A systematic review of the clinical utility of the categorical and alternative models of personality disorders

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Permission to Submit Mini-Dissertation (Article Format) for Examination Purposes

I, Dr R Spies the supervisor of this Magister of Arts in Research Psychology study by Michelle Janse van Rensburg, hereby declare that the mini dissertation titled *"A systematic review of the clinical utility of the categorical and alternative models of personality disorders"*, reflects the entire research endeavour as was planned and executed. I hereby grant permission for her to submit the mini-dissertation (article format) for examination purposes and I confirm that the mini-dissertation submitted is in fulfilment of the requirements for the degree, Magister of Arts in Research Psychology at the Potchefstroom Campus of the North-West University.

Dr R. (Ruan) Spies
Supervisor

ABSTRACT

For years the clinical utility of the categorical and alternative models of personality disorders have been the focus point of research. Many researchers set out to evaluate the utility of these models, and they used various methodologies and samples which lead to mixed and often contradicting results. From this we found it prudent to conduct a systematic review on relevant literature to provide a holistic view of the clinical utility of the alternative and categorical models. Eleven articles were identified for data analysis, and the findings showed higher clinical utility for the alternative model, with the categorical model's utility mostly due to familiarity of clinicians with the model. Ultimately, the alternative model has shown superior clinical utility and empirical soundness as shown in previous research.

Keywords: Clinical utility, Alternative model, Categorical model, Personality Disorders, DSM-5

PREFACE

This mini dissertation was written as part of the requirements for the completion of the Master of Science program in Research Psychology at the North-West University Potchefstroom campus and was supervised by Dr Ruan Spies.

This mini dissertation was written in article format and according to the guidelines and requirements set out by the North-West University Manual for Master's and Doctoral Studies.
This mini dissertation consists of three chapters. Chapter one provides an in-depth literature review of relevant literature, while chapter two consists of an article. Chapter three consists of a critical reflection on the research process.

Chapter one and three comply with the American Psychological Association's seventh edition (APA 7th edition) style and referencing format. Chapter two was written in accordance with the journal for Personality and Social Psychology Review's (PSPR) guidelines.
The article in chapter 2 will be submitted to the PSPR for possible publication. The PSPR publishes theoretical papers and conceptual review articles in personality and social psychology.

The Community Psychosocial Research Committee (COMPRES) at the North-West University's faculty of Health Sciences provided scientific approval, after which the Human Research Ethics Committee (HREC) of the North-West University provided ethical clearance and approval. The ethics approval letter is attached as addendum B.

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CHAPTER 1 AN OVERVIEW OF LITERATURE ON PERSONALITY DISORDERS

Personality is a construct most lay persons are familiar with; in fact, most people will argue that they are experts in judging personality, predicting behavior, interpreting conversations, and making inferences about others and themselves (Ellis et al., 2009; Frick et al., 2020; Karterud & Kongerslev, 2019). However, most would have a difficult time providing an exact explanation for their conclusions (Ellis et al., 2009)

Personality as a scientific construct is difficult to define, mostly because of its abstract nature (Karterud &Kongerslev, 2019), and disputes have arisen between researchers on what constitutes personality (Corr & Matthews, 2009; Ellis et al., 2009; McAdams, 1997). Definitions of personality are varied as each definition of personality reflects the view of the theorist, psychologist, or school of personality (Funder, 2004; Larsen & Buss, 2005; Mayer, 2007a; Pervin et al., 2005).

Origin of Personality Psychology

Some of the earliest theories on personality came from philosophers such as Plato, Aristotle, and Descartes. Modern theories on personality often echo the theories of early philosophers (Ellis et al., 2009 Plato believed the soul was the seat of personality, while Aristotle, a student of Plato, thought the psyche was the seat of personality. Based on Aristotle's descriptions of the psyche, it is believed that he was the first biological psychologist (Ellis et al., 2009; Hergenhahn & Henley, 2013; Leahey, 2017). Claudius Galen believed that personality was influenced by the four humors or bodily fluids. These four fluids were blood, phlegm, black bile, and yellow bile, and the combinations in which they appeared in the body could affect temperament (Ellis et al., 2009)

Personality Psychology Perspectives

As psychologists and philosophers moved from descriptive accounts of personality towards specific theories and models, there was a progressive divide between researchers. One of the divides related to idiographic and nomothetic approaches. The idiographic approach is the oldest approach, and theorists belonging to this approach believe in the uniqueness of the individual, suggesting that no two

personalities are the same (Ellis et al., 2009). The nomothetic approach proposes that uniqueness exists, but only as a combination of fixed traits (Ellis et al., 2009).

Personality psychology is further divided into 'schools' of thought based on the view of human nature and the structure of personality (Meyer et al., 2008).

Table 1 provides an overview of the major schools of personality psychology along with the founders of each school and the essential premises of each school (Ellis et al., 2009).

Table 1

Major Schools of Personality Psychology

School	Founders	Essential Premises
Psychoanalytic	Sigmund Freud	Self-regulating and independent unconscious processes make up the essence of personality. They operate through mental structures that are in continual conflict.
Neo-Psychoanalytic	Alfred Adler, Carl Jung, Karen Horney	Conscious individual, social, and interpersonal factors are powerful forces in shaping personality.
Humanistic	Albert Ellis, Carl Rogers, Abraham Maslow	People are basically good and strive towards maximum personal development or self-actualization.
Behavioral	John Watson, B.F. Skinner	Personality is the observable result of reinforcement.
Genetic/biological	William Sheldon, Edmund O. Wilson, Hans Eysenck	Genes, hormones, and neurochemicals in the brain regulate the greater portion of human personality.
Trait	Raymond Cattell, Hans Eysenck	Differences among people can be reduced to a limited number of distinct behavioral styles or traits.

Cognitive/REBT	Albert Bandura, Ulric Neisser, Albert Ellis	Personality results from the interplay of learned and innate styles of thinking.

As the study of personality developed, disordered personality also became a subject of research (First et al., 2002).

1.1 Psychopathology

Psychopathology, like normal personality, is divided into different perspectives and schools of thinking (Cambridge University Press, 2009; First et al., 2002; Hopwood et al., 2019; Trull & Durrett, 2005). Two major perspectives of psychopathology include categorical and dimensional paradigms (Hopwood et al., 2019).

A categorical diagnosis, as with psychopathology, has a specific organization to its classificatory elements. This constitutes the idea of a syndrome, a discrete structure and etiology. The Categorical Model of Personality Disorders (CMPD) in the DSM-5 section 2 is a model for the diagnosis of personality disorders that uses a categorical approach.

In terms of psychopathology, most studies and analyses of theories question the validity of a categorical structure, with research finding that psychopathology may only include a few categorical disorders, such as autism, substance use, and schizotypy (Hopwood et al., 2019). A categorical paradigm with regard to personality disorders seems even less likely.

A dimensional paradigm is gaining popularity in psychopathology. The dimensional paradigm proposes that all psychiatric symptoms can be represented on a dimension of low to high psychopathology (Caspi & Moffitt, 2018). In the field of personality disorders, great strides have been made towards a dimensional paradigm (Hopwood et al., 2019; Widiger & Trull, 2007). One of the models of personality disorder diagnosis that uses a dimensional approach is the Alternative Model of Personality Disorders (AMPD).

The DSM-5

The *Diagnostic and Statistical Manual of Mental Disorders (DSM)* is the classification system

with arguably the most influence in clinical settings (Krueger & Eaton, 2010). It is stated in the fourth text- revised edition of the DSM (DSM-4-TR) that "there is no assumption that each category of mental disorder is a complete discrete entity with absolute boundaries dividing it from other mental disorders or from no mental disorder". Nevertheless, the "DSM-4-TR is a categorical classification that divides mental disorders into types based on criterion sets with defining features" (American Psychiatric Association, 2000, p. xxxi).

In 1999, the process of planning and revising the DSM-5 started with an initial DSM-5 Research PlanningConference held by the APA and the National Institute of Mental Health (NIMH) (Kupfer, First, & Regier, 2002). Several important topics were identified, and a series of white papers were written to promote research and further discussion on these topics (Kupfer et al., 2002). One of the white papers was dedicated to the diagnostic criteria of personality disorders and their relation to axis 1 disorders as well as the limited provision of diagnoses of relational disorders.

Based on the research generated by these white papers, the APA Board of Trustees included both the traditional categorical model of personality disorders (CMPD), and an alternative dimensional model (AMPD). To preserve continuity in current clinical practice, the CMPD as presented in the DSM-IV-TR was included in the DSM-5 section 2, and the AMPD was included in section 3. The inclusion of the AMPD aims to address the shortcomings of the CMPD (American Psychiatric Association, 2013).

The Categorical Model. In the DSM-5 section 2, the same model of personality disorders as in the DSM-IV-TR is included. This model of personality disorders has been used in the DSM for many years, mostly unchanged (Bernstein, Iscan, & Maser, 2007). According to the CMPD, personality disorders are qualitatively distinct clinical syndromes (American Psychiatric Association, 2013; Trull & Durrett, 2005). The definition provided for personality disorders using the CMPD is "an enduring pattern of inner experiences and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment" (American Psychiatric Association, 2013, p. 645)

The CMPD provides diagnostic criteria for ten PDs, grouped together into three clusters. These clusters are based on descriptive similarities (American Psychiatric Association, 2013). Cluster A appears odd or eccentric, cluster B appears dramatic, emotional, or erratic, and cluster C appears anxious or

fearful. The DSM-5 also makes provision for a diagnosis of "personality change due to another medical condition", aswell as "personality disorder not otherwise specified" (American Psychiatric Association, 2013). Figure 1 provides an overview of the 10 PDs and their groupings into the three clusters.

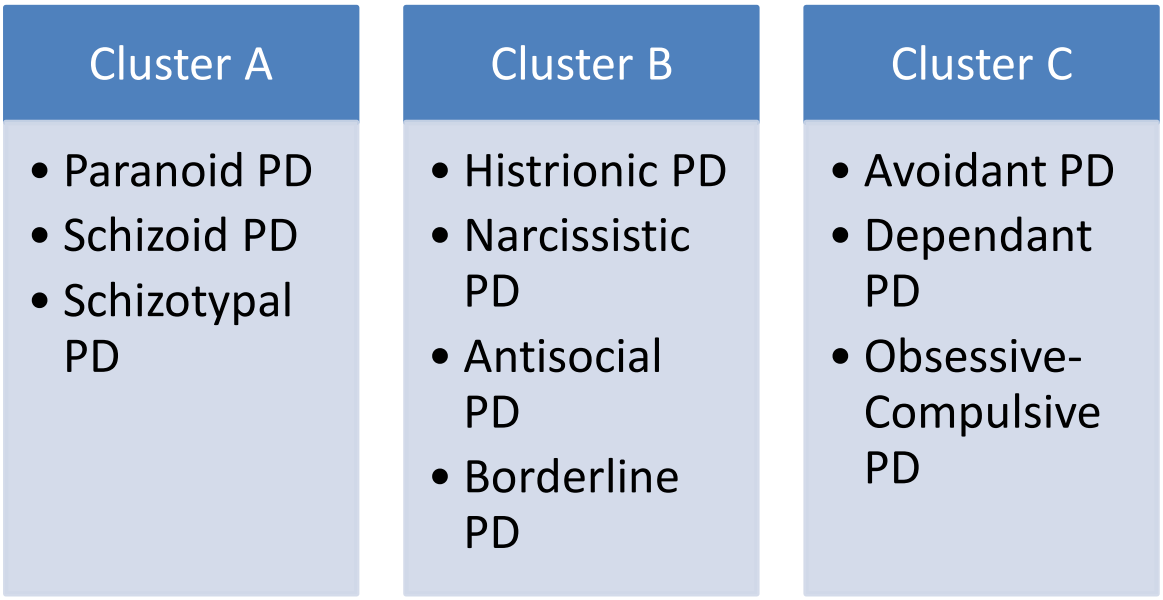

Figure 1. DSM-5 Personality Disorders.

The CMPD utilizes a polythetic approach to diagnosing PDs, and hierarchical exclusion rules. This should prevent a clinician from diagnosing a PD if another diagnosis can potentially account for the patient's clinical picture (Hopwood et al., 2012; Widiger & Trull, 2007).

An example of the polythetic nature of the CMPD can be found in the diagnostic criteria of Borderline PD in which an individual needs to display at least five of the nine diagnostic criteria (American Psychiatric Association, 2013; Krueger & Eaton, 2010). The hierarchical exclusion criteria can be found in criteria E and F which states that the enduring pattern is not better explained as another mental disorder, or because of the effects of a substance or medical condition.

Almost from the inception of the CMPD there has been criticism of the model (Morey & Hopwood, 2019). The CMPD has been criticized for its high diagnostic comorbidity, arbitrary diagnostic thresholds,poor convergent and discriminant validity, problematic reliability, and the high proportion of cases classified as Personality Disorder Not Otherwise Specified (American Psychiatric Association, 2013; Anderson, Snider, Sellbom, Krueger, & Hopwood, 2014; Bernstein et al., 2007; First et al., 2002;

Karterud & Kongerslev, 2019; Milinkovic & Tiliopoulos, 2020).

The Alternative Model. According to the alternative model of personality disorders, a personality disorder is characterized by impaired personality functioning and pathological personality traits (American Psychiatric Association, 2013). For a patient to be diagnosed with a personality disorder using the alternative model, an assessment of level of impairment in personality functioning must be made, as well as an evaluation of pathological personality traits (American Psychiatric Association, 2013). The overall level of impairment of personality functioning is evaluated on a dimension of severity for two facets: self and interpersonal dysfunction (Hopwood et al., 2012).

According to some clinicians, the alternative model is superior to the traditional model as the dimensions of the alternative model are empirically derived, it holds higher levels of diagnostic reliability and stability over time, and it eliminates the excessive comorbidity of PD that is found in the categorical model. It also eliminates the arbitrary diagnostic thresholds set in the categorical model (Anderson et al, 2014; First et al, 2002; First, 2005). Other strong points of the model are the strong associations that it has with the Personality Psychopathology – Five (PSY-5) and the Five-Factor Model (FFM) of personality, which is reflective of other empirically driven personality models. According to Anderson, etal, (2014), the association between the FFM and the alternative model is important as the FFM is a model of normal personality functioning, and the alternative model is based on an extreme range of normal traits.

Despite the various criticisms, research over the years has shown that both models have empirical reliability and validity as well as a well-deserved place in clinical practice (Anderson et al, 2014; First, 2005; Siever & Davis, 2004). As both models have shown some form of empirical reliability and validity, it is important to look at other qualities of the models when deciding which model will be considered the 'dominant' model of diagnosing personality disorders. One such quality that has been researched about both models is the clinical utility of the model (Bach et al, 2015; Bernstein et al, 2007; First, 2005; Fowler et al., 2018; Samuel & Widiger, 2006).

1.2 Clinical Utility in the DSM

Clinical utility has always been of great concern to the authors of the diagnostic nomenclature as

it is stated explicitly in the first paragraph of the introduction to the DSM-IV that "our highest priority has been to provide a helpful guide to clinical practice" (American Psychiatric Association, 2000, p. xxiii). In the DSM-5 introduction, the following is stated: "All of these efforts were directed towards the goal of enhancing the clinical usefulness of DSM-5 as a guide in the diagnoses of mental disorders" (American Psychiatric Association, 2013, p. 5).

Clinical utility refers to the ease of use, communication, and treatment planning of a model. This encompasses aspects such as the conceptualization of a disorder, communication between professionals, communicating information to the client, ease, and acceptability of use in clinical practice, choosing the appropriate and effective treatment, and predicting the future course of the disorder (First, 2005).

According to First, (2005), another component of clinical utility is user acceptability. That is the extent towhich the model is used by the intended population. In this case, the intended population would be the clinicians using either the categorical or alternative model in clinical practice.

Clinical Utility of the Categorical and Alternative Models

Multiple studies have been done to determine the clinical utility of the alternative model and compare the clinical utility of the categorical and alternative models (Bach et al, 2015; Bernstein et al, 2007; First, 2005; Fowler et al., 2018; Milinkovic & Tiliopoulos, 2020; Samuel & Widiger, 2006).

However, the findings of these studies vary and often contradict each other. For example, Milinkovic and Tilliopoulos (2020) and Bach et al. (2015) had findings that contradicted Nelson et al.'s (2017) findings on the utility of the AMPD to facilitate clinicians' understanding of patients. This can be due to the different research methods used, the time at which the research was conducted, and even the definitions of clinical utility used. These varying and contradicting results can make it difficult to form a comprehensive understanding of the clinical utility of these models.

Using a model that is clinically not useful can impede a clinicians practice especially in terms of communication with the patient and other professionals and treatment planning. It is therefore important to be knowledgeable on the clinical utility of the models used in practice. Due to the varying results of the studies done on the clinical utility of the categorical and alternative models of personality disorders, it would be prudent to conduct a review study to synthesize the available information into a comprehensive and concise report. A systematic review would be most suitable for a task such as this as

it would provide in-depth knowledge of the utility of these models in clinical practice and research.

This will add value to the scientific community and clinicians by providing a comprehensive and in-depth view of the clinical utility of these models while possibly facilitating further research into personality disorders, their classification and diagnosis.

1.3 Purpose of the Study

The aim of this study was to systematically review and critically discuss available literature on the clinical utility of the alternative and categorical models of personality disorders. This review will aim to describe the models' utility in clinical practice as well as in research.

1.4 Research Question

How does the clinical utility of the categorical and alternative models of personality disorders compare asdetermined by a systematic review of all relevant literature?

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CHAPTER 2 ARTICLE

A Systematic Review of the Clinical Utility of the Alternative and Categorical Models of Personality Disorders

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2.1 Abstract

The clinical utility of the alternative and categorical models of personality disorders has been debated andresearched for many years. With various methodologies employed and mixed results, we found it prudent to conduct a systematic review to give a holistic view of the clinical utility of these models. Eleven relevant articles were thematically analyzed, and the findings showed that the alternative model does indeed have higher clinical utility. The utility of the categorical model seems mostly due to clinicians' familiarity with the model. The alternative model thus seems superior to the categorical model, both in clinical utility and previously shown empirical soundness.

Keywords: Clinical utility, Alternative model, Categorical model, Personality Disorders, DSM-5

2.2 Introduction

The construct of personality has been a talking point for psychologists and theorists for many years (Corr & Matthews, 2009; Ellis et al., 2009; McAdams, 1997), with disputes on what constitutes personality and how to accurately define personality. Definitions of personality are varied, as they reflect the views of the theorists, psychologist, or school of thought (Funder, 2004; Larsen & Buss, 2005; Mayer, 2007a; Pervinet al., 2005). At the same time, psychologists and theorists are divided on what constitutes personality pathology and how personality pathology can be conceptualized (Cambridge University Press, 2009; Firstet al., 2002; Hopwood et al., 2019; Trull & Durrett, 2005).

Some believe that personality pathology can be conceptualized as discrete and qualitatively distinct clinical syndromes (American Psychiatric Association [APA], 2013; Trull & Durrett, 2005). In the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), section 2, a model of personality disorders is presented. This model is a categorical model, hereafter called the Categorical Model of Personality Disorders (CMPD). This model views personality disorders as clinically distinct syndromes (APA, 2013).

The CMPD provides diagnostic criteria for ten personality disorders (PDs) that are grouped into three clusters based on descriptive similarities (APA, 2013), and utilizes a polythetic approach (Hopwood et al.,2012; Widiger & Trull, 2007). According to Morey and Hopwood (2019), the CMPD has been criticized almost from its inception. The criticism includes high diagnostic comorbidity, arbitrary diagnostic thresholds, poor convergent and discriminant validity, problematic reliability, and a high proportion of cases classified as Personality Disorder Not Otherwise Specified (Anderson et al., 2014; Bernstein et al., 2007; First et al., 2002; Karterud & Kongerslev, 2019; Milinkovic & Tiliopoulos, 2020).

To address some of the shortcomings of the CMPD, an alternative model for diagnosing personality disorders was suggested, namely the Alternative Model of Personality Disorders (AMPD; APA, 2013). The AMPD was included in the DSM-5 under section 3, a section designated to increase research and discussion on topics such as the alternative model of diagnosing personality disorders (APA, 2013). For a PD diagnosis to be made with the AMPD, personality functioning is measured on a severity scale from no impairment to severe impairment in two facets: the self and interpersonal dysfunction

(Hopwood et al., 2012), along with an evaluation of pathological personality traits (APA, 2013).

The AMPD is superior to the CMPD, according to some, as the AMPD was empirically derived, has higher diagnostic reliability and stability over time, and eliminates the CMPD's excessive comorbidity while also eliminating arbitrary diagnostic thresholds (Anderson et al., 2014; First et al., 2002; First, 2005). At the same time, the AMPD is strongly associated with the Personality Psychopathology – Five (PSY-5) and the Five-Factor Model (FFM), which are also empirically driven personality models (Anderson et al., 2014; Venema et al., 2021). According to Anderson et al. (2014), the association between the AMPD and the FFM is important as the FFM is representative of normal personality functioning, whereas the AMPD is based on extreme ranges of normal traits.

Over the years, research has shown that both the CMPD and AMPD have empirical reliability and validity, and both models have a well-deserved place in clinical practice (Anderson et al., 2014; First, 2005; Siever & Davis, 2004). Because both models have shown some form of empirical reliability and validity, it is important to look at other qualities of the models when making decisions on the use of one of these models in clinical practice. One important quality to consider is the clinical utility of a model.

In the DSM – IV it is explicitly stated that the highest priority of the DSM has been to provide a helpful guide to clinical practice (APA, 2000, p. xxiii) and, as such, clinical utility has always been a concern for the authors of the DSM. According to First (2005), clinical utility refers to the ease of use, communication, and treatment planning of a model. This includes aspects such as communication between professionals, communication with clients and their families, conceptualization of disorders, treatment planning, and predicting treatment outcomes (First, 2005). Another component of clinical utility is user acceptability (First, 2005). This refers to the extent to which a model is accepted and used by the intended population, which, in this case, is clinicians working with clients with personality disorders.

At the inception of the AMPD, many researchers and clinicians were concerned over the clinical utility ofthe AMPD (First, 2005; Hopwood, 2018). As such, many researchers conducted studies on the clinical utility of the AMPD, and some compared the clinical utility of the AMPD and CMPD (Bach et al, 2015; Bernstein et al, 2007; First, 2005; Fowler et al., 2018; Milinkovic & Tiliopoulos, 2020; Samuel & Widiger, 2006).

However, the methods of these studies varied along with the definitions of clinical utility. This

led to findings that often contradicted each other and makes it difficult to form a comprehensive understanding of the clinical utility of the AMPD and CMPD. The aim of this study was to systematically review and critically discuss available literature on the clinical utility of the alternative and categorical models of personality disorders. This review will aim to describe the models' utility in clinical practice as well as in research.

2.3 Methods

Research Design

Due to the variety of results generated by the research done on the clinical utility of the AMPD and CMPD, a systematic review will provide a holistic and comprehensive overview of these models' utility in clinical practice. This systematic review was conducted using steps from Bettaney-Saltikov's (2012) How to Do a Systematic Literature Review in Nursing, the Cochrane Handbook for Systematic Reviews of Interventions, the Centre for Review Dissemination (CRD) Guidelines (Akers et al., 2009), and 'Five steps to conducting a systematic review' by Khan and Kunz et al (2003). Khan and Kunz et al (2003) propose the following five steps:

Step 1 – Framing questions for a review. The researcher decided on the following research question. 'How does the clinical utility of the categorical and alternative models of personality disorders compare asdetermined by a systematic review of all relevant literature?'

Step 2 – Identifying relevant work. An extensive search was done by identifying relevant databases and key words.

Step 3. – Assessing the quality of the studies identified. Due to the nature of the studies identified by the database search, the researcher deemed it fitting to use the Mixed Methods Appraisal Tool (MMAT) version 2018 (Hong et al., 2018)

Step 4 – Summarizing the evidence. All resulting themes will be listed in the Findings section

Step 5 – Interpreting the findings. The findings of this review will be discussed in detail in the Discussion section of this paper.

Search Strategy

Once ethical clearance was received by the HREC of the North-West University to conduct the proposed systematic review, the following databases were searched using the key words as listed in table 1. The databases searched were: Academic Search Complete, APA PsycArticles, SPORTDiscus SocINDEX, Health Source: Nursing/Academic Edition, APA PsycInfo, CINAHL, Social Sciences Citation Index, MEDLINE, EBSCOhost, Science Citation Index, ScienceDirect, OpenDissertations, and Onesearch.

Table 2

Keywords and Search Terms Used in Database Search

Keyword	Search terms
Personality Disorder	Personality AND disorder* OR pathology OR traits OR pathological traits
Alternative model	Alternative model, OR hybrid model, OR dimensional model, OR DSM5 Section 3
Categorical model	Traditional model, OR Categorical model, OR DSM 5 Section 2
Clinical utility	Clinical Utility
DSM-5	DSM-5 OR Diagnostic and Statistical Manual 5

Study Selection

According to the CRD guidelines, the selection of studies to include in the review should be based on inclusion criteria that is directly derived from the review question. Bettany-Saltikov (2012) and Lefebver et al. (2019) described the PICO (Population, Intervention, Comparative intervention, and Outcome) method to determine inclusion and exclusion criteria. Bettany-Saltikov (2012) indicates that a clear and concise research question, aim, and objectives are necessary to determine the different components of the PICO method. Keeping the research question, aim, and objectives of the research study in mind, the researcher compiled a table (table 3) listing the inclusion and exclusion criteria.

Using the keywords and databases indicated a search was conducted. The search provided 581 titles for

screening. Figure 1 provides an overview of the titles produces by the database search. 171 duplicates were excluded and a further 410 titles were screened based on the inclusion and exclusion criteria. 399 articles were excluded on grounds of the inclusion criteria with 11 articles matching the inclusion criteria. These 11 articles were deemed fitting for the review and were then considered for quality control.

Figure 2. Titles extracted from database search.

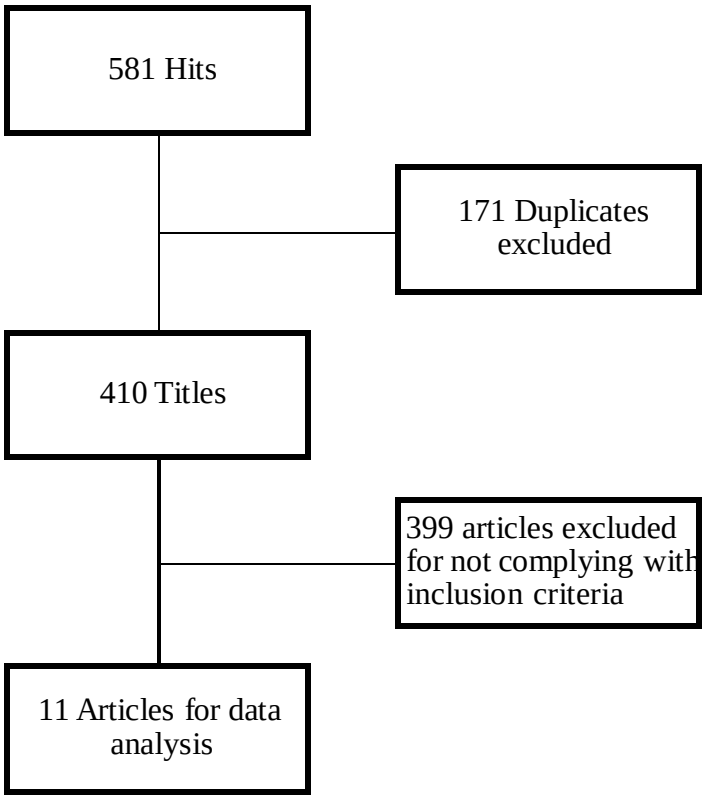

Table 3

Inclusion and Exclusion criteria

PICO Components	Inclusion criteria	Exclusion criteria
Population	Participants over 18 years Inpatients AND outpatients Clinicians	Participants below 18 years Non-clinicians
Intervention	Measurement of clinical utility Experiences or opinions of clinical utility	
Comparative interventions	Alternative model Categorical model	Any other model of personality or personality disorders
Outcomes	Clinical utility	Outcomes not related to clinical utility

Quality Assessment

All articles included in the data analysis were reviewed and the methodological quality of the articles was assessed. Due to the inclusion of qualitative, quantitative, and mixed method studies, the Mixed Methods Appraisal Tool (MMAT) version 2018 (Hong et al., 2018) was used to assess the methodological soundness of the articles.

Of the eleven articles included in the data analysis, six used a quantitative methodology, three qualitative, and two mixed methods methodologies. All articles met the quality criteria as set out by the MMAT andwere considered methodologically sound (Hong et al., 2018). Table 4 provides a summary of the 11 articles included in the analysis of this review.

Data Analysis

Taking into consideration the variety of methodological approaches of the articles included for data analysis, the review question, and the purpose of this study, it was deemed that thematic analysis would be used as the data analysis method (Booth et al., 2016). Thematic analysis provides a flexibility to the analysis and allows researchers to be guided by the data (Braun & Clarke, 2012). The data was extracted from multiple components of the articles included to ensure that it was rich in detail and would add value to the findings. Data was extracted from the samples, methods, findings/results, discussions, and conclusions.

For this review study, the researcher followed the six steps set out by Braun and Clarke (2006, 2012). Thesix steps for thematic analysis as set out by Braun and Clarke (2006) are as follows: familiarization with the data, coding, searching for themes, reviewing themes, defining, and naming themes, and writing up.

After the researcher familiarized themselves with the articles selected for data analysis, she began coding the data using Atlas.ti, a software used for qualitative data analysis. Still using Atlas.ti, the researcher began searching for themes by grouping the codes together. Once preliminary themes were identified, the second author assisted the researcher in reviewing the themes. The researcher defined and named the themes and commenced write-up.

Ethics

According to Vergnes et al, (2010), systematic reviews carry several ethical risks. These include selecting studies for the review that have ethical insufficiencies, informed consent for the original study may not be valid for a systematic review, and lastly, systematic reviews may be prone to conflict of interest and bias.

There are several ways to address these risks, one of which is ensuring that rigorous quality control is conducted. When conducting the quality control process, it is not only important to look at the methodological rigor of the studies, but also the ethical considerations. This way the overall ethical quality of the review can be ensured.

In dealing with the possible bias that can arrive due to the subjective nature of selecting research to be included, the inclusion and exclusion criteria are explicitly stated and the methods for selecting

studies and quality appraisal are provided in detail. Other ways in which bias was eliminated was the continuous consultation with the secondary reviewer and the use of a reflective diary to keep track of decisions.

2.4 Findings and Discussion

The thematic analysis of the included articles resulted in six main themes that are shown in table 5. In summary, the themes are: Comprehensive understanding of the patient, patient and professional communication, treatment planning, ease of use, diagnostic use, likeliness of future use, and overall usefulness.

Table 5

Themes and definitions

Theme	Definition
Comprehensive understanding of the patient	The ability of the model to facilitate a comprehensive understanding of the patient and provide an expanded view of pathology
Patient and professional communication	The ability of the model to facilitate communication between the clinician and the patient, as well as communication between professionals
Treatment planning	The ability of the model to assist clinicians in developing treatment options for patients
Ease of use	The relative ease of learning and using the model in clinical practice
Diagnostic use	The models diagnostic accuracy, the ability of the model to assist in diagnostic decision making, and case

	conceptualisation
Likeliness of future use	The probability that a clinician would use the model in future practice and recommend the use of the model to other clinicians
Overall utility	The general utility of the model

Comprehensive Understanding of Patients

A theme that came forth most in the data was the ability of a model to facilitate a clinician's comprehensive understanding of patients. Across all articles included in the data analysis clinicians commented on both models' ability to help them understand patient difficulties and provide an expanded way of thinking about pathology.

Clinicians regarded the AMPD as a model that provides a more comprehensive understanding of patients. Participants in Milinkovic and Tiliopoulos's (2020) study indicated that "The AMPD provides more detailed, comprehensive information than the traditional, categorical model, in terms of *how* patients suffer, rather than simply whether they suffer or not." Bach et al., (2015) found that clinicians had a greater understanding of the patients as individuals and not just as someone with a mental illness. This is expressed in the quote: "… we can actually come closer to an understanding of the person behind the illness, including the individual's temperamental and learned features." (Bach et al., 2015)

This ability of the AMPD to facilitate a comprehensive understanding of patients can be due to the way in which the AMPD conceptualizes PD in terms of extreme variants of normal personality functioning, thus providing clinicians with insights into patients' relative strengths as well as weaknesses. This provides a more holistic view of patients and adds to clinicians' comprehension of patients.

Conversely, one article (Nelson et al., 2017) indicated that some clinicians did not agree that the AMPD helped in conceptualizing their clients. "Participants rated the section 3 specific PD model as the most useful in formulating diagnosis, but the least helpful in assisting the clinician in better understanding or conceptualizing their client" (Nelson et al., 2017). This contradiction of Nelson et al. (2017) could be

ascribed to the fact that their sample consisted of trainees who have not had as much experience with seeing clients, or who have not had much practice with the AMPD.

The CMPD was regarded as not being as useful as dimensional models when it came to comprehensively understanding patients. This was evident in the study by Samuel and Widiger (2006), in which clinicians stated that the CMPD was less useful in providing "… comprehensive descriptions of the individual's important personality difficulties" and "for providing a global personality description".

According to Samuel and Widiger (2006), this can be due to the fact that it was never the intention of the DSM nomenclature to provide thorough and comprehensive descriptions of personality. Rather, it serves to highlight disordered personality and as an aid to diagnosing PD. This can leave clinicians without a guide to comprehensively understand the difficulties faced by those who do have PD. This shortcoming of the CMPD highlights the value of a model such as the AMPD that can facilitate a comprehensive understanding of patients.

Patient and Professional Communication

The second most prominent theme to arise from the data concerned both patient and professional communication. This theme is concerned with the level of communication that is facilitated by the AMPD and CMPD.

Interestingly, clinicians indicated that the AMPD was more useful in terms of communication with patients, but student clinicians indicated the inverse. Student clinicians believed the AMPD was "somewhat less useful for communicating with patients". While the data indicated that "… clinicians view the AMPD as more useful than the current model (CMPD) with respect to communicatingwith their patients." Clinicians also stated that, "the DSM-5 section 3 traits are more easily applied to patients, more useful for communicating with patients, and more useful for comprehensively describing global personality and personality problems" (Krueger et al., 2014; Milinkovic & Tiliopoulos, 2020).

One possible reason for clinicians rating the APMD higher in terms of patient communication is because the AMPD is more descriptive in the dimensions provided when making a diagnosis, allowing for the clinician to formulate more nuanced and individualized feedback to the client that addresses multiple aspects of the personality. Providing clients with trait-specific feedback deconstructs the single diagnosis into several attributes that can be systematically discussed in treatment.

At the same time, communication with other professionals is not hindered by the same constraints as communication with patients. Clinicians are well versed in the terminology surrounding personality disorders unlike most patients. Therefore, most professionals would be knowledgeable on both the AMPD and CMPD. It is perhaps for this reason that Morey et al. (2014) found no discernable difference in the usefulness of the AMPD and CMPD when it came to professional communication. "Even with respect to communicating with other professionals, the DSM-5 trait model was seen as being just as useful as the DSM-IV-TR (CMPD) system" (Morey et al., 2014).

Morey et al. (2014) did, however, find that non-psychiatrists preferred the AMPD, while psychiatrists preferred the CMPD. This could be due to the different roles psychiatrists and non-psychiatrists play in a clinical setting and their use of diagnostic models. Morey et al. (2014) found that "For patient communication, comprehensiveness and treatment formulation, a profession by system interaction was found, such that non-psychiatrists viewed the DSM-5 proposal as superior in each of these respects, whereas the psychiatrists tended to view the DSM-4-TR as equally or more useful" (Morey et al., 2014).

Treatment Planning

Treatment planning is an important aspect of clinical utility and, as such, was one of the themes that presented strongly in the data (First, 2005).

Clinicians indicated that the AMPD was more useful when it came to treatment planning as "the AMPD allowed for better understanding of the needs of specific PDs so that a therapeutic program could be adapted appropriately" (Milinkovic & Tiliopoulos, 2020). Student clinicians also found the AMPD to be more useful in treatment planning: "Regarding clinical utility, students found the [AMPD] particularly useful for treatment planning" (Garcia et al., 2018).

However, Nelson et al. (2017) found that some clinicians indicated that the AMPD was not as useful for treatment planning. Once more, the clinicians included in Nelson et al.'s (2017) study were trainee clinicians, and perhaps their lack of experience with the AMPD influenced their views on the utility of the AMPD when it comes to treatment planning. This can possibly be corrected for in future studies by including participants who are more familiar with the AMPD and treatment planning in general.

Findings regarding treatment planning and the CMPD yielded mixed results with some claiming that the CMPD was more useful for treatment planning and some claiming it was less useful. A study done by Sprock (2003) indicated that the CMPD received higher ratings for treatment planning when considering prototypic cases, while a study by Samuel and Widiger (2006) indicated the opposite. The reason for Sprock's (2003) findings may be due to the use of prototypic cases, which were written according to the CMPD diagnostic criteria. This could have led participating clinicians to use the CMPD more readily when considering treatment options as the cases and treatment options would have been aligned. In contrast, Samuel and Widiger (2006) used case studies that were screened for bias towards either categorical or dimensional terminology, which would account for the differences in findings in the two studies.

Ease of Use

The ease of use of the AMPD was commented on multiple times in the data, with clinicians noting that "the DSM-5 alternative PD model seems rather 'fool proof' and its ease of use is clear" (Bach et al., 2015). Other research showed that "both psychiatrists and psychologists viewed the trait model as easier to use and more favorable as compared to categorical PD diagnosis" (Garcia et al., 2018). One study also revealed that clinicians found the layout of the AMPD model to be useful (Nelson et al., 2017). The ease of the AMPD may lay in its association with other models of normal personality functioning, such as the Five-Factor Model (FFM) or the Personality Psychopathology – Five (PSY-5).

Clinicians may already be experienced and have a sense of familiarity with dimensional models ofpersonality, and therefore prefer the AMPD (a dimensional model of extreme or disordered personality). On the other hand, Garcia et al. (2018) found that students found the AMPD to be slightly less easy touse, while Bach et al. noted that "the number of levels, areas, and facets in the alternative PD model mayseem complex and overwhelming to many clinicians". Once again, student clinicians or trainees may lackclinical experience in general, which would impact their views on the ease of use of the AMPD.

At the same time, clinicians in Morey et al.'s study rated the CMPD as easier to use than the AMPD. This can also be due to familiarity with the CMPD which has been in use, mostly unchanged, since 1994, which can prove to be a great advantage over the AMPD which was only published in the

DSM in 2013 (APA, 1994, 2013). It may also be possible that students were more familiar with the CMPD model which is frequently the first encounter that students have with personality pathology.

Diagnostic Use

The theme of diagnostic use encompasses the diagnostic accuracy of the models, diagnostic decision making, and case conceptualization. Overall, the AMPD seems to have a higher diagnostic use, while clinicians seem to have differing views on the diagnostic use of the CMPD.

Milinkovic and Tiliopoulos (2020) noted on the AMPD's "clinical usefulness in differentiating between various clinical and non-clinical populations". Bach et al. (2015) also noted that the AMPD has the "flexibility to provide different thresholds for different social and clinical decisions and may consequentlybe more useful in different clinical fields".

The AMPD's high diagnostic accuracy was also mentioned in Milinkovic and Tiliopoulos' (2020), noting on "the AMPD's clarity, consistency, and coherence, as a useful system for identifying PD's quantifying severity, and characterizing specific clinical manifestations".

In Nelson et al.'s (2017) study, participants rated the AMPD as having higher potential for improving diagnostic assessment. In the same study, some participants, however, commented that the AMPD "did not help with identifying specific diagnoses". This does indicate some discrepancy in the findings and could warrant further research.

Overall, it seems that the AMPD has the potential to be useful in a range of clinical settings as it provides a range of diagnostic thresholds for different social and clinical situations. This flexibility of the AMPD could mean that this model can be useful in settings outside of clinical practice, such as community clinics and mental health screenings. However, this flexibility could also mean that some clinicians, especially student or trainees my find it more difficult to use the model for diagnostic decision making.

Morey and Benson (2016) found that the CMPD was less useful when it came to making diagnostic decisions. They stated that "Clinicians treating individuals with PD's must make complex choices… Unfortunately, it is not clear that the extant categorical system for personality disorder diagnosis provides much guidance for assisting such choices". On the other hand, Sprock (2003) found that clinicians rated the CMPD as more useful when it came to case conceptualization. Once again one

must consider the familiarity of clinicians with the CMPD when looking at the findings on diagnostic use. Clinicians have been using the CMPD mostly unchanged for years while the AMPD has only been in use for a few years. It is therefore to be expected that some clinicians who have more experience with the CMPD model would rate the model as more useful. This however does not necessarily mean that the CMPD is superior to the AMPD, only that diagnostic use is influenced by familiarity with the model.

Likeliness of Future Use

As mentioned, the theme of likeliness of future use was only present in two articles but is nevertheless interesting. It seems that few researchers considered this to be an important part of measuring a model's clinical utility. Nelson et al.'s (2017) article noted that the AMPD was rated higher for future use with clients, with Milinkovic and Tiliopoulos' (2020) study indicating that the "AMPD had the highest level of recommendation". This likeliness of future use speaks to the acceptability of the AMPD and could indicate an important facet of clinical utility to be investigated in the future.

Overall Utility

The AMPD model seems to be considered as more useful. This can be seen in the following findings of Nelson et al. (2017), Krueger et al. (2014), and Morey and Benson (2016).

"Perhaps most notably, participants rate the section 3 trait model significantly higher in most clinical utility domains" (Nelson et al., 2017). "The DSM-5 trait model was seen as more clinically useful than DSM-IV-TR PD" (Krueger et al., 2014). "In particular, the DSM-5-dimensional trait model was seen as more useful than the DSM-IV model in 5 of 6 comparisons".

Overall, clinicians viewed the AMPD as more useful in terms of comprehension of patients, communication, treatment planning, ease of use, and diagnostic use. It only seems as though students or clinicians not very familiar with the AMPD views it as slightly difficult to use. This can be easily rectified with proper education and exposure to the model.

The study by Morey et al. (2014) indicated that "non-psychiatrists tended to view the DSM-5 global rating as more useful than the DSM-IV-TR, with psychiatrists favoring DSM-IV-TR in those respects", which can be due to the differences in roles psychiatrists and non-psychiatrists fulfil in a clinical setting.

Overall, the CMPD was viewed as less clinically useful. Morey et al. (2014) found that "the

DSM-4-TR is consistently viewed as less clinically useful than dimensional trait ratings schemes".

The lack of utility of the CMPD could stem from its empirical failings such as high diagnostic comorbidity, arbitrary diagnostic thresholds, poor convergent and discriminant validity, and problematic reliability. The CMPD has been in use for many years and many clinicians are familiar with the model; however, this familiarity should not stand in the way of a model that is empirically derived and that has proven itself to be more clinically useful.

2.5 Conclusion

The findings of this study indicated that the AMPD seems to have a higher clinical utility overall, with the CMPD only showing more clinical utility in terms of communication and ease of use, both of which can be ascribed to familiarity of clinicians with the model. With proper education and exposure to the AMPD model, its clinical utility can be improved even more. With the mounting evidence of the AMPD's empirical validity and increasing clinical utility, it is more and more likely that the AMPD may one day replace the CMPD. This can be a step towards a nomenclature that is more empirically minded and developed with the everyday practical use of the clinician in mind.

While care was taken to ensure the methodological soundness of this research project and quality of the work delivered, this study does have limitations that can influence the conclusions drawn from the data.

The limitation of this study includes the relatively small sample sizes of the studies included for data analysis, the inclusion of studies only available in English and Afrikaans, and only including studies that are provided on open sources due to financial constraints.

One suggestion for future research would be to investigate the clinical utility of these two models in the South African context. Another possible suggestion future research would be to investigate the likelihood of future use as a component for clinical utility.

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CHAPTER 3 CRITICAL REFLECTION

5.1 Reflection on the Research

I never thought that conducting a research project would leave such a big mark on me. Since the momentI decided to do my master's in research psychology, I started imagining what it would be like to conduct research. During our first year we were a part of many research projects, and we experienced many different sides of research. But only later did I realize the magnitude of the project I was embarking on – amini-dissertation. There is nothing 'mini' about the work that went into this project.

At first, I was overwhelmed by the vastness of our field of psychology and the number of topics that can be researched. How do you choose a topic? How do you know what topic is worth researching? My only hope was to read as many articles as I could while hoping that inspiration will strike me. And it did. Half an hour before my meeting with my supervisor Ruan, I read an interesting article on clinical utility, and I had a topic.

As I read more, I started seeing a trend in the articles and journals. A few names kept repeating. And while this repetition does speak to these authors' knowledge and authority in the field of personality disorders, I do think that we sometimes forget to listen to the smaller voices, other researchers with fewer publications, or researchers new to the field. We tend to skip over articles with unfamiliar names, and only look for those names we know, all in the name of validity and methodological soundness. No well-known author would publish a poor paper. But I think we forget to judge a paper on its own merit, and not on the name of the journal or author.

I also realized just how much of personality is still unknown. We learn theories in undergraduate classes, and they seem like the only answer to our questions. But as soon as you start reading, you notice the discourse. We need to continuously question our knowledge. I believed without question that personality disorders are divided into three groups. I believed that you either had a personality disorder or you didn't. Only after taking the time to think on what that would mean in a clinical situation or what it would look like in the real world did I start questioning the categorical model. Now I look at the categorical model and all I see is a field of professionals comfortable with how things are. I see the arbitrary cut-offs for a diagnosis that greatly impacts an individual's quality of life. I see individuals who

must fight for a diagnosis, otherwise they might not receive the proper treatment that they need.

While the alternative model is not a perfect model, it is a step towards a model that can help clinicians fully understand individuals with personality disorders. I see a model that is more in line with empirical evidence on personality dysfunction.

When it came to the data analysis phase of this research project, I was very excited. Because I had assisted with other research projects before, I knew what to expect. I knew it would take time, that it could feel tedious to read and reread and to code all the articles. But I also knew the thrill of seeing the themes take shape as you are busy analyzing. I knew how very proud I would feel the moment I finalized my themes. But honestly nothing could have prepared me for the immense feeling of pride and relief I felt once I had finished my Chapter 2.

There were times in which I doubted myself and my ability to complete this project, but every day I sat down and worked a little more. Some days were easier to start, and others required many cups of coffee before I could type a sentence that made a little sense.

At times I promised myself that I would never again do something like this. But as I kept reading, I kept thinking about possible future research. I kept a book next to me in which I made notes and planned my project. And as I read and wrote and read some more, I made a page in my book specifically for ideas for future research. Some of the ideas are silly and would probably never become a full research project, but they are a useful tool to practice critical thinking skills. Others can possibly be used for a PhD study in thefuture.

This book helped me keep track of my progress, it helped organize my thoughts, and I used it when I started doing my data analysis.

The findings of this study were very interesting, with the categorical model showing more clinical utility when it came to ease of use and communication, both factors that can be accounted for by the familiarity of clinicians with the categorical model. The alternative model showed more clinical utility in general; however, the only thing that negatively impacted the alternative model's clinical utility was familiarity with the model. But I do think that as the model is taught more and becomes more widely known, its clinical utility will increase.

In terms of the contribution of this research project to the scientific community, I think that this

researchis only stating what has been known for some time. The alternative model is empirically superior to the categorical model and is more or equally useful in clinical practice. This means that all reservations to thealternative model replacing the categorical model have been proven to be unfounded. Yes, it may take some time to completely accept the alternative model as the model with which to diagnose personality disorders, and it may take time to teach clinicians how to accurately use the model, but in the long run it would be beneficial for clinicians and patients of these clinicians to use a model that is based on empiricalresearch and that has more clinical use.

5.2 Personal reflection

Going into my master's degree, I had a certain perspective on research and how it should be conducted. I felt very confident in my own skills and abilities. However, each class that I attended and each project I completed formed a new view of research and of life.

During these last three years I have learned much about myself and I have learned that I am capable ofmany wonderful things. These three years have been some of the most difficult years. Not only did Istruggle with my health, but we entered a pandemic. I saw the world change, and I was changing with it. Ihad to learn how to adapt, how to cope and how to keep on working towards my dream in a crazy world. As I learned and grew in these three years, I found a new understanding of research and how we gatherand use knowledge. These days, as soon as someone poses a question, I immediately think of it in termsof a research project: I think of which design would fit best, how we will be collecting and analysing data,and what possible influence will our biases have. I now think in terms of confounding variables andstatistical techniques.

But at the same time, I see research as a way of developing understanding. Understanding of people, people who struggle, people who need help and a shoulder to lean on. With research we have the potentialto give voice to people who have been silent for too long and to situations that should have been brought to light long ago.

I firmly believe that in understanding people, we move closer to loving them, and loving our neighbours is our sacred duty

Knowledge is power, and research is the means to grasp that power.

Addendum A

Author; Year Country	Study Design	Sample and setting	Purpose	Main findings
Morey et al. (2014) America	Survey design	(N = 337) mental health clinicians belonging to one of the following organizations: American Psychiatric Association, Arizona Psychiatric Association, International Society for the Study of Personality Disorders, Society for Personality Assessment, American Board of Professional Psychology, American Board of Forensic Psychology, Southwestern Psychoanalytic Society, and the Association for Behavioral and Cognitive Therapy.	The purpose of this study was to extend the research done on the clinical utility of the AMPD as well as explore the role that professional discipline plays in shaping judgements of clinical utility.	Although the CMPD was viewed as easy to use and useful in professional communication, the AMPD was viewed as being equally or more clinically useful. The AMPD was viewed as more useful in 5 out of 6 comparisons. This study shows that aside form familiarity with the CMPD, it offers little advantage in clinical utility
Milinkovic & Tiliopoules (2020) Australia	Systematic review	20 included studies	The purpose of the review was to determine the current clinical utility of the AMPD objectively and comprehensively and to propose plausible future research direction through the identification of areas for improvement.	The convergent, narrative synthesis of results was largely in support of the AMPD's clinical utility. This study found that the AMPD's clinical utility is consistent with findings of previous research into dimensional approaches in contrast to categorical approaches.
Nelson et al. (2017) America	Survey design	n = 329, 32.2% students on predoctoral internship, 40.1% currently enrolled in PhD program, and 27.7% enrolled in a PsyD	The purpose of the study was to evaluate the clinical utility of the SWAP-II the DSM-5 Section III trait model,	This study found that clinicians rated the AMPD significantly higher in most clinical utility domains and that the AMPD was the easiest and most useful on several areas. Notably, the AMPD provided a comprehensive understanding of patients.

		program	DSM-5 Section III specific PD model, and the PDM prototypes in graduate students and interns, as applied to their current patients.	
Samuel & Widiger (2006) America	Survey design	n = 245 members from the division 42 of the American Psychiatric Association.	The purpose of this study was to evaluate the clinical utility of the Five Factor Model and CMPD by rating each model on six aspects of clinical utility.	Both models were applied in consistent ways. The CMPD was consistently rated lower in four of the six aspects of clinical utility. It was rated lower for its ability to provide a global description of the individual's personality, communication with patients, encompassing all of the patient's important personality difficulties, and assisting clinicians with treatment planning.
Sprock (2003) America	Survey design	Two national samples of 185 (n = 93, n= 92) practicing psychologists matched on age, sex and stratified geographic region.	The purpose of this study was to determine whether a general sample of practicing psychologists could reliably use dimensional models to diagnose a series of case vignettes depicting various personality disorders and to examine perceived clinical usefulness of the dimensional models.	The results of this study found that clinical utility for the CMPD was highest even though interrater reliability was poor.
Krueger et al. (2014) America	Qual		The purpose of this article was to review the AMPD model, focusing on how it contrasts with the CMPD.	The AMPD has many forward-thinking aspects such as the inclusion of a conceptualisation of the overall extent of personality psychopathology in the domains of the self and interpersonal functioning that distinguishes personality pathology from health and other classes of disorder. This inclusion of dimensional aspects such as the

				AMPD in the DSM could result in enhanced clinical utility.
Garcia et al. (2018) America	Vignette methodology?	n = 13 Advanced clinical psychology doctoral students at a large university in the south-eastern United States	The purpose of this study was to examine the learnability, interrater reliability, and clinical utility of the AMPD using a vignette methodology and graduate student raters	The study showed that student clinicians can learn the AMPD to a high level of interrater reliability and agreement with expert ratings. Interrater reliability of the 25 traits facets of the AMPD varied but showed overall acceptable levels of agreement. The level of personality functioning (LPF) added information beyond that of global assessment of functioning (GAF). Clinical utility ratings were generally strong. This indicates that the AMPD is very learnable.
Waugh et al. (2017) America	Qual		The purpose of this article was to introduce the AMPD to practitioners while highlighting its roots in established paradigms of personality assessment, review its clinical utility and validity and demonstrate its application via a case example	The AMPD represents an innovative system for simultaneous psychiatric classification and psychological assessment of personality disorders. It combines major paradigms of personality assessment and provides an original, heuristic, flexible, and practical framework. The AMPD facilitates case conceptualisation, is easy to learn and use and it assists in providing patient feedback.
Bach et al. (2015) Denmark			The purpose of this study was to evaluate the clinical utility of the AMPD	This study generally supported the clinical utility of the AMPD while identifying areas for refinement.
Morey & Benson (2016) America	Survey	n = 377 doctoral-level psychologists (213) or psychiatrists (85)	The purpose of this study was to determine whether the constructs of the AMPD are more closely related to clinicians' treatment-related decision-making processes than those of the CMPD.	The AMPD demonstrated stronger relationships to 10 of 11 clinical judgements regarding differential treatment planning, optimal treatment intensity, and long-term prognosis than the CMPD. The AMPD can provide more clinically useful information for treatment planning.

Bornstein & Natoli (2019) America	Meta-analysis	11 studies	The purpose of this study was to synthesise extant findings of utility ratings of categorical and dimensional PD frameworks using meta-analytic techniques	The CMPD received lower ratings for most clinical utility domains. Stronger results were obtained for ratings of actual patients than ratings for case vignettes.

Addendum B

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North-West University Health Research Ethics Committee (NWU-HREC)

Tel: 018 299-1206
Email: Ethics-HRECApply@nwu.ac.za (for human studies)

09 July 2021

ETHICS APPROVAL LETTER OF STUDY

Based on approval by the North-West University Health Research Ethics Committee (NWU-HREC) on 09/07/2021, the NWU-HREC hereby approves your study as indicated below. This implies that the NWU-HREC grants its permission that, provided the general conditions specified below are met and pendingany other authorisation that may be necessary, the study may be initiated, using the ethics number below.

Study title: A systematic review of the clinical utility of the categorical and alternative models of personality disorders
Principal Investigator/Study Supervisor/Researcher: Dr R Spies
Student: M Janse van Rensburg- 25930060

Ethics number:

N	W	U	-	0	0	2	0	9	-	2	1	-	A	1
Institution				Study Number						Year			Status	

Status: S = Submission; R = Re-Submission; P = Provisional Authorisation; A = Authorisation

Application Type: Systematic review
Commencement date: 09/07/2021
Expiry date: 31/07/2022

Risk: **Minimal**

Approval of the study is provided for a year, after which continuation of the study is dependent on receipt and review of an annual monitoring report and the concomitant issuing of a letter of continuation. A monitoring report is due at the end of July annually until completion.

General conditions:

While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, the following general terms and conditions will apply:

- *The principal investigator/study supervisor/researcher must report in the prescribed format to the NWU-HREC:*
  - *Annually on the monitoring of the study, whereby a letter of continuation will be provided annually, and upon completion of the study; and*
  - *without any delay in case of any adverse event or incident (or any matter that interrupts sound ethical principles) during the course of the study.*
- *The approval applies strictly to the proposal as stipulated in the application form. Should any amendments to the proposal be deemed necessary during the course of the study, the principal investigator/study supervisor/researcher must apply for approval of these amendments at the NWU-HREC, prior to implementation. Should there be any deviations from the study proposal without the necessary approval of such amendments, the ethics approval is immediately and automatically forfeited.*
- *Annually a number of studies may be randomly selected for active monitoring.*
- *The date of approval indicates the first date that the study may be started.*
- *In the interest of ethical responsibility, the NWU-HREC reserves the right to:*
  - *request access to any information or data at any time during the course or after completion of the study;*
  - *to ask further questions, seek additional information, require further modification or monitor the conduct of your research or the informed consent process;*

- *withdraw or postpone approval if:*
  - *any unethical principles or practices of the study are revealed or suspected;*
  - *it becomes apparent that any relevant information was withheld from the NWU-HREC or that information has been false or misrepresented;*
  - *submission of the annual monitoring report, the required amendments, or reporting of adverse events or incidents was not done in a timely manner and accurately; and/or*
  - *new institutional rules, national legislation or international conventions deem it necessary.*
- *NWU-HREC can be contacted for further information via Ethics-HRECApply@nwu.ac.za or 018 299 1206*

Special conditions of the research approval due to the COVID-19 pandemic:

Please note: Due to the nature of the study i.e. (systematic review of previously published manuscripts), this study will be able to proceed during the current alert level, following receipt of the approval letter. No additional COVID-19 restrictions have been placed on the study except that the researcher must ensure that before proceeding with the study that all research team members have reviewed the North-West University COVID-19 Occupational Health and Safety Standard Operating Procedure.

The NWU-HREC would like to remain at your service and wishes you well with your study. Please do not hesitate to contact the NWU-HREC for any further enquiries or requests for assistance.

Yours sincerely,

Digitally signed by
Prof Petra Bester
Date: 2021.07.12
16:22:46 +02'00'

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