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Research Paper

Development and Validation of PSG-Personality Disorder Inventory (PSG-PDI)

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Curiosity to categorize peoples into specific cluster has never lost its value in the history of psychological studies. The contradiction in the definition of personality is still enduring but still the most appreciable definition for personality was given by Gordon Allport as "Personality is the dynamic representation within the individual of those psychophysical systems that determine his unique way of adjustments to his environment" (Schachtel, 1938). Most of the professionals agreed with the definition of personality as it stresses on the behavioral pattern which considered to be the outcome of inner qualities or psychological characteristics. Personality as a construct holds its vital worth in achieving the task of categorizing people using various theoretical constructs. The categorization of individual was started with the work of Hippocrates in segregating the people according to their bodily humors as sanguine (optimistic), melancholic (depressed), choleric (hot-tempered) and phlegmatic (unexcitable). The modern classification of personality was on the basis of type and trait theories. Jung proposed two types of personality type as extroversion and introversion. Eysenck clustered people into three personality types as extroversion, neuroticism and psychoticism. Later it was further extended into five ('the Big Five') by adding conscientiousness and agreeableness (Zimmerman, 1994). The trait approach was led by the Gordon Allport, he collected 18,000 trait like terms in English language that actually, most adjectively, describes how people act, think, perceive and feel. The collected trait like terms resulted in formulation of three clusters as Cardinal trait, Central trait and Secondary trait. The view on personality was conflicting and sometimes overlapping among the dynamic theorist, trait and type theorist, behaviorist, humanitarian and biological perspectives.

Personality Disorder

The terms insanity, mental illness, psychopathology, emotional disturbance, behavioral disorder, mental disorder, abnormality, and psychological disorder have roughly similar meanings (Morgan, 2015). Mental disorder can be defined as "A clinically significant

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behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one". During 1800s, German physicians Emil Kraepelin and Alzheimer primarily worked on categorizing psychiatric conditions by systematic observation of symptoms, course, pattern and its outcome. But their works were ignored by American psychiatry during those days (Fischer, 2012). However personality disorder as an inevitable cluster that got positioned in the very first edition of the Diagnostic and Statistical Manual, Mental Disorders (DSM) which included psychosis, psychoneurosis, and personality. The multi-axial approach to the DSM is introduced in its 3rd version as DSM-III in 1980 was removed from the manual with the emergence of 5th edition of DSM. The rationale was based on unclear boundaries between medical and psychiatric diagnoses, inconsistent use of Axis IV by clinicians and researchers, and or psychometric and clinical validity of Axis V (Aas, 2010; Association, 2013; Røysamb et al., 2011). Another conventional practice that has broken down with the introduction of 5th edition is that alteration in the representation of the edition from Roman letter (I, II, III, IV) to the Arabic letter as 5 by representing the fifth edition as DSM-5. The advancement is for facilitating infinite revision within the fifth edition as DSM-5.1, DSM-5.2, DSM-5.3, etc. as when it is needed (Regier, Narrow, Kuhl, & Kupfer, 2009). The DSM-5 holds the Personality Disorders (PD) in its section-2 like distinguished in DSM-IV, whilst an alternate trait model was introduced in section-3 of DSM-V for further evaluation and research (Association, 2013). The measuring tools for addressing the PDs as proposed in section-3 was under construction like the Personality Inventory for DSM-5 (PID-5) (Krueger, Derringer, Markon, Watson, & Skodol, 2012) to assess and evaluate (Bagby, 2013) this modern trait model, the diagnosis and assessment of categorical PDs is primarily advocated in the official nomenclature of the American Psychiatric Association.

The assessment of personality disorder could be organized in four categories as structured interviews, questionnaires, multidimensional measures targeting categorical personality disorders and assessments of single personality disorders. The example of structured interview for assessing personality disorders are The Iowa Personality Disorder Screen (Langbehn et al., 1999), The Shedler-Westen Assessment Procedure 200 (Westen & Shedler, 2007), The Diagnostic Interview for DSM-IV Personality Disorders (M. C. Zanarini, Gunderson, Frankenburg, & Chauncey, 1989). The examples of the questionnaires are The Personality Diagnostic Questionnaire-4 (Hyler, 1994), The Millon Clinical Multiaxial Inventory-III (Millon & Davis, 1997). Some of the multidimensional measures targeting categorical personality disorder are Widiger and Costa in the year 2013 updated and summarized the available evidence for using a general trait model like the FFM for the description of Personality Disorders by having the assumption that the discrepancy between general traits and personality pathology reflects more a quantitative than a qualitative difference (Simms & Clark, 2006). The examples of assessment of single personality disorder are The Paranoid Personality Disorder Features Questionnaire (Useda, 2002) for paranoid PD. The Interpersonal Measure of Schizoid Personality Disorder (Kosson et al., 2008) for schizoid PD. The Referential Thinking Scale (Lenzenweger, Bennett, & Lilenfeld, 1997), The Schizotypal Personality Questionnaire (Raine, 1991), Schizotypal Personality Questionnaire-Brief (Raine & Benishay, 1995), The Structured Interview for Schizotypy (SIS) (Kendler, Lieberman, & Walsh, 1989) for schizotypal PD. The Antisocial Personality Questionnaire (Blackburn & Fawcett, 1999), The Psychopathy Checklist (Hare, 1980), The Psychopathic Personality Inventory Revised (Lilienfeld & Widows, 2005), The Elemental Psychopathy

Assessment (Lynam et al., 2011) for Antisocial PD. The Diagnostic Interview for Borderlines (M. C. Zanarini et al., 1989), The Zanarini Rating Scale for Borderline Personality Disorder (Mary C. Zanarini, Frankenburg, Hennen, & Silk, 2003), The Borderline Evaluation of Severity Over Time (Pfohl et al., 2009) for Boderline PD. The Five-Factor Measure of Histrionic Traits (Lynam, Loehr, Miller, & Widiger, 2012) for Histrionic PD. The Narcissistic Personality Inventory (Raskin & Hall, 1979), Margolis-Thomas Measure of Narcissism (Margolis & Thomas, 1980) for Narcissistic PD. The Five-Factor Avoidant Assessment (Lynam et al., 2012) for Avoidant PD. The Dependent Personality Inventory (Huber, 2005), The Dependent Personality Questionnaire (Tyrer, Morgan, & Cicchetti, 2004) for Dependent PD. The Five Factor Obsessive-Compulsive Inventory (Samuel, Riddell, Lynam, Miller, & Widiger, 2012) for Obsessive-Compulsive PD.

There exists enormous measures to assess the personality disorder among the clinical and as well as non-clinical individuals. The study of personality disorder in the developing countries like India is very few. The screening tool for the personality disorder in the Indian context is untraceable. The reliability of application of ICD-10 to diagnose PD has been appealed earlier (Sartorius et al., 1993). The developed measure in the Indian context with having the DSM-5 section 2 PD criteria as a basic theoretical model will enhance the Indian Clinicians to overcome the steeplechases in using the foreign measures to assess the prime behavioral patterns of an individual.

METHODOLOGY

Aim:

To develop and standardize a tool for Screening Personality Disorder based on DSM-V, Personality Disorder Diagnostic Criteria.

Objectives*:*

1. To develop the screening tool to measure Personality Disorder based on DSM-V.
2. To establish the psychometric properties for the developed tool.

Procedure

This study was executed in two phases. In study 1, the items were generated and the items were reviewed by the panel of masters' experts and the pilot testing was conducted and item response analysis was executed. Number of items were reduced on each phase of the study 1. In study 2, the content validation was obtained through expert rating method and other psychometric properties such as internal consistency reliability, concurrent validity and clinical validity was established.

RESULTS

The results of the Study 1 are discussed under 3 phases. The study 1 started with the generation of item then followed by reviewing the item through focus group discussion. Then the pilot study was conducted.

Study 1: Item Generation and Pilot Testing

Phase-I: Item Generation:

Items were generated by having the symptomology provided by DSM-5 text as a basis and some items are pooled from the other existing scales which intended to assess, screen and measure personality disorder.

The number of items generated for paranoid PD is 19, for schizoid PD is 17 and for schizotypal PD is 26, and for the cluster B Personality Disorders Histrionic PD, Antisocial

PD, Narcissistic PD and Borderline PD are 30, 23, 30 and 20 respectively. The number of items generated for Cluster C Personality Disorders like Avoidant PD, Dependent PD and Obsessive-Compulsive PD are 20, 12 and 27 respectively. A total of 260 items are generated in the first phase of item generation.

Phase-II: Focus Group Discussion:

The generated items were discussed with the students and scholars in Psychology. Three focus group discussions were carried out. In the first phase of focus group discussion, 4 students from II- year Master's in Applied Psychology were included. The second focus group discussion comprised of 5 M.Phil research scholars and one I-year student from Master's in Applied Psychology. The last focus group discussion included 2 M.Phil research scholars, two I-year Master's student and 2 III-year Under Graduate students in Psychology. All the focus group discussions were moderated by the clinically trained professional. Grammatical mistakes, syntax errors and structure of the sentences were the primary concern of first focus group discussion. In the second and third focus group discussion, item's content, appropriateness, simplicity and the accuracy of the construct were the concerns. Items were reduced in the each phase and the total of 260 items was reduced in to 107 items at the end of three focus discussions.

Phase-III: Pilot testing:

Purpose:

The purpose of the pilot testing is to eliminate items that are psychometrically not functioning efficiently (ceiling and floor effect). For this purpose the developed scale with the 107 items was administered on the psychiatric patients residing in the temporary rehabilitation center at Coimbatore.

***Participants*:**

The sample (N = 30) consisted of 25 males (80.6%) and 5 females (16.1%) age ranged between 20 and 50 (M=36.64, SD= 8.94). The group was distributed with regard to their age in which 9 patients aged between 20-30 years (29.0%), the number of patients distributed between 30-40 is 12 (38.7%) and 9 patients with the age range of 40-50 (29.0%). In terms of education there were 3 (6.5%) patients were illiterate, 9 (29%) of them have studied till 10^{th} standard, 4 (12.9%) of them were passed 12^{th} standard, 3 (9.7%) were Diploma holders in different majors, 9 (29%) of the patients have completed their Under Graduate degree and 4 (12.9%) of them were Post Graduate. In the total sample 2 (3.2%) of them have 5 siblings, 1 (3.2%) has 4 siblings, 9 (29%) has 3 siblings, 9 (29%) has 2 siblings, 11 (35.5%) have only one siblings and there were no single born child in this study. In terms of birth order, 9 (29%) of them were first born kids, 12 (38.7%) were second born, 6 (19.4%) were third born and 2 (6.5%) were the forth born and only one participant (3.2%) is the fifth born child in the families. The 12 (38.7%) and 18 (58.1%) of them were belonging to nuclear and joint family respectively. Among the 30 patients, 12 (38.7%) patients were married and 18 (58.1%) patients were single. With regards to their domicile, most of the patients 17 (54.8%) were from Urban area, 4 (12.9%) from Suburban and 9 (29%) were from Rural area. Since the data were collected from the psychiatric population, describing the nature of the disorder is inevitable. Among the patients, 1 (3.2%) was affected from OCD, 3 (9.7%) were suffering from Mood disorder, 12 (38.7%) were Schizophrenic, 4 (12.9%) were diagnosed with Delusional disorder, 7 (22.6%) were affected by ADS, 1 (3.2%) was suffering from Poly substance abuse and 2 (6.5%) were diagnosed as Substance induced psychotic disorder.

RESULTS

By carrying out the frequency and percentage analysis, the items for which two third of the participants responded in the same way were eliminated from the tool and rest of the items were retained in the scale (i.e.) the items for which nearly half of the sample reported yes and the rest reported no were only retained for further steps. Thus after the item analysis a total of 89 statements were retained as those met the criteria for inclusion.

Table 1: Showing the number of items initially developed and retained after focus group discussion and item analysis on each domain:

Dimensions	No. of items developed initially	No. of items after focus group discussion	No. of items after item analysis
Paranoid PD	19	11	9
Schizoid PD	17	9	8
Schizotypal PD	26	10	9
Histrionic PD	30	11	9
Narcissistic PD	23	14	10
Borderline PD	30	11	10
Antisocial PD	20	12	8
Dependent PD	12	10	10
Avoidant PD	27	8	6
Obsessive Compulsive PD	19	11	9
Total	260	170	89

Study 2- Establishing Reliability and Validity:

Purpose:

To establish the psychometric property of the developed measure, various psychometric properties was considered. Since expert opinion about the measure was seen as inevitable for the clinical tool, so content validity through expert rating was executed at the first level. Then the developed measure was compared with one existing tool to establish the concurrent validity. The clinical validity of the tool was established by comparing the result of clinical samples and the data collected from non-clinical samples. The internal consistency of the tool was also established.

Participants

Sample for the concurrent validity analysis (N=100) consisted of 40 male and 60 female with the age range of 18 to 23 (M=21.14, SD=0.89). All the participants were college students. 50 participants from the previous phase were randomly selected and included in the study to establish test-retest reliability. The clinical sample (N=30) consisted of 20 male (66.7%) and 10 female (33.3%) with the age range between 20 years to 50 years.

Content validity

The expert board for content validation consisted of 10 professionals who are currently in the clinical practice. The board comprises of 5 clinical psychologist and 3 counseling psychologist and 2 assistant professors who have completed their clinical training. They were provided with the developed items with 5 point rating option in the context of its appropriateness, level of relevance and readability. Before participating in the study the experts were explained detail about the purpose of the study, ethical considerations were discussed and got signed in the informed consent form. The mean score of expert's ratings

on each item was calculated and the items having mean rating score lesser than 3 were eliminated from the scale (Item 20, 24 and 57).

Concurrent validity

The intention of establishing the concurrent validity for a tool is to prove that the developed tool assess the same construct that has been measured by the already standardized one.

Correlation	PSG-PDI total
IPDE total	.29*

*** indicates 0.05 level of significance**

The above table indicating the relationship among the scores obtained from the IPDE (International Personality Disorder Examination) and PSG-PDI (PSG-Personality Disorder Inventory). The correlation analysis (r = 0.29*, Sig = .041), reveals that there is a positive relationship between those two measure's score which could be inferred as that IPDE and PSG-PDI tools measures the same construct as that of IPDE.

Clinical validity

The clinical validity of the tool was found by comparing the data collected from the clinical sample and the non-clinical sample. The data for the clinical sample (N = 30) were collected from the psychiatric patients living in the temporary residence where they were admitted for rehabilitation. The data for the non-clinical sample (n=50) were derived from individuals who volunteered for the re-test administration. The independent sample t-test was the statistical procedure executed for the data analysis. This test was carried out with the intention of comparing the two group scores. It was hypothesized that the clinical samples will have a greater score than the normal sample in the entire dimensions.

Dimensions	**Sample**	**Mean**	**Std. Dev.**	**'t'**	**Sig.**
Paranoid PD	Non-clinical	2.50	1.23	-3.68	**.000**
	Clinical	3.97	2.32		
Schizoid PD	Non-clinical	2	1.65	-3.81	**.000**
	Clinical	3.70	2.32		
Schizotypal PD	Non-clinical	2.84	1.77	-3.17	**.002**
	Clinical	3.73	1.73		
Histrionic PD	Non-clinical	2.60	1.92	-2.16	**.033**
	Clinical	3.73	2.74		
Antisocial PD	Non-clinical	2.02	1.57	-4.31	**.000**
	Clinical	3.77	2.02		
Narcissistic PD	Non-clinical	5.36	2.6	0.94	.348
	Clinical	4.80	2.51		
Borderline PD	Non-clinical	3.26	2.14	-2.07	**.041**
	Clinical	4.32	1.81		
Avoidant PD	Non-clinical	2.24	1.27	-2.49	**.015**
	Clinical	3.07	1.68		
Dependent PD	Non-clinical	4.06	2.53	-2.09	**.039**
	Clinical	5.33	2.78		
Obsessive Compulsive PD	Non-clinical	3.68	2.25	0.93	.353
	Clinical	3.20	2.17		

The Independent sample 't' test was carried out to establish the clinical validity. The analysis of the data shows that the mean value of normal sample for Paranoid is (M = 2. 50, S.D = 1. 23) and the mean value of clinical sample is (M = 3. 97, S.D = 2. 32). The results reveals that there is a difference between clinical and normal sample mean with the significant 't' value (t = 3. 689, Sig.= . 000). Therefore 't' value and the significance level indicates that there is a significant difference between clinical and normal sample and the clinical samples have scored more than that of the normal sample. This result is applicable to the dimensions such as schizoid (M =2, S.D=1. 65; M=3. 70, S.D=2. 32), (t=3. 816, Sig.=. 000), schizotypal (M=2. 84, S.D=1. 77; M=3. 73, S.D=1. 73)(t=3. 17, Sig.=. 002), Histrionic (M=2. 60, S.D=1. 92; M=3. 73, S.D=2. 74) (t=2. 167, Sig.=. 033), Antisocial (M=2. 02, S.D=1. 57; M=3. 73, S.D=2. 02) (t=4. 30, Sig.=. 000), Borderline (M=3. 26, S.D=2. 14; M=4. 23, S.D=1. 81) (t=2. 07, Sig.=. 041), Avoidant (M=2. 24, S.D=1. 27; M=3. 07, S.D=1. 68) (t=2. 49, Sig.=. 015), Dependent (M=4. 06, S.D=2. 53; M=5. 33, S.D=2. 78) (t=2. 09, Sig.=. 039). For all the above mentioned dimensions the mean value of the Clinical sample is higher than the mean value of the normal sample. The difference between those two samples mean is statistically significant at varied level with the range from .000 to .041. However the mean value of normal sample in the Narcissistic dimension in PSG-PDI is (M=5. 36, S.D=2. 6) and for the clinical sample is (M=4. 8, S.D=2. 51) with the t value (t=. 944, Sig=. 348), which is not statistically significant. Further in the Obsessive Compulsive personality disorder dimension, the mean value of normal sample is (M=3. 68, S.D=2. 25) and the mean value of clinical sample is (M = 3. 20, S.D=2. 17) with the t value (t=. 935, Sig=. 353) which is also not statistically significantly. For the Narcissistic and OCPD dimension the mean value of normal sample is higher than the mean value of clinical sample.

Temporal consistency

The temporal stability (test-retest reliability) of the tool intends to prove that the tool is consistent with the result it produces. To establishing the temporal stability the tool was administered twice on the same sample with the interval period of 20 days.

S. No.	Statements	Test-retest reliability
1	I always try to find out hidden meanings while talking to others.	0.825
2	I think that my partner is unfaithful to me.	0.785
3	I avoid sharing my personal details to others because someone will misuse it.	0.858
4	I think people will do things that may harm my character and reputation.	0.901
5	I feel that my friends/ family members will plan against me.	0.891
6	I find myself as a person who holds grudges persistently.	0.911
7	I react furiously when I find threat to my name or character.	0.653
8	I'm preoccupied of not being exploited by others.	0.875
9	I avoid socializing with people because I think that they have hidden motives.	0.896
10	I don't like to have close relationship with anyone even with my family members.	0.905
11	I prefer being detached from my surroundings.	0.829
12	I have least interest to have sex with my partner.	0.691
13	*I enjoy activities which involves people.	0.702
14	I find it difficult to react when others praise/ criticize me.	0.821

S. No.	Statements	Test-retest reliability
15	*I enjoy almost everything in my life.	0.895
16	I never tried to have close relationship with people.	0.957
17	I prefer keeping my feelings to myself.	0.894
18	When I'm out, I will be more conscious of being under surveillance.	0.712
19	I can see many people talking about me at a distance.	0.837
20	My interpretation towards things seems different from others.	0.784
21	I experience the presence of special force around me that is invisible to others.	0.910
22	I am afraid that my thoughts are audible to others.	0.856
23	I get nervous when I'm surrounded by people.	0.970
24	I consider myself as an odd and unusual person.	0.858
25	I often attempt to attract others by my physical appearance.	0.720
26	I consider myself as sexually attractive.	0.784
27	I flirt with opposite sex even though they are not attractive.	0.695
28	I insist to have intimate relationship with my partner.	0.769
29	I wish relationships to be more intimate as in movies.	0.896
30	I get easily influenced by other people.	0.597
31	My expressive emotions get swing as time passes.	0.730
32	People often say that my expressions are cinematic.	0.804
33	As in conversation, I tend to impress others.	0.684
34	It's hard for me to obey the rules.	0.797
35	I engage in physical fights easily.	0.712
36	I never think before I act.	0.957
37	It's hard for me to obey the rules. I engage in physical fights easily. I never think before I act.	0.845
38	*I feel guilty for my past mistakes.	0.917
39	People around me describe me as an irresponsible person.	0.863
40	I blame others easily.	0.840
41	I lie for my benefits.	0.917
42	I accept that lying and cheating for our personal benefits is right.	0.738
43	I enjoy being the center of attention.	0.847
44	I always believe that I'm capable of doing anything.	0.927
45	Many people view me as extraordinary.	0.801
46	I like almost everything about me.	0.718
47	I love to describe about myself.	0.912
48	I always prefer myself being in the top/ best position in a group.	0.810
49	It is very easy for me to influence people around me.	0.862
50	*I consider myself less capable than others.	0.649
51	I feel that I am a precious gift for this world.	0.784
52	I have a strong believe that 'I am a special person.	0.861
53	I will go to any extreme to hold my relationship with others.	0.910
54	Very often I change my friends as I easily develop dislike towards them.	0.821
55	*I have never threatened people with suicidal attempts.	0.849
56	I often feel empty.	0.915
57	I find it difficult to hold my mood and emotion in a stable manner.	0.802
58	In a stressful situation, I get very suspicious.	0.718

S. No.	Statements	Test-retest reliability
59	I engage in physical fights to express my uncontrollable anger.	0.798
60	I experience sudden mood shifts many times a day.	0.914
61	Many times I feel myself unconnected with myself when encountering with stressful situation.	0.639
62	Before committing myself to others I assure myself that they truly like me.	0.895
63	I show restriction even to my intimate group to avoid shame.	0.816
64	I always avoid engaging in new activities as I believe that may prove my inadequacy and end up in embarrassment.	0.890
65	I always view myself as incompetent in the society than others.	0.852
66	*I prefer activities which involves cooperation from others.	0.658
67	I have a fear of being humiliated if I don't plot any limitation to my close friends.	0.739
68	To hold my existing relationship I do something as per their wish even though it is unpleasant for me.	0.937
69	As having the fear of losing support, I have never disagreed with my friends even though I have different opinion.	0.841
70	I wish to be always covered by someone who really cares for me.	0.709
71	I always need someone to take care of me.	0.625
72	I afraid of being left alone in this world.	0.825
73	I feel helpless and uncomfortable if I left alone.	0.794
74	As soon as I have lost the support of my friend, I urgently seek another relationship to take care of me.	0.840
75	I find it very difficult to take even minor decisions without any advises/ reassurance from others.	0.795
76	I give full authority to my close ones to take major decisions of my life.	0.943
77	I'm comfortable when someone close to me take over responsibility for my major life decisions.	0.839
78	I insist people to do work in my style only.	0.837
79	I fail to complete my works on time because I repeatedly check on minute possible mistakes.	0.853
80	I can't resist myself from cleaning my things/ surroundings frequently.	0.914
81	I keep on saving many unnecessary things that will be of no use in future.	0.836
82	I will be severely upset if my regular activities get upset.	0.917
83	I have some specific sets of repeated behavior that intrudes my personal life.	0.863
84	Sticking on to rules gives me peace of mind.	0.794
85	I always make plan of action even for daily life events.	0.715
86	I never go late to work places because it makes me restless.	0.864
Overall Temporal Stability		**0.821**

The test-retest reliability was established using the correlation analysis by correlating the two responses given for same item but in different point of time. The higher correlational value indicates the high level of consistency and the lower value indicates the low level of consistency between two sets of responses. The above table indicated that the temporal stability of the tool ranges from 0. 59 to 0. 97, with the overall temporal stability as 0.82. This result indicates that the temporal stability of the tool is high and so it is reliable. The

analysis attest that this tool could have the tendency to produce same result when it is been administered on the same individual in different point of time.

Internal consistency reliability

Cronbach's alpha value of the scale's dimension such as Schizoid, Histrionic and Dependent PD was more than 0.70. The PD dimensions such Paranoid, Schizotypal, Narcissistic and Obsessive-Compulsive PD has a value more than 0.60. The dimensions such Antisocial and Borderline has a value less than 0.60. Thus the internal consistency of the tool is ranging from high to moderate. Usually the Cronbach's alpha value between .061 and .080 is referred to be high. So the scale consists of 10 sub-scales with the high internal consistency value.

CONCLUSION

The primary purpose of the study was to develop the statements targeting at screening the individuals having personality disorder and to establish the psychometric property of the same. To accomplish the above mentioned objectives, study was conducted in two different phases. The items were developed, refined through focus group discussion and pilot testing was conducted. Items were reduced on each phase. The psychometric properties such as content validity, concurrent validity, clinical validity, internal consistency and test-retest reliability. The developed tool could be used in the clinical setting for the purpose of screening. Further research in this area could focus on developing a norms for the diagnosis purpose.

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Conflict of Interest

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