequent set of questions. They have been found to have a superior reliability compared to self-report measures and clinical judgment (Widiger et al., 1995).Clinical judgment procedures often seem to lead to

underestimation of the actual pathology, while self-report measures give an overestimation compared to semi-structured interview measures (Verheul, 1997).

The Structured Interview for DSM-IV Personality (SIDP-IV; Pfohl, Blum & Zimmerman, 1995) is one such in interview. The interview consists of sections which each address a theme, which results in a natural conversation with the patient. The second aim of this study is to evaluate different facets of reliability and validity of the SIDP-IV in a sample of opioid-dependent patients (N=279).

Psychometric evaluation of the SIDP-IV; Aspects of reliability and validity

In order to answer the research questions, the SIDP-IV was administered in a total sample of 279 participants. In line with the interrater reliability protocol, two trained interviewers were present at 50 SIDP-IV administrations. In each of these sessions only one of interviewer of this interviewing pair, administered the interview. In addition, the European version of the Addiction severity Index EuropASI, was administered in the total patient sample, in order to gather extensive information on participant-characteristics.

Results from the psychometric evaluation of the SIDP-IV indicate that the instrument is valid and reliable for the assessment of personality pathology in opioid-dependent patients. In order to establish the validity of an instrument, good reliability is a necessity. The reliability was investigated by the establishment of the interrater reliability, internal consistence and diagnostic efficiency for the total criteria set.

We examined the interrater reliability on criterion (agreement on the presence of a criterion) - as well as a diagnostic (agreement on the presence of a disorder) level, for both categorical (whether or not a criterion or disorder is present) and dimensional (the extent to which a disorder or criterion is present) data. At a criterion level (Cohen's kappa [κ] ranging from .76 to .93, and Intraclass Correlation Coefficient [*ICC*] ranging from .67 to .97), as well as on a diagnostic level (κ ranging from .66 to 1.00, and *ICC* ranging from .88 to .99), the reliability was excellent.

Second, we established the internal consistence and diagnostic efficiency

of *DSM-IV* Axis-II criteria-sets. In order to develop a stepped assessment model, we critically examined the criteria. The results show the SIDP-IV to constitute an adequate and reliable instrument with acceptable internal consistency and good diagnostic efficiency. To reliably identify the presence of PDs in opioid-dependent patients the instrument should be administered as a whole. However, a set of 7-criteria can be used for screening purposes and thus to decide whether the entire instrument should be further administered or not.

Third, in this study, the underlying structure of the *DSM-IV* personality disorders was explored in order to contribute to the construct validity of this instrument. Explorative factor analysis yielded a three-factor solution, largely resembling the *DSM-IV* Cluster model. The optional disorders (these disorders are not part of DSM-IV yet, but are being evaluated on their usefulness for DSM-V), depressive and negativistic personality disorder, did not detract from the presumed model. Confirmatory Fit Analysis did not confirm a good fit of the model to the data, which is due to the paranoid PD which groups with cluster B PDs. Overall, the underlying structure of *DSM-IV* PDs resembles the presumed *DSM-IV* Cluster model, thereby suggesting good construct validity of the SIDP-IV.

The Interpersonal Model

The DSM classification system is not a theory-based model. Therefore alternative theory-based models are investigated. One such model is the interpersonal behavioral model by Leary. The convergence of the empirically-based Diagnostic Statistical Manual- and theory-based Interpersonal behavioral approaches to personality, measured by the SIDP-IV and the Interpersonal Checklist-Revised, ICL-R was established. The ICL-R was administered in a sample of 110 out of the 279 participants.

As hypothesized, based on prior research, we found the two approaches to be complementary rather than interchangeable. The theory-based Interpersonal Behavioral Model does not appear to be an adequate alternative for the *DSM-IV* in this patient population. However, some overlap was found between the SIDP-IV dimensions and the ICL-R, mainly with rebellious/distrustful, reserved/silent and masochistic/self-effacing styles. Results indicate that drug-dependence in

itself is not a predictor of interpersonal style, while personality pathology is. Patients with a PD perceive themselves as hostile and submissive, while patients without a PD view themselves as friendly and controlling. Although there is considerable overlap, the ICL-R and SIDP-IV tap on different constructs. Therefore The SIDP-IV cannot be replaced by the ICL-R. The SIDP-IV seems informative in classifying PDs, in addition guidelines for behavioral change, in addicted patients, can be provided based on the ICL-R.

Results of the prevalence study

Prevalence rates were found to vary substantially across treatment facilities. In the inpatient facility, 70.0% of the patients have at least one personality disorder. In the outpatient detoxification and methadone maintenance facilities, the prevalence was substantially lower (43.2% and 44.3%, respectively). Results for individual PDs indicate, that across these samples there is no difference in the percentage of patients with a schizoid, schizotypal, histrionic, narcissistic, avoidant, dependent and negativistic PD ($p>.01$). In the inpatient setting, there are more patients with antisocial ($Z=3.6$; $p<.001$), borderline ($Z=3.5$; $p<.001$), and obsessive-compulsive PD ($Z=5.0$; $p<.001$), compared to the rapid-detoxification group. In the Methadone-maintenance program, there are more patients with paranoid ($Z=2.9$; $p=.004$) and depressive PD ($Z=3.3$; $p=.001$), compared to the rapid detoxification group. In addition, in the inpatient sample, there are more patients with obsessive-compulsive PD ($Z=3.3$; $p=.001$), compared to the methadone maintenance sample.

Efficient and effective assessment strategies

Screeningsingsinstruments

In this study the diagnostic efficiency of the EuropASI as a screening device for personality pathology, was investigated. Results lend little support for the diagnostic efficiency of the EuropASI as a screening device for personality pathology. For clinical practice in addiction care, this means alternative assessment

procedures for personality pathology in all opioid-dependent patients should be added to the standard EuropASI assessment procedure.

From literature, we know of two screening interviews for the presence of personality disorders. These are the Standardized Assessment of Personality-abbreviated scale (SAPAS; Moran, Leese, Lee, Walters, Thornicroft & Mann, 2003) and the Iowa Personality Disorder Screen (IPDS; Langbehn, Pfohl, Reynolds, Clarck, Battaglia, Bellodi, Cadoret, Grove, Pilkonis & Links, 1999). These instruments were found to have good sensitivity and specificity measures in samples of patients with a wide range of psychiatric pathology. For the establishment of the presence of personality pathology in Dutch opioid-dependent patients, in our study, we found a set of 7 criteria, which form the bases of a screening interview. The three screeners differ remarkably in their content of the criteria. Our screening criteria set is not developed for the administration in a general psychiatric population, like the two other instruments, but more specifically applicable in Dutch opioid-dependent patients.

Assessment procedures attuned to specific characteristics of patients in a variety of care and cure facilities; a proposition for stepped assessment of personality pathology

Depending on the type of facility and treatment stage, effective and efficient assessment strategies of personality pathology can be developed. Several issues contribute to the development of efficient assessment procedures which can be conducted in everyday practice of addiction care. These issues are related to the intensity and stage of care in which the individual patient is positioned. First, in a crisis intervention situation, interventions are primarily directed toward survival of the patient in agony. In this stage no assessment of personality pathology takes place. Second, patients in methadone maintenance programs do not need personality assessment, unless the treatment appears to be insufficient in the case of the individual patient (e.g., when a patient shows dangerous, extremely hostile or reluctant behavior). Third, patients participating in outpatient treatment programs, often do not have an extensive treatment history. Therefore, this first step in assessment of patients in type of treatment facility, should not be too extensive. When there has been prior treatment which has not lead to a positive treatment outcome (e.g. abstinence), a PD screening should be done. When, in the course of the outpatient treatment, the program does not appear to be effective, a screening should also be administered. Finally, patients in

inpatient treatment facilities have substantial problems on several life areas, a longer history of treatment and participate in a more intensive treatment program focusing on a variety of problems in different facets of life. Therefore, in this type of treatment, all patients should receive extensive PD assessment through the administration of the SIDP-IV.

Conclusion

In this thesis, we have searched for the person behind the addiction. Did we find the person behind the addiction? The question can be answered both positive and negative. We did not find "*the* person" behind the addiction, for patients appear to display a wide variety of feelings, thoughts and behavioural patterns. These aspects of personality could not be predicted by other patient characteristics such as employment status, severity of drug-abuse, treatment history, age, socio-economic status, etcetera. What we did find, were methodologies and recommendations on how to make a fairly good portrait of the person hidden behind the addiction, in an efficient way, which fits the patient's situation, motivational phase and treatment goals and planning.

Summary (Dutch translation)

Doelstelling

Dit proefschrift gaat over de persoonlijkheid van opiaat-afhankelijke patiënten. We zoeken als het ware naar "de persoon achter de verslaving". Opiaat-afhankelijkheid is een wereldwijd verschijnsel, wat een probleem vormt voor de maatschappij. Een belangrijk doel van Nederlandse overheidsbeleid ten aanzien van drugs is het aan banden leggen van de productie van en handel in illegale drugs en bevorderen van preventie van probleem gebruik. Vanuit gezondheidszorg perspectief, zijn preventie, de behandeling van middelen afhankelijke patiënten en daaraan gerelateerde problematiek en gedrag belangrijk. In Nederland zijn er 32 verslavingszorg voorzieningen, bestaand uit 144 faciliteiten voor ambulante behandeling (b.v. methadon onderhoudsprogramma's; ondersteuning bij detoxificatie; preventie) of counseling, 22 faciliteiten voor semi-murale behandeling of counseling (b.v. dagbehandeling) en 65 faciliteiten voor intramurale behandeling (b.v. crisis interventie voorzieningen; lichamelijke detoxificatie; behandeling).

Opiaten worden vaak gebruikt door mensen met slaapproblemen, angst stoornissen, persoonlijke problemen of problemen betreffende sociale relaties, of werkgelegenheid. Het is daarom geen verrassing dat er een hoge comorbiditeit bestaat met psychiatrische stoornissen, in het bijzonder persoonlijkheidspathologie, waar in de behandeling van middelen-afhankelijkheid aandacht aan zou moeten worden besteed. In Nederland bestaan er verscheidene behandel modaliteiten en faciliteiten voor verslavingszorg, welke ieder een verschillende focus van behandeling hebben en verschillen in de mate waarin aandacht wordt besteed aan tevens aanwezige psychopathologie. Het is van belang informatie te verzamelen over de prevalentie en het type psychopathologie in deze verschillende settings om op deze wijze vorm te kunnen geven aan de ontwikkeling van adequate zorgprogramma's. Daarom behelst de eerste doelstelling van deze dissertatie het vaststellen van de prevalentie van persoonlijkheidspathologie bij opiaat-afhankelijke patiënten, binnen de verscheidene zorgprogramma's, die als representatief gezien kunnen worden voor de Nederlandse verslavingszorg (N=279).

Een aantal methoden zijn beschikbaar voor de diagnosestelling van persoonlijkheidspathologie. Er is niet zoiets als een "gouden standaard"voor het meten van persoonlijkheid, maar semi-gestructureerde interview methoden bieden een mogelijkheid om te komen tot een meer systematische, repliceerbare en informatieve diagnostiek door het aanbod van een standaard vragenlijst. Aangetoond is dat semi-gestructureerde interviews een superieure betrouwbaarheid hebben ten aanzien van zelfrapportage instrumenten en het klinisch oordeel (Widiger, 1995). Diagnostiek gebaseerd op het klinisch oordeel lijken vaak te leiden tot een onderschatting van de eigenlijke pathologie, terwijl zelfrapportage een overschatting geven van de pathologie in vergelijking tot semi-gestructureerde interview methoden (Verheul, 1997).

Het Gestructureerd interview voor DSM-IV Personality (SIDP-IV; Pfohl, Blum & Zimmerman, 1995) is zo'n interview. Het interview bestaat uit secties, welke ieder betrekking hebben op een thema, wat resulteert in een natuurlijk gespreksverloop. Het tweede doel van de studie is psychometrisch evalueren van verschillende aspecten van betrouwbaarheid en validiteit van de SIDP-IV in een steekproef van opiaat-afhankelijke patiënten (N=279).

Psychometrische evaluatie van de SIDP-IV; Aspecten van betrouwbaarheid en validiteit

Om de onderzoeksvragen te kunnen beantwoorden werd bij 279 personen de SIDP-IV afgenomen. Voor het interbeoordelaarsprotocol waren bij 50 respondenten twee interviewers aanwezig bij de afname van de SIDP-IV , waarbij steeds een interviewer het gesprek voerde. Tevens werd bij alle respondenten voorafgaand aan de behandeling een de Europese versie van de Addiction Severity Index (EuropASI) afgenomen om op deze wijze een uitgebreide beschrijving van participant kenmerken te genereren.

Resultaten van de psychometrische evaluatie van de SIDP-IV wijzen erop dat het instrument betrouwbaar en valide is voor de diagnostiek van persoonlijkheidspathologie bij opiaat-afhankelijke patiënten. Om de validiteit van een instrument vast te kunnen stellen is een goede betrouwbaarheid een voorwaarde. De betrouwbaarheid is onderzocht door het vaststellen van de interbeoordelaars

betrouwbaarheid, interne consistentie en diagnostische efficiëntie voor de gehele criteria set.

We onderzochten de interbeoordelaars betrouwbaarheid op criterium (de overeenstemming over de aanwezigheid van het criterium)- alsmede op diagnostisch (overeenstemming over de aanwezigheid van de stoornis) niveau, voor zowel categorische- (het al dat niet aanwezig zijn van de stoornis/criterium) als dimensionele (de mate waarin een stoornis/ criterium aanwezig is) data. Zowel op criterium niveau (Cohen's kappa [κ] variërend van 0,76 tot 0,93, en Intraclass Correlatie Coëfficiënt [*ICC*] variërend van 0,67 tot 0.97), als op diagnostisch niveau (κ variërend van 0,66 tot 1,00, en *ICC* variërend van 0,88 tot 0,99), is de interbeoordelaars betrouwbaarheid uitstekend gebleken.

Ten tweede hebben we de interne consistentie en diagnostische efficiëntie vastgesteld van de DSM-IV As-II crieteria-sets. Daarnaast hebben we, om een getrapt diagnostisch model te kunnen ontwikkelen, de criteria kritisch onderzocht. De resultaten laten zien dat de SIDP-IV gezien kan worden als een adequaat en betrouwbaar instrument met een acceptabele interne consistentie en een goede diagnostische efficiëntie. Om op een betrouwbare wijze de aanwezigheid of afwezigheid van persoonlijkheidspathologie vast te kunnen stellen, moet het instrument in zijn geheel worden afgenomen. Wel kan een set van 7 criteria gebruikt worden als een sreeningsinstrument om te kunnen beslissen of het gehele instrument zou moeten worden afgenomen of niet.

Ten derde is in deze studie de onderliggende structuur van de SIDP-IV geëxploreerd om op deze wijze bij te dragen aan de construct validiteit van het instrument. Exploratieve factor analyse leverde een drie-factor oplossing, die grotendeels overeenkomt met het DSM-IV Cluster Model. De optionele stoornissen (deze stoornissen maken nog geen vast onderdeel uit van DSM-IV, maar worden momenteel geëvalueerd ten aanzien van hun bruikbaarheid voor DSM-V), de depressieve en negativistische persoonlijkheidsstoornis, weken niet af van het veronderstelde model. Door middel van Confirmatieve Fit Analyse kon de goede fit ten opzichte van het model niet bevestigd worden, wat te wijten was aan de paranoïde persoonlijkheidsstoornis welke groepeerde binnen cluster B. Al met al, komt de onderliggende structuur van de DSM-IV persoonlijkheidsstoornissen overeen met het

veronderstelde DSM-IV Cluster Model, waarmee een goede construct validiteit van de SIDP-IV gesuggereerd wordt.

Het Interpersoonlijk Gedragsmodel

De DSM-IV is geen theoretisch onderbouwd classificatie systeem. Alternatieven voor dit systeem worden gezocht in theoretisch onderbouwde constructen zoals het interpersoonlijk gedragmodel van Leary. Convergentie tussen de op empirisch materiaal gebaseerde DSM, en op theorie gebaseerde interpersoonlijke benaderingen van persoonlijkheid werd onderzocht en gemeten door de SIDP-IV en de Interpersonal Checklist-Reviserd (ICL-R). Voor de studie naar het interpersoonlijk gedragsmodel, werd bij 110 van de 279 proefpersonen een ICL-R afgenomen. Zoals voorspeld op basis van voorafgaand onderzoek, wezen de bevindingen erop dat de twee benaderingen eerder complementair dan uitwisselbaar zijn. Het Interpersoonlijk Gedragsmodel blijkt geen adequaat alternatief voor de DSM-IV te zijn binnen deze populatie. Desondanks is er wel enige overlap gevonden tussen SIDP-IV dimensies en de ICL-R, voornamelijk ten aanzien van de kritisch/wantrouwende, teruggetrokken/verlegen en de afhankelijk/volgzame stijl. Resultaten wijzen erop dat middelen-afhankelijkheid op zichzelf geen voorspellende waarde heeft ten aanzien van de interpersoonlijke stijl die iemand hanteert, terwijl dit wel geldt voor de persoonlijkheidspathologie op zich. Patiënten met een persoonlijkheidsstoornis zien zichzelf als vijandig en onderdanig, terwijl patiënten zonder een persoonlijkheidsstoornis zichzelf zien al vriendelijk en overheersend. Ondanks dat er een aanzienlijke overlap bestaat, hebben de SIDP-IV en ICL-R betrekking op andere constructen. De ICL-R biedt dus geen vervanging voor de SIDP-IV en kan ook niet als zodanig ingezet worden. De SIDP-IV blijkt informatief te zijn ten aanzien van de classificatie van persoonlijkheidsstoornissen, aanvullend kunnen er richtlijnen voor gedragsverandering bij verslaafde patiënten gegeven worden op basis van de ICL-R.

Resultaten van het prevalentie onderzoek

Prevalentie cijfers blijken aanzienlijk te variëren tussen zorgprogramma's. Bij de intramurale behandel setting, heeft zo'n 70% van de patiënten een persoonlijkheidsstoornis. Bij de groep patiënten binnen het detoxificatie programma en

de methadon-onderhoudsbehandeling, was de prevalentie aanzienlijk lager (respectievelijk, 43,2% en 44,3%). Resultaten betreffende de afzonderlijke stoornissen wijzen er op dat er tussen de drie steekproeven geen verschil is in het percentage patiënten met een schizoïde, schizotypische, theatrale, narcistische, vermijdende, afhankelijke of negativistische persoonlijkheidsstoornis (p>.01). Bij de klinisch opgenomen patiënt groep waren er meer patiënten met een antisociale (Z=3.6; p<.001), borderline (Z=3.5; p<.001), en obsessief-compulsieve (Z=5.0; p<.001) persoonlijkheidsstoornis in vergelijking tot de patiënten in de detoxificatie groep. In het methadon onderhoudsprogramma, waren er meer patiënten met een paranoïde (Z=2.9; p=.004) en depressieve PD (Z=3.3; p=.001), in vergelijking tot de snelle detoxificatie groep. Bovendien, in steekproef klinische patiënten, waren er meer patiënten met een obsessief-compulsieve persoonlijkheidsstoornis (Z=3.3; p=.001), in vergelijking tot de patiënten in het methadon onderhoudsprogramma.

Efficiënte and effectieve behandel strategieën

Screeningsinstrumenten

In dit onderzoek werd de diagnostische efficiëntie van de EuropASI als screeningsinstrument onderzocht. De resultaten leveren weinig onderbouwing voor de diagnostische efficiëntie van de EuropASI als screeningsinstrument voor persoonlijkheidspathologie. Voor de klinische praktijk binnen de verslavingszorg betekent dit dat er alternatieve diagnostische strategieën voor het vaststellen van persoonlijkheidspathologie zouden moeten worden toegevoegd aan de standaard intake procedure.

In de literatuur worden twee screeningsinstrumenten voor persoonlijkheidspathologie beschreven. Dit zijn de SAPAS (Standardised Assessment of Personality-abbreviated scale; Moran, Leese, Lee, Walters, Thornicroft & Mann, 2003) en de IOWA Personality Disorder Screen (IPDS; Langbehn, Pfohl, Reynolds, Clarck, Battaglia, Bellodi, Cadoret, Grove, Pilkonis & Links, 1999). Deze instrumenten blijken een goede sensitiviteit en specificiteit te hebben binnen steekproeven van patiënten met een brede variatie van psychiatrische stoornissen. Voor het vaststellen van de aan- of afwezigheid van persoonlijkheidspathologie bij Nederlandse opiaat-afhankelijke patiënten, vonden we in ons onderzoek een set van

zeven criteria, wat de basis vormt voor een screeningsinterview. De drie screeners variëren opvallend in de inhoud van de criteria. Ons instrument is niet ontwikkeld voor de gebruik in een algemene psychiatrische populatie, zoals de twee andere instrumenten, maar meer specifiek toepasbaar bij Nederlandse opiaat-afhankelijke patiënten.

Diagnostische procedures afgestemd op specifieke patiënt karakteristieken in de verschillende zorg en behandel faciliteiten; een voorstel voor getrapte diagnostiek.

Afhankelijk van het type zorgprogramma en behandel of zorg stadium, kunnen effectieve diagnostische strategieën om persoonlijkheidspathologie vast te stellen worden ontwikkeld. Een aantal uitgaanspunten dragen bij aan de ontwikkeling van efficiënte diagnostische procedures, die kunnen worden ingezet in de klinische praktijk van de verslavingszorg. Deze richtlijnen zijn gerelateerd aan de intensiteit en het stadium van zorg waarin de patiënt verkeert. Allereerst, in een crisis interventie situatie, zijn interventies voornamelijk gericht op het laten overleven van de in crisis geraakte patiënt. In dat stadium vindt er geen persoonlijkheidonderzoek plaats. Ten tweede, patiënten in methadon onderhoudsprogramma's hebben geen persoonlijkheidsonderzoek nodig, tenzij de behandeling onvoldoende effectief blijkt te zijn voor de individuele patiënt (b.v., wanneer een patiënt gevaarlijk, extreem vijandig of nalatig gedrag vertoont). Ten derde, patiënten die deelnemen aan ambulante behandel programma's, hebben vaak nog geen uitgebreide behandel voorgeschiedenis. Daarom zou de eerste stap in de het diagnostisch proces voor deze patiënten niet te veelomvattend moeten zijn. Wanneer er eerdere behandeling heeft plaatsgevonden wat niet heeft geleid tot een positief resultaat (b.v. abstinentie op lange termijn), zouden patiënten gescreend kunnen worden gedaan tav de persoonlijkheidspathologie. Wanneer, in de loop van de ambulante behandeling, het programma niet effectief blijkt te zijn, zou alsnog een screening ingezet dienen te worden. Ten slotte hebben patiënten in klinische behandel faciliteiten aanzienlijke problemen op meerdere levensgebieden, een langere behandelgeschiedenis en nemen deel aan een intensievere vorm van behandeling, waarin de problematiek op verscheidene levensgebieden aan de orde komt. Daarom, zouden in dit type behandelsetting, alle patiënten uitgebreid persoonlijkheidsonderzoek aangeboden moeten krijgen door middel van afname van de SIDP-IV.

Conclusie

In dit proefschrift hebben we gezocht naar de persoon achter de verslaving. Hebben we deze persoon achter de verslaving gevonden? Deze vraag kan zowel positief als negatief beantwoord worden. We hebben niet "*de* persoon" achter de verslaving gevonden, want patiënten blijken een variëteit aan gevoelens, gedachten en gedragspatronen te vertonen. Deze aspecten van persoonlijkheid konden niet voorspeld worden door andere patiënt kenmerken zoals werkgelegenheid, verslavingsernst, behandelgeschiedenis, leeftijd, sociaal-economische status, etcetera. Wat we wel hebben gevonden, zijn methoden en aanbevelingen over hoe we een goede schets kunnen maken van de persoon die schuilgaat achter de verslaving, op een efficiënte manier die passend is voor de situatie, motivationele fase en behandeldoelen en planning van de patiënt.

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Curriculum Vitae

Katinka Damen werd geboren op 17 december 1974 te ’s-Hertogenbosch. Na het behalen van haar HAVO en VWO diploma aan het Maurick College te Vught, ging zij in 1994 Algemene Sociale Wetenschappen studeren aan de Rijksuniversiteit Utrecht. Na het behalen van haar propedeutisch examen, koos zij voor de studie Psychologie. Na de uitvoering van een onderzoek naar de effecten van een vervroegde puberteitsaanvang op de lichaamsbeleving van jonge vrouwen en het lopen van een klinische stage bij Novadic, Netwerk voor verslavingszorg, voltooide zij in 1999 deze studie, met als afstudeerrichting Klinische- en Gezondheidspsychologie. In hetzelfde jaar, werd ze voor tweeëneenhalf jaar aangesteld als onderzoekspsycholoog bij Novadic-Kentron, waar zij de data verzamelde voor het onderzoeksproject “Searching for the Person Behind the Addiction”. Tevens werkte zij in 2001 als therapeut binnen het “EDOCRA” (snelle detox) project. Van 2002 tot 2004 volgde een aanstelling als junior onderzoeker bij het Academisch Centrum voor Sociale Wetenschappen aan de Radboud Universiteit Nijmegen (toen nog Katholieke Universiteit Nijmegen geheten), waar zij het onderzoeksproject vervolgde waar dit proefschrift het resultaat van is. In 2003 startte zij tevens parttime als psycholoog binnen een milieutherapeutische afdeling van Novadic-Kentron. Deze werkplek werd omgezet in een opleidingsplaats in het kader van de opleiding tot Gezondheidszorg Psycholoog, waar zij in 2004 mee startte en die ze eind 2005 hoopt te voltooien.