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# RELIABILITY OF THE ICD-10 INTERNATIONAL PERSONALITY DISORDER EXAMINATION (IPDE) (HINDI VERSION): A PRELIMINARY STUDY

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## *ABSTRACT*

*The study was aimed at estimating the joint-rater reliability and applicability of Hindi version of ICD-10 IPDE that was obtained following a standard translation protocol. The instrument was administered to 22 non-psychotic patients by two raters. The average intraclass correlation for each item (0.89), number of criteria met per disorder (0.92) and dimensional scores (0.98) was high. Kappa for definite (0.65-0.78) and probable personality disorder (PD) (0.78-1.00) and for presence/ absence of any PD (0.78) was acceptable. Overall weighted kappa was 0.81 for definite and 0.91 for probable PD. Findings suggest that ICD-10 IPDE (Hindi version) has acceptable joint- rater reliability and applicability in the North Indian Hindi speaking population.*

*Key words: International Personality disorder Examination, Hindi Version, Reliability*

Experience with unstructured interviews showed that despite the utilization of operational criteria, joint-rater agreement for the presence or absence of personality disorder (PD) was much lower than the reliability for Axis I disorders (Spitzer et al.,1979). Standardized measurement of personality disorder led to higher reliability(Zimmerman,1994). Loranger et al.(1997) established that International Personality Disorder Examination (IPDE) was reliable (median K-0.70 for DSM-III-R, 0.72 for ICD-10) and acceptable to clinicians across the world (including Indians).

The present study was aimed at estimating the joint-rater reliability of ICD-10 IPDE (Hindi Version) and at assessing its applicability in a North Indian population.

One of major problem with IPDE is the length of administration (average 2 hours and 20 minutes) (Dahl and Andreoli,1997). The feasibility of using screening instruments for personality disorders in epidemiological studies is being researched (Lenzwenger,1999; Mann et al.,1999) at times, with limited success (Hartgers et al.,1998). In the clinical situation, the only way to reduce the time of administration seems to be the use of separate modules for ICD-10 and DSM-III-R personality disorders.

## MATERIAL AND METHOD

Twenty-two non-psychotic outpatients (organic mental disorders, mental retardation and medical illnesses were excluded ) in the age range of 18 to 60 years were assessed with ICD-10 IPDE module consisting of 67 items (Loranger et al.,1997). One third of the patients were suspected to have PD and two-thirds were women(n=15).

Permission was taken from the World Health Organisation to translate the IPDE (Janca, Personal Communication). Items were selected from independent translations made by five bilingual mental health professionals. Linguistic equivalence was assessed through back-

translation and conceptual equivalence through opinion of mental health experts. The final Hindi draft was obtained after incorporating modifications suggested by experts following a feasibility study on 20 outpatients. As recommended in the IPDE manual, two raters familiarised themselves with the ICD-10 module by interviewing 10 patients each with the Hindi draft. The IPDE was then administered by one of the two raters (the other rater was not permitted to ask questions) according to a preset randomized schedule.

Agreement was assessed with Cohen's Kappa for dichotomous variables, and intra class correlation for continuous variables. K was computed only when the base rate for a PD was 5%, as required by Grove et al.(1981). An overall weighted Kappa was also determined for all PDs by the method given in Loranger et al.(1997).

## RESULTS

Three patients(13.6%) had definite and four patients (18.2%) had probable PD diagnosis (the IPDE assigns a probable diagnosis when a subject meets one criterion less than the number required for definite PD). The commonest definite (and probable) PD was emotionally unstable PD: impulsive type (13.6%, definite;22.7% probable or definite).

TABLE 1

INTERRATER AGREEMENT(K)

| Diagnoses | Present sample (n=22) Definite n(base rate) # | Probable/Definite n(base rate) |
|---|---|---|
| Paranoid | 0% | 2% |
| Schizoid | 0% | 1% |
| Dissocial | 4.5% | 4% |
| Emotionally unstable | | |
| Impulsive | 0.78(11.4%) | 4% |
| Borderline | 0.65(6.8%) | 0.76(12%) |
| Histrionic | 4.5% | 3% |
| Anankastic | 0% | 2% |
| Anxious | 2.3% | 0.72(11%) |
| Dependent | 0% | 4% |
| Any Specific PD | 0.78(13.6%) | 0.64(25%) |
| Overall Weighted Kappa | 0.81 | 0.65 |

# K Calculated only when base rates were> 5% according to both raters; base rates in the table are means of both raters.

Intraclass correlations ranged from 0.65 to 1.00 (average 0.89) for each item, from 0.63 to 1.00 (average 0.92) for the number of criteria met for each PD and from 0.94 to 1.00 (average 0.98) for dimensional score for each PD. Kappa for definite diagnosis, emotionally unstable: impulsive type was 0.78 and for emotionally unstable: borderline type was 0.65. Kappa for probable/definite diagnosis of specific PD ranged from 0.78 to 1.00. Kappa for presence or absence of any (specific) PD was 0.78 for definite and 0.79 for probable diagnoses. Overall weighted kappa was 0.81 for definite PD and 0.91 for probable PD(Table1).

## DISCUSSION

The results of the present study compare quite favourably with published reports on semistructured interview used to diagnose PDs (Zimmerman,1994) including the IPDE (Loranger et al.,1997) (Table 1).

However, the raters for this study were involved in the Hindi adaptation of the instrument, so it is possible that agreements may be lower in hands of other raters (who are not involved in the development process) as suggested by Zimmerman (1994).

IPDE permits the interviewer to improvise equivalent questions (Loranger,1997 ). However, despite such attempts many patients had difficulty with questions related to self-image (Q5), internal preference (Q 25), emptiness (Q 45), and emotional shallowness (Q49). Dahl & Andreoli (1997) had reported a similar difficulty with items related to identity. Further, we had considerable difficulty in scoring certain items because of cultural variations in behaviour: avoidance of occupational behaviours that involve interpersonal contact (for housewives), encouraging/allowing others to make important decisions (for many women/young adults), unwillingness to become involved with persons unless certain of being liked (for missing out on relationship with a member of

the opposite sex); hitting family members; lying and speeding/reckless driving. Dahl & Andreoli (1997) had reported problems with questions in relation to reckless driving, physical abuse of family members, work experience and the relative importance of work and relationship. These difficulties are not actually related to how the question is asked but to the inapplicability of the ICD-10 criterion in certain sub-populations.

In summarizing, it may be stated that IPDE ICD-10 Hindi version can be applied with acceptable reliability in a North Indian Hindi speaking population.

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